



CHIME Policy Webinar: Meeting CMS Compliance Deadlines on Alerts & Price Transparency

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Today's Panelists



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Topics Covered Today

- 1. Real time benefits tools** - Learn how this is empowering patients and the impact it will have on Part D subscribers and providers
- 2. Admission, discharge and transfer alerts** – The May 1 compliance deadline is right around the corner. We'll give an overview of what is required and different ways to comply.
- 3. Price transparency requirements** – By January 1, hospital compliance is required. Detailed pricing information must be made public by this date.



Overview of Deadlines

Mandate	Finalized / Delayed to
Price Transparency - Providers	January 1, 2021
ADT	May 1, 2021
RTBA – for prescribers	Jan. 1, 2021
RTBA – for beneficiaries	January 1, 2022 (proposed)
Price Transparency – Payers – part 1	January 1, 2023
Price Transparency – Payers – part 2	January 1, 2024

[UPDATED Cheat Sheet - 2021 Health IT Compliance deadlines](#)



Price
Transparency
Requirements



Executive Order



- On June 24, 2019 President Trump published an [executive order](#) taking aim at ensuring patients have access to information about the cost and quality of their care. The EO says:

Patients often lack both access to useful price and quality information and the incentives to find low-cost, high-quality care. Opaque pricing structures may benefit powerful special interest groups, such as large hospital systems and insurance companies, but they generally leave patients and taxpayers worse off than would a more transparent system.

Price Transparency - Hospitals

- **Comprehensive Machine-Readable File:** Hospitals must make public all hospital standard charges for all items and services on the Internet in a single data file that can be read by other computer systems.
- **Display of Shoppable Services in a Consumer-Friendly Manner:** Hospitals must make public payer-specific negotiated charges for 300 common shoppable services (including 70 CMS-specified and 230 hospital-selected) in a manner that is consumer-friendly and update the information at least annually.
- **Effected Hospitals:** Medicare-enrolled institutions that are licensed as hospitals and any non-Medicare enrolled institutions that are licensed as a hospital.
- **Enforcement:** Failure to comply could result in a penalty of up to \$300 per day.
- **Background materials:** A CMS Fact Sheet is [here](#). The final rule is [here](#). CMS website [here](#).
- **Compliance date:** **January 1, 2021.**



Price Transparency - Payers

- **Joint rule:** Published by HHS, Dept. of Labor & Treasury Dept.
- **Consumer tool:** Finalizing a requirement to give consumers real-time, personalized access to cost-sharing information, including an estimate of their cost-sharing liability, through an internet based self-service tool
- **Effected Payers:** This rule will require most group health plans, and health insurance issuers in the group and individual market to disclose price and cost-sharing information to participants, beneficiaries, and enrollees
- **Publicly available info:** Payer also required to disclose on a public website their in-network negotiated rates, billed charges and allowed amounts paid for out-of-network providers, and the negotiated rate and historical net price for prescription drugs.
- **Background material:** CMS Fact sheet [here](#). The final rule is [here](#).
- **Compliance date:**
 - **January 1, 2023:** An initial list of 500 shoppable services (TBD) will be required to be available via the internet based self-service tool for plan years that begin on or after this date.
 - **January 1, 2024:** The remainder of all items and services will be required for these self-service tools for plan years that begin on or after this date.



Real Time Benefit Tools

Going Back in Policy Time Machine...

- Where were you in 2003? We've come a long way....seventeen years later

2003

- **eRrxg rates:** only 5 percent and 18 physicians using erxg

Fun Fact

- **One of the top songs in the US - [The Black Eyed Peas - Where is the Love? \(2003 Music Video\) | #3 Song \(playback.fm\)](#)**

2020

- **eRrxg rates:** More than 86% and EPCS soon to be mandated

Fun Fact

- **One of the top songs in the US - [Memories by Maroon 5 | Billboard The Hot 100 Chart](#)**

Statutory Authority Originates with MMA

- **2003:** [Medicare Prescription Drug, Improvement and Modernization Act \(MMA\)](#) signed into law
 - Creates new, voluntary prescription drug benefit program (aka Part D, Section 101)
 - Requires the adoption of Part D E-Prescribing (eRx) standards.
 - Contains provisions around “providing information to beneficiaries” including comparative information on cost and quality
 - Requires use of eprescribing standards
 - To the degree feasible, information exchanged shall occur in a real-time, interactive basis
- **2005:** CMS publishes final rule requiring plan sponsors comply with erxg standards before the drug benefit begins
- **2006:** Coverage for new benefit becomes effective



1860D-4(e)(2)(D)- Just what does this say?

