HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION

Washington Report – May, 2018
(Covers activity between 5/1/18 and 5/31/18)
Bill Finerfrock, Matt Reiter, Sarah Wilson and Carolyn Bounds

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HBMA Participates in NCVHS Healthcare Transaction Forum

On May 17th, HBMA Government Relations Committee Vice Chair Dave Nicholson, CHBME, participated in a healthcare CIO forum hosted by the National Committee on Vital and Health Statistics (NCVHS). NCVHS is the public advisory body to the Secretary of Health and Human Services (HHS) that provides advice and assistance on key health data issues, electronic transaction standards, privacy and confidentiality and healthcare administrative simplification. NCVHS reports regularly to Congress on HIPAA implementation, and serves as a forum for interaction between HHS and interested private sector groups.

The purpose of the forum was to solicit industry/stakeholder information and expertise from end users of the adopted HIPAA transaction standards and operating rules. HBMA was one of approximately 20 organizations invited to participate in this roundtable discussion.

NCVHS will use the ideas, suggestions and comments from this forum to inform recommendations for a "roadmap" they are developing that will guide future efforts to improve the process for updating and adopting future HIPAA transaction standards and operating rules.

In his opening remarks, Nicholson addressed his and his company's experience with the transaction standards and operating rules and made these points:

1. **Transaction standards must reflect the real world requirements to process the claim and capture client payment as efficiently and timely as possible, versus the purity of meeting the Standards.**
2. **The frequency of updates (i.e. CPT/ICD changes each year) and the implementation time needed to fully adopt the updates by payers.**
3. **Enforcement of the HIPAA Transaction Standards with the same level of aggressiveness as the HIPAA Privacy Standards.**

After each organization representative made brief opening remarks, the remainder of the full-day meeting was an exchange of ideas, experiences and perspectives from the various Forum participants, including several NCVHS committee members.

In addition to HBMA representing healthcare business management companies, other sectors of the healthcare business transaction community represented at the forum included health plans, providers (hospitals and physicians), practice management software developers, EHR vendors, standard setting organizations and clearinghouses.

At various points during the Forum, Nicholson echoed comments shared with him by other HBMA member companies in preparation for his remarks.

As one point, Nicholson passed along a concern expressed by HBMA Government Relations Committee Chair Arthur Roosa that government regulations cannot (ever) keep pace with technology developments. By definition, regulations have to lag behind the developments and that whatever method is used to vet the new regulations will serve to increase that time lag. In addition he noted, that government standards should be the "minimum necessary" regulation for defining a transaction standard.

For example, the transmission of and acceptance of the 837 transaction would be seen as minimum necessary for transmitting claim and encounter information. Payers/vendors/providers would be free to develop other forms of data interchange that would meet a set of HIPAA requirements that were not tied to data format but still set a standard for privacy and security. Also, to avoid manipulation, the minimum necessary standard must be provided/accepted free of charge.

Taking this type of approach would free-up industry to innovate and use new technology while guaranteeing that all players would be able to exchange data reliably and free of charge at some base level.

Finally, it was noted that flexibility is the death of any standard. While on the one hand we all want flexibility, we loathe flexibility when others don't adhere to a "standard." Since the beginning of HIPAA in the mid-90s, there has been a desire by the government to be flexible. However, this flexibility has led to many of the problems we are now trying to cure. A "standard" should be universally recognized and accepted (even if not loved) and flexibility within that standard breeds chaos.

Other topics that were discussed during the meeting included:

1. **Standards Development and update process:** Frequency of updates to standards and operating rules not aligning with industry business and technical changes. Inability of covered entities, trading partners, or business associates to take advantage of technology developments.
2. **Governance, or oversight of the standards review process:** Current coordinating bodies are charged with oversight of standards revision priorities but may be operating with too narrow a charter or lacking the authority and resources to be effective.
3. **Federal regulatory process to adopt new versions of standards:** The Federal process for adoption of standards and operating rules is lengthy, of unpredictable duration and contains numerous checks and balances that arguably duplicate similar processes within the standards development organizations. The lack of predictability and timeliness jeopardizes the smooth adoption and uptake of standards and operating rules once they are developed and published by the SDO.
4. **Data harmonization:** The lack of data cohesion jeopardizes interoperability due to inconsistencies in data dictionaries and data elements across SDOs.
5. **Inclusion of non-covered entities under HIPAA:** Covered entities include providers, health plans and health care clearinghouses. Vendors and other business associates are not covered entities but often play a role in the conduct of the adopted standards. The Federal Government is limited in its authority over non-covered entities. This impacts the use of standards in a variety of ways, from costs to actual utilization.

