# Washington Report – February, 2017

**(Covers activity between 2/1/17 and 2/28/17)**

**Bill Finerfrock, Matt Reiter, Nathan Baugh, Krupa Zachariah, Carolyn Bounds**



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## ACA Replacement Starts to Take Shape

***On Monday, March 6th Republicans in the House of Representatives introduced the American Health Care Act (AHCA). This bill, if enacted, will effectively repeal and replace the Affordable Care Act (aka Obamacare). The HBMA GR Committee staff have prepared a summary of this bill as approved by two House Committees. You can see our detailed summary of the bill by going here. The article below provides general information about the legislation and some of the history behind this initiative as it unfolded in February. The HBMA GR Committee will provide continuing coverage on this issue as it unfolds in the coming weeks.***

On Monday, March 6, 2017, the House Energy and Commerce Committee and Ways and Means Committee formally introduced the American Health Care Act (AHCA), which repeals and replaces significant parts to the Affordable Care Act (ACA). The jurisdiction for writing the bill was divided between the two committees and release of the bills was coordinated between the two committees.

On Thursday, March 9th, each committee completed their markups of their bills. During Committee consideration, numerous amendments were offered, debated and rejected largely along party-lines. In the end, no significant changes were approved during Committee consideration. The bill still awaits a score from the Congressional Budget Office (CBO) to determine the impact the AHCA will have on the Federal budget.

Recall, Congress is using the budget reconciliation process as a mechanism for repealing and replacing the ACA in order to avoid a filibuster by Senate Democrats. However, this process limits the bill's provisions to policies having to do with the raising or spending of money. Under

the budget reconciliation process, the House Budget Committee instructed each committee to identify $1 billion in savings. As long as the committees meet the savings target they can make any other policy changes they want so long as they are budgetary in nature.

Each bill now goes to the House Budget Committee which will combine the two pieces into a single bill. The Budget Committee, in conjunction with the Congressional Budget Office must verify that the combined bill meets the requirements of the Budget Resolution. If the bills, as passed, fail to meet the requirements of the Budget Resolution, the Budget Committee is authorized to make changes in the bill to put it into compliance with the Budget.

Although some disagreements within the Republican caucus remain, Republican Leadership in Congress and President Trump have thrown their support behind the bill. The politics of the replacement efforts are tricky. Republican Leadership in Congress must take into account the views of the conservative House Freedom Caucus, President Trump and his Administration as well as state governors who have recently sought to increase their influence over a replacement plan.

In general, the bill would replace the financial subsidies that the ACA made available to individuals who purchase health insurance on the federal and state exchanges with a refundable tax credit that varies based on age to help individuals purchase health coverage. Under the proposal, Americans would receive a larger tax credit as they got older. This is a significant departure from the ACA which based its financial assistance on income and required individuals to purchase their insurance through the exchange in order to qualify for the subsidy.

The bill would eliminate most of the ACA's taxes as well as the penalties under the individual mandate. The plan would require individuals to maintain continuous coverage. Individuals who do not maintain continuous coverage would be required to pay an extra 30 percent of the plan's premium the year they choose to enroll in a plan. It also incentivizes states to high-risk pools for sick enrollees with pre-existing conditions.

The bill seeks to create new incentives for consumers to use tax-advantaged high deductible health savings accounts (HSA) to save money to be used on healthcare expenses. The philosophy behind HSAs coupled with High Deductible Health Plans (HDHPs) is that consumers will have lower premiums but will pay more for what they actually consume via the higher deductible. The HSA allows individuals to save up tax-advantaged money each year that will go towards their out-of-pocket medical costs. It is also thought that this will make consumers more cost conscious with their healthcare decisions.

The bill also raises the amount plans can charge older enrollees more than younger enrollees from three times more to five times more.

Perhaps the most dramatic provisions of the AHCA fall within the Medicaid program. The bill not only changes many of the existing ACA's Medicaid provisions, it goes beyond the ACA and makes significant changes in federal Medicaid policy. The bill would repeal the ACA Medicaid Expansion which allows states to increase Medicaid eligibility to 138 percent of the federal

poverty line. The federal government pays for most of the cost of the expansion. The bill repeals the expansion funding by 2020.

