HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION

Washington Report – June, 2018
(Covers activity between 6/1/18 and 6/30/18)
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HBMA GR Committee Holds Annual Visit to CMS and Washington, D.C.

- The HBMA GR Committee met with Medicare staff who oversee the day-to-day operations of the Medicare program at CMS Headquarters in Baltimore, M.D.
- The Committee also met with federal policy makers and fellow industry stakeholders in Washington, D.C.
- A full summary of the meetings will be published in the September issue of *RCM Advisor*

On June 13th and 14th, the HBMA Government Relations Committee held its 11th consecutive trip to Baltimore, M.D. and Washington, D.C. The purpose of this annual trip is to meet with federal policy makers to advocate for improvements to the Federal Health Programs on behalf of the healthcare revenue cycle management (RCM) industry.

These meetings also provide an invaluable opportunity to build or maintain relationships with key federal offices that make new policies as well as agency staff who are responsible for the day-to-day operations of the Medicare program.

As usual, this year's visit included a full day of meetings at the Centers for Medicare and Medicaid Services (CMS) headquarters in Baltimore, M.D. with CMS staff. CMS knows that HBMA members live in this administrative space and is always eager to hear our "on the ground" perspective on the programs and policies they oversee.

In recent years, the CMS meetings have been followed by a second full day of meetings with federal policy makers and industry partners in Washington, D.C. This year, the Committee spent the day in our Nation's Capital meeting with President Trump's Special Assistant for Health Policy, the Principle Deputy Administrator of CMS, staff from the House Ways and Means Committee's Health Subcommittee, the Executive Director and staff from Medicare Payment Advisory Committee (MedPAC) and with fellow practice management and health IT stakeholder organizations.

A brief summary of the notable information that was provided to HBMA during the meetings was published on the HBMA General Listserv. A full summary of each individual meeting will be published in the September issue of *RCM Advisor*.

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2017 MIPS Performance Feedback is Available via EIDM Accounts

- MIPS-Eligible Clinicians can view their 2017 MIPS performance data via their EIDM accounts.
- This data will also include the EC's 2019 payment adjustments that correspond to their 2017 performance data.
- ECs can appeal this feedback data until September 30th.

Every eligible clinician (EC) for the Medicare Quality Payment Program (QPP) can view their 2017 performance data and 2019 payment adjustments via their EIDM account. ECs can also appeal their performance data until September 30th. CMS has also provided a fact sheet to help EC understand their data.

ECs are required to participate in the Merit-based Incentive Payment System (MIPS) unless they are exempt from MIPS for falling below the low-volume provider threshold or by qualifying as a

participant in an Advanced Alternative Payment Model (Advanced APM). Most ECs participate in MIPS.

The QPP replaces the Medicare Sustainable Growth Rate Formula (SGR) methodology for determining annual updates to Medicare Part B payments. ECs can earn positive or negative payment adjustments based on how their MIPS performance score compares to that of all other MIPS ECs.

For the 2017 reporting year, ECs can earn up to a four percent increase to their Medicare Part B payments in 2019. ECs who did not submit any data for 2017 will receive an automatic four percent payment reduction to their Medicare Part B payments in 2019.

MIPS is budget neutral meaning that the money used to pay the bonus payments to high performing ECs, comes from the payment reductions levied against ECs who underperform relative to the other ECs. The highest performing ECs can earn additional bonus payments from a separate pool of money that is not subject to the budget neutrality requirement.

For the 2017 reporting year, CMS made it incredibly easy for ECs to avoid negative payment adjustments. ECs can only earn a negative payment adjustment if they failed to report **any** amount of data for **any** number of patients for **any** period of time in 2017.

According to CMS, 91 percent of ECs successfully participated in MIPS meaning the nine percent of ECs who did not participate must fund the positive payment adjustments for the other 91 percent. It is therefore very unlikely that ECs who participated in MIPS will receive a significant payment increase in 2019.

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CAQH Index Shows Billions in Potential Savings Remain from Transition to Electronic Transactions

- CAQH published its annual Index that measures the adoption of healthcare electronic transaction standards.
- According to the Index, the US healthcare system is continuing to make gradual progress towards adoption of electronic transactions.
- The Index estimates the industry could save up to $11.1 billion by fully adopting electronic standards.

The Council for Affordable Quality Healthcare (CAQH) has released its 2017 Index, an annual report that measures the adoption of electronic business transactions in healthcare. According to the Index, the healthcare industry is continuing to make slow progress towards adoption of electronic transactions established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Index collects data using voluntary surveys. Data is submitted from health plans representing 155 million lives, which is 51 percent of the commercially insured U.S. population. The data represents 1.6 billion claims and over 6 billion total transactions.