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CMS Publishes 2019 ICD-10 PCS Updates

The Centers for Medicare and Medicaid Services (CMS) has published the FY 2019 ICD-10 Procedure Coding System (ICD-10-PCS) updates on its website. According to the CMS announcement, these 2019 ICD-10-PCS codes are to be used for discharges occurring from October 1, 2018 through September 30, 2019.

For 2019, CMS is adding a net of 176 ICD-10 PCS codes. CMS is adding 392 new codes, deleting 216 codes and revising the titles of eight codes.

- 2019 Official ICD-10-PCS Coding Guidelines [ZIP, 353KB]

- 2019 Version Update Summary [ZIP, 212KB]
- 2019 ICD-10-PCS Code Tables and Index [ZIP, 7MB]
- 2019 ICD-10-PCS Codes File [ZIP, 585KB]
- 2019 ICD-10-PCS Order File (Long and Abbreviated Titles) [ZIP, 1MB]
- 2019 ICD-10-PCS Addendum [ZIP, 608KB]
- 2019 ICD-10-PCS Conversion Table [ZIP, 1MB]

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CAQH CORE Releases Newest CARC and RARC Combinations

The Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) has released its newest update to the Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) code combination list. CAQH CORE is an entity authorized by the Department of Health and Human Services (HHS) to develop code combinations for CARCs and RARCs.

This update, "v.3.5.0 June 2018" includes:

- **Compliance-based Adjustments** as a result of code list updates published on March 1st.
- **Market-based Adjustments** in response to the 2018 Market-based Review.

According to CAQH, since its inception, this process has resulted in a reduction of over 300,000 CARC/RARC combinations to about 1,600 "key code combinations."

HBMA believes that further refinement to the number of code combinations is needed. Often times, CARC and RARC combinations do not provide enough meaningful information to eliminate the need for additional administrative steps such as following up with the payer to receive more information.

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Congress Passes VA Choice Program Reform Bill

This month, Congress passed H.R. 5674, the VA MISSION Act, a bill that would sunset and replace the VA Choice Program. Created in the wake of a large scandal in 2014 over wait times and scheduling at VA healthcare facilities, the VA Choice Program allows veterans to seek care outside of the VA health system under a set of specific circumstances related to inability to access care through the VA.

The VA Choice Program allows veterans to seek care outside the VA if they are unable to schedule an appointment within a specific time frame or if they live a certain distance from their nearest VA facility.

The MISSION Act, would function similarly to the program it is replacing but gives the VA broader authority and discretion to allow veterans to receive care outside of the VA system. The MISSION Act would allow veterans to seek care outside of the VA if their VA physician approves their request. The patient would also have to demonstrate that they are experiencing a barrier to accessing care from a set of criteria outlined in the bill. This criteria is broader than that of the Choice program.

The MISSION Act would sunset the Choice Program one-year after the date of the bill's enactment, at which point the new program would take effect.

Section 111 of the MISSION Act dictates requirements for the VA to promptly pay claims to providers who perform covered services under this program. Providers would have 180 days after the date of service to submit a claim to the VA. The VA would have 45 days to pay "clean" paper claims and 30 days to pay "clean" electronic claims. When denying a claim, the VA would have to explain why the claim was denied and allow the provider to resubmit the claim. The VA would then have an additional 30 days to pay the claim once the provider submits the missing information. The VA will also submit an annual report to Congress on its payment timeliness.

A "clean claim" is defined in the bill as, "the transmission of data for purposes of payment of covered health care expenses that is submitted to the [VA] Secretary which contains substantially all of the required data elements necessary for accurate adjudication, without obtaining additional information from the entity or provider that furnished the care or service, submitted in such format as prescribed by the [VA] Secretary in regulations for the purpose of paying claims for care or services."

The VA Secretary will be required to develop a list of information it will require for a "clean" claim. The VA will provide this list to healthcare providers who submit claims through this program. The bill instructs the VA to solicit feedback from industry stakeholders on what information it would require and how to document this information. The VA is required to develop and implement a program to educate community providers about this program including the claims submission process.

