SB 209 Work Group Meeting

Transcript

Webinar

Meeting leader – Clint Farr

Meeting transcriber - Clint Farr

Note from transcriber – to the best of my abilities I transcribed the work group meeting word for word. There are times where speakers cannot be identified. There are other times where language was lost due to people talking over one another or a beep or electronic notification masked the words. I cannot attest to this transcript then being exact, but is the best I could do.

November 20, 2018

Clint Farr (CF) (Speaking to slides 1 and 2) – Good morning everyone. Thank you for joining us. My name is Clint Farr. I'm with the Alaska Health Analytics and Vital Records at the Divisions of Public Health at the Department of Health and Social Services. We're probably going to have people sort of filtering in over the next five minutes as we get going. I apologize if a little beep or something cancels out a word or what not. But we've got a lot of ground to cover today. And, uh, hopefully we can get some things discussed in the next couple of hours.

(Speaking to slide 3) So, let's see here, let's go on to this slide here. Just a welcome slide. Today we're going to discuss the cost transparency portions of this, of this, bill, SB 105. Discussions today will include identifying those who have to comply with the bill, the process to comply, timing of reports and posts, and more. Alaska department of health an social services is tasked with implementing and enforcing this bill's language, a task that has filtered down to the section of Health Analytics and Vital Records and then on to me. What we learn today will inform department of health and social services on how to implement programmatic changes within the department to administer this bill. And I apologize up front that I am neither a health professional nor lawyer. And I know there will be a number of questions that come up that I cannot answer. However, we are recording this meeting and it will be transcribed. And I endeavor to get those transcriptions to people who are interested. So during the course of the meeting, please put your name and who you represent and, uh, an email in the chat box. One of the nifty things of the webex is that I can save the chat box and, and, it becomes a document, and so I can cover that.

(Speaking to slide 4) Slide 3 here. The purpose of the meeting. We're not starting at zero, let's do just a quick, a really broad overview of the bill. And then I'm going to get into, uh, some introductions here in a little bit. But I just want to make sure for folks that are on the phone that we are talking strictly about the provisions of the bill involving health care service price information. There is language in the bill on maritable, marital, maritable, marital and family therapists and we are NOT addressing those issues. Specifically, again, we're here to talk about the provisions involving posting health care prices, submittal of health service prices to department of health and social services, and provision of health service price estimates. And we'll get into those specifics here in just a bit.

(Speaking to slide 5) So health and social services must change programmatic functions to –oh, let me get this out of the way here, there it is, where's my, where's my mouse, well, I'll worry about that later. We must change programmatic functions to address the health care service pricing provisions in SB 105.

And that is why we're here today. Basically, today's meeting is to begin identifying the bare minimum of requirements that health and social services, and the impacted community, must meet to comply with SB 105 while ensuring useful information is available to the public to inform their health care choices.

(Speaking to slide 6) Now a couple ground rules cause we're on a webinar. And, um, I know I'm kind of flying through these but the purp…purpose is so we can get to the meat of the discussion here in a little bit. But we're on a webinar so a few ground rules for smoother communication. First, pease, please be patient with each other. As we're not in the same room we can't see the clues we give each other when we're in person whether it's okay to jump in or not, so we're probably going to talk over each other on occasion. So it's not personal, um, and it's it's just a product of the format we're in today. Second, given that we cannot see each other, it's also a good idea to give us an "I'm done" or "over and out" when you're finished speaking so another person can add their thoughts. And third, it's not uncommon for two or three people in a format like this to start at once. So please preface your statement with a, "Hey, I've got a question," or "I've got something to add," so that if you're talked over, we haven't lost good information. And fourthly, (which I don't, is that a word?) I'll be monitoring the webinar chat box. So feel free to put your questions and comments in there and I'll make sure they're brought up. We are recording this meeting again, so I intend to have minutes available. And probably again the easiest thing is to put your name and email in the chat box. And I see many of you are already doing that.

Okay. And I see Jeannie, you've uhhh…

Heidi Lengdorfer (HL) – It looks like Debbie Lowenthal.

Clint Farr (CF) – Oh Debbie, Debbie's, Debbie's coming in. I see your note there Debbie and and thank you for that, and, uh, I will make sure Jeannie gets the minutes of the meeting. Thank you for that.

(Speaking to slide 7) Okay. Introductions. So I know that there's quite a few people on the phone now and that's pretty exciting. So, ah, the way, what I'm going to, how I'm going to do this is, uh, by geography. So, um, wouldn't mind if folks who are not in Fairbanks, Anchorage, or Juneau. Anybody outside of the three largest communities in Alaska, if you could, uh, just say your name and who you're with.

Matt Eisenhower (ME) – Hi this is Matt Eisenhower with Peace Health Ketchikan Medical Center.

CF – Thank you sir. Anyone else outside of the big three? … Okay. Is there anybody calling in from Fairbanks?

(Garbled – multiple people talking)

Keryl Porter – Keryl Porter with Fairbanks Memorial Hospital.

CF - Thank you Keryl. Was there another person fr…from Fairbanks?

Beverly Mcdevitt (BM) - Yes, Tanana Valley Clinic, and actually I'm in a room full of people at Tanana Valley Clinic. My name is Beverly.

CF – Hi Beverly.

BM – Do you want me to introduce everyone in the room?

CF – Oh, no, I think that's okay. I just, it's just good to know who's on, who's listening in. Thank you so much for calling in Beverly.

BM – You're welcome.

Jackie Gahan (JG) - Hey there Clint?

CF – Yes.

JG – This is Jackie Gahan. I'm CDM Manager for Peace Health Systems organization. So we're looking at three states but interested in Alaska's senate bill.

Clint Farr (CF) – Okay, thank you for that…Alright. So we have, have, so those are the Fairbanks folks, and, uh, down here in Juneau is myself…

Heide Lengdorfer (HL) – Heide Lengdorfer, I'm the section chief for health analytics and vital records.

CF – And do we have anybody else on the phone in Juneau?

Debbie Lowenthal - I'm here, Debbie Lowenthal representing ASHNA. Jeannie Monk wasn't able to attend.

CF – Thank you for calling in Debbie.

Jill Lewis (JL) – This is Jill Lewis. I'm Deputy Director for the Division of Public Health.

CF – Thank you for calling in Jill. Anybody else on? Juneau.

Kim Laird – This is Kim Laird. I work with Health Facilities Data Reporting.

CF – Thank you Kim. Anybody from, uh, any hospital? Or from a clinic? Or a facility in Juneau? … Okay. And now Anchorage. Um, so it's probably quite a few people from Anchorage. Uh, do we have folks from the, from the, the larger, larger facilities, like Providence or Humana on? … Or Alaska Regional or Alaska Native Tribal Health Consor…Mat-Su? Any of those?

Brice Alexander (BA) – Well, I'm Brice Alexander. I'm with the Anchorage Pediatric Group. And …

CF – …Thank you…

BA – … representing Alaska MGMA.

CF – Thank you Brice. Is there anyone else from Anchorage on?

(Garbled – multiple people talking)

Cheryl Rinehart (CR) - Cheryl Rinehart from the Alaska Spine Institute.

CF – Thank you Carol. And there was another person there.

CR – It's actually Cheryl.

CF – Oh! I'm sorry Cheryl. Sorry about that.

CR – No worries at all.

(Garbled – multiple people talking)

Robert Jasa (RJ) – This is Bob Jasa, from Pacific Cataract and Laser Institute.

CF – And that was Marc?

RJ – Bob…

CF – Bob! (laughs)

RJ - …from Pacific Cataract and Laser. Yeah, that's alright.

Clint Farr (CF) – Thank you Bob. Who else?

Linda Carroll - Hi. This is Linda with Aurora Maternal Fetal Medicine.

CF – Hi Linda. Thank you for calling.

Nancy Baisinger - Nancy from Medical Park Family Care.

CF – Thank you Nancy.

Jenn Heath (JH) – Jenn Health from Geneva Woods Health Supplies.

CF – Was that Kim, I'm sorry?

JH – Jenn.

CF – Jenn. Okay. Gotcha. Thank you so much.

JG - Hey Clint…

CF - …Yeah…

JG - This is Jackie again. I'm going to introduce my director, she's having trouble. I don't think you can hear for some reason. But Mimi Howie is on. She's director of revenue cycle operations for Peace Health. And we're down in Vancouver about. We're listening today.

CF – Okay. Thank you so much…And there is a, there is a way Mimi might be able to have the, um, the webinar call her. Uh, that's a possibility. If you go, (if my mouse would work…there it is), go to …

Heidi Lengdorfer (HL) – At the bottom of the webex there should be a little phone icon and she would be able to click on that …

CF - … click on that, yeah…

HL – And it will give her options…

CF - …including to call a number and that might, that might, help to clear that up.

(00:10:00)

JG – Okay. I know she's listening…

CF – Okay.

JG - …she's just having trouble talking.

CF – Thank you for listening Mimi. Sorry.

HL – Should we move on to some of the professional associations perhaps?

CF – Yeah. And is there? Uh, ah, professional associations? (pause) Okay. Alright. So, if we, if we have not gotten to you, that's okay. Just put your name and, ah, email down in the chat box so we make sure we keep you, uh, uh, uh, informed and in the loop for any future communication.