Electronic transactions generally refers to the electronic transaction standards established under HIPAA. Although technically "electronic", transactions through online portals are considered manual transactions for providers. However, portal transactions are considered electronic for health plans.

The report found that fully transitioning to electronic transactions would save the healthcare industry $11.1 billion annually. $9.5 billion of these savings would "accrue to healthcare providers."

The Index measures industry adoption of eight transactions for medical providers and five transactions for dental providers.

According to the Index, Claims Submission, Eligibility and Benefit Verification, Claim Status Inquiries, Coordination of Benefit (COB) Claims, Remittance Advice and Claim Attachments all saw increases in electronic transaction utilization. COB claims saw the greatest increase in adoption of 21 percent while the other transactions all increased by between one and three percent.

Prior Authorization, and Claim Payment were the only transaction that saw a decrease, with a respective ten percent and two percent reduction in electronic utilization compared to 2016.

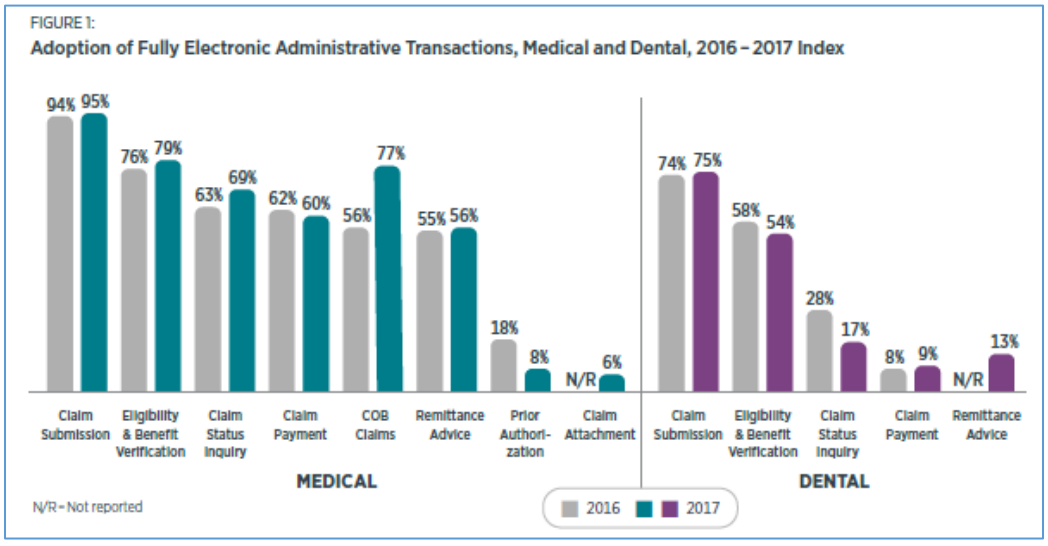

TABLE 6:
Average Cost per Transaction and Savings Opportunity for Medical Health Plans and Providers for Manual and Electronic Transactions, 2017 Index

Transaction	Method	Health Plan Cost	Provider Cost	Industry Cost	Health Plan Savings Opportunity	Provider Savings Opportunity	Industry Savings Opportunity
Claim Submission	Manual	$0.62	$2.46	$3.08	$0.53	$1.83	$2.35
	Electronic	$0.09	$0.63	$0.73			
Eligibility & Benefit Verification	Manual	$4.36	$2.84	$7.20	$4.29	$2.17	$6.46
	Electronic	$0.07	$0.67	$0.74			
Prior Authorization	Manual	$3.68	$5.75	$9.43	$3.64	$3.20	$6.84
	Electronic	$0.04	$2.55	$2.59			
Claim Status Inquiry	Manual	$4.39	$5.26	$9.65	$4.35	$3.63	$7.98
	Electronic	$0.04	$1.63	$1.67			
Claim Payment	Manual	$0.57	$1.59	$2.16	$0.48	$0.40	$0.88
	Electronic	$0.09	$1.19	$1.28			
Remittance Advice	Manual	$0.50	$4.82	$5.32	$0.45	$3.69	$4.14
	Electronic	$0.05	$1.13	$1.18			
Claim Attachment	Manual	$1.74	$1.68	$3.42	$1.64	$0.51	$2.15
	Electronic	$0.10	$1.17	$1.27			

Although 95 percent of claim submissions were electronic, 37 percent of claim payments were fully manual (e.g. paper check).