The VA would reimburse community providers at the Medicare payment rate with an exception that allows the VA to reimburse "highly" rural providers above the Medicare rate. Veterans would be able to select a community provider and schedule their own appointments but the VA would also be allowed to schedule appointments on their behalf.

Not every healthcare provider would have to participate in this program. The VA would hire contractors to negotiate networks of non-VA community providers who would participated in this program. This would not be the only way for community providers to participate.

Community providers can enter into a direct agreement with the VA to provide care for eligible veterans. The VA will develop a certification/recertification process for community providers to

participate in the program. The VA is also required to contract with providers to accept walk-in visits from covered veterans.

The law does include a mechanism for the VA to directly negotiate contracts with community providers who are not in one of these pre-set networks if a provider from a pre-set network is not available.

Community providers would submit claims directly to the VA, not through a contractor. However, the VA is authorized, but not required to hire a contractor to handle the claims processing operations.

The Choice Program embodies a broader debate about VA privatization. Veteran interest groups as well as politicians from both parties have been debating whether veterans should be allowed to seek care outside of the VA system or if only the VA should be allowed to provide care to veterans. This is a highly contentious issue among VA stakeholders.

Since the Choice Program began, many HBMA members have experienced great difficulty in having claims successfully paid by the VA for covered Choice Program services. Many HBMA Members have expressed their frustration with this process on the HBMA Listserv. The HBMA Government Relations (GR) Committee is aware of this problem and is considering the best strategy to advocate on this issue on behalf of the membership.

To assist in this effort, the GR Committee would appreciate if HBMA members would send us (de-identified) examples of VA payment issues. The Committee asks that you please include a timeline of when the claim was submitted, information on if/when the claim was paid, and a brief description of the process you went through with the VA or its contractors.

Please provide examples by email to gr@hbma.org.

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91 Percent of Eligible Clinicians Participated in QPP in 2017

On May 31st, Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma published a blog post on the CMS website highlighting the participation rates in the Quality Payment Program (QPP).

Established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the QPP replaced the Medicare Sustainable Growth Rate Formula (SGR) methodology for determining annual updates to Medicare Part B payments.

The QPP requires eligible clinicians (physicians, PAs, NPs, CNS and CRNA) to either participate in the Merit-based Incentive Payment System (MIPS) or in an Advanced Alternative Payment Model (Advanced APM). ECs who do not participate in MIPS will receive automatic negative payment adjustments to their Medicare Part B reimbursements for the corresponding payment year. ECs can be exempt from MIPS if they are a low-volume provider or if they qualify as participants in an Advanced APM.

According to CMS, 91 percent of ECs participated in the 2017 QPP reporting year. CMS' goal was for 90 percent of ECs to participate in 2017. It should be noted that CMS made it incredibly easy for ECs to receive full participation credit for MIPS in 2017. ECs only had to report any amount of data for any number of patients for any period of time to receive full participation credit that exempted them from the negative payment adjustments.

The 91 percent participation rate also means that nine percent of ECs did not report any data and will therefore receive a four percent downward payment adjustment to their Part B reimbursements in 2019.

The blog post did not go into further detail about QPP participation in 2017. The post also highlights CMS' efforts to reduce the burdens of participation including CMS' Patients over Paperwork initiative and the Meaningful Measures initiative. According to the blog post, the Patients over Paperwork initiative has:

- Reduced the number of clinicians that are required to participate giving them more time with their patients, not computers.
- Added new bonus points for clinicians who are in small practices, treat complex patients, or use 2015 Edition Certified Electronic Health Record Technology (CEHRT) exclusively as a means of promoting the interoperability of health information.
- Increased the opportunity for clinicians to earn a positive payment adjustment.
- Continued offering free technical assistance to clinicians in the program.

The post also reminds ECs about the technical assistance that CMS has made available and reiterates CMS' commitment to a successful QPP while continuing to reduce clinician burden.

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GAO Recommends that CMS Continue its Prior Authorization Initiatives

In an effort to combat fraudulent and improper Medicare payments, the Centers for Medicare and Medicaid Services (CMS) has been increasingly relying on prior authorization for certain medical services/devices that it believes pose a high risk for abuse.