(e)[482] ELECTRONIC PRESCRIPTION PROGRAM.—

(1) APPLICATION OF STANDARDS.—As of such date as the Secretary may specify, but not later than 1 year after the date of promulgation of final standards under paragraph (4)(D), prescriptions and other information described in paragraph (2)(A) for covered part D drugs prescribed for part D eligible individuals that are transmitted electronically shall be transmitted only in accordance with such standards under an electronic prescription drug program that meets the requirements of paragraph (2).

(2) PROGRAM REQUIREMENTS.—Consistent with uniform standards established under paragraph (3)—

(A) PROVISION OF INFORMATION TO PRESCRIBING HEALTH CARE PROFESSIONAL AND DISPENSING PHARMACIES AND PHARMACISTS.—An electronic prescription drug program shall provide for the electronic transmittal to the prescribing health care professional and to the dispensing pharmacy and pharmacist of the prescription and information on eligibility and benefits (including the drugs included in the applicable formulary, any tiered formulary structure, and any requirements for prior authorization) and of the following information with respect to the prescribing and dispensing of a covered part D drug:

(i) Information on the drug being prescribed or dispensed and other drugs listed on the medication history, including information on drug-drug interactions, warnings or cautions, and, when indicated, dosage adjustments.

(ii) Information on the availability of lower cost, therapeutically appropriate alternatives (if any) for the drug prescribed.

(B) APPLICATION TO MEDICAL HISTORY INFORMATION.—Effective on and after such date as the Secretary specifies and after the establishment of appropriate standards to carry out this subparagraph, the program shall provide for the electronic transmittal in a manner similar to the manner under subparagraph (A) of information that relates to the medical history concerning the individual and related to a covered part D drug being prescribed or dispensed, upon request of the professional or pharmacist involved.

(C) LIMITATIONS.—Information shall only be disclosed under subparagraph (A) or (B) if the disclosure of such information is permitted under the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

(D) TIMING.—To the extent feasible, the information exchanged under this paragraph shall be on an interactive, real-time basis.



Brings us to present day

- Case for transparency is originally rooted in MMA
- Bi-partisan support for increasing transparency for consumers
- Trump transparency rules related to RTBT also point back to his [Executive Order](#)

CMS is delivering on price transparency, because patients have a right to know the cost of their healthcare services before they receive them.

- CMS Administrator Seema Verma.



Evolution of Part D Requirements

- **2019:** In May CMS [finalizes](#) Part D price transparency requirements
- **2020:** Use of the NCPDP SCRIPT standard became mandatory on January 1.
- **2021:** Use of a real-time benefit tool (RTBT) for *prescribers* becomes mandatory
- **2022:** In February 2020 CMS [proposed](#) calling for Part D plan sponsors to implement, no later than January 1, 2022, a *beneficiary* real-time benefit tool (RTBT)

RTBT Mandates Prescribers



CMS Finalizes Part D Price Transparency

- [Rule](#) requires Part D plans support a prescriber electronic real-time benefit tool (RTBT) capable of integrating with at least one e-prescribing or electronic health record (EHR) system ([CMS Fact Sheet](#))
- Plans must adopt tools that give clinicians information they can use to discuss with patients out-of-pocket costs for Rx drugs when script is written
- Aims to avoid costly surprises at the pharmacy counter
- After an implementation period requires:
 - Plans required to provide access to such a tool that is integrated into clinicians' erxg or EHR systems.
 - Explanation of Benefits document that patients receive each month to include information on drug price increases and lower-cost therapeutic alternatives.
- **Compliance date: January 1, 2021 (prescriber RTBT)**



Q. *Must RTBT include drugs' applicable cash price, beneficiary copayment, any drug utilization controls, or side effects of alternative therapies presented?*

A. Some minimal data to allow prescribers and patients to make informed medication choices at the point of prescribing is required.