HL – And if anyone else has not introduced themselves, please go ahead.

Clint Farr (CF) – That too.

Bernice Nisbett – Hi everyone, this is Bernice Nisbett from Ivy Spohnholz's office.

CF – Thank you for calling in Bernice.

Jennifer - This is Jennifer from AA Spine and Pain clinic.

CF – Hi Jennifer.

Mimi Howie (MH) – This is Mimi. Can you hear me now?

CF – I can hear you Mimi!

MH – Yay!

CF – Yay!

Heidi Lengdorfer (HL) – Welcome Mimi.

MH – Thanks.

CF (speaking to slide 8) – So, I think it's important to start, I'm gonna, um, these things are kind of in the way, usually there a little bit over on the side. There we go. I can move those over. Okay, so, we're going to start here with the, just some definitions in the senate bill, and, um, specific to who the bill covers. And, if we look at this, uh, this slide here the health, the, the, the term health care facility is pretty broad. Um, covers a lot of folks. In the senate bill itself, almost all of these, uh, categories have their own definition in statute. I'm not going to go over that today. Um, but, but, residential psychiatric treatment center is defined in Alaska statute. Ah, um, as is, uh, ambulatory surgical center, free-standing birth center, rural health center. And it's also important to note that by definition in the, in 105, health care facility does not include Alaska Pioneer Home, Alaska veteran's home, and and some of these other places that are listed here . Um, so, so, want to, you know, get that out there for, uh, who – in terms of facilities – is covered by the bill.

(Speaking to slide 9) And then also, uh, we have the definitions for insurer and health care provider and what a health care service is. So, just, just for clarification "health care insurer" means a person transacting the business of health care insurance, including an insurance company and it has its own, uh, definition under Alaska statute. A hospital or medical service corporation licensed under a certain Alaska statute, a fraternal benefit society, health maintenance organization, or a multiple employer welfare arrangement among others. Um, so my question here is, yeah, I'm relatively new to this bill, so my

question here for folks, to get it out, is who would I be surprised by that is covered by this, by this bill, by this rule? Um, and I'm thinking in terms of, you know we doctors and nurse facilities and all that stuff is, is, is kind of obvious but what about massage therapists? Or that sort of thing? And so I'm trying to figure out, uh, with your help, what's the…breadth of this?

Linda Carroll (LC) – Well, I take it, this is Linda,

CF – Hi.

LC – I take it that under health care provider that chiropractics and dentists would be included, correct? Or when you say "medical" is simply like…medical?

Clint Farr (CF) - Well, when we look under facility, um, dentist is specifically called out. Um, for sure. Uh, I'm not seeing chiropractry specifically called out but I don't know if, but that doesn't necessarily mean they're not providing a health care service under (n)(6). So you know I'm trying to get a, my arms around the impacted community. Um, and, and, and it, you know, we don't have to answer this now but of course if people have thoughts and, and that sort of thing, I would love to hear 'em. You can email me. And I'll have my contact information at the end of this, end of this, end of this presentation.

Heidi Lengdorfer (HL) – Well, and this is Heidi. I just want to step in here for a moment and say, you know, judging by the definition of health care service, is that something you, your facility, your practice, provide. And I think that's where we're coming from in trying to nail down who are those providing this definition of health service. That may then become a health provider under this bill.

Brice Alexander (BA) – This is Brice with Anchorage Pediatric Group. I'm just compiling a number of questions that Alaska MGMA has in common with one another. One of the big things is not necessarily who the individual is but when we're looking at different departments or specialties or groups and how that plays out. Whether or not each individual department specialty needs to have their own reporting and own lists published or if all these specialties fall under one business name, is it just the one business that needs to publish one list?

CF – Right, and we do, um, bring this up. You know, you notice the red flags are sort of discussion points throughout this presentation and, and, we do talk about that, particularly for the larger facilities that have many many groups, from hospitalists, anesthesiologists, the, and those folks. You know, how does that…do they just get subsumed by the facility's calculation of the, uh, what's supposed to be reported? Or, yeah, is it, is it different? And I don't have an answer right now. So, so, that's a very good question and something that will need to be, we'll need to discuss.

Um, so, so because we still have this question, and then if I can continue on here.

(Speaking to slide 10) Um, just in very broad terms, I'll be referring to providers and facilities, which, uh, basically have disclosure, posting, and reporting of health care service price and fee information requirements. Providers, facilities, and insurance companies have requirements in the bill for good faith estimates for specific procedures. And then for Health and Social Services, we have to accept and publish those prices that are provided by you folks. And, of course, um, we are in, in charge, we've been given the charge of enforcing the bill provisions. And so, you know this is who the bill impacts, in terms of, um, the impacted community.

(Speaking to slide 11) Um, specifically for what's to be reported or compiled, the bill calls for, uh, by January 31 of each year, the impacted entity must compile a list of the top ten services within each of the Current Procedural Technology diagnosis codes for the previous calendar year. And I do want to make clear here that reporting is once a year and reporters do not have to, as far as I can tell, in the bill language, uh do not have to keep the previous year's submittals. Um so those six codes for evaluation and management, are evaluation and management, anesthesia, surgery, radiology, pathology and laboratory, and medicine. Um, and then, we've already brought up the, you know, in terms of the breadth of this, dentists and there may be other groups that are captured by this bill but do not actually use CPT codes. And that was a big question, CPT codes are specifically called out in the bill but groups like dentists and there may be others don't actually use them. So what would they compile, for lack of a better word, to be in compliance with SB 105?

Unknown 1 – Dentists use CDT. Like it says on your slide.

Clint Farr (CF) – Yeah. Yeah. And I don't, and I, and I don't know if I have any dentists on. You know, without it being specifically called out in the bill, um, would use of CDT codes be allowed. Or, are there cross walks between CDT and CBT...

Heidi Lengdorfer (HL) – …CPT...

CF – CPT for certain, for certain procedures?

Unknown – They're completely separate.

HL – Well, this is Heidi again…

CF – They're completely separate.

HL – Well, there we go. The other question is, are there other specialties that use a different common coding taxonomy that we are also not aware of outside of CPT?

CF – Yeah.

Unknown - Uh, I work at (undetermined) medical equipment. We use HCPC (editor: Healthcare Common Procedure Coding System) codes.

HL – Okay.

CF – I'm sorry, that was…

Unknown 2 – HCPC.

CF – Thank you.

Unknown 2 – Yep.

Unknown 3 – That was for home medical?

Unknown 2 – Yeah. It depends on what you're …. Go ahead.

(00:20:00)

Unknown 3 – That brings up another question? Does this rule actually apply to home medical providers, for providing equipment as opposed to more direct care?

HL – So this is Heide Lengdorfer again, my reading of "providing health care services" and, it's been a little while, beside the slide, since I've gone through the bill in its entirety, but I would think that durable medical equipment would not fall under a health care service, on its face. And maybe I'm completely off base with that idea.

Unknown 3 – That's what I'm kind of thinking too.

HL – Okay.

Unknown 3 – But…(pause)

Clint Farr (CF) – Okay. Yeah, I mean, the, uh, a lot of what we're doing today is we're gathering the question. Like I said, we may not have answers, and, um, that's a good, you know, that's a good point to bring up that I had not, had not anticipated yet.

Heidi Lengdorfer (HL) – Are there other code (indistinguishable)?

Suzanne Niemi (SN) – Suzanne, APCA, I have one other question. Um, going back to who's included…

CF – Yeah.

SN - … If I remember from the slide, it talked about private physicians. What about groups that are non-profit organizations?

HL – That's a very good question. (Pause). I think if you go back.

CF – Let's go back.

HL – Yeah.

CF – I don't know if the profit status. (Scrolled back to slide 9).

HL – Yeah. It seems to be licensed or certified.

SN – It says "Office of a private physician or dentist whether in group or individual practices." The community health center in Alaska, the non-tribal ones are non-profit.

Unknown 1 – But most hospitals are non-profit in the state. I can only think of one or maybe two that are for profit.

SN – But it actually talks about hospitals above, "Private, municipal, or state hospitals." And then "private physician or dentists." It does not talk about providers, or NPs (Indistinguishable).

HL - This is Heidi (someone tries to speak). Okay, go ahead.

Jill Lewis (JL) – Um, this is Jill, with the Division of Public Health. If we could go one slide up to where it has health care provider and health care service in definition? (Slide changed to slide 9). Thank you. So the bill applies to facilities, but not only facilities. If you are a health care provider, then it means you. So, it doesn't…if you are an individual, you don't have to be in a facility for this to apply to you. I hope that clarifies. Thanks.

SN – Right, but a non-profit is not going to post different lists for each provider, it's all part of the organization. Yeah. But this doesn't include …

JL – Excuse me, I'm sorry, this is Jill again. I think we're going to get to the part where we actually talk about how there is an allowance for the fact that you work in a group, and how to report on that. We just haven't gotten there.