CMS has been testing a number of fixed-length prior authorization demonstrations for specific services to measure their effectiveness before determining if the demonstration should be adopted on a more permanent basis.

The Government Accountability Office (GAO) conducted an analysis of these demonstrations and provided recommendations to CMS on next steps for this initiative. The GAO believes CMS should extend the demonstrations – all of which expire this year.

The prior authorization demonstrations are for:

1. Certain power mobility devices (expires in August, 2018),
2. Repetitive scheduled non-emergency ambulance services (expires in November),
3. Non-emergency hyperbaric oxygen therapy (expired in February), and
4. Home health services (this demonstration has been "paused" since April, 2017).

In addition, CMS implemented a permanent program for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items. CMS also includes pre-claim reviews in some of the demonstrations.

The GAO found that Medicare expenditures decreased for items and services subject to prior authorization in four demonstrations. GAO believes that CMS' prior authorization demonstrations saved between $1.1 and $1.9 billion from when the program was first implemented in 2012 through March 2017.

However, GAO cannot be certain that the entirety of these savings can be attributed to prior authorization. GAO acknowledges that other CMS program integrity initiatives could have factored into these savings.

In its report, the GAO also acknowledges that many providers have reported the prior authorization system to be overly burdensome. Some providers and suppliers interviewed by the GAO claimed that it can take up to seven weeks to obtain the necessary documentation from a referring provider. Others highlighted how prior authorization exacerbates existing documentation challenges and that CMS's documentation requirements can be difficult to meet.

CMS has taken some steps to help providers submit prior authorization requests such as providing a template for a request for certain supplies and services.

GAO recommended that CMS should take steps to continue prior authorization. These steps could include:

- Resuming the paused home health services demonstration;
- Extending current demonstrations; or,
- Identifying new opportunities for expanding prior authorization to additional items and services with high unnecessary utilization and high improper payment rates.

CMS neither agreed nor disagreed with the recommendations. CMS did agree to consider GAO's recommendations – which are non-binding.

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HHS Releases List of Upcoming Regulations

On May 10th, the Office of Management and Budget (OMB) Office of Information and Regulatory Affairs (OIRA) released its Spring 2018 Unified Agenda for the Department of Health and Human Services (HHS). The Unified Agenda is the list of regulations (proposed and final) that HHS intends to release in the coming months.

In addition to the annual Centers for Medicare and Medicaid Services (CMS) Medicare payment regulations such as the Medicare Physician Fee Schedule (PFS), a number of pending regulations stood out that will be of interest to the Healthcare Revenue Cycle Management (RCM) industry.

The first proposed rule of note on this list would formally rescind the Health Plan ID standard. Although finalized in previous rulemaking, CMS never implemented these requirements due to significant industry opposition. CMS announced its intent to formally rescind the requirements last year.

In 2017, HBMA testified before the National Committee on Vital and Health Statistics (NCVHS) advocating for CMS to formally rescind the Health Plan ID standards. At that meeting, CMS and NCVHS acknowledged that this standard would not be implemented and would be rescinded. This proposed rule will begin the formal process to rescind the Health Plan ID standard.

The second proposed rule would propose to create an electronic standard for claims attachments. This is a much anticipated proposal for the Healthcare RCM industry.

The third proposed rule applies to the ability of third parties, such as companies or charitable non-profits, to pay the health insurance premiums for consumers. Some have criticized this practice because those third parties are steering patients towards plans that reimburse providers at the highest rates and are withholding information about other coverage options such as Medicare and Medicaid that reimburse at lower rates than commercial plans.

The final proposed rule on this list from the Office of the National Coordinator (ONC) for Health Information and Technology would propose new requirements for EHR interoperability which is of significant interest to HBMA members and their clients.

Agency	Type of Regulation	Regulation	Link
HHS/CMS	Proposed Rule Stage	Administrative Simplification: Rescinding the Adoption of the Standard Unique Health Plan Identifier and Other Entity Identifier (CMS-0054-P)	0938-AT42

HHS/CMS	Proposed Rule Stage	Adoption of Standards for Health Care Attachments Transactions, Acknowledgments Transactions, Electronic Signatures, and Modification to Referral Certification and Authorization Standard (CMS-0053-P)	0938-AT38
HHS/CMS	Proposed Rule Stage	Third Party Payments for Coverage Under Qualified Health Plans (CMS-3337-P)	0938-AT11
HHS/ONC	Proposed Rule Stage	Health Information Technology: Certification and Interoperability Enhancements	0955-AA01

The Unified Agenda does not specify the date these proposed regulations will be issued. The HBMA Government Relations Committee will monitor the Federal Register for these proposed regulations.