The bill would make significant changes to the current system where the federal government matches a percentage of state Medicaid spending. This system of matching is an open-ended commitment from the federal government. This bill changes the way the federal government matches state Medicaid spending by instituting a per capita spending cap based on the amount of people a state is projected to enroll each year. The federal government will match Medicaid spending as it is now but will match spending beyond the total yearly allotment under the per capita cap at a reduced rate.

The AHCA still has a long way to go before it becomes law. Republican leadership still needs to shore up votes from their own ranks to ensure the bill will pass in both Chambers. Some of the more conservative members of the House of Representatives have yet to endorse the bill. They are upset that the bill does not go far enough in repealing the ACA. Additionally, four moderate Republican Senators are opposing the repeal of the Medicaid expansion.

Republicans are hoping to pass the bill into law by Easter. Now that AHCA has been advanced by both Committees of jurisdiction, it goes to the full House of Representatives for a vote. It would then go to the Senate. Additional changes to the bill could still be made.

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**Price Gets Confirmed, Verma One Step Away**

In a party line vote, the Senate confirmed President Trump's nominee for Secretary of Health and Human Services (HHS), Congressman Tom Price (R-GA). Despite unanimous opposition from Senate Democrats, Price's confirmation was never in doubt. The full Senate vote followed intense confirmation hearings regarding Price's investments in health companies and his conservative policy views.

Secretary Price will be a key leader in the efforts to repeal and replace the Affordable Care Act (ACA). Separate from the ACA, many in the provider community are optimistic that Secretary Price's background as a physician prior to becoming a full time politician will lead to positive changes on important issues such as the administrative burdens of healthcare.

It is also likely that Seema Verma will soon join the Trump Administration as Administrator of the Centers for Medicare and Medicaid Services (CMS). On March 2nd, the Senate Finance Committee voted 13-12 to advance her nomination to the full Senate.

Prior to her nomination, Verma was a consultant who specialized in helping States obtain ACA Medicaid innovation waivers. She is considered an architect of Indiana's Medicaid plan which was initiated under Vice President Mike Pence during his tenure as governor of the state.
At press time, Verma's Senate confirmation vote has not been scheduled. It will likely be held within the next few weeks.

President Trump is also beginning to fill out the sub-cabinet level positions in his administration.

In early February, President Trump announced that he had selected another Pence ally, Brian Neale, to serve as the Director for the Center for Medicaid and CHIP Services. Neale, who would report to Verma, had previously served as healthcare policy director under Vice President Pence when he was Governor of Indiana. Neale collaborated with Verma very closely on the Indiana Medicaid plan.

No word yet on who will be nominated to serve as Director of the Medicare Program.

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**HHS OIG Hotline Number Used in Fraud Scam**

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) is making people aware that the OIGs hotline telephone number was used in a fraud scheme.

According to HHS, the scammers represent themselves as HHS OIG Hotline employees and can alter the appearance of the caller ID to make it seem as if the call is coming from the HHS OIG Hotline 1-800-HHS-TIPS (1-800-447-8477).

The scammers tried to obtain personal information from victims by asking them to verify information. OIG is clarifying that it does not use the HHS OIG Hotline telephone number to make outgoing calls and individuals should not answer calls from 1-800-HHS-TIPS (1-800-447-8477). Despite the scam, the hotline is still able to receive calls to report fraud without compromising the caller's information.

HHS is requesting for those who believe they may have been a victim of the scam to report that information via the HHS OIG Hotline 1-800-HHS-TIPS (1-800-447-8477) or by email to spoof@oig.hhs.gov. Individuals may also file a complaint with the Federal Trade Commission 1-877-FTC-HELP (1-877-382-4357). HHS would like these reports to include the date and time the victim received the call as well as any other details from the call.

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**National Health Expenditures Data Shows Accelerating Growth in Healthcare Spending**

The Centers for Medicare and Medicaid Services (CMS) Office of the Actuary (OACT) has released its annual National Health Expenditures projections. This annual report tracks the pace of National healthcare spending over a ten year period. The report also categorizes the data based on who is doing the spending. CMS published an article accompanying the data in Health Affairs (subscription required).