Prior Authorization transactions saw a decrease for what the Index describes as a "confluence of market factors." One such factor described in the report is the increased utilization of health plan portals over HIPAA standard transactions.

Going forward, the Index does not make detailed recommendations. However it does feature an "industry call to action" that includes expanding the understanding of portals and embracing the transition to fully electronic transitions.

CAQH expects the trends from 2017 will continue, leading to positive adoption growth in 2018. CAQH believes that there will be an increase in enrollment in high-deductible health plans which will put a greater emphasis on eligibility transactions and claim status transactions.

CAQH also believes that the transition to value-based payment models presents new obstacles for the adoption of electronic transactions. According to CAQH, value-based payment models will integrate clinical, financial and administrative data which will "require more precise

operational processes than those required to administer fee-for-service claims" and will therefore present challenges to the adoption of electronic standards.

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Department of Labor Issues Association Health Plan Final Rule

- The Department of Labor published the final regulation that will allow associations to offer health insurance to their members.
- Associations can begin offering these plans on September 1st of this year.

The Department of Labor (DOL) has issued a final rule explaining, among other things, how the DOL will redefine an "employer" for health plans governed by the Employee Retirement Income Security Act (EIRSA) so that Associations can offer health insurance to their members similar to how large employers offer health insurance to their employees.

The Trump Administration originally proposed Association Health Plans (AHP) as an alternative to plans sold in the individual and small group markets established by the Affordable Care Act (ACA). The Administration believes that AHPs will be a cheaper alternative to many ACA plans.

Similar to ACA plans, AHPs will not be allowed to deny coverage based on preexisting conditions nor will they be able to charge significantly higher premiums based on health status. However, AHPs are largely exempt from many of the ACA's health plan standards such as the essential health benefit regulations.

AHPs can be self-funded, meaning the association pays health insurance claims through its financial reserves. However, it is expected that most associations will choose to offer commercial insurance products to their members similar to the employer insurance model.

AHPs have been subject to some criticism because AHPs will not be subjected to the same health plan regulations that ACA plans must follow. Also, the Trump Administration estimates that up to four million people will enroll in an AHP, many of whom would forego ACA plans for AHPs. To the extent AHPs prove attractive to younger, healthier individuals, the movement of these individuals from the ACA market to the AHP market could prove harmful to the ACA markets Such a shift would increase ACA premiums because the ACA market would be made up of a disproportionately higher percentage of less healthy individuals.

The Administration acknowledges that AHPs could have this effect on ACA markets but does not believe the effect will be as significant as critics suggest.

The final regulation defines "associations" not just as an organization representing an industry or profession (such as HBMA) but could also be people who come together to form an association that can offer AHPs based on residence in a geographic region. The final rule allows associations

to be formed for the sole purpose of offering an AHP to their members however the association must have a formal governing structure.

The final rule allows AHPs formed under these regulations to begin being offered on September 1, 2018.

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Social Security Number Removal Initiative Update

- CMS is continuing its transition to new Medicare beneficiary cards.
- Phase three of the card mailings recently began.
- CMS is notifying providers to ignore QR codes that some new cards have.

As the Centers for Medicare and Medicaid Services (CMS) continues its rollout of the new Medicare beneficiary cards, it has been publishing important updates for both providers and beneficiaries.

The purpose of the transition is to replace the Social Security Number (SSN) as a beneficiary's Medicare identification number. CMS is replacing the current, Health Insurance Claim Number (HICN) with a new, alpha numeric Medicare Beneficiary Identifier (MBI). The transition to new cards was mandated by Congress to protect beneficiary SSNs and reduce Social Security and Medicare Fraud.

CMS will accept claims with either the HICN or the MBI through 2019. Beginning on January 1, 2020, CMS will only accept the MBI.

Beginning in April, all **new** Medicare beneficiaries received a beneficiary card with an MBI. For those enrolled in Medicare prior to April, CMS is continuing to roll out the new cards to a few states a time in seven waves. According to a CMS announcement, Wave 3 recently began. Wave 3 includes Arkansas, Illinois, Indiana, Iowa, Kansas, Minnesota, Nebraska, North Dakota, Oklahoma, South Dakota and Wisconsin.

CMS is still mailing new cards to beneficiaries who live in Wave 2 states and territories which are Alaska, American Samoa, California, Guam, Hawaii, Northern Mariana Islands and Oregon.

CMS has almost finished mailing new cards to beneficiaries in Wave 1 states which are Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia.

Providers can look up MBIs through their MACs.

CMS is also notifying providers that some new Medicare cards will have a square QR Code. The QR codes on Medicare cards allow the contractor who prints the cards to ensure the right card

goes to the right beneficiary. The QR code does not serve any other purpose and CMS says providers should not attempt to use it.