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Five New MedPAC Commissioners Selected

The Government Accountability Office (GAO) has selected five new Commissioners to serve on the Medicare Payment Advisory Commission (MedPAC), an influential non-partisan agency that advises Congress on Medicare payment policy. These five new Commissioners will replace five current Commissioners whose terms expired in April.

MedPAC issues two annual reports to Congress that make legislative recommendations for improving Medicare payment policies and programs. These reports are issued in March and in June. MedPAC holds a number of public meetings throughout the year to discuss the recommendations it is considering for each report.

One of the new Commissioners is Karen DeSalvo, MD, MPH, MSc. Dr. DeSalvo is the former Acting Assistant Secretary for Health and Human Services (HHS) and former National Coordinator for Health Information Technology under President Obama. Dr. DeSalvo is currently a Professor of Medicine and Population Health at the Dell Medical School at the University of Texas at Austin

The other new Commissioners are:

- Marjorie Ginsburg, BSN, MPH, who is the Founding Executive Director of the Center for Healthcare Decisions, Inc.
- Jonathan Jaffery, MD, MS, MMM, who is a Professor of Medicine at the University of Wisconsin School of Medicine and Public Health in Madison, WI, and a practicing nephrologist.
- Jonathan Perlin, MD, PhD, MSHA, who is the President of Clinical Services and Chief Medical Officer of HCA Healthcare in Nashville, TN.

- Jaewon Ryu, MD, JD, who is the Executive Vice President and Chief Medical Officer for Geisinger Health System.

These Commissioners were appointed to a three-year term ending April 2021.

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CMS Announces New Rural Health Strategy

After acknowledging a need to address the unique challenges of providing care and reducing provider burden in rural areas, the Centers for Medicare and Medicaid Services (CMS) has released a formal Rural Health Strategy outlining its approach for improving rural health care.

The Strategy has five objectives:

1. Apply a rural lens to CMS programs and policies
2. Improve access to care through provider engagement and support
3. Advance telehealth and telemedicine
4. Empower patients in rural communities to make decisions about their health care
5. Leverage partnerships to achieve the goals of the CMS Rural Health Strategy

The plan was developed by the CMS Rural Health Council, a group of internal CMS rural health policy experts. The Council held listening sessions with industry and also conducted an internal analysis of the rural health work being done within CMS.

The Council organized the feedback it received into several (familiar) themes including improving reimbursement, improving quality measures and reporting, improving affordability and improving access.

CMS did not propose specific solutions to the identified issues. In general, CMS will do a better job of applying a "rural lens" to new policies and programs. This includes greater coordination within the agency and continuing to work with industry groups to address these challenges.

CMS launched a new website for this initiative where it will post additional information and resources as they become available in the future.

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White House Unveils Plan to Address Rising Prescription Drug Prices

Earlier this month, the White House rolled out its plan for addressing rising prescription drug prices. Titled, the American Patients First Plan, the Administration is proposing to take a multi-level approach to addressing high drug prices.

In a speech introducing the initiative, President Trump attributed several causes to high drug prices but offered a particularly pointed criticism of drug supply chain middlemen such as Pharmacy Benefit Managers (PBM). This prompted speculation that the Plan would take aggressive measures such as directing the Administration to apply anti-kickback laws to the rebates PBMs receive from manufacturers for including their drugs in formularies used by health plans.

The official plan ultimately did not include changing the PBM rebate structure but proposed a number of other policy solutions to help lower drug prices. These proposals include:

- Allowing the Centers for Medicare and Medicaid Services to develop new reimbursement models for prescription drugs such as site-neutral payments for Part B drugs.
- Giving Part D plans greater flexibility to adjust their benefit design.
- Requiring manufacturers to include a drug's list price in advertisements.
- Improve price transparency.
- Allowing pharmacists to tell patients if they can purchase a drug for a lower price if they pay in cash instead of using their insurance. This practice is currently banned.
- Moving some drugs from Part B to Part D to achieve savings.