CF (speaking to slide 11) – Okay. So, um, moving on here then to the, um, to the next slide. (Speaking to slide 12). For the compilation of services there's the things you need to, um, include in that compilation. And they include a plain English description of the procedure, ah, the CPT code, the undiscounted undiscounted price, which from the bill means, in statute, an amount billed for a service rendered without complications or exceptional circumstances and does not include a negotiated discount for an …

Clint Farr (CF) … in-network or out-of-network services. And I'm getting a little bit of noise. We're getting a little bit of noise. So if you're not talking, um, please hit your mute button. Should of put that in the ground rules. I, I apologize. Um, and then you have to include any facility fees, and in this case if there's a charge or fee billed by a health care provider or health care facility, ah, that is in addition to fees billed for the health care and is usually intended to cover building, electronic medical records, and those kinds of things.

One of the issues that has come up in use of CPT codes is that, their likely proprietary. And are we tripping into some sort of legal issues by posting CPT codes? And it's not just you guys in this case, it's also health and social services as we'll get into later, we'll have to post these prices on our website. Um, so, that's that's one issue that came up. Anymore?

Unknown 1 - The other question that I have, that has come up with at least, I think the Alaska Medical Group Managers Association is that, how are we going to regulate, for like instance, several offices use the same CPT code, like for instance 99212. We all have to put that into plain language. So every potential office is going to list that same code but perhaps have a different plain language descriptor of it. Is that going to be an issue? Or, because it's required to be in plain language, the state will realize well we said it's in plain language so whatever each office's definition in plain language is we'll accept.

Robert Jasa (RJ) - This is Bob, I have something to add. That's a really good point because for 99212 I'm going to put down cataract evaluation as a plain language definition. But that's not going to mean, that's not going to be the same as a primary care doc who's going to put down, an exam or something like that.

CF – Right. And, and, and we'll talk about this a little bit later too. Um, about plain language issues is, if somebody misconstrues a pain, a plain language description …

Heidi Lengdorfer (HL) – A member of the public.

CF - …a member of the public, that's, that's getting that information, ah, is there a liability issue? If they think they're getting something and they get something else, ah, because they didn't capture, the plain language didn't capture it. Um, so, that, I think they're a lot of questions surrounding the plain language issue, for sure. And…And I'm glad you guy's are speaking up. I also was wondering if anybody had anything more to add on the CPT issue and and concerns with proprietary use and, you know, legal

ramifications of putting this stuff out there when apparently it's owned by the American Medical Association?

Brice Alexander (BA) – I think it's probably pretty common knowledge…(Another person was talking too).

CF – Go ahead, common knowledge.

BA - Yeah, this is Brice. I think it's pretty common knowledge that CPT codes aren't our creation, right. You can look it up on a google search using up and find out what it is. Yes, it's proprietary but I think the bigger issue is that we're trying to rewrite their definition and their definition has been screened by lawyers and medical personnel to create a published legal document for us all to use across the nation, and them we're trying to rewrite that. That's weird. And again the litigation issue comes into play, trying to create a plain English description.

Heidi Lengdorfer (HL) – Those are really good points. Thank you.

Clint Farr (CF) – Yeah. (Pause) And then, um, there was another person that had something to add there.

Linda Carroll – So this is Linda. I agree with what Brice has put out there that it's copyrighted information, it's gone through a legal process and then yet we're supposed to be responsible for rewriting something that's been, you know, evaluated by attorneys.

Brice Alexander (BA) – My favorite description so far of the issue is trying to describe in a plain English language method, um, a circumcision, without using any medical terminology and try and figure out how many ways I could be misconstrued.

CF – Right. Okay.

Unknown 1 – Have you looked at other states websites that post provider charges to see what kind of language they use out there?

CF – That's a great suggestion. Um, I have yet to look at other states.

HL – Let me, let me, this is Heidi, let me preface this. Clint has only been working for us for a couple weeks. He's dove right in. In our experience we have looked at some other states and we determined that a lot of the similar, similar laws derive from an all payer claims database. And so, what we're looking at is kind of how we can recreate that using using this data. (pause) Is that helpful? Can I expand on that?

Unknown 1 – Well, I'm just saying, you know, instead of reinventing the wheel is there some language, or some formatting, that other states use that we might want to consider adopting.

CF – You know, that's an, that's an excellent suggestion and I think, for me, um, one of the things I'll do is exactly that. There may be acceptable plain English translations, at least for some of these codes that are already in use, um, down south, and I apologize for not anticipating that. Uh, uh, but that could, that's a, that's a great direction to go, uh, at least initially, to see if there's something already out there that we can use.

(00:30:00)

Beverly Mcdevitt (BM) – I have a comment and a question. This is Beverly. So for the plain English, they do publish an AMA plain English or plain language out there that can be purchased. I don't know if anybody would want to do that. Also, when we're doing this in English, is there for people that don't speak English, how is that going to work?

CF – That's fantastic. I think it's a great question. The bill is specific, it says specifically plain English, so we're going to, um, do plain English initially. Um, that said, I do think that over time there's probably a whole ton of improvements that can be made, and, and to look upon this as iterative. I know in the discussion around the bill, what I've reviewed, was there was a lot of talk about this being a start. So maybe that's something that gets addressed later legislatively or otherwise, I'm not sure, but, it's a, that's a great question and I think would enhance the, the, the product.

HL – And this is Heidi again. And that's not to say your own offices couldn't do it…

CF – Right.

Heidi Lengdorfer (HL) – … whether or not we regulate it.

Clint Farr (CF) – Good point. Yeah.

HL – If you feel that's a in the interest of your patients, then by all means we would, we would love to follow that example.

Linda Carroll – This is Linda. I just have a comment then to that. There's been a lot of talk about how, oh, what's causing prices to go up, why are doctors charging so much. There are some things about this bill I agree with but I just want to say overall I hope that the state then realizes what an administrative task and burden this is to all of the entities that are covered by this. And really how much this is going to cost us as the covered entities in here to put all this together, then have to turn around and if we have to provide it in different languages then as somebody mentioned, well you can purchase a plain language step. Why should, as a provider, from the provider's side, my question is, why should I have to purchase that? It should be, if it's a requirement from the state that I do this, that should be provided to me. Just a comment.

Unknown 1 - I wanted to piggy back on that a little bit. With the language requirement that we have, every publication that we have in the office has to have those statements and taglines saying that we have translation services available to our patients at no cost in the top, what, ten, fifteen, different languages. Essentially trying to take this and give it to our translator somewhere, it's just, I'm not sure how that would be even doable at this point because a document that we're looking at with all these is rather large.

CF – Yes. And and thank you for bringing up those comments and concerns as we, you know, figure out. Right now, we're trying to find, internally, you know, the minimum that needs to be done by the impacted community and H, S, and S to comply with this bill. Um, to that end, let me move on, (Speaking to slide 13), and talk about what's in the bill in terms of the format of these postings. Um, the information that you've compiled, uh, has to be posted – and there's some specifics in the bill. Such as a 20 point font size for the posting. And the posting must be in a conspicuous part of the office or facility. And the posting must have the address of our website – which we'll, uh, provide at some point once we get it set up - where we're posting the submittals from all over the state. And, and that website, by the

way, has yet to be defined – and and, like I said, we'll get to submittals to us, to health and social services, in the next slide. Um, the posting may include some language regarding how the price might be different than what the patient actually pays. And there should be a statement encouraging patients to ask for estimates, and later on we're going to talk about good faith estimates and what that's about. And the posting must list health care insurers that are contracted with the facility or provider as preferred. And then, if you have a website, that posting has to go there as well. And, and so, here we get into a little bit, um, one of the questions I had, that I had, was how does this apply to office – less providers, for lack of a better term, like hospitalists and and that sort of thing. We talked a little bit about that. Are they their own group? Do they have to post their, um, their, their procedures, ah, or, ah, do they get subsumed by the larger organization that they're within? So that was one of my questions and then, um, these postings, you know, they, they have, they're pretty prescribed in terms of things like font size but, but we're kind of left to our own devices on some other aspects like the media of the posting. Is it an actual poster on the wall? Or could it be, uh, an an ipad, you know, that's that's cycling though, um, the information that's required by the, by SB 105?

Heidi Lengdorfer (HL) – Or a TV…

Clint Farr (CF) – Or a TV screen, something like that, yeah. So, um, so, some thoughts on these couple of red flags and then, you know, other other comments that you have?

Debbie Lowenthal (DL) - Clint, this is Debbie at ASHNHA? That was question our CFO all had was if they could use a dedicated computer just for that, where patients could look up prices. So that, I don't the answer, but that was a question they had too.

CF – Right. Yeah.

Beverly Mcdevitt (BM) – This is Beverly. I have a question.

CF – Yeah.

BM – Actually, Kania [name could be wrong] in the room has a question. Hold on.

BM/Kania – And what font are they going to have us use because Arial is different than a 20 point Times New Roman? So you're going to have facilities across the state that are using different fonts that are still different sizes.

CF – Yes. Um, that's, that's true. Font was not prescribed in the bill. Font type.

HL – And a good comment we can take into consideration.

CF – Yeah, absolutely. I mean, um, it's, it's certainly something we, we, we saw as well. So, um, yeah. We, I'm not sure we want to prescribe the font type at this point and and we can't anyway.

HL – It's something we can look at.

CF – Yeah, it's something we'll look at. (Pause) Any other thoughts on these postings?

Jackie Gahan (JG) – Hi, this is Jackie from Peace Health. I've done a lot of research on this and most of it has been from the federal level. So I guess my question for you guys, since you have such a specific state legislature on this, I know you're trying to follow your state direction, when it's not clear would you not revert to the federal register and the language in there?