Lastly, CMS has also published an updated fact sheet on the transition that can direct providers to additional resources.

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CMS Publishes FY 2019 ICD-10-CM Diagnosis Codes

The Centers for Medicare and Medicaid Services (CMS) has published the Final FY 2019 ICD-10-CM diagnosis code updates are available on the 2019 ICD-10-CM webpage. These 2019 ICD-10-CM codes are to be used for discharges occurring from October 1, 2018 through September 30, 2019 and for patient encounters occurring from October 1, 2018 through September 30, 2019.

- 2019 Code Descriptions in Tabular Order [ZIP, 2MB]
- 2019 Code Tables and Index [ZIP, 18MB]
- 2019 Addendum [ZIP, 685KB]
- 2019 Conversion Table [ZIP, 73KB]

In a somewhat related story, on June 18th, the World Health Organization (WHO) released ICD-11 which is eventually expected to replace the ICD-10. If past is prologue, it will be several years before ICD-11 makes its way to American shores.

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CMS to Again Include QMB Status on Remittance Advice

- QMB status will be indicated in remittance advice. CMS previously included this information in remittance advice but had to stop to address unforeseen issues which have now been resolved.
- CMS is also introducing two new remark codes for QMB status.
- CMS informed the HBMA GR Committee about this change in our meeting at CMS.

In an effort to improve the availability of information regarding Qualified Medicare Beneficiary (QMB) status, the Centers for Medicare and Medicaid Services (CMS) began indicating QMB status on remittance advice (RA) for Medicare claims on July 2nd.

QMBs are dually eligible for Medicare and Medicaid. Providers are not allowed to bill QMBs for Medicare cost sharing including copays and deductibles. Providers can bill Medicaid for the cost sharing.

CMS has been making a serious effort to reduce the improper QMB billing. CMS understands that most instances of improper QMB billing is due to a provider not knowing a beneficiary is a QMB rather than fraud. CMS has therefore been taking steps to improve the availability of this information.

For example, CMS began including QMB status in HIPAA Eligibility Transaction System (HETS) 270/271 transactions. It also began including QMB status on RA in 2017 but had to suspend that function after a few months due to "unforeseen" circumstances.

During the HBMA Government Relations (GR) Committee's annual visit to CMS headquarters earlier this month, CMS informed the GR Committee that it would begin including QMB status in RA and in Medicare Summary Notices (MSN) in July.

On June 28th, CMS formally announced that it would reintroduce QMB status to RA and MSNs on July 2, 2018.

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CMS Publishes 2017 Open Payments Data

- CMS published all "transfers of value" from drug and device manufacturers to providers on the Open Payments website.
- This data release is intended to foster transparency so patients can better understand if manufacturers influenced a provider's decision making when prescribing drugs or devices.

The Centers for Medicare and Medicaid Services (CMS) has published the 2017 Open Payments data, which discloses how much money drug and device manufacturers paid to healthcare providers.

The CMS Open Payments website is intended to provide transparency to patients to understand how manufactures might influence a provider's decision with regard to what drugs and devices they prescribe. This program was created in response to concerns that manufacturers influence providers to favor their drug or device over competitors through practices such as taking providers out for nice meals or arranging conference speaking appearances with speaking fees.

According to the data, manufacturers made $8.4 billion in payments to providers in 2017. In total, 11.54 million "transfer of value" transactions were reported. 628,214 physicians and 1,158 teaching hospitals were recipients of transfers of value. Of this total,

- $2.82 billion was in general (i.e., non-research related) payments,
- $4.66 billion was in research payments,
- $927 million was transferred as ownership or investment interests held by physicians or their immediate family members.

According to CMS, the Open Payments data is refreshed annually to include any changes that may have been made after the initial publication. The refresh of the current published data will take place in January 2019.

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HHS Throws Cold Water on Physician-Focused Payment Models

- HHS Secretary Alex Azar says CMMI is not interested in testing Physician-Focused Payment Models (PFPM) that have been recommended by the PFPM Technical Advisory Committee.
- Secretary Azar reaffirmed his commitment to testing new value-based payment models and his preference that HHS be the driving force behind the development of new models.

The Department of Health and Human Services (HHS) is perhaps the biggest driver of the transition to value-based payments in healthcare. The Affordable Care Act (ACA) created the Centers for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services (CMS) and grants CMMI broad authority to design, test and implement new payment models.

The provider community has responded to these new models with varying levels of interest. The models themselves have also had mixed results with few models accomplishing their intended goals of improving quality while also reducing cost.