The Administration also supports promoting innovation and competition for drugs and biologics to achieve lower prices. As part of this initiative, the Food and Drug Administration (FDA) announced that it will publicly display the names of companies it believes are paying competitors to keep their generic drug from market. This practice has long been criticized by policy makers from both parties.

Although the drug plan stopped short of some of the more drastic proposals the President had discussed, Secretary of Health and Human Services (HHS) Alex Azar gave follow up remarks indicating that the Administration could do more in the future if these proposals do not accomplish their intended goal.

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GAO Report Finds Limited Success for New Medicare Payment Models

The Government Accountability Office (GAO) released a report assessing the performance of the new Medicare payment models being tested by the Center for Medicare and Medicaid Innovation (CMMI). The report found that the CMMI is falling short of several of its goals for these initiatives.

CMMI was established by the Affordable Care Act (ACA) to serve as the office within the Centers for Medicare and Medicaid Services (CMS) with broad authority to generate and test new payment and health care delivery models for Medicare, Medicaid and CHIP. CMMI typically tests models on a small scale and then conducts an evaluation to decide if the model should be expanded to the entire Medicare program.

To date, CMMI has tested or overseen 37 models. This study built upon a previous GAO report on this topic from 2012 by evaluating the center's efforts since 2012 to implement and evaluate current models and its own performance.

GAO evaluated CMMI on three performance measures that CMMI established for itself to measure the center's efficacy:

1. Reform delivery systems to reduce costs while increasing health care quality and outcomes
2. Evaluate and improve models that increase quality while maintaining or reducing cost or reduce cost while maintaining or improving quality
3. Promote the adoption of successful models by States

GAO found that CMMI has largely underperformed in meeting these goals. For example, the report found that only four of the 37 models tested by CMMI met the criteria for the second goal.

The four models are the:

1. Pioneer Accountable Care Organization (ACO) initiative,
2. Diabetes Prevention Program,
3. Initiative to Prevent Avoidable Hospitalizations among Nursing Facilities Residents Phase I, and
4. Bundled Payments for Care Improvement (BPCI) initiative's lower-extremity joint replacement bundles.

Of these four demonstrations, CMMI has only recommended two models, the Pioneer Accountable Care Organization initiative and Diabetes Prevention Program, for expansion to the whole Medicare program.

GAO's finding that many of CMMI's models are underperforming on key goals calls into question the viability of ACOs and other alternative payment models. CMMI acknowledges that many models are not meeting performance goals but points to time as a key factor. A study conducted by the Office of Inspector General (OIG) found that ACOs tend to improve their quality and cost performance over time.

However, CMS Administrator Seema Verma has indicated that the Center for Medicare and Medicaid Services (CMS) will be more aggressive in pushing ACOs to accept downside risk. In a speech to the American Hospital Association, Verma praised "a subset" of ACOs that have taken on downside risk while criticizing those that have continued on the "upside only" track. She stated that the majority of ACOs are failing to reduce Medicare spending. Verma's

comments indicate that CMS will not be as patient with ACOs avoiding downside risk and that CMS might scale back its ACO programs.

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CMS Rejects Lifetime Caps for Medicaid

Under the Trump Administration, the Centers for Medicare and Medicaid Services (CMS) has demonstrated an increased willingness to allow states to adopt eligibility changes to Medicaid including work requirements and drug testing for Medicaid recipients. CMS has already approved work requirements in three states – Kentucky, Indiana and Arkansas – and is supportive of Wisconsin's effort to implement drug testing.

However, CMS had delayed responding to a proposed change from Kansas to impose lifetime limits on Medicaid coverage for eligible beneficiaries until earlier this month when it formally rejected this proposal.

In a speech to the American Hospital Association (AHA), CMS Administrator Seema Verma announced that CMS would not approve Kansas' request to place a three-year lifetime limit on Medicaid coverage. Administrator Verma cited a need for sustainable and available coverage in her explanation of why CMS rejected Kansas' proposal.

This decision was reiterated in a letter sent the same day to the Kansas office that oversees the state's Medicaid program. Verma emphasized the administration's continued support for the work requirements that Kansas has proposed.

Kansas was among four other states - Arizona, Maine, Utah, and Wisconsin – to file Section 1115 waivers to limit duration of coverage.