HL – I know there is similar…we've heard discussions of similar federal requirements, notably, at some point from CMS. And I think where there is overlap – I'm sorry this is Heidi again – where there is overlap we would, we would definitely look into that as a way to minimize the reporting burden.

JG – I'm just thinking it might help clarify some of this, some of these questions that are coming out.

HL – Sure. And you noted as a state agency we're beholden to state law.

JG – Right. Yep.

BM – This is Beverly. I have a question.

HL – Go ahead.

BM – So, with us having nine different departments here, you know our top ten is different in every department. So, we would have to display in every department the top ten codes for that service? Because we have specialty departments like obgyn, orthopedic, dermatology, and so how does that work?

Clint Farr (CF) – Well, one of the questions we are trying to answer is if the facility subsumes that and it's the top for …

Heidi Lengdorfer (HL) – for the entire…

(00:40:00)

CF – for the entire facility. So, within, you know, including your departments. So that you're posting one thing for all your departments. That, that could be an option, there might, there might be something else. My read of it is it's a facility wide thing but I could be wrong and that's why we're chatting.

Beverly Mcdevitt (BM) – Okay.

CF – Yeah, you know, and, um, I don't think we have, yeah, I don't think we have anybody on, legal, you know, from Law on. So, right now again we're raising the questions and, um, we'll start trying to find answers, but, uh, initially, uh, it's, it's, my read is that we have these facility, facility wide requirements. Um, so.

HL – Right, and that's a good point. You know, looking at the health facility data reporting data, it would be very different if you're looking hospital wide. From that data, we've seen that it's primarily new born and deliveries that are some the top health care services, if you will, versus that would be very different if you broke them up by the departments, certainly dermatology would not have that as their top ten.

BM – Right. Kaina has another question, hold on.

BM/Kaina – So to follow up on this, if it is for the facility our clinic has four floors, do we have to post the signage on the first floor so everybody can see it or does it have to be on every floor, or in every department?

HL – Right. And that's where we tear apart "conspicuous".

CF – Yeah. (Pause). Don't have an answer on that initially, but I'm, we're certainly, um, you know, taking into consideration what you're saying. And I'll go overall is to keep this, uh, as simple and compliance as, as minimal as, as required to meet the law. Um, so just, so keep that in mind too.

Brice Alexander (BA) – This is Brice. We've had a number of individuals already start to work on this, obviously there are things we can't do yet. But the longest piece of it is coming up with that plain English description. Have you guys considered just saying, hey, please send us your fee schedule on an annual basis? Would that satisfy this requirement of the senate bill and then go from there?

HL – This is Heidi. I think if you could send Clint an example of that we could take a look at it. Not, not having that in front of us it's hard to make a determination one way or another. But that would be really helpful to look at.

BA – Well, sure. The example would be an excel file, and you just say we want the CPT code in column A, you want your price in column B, send it to us. That would be super easy to compile it, for most systems I would think.

Clint Farr (CF) – Thank you. Yeah. And, and I actually have a, you might see later, where I have a, a, dummy, uh, uh…

Heidi Lengdorfer (HL) – A template…

CF - … A template, (Yeah, dummy was the wrong word), template to, ah, that, that people might want to use. That might be kind of along the lines of what you're thinking there Brice. So, um, we can discuss that.

HL – Hang tight.

CF – Yeah.

HL – Is there any other ones before we move on?

Beverly Mcdevitt (BM) – Yes, I have a question. This is Beverly. When we do the estimate posting and there was a question that, you know, if we give a good estimate or that's the estimate on the board and the patient gets back in the room and something more complex happens and, you know, kind of bumps the bill up more, would we need to post that on our poster that there should be a clear disclaimer that prices may change varying on the dependency of complexity of their appointment? I mean, because we never know what's going on. We can only get the bottom price on a posting.

CF – Right, and so, in the law, as I understand it, we have the posting of the top ten procedures within the six categories of the CPT codes and that's what gets, that what gets on, on a poster, computer, or television screen, or, or what have you. And then later in the bill, there's the language for good faith estimates.

HL – Separately.

CF – Which is a separate thing. Which is given upon request. And in that case you can give a range, and we'll talk about this in a, in a later slide, but you can give a range of prices, ah, to that individual, uh, who's requesting it. Um, and, and, if, if that's what's necessary. And so we'll talk about that. Does that help clarify? The posting versus the estimate?

BM – Yes.

CF (Speaking to slide 14) - The rule requires health and social services post the pricings that are collected and then sent to us, and, and we put them on our website. And it's probably in all our best interest to keep the format of the submittal as simple as possible. So, I have a couple questions about how simple maybe we could even go with this. Um, is, you know, if you have a postings on your wall, would it even acceptable to take a picture of it and send me the JPEG, for example? You know, try to keep the submittal…

HL - … Or scan …

CF - … or scan, or a PDF, something…you know, you know it's in all our best interest to keep this as, as simple as possible. And just email this, ah, um, um, um, email address up here. You know that posting that you're using and then we would just put it onto the site. Yeah, so we're just. Some thoughts on that.

HL – I think Clint's question is how do we make this easy for you?

Clint Farr (CF) – Right. Would that be useful? To keep it, sort of, that simple?

Linda Carrol (LC) – This is Linda.

CF – Okay Linda.

LC – I was going to say, I mean that would actually be fantastic because, I mean, you know, for ease of use. On the flip side, my question is, the state, you know, I understand, will be posting this information, I presume it so that patient's can compare, right, like prices and shop essentially …

CF – Right.

LC – … and in that aspect then if they're trying to compare that might be hard to look at. But as a provider, of course, I would love to just be able to take a picture of my stuff or send it to you as a PDF, save as PDF, and then email it off. That would be fantastic.

CF (as Linda was speaking) – Right … right … right. Yeah, again, I'm thinking, you know, minimum compliance with the bill. What's the minimum effort to ensure compliance with the bill? As long as the PDF, or JPEG, whatever we receive is clear and you can read it, I, I don't know where we would have any problems with it at this time. That's what we're knocking around internally.

Jackie Gahan (JG) – Clint?

CF – Yes.

JG – Can I bug you one more time? This is Jackie from Peace Health.

CF – Yes, Jackie. Of course.

JG – So, going back, I'm sorry to do this, but going back to the federal register, their rule for one one nineteen is machine readable format which means an excel format. And it specifically says that a PDF is not adequate, so if your state law doesn't define it, wouldn't you refer to the federal register? I would

think that you'd want to be in line with the federal guidelines as well. I just want to point that out. They're saying PDFs are not adequate.

Heidi Lengdorfer (HL) – Thank you for that. This is Heidi. We have looked at the CMS guidelines for machine readable format and I want to stress that, because this, the time period to comply is coming up quickly, we want to, at least in this first iteration maintain and enhance compliance. And then, look at how we can, if there are avenues that overlap with the federal requirements, that we move to that. Especially if that infrastructure within the provider and hospital community and facilities would already be in place.

Brice Alexander (BA) – Hi, this is Brice. Looking at using different file formats, I guess the meat of this question is one, what does the state want to do with the information? Because if you're just looking to make sure we're posting the info, sure we can send you a picture. But if you want to take that and make it usable data for the public to know the average cost of a nine nine two one three, level three (indistinguishable) visit for an office, you're going to have to find someone at the state to manually create that document. And that's prone to typing errors, and a lot of time spent. Versus having us just generate a report in excel format anyways. And do it that way.

(00:50:00)

Clint Farr (CF) – Well, would, would another idea for, most of you I would imagine, but though not all, have a website? Am I speaking out of turn? Do most of you not have a website?

Unknown 1 – We do.

Unknown 2 – We do.

CF – Okay. I wonder if, if maybe the one, an idea too, might be to just link to your, your post, your website post. Just create a hyper link from our site to your website post. And, and, and in that way your just sort of utterly in charge of the, of the look and feel.

Suzanne Niemi (SN) – (very quiet) I think it would be incorrect to assume that every practice has a website. Especially different…(indecipherable).

CF – So, um, whomever just spoke, thank you. Unfortunately that was very very light. I just barely caught that somebody was talking.

Unknown 3 – She, they're were saying that…

SN – Sorry, this is Suzanne. I think it would be, it's not reasonable to assume that every health center or that every clinic, would have a website.

CF – Right.

SN – Especially a small one.

CF – Right. And I think…

SN – They may have a Facebook page, but not a website.

CF – Good point. And I think in this case it would be, if we were to do something like this, it would be for the people that have websites, and then we would do something else for everybody else.

Heidi Lengdorfer (HL) – Well, I think that brings up another question. This is Heidi. Does a Facebook page for your practice qualify as your website?

CF – Yeah. Yeah. And I don't…Well, you know, the thing is we can't even, people can't even access Facebook from their work in many cases. And so, I don't know if that would be, um…Like, you know, I wouldn't be able to check on the posting because I can't get on Facebook from my, from my computer. (Laughs).

HL – Just posing the question.

Jennifer (not sure on last name) – This is Jennifer in Fairbanks. And I just want to echo that for the facilities that do have websites we would, we would want that option.

CF – Right.

HL – Okay.

