

PROVIDER STABILITY ACT



For nearly four years, the Tennessee Medical Association and several other healthcare advocacy organizations pushed for passage of legislation to address problems physicians and other healthcare providers incurred due to business practices of health insurance carriers. TMA heard from members and medical group practice administrators that health plans would, unilaterally and without notice, change terms of provider fee schedules, change provider reimbursement policies and lower reimbursement, fail to timely provide copies of fee schedules or fail to submit fee schedules in a usable format. Providers had difficulty fighting back because they often did not even have a copy of their fee schedule from the carrier and/or had provisions in their provider agreements that effectively allowed health insurance companies to change policies and reimbursement unilaterally and without notice.

Practices overwhelmingly expressed frustration that they had planned the services they would offer for the year, the healthcare personnel they would use, and their practice operations based on reasonably predictable reimbursement expectations, only to have the carrier reduce their reimbursement without notice in mid-contract. These unfair business practices forced clinical service and job curtailments and abrupt operational interruptions that negatively impacted patient care.

In 2017 the Tennessee General Assembly finally addressed these issues through bipartisan legislation sponsored by Senator Bo Watson (R-Hixon) and Representative Cameron Sexton (R-Crossville).

SCOPE OF THE LAW

There are three general areas of health insurance carrier law that the Provider Stability Act addresses: **provider fee schedule accessibility, changes made to provider fee schedules, and changes made to reimbursement rules and policies**. The law is effective on **January 1, 2019**.

The scope of the law is Tennessee commercial health plan contracts with healthcare providers for the provision of healthcare services and commercial health plan policies that affect contracted provider reimbursement for healthcare services to the plans' members.

There are exceptions specific to particular subsections of the law. However, the following exceptions apply to the entire Provider Stability Act. Thus, the Act **does not** apply to:

- An enrollee's benefit package, or coverage terms and conditions, unrelated to application of fee schedules and reimbursements, including, but not limited to, provisions regarding eligibility for coverage, deductibles and copayments, coordination of benefits, and coverage limitations and exclusions.
- An entity that is subject to delinquency proceedings, receivership, or supervision by the commissioner of commerce and insurance.
- A contract amendment that is made due to a change in federal or state law.
- A contract between a health insurance carrier and a healthcare provider for items or services to be provided for individuals covered by any Medicare Advantage, Medicare Select, Medicare Supplement, Medicare and Medicaid Enrollees (MME), Medicare Dual Special Needs, and Medicare Private Fee for Service; or the state, local government, and local education insurance plans.
- The TennCare program, CoverKids, Access Tennessee, or any other plan managed by the Tennessee Department of Health Care Finance & Administration.

ACCESS TO YOUR FEE SCHEDULE

A contracted healthcare provider is entitled to a copy of the provider's fee schedule from a commercial health insurance carrier according to amendments to TCA 56-7-1013. There are two processes by which the fee schedule may be accessed.

- First, a health plan can provide a copy of the fee schedule pursuant to a written request from the provider. The request must be fulfilled by the carrier within ten (10) business days of receipt. The carrier will email it to the provider's dedicated email address, free of charge, in either a partial or full version as requested by the provider, in a transferable industry standard spreadsheet, including Microsoft Excel or other comparable format.
- The second option the carrier has is to provide access via a secure website. That way, the fee schedule can be accessed at any time as long as the provider remains contracted with the carrier.

The carrier can decide whether it will offer access to provider fee schedules one way or the other, or both.

TMA Guidance:

If you contemplate submitting notice to a carrier that you intend to terminate a provider agreement, or if you receive notice from the carrier that you might be terminated from the carrier's provider network, TMA advises you to access the fee schedule in order to preserve it, since access will be cut off once you are no longer contracted.

The law does not require health insurance carriers to provide fee schedules using a website. Again, the plan can choose to email the fee schedule to the provider, only allow access on a secure website, or both.

CHANGES TO YOUR FEE SCHEDULE

There are two issues addressed regarding health insurance carrier changes to your fee schedule, notice of the change and how often changes can be made.

Notice of Fee Schedule Change

Unless an exception applies, amendments to TCA 56-7-103 require commercial health insurance carriers to give providers at least 90 days' notice of a change to their fee schedule before the effective date of the change. Notice shall be sent to a dedicated email address or as otherwise stipulated in the contract between the provider and the health insurance carrier. The law requires providers to submit a dedicated email address to the health insurance carrier in order to receive notices of fee schedule changes. The notice requirement does not apply to changes in standard codes and guidelines developed by the American Medical Association or a similar organization.