OACT projects that between 2016 and 2025 annual national health spending growth will be 5.6 percent. OACT also projects that per capita spending will grow at an annual rate of 4.7 percent over this same time period. This is a 0.8 percent acceleration compared to the previous year. As a

percentage of GDP, healthcare is expected to rise from 17.8 percent in 2015 to 19.9 percent by 2025. On a positive note, OACT says that these increases will be partially offset by a projected slowing in the utilization of medical goods and services.

The OACT data is also broken down by payer allowing the reader to specifically review Medicare, Medicaid and private health insurance data, as well as out-of-pocket spending. Within each payer category, you can review how much was spent on different services such as hospital service, physician services and prescription drugs.

Medicare spending growth is projected to average 7.1 percent over the 2016-2025 period. The faster growth is due to the increased use of Medicare services by our nation's aging population. Medicaid spending is expected to accelerate from 3.7 percent over the last year to 6 percent during this ten year period. The Medicaid acceleration is attributed to an intensification of care needs by the increasingly larger proportion of the Medicaid program's population that is aged or disabled.

Private health insurance spending growth has slowed from 7.2 percent in 2015 to 5.9 percent in 2016. However spending growth in this area is projected to increase to 6.5 percent due to faster premium growth in Marketplace plans related to previous underpricing of premiums and the end of the temporary risk corridors. Out-of-pocket (OOP) spending growth is projected to accelerate 3.6 percent in 2016 as the number of individuals covered through high-deductible health plans is expected to grow. OOP spending growth is projected to average 4.8 percent over the full ten year period.

Total hospital spending is projected to grow at an average rate of 5.5 percent per year over the ten year period, an increase compared to the past five years. This faster growth partly reflects anticipated increases in the use and intensity of hospital services. Hospital price growth is projected to rise from 0.9 percent in 2015 to an average rate of 2.4 percent for 2016-25.

Growth in spending on physician services is projected to have accelerated slightly in 2016 to 6.6 percent, from 6.3 percent in 2015, largely reflecting an acceleration in prices. However, spending on physician services is projected to slow to 5.9 percent in 2017.

Prescription drug spending growth is projected to decelerate from 9.0 percent in 2015 to 5.0 percent in 2016 due to reduced use of newly approved specialty drugs which tend to be very expensive. Prescription drug spending is projected to grow an average of 6.3 percent per year for 2016 through 2025.

The OACT projections are based on current law and do not account for potential legislative changes over this ten year period. Republicans in Congress as well as the Trump Administration are in the process of introducing major changes to the ACA. The OACT projections are likely to change next year as a result of these new health reforms. It is unknown what effects will occur until a replacement is announced by Congress.

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**Federal Courts Block Mega Insurance Mergers**

Federal Judge Amy Berman Jackson of the U.S. District Court for the District of Columbia has blocked the proposed landmark merger of insurance giants Anthem and Cigna.

This ruling follows a ruling last month by the U.S. District Court that blocked the competing mega merger of Aetna and Humana. The Department of Justice (DOJ) was successful in convincing the federal judge that both mergers would result in reduced competition in health insurance markets and would harm customers.

In both cases, the insurance giants argued that any anticompetitive effects will be counterbalanced by the administrative efficiencies the mergers would produce. The companies contend that the combining of their companies would result in cost savings that would ultimately be passed on to consumers in the form of less-expensive insurance products. In both cases the court concluded that the claimed cost savings are not merger-specific nor are they verifiable.

Additionally, the court found that the merger would "eliminate the two firms' vigorous competition with each other for national accounts, reduce the number of national carriers available…and diminish the prospects for innovation in the market." These four companies, along with UnitedHealth make up the top five largest insurance companies in the country. If the mergers were completed, the five largest health insurance companies would have been reduced to three with a large gap between the top three and all of the other companies.

The $48 billion dollar Anthem/Cigna merger would have combined the nation's second and third largest health insurance carriers. Per the terms of the merger agreement, if the merger fails, as seems likely, Anthem must pay Cigna a $1.85 billion "breakup" fee. In addition to this fee, Cigna has filed a lawsuit against Anthem seeking $13 billion in damages for harm allegedly suffered by Cigna shareholders.