CMS says, “These include benefit information about the drug which the provider intends on prescribing, enrollee cost-sharing information, and comparable information on formulary alternatives (meaning those medications that may have a different copayment or coinsurance amount than the medication about to be prescribed but may have the same therapeutic efficacy). The benefit information should include patient-specific utilization requirements (such as prior authorization or step therapy requirements) that have yet to be satisfied at the time when the prescription is written, and copayment or coinsurance (or negotiated price values if included) at the patient’s selected pharmacy.”



Q. Must RTBT include the negotiated price?

A. No.

CMS says, “although we encourage the inclusion of the negotiated price in RTBT, we are not mandating it at this time as the majority of commenters opposed its inclusion stating that the information was proprietary and overly confusing.”

Q. Did CMS adopt a RTBT standard?

- A. No. Since there are no industry-wide standards for RTBTs, they did not adopt a standard at this time.

CMS writes, “existing SCRIPT standard allows them a means to conduct electronic prescribing, while the F&B standard allows a prescriber to see what is on the plan’s formulary. However, neither of those standards can convey patient-specific real-time cost or coverage information that includes formulary alternatives or utilization management data to the prescriber at the point of prescribing.”

They also add, "We believe many EHRs are moving to integrate RTBTs into prescribers' works flows. In addition, since RTBTs are variable in their functionality it would be difficult for ONC to incentivize use of RTBT until an industry standard is implemented and tested."



Q. *What is required?*

- A. CMS is requiring Part D plans implement at least one RTBT of its choosing that is capable of integrating with at least one prescriber's eRx system or EHR to provide prescribers with complete, accurate, timely and clinically appropriate patient-specific real-time formulary and benefit (F&B) information to include:
- Cost;
 - Formulary alternatives; and
 - Utilization management requirements by January 1, 2021.

Q. *What minimal data points must be included in the RTBT?*

1. Benefit information about the drug which the provider intends on prescribing
NOTE: The benefit information should include patient-specific utilization requirements (such as prior authorization or step therapy requirements) that have yet to be satisfied at the time when the prescription is written
2. Enrollee cost-sharing information, and
3. Comparable information on formulary alternatives (meaning those medications that may have a different copayment or coinsurance amount than the medication about to be prescribed but may have the same therapeutic efficacy).

Q. Must providers seek affirmative consent from patients before using the RTBT?

A. No. CMS considered requiring this but ultimately did not require it.

CMS writes, “In most instances, we expect that the choice about what prescription to prescribe will happen when a beneficiary is present, because the current ePrescribing standard requires the beneficiary to choose where the prescription is to be sent. This means they will be aware that their data will likely be transmitted to parties other than the prescriber.”

RTBT Mandates
Beneficiaries



Real-time Benefit Alerts (RTBAs)

- On February 18, 2020 CMS issued a proposed rule calling for Part D plan sponsors to implement, no later than January 1, 2022, a beneficiary real-time benefit tool (RTBT)
- While CMS issued a final rule on May 16, 2020 addressing many of the items in the proposed rule, they punted on several items noting they would address them in a separate final and forthcoming rule.
- One of the things that was not yet finalized was was the beneficiary RTBT proposal.
- There is a final rule awaiting [OMB approval](#) – likely to get finalized before Administration changes

What Would the Tool Have to Do?

- This tool would allow enrollees to view a plan-defined subset of the information included in the prescriber RTBT system to include:
 - Accurate,
 - timely, and
 - clinically appropriate patient-specific real-time formulary
- And benefit information including:
 - Cost,
 - Formulary alternatives and
 - Utilization management requirements.



Encouraging Patient Use of the Tool

- CMS will allow plans to offer rewards and incentives (RI) to patients who log onto the beneficiary RTBT or seek to access this information via the plan's customer service call center.



Portals & Call Centers

- Plans would be permitted to:
 - Use existing secure patient portals to fulfill this requirement,
 - Develop a new portal, or
 - Use a computer application.
- Plans would be required to make this information available to enrollees who call the plans' customer service call center.



Cost to Implement a RTBT

- CMS says the adoption of a beneficiary RTBT will be an additional cost and burden on Part D sponsors.
- The Agency estimates this will cost Part D plans about \$3.9 million for all plans in the first year based on the costs for them to reprogram their computer systems.
- And, if rewards are offered to patients by Part D sponsors for using a RTBT that this could cost \$0.7 million in the first year, in order to implement the program, and \$0.4 million in subsequent years in order to maintain the program.