CF – Okay! Thank you. And, (speaking to slide 15), and then one of the things I was thinking about, and Brice, this is, um, where I, I thought maybe there might be an ability to come up with a, a, a template, uh, a fillable PDF for example that could be sent, you know I'm, I'm spit balling here obviously, I got all these ideas. So I'm just trying to figure out what might work best. You know, some sort of fillable PDF like this that would get sent to facilities, gets filled out and sent back to us. Um, and I know that's, that's time obviously, but on the other hand you'd have consistency of format and, and, and that sort of thing. And maybe that feeds into your excel spreadsheet um, idea too Brice. Is this something that people, I mean if we, you know, if I made it a little bit probably bigger and neater and, and what not, but would this be something that would be useful to people at all.

Linda Caroll (LC) – This is Linda. To have to copy and paste all my info into this template would be, is still time consuming. It would be so much easier just to send you than … my excel spreadsheet.

CF – Right, okay.

Unknown 1 – And it would be great if it could be the generic CPT procedure description. Are you looking for the plain language description, it's not going to fit in your little box.

CF – Well, yeah, I understand. Well, I mean, it's a temp…, you know, it's an example, uh but yes, it would be the plain language. (Pause). Okay, so I just wanted to throw that out as well.

Brice Alexander (BA) – I've got a quick question for you Clint. Because someone had said that our first deadline is coming up here quickly, are we actually looking at needing to meet this deadline, the January thirty first, with all the unknown factors?

(Echo on audio)

CF – You're on somebody … somebody needs to hit their mute. Thank you. So good question Brice, um, you know that this point, we don't, we're just working on our internal processes, um, the, you know, the, on down the line there's going to be a regs process. Um, you know I don't, until there's something in law for you guys to follow, um, I'm not seeing, ah, where the January 31 of 2019 realistically gets met

this year. Um, but, we're going to continue working that issue, but um, um, just a, a timeline of, of processes and stuff that have to occur between now and having something for, that people have to comply with from the administrative code perspective, um, um, I don't, I don't, I don't see how January 31st gets captured.

Heidi Lengdorfer (HL) – Well, this is Heidi. And I just want to step in here and say our goal is to get something, guidance, out by December…

CF – Yeah.

HL - … so that folks have time to implement that they need to implement and we are ready and willing to work with you all to make sure that everybody is where they need to be by the end of January. And there is, I think Clint later you have the request for extension that we had thought about…

CF – Some other things like that to kind a, to kind of help us meet, again, meet the letter of the law. Um, understanding the realities of getting administrative processes in place.

HL – Yeah, our focus is compliance based not enforcement based.

CF – Right. So, in other words, we've, we've still got, we're still talking a lot internally about how to best to proceed. Uh, knowing that deadline is in law and out there.

BA – Well thank you.

Clint Farr (CF) – (Speaking to slide 16) So health and social services, um, will provide that website and links to how, however the format is that submitted to us. Um, and we're going to organize that list by providers and facilities, I would imagine, uh, the law does require the physical address of the, um, of the facility and I imagine we'll list it alphabetically. And the text of the names and addresses will be a clickable. And it will take the viewer to the PDF document, the JPEG, or the website of the, um, facility. And, or, whatever format we decide on. The, and, we're going to post these, these, these postings, we're going to post what you submit to us, as is. Ah, I mean that is what we anticipate. We don't anticipate modifying the submittals. Um, you know, it just sort of presumes that it meets requirements, and we're just going to put it up. Uh, at least that's what, where we're at right now.

Heidi Lengdorfer (HL) – And we will specify and share those posting requirements.

CF – Oh! Yeah, absolutely.

HL – Yeah.

CF – But, but I think, you know, it, it just needs, the posting needs to meet the, what information is required in the bill. And, you know, if they take a picture of it and send it to us, you know, we can put it online. (Speaking to slide 17) You know, there's quite a bit, I'm sorry, was there some … thought I might've heard somebody … Okay…

HL – Do we want to take a five, five minute break here?

CF – Oh. Are we at a…

HL – Before we dive into good faith estimate? It's almost eleven.

CF – Sure, let's do that. It's almost eleven. Let's do five minutes folks.

HL – So, back at eleven 'o' two.

CF – Back at eleven…yeah, eleven 'o' two. Got an engineer here with me. Okay, thank you everyone.

HL – Thank you.

(break at 00:57:55)

(01:00:00)

(break ends at 01:03:20)

CF – Okay, it is eleven 'o' three. Um, let's start up here again. Thank you all so much for spending the time today with us, ah, as we work our way through SB 105. Um, a good chunk of SB 105, uh, health care pricing language deals with providing good faith estimates upon request. And, a couple of things, uh, here is that emergency departments are not included here. Um, which kind of makes sense. And then, uh, the term 'patient' is used a lot. And, so my question to you folks, I've got the defineetion, definition of patient here means an individual to whom health care services are provided in the state by health care provider or at a health care facility. And I just wanted to ask you folks if, is the patient specific to the exis…is, is, is the definition of patient specific to an existing patient of the provider or facility? Say, if the patient is defined as an existing patient of the office, or the provider, then that could lessen some of the administrative burden ass., associated with running down quotes. On the other hand, um, does somebody coming off of the street, like a potential patient, asking for a quote, does, uh, do they get captured by this? Um, so that's kind of my, my question here is, who's a patient?

Kevin Jardell (KJ) - So this is Kevin.

Clint Farr (CF) – Hi Kevin.

KJ – Can you hear me? Yeah. Hi.

CF – I can hear you Kevin.

KJ – I think for us, a physician patient relationship is a term that's used and understood. When they had in the bill the requirement for an oral one and that you have to document that, if you don't, if you don't require it to be a current patient then you would almost have to be required to create a patient record for just somebody calling in. It would likely require HIPAA security and so, if anybody just calls in to say what does this cost, you would almost have to create a patient record, a new patient record, file that in, and treat it as a patient, and, you know, whether that's what the bill requires or not, I don't know. But certainly the physician patient relationship when it gets created, and how it exists, is a pretty standard understandable relationship.

CF – Okay, very good. Thank you. And, you know, it makes sense that a good faith estimate requires some knowledge of that, that person, and, and not something you could just provide, um, just off the bat. So, that makes sense. And so we'll talk about that internally more and, and see, what you know, what the intent was there and, uh…

Heidi Lengdorfer (HL) – Does anyone have any different definition of a patient from that patient relationship…

CF – is that fairly broad, does that apply to everybody?

Matt Eisenhower (ME) – Well I know…this is Matt Eisenhower in Ketchikan and I know I won't make a whole lot of friends with this statement, but, you know, when we talk about population health, we recognize that a patient in our community may not have a direct relationship with us and I do think the intent of this law includes those patients who are seeking services that may not have an existing relationship but that's just my interpretation.

CF – Sure.

Unknown 1 - But then how do you track what you've told someone?

ME – Yeah, I'm not suggesting they're aren't complications with it. But that's a term that we reference is patients in our community that may not have a relationship with us.

Unknown 2 - Hi. I think I agree with that statement as well. I mean when someone is calling in and they're a new patient, or trying to establish as a new patient, I mean I think that's a general term that we use for anybody within our clinic as well as anybody potentially wanting to be, you know, a patient here is the word patient is used. Whereas when you go out in the community they may be considered clients. So I think it's a very generalized term that's used, in better definition of what we need to use for I think needs to be clarified.

HL – This is Heidi.

Unknown 1 – This is (unintellible)…

Heidi Lengdorfer (HL) – Go ahead.

Clint Farr (CF) – Go ahead. I don't know who that was…

Unknown 1 – Go ahead.

HL – Okay. If I, I'm trying to work this through, for example, I'm looking to find the compare prices for example of an MRI. And I am a patient, you know, I got that MRI referral by my specialist but I want to go, you know, around between facilities and say, you know, how much is this going to cost. Is there, is there anything you would have to do in terms of intake to evaluate me to determine how much that might, might cost? Maybe an MRI is not the best example, but maybe a physical or some kind of procedure. Is there, is there something you would need to see me for beforehand in order to give me that good faith estimate within a reasonable range?

Linda Caroll (LC) – I mean, this is Linda, and potentially, I think, just coming from a surgical background as far as what my, you know, last fifteen years of work probably was in, I can say, if a person calls me and says, well, I have a fractured ankle and I need a repair, what's that going to cost? You know, anyone in ortho, who does surgery knows that there are some…are we having to repair two bones? One bone? And it can make a significant cost difference, so that's one of the reasons why it's hard to give out information over the phone with someone you've never seen; haven't even seen an x-ray to know how severe perhaps like a fracture is, or something like that. So you could, like you said, give a range. You know, my staff could say, well, depending on the type of facture it is exactly you're looking at, this is a made up number, five hundred to fifteen hundred dollars dependent on, you know, the type of fracture. If the state feels that's acceptable then …

(01:10:00)

HL – Sure.

LC – … it shouldn't be an issue with it then.

Kevin Jardell - So this is Kevin. I was just going to comment, there's the ability to give good faith estimates to whomever you want, and then there's a legal requirement to provide them in a specific way. And so when someone has requested orally, you're required to give them the estimate orally back to them and you have to have written documentation of what you told them and who it is. And maybe that's not a problem, but it would seem like you basically would be required to create a new patient form and enter them into your system as a new patient just to document what they're calling about 'cause they're giving you health information, private health information. And so, it just, I guess my question is, how big of an issue is that for any of these offices if you get, you know, twenty five, fifty, people calling and saying what's the price and you have to create a new patient code?