Most providers are aware that the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) created the Merit-based Incentive Payment System (MIPS). Fewer seem to be aware that MACRA also promoted the creation of a Physician-Focused Payment Models (PFPM).

PFPMs are condition-specific or specialty-specific models designed by medical specialty associations or other stakeholder organizations rather than by CMMI. Congress, by encouraging the creation of PFPMs, wanted providers to take greater ownership of the development of value-based payment models.

MACRA created a PFPM Technical Advisory Committee (PTAC), composed of experts in value-based payment models, to accept and evaluate PFPM proposals. The PTAC works with the sponsoring organizations to evaluate and refine PFPM proposals. The PTAC then recommends models it likes to CMMI who then decides if the model should be tested in the Medicare or Medicaid programs.

Since the PTAC was formed, it has received many PFPM proposals and has recommended approximately a dozen to CMMI for testing in the Medicare program. However, based on the Administration's recent response to the PTAC, it appears that none of the PFPMs recommended by the PTAC will be tested by CMMI.

The response, written by HHS Secretary Alex Azar, identifies supposed flaws with each model as a justification for rejecting each recommendation.

Although Secretary Azar has reiterated HHS's commitment to the development of value-based payment models on numerous occasions, his response seems to indicate that CMMI will retain tight control over the model creation process – much to the disappointment of the provider community.

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CMS Solicits Public Input on how to Reform Physician Self-referral Law

- CMS is soliciting public input on how to reform the physician self-referral laws to improve how value-based payment models are designed.
- Comments are due to CMS by August 24th.

The Centers for Medicare and Medicaid Services (CMS) has issued a formal Request for Information (RFI) asking the public to submit suggestions for how to reform the physician self-referral law, commonly known as the Stark Law.

Originally enacted in 1989, this law was passed to address the concern that health care decision making can be influenced by a profit motive due to ownership interests. For example, a primary care provider who owns an imaging center could be incentivized to order unnecessary images and refer patients to his/her imaging center.

According to the RFI, by design, the physician self-referral law is intended to disconnect a physician's health care decision making from his or her financial interests in other health care providers and suppliers.

CMS wants to reform the Stark Law as part of its effort to reduce regulatory burden on providers. However, most of the RFI's questions are regarding how the self-referral law can inhibit the success of alternative payment models (APM). Many APMs promote care coordination and integrated care, which could be limited by self-referral laws. According to the RFI, CMS has identified some aspects of the physician self-referral law as a potential barrier to coordinated care.

CMS does maintain a list of "Safe Harbor" practices that are exempt from the self-referral law. This list is updated on a regular basis.

CMS is accepting comments until 5 p.m. on August 24, 2018. Comments can be submitted electronically via http://www.regulations.gov.

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MedPAC Suggests Ten Percent Increase for E&M Payments

- MedPAC, a Congressional Medicare policy advisory body, believes that Evaluation and Management services are undervalued yet are being increasingly leveraged as central components of new payment models.
- MedPAC is suggesting a one-time payment increase for Evaluation and Management services by 10 percent.
- This would decrease payments for all other services by 3.8 percent to maintain budget neutrality.

In its annual June Report to the Congress, the Medicare Payment Advisory Commission (MedPAC) is advocating for a major rebalancing of the Medicare Physician Fee Schedule (PFS). The shift would increase payments for ambulatory evaluation and management (E&M) services and decrease payments for all other services to maintain budget neutrality.

MedPAC is a non-partisan agency of Congress that provides analysis and recommendations to Congress on Medicare payment policy. Its recommendations are influential but non-binding. Congress usually acts on few, if any, MedPAC recommendations each year.

Under the Physician Fee Schedule (PFS), Medicare payments to providers are based on relative value units (RVU), which factor the time, technical skill, cognitive effort, expense and liability of a service relative to another service. RVUs are determined by CMS in conjunction with the American Medical Association's Relative Value Scale Update Committee (RUC).

The RUC makes recommendations for RVU revaluations to CMS based on responses from surveys issued to providers. CMS can accept or reject RUC proposals.

RVU revaluations must be budget neutral meaning any increases to a service's RVUs must be offset by RVU decreases to other services.

MedPAC acknowledges flaws with the RUC's survey methodology. First, the response rate for surveys is typically very low and therefore does not provide an accurate representation. Secondly, providers have a financial stake in maintaining or increasing RVUs for the services they provide. This can lead to overestimates and exaggerations in their responses that obscure the actual time and effort it takes to perform these services. Lastly, according to MedPAC, CMS is often slow in reviewing RVU value data.