Anthem vowed to appeal Judge Jackson's ruling against the Anthem-Cigna merger.

Aetna and Humana have announced that they will end their merger agreement and will not appeal the ruling in their case. Per the terms of their merger agreement Aetna will pay Humana a $1 billion "breakup" fee for the failed merger.

The American Medical Association (AMA) is concerned that Anthem and Cigna are continuing to negotiate with the DOJ for an acceptable merger deal. The AMA wrote a letter to the Justice Department opposing this type of settlement. The AMA cites remarks made in court by an Anthem attorney expressing optimism that the Trump Administration is more willing to accept the merger than the Obama Administration.

Congress is also paying increased attention to anti-trust issues in the health insurance industry.

Representative Paul Gosar (R-AZ) introduced a bill that exempts the "business of health insurance" from certain anti-trust laws. The bill is intended to foster greater competition in the health insurance industry. The bill was featured in a hearing by the House Judiciary Committee where it awaits further action. Others have introduced similar legislation in the past but none have become law.

In an unrelated matter, UnitedHealth, the nation's largest health insurance company, found itself in the DOJ's crosshairs but for very different reasons. The DOJ joined a False Claims Act whistle-blower lawsuit accusing the insurer of exaggerating risk scores on Medicare Advantage (MA) claims. Final disposition of this case may take a while to resolve.

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**Trump Administration Easing Up on Insurers for 2018 Health Exchanges**

While Republicans in Congress continue to debate how to repeal and replace the Affordable Care Act (ACA), the Trump Administration has proposed easing the requirements on insurers that will sell plans on the health insurance exchanges in the 2018 plan year. It is likely that the forthcoming ACA replacement plan the GOP will put forward will include a transition period to allow stakeholders to prepare for the drastic changes to the healthcare system that are expected from the bill. This means that the ACA will most likely continue in 2018. Therefore, the government is taking steps to prepare for the 2018 plan year as if it is going to happen.

On February 15th, the Centers for Medicare and Medicaid Services (CMS) published a proposed rule that makes significant insurer-friendly changes to the ACA for the 2018 plan year. CMS is proposing to shorten the open enrollment period for the 2018 plan year from November 1, 2017 to December 15, 2017 (six weeks). The current deadline to enroll for coverage is set at January 31, 2018 (eight weeks).

This proposed rule would, if adopted, increase the verification requirements for enrolling outside of the open enrollment period through a special enrollment period (SEP). Insurers have long felt that the lax verification requirements led to consumers gaming the system by giving them the ability to avoid purchasing coverage until they became sick.

The proposed rule also defers to states with regard to network adequacy standards. And it proposes a change in the guaranteed availability requirement to allow issuers to apply a premium payment to an individual's past debt owed for coverage from the same insurer enrolled in within the prior 12 months.

CMS is also giving insurers more time to file their rate proposals for 2018. Insurers have been pressuring Congress to provide them with greater certainty on what changes are to come so that

they can make informed decisions with their rate proposals. CMS is instead giving them until June 21st to file rate proposals. The deadline was originally May 3rd.

On February 23rd, CMS published a guidance document extending the exemption for "grandfathered" health plans to continue operating through 2018. These so-called "grandfather" plans are plans that were sold prior to enactment of the ACA that do not meet the minimum benefit requirements of the ACA. Individuals enrolled in the grand-fathered plans were not subject to the individual mandate penalty for failure to enroll in an ACA approved health plan. However, these plans were to be phased out by the end of 2017. The Trump Administration is extending the grand-fathering of these plans assuming that with the repeal of the ACA and the individual mandate penalty, these plans will once again be "legal".

The Internal Revenue Service (IRS) is also backing off its intent to reject income tax filings that fail to indicate if that tax filer had health insurance for the year. This is a result of an Executive Order issued by President Trump to reduce the regulatory burden of the ACA.