Unknown 2 - That's a lot of work. That's a lot of work to put on your receptionist and then maybe that person on the phone doesn't want you to know their name. And then what do you do?

Bernice Nisbett – This is Bernice from Rep. Spohnholz's office. If I could just jump in really quick. It was mentioned that the provider has to provide the estimate orally. But the bill actually states that if the patient wants the estimate they can provide it either orally, in writing, or by electronic means. So there's several options. It also says if the estimate is provided orally, then the provider shall keep a record of the estimate.

Clint Farr (CF) – Right. And we'll. This is Clint. And we'll get to some of that in a, in a later slide. Absolutely. Um, um, but if the, um, requestor wants that orally, um, that, I think that that's partly what we're…having to create the paperwork.

Heidi Lengdorfer (HL) – Well, I thinks it's a question of where does that paperwork live and in what form. And I think, you know, what we were trying to go for was defining patient in this way is if there is an existing patient file you can put that in the patient file rather than creating a whole new patient quote slash unquote file for somebody who's calling around for their fractured ankle surgery, to use a previous example.

Unknown 1 – What are we supposed to do with those potentially new patients that call in and do the request? Still required to document though, correct?

CF - You are required to document, ah, oral, yeah.

Unknown 1 – Yeah.

CF – Oral, uh…

Unknown 1 – So the word patient pertains to whether they're existing, established, or potentially new.

CF – Well that's one, that's one interpretation and we're going to have to take these comments into consideration about how we're going to define patient.

Unknown 1 – Okay. Yeah.

Unknown 2 – But if the patient doesn't want to give us their name…

Unknown 3 – Does document mean you have to get their name though? Or does document just mean I had three people call to get these estimates this week?

CF – So, that's that's correct. I just jumped a couple of slides (speaking to slide 19) ahead because we're getting into, sort of, this area here where, um, a qualified estimate, you know some of the specifics about the qualified estimate. Has to be made within ten days. It can be oral, written, or electronic depending on the preference of the requestor. And then the oral estimate must be recorded, and the red flag was, as you guys have been pointing out, for an oral quote, what do you need to keep a record of, of that? And, and is there a way of keeping a record of the oral quote without collecting a name or address? For example, if they don't want to give you a name. Or is it, if they don't want to give you a name, they don't get a quote. That potentially could be, um, what happens as well. So, um, I'm not, you know, I'm not sure but you're definitely bringing up many of the, many of the questions and concerns that we've already heard and, and are going to try to, try work through.

Unknown 4 – …phone number, you should be able to google that phone. But the name that's attached to that number is not always the person that would be calling … (Indistinguishable)

CF – That's true too. Somebody could be asking for, uh, somebody else. Yeah.

Heidi Lengdorfer (HL) – And for example, you know my husband and I have the same phone plan and it's in his name. So if you do caller ID, my phone number pops up with his name.

Clint Farr (CF) – Yeah. So there's, yeah, there's definitely things that need to be worked out there. And, and I mean, and, and keeping a record of the oral may or in some respects makes sense obviously if something was mistaken and you wanted to call them back, you'd need to know who to talk to. Um, and then ultimately, you know, some day, when we have compliance and stuff figured out, if we get a complaint it'd be nice to be able to call the facility and go, "Did you give an oral estimate to this person? Oh, you did. Okay, thank you for your time," and, and then we're done. We don't have to, you know, somebody complained they didn't get a good estimate, or something.

HL – Well, and I think there's the pitfall, right?

CF – Yeah.

HL – An estimate is provided to a patient, however that is defined and the patient comes back and says, "Well, it was, you know, this much outside of the range I was provided in the end," and there has to be that documentation in terms of, well, this is what we gave you and here is the disclaimer and we gave you this on October 26. The devil just seems in the details.

CF – Yeah. Yeah. I think here this slide comes into play as well. (Speaking to slide 18) It's important to note the law has language to reduce a provider, facility, or insurer's liability in providing good faith estimate. And that protection, um, you know, is in, is in the law and it, and, and it's specific to the good faith estimate, and I didn't see a similar, didn't see similar language for the postings necessarily with the plain language requirements, the postings and reporting requirements. But at least for the good faith estimate, um, you know, if you're off, uh, there, you're not liable for damages or anything like that. At least in SB 105.

So, um, so we've, so we've kind of talked around the plain language thing, I just wanted to bring that up here in the context of that fact that you have a caveat for good faith estimates that doesn't kind of, doesn't really seem to exist for the postings.

Unknown 1 – Well, that would've been helpful. I wrote on my (indistinguishable). There's a page.

CF – So, there…was that a comment? I'm sorry.

(Speaking to slide 19) Okay, so again, um, oral, written, or electronic depending on the preference of the requestor. And then, if we go, continue on, there's quite a few more, uh, aspects to the requ… to the good faith estimate.

(Speaking to slide 20) Um, whole course of treatment can be, ah, an estimate can be for a whole course of treatment or for a single service within that course of treatment. If the estimate is for a single service within a course of treatment, the estimate MAY include a statement explaining how the estimate only includes the charges for a portion of the anticipated treatment.

You can provide a range of service prices. A reasonable range can be given if the expected service provided to the patient may vary significantly due to conditions the provider, facility, or insurer cannot reasonably anticipate. If we just had an example of that.

Um, the estimate must must disclose the in- or out-of-network, uh, status of the provider facility and note, with some language that's prescribed in the mule, in the rule (mule) the rule. Ah, whether it's contracted in-network preferred provider or only for certain plans, uh, and and there's a couple other um, ah, statements that would have to be given with the estimate in terms of the network status.

And then you have the estimate must include a brief description of the service, product or proc…procedure, and supplies in plain language, once again we have that term, where an individual with no medical training can understand.

The procedure code for each health care service is included in the estimate.

And the estimate must include any facility fees, along with an explanation of those fees.

And any good faith estimate must include the identity, or suspected identity, of any person that may charge the patient for a service, product, or procedure, and supply in connection with the health care services included in the estimate, along with an explanation of whether the charges are included.

And here again we have the need to provide a CPT code, or a procedure code. Um, these estimates are not just a simple, you know, according to this this language, they're not just a simple provider price, there's a lot that comes, goes along with it. Much of what's, much of it is similar information that you would post for your top ten procedures would also be included in an estimate to any individual.

Um, so, I imagine there's a lot of things people might want to say about the good faith estimate at this point. I open the floor.

(01:20:00)

Barbara - Clint? We have a question.

Clint – Yeah.

Barbara – This is Barbara.

Clint – Go ahead.

Unknown 1/Barbara – So, we're giving an estimate, if you're doing multiple procedures on the patient, do you have to apply the multiple surgery discount before you give them the estimate or you just give them the straight pricing for the estimate?

Heidi Lengdorfer (HL) – Could you give them both?

Linda Carrol (LC) – This is Linda, I would say the answer is you should probably just give them the straight pricing because that's what you're going to send to their insurance company. I mean, for us, that's what I would do. If I'm billing out three procedures, even with the correct modifiers, we bill out the full fee to the insurance company. So this way, the estimate that you give the patient matches what you send to the insurance company.

HL – That makes sense.

CF – So essentially we're talking about the undiscounted price that would be posted, or charged, that would be posted essentially. If you were posting for that particular procedure or range of procedures.

Clint Farr (CF) It, it would be consistent with the rest of the bill at least. Does that make sense, or is that off?

Kevin Jardell – This is Kevin. I think if you prescribe that, as you have to do it that way, I think that could create problems. Some providers have purchased software that provides really detailed estimates and they can put in what you're likely to pay. Maybe you can put, well I don't know. I think prescribing how you have to do it, if it's a good faith estimate from the provider, I think you would allow the provider to determine kind of what their capabilities are in their office to provide that, quote, good faith estimate of what it's going to cost.

CF – Okay. Thank you for that comment. And that's a good…go ahead.

Brice Alexander (BA) - Just to piggy back on that one. Good faith in business dealings is kind of already a standard terminology. So, whatever estimate the provider is able to give there's no reason we're trying to be giving them weird estimates. Ultimately, if you give them a bad estimate, and it charged them way more than they were supposed to be, than they were expecting, you're going to get a bad report. I don't think anybody's aiming for that. I think making this as simple as possible is probably the goal. Saying, hey we want you to provide this good faith estimate. Having to record and document the estimate too is a little bit strange and we've got, it becomes he said, she said. Are you going to believe the patient and what they recall being told or you going to believe our documentation, which the patient is going to claim we made up anyway. We've got patient reminders just for an appointment that goes out and patients claim that they got different information from the reminder all the time, even though we can pull it up and say, hey no look see, it told you the correct date and time and you just didn't show up. It's a he said, she said thing.

CF –Thank you for that. That anticipates maybe some enforcement issues that we'll come up against when we get calls, um, from folks. Um, if we get calls. Which, hopefully not too many. Uh, and we're

going to talk a little bit about enforcement here next, but before I move on to that, that next slide, is there anything else on the good faith estimate? So far these have been fantastic comments. Thank you.