Following the decision on Kansas' request, Verma clarified at a Washington Post live news event that CMS would not approve any state proposals to impose lifetime coverage limits for Medicaid.

Prior to leading CMS, Verma owned a consulting firm that helped states redesign their Medicaid programs. Verma was a key architect of Indiana's Medicaid program.

Under Verma's leadership, it is clear that CMS continues to support giving states greater authority to design their Medicaid programs but this decision draws a line in the sand as to how far states can go in redesigning Medicaid eligibility requirements.

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GAO Study of State Laws on Medical Record Transfer Fees

The Government Accountability Office (GAO) has issued a report on the varying state laws that govern the fees providers can charge third parties for medical record transfer requests. The 21st Century Cures Act required the GAO to conduct this analysis of patient access to medical records.

The Health Insurance Portability and Accountability Act (HIPAA) allows providers to charge patients for providing them with copies of their medical records but places limits on how much patients can be charged.

HIPAA authorizes providers to charge a reasonable, cost-based fee when patients request copies of their medical records for themselves or request their medical records be forwarded to another party. States have flexibility in determining how to regulate provider ability to charge patients for their records as long as these charges are "cost-based" and "reasonable." Some states set a maximum fee that can be charged while others establish a per-page fee schedule.

However, the same federal limitations do not apply when patients authorize a third party, such as an attorney, to request their medical records on their behalf. Third-party-initiated requests are governed by state law and are not subject to the same HIPAA requirements as requests initiated by patients. According to the GAO, providers often set fees that exceed the "cost-based" standard for third party requests.

For its analysis, the GAO examined the medical record request laws of four state: Kentucky, Ohio, Rhode Island, and Wisconsin. GAO found that these laws vary in terms of the fees allowed for patient and third-party requests for medical records.

For three of the states (OH, RI and WI), charges are based on the number of pages requested and vary across the three states.

- One of the three states has established a different per-page fee amount for third-party requests. The other two do not authorize a different fee for patient and third-party requests.
- One of the three states also specifies a maximum allowable fee if the provider uses an electronic health records system. The other two do not differentiate costs for electronic or paper records.

In the fourth state (KY), state law entitles individuals to one free copy of their medical record. The statute allows a charge of up to $1 per page for additional copies.

As part of its report, the GAO interviewed several patient advocate organizations. These organizations expressed concern over patients still facing high fees for accessing their medical records.

One patient advocacy organization described the following examples reported to them by patients:

- Two patients described being charged fees exceeding $500 for a single medical record request.
- One patient was charged $148 for a PDF version of her medical record.
- Two patients were directed to pay an annual subscription fee in order to access their medical records.
- One patient was charged a retrieval fee by a hospital's ROI vendor for a copy of her medical records. Retrieval fees are prohibited under HIPAA.

The GAO also interviewed provider organizations who described challenges they face in fulfilling these requests such as allocating staff time and other resources to respond to medical record requests. The provider stakeholders noted the following:

- Extracting medical records from EHRs is not a simple "push of a button" and often requires providers or their ROI vendors to go through multiple systems to compile the requested information. Stakeholders noted that printing a complete record from an EHR system can result in a document that is hundreds of pages long due to the amount of data stored in EHR systems.
- Representatives from three ROI vendors told us that as providers have transitioned from using paper records to using EHR systems, information has been scanned into electronic medical records. This has, in some cases, resulted in records being incorrectly merged (e.g., the records of two patients merged into a single record). As a result, when responding to a medical record request, providers or their vendors must carefully go through each page of the record to ensure only the correct patient's medical records are being released.
- A provider representative and other stakeholders said that while patients can request copies of their records in an electronic format, providers may have security concerns about sending information via unsecured email or providing electronic information via a patient's USB stick, which increases the risk of a provider's system becoming infected with malware.

The Department of Health and Human Services (HHS) Office of Civil Rights (OCR) investigates and enforces HIPAA violations related to patient access to their medical records. According to the GAO, OCR enforcement of these violations with penalties such as civil monetary penalties (CMP) is rare and reserved for "egregious" provider behavior. OCR prefers to work with providers to take corrective action.

The GAO did not issue recommendations for Congress or HHS to consider.

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CMS Transmittals

The following transmittals were issued by CMS in May.