TMA Guidance:

Contact each commercial health insurance carrier with which you contract prior to the effective date of the law to find out how you must submit the dedicated email address to the carrier in order to receive notices of fee schedule changes. TMA also advises that you not submit dedicated email addresses specific to a person to ensure the practice receives timely information from the health plan in the event a staff member leaves employment or is on extended leave. Make sure the generic email address is always tied to a position in the practice which is occupied.

Don't use: Jane.Doe@ABCMedicalPractice.com

Do use: Administrator@ABCMedicalPractice.com but make sure emails are monitored by a current employee.

Frequency of Changes to Fee Schedule

Unless an exception applies, a carrier may only make a change to a provider's fee schedule up to one (1) time during a consecutive 12-month period. After a carrier makes a change or changes to the provider's fee schedule, it is prohibited from doing so again for at least 12 months following the effective date of the change or changes.

Exceptions to law regarding changes to your fee schedule

As mentioned above, there are exceptions that allow health insurance carriers to make changes to your fee schedule without notice, and the limit on fee schedule changes will not apply. Those exceptions include:

- Any change in a provider's fee schedule due to a change effected by the federal or state government to its healthcare fee schedule, if the provider and health insurance carrier have previously agreed that the provider's fee schedule is based on a percentage or some other formula of a current government healthcare fee schedule, such as Medicare.
- Any change in a provider's reimbursement for drugs, immunizations, injectables, supplies, or devices if the provider and health insurance carrier or pharmacy benefits manager as defined by § 56-7-3102 have previously agreed that any reimbursement for drugs, immunizations, injectables, supplies, or devices will be based on a percentage, or some other formula, of a price index not established by the health insurance carrier, such as the average wholesale price or average sales price.

- Any changes in the provider's reimbursement for drugs, immunizations, injectables, supplies, or devices if the provider and the health insurance carrier or pharmacy benefits manager as defined in § 56-7-3102 have previously agreed to any reimbursement for drugs, immunizations, injectables, supplies, or devices in accordance with § 56-7-3104 and based upon maximum allowable cost pricing as regulated by §§ 56-7-3101 and 56-7-3106.
- Any change to Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, International Statistical Classification of Disease and Related Health Problems (ICD) Codes, or other coding sets recognized or used by CMS that a health insurance carrier utilized in creating a provider's fee schedule.
- Any change to revenue codes as established by the National Uniform Billing Committee (NUBC).
- Any changes in a provider's fee schedule due to one (1) or more of the following if previously agreed to in a provider's agreement with a health insurance carrier:
 - Payments made to the healthcare provider by the health insurance carrier or payments made to the health insurance carrier by the provider that are based on values or quality measures explicitly described in the written agreement between the provider and the health insurance carrier intended to improve care provided to the health insurance carrier's members;
 - Escalator or de-escalator clauses;
 - Provisions that require adjustments to payment due to population health management performance or results; or
 - Any arrangements, initiatives, or value-based payments relating to or resulting from the implementation or operation of the Tennessee episodes of care program.

CHANGES TO HEALTH PLAN REIMBURSEMENT RULES AND POLICIES

Amendments to TCA 56-7-3302 require commercial health insurance carriers to give 60 calendar days' notice to a healthcare provider in the carrier's network prior to implementing a material change to the carrier's provider manual, reimbursement rules, policies, or other similar vehicle developed by the carrier, including a carrier's medical policies. The requirement of this notice only applies to changes made in the carrier's sole discretion, and is applicable to changes that both increase or decrease the level of a provider's reimbursement for any service or procedure performed pursuant to the provider's contract with a carrier.

Changes by a health insurance carrier to its provider manual or reimbursement rules and policy may be disclosed to you in two ways.

- First, changes to provider manuals must be identified through the use of bold print or a font, or both, with the bold print or font being the same or larger size as the font generally used throughout the policy or manual.
- Second, by disclosing or identifying the change in the reimbursement rules and policies and the effective date of the change through the use of a separately categorized communication to the provider.

Providers will receive these identified changes to carrier reimbursement rules and policies either through an Internet posting or written communication to your dedicated email address.

TMA Guidance:

Find out before the effective date of the law how each carrier wants you to register your dedicated email address, as also suggested in changes to your fee schedule.

The law regarding notice to a provider of changes to carrier reimbursement rules and policies does not apply to the TennCare program, CoverKids, Access Tennessee, or any other plan managed by the Tennessee Department of Health Care Finance & Administration or to the state employee health insurance plan. Nor does the law apply to any federal programs such as Medicare, Medicare Advantage, or TriCare.

*TMA members who believe that a health plan violated this law should **submit a complaint to the Tennessee Department of Commerce and Insurance.***

QUESTIONS?

Contact TMA's legal department at 615.385.2100 or legal@tnmed.org for help with this or any other healthcare law.