(Speaking to slide 21) – The health care, the SB 105 does have language for compliance and providers and facilities and, and insurers that fail to comply with the price postings are subject to, um, civil, civil penalties potentially. And I, I do want to stress before I launch into these slides, next slides that we are compliance focused, not enforcement focused at all at this point, and uh, uh, just please keep that in mind. But I did want to, you know, bring up the, the language and that's in the bill that's been given to health and social services.

So, um, failure to comply with price postings or not reporting for each day of noncompliance after March 31 for example there could be a fee imposed. Um, good faith estimates, uh there could, if, if after that ten days or something, or somebody has a complaint, there could be fees, uh, imposed.

(Speaking to slide 22) – And this enforcement, such as it is, would look like, what I like to call, com, complaint based enforcement. And, and, this would be pretty specific to the postings and good faith estimates. Um, so if, if some patient claims facility or provider was not meeting the price posting or estimates require… requirements, we'd get a call. And I'm, you know, I'm, this is what we, we internally discussing as, as, you know, a process I suppose. Health and social services would contact the facility. I would, I would be, basically you'd get a call from me and I'd say, hey we got a call from this person, um,

Clint Farr (CF) - …you know, let's, let's talk about it. And if the complaint was proved valid or something like that, we'd send a certified letter to, um, the facility or provider with some sort of a deadline to fix the problem. I have sixty days here because in the bill, ah, if you, if you don't get your postings up by March thirty first that's when the, the potential fees set in so that sixty days from January thirtieth through the thirty first, and that's why I have a sixty day, uh, length here. Um, if the problem is not fixed within sixty days, we send you another certified letter and then the daily penalties would potentially start to apply at that point if the problem hasn't been fixed.

Um, so that's sort of a very drafty look at, um, you know, a potential enforcement process for SB 105, particularly for the postings and good faith estimates. And, um, you know, so, I put that out here for, for comment. What do you guys think?

Beverly Mcdevitt (BM) - Clint, this is Beverly.

CF – Hi Beverly.

BM/Jill - In the room, Jill (?) has a question.

CF – Yeah.

BM/Jill – Yeah. When you, before when you were talking about we needed a calendar year to basically get our pricings and stuff to post, but it doesn't specify what year we're supposed to use to get that pricing so that we have time to get that data and then post it. Is there a calendar year? Can we do December first to December first? What is the time period that we need to get this information out, pull the information from I guess?

CF – Yes, I, and I apologize for not making that clear. My read of the rule, and I, you know, and I fully admit I could be wrong, so if the sponsor wants to speak up that's good too, but my, my, my read of the

bill is we have a calendar year of pricing data that you've, that you'll gin up some sort of list, top ten list, at the end of the year. And you would have January to gin up that list and post it by January thirty first. So, for example, in the future, by January thirty first of two thousand twenty, the two thousand nineteen top ten list would be posted. Does that make sense?

BM/Jill – Thank you. Yes it does.

CF – Okay, so, there's that aspect and then (Speaking to slide 23) for submittals to us, health and social services, it, it, it follows a similar thing but it would not be complaint based. We would know whether or not we had received, ah, the, posting for us to put up on our website and so we would follow a similar format of certified letters, sixty days, so on and so forth. Um, it, it, the only reason I put it on its own slide is that it's not, it's not complaint based, we would know. Um, but it would follow a similar format.

(Speaking to slide 24) And then, and knowing that, you know, things happen, I, I do think the idea, we've been knocking around the idea of extensions, ah, providing a facility, um, um, an extension for submittals to health and social services. And, you know, we would entertain a month at a time or something like that. And what I have down below here is, you know, initially we might even entertain extensions for up to six months, ah, as we try to get our, our a, you know our feet under this, on this, on this, on this new rule.

Heidi Lengdorfer (HL) – Collectively.

Clint Farr (CF) – Yeah, yeah. (Speaking to slide 25) And I went ahead and ginned up, uh, an example extension request form. Hopefully, hopefully simple and straight forward that you would fill out and send to me and say we're not going to make it, um, this is why, and then I would, and then I would take a look at it and, and you know.

(01:30:00)

So this is the kind of stuff that we're, we're bouncing around over here. So on the, again, on the process, or, you know, our drafty process of enforcement and this, uh, extension request form, are there any comments so far?

(pause)

(talking over someone) Okay, my email…go ahead.

Unknown 1 – Sorry, I was going to ask, are you our main contact for all of this going forward and after things have been settled or, is there contact information we should all be jotting down for future reference at this point? Who's our main contact for guidance?

CF – Yes. I am your main contact. And my email will be on the last slide. And, and so yes. Contact me with thoughts, questions, feelings, anecdotes…

Heidi Lengdorfer (HL) – And we welcome all of those.

CF – Yes.

Beverly Mcdevitt (BM) – Clint?

CF – Are there any other…Yes.

BM – I don't have a question about this form but there was a question at the half time that Jamie…

CF – Okay.

BM/Jamie – Are you guys going to evaluate whether a non-profit falls under a private entity? Is that still something up for evaluation?

HL – Yes. We'll look into that.

CF – We will look into that. Ah, um, uh, to get more clarification to you folks on that one. Um, I do, I do, you know, just and initial read the provider part should capture most everybody regardless of their financial, um, categorization.

HL – But yeah, we will take it back.

CF – But, but we'll certainly take it, take it to folks who can give us more of a definitive answer there.

(Speaking to slide 26) I do need to, uh, as, as you might imagine, just bring up, um HIPAA. There's nothing in the bill that would suggest, uh, that any personal identifying information would be, would be submitted to us or anything like that. But, you know, we would always want facilities and everyone else to take care, and you guys already do this, so this is, sort of a, just a cover for our back sides that we are mentioning HIPAA and the importance of, of keeping personal identifiers out of, out of the submittals and the data that we post. And then, um, also just note that this is public information. Uh, the stuff that we put out on our website is public. I may only have those postings up a year, but we'll probably have to keep them for up to seven years in accordance with our document retention, ah, schedules and that sort of thing. So please note that as well.

(Speaking to slide 27) And now we're at the point where I..I knew, learned about this bill on October fifteenth. So, heh, as I'm working my way through it, um, I have no doubt that I have missed, uh, some important issues and things that people have, concerns that people have. So this is a good time to have a free form discussion on the bill. We've got, you know, about thirty minutes left in our allotted time, so, um, now's a good chance to speak up.

Brice Alexander (BA) – Hey Clint it's Brice with Anchorage Pediatric Group again. One thing that I don't think we've covered that I had a question from our group was regarding the insurance. One of the things that we have to include is who we're in network for, right? – If we have an umbrella…

Clint Farr (CF) – That's what I understand.

BA – …If we have an umbrella payer, are we listing every insurance under that umbrella or the main one like multi plan or Beach Street? Similarly, are we able to use the logo instead of listing out the individual plans? Like Blue Cross has a definitive logo but you could have Blue Cross of Alaska, Blue Cross Federal, et cetera, et cetera.

CF – Right. (Pause). I do not have an answer, um, for you right now. But it's important that you bring it up. And that will be one of the many things we'll be churning over here.

Linda Carroll (LC) - Hi. This is Linda. I do have a question because I noticed insurance companies are covered under this as well, and I don't think there are any insurers that were on the call. In the past, I have given estimates to patients, and when they ask, well what's my portion, especially for an insurance

company that, perhaps we were not contracted with, like the office at the time, we didn't have a contract with ABC Insurance Company. We would tell them we're not in network with your insurance company, they won't give us what they will allow, so I can't tell you. But we've given the patients all of the codes, and we had given the patients what our charge will be, and we've said to the patient call your insurance company. They can tell you what the allowed amount is, or what your percentage is, and then you can do the math to figure out what you may end up paying. We have the same patients in the past who then call us back and say their insurance company won't even tell them what the allowed amount will be. So, in these instances of good faith estimates, if I am the patient, and I call my insurance company and say, this doctor's office told me to they were out of network, these are the codes they gave me for a procedure I need to have done, this is their fee. If the insurance company does that same thing and says, well we can't tell you, we can only tell you the out-of-network you pay 'x' amount percent, are they going to be held liable then under that good faith estimate portion for a patient trying to figure out what they may have to pay out of pocket?

CF – So, if a patient calls the insurance company with a request for an estimate, the insurance company does have to provide the estimate in the same fashion as the medical provider or the facility.

LC – Okay.

CF – So, my, my read, is that the insurance providers are on the hook for good faith estimate.

Linda Carroll (LC) - Okay. Good to know. That's great. I think that's great that they have to do that for th patients.

Clint Farr (CF) – Yeah, that's, that's certainly my read. I don't see anything in the bill that would suggegst that that's not the case. Um, I'm not a lawyer though.

Beverly Mcdevitt (BM) – This is Beverly. I have a question. Once the fees are reported to the state, in January, are we required to update. If we have an update on pricing mid-year, are we, do we report right then and there or do we wait for the next update.

Clint Farr (CF) – Um, my read of the language, so far, is that that would not, you would not need to update it halfway through a year, just at the end of the year, you know, an aggregate calculation of your top ten, and then that gets reported to, that gets posted and then reported as well. Um, but there wouldn't, there wouldn't have to be a midyear, not required to have a midyear, ah, cost adjustment. That said, if, I don't think we would say no to to any submittals that you might make. But, but, but in accordance with the law, as I read it, it's calendar year, January thirty first. That make sense?