Transmittal Number	Subject	Effective Date
R3968CP	Consumer Friendly Spanish Descriptors for the Current Procedural Terminology (CPT) / Level 1 Healthcare Common Procedure Coding System (HCPCS) Codes and a Correction to the Part A Spanish Medicare Summary Notices (MSNs)	2018-07-02
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
R797PI	Reviewing for Adverse Legal Actions (ALA)	2018-04-30
R4068CP	E/M Service Documentation Provided by Students (Manual Update)	2018-03-05
R2091OTN	Identifying and Eliminating Discrepancies between the Provider Enrollment, Chain and Ownership System (PECOS) and the Fiscal Intermediary Shared System (FISS)	2018-10-01
R4061CP	July 2018 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files	2018-07-02
R2090OTN	Use the VMAP/4D States Table in all VMS Address Processing	2019-01-07
R4062CP	Diagnosis Code Update for Add-on Payments for Blood Clotting Factor Administered to Hemophilia Inpatients	2018-07-02
R1P245	Medicare Provider Reimbursement Manual Part 2, Provider Cost Reporting Forms and Instructions, Chapter 45, Form CMS-2088-17	2018-09-30
R4053CP	Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July 2018 Update	2018-07-02

R4055CP	Annual Updates to the Prior Authorization/Pre-Claim Review Federal Holiday Schedule Tables for Generating Reports	2018-10-01
R4056CP	Instructions for Downloading the Medicare ZIP Code File for October Files	2018-10-01
R4057CP	Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update	2018-10-01
R1P246	Medicare Provider Reimbursement Manual Part 2, Provider Cost Reporting Forms and Instructions, Chapter 46, Form CMS-222-17	2018-09-30
R2089OTN	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
R4058CP	Common Edits and Enhancements Modules (CEM) Code Set Update	2018-10-01
R4054CP	Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE	2018-10-01
R4052CP	Removal of KH Modifier from Capped Rental Claims	2018-10-01
R2081OTN	Transition Letter Writing from Client Letter Software to the Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs)	N/A
R4045CP	Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment	2018-07-02
R4047CP	Updates to Publication 100-04, Chapters 1 and 27 to Replace Remittance Advice Remark Code (RARC) MA61 with N382	2018-08-13
R796PI	Intent to Reopen	2018-08-13
R4046CP	Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Extensions per the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act Included in the Bipartisan Budget Act of 2018	2018-04-02
R207NCD	Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)	2018-07-02
R4049CP	Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)	2018-07-02
R4048CP	Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2018 Update	2018-07-02

R2068OTN	Common Working File (CWF) Split Medicare Part A Claims to Carry 50 Lines per Segment Rather than 100 Lines per Segment	2019-01-07
R2083OTN	Implementation of Changes to the Pre-Payment Additional Documentation Request (ADR) Letters for Medical Review	2018-10-01
R2084OTN	Analysis and Design for Fiscal Intermediary Shared System (FISS), Multi-Carrier System (MCS), and Viable Information Processing System (VIPS) Medicare System (VMS) Prepayment Review Report	2018-10-01
R2076OTN	International Code of Diseases, Tenth Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)	2018-10-01
R2077OTN	Clean-up of Fiscal Intermediary Shared System (FISS) Reason Codes and Quarterly Reports	2018-10-01
R2079OTN	Identifying and Eliminating Discrepancies between the Provider Enrollment, Chain and Ownership System (PECOS) and the Fiscal Intermediary Shared System (FISS)	2018-10-01
R2080OTN	Fee-For-Service (FFS) Shared System Maintainers (SSMs) Standardized Release Identification (ID) Format	N/A
R2082OTN	Analysis for Mandatory Support of Review Contractors to Send Electronic Medical Documentation Requests (eMDR) to Participating Providers via the Electronic Submission of Medical Documentation (esMD) System	2018-10-01
R2085OTN	Implementation of Procedures for Undeliverable Medicare Summary Notices (uMSNs) and Summary MSNs for Previously Undeliverable MSNs for FISS and MCS (No-Pay only)	2018-10-01
R2086OTN	Combined Common Edits/Enhancements Module (CCEM) Updates for Apache POI (version 3.14.0) to Apache POI (version 3.17) and Analysis from JAVA (version 6) to JAVA (version 7)	2018-10-01

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