Despite all of these attempts to assuage the concerns of insurers, Humana announced that it will not sell insurance products on the ACA exchanges in 2018. Humana cites unbalanced risk pools and the financial challenges of the exchange market in its withdrawal announcement. It didn't go unnoticed that the Humana announcement came shortly after it formally ended its attempted merger with Aetna due to a legal challenge from the U.S. Department of Justice (DOJ) on anti-trust grounds.

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**CMS Extends 2016 PQRS Reporting Deadline for Reporting via EHR**

The Centers for Medicare and Medicaid Services has issued an extension of the deadline for eligible professionals to report 2016 data via an electronic health record under the Physician Quality Reporting System (PQRS).

Individual eligible professionals (EPs), PQRS group practices, qualified clinical data registries (QCDRs), and qualified EHR data submission vendors (DSVs) now have until Friday, March 31, 2017 to submit 2016 EHR data via the Quality Reporting Document Architecture (QRDA) data submission mechanism.

2016 is the last reporting year before the PQRS and EHR programs sunset and form key components of the new, Merit-based Incentive Payment System (MIPS).

Last month, CMS issued an extension to March 13, 2017 for other forms of PQRS and EHR Meaningful Use reporting. Eligible professionals have several options for reporting data under the PQRS and EHR Meaningful use programs.

To clarify the updated reporting deadlines for each reporting option, CMS provided an updated list of 2016 data submission timeframes below:

**March 13, 2017 deadline:**

- eCQM reporting for hospitals – 1/3/17 - 3/13/17
- CQM reporting via attestation – 1/3/17 - 3/13/17
- Meaningful Use objectives and measures – 1/3/17 - 3/13/17

**March 17, 2017 deadline:**

- Web Interface – 1/16/17 - 3/17/17

**March 31, 2017 deadlines:**

- EHR Direct or Data Submission Vendor (QRDA I or III) – 1/3/17 - 3/31/17
- Qualified Clinical Data Registries (QRDA III) – 1/3/17 - 3/31/17
- Qualified Registries (Registry XML) – 1/3/17 - 3/31/17
- QCDRs (QCDR XML) – 1/3/17 - 3/31/17
- eCQM reporting for EPs – 1/3/17 - 3/31/17

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**Major Changes to Medicaid are on the Horizon**

The way the Federal Government provides financial assistance to states for their Medicaid programs is likely to undergo major changes over the next few months. The Republican-controlled Congress is considering several major reforms to the Medicaid program as part of its effort to repeal and replace the Affordable Care Act (ACA) with their own alternative.

Additionally, President Trump's nominee to lead the Centers for Medicare and Medicaid Services (CMS), Seema Verma, is an expert on innovating state Medicaid programs. Verma, who is expected to be confirmed to her position by the Senate in the coming weeks, owned a consulting firm that helped states redesign their Medicaid programs and apply for Innovation Waivers from the federal government under the ACA. Verma was an architect of Indiana's Medicaid plan called the Healthy Indiana 2.0. Trump picked another architect of the Healthy Indiana 2.0 plan, Brian Neale, to serve as Director for the Center for Medicaid and CHIP Services.

Each state's Medicaid program is different. Some states have been innovating their systems to be more efficient and hold providers accountable for cost and quality. Many states rely on a managed care system in which the states contract with entities to provide Medicaid coverage to eligible beneficiaries in exchange for a capitated payment for each beneficiary. The Healthy Indiana Plan that Verma and Neale helped create under then Governor-Mike Pence's administration actually had beneficiaries obtain and contribute to health savings accounts (HSA). Having Medicaid beneficiaries contribute towards their coverage is a radical concept for most Medicaid systems.

Republicans in Congress seem intent on providing states with much greater flexibility to reform their Medicaid programs. In her confirmation hearing testimony, Verma discussed how difficult it currently is for states to obtain innovation waivers from the federal government.

Currently, the Federal Government helps states finance their Medicaid programs by "matching" a percent of what states spend. This percentage, called the Federal Medical Assistance Percentage (FMAP) averages at 57 percent, but ranges from 50 percent in wealthier states up to 75 percent in states with lower per capita incomes.

