HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION

Washington Report – December 2018
(Covers activity between 12/1/18 and 12/31/18)
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District Court Rules Entire ACA is Unconstitutional

- A Federal District Court in Texas has ruled that the entire Affordable Care Act (ACA) is unconstitutional. The judge's reasoning is based on how the ACA was found to be constitutional in the first place.
- The Judge found that the narrow issue brought before the court was not severable from the rest of the law.
- This ruling will not immediately take effect. The ACA will continue to exist without change as the case is appealed.

A Federal District Court in Texas has ruled that the entire Affordable Care Act (ACA) is unconstitutional. The case, brought by a group of 20 state attorneys general, challenged the ACA's constitutionality in light of Congress eliminating the individual mandate penalty in the massive tax reform bill passed last year, the Tax Cuts and Jobs Act (TCJA).

The State of Texas led the case challenging the ACA. Texas' argument centered on how the mandate was ruled constitutional by the US Supreme Court. In the original case challenging the constitutionality of the ACA (NFIB v. Sebelius), Chief Justice John Roberts stated in his opinion for the majority that the individual mandate is unconstitutional as a mandate. However, Chief Justice Roberts affirmed that the individual mandate is a constitutional exercise of Congress' taxing powers.

According to Texas, the individual mandate was upheld by the US Supreme Court as a tax. Texas now argues that because there is no individual mandate penalty, there is no longer a tax. Therefore, the law is no longer constitutional. Judge Reed O'Connor of the Federal District Court in Fort Worth agreed with Texas.

Judge O'Connor also had to decide if the mandate was "severable" from the rest of the ACA. Severability means that a law still stands if an individual piece of that law is ruled unconstitutional or repealed by Congress. Judge O'Connor affirmed the mandate is such a central component of the law that it is not severable from the rest of the ACA. Therefore, he ruled the entire ACA unconstitutional.

A group of state attorneys general representing a different group of states who are defending the ACA in this case will appeal the ruling. The ruling will not take effect until the case has worked its way through the appeals process. The ACA will continue to exist unchanged for the time being. Centers for Medicare and Medicaid Service (CMS) Administrator Seema Verma affirmed that the ACA exchanges will continue to function normally while this case continues to work itself through the courts, which could take years.

Recall, the ACA included much more than the individual and small business health insurance market reforms. The law set sweeping health insurance standards that prevent insurers from denying coverage or charging more for coverage for preexisting conditions. The law allowed states to expand Medicaid eligibility, created the Center for Medicare and Medicaid Innovation (CMMI), and required the creation of new electronic transaction operating rules, among many other provisions established by 974 pages of legislative text.

Judge O'Connor issued his ruling on December 14th, one day before the conclusion of the open enrollment period for the federal health exchange (healthcare.gov) 2019 plan year.

Preliminary data shows a huge uptick in enrollments as the deadline approached. About half of all enrollments took place in the final week of the open enrollment period.

In total, 8.4 million people have enrolled in a health plan through the federal exchange. About 2 million were new consumers, and about 6.4 million were consumers who renewed their coverage from last year. This data does not include enrollments through the 11 exchanges operated by states.

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HBMA GR Committee Chair Participates In NCVHS Feedback Session on Standards Predictability Roadmap

- HBMA Government Relations Committee Chair Arthur Roosa participated in a NCVHS stakeholder listening session to provide input on a draft plan for reforming the administrative transaction standards development process.
- Roosa reiterated the GR Committee's position that there needs to be more robust enforcement of noncompliance with these standards.

On December 12th and 13th, the National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards held a listening session to hear feedback from industry stakeholders on its draft administrative transaction standards development Predictability

Roadmap. The purpose of this roadmap is to improve efficiency of the standards development process.

HBMA was invited to participate in the listening session. HBMA Government Relations Committee Chair Arthur Roosa represented HBMA in the session.

The Subcommittee on Standards monitors and makes recommendations to the Full Committee on health data standards, including implementation of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare Modernization and Improvement Act of 2006 (MMA), and the Affordable Care Act.

NCVHS acknowledges the complaints by many industries that standards development, adoption and implementation are not predictable and are not keeping pace with business and technology innovations. By the time a standard goes through the development, consideration, approval and implementation processes, the standard might be significantly outdated compared to when it was introduced. The NCVHS Predictability Roadmap is an initiative to evaluate barriers to the update, adoption and implementation of standards and operating rules.

Roosa focused his comments on the need for enforcement of the standards that are already on the books. Roosa shared his personal experience working through the formal complaint process to resolve an issue with a non-compliant health plan. It took the health plan over three years to come into compliance after the Centers for Medicare and Medicaid Services (CMS) determined the health plan was out of compliance.