MedPAC is urging CMS to increase the RVUs for Evaluation and Management (E&M) services. The Commission's report provides evidence for why ambulatory E&M services should be the focus of the proposed shift in payment. Ambulatory E&M services, which include office visits, hospital outpatient department visits, home health and nursing facility visits, are an integral part of the types of coordinated care that MedPAC wants CMS to emphasize in new payment models.

MedPAC believes that under the current fee schedule, E&M services are underpriced compared to other, mainly procedural, services. E&M services require the attention and time of the provider to make judgements and engage in decision making.

According to MedPAC, the reason procedures have received higher valuations than cognitive services such as E&M has to do with the new technologies and techniques for procedures.

When a service is first introduced, it requires additional time to learn the procedure and perform it correctly. Therefore it receives higher RVUs. Over time, these services become more familiar and require less effort on the part of the provider yet these services often do not see a reduction in their RVUs to reflect this increased efficiency.

Because of its stated criticisms of the RUC process, MedPAC proposes a one-time, across the board ten percent increase for all ambulatory E&M services. The report also describes alternative options for implementing the increase, including a gradual increase in payment occurring over multiple years. MedPAC believes this RVU increase for E&M services would require a 3.8 percent decrease for all other services to maintain budget neutrality.

The report argues that the distribution of RVUs is creating a disproportionate incentive for non-ambulatory services. MedPAC's proposal shifts what they consider "inflated payments" for tests, imaging and procedures towards the type of integrated and coordinated care delivery that is considers to be central to value-based payments.

This proposal is not yet a formal recommendation to Congress. MedPAC strongly believes that E&M services should receive an increase in Medicare reimbursement. This chapter illustrated what a ten percent increase would look like and how it would impact other services to maintain budget neutrality. MedPAC could refine this illustration in future reports.

The June report is the final report MedPAC will issue in 2018. The next opportunity for this proposal to become an official recommendation will be the Commission's March 2019 Report to Congress.

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2018 Trustees Report Projects Accelerated Timeline for Hospital Trust Fund Insolvency

- A report issued by the Medicare Trustees projects that the Medicare Part A trust fund will be insolvent by 2026.
- The report found the trust fund for Medicare Part B and D is financially stable.

The Medicare Board of Trustees released its annual report detailing the financial outlook of Medicare.

The Board of Trustees is comprised of four members: Secretary of the Treasury Steven Mnuchin, Secretary of Labor Alexander Acosta, Secretary of Health and Human Services Alex Azar and the Acting Commissioner of Social Security, Nancy Berryhill.

According to the Report, Medicare's total spending was $710 billion in 2017, equal to 3.7 percent of Gross Domestic Product (GDP).

In 2017, Medicare covered 58.4 million people: 49.5 million people aged 65 and older, and 8.9 million disabled individuals. Over 34 percent of these beneficiaries have chosen to enroll in commercial Medicare plans under Medicare Part C (Medicare Advantage).

Medicare is financed through two separate trust funds: The Hospital Insurance Trust Fund (HI), which covers Medicare Part A expenditures and the Supplementary Medical Insurance Trust Fund (SMI) which covers Medicare Part B and Part D expenditures. Revenue for the HI Trust Fund comes exclusively from the Medicare portion of the Social Security payroll tax whereas revenues for the SMI Trust Fund come from a combination of payroll tax revenue and general fund revenues.

The Trustees Report estimates that the HI will become insolvent by 2026, three years earlier than estimated in 2016. The report cites a combination of decreased revenues and higher spending as the contributing factors to the HI's advancing insolvency.

Lower payroll taxes as a result of lower wages, lower-than-predicted GDP growth and lower income from taxation of Social Security benefits are all projected to contribute to decreased HI revenue. Additionally, Medicare is receiving a huge influx of beneficiaries as the baby boomer generation ages into Medicare eligibility.

Despite the HI's challenges, projections for the SMI indicate a stable outlook.

The report is an analysis of the Medicare program's finances. It does not propose solutions to improve the financial outlook of the Medicare Part A Trust Fund.

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House Passes Series of Opioid Bills

The House of Representatives passed a series of bills that are intended to address the opioid crisis. Most of these bills were passed with broad bipartisan support. The bills are organized into three general categories, those that fund grants and public health initiatives, those that use the Medicare and Medicaid programs to address the issue, and those regarding law enforcement activities.

Below is a summary of the bills that directly affect the ability of providers to prescribe opioids as well as other bills of interest to the practice of medicine.