The ACA Medicaid expansion allowed states to increase Medicaid eligibility to individuals earning up to 138% of the Federal Poverty Line. The Federal Government also initially provided a 100 percent match of the Medicaid spending on the expansion population. This match would gradually decrease to about 90 percent over several years where it would remain indefinitely.

The FMAP methodology has been criticized for being open ended. There is no cap on the amount that federal match. Federal Medicaid spending is largely dependent on what states spend and the match methodology does not provide an incentive for states to keep costs down. In addition, many states have been artificially inflating their Medicaid costs via so-called "provider taxes" in order to secure higher than warranted federal reimbursements.

Medicaid Provider Taxes – How this works

State A imposes a tax on hospitals and physicians that results in generating an additional $100 million into the state treasury. In approving the provider tax, the state guarantees to the providers that this money will be returned to them – dollar-for-dollar – in the form of higher Medicaid payments.

After the tax goes into effect, as promised, the state raises Medicaid provider payments sufficient to fulfill the commitment and returns the entire amount - $100 Million – to the providers.

State A submits their Medicaid cost data to CMS demonstrating that they paid $100 Million more to providers. Under the matching program, the federal government will reimburse the state using the FMAP to which the state is entitled. In this case, let's say it is a 60% FMAP state. In this instance, the federal government reimburses the state $60 Million for making the higher payments.

Ideally, the state could use this additional $60 Million to expand Medicaid but increasingly, the states are just viewing this as a windfall and putting the money into other, non-health related programs for which the state is short on revenue.

Republicans want to change the open-ended nature of the financing structure.

One way Republicans are proposing to do this is by instituting a per-capita cap on federal contributions. Under this methodology, the federal government would provide states with a per-enrollee contribution each year. This amount would also adjust over time based on predetermined factors (medical inflation, for example). The contribution could be adjusted based on beneficiary-type (children, elderly, disabled, medically fragile, etc.). States would have the flexibility to redesign their Medicaid program and the incentive to deliver care in a more efficient manner.

Another reform option is "block granting" Medicaid. Block granting, is essentially where the federal government gives states a set amount of money for specific period of time based on past program spending. Usually the grant is established using a base year and then is adjusted each year for inflation or other factors. If the state spent less on providing care to the Medicaid population than they received in the Block Grant, the states could be eligible to share a portion of financial savings with the federal government.

In both cases (per capita cap or block grant) states would have the increased authority to design their Medicaid system and determine how to spend the money. States would be able to change reimbursement rates to providers, coverage benefits, institute wait lists, and other aspects of their Medicaid programs. States could also use the money to fund a managed care system.

Block granting is somewhat more controversial per capita caps because of the potential it has to lead to reduced benefits. Critics also worry about states taking on financial risk for the most vulnerable population. What happens to beneficiaries if the grant is not enough and states run out of Medicaid money?

Finally, there are also hybrid approach that would reduce the federal match for state spending above a certain threshold. This essentially caps a state's risk.

Recently, many Governors, including some GOP Governors from states that have expanded Medicaid coverage, have begun to push back against these types of reform. Instead, they have advocated for preserving the Medicaid expansion. However, it is almost certain that the structure for how the federal government helps states finance their Medicaid programs is going to change and that States will receive more flexibility to design their Medicaid programs.

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**CMS Awards MACRA Technical Assistance Grants to Help Small and Rural Practices**

On February 17, 2017, the Centers for Medicare and Medicaid Services (CMS) announced that it is awarding $20 million in grant money across 11 organizations to provide technical assistance to help small and rural practices succeed in the new Quality Payment Program (QPP). CMS intends to award this amount in technical assistance grants over the next four years as well.

The organizations that receive this grant money will provide "on-the-ground training and education about the QPP for clinicians in individual or small group practices of 15 clinicians or fewer." There will be an emphasis on practices in underserved and rural areas.