BM – That does. Thank you.

CF – Okay.

Unknown 1 – I had a quick question on slide 20, when we were talking about the good faith estimate. (Flipped back to slide 20). Is everything that was listed what's in law now or proposed of what we would be required to give when someone calls in? So meaning, the CPT codes, the plain English description, is that all part of that bill now or what's on the table to possibly be what we need to give them?

CF – That's what's in the bill.

Unknown 1 – Okay. Perfect.

CF – It's in the law. Excuse me, not the bill.

Heidi Lengdorfer (HL) – Yeah.

CF – Now law. Yeah. Sorry for that.

Unknown 1 – Okay. Perfect. That's what I thought but I wanted to clarify, thank you.

CF – No problem.

Brice Alexander (BA) – Depending where you're at, there's municipality rules, I don't know how to define it. But for Anchorage, where we've already had to be providing these estimates of prices for our patients.

Unknown 2 – Clint? In these estimates…

CF – Yeah.

Unknown 2 – In these estimates, so we're giving an estimate for our pricing, but within our clinic, they have other services. I mean they could have other billings…

(01:40:00)

Unknown 2 con't – besides the estimate that we give them. If they, you know, suppose they get back into the room and they have some kind of lab charge, that's not our estimate. We wouldn't give an estimate for that because we don't do the billing for that. But we do the service here in our clinic.

Heidi Lengdorfer (HL) – I think. This is Heidi. I think that falls under the last bullet point on this slide of the…I think the bill language says suspected identity of any person that may charge. Am I remembering that correctly Clint?

Clint Farr (CF) – Yeah. Yeah. It, it's … there's a couple of things there and this is a really good point because a couple of thing there. You, uh, from what my read of this is, um, you're, the insurer is not required to disclose prices for the total anticipated course of any treatment. Um, so, you can give a partial estimate of what you, you know, of what you understand and know. Um, that, that is possible, but you may have, you may include an, an explanation of that – that it's, that it's, um, you know, just part of a larger process kind of thing. But I don't think the law requires the, uh, a full course of treatment. That, that, that you can give partial, uh, uh, price estimate. Does that help?

Unknown 2 con't – Yes. Thank you.

HL – Yeah. For example, if you're having some sort of orthopedic surgery, I wouldn't expect my good faith estimate from the surgeon's office to include any physical therapy thereafter.

CF – Yeah, and I think, I think that, you know, basically, the, the bill has flexibility. Like, like was mentioned earlier, this is a good faith estimate between doctor and patient. So, it's about what your good faith is in providing them the information that they need to know in order to make a good decision right? And so whatever that looks like, there's some flexibility in this bill. Could be partial, could be a total course, that sort of thing.

Yeah I'm going to scroll back down to questions. Or contacts (Now on slide 28).

Does every, has everybody put their name and email into the chat box? That wants to get emails. Make sure you do that.

Unknown 3 – Will you be sending this powerpoint as well?

CF – Yes. Yes.

Unknown 3 – Okay, thank you.

CF – Yes, I'll have the powerpoint, I'll have a, a transcript of the, of the minutes, of the meeting. Um, yeah.

Unknown 3 – Okay, thank you.

CF – Thank you.

HL – Are there any more…

Unknown 4 – On the agenda today, Clint, it said there would be summary of identified tasks and next steps.

CF – Yes.

Unknown 4 cont – Is that going to be sent out via email or …?

Clint Farr (CF) – Oh, right now, the, you know, in, in, Heidi can help me out here a little bit. We have, we have, obviously some internal churning to do with the, the information and the comments that you've given us. And the development of an internal set of guidelines on how we want to approach SB 105. That's the, sort of, the immediate next step internally. On down the line there's, you know, there's going to be this process, uh, regulations process. Um, so, that will be separate thing. You'll get emails on that, ah, when the time comes. But that's not what we're doing right now. Right now, it's trying to get information for our internal guidelines and then, and then we'll go from there. Did you want to add?

Heidi Lengdorfer (HL) – No, I think. This is Heidi again. I think you're pretty spot on what we're looking to do is provide an FAQ for you all, somewhat immediately after this meeting and addition to providing the powerpoint and the minutes slash transcription. And from there, you know, providing what technical assistance we can either through pouched emails or batched emails, etc. We're just trying to get our hands around this process with your input so that we can address your needs in making this a success.

CF – Yeah.

Unknown 4 – Great. Thank you.

CF – Thank you!

Beverly Mcdevitt (BM) – Clint, this is Beverly. Jaime has a question.

CF – Okay.

BM/Jaime – In your opinion, as you are building this, should we be holding off on getting cost estimates for signage and potential digital signage? Should we have those wheels in motion? Or, in your opinion, should we be holding off until these regulations are more drafted.

CF – I think if the wheels are in motion, they should continue to be in motion. You still have a law, ah, that requires, ah, the, the postings by January thirtieth, thirty first. And we recognize that we don't have regulations in place and that sort of thing, but we don't want to have anybody in arrears either while they're waiting for us to get our act together. So, it's going to be a little bit of back and forth. We hope to have some guidelines out very soon. They will not have the force of law however, so it's more of a, this is what we're looking at right now and…

HL - …and if you have any questions, please contact us. We, we're here to help.

CF – Yeah. So, I, I wouldn't hold off because I don't want anybody to get in trouble, you know what I mean. So, as, as we try to get, ah, more clarification out to you guys. And so, um, you know I know that many of you have already been working on this, so, ah, keep going, and that's going to help, you know, help us figure the direction of, of the program. You know, what's feasible? What's realistic? What… you know, hindrances have you encountered? Challenges have you encountered? That sort of thing.

(Pause)

Do I have everybody's email?

Unknown 5 – Yes. You have mine I know!

Clint Farr (CF) – Okay. It's almost, it's really a rhetorical question. Um. I want to thank everyone for calling in for nearly two hours and talking about this. We got a lot to go over, um, your participation is greatly appreciated. Thank you so much. I wish you all the best and a happy thanksgiving. And this is my contact ….

Beverly Mcdevitt (BM) - Oh, Clint?

CF – Go ahead.

BM – One more question before we go. Kailey has a question.

BM/Kailey – Hi, I was wondering, so, for clinics that have multiple locations, for example we have a main clinic and then we have specialty clinics that are outside in separate buildings. There had been a comment earlier about submitting an address to go on the DHSS' website. Would we need to submit the multiple addresses for all of the buildings associated with our clinic? And also, as far as posting, if we are looking at this potentially only having this be facility wide and not department based, would we need to be posting in each separate building?

CF – That's a fantastic, um, point. My read, right now, would be, and this is not anything, um, definitive, but it would be that you, you would provide the address of your main, or corporate if you will, your main office and we would leave it at that. I don't, I don't know at this point, you know because, I, my guess is that the facilities would be subsumed by overall activities of the, of your, of your clinic. Um, your top ten would include things from the facilities as well as the main office in aggregate. Ah, and so, the, the posting would be something like, you know, at the main office for the aggregate of activities for your facil…for your clinic. Um, that would be my read right now.

Heidi Lengdorfer (HL) – And this is Heidi, to answer your second question. I would, yes, expect that they, that would be posted in your multiple offices.

BM/Kailey – Thank you. Thank you.

CF – Thank you. Okay. Are there any final questions? Then I'm going to end the call. Go ahead.

Unknown 1 – Thank you.

CF – Thank you so much.

(phones disconnecting)

Brice Alexander – Many thanks Clint. Good luck.

(phones disconnecting)

CF – Thank you. Thank you for that.

(phones disconnecting)

HL – Alright.

(phones disconnecting)

(01:50:00)

(Webinar disconnected at 01:52:54)

CHAT LOG – To everyone only:

Date	Time	Author	Note
20-Nov-18	10:03 AM	from Brice Alexander to everyone:	Brice Alexander, CMPE Practice Administrator for Anchorage Pediatric Group & a representative contact for AKMGMA EMAIL: management@apgkids.com
20-Nov-18	10:03 AM	from Bernice Nisbett to everyone:	Bernice Nisbett, Office of Rep. Ivy Spohnholz: bernice.nisbett@akleg.gov
20-Nov-18	10:04 AM	from Suzanne Niemi to everyone:	Suzanne Niemi, Alaska Primary Care Association. suzannen@alaskapca.org

20-Nov-18	10:24 AM	from Brice Alexander to everyone:	2. The Current Procedural Terminology (CPT) code set is a medical code set maintained by the American Medical Association (AMA) through the CPT Editorial Panel. The CPT code set (copyright protected by the AMA) describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes. (~Wikipedia Definition~) a. Is the State of Alaska really requiring medical entities as described in SB 105 to re-write a copyright protected reference material and overlook the designed function to accurately and precisely describe what occurred – a design continuously reviewed by administrative, medical, and legal panels within the AMA?
20-Nov-18	11:42 AM	from Gloria Jueneman to everyone:	Gloria Jueneman
20-Nov-18	11:43 AM	from Shauna Credit to everyone:	Shauna Credit scredit@akchild.org
20-Nov-18	11:43 AM	from Gloria Jueneman to everyone:	Gloria Jueneman gjueneman@alaskaheart.com