Resources

- **May 16, 2019 – Medicare Advantage and Part D Drug Pricing Final Rule (CMS-4180-F)**
 - [Fact Sheet](#)
 - [Rule](#)
- **February 18, 2020 - Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly [CMS-4190-P]**
 - [News release](#)
 - [Rule](#)
- **May 22, 2020 - Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program [CMS-4190-F]**
 - [Fact Sheets](#)
 - [Rule](#)



Admission, Discharge & Transfer



New Requirement under Medicare CoP

- Certain hospitals will be required to send electronic notifications of admission, discharge or transfer (ADT) to certain applicable providers where they have certified EHR systems capable of sending such notices.
- Intended to:
 - foster better care hand offs and coordination between acute and post-acute settings
 - reduce readmissions
 - Improve information sharing and interoperability
 - Builds on CMS' hospital discharge planning rule
- **Compliance date: May 1, 2021**



Who must send notifications?

- Hospitals
- Psychiatric hospital, and
- Critical Access Hospitals (CAHs)

Where Must Notifications be Sent?

- All applicable post-acute care services providers and suppliers PLUS
- Any of the following practitioners and entities, which need to receive notification of the patient's status for treatment, care coordination, or quality improvement purposes:
 - (i)** The patient's established primary care practitioner;
 - (ii)** The patient's established primary care practice group or entity; or
 - (iii)** Other practitioner, or other practice group or entity, identified by the patient as the practitioner, or practice group or entity, primarily responsible for his or her care.

What Information Must be Sent?

- Patient name,
- Treating practitioner name, and
- Sending institution name
- Diagnosis is NOT required but if you have it's ok to send

Electronic Patient Notifications Required When it Meets these Requirements

- ✓ Are you a hospital, psychiatric hospital, or CAH that use an EHR or other electronic administrative system?
- ✓ Is your system conformant with the HL7 2.5.1 content exchange standard?

NOTE: Notification mandate is limited to hospitals with EHR systems with the technical capacity to generate information for electronic patient event notifications.



If you answer “yes” then you must demonstrate....

1. Your system notification capacity is fully operational and used in accordance with all state / federal statutes & regulations applicable to the hospital’s (or CAH’s) exchange of patient health information;
2. You sending notifications either directly, or through an intermediary that facilitates exchange of health information consistent with patient privacy preferences;
3. The notifications include at least patient name, treating practitioner name, and sending institution name; and
4. That a reasonable effort has been made to send notifications to PACs and other required providers



Are hospitals responsible for sending notifications to providers, including PACs, that do not accept HL7 patient event notifications?

- There is no requirement that patient event notifications be sent using the HL7 Messaging Standard.

Reasonable Effort

A hospital is required to demonstrate that it has made a “reasonable effort” to send patient event notifications to the requisite clinicians or providers

CMS does NOT “expect a hospital’s system to be capable of electronically communicating with every possible provider...or of satisfying every possible preference for delivery of patient event notifications that a provider, facility, or practitioner might attempt to impose on the hospital.”

Standard for transmitting information

- A hospital must meet the notification requirement that is triggered in part by whether their system is conformant with the HL7 2.5.1 content exchange standard (meaning it has the capability to send notifications)
- However, CMS did not specify a format, content or transport method for patient event notifications.
- CMS also did not mandate that a hospital use CEHRT capabilities to perform the notifications.
- CMS even clarifies that “many successful patient event notification implementations have used the content of HL7 messages in conjunction with other forms of transport, such as Direct messages.”



Variability in how ADT is Currently Used

- CMS recognizes there is significant variation in how hospitals have utilized the ADT messages to support implementation of patient event notifications.
- Many hospitals using alerts may be delivering additional information beyond the basic information included in the ADT message (both automatically and upon request) to receiving providers with whom they have established patient care relationships and agreements for patient health information exchange as allowed by law

Use of Intermediaries



CMS permits their use to deliver patient notifications



However, if a hospital is using an intermediary today and they are only sending to some of the requirement recipients but not all, they would be out of compliance

Resources

- [CHIME Cheat Sheet on ADT](#)
- [Key ONC & ONC Interoperability and Information Blocking Timelines](#)
- [Updated FAQ document on ADT mandate](#)



Panel Discussion



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