Addressing the opioid crisis is a key priority for both parties and both Chambers of Congress. Although the Senate has not begun to consider these bills, eventual Senate action on bills to address the opioid crisis is expected.

- H.R. 3331 authorizes the Center for Medicare and Medicaid Innovation (CMMI) to test an incentive payment model for behavioral health providers to use electronic health record technology for purposes of improving the quality and coordination of care.
- H.R. 5009, Jessie's Law, requires the Department of Health and Human Services (HHS) to develop and disseminate best practices for health care providers and state agencies regarding the display of a patient's history of opioid addiction in the patient's medical records.
- H.R. 5483, the Special Registration for Telemedicine Clarification Act requires the Drug Enforcement Agency (DEA) to issue regulations for implementing special registrations for providers to prescribe controlled substances such as opioids using telemedicine.
- H.R. 5685, the Medicare Opioid Safety Education Act requires the Centers for Medicare and Medicaid Services (CMS) to provide Medicare beneficiaries with educational resources regarding opioid use and pain management, including descriptions of Medicare-covered alternative (non-opioid) pain-management treatments.
- H.R. 6, the SUPPORT for Patients and Communities Act, among other things, requires the initial examination for new Medicare enrollees to include an opioid use disorder screening and requires coverage for services provided by certified opioid treatment programs.

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CMS Creates First Medicaid and CHIP "Scorecard"

- CMS published a new "scorecard" that measures each state Medicaid program's performance.
- The scorecard also assesses the federal government's performance for its role in each Medicaid program.

The Centers for Medicare and Medicaid Services (CMS) released a state-by-state Medicaid and CHIP scorecard. The scorecard will provide transparency for many aspects of a Medicaid program's performance ranging from providing care to administrative processes.

The scorecard initiative was first announced by CMS Administrator Seema Verma in late 2017 as part of an effort to improve transparency about spending and outcomes in the Medicaid program.

The scorecard draws upon federally reported data as well as measures obtained on a voluntary basis from states. The scorecard gives information on three categories:

- State Health System Performance,
- State Administrative Accountability, and
- Federal Administrative Accountability.

State Health System Performance includes measures such as number of emergency department visits, well-visits and child immunizations. Both the State and Federal Administrative Accountability categories measure the performance of state Medicaid offices and CMS itself in measures like State Plan Amendments and Section 1115 demonstrations.

Since its announcement, the scorecard initiative has garnered criticism from a number of groups. Many are concerned about the accuracy of data because of the voluntary nature of reporting. Some always worry about the fairness of making comparisons across states with many structural differences.

The release of the scorecard has prompted questions about what CMS intends to do with the information. It is unclear whether there will be consequences for low scoring states. Verma called the release "a huge step forward" but emphasized that the agency will continue to expand the scorecard. Verma indicated that CMS will continue to evaluate and add new measures and may move to mandate reporting from states.

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DOJ Boasts Largest Annual Fraud Takedown to Date

- The Department of Justice announced the results of its annual healthcare fraud "takedown."
- Almost every charge is related to inappropriate opioid prescribing.

The Department of Justice (DOJ) recently completed its annual healthcare fraud "takedown" and has reported that it has charged 601 individuals who are responsible for over $2 billion in combined losses to the Federal Healthcare Programs due to fraudulent activity.

According to the DOJ, this is the largest healthcare fraud enforcement action that has ever been taken by the Agency. The DOJ has been conducting an annual takedown in conjunction with the Department of Health and Human Services (HHS) for several years. The DOJ always publicizes the results of their enforcement action in a press release.

According to this year's announcement, 165 doctors, nurses and other licensed medical professionals have been charged for their alleged participation in health care fraud schemes involving more than $2 billion in false billings to the Federal Healthcare Programs (Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and TRICARE).

This year's takedown placed a strong emphasis on violations regarding opioid prescribing practices. According to the DOJ announcement, "Of those charged, 162 defendants, including 76 doctors, were charged for their roles in prescribing and distributing opioids and other dangerous narcotics."

Charges include submitting false claims to government or commercial payers for medically unnecessary services or services that were never provide, recruiting beneficiaries or other providers into the schemes and paying kickbacks to co-conspirators for their role in the schemes.

The same week the DOJ announced the results of its takedown, the Centers for Medicare and Medicaid Services (CMS) announced a series of new Medicaid performance integrity initiatives. These initiatives include:

- Stronger audit functions,
- Enhanced oversight of state contracts with private insurance companies,
- Increased beneficiary eligibility oversight, and
- Stricter enforcement of state compliance with federal rules.