In December, the Government Accountability Office (GAO) released a report speaking to the challenges that small and rural providers face in succeeding in the QPP. CMS is also conducting its own education in addition to the assistance this grant money will support.
The 11 organizations that received money to provide technical assistance are:

- Altarum
- Georgia Medical Care Foundation (GMCF)
- HealthCentric
- Health Services Advisory Group (HSAG)
- IPRO
- Network for Regional Healthcare Improvement (NRHI)
- QSource
- Qualis
- Quality Insights (West Virginia Medical Institute)
- Telligen
- TMF Health Quality Institute

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**Filing a HIPAA Transaction Complaint**

When President Clinton signed the Health Insurance Portability and Accountability Act (HIPAA) into law in the mid-90s, one of the principle goals of the legislation was to establish uniform rules for the electronic filing, processing and payment of a medical claim. The hope was that through this standardization process, physicians and hospitals (and their billing company business partners) could realize significant administrative savings.

Enforcement of the HIPAA rules for Electronic Transactions is complaint-driven. In other words, CMS, which has enforcement responsibility for the transaction regulations, does not conduct transaction audits or start investigation without there first being a formal complaint.

Any individual or billing company that wishes to submit a complaint related to an alleged Transactions violation against a HIPAA covered entity (provider, health plan, clearinghouse, etc.) may do so through the Administrative Simplification Enforcement and Testing Tool (ASETT).

Individuals or organizations wishing to file a transaction complaint should provide as much detail as possible to support the allegations. Please note that before you can electronically file a transaction complaint, you MUST first register and create an account on the CMS Enterprise Portal. This requires you to provide specific personal information as part of the CMS security protocols. In perhaps the greatest example of the word “irony” if you do not wish to create an on-line account with CMS and provide the security information they require, you can file an electronic transaction complaint with a paper form using the HIPAA Non-Privacy Complaint Form.

Once the complaint is filed and verified, CMS will contact the entity against whom the complaint has been filed, notify them of the allegations and to advise them that a letter will be sent with details and a request for follow-up.

When there is a determination that there has been a **transaction** violation, CMS seeks to obtain a Corrective Action Plan (CAP) from the violator. To our knowledge, CMS has never sought to impose a financial penalty in conjunction with a transaction violation.

Since 2003, more than 140,000 HIPAA **privacy** complaints have been filed with the Department of Health and Human Services. After investigation, many of the complaints are found to be without merit. But many result in the violator agreeing to undertake a CAP *and* pay a penalty for the violation. Most penalties are relatively small (less than $10,000) but some of the more highly publicized cases result in fines in the millions.

HHS has collected more than $50 Million dollars from HIPAA privacy violators but no money for HIPAA transaction violators.

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**CMS Transmittals**

The following Transmittals were issued by CMS during the month of February.

| Transmittal Number | Subject | Effective Date |
|---|---|---|
| R3722CP | Instructions for Downloading the Medicare ZIP Code File for July 2017 | 2017-07-03 |
| R233BP | Clarification of Payment Policy Changes for Negative Pressure Wound Therapy (NPWT) Using a Disposable Device and the Outlier Payment Methodology for Home Health Services | 2017-03-27 |
| R3721CP | Updates to Pub. 100-04, Chapters 12, 17 and 23 to Correct Remittance Advice Messages | 2017-05-25 |
| R3723CP | Healthcare Provider Taxonomy Codes (HPTCs) April 2017 Code Set Update | 2017-07-03 |
| R3724CP | Common Edits and Enhancements Modules (CEM) Code Set Update | 2017-07-03 |
| R3725CP | Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update | 2017-07-03 |
| R169DEMO | Episode Payment Model Operations | 2017-07-03 |
| R1799OTN | Preventing Hospice Notices of Election with Future Dates | 2017-07-03 |
| R1798OTN | ICD-10 Coding Revisions to National Coverage Determinations (NCDs) | 2017-07-03 |
| R13P299 | Provider Reimbursement Manual Part 2, Provider Cost Reporting Forms and Instructions, Chapter 29, Form CMS-222-92 | 2017-02-17 |
| R1803OTN | Innovation Payment Contractor (IPC) for D1 D4 File Exchange | 2017-07-03 |