He also weighed in on the need for a strong regulatory framework to support updating existing standards and developing new standards. He also stressed the need for a floor or baseline in all data standards so that providers can be assured of both having their claims processed correctly and receiving a processable remittance advice response across all payers if providing the payer with a HIPAA compliant transaction. The lack of an efficient standard development and maintenance process adds to administrative burdens as practices (and their RCM companies) are forced to develop workarounds to the issues presented by outdated and unenforced standards.

The full NCVHS Committee will meet in February to review the feedback received by the Standards Committee. NCVHS intends to submit its recommendations to the Department of Health and Human Services (HHS) in the first quarter of 2019.

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HHS Officially Proposes to Rescind Health Plan ID Regulations

- HHS issued a proposed rule to begin the official process of rescinding previously finalized – but never implemented – Health Plan ID regulations.
- HBMA provided testimony to NCVHS in 2017 recommending HHS rescind the regulations.

The Department of Health and Human Services (HHS) took the first official step to rescind the unique health plan identifier (HPID) regulations after stating it would do so for over a year.

HHS finalized regulations requiring all covered entities to use an HPID whenever a covered entity identifies a health plan in a covered transaction. The regulations also defined "Controlling health plan" (CHP) and "Subhealth plan" (SHP). The definitions of these two terms differentiate health plan entities that are required to obtain an HPID and those that are eligible, but not required, to obtain an HPID.

However, HHS never implemented the regulations due to industry opposition.

On December 19, 2018, HHS issued its long-awaited proposed rule to rescind the HPID regulations.

The proposed rule references a 2017 National Committee on Vital and Health Statistics (NCVHS) public hearing on rescinding the HPID regulations in the proposed rule, "Overall, there was near unanimity from testifiers that HHS should rescind the HPID and OEID. The oral and written testimony can be found on the NCVHS website at https://www.ncvhs.hhs.gov/meeting-calendar/agenda-of-the-may-3-2017-ncvhs-subcommittee-on-standards-hearing-on-health-plan-identifier-hpid/."

HBMA Government Relations Committee Vice Chair Dave Nicholson, CHBME testified in favor of rescinding the regulations on behalf of HBMA at the NCVHS meeting.

Following the hearing, the NCVHS wrote to HHS that testifiers were unanimous regarding their preferred use of Payer IDs versus the HPID. The net of all the testimony was that while Payer IDs do not identify the health plan, they identify the payers, which is necessary to meet transaction routing needs. The NCVHS wrote that they heard from testifiers that the HPID interferes with the established processes and provides no value to industry. The NCVHS made three recommendations to HHS following the hearing:

- HHS should rescind its September 2012 final rule which required health plans to obtain and use the HPID.
- HHS should communicate its intent to rescind the HPID final rule to all affected industry stakeholders as soon as a decision is made. HHS should provide the applicable guidance on the effect a rescission may have on all parties involved.
- HHS should continue with the 2014 HPID enforcement discretion until publication of a final regulation rescinding the HPID final rule.

HHS is agreeing with NCVHS' recommendations and proposing to rescind its HPID regulations. However, HHS notes in the proposed rule that it has a statutory requirement to adopt a standard unique health plan identifier. HHS intends to continue working with industry on other solutions to meet those requirements.

HHS is accepting public comments on the proposed rule until February 19, 2019. HHS will then review those comments for consideration in the final version of the rule.

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Payer, Patient and Business Groups form Surprise Billing Coalition

- The issue of “surprise” out-of-network medical bills continues to gain traction in Washington. Industry groups are beginning to stake out positions ahead of an anticipated effort by Congress to pass legislation to address this issue.
- Earlier this month, payer, patient and business groups aligned to form a coalition on this issue. Noticeably absent from this coalition are provider organizations.

Nine organizations representing healthcare payers, employers and patient groups announced the formation of a coalition to advocate for federal policy changes to protect consumers from “surprise” out of network (OON) healthcare bills. “Surprise” bills refers to when patients receive a bill for care provided by an OON provider at an in-network facility.

Some states have enacted laws to protect patients from surprise medical bills while also establishing a methodology for the patient’s health plan to reimburse the OON provider. In general, these methodologies are overly prescriptive and below market rates.

Not every state has a surprise billing law on the books. Congress has been paying increased attention to this issue and several Senators, from both parties, have introduced bills to provide a federal protection for states that have not enacted their own surprise billing law.

The federal proposals have mirrored state laws, especially with regard to how the patient’s health plan will be required to reimburse the OON provider. Other proposals can be administratively burdensome by requiring forced arbitration to determine the payment.

This issue is almost certain to be a top healthcare policy priority for the new Congress. Not only is it a compelling consumer-facing issue, it could be one of the few issues that can garner broad bipartisan support from a Republican-controlled Senate and Democratic-controlled House.

The organizations making up the coalition are America’s Health Insurance Plans (AHIP), American Benefits Council, Blue Cross Blue Shield Association, Consumers Union, The ERISA Industry Committee, Families USA, National Association of Health Underwriters, National Business Group on Health, and