Medicaid program integrity was also the topic of a June 27th Senate Committee on Homeland Security and Government Affairs hearing. Witnesses from the HHS Office of Inspector General (OIG) and the Government Accountability Office (GAO) testified that CMS needs to do more to combat Medicaid fraud and abuse. The GAO cited a report it issued in April stating that Medicaid made $37 billion in improper payments in 2017

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Federal Court Blocks Kentucky's Medicaid Work Requirement

On June 29th, U.S. District Court for the District of Columbia Judge James Boasberg issued a decision on a lawsuit brought against the Department of Health and Human Services (HHS) by a number of Kentucky residents challenging the waiver Kentucky received that allowed it to impose work requirements as a condition for Medicaid coverage. The Medicaid-eligible Kentucky residents who filed the suit believe they will be adversely affected by this new requirement.

Judge Boasberg sided with the plaintiffs and against HHS and Kentucky in blocking Kentucky's requirement that able bodied Medicaid beneficiaries work at least 80 hours per month as condition of Medicaid coverage. Kentucky received a waiver from the Centers for Medicare and Medicaid Services (CMS) to impose the work requirements.

In his opinion, Judge Boasberg wrote that HHS "never adequately considered whether Kentucky HEALTH would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid. This signal omission renders [HHS'] determination arbitrary and capricious."

A number of other states have also instituted work requirements as a condition for Medicaid coverage. It is unclear what effect this decision will have on those states. This is the first action a court has taken to block Medicaid work requirements.

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CMS Transmittals

Transmittal Number	Subject	Effective Date
R4080CP	Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 24.3 Effective October 1, 2018	2018-10-01
R198DEMO	Comprehensive ESRD Care (CEC) Model Telehealth - Implementation	2018-10-01
R4076CP	July 2018 Update of the Ambulatory Surgical Center (ASC) Payment System	2018-07-02
R4077CP	Revision to the Skilled Nursing Facility (SNF) Pricer to Support Value-Based Purchasing (VBP)	2018-10-01
R2097OTN	Clean-up of Fiscal Intermediary Shared System (FISS) Reason Codes and Quarterly Reports	2018-10-01
R4078CP	Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2018 Update	2018-07-02
R802PI	Use of Accessible and Applicable Claims History During Medical Review	2018-07-24
R2096OTN	Global Surgical Days for Critical Access Hospital (CAH) Method II	2018-07-02
R2094OTN	Update to the Hospital Transfer Policy for Early Discharges to Hospice Care	2018-10-01
R2095OTN	Revisions to the Telehealth Billing Requirements for Distant Site Services	2018-10-01
R4073CP	Quarterly Update to the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS)	2018-07-02
R800PI	Comprehensive Error Rate Testing (CERT) Update to Chapter 12 of Publication (Pub.) 100-08	2018-07-17
R14SS	IOM 100-17 Updates	2018-11-30
R4075CP	July 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS)	2018-07-02
R4074CP	July 2018 Integrated Outpatient Code Editor (I/OCE) Specifications Version 19.2	2018-07-02
R4069CP	Alignment of Coordination of Benefits Agreement (COBA) Internet Only Manual References	2018-07-09

R4070CP	Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2018	2018-10-01
R4071CP	Update of Internet Only Manual (IOM), Medicare Claims Processing Manual, Publication 100-04, Chapter 18-Preventive and Screening Services, and Chapter 35 - Independent Diagnostic Testing Facility (IDTF)	2018-07-09
R4072CP	July Quarterly Update for 2018 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule	2018-07-02
R2092OTN	Analysis for First Coast Service Options (FCSO) and Novitas for the Security Assertion Markup Language 2.0 (SAML 2.0) Migration	N/A
R2093OTN	Standardization of Case File Transmittal and Provider Information Processes, Bankruptcy, Payment Hold, and Cancellation Reporting Between the Medicare Administrative Contractors (MAC) and the Recovery Audit Contractor (RAC)	2018-10-01
R4063CP	New Q Code for In-Line Cartridge Containing Digestive Enzyme(s)	2018-07-02
R4066CP	Claim Status Category and Claim Status Codes Update	2018-10-01
R4067CP	July 2018 Update of the Ambulatory Surgical Center (ASC) Payment System	2018-07-02
R121MSP	Update the International Classification of Diseases, Tenth Revision (ICD-10) 2019 Tables in the Common Working File (CWF) for Purposes of Processing Non-Group Health Plan (NGHP) Medicare Secondary Payer (MSP) Records and Claims	2018-10-01
R4065CP	July 2018 Integrated Outpatient Code Editor (I/OCE) Specifications Version 19.2	2018-07-02
R4064CP	July 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS)	2018-07-02

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