| Transmittal Number | Subject | Effective Date |
|---|---|---|
| R3719CP | Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April CY 2017 Update | 2017-04-03 |
| R3718CP | Instructions to Process Services Not Authorized by the Veterans Administration (VA) in a Non-VA Facility Reported With Value Code (VC) 42 | 2017-04-03 |
| R3716CP | Extension of the Transition to the Fully Adjusted Durable Medical Equipment, Prosthetics, Orthotics and Supplies Payment Rates under Section 16007 of the 21st Century Cures Act | 2017-07-03 |
| R1794OTN | Provider Enrollment, Chain and Ownership System (PECOS) Extract File - Analysis | 2017-07-03 |
| R1796OTN | Processing Updates for VMS From Provider Enrollment, Chain and Ownership System (PECOS) Extract File | 2017-07-03 |
| R167SOMA | Revision to State Operations Manual (SOM) Appendix PP - Incorporate revised Requirements of Participation for Medicare and Medicaid certified nursing facilities | 2017-02-10 |
| R1797OTN | Guidance on Implementing System Edits for Certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) | N/A |
| R3717CP | Clinical Laboratory Fee Schedule - Medicare Travel Allowance Fees for Collection of Specimens | 2017-05-12 |
| R125MCM | Update of Chapter 1 | 2017-02-10 |
| R1795OTN | Advance Care Planning (ACP) Implementation for Outpatient Prospective Payment System (OPPS) Claims | 2017-07-03 |
| R1793OTN | Analysis Only - Modification of Process for Handling the Provider Enrollment Chain Ownership System (PECOS) Extract File | 2017-04-03 |
| R166SOMA | Revisions to State Operations Manual (SOM), Appendix C-Survey Procedures and Interpretive Guidelines for Laboratories and Laboratory Services | 2017-03-03 |
| R3714CP | Changes to the National Coordination of Benefits Agreement (COBA) Crossover Process as a Result of the Social Security Number Removal Initiative (SSNRI) | 2017-07-03 |
| R3701CP | Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits | 2017-04-03 |
| R3702CP | Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) - April 2017 | 2017-04-03 |
| R3710CP | New “K” Code for Continuous Positive Airway Pressure Device Bundle | 2017-04-03 |
| R3708CP | Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) Edits, Version 23.1, Effective April 1, 2017 | 2017-04-03 |
| R3709CP | Internet Only Manual (IOM) Chapter 25 Revision | 2017-04-04 |
| R1785OTN | Payment for Oxygen Volume Adjustments and Portable Oxygen | 2017-07-03 |

| Transmittal Number | Subject | Effective Date |
|---|---|---|
| | Equipment- FISS | |
| R3711CP | Implementation of New Influenza Virus Vaccine Code | 2017-07-03 |
| R1791OTN | Change to Beneficiary Liability and Cost Report Days for Subclause (II) Long Term Care Hospitals (LTCHs) | 2017-07-03 |
| R1787OTN | New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Liability Medicare Set-Aside Arrangements (LMSAs) and No-Fault Medicare Set-Aside Arrangements (NFMSAs) | N/A |
| R3715CP | Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System | N/A |
| R1790OTN | Shared System Enhancement 2016: Complete Disablement of Health Maintenance Organization (HMO) Inquiry Transaction, HIHO, and Related Vestige Within Common Working File (CWF) | 2017-07-03 |
| R1786OTN | Update for Additional International Classification of Diseases (ICD)-10 Codes for the System Changes to Implement Section 231 of the Consolidated Appropriations Act, 2016, Temporary Exception for Certain Severe Wound Discharges From Certain Long-Term Care Hospitals (LTCHs) | 2017-02-03 |
| R3712CP | New Fields in the Fiscal Intermediary Shared System (FISS) Inpatient and Outpatient Provider Specific Files (PSF) | 2017-07-03 |
| R1789OTN | Shared System Enhancement 2016: Common Working File (CWF) to Show Date for Informational Unsolicited Response (IUR) Indicator on Claim History | 2017-07-03 |
| R1788OTN | Combined Common Edits/Enhancements (CCEM) Proxool and Apache Software Upgrades | 2017-07-03 |
| R3713CP | Extension of Payment Change for Group 3 Complex Rehabilitative Power Wheelchairs Accessories and Seat and Back Cushions under Section 16005 of the 21st Century Cures Act | 2017-07-03 |
| R1792OTN | ICD-10 Coding Revisions to National Coverage Determination (NCDs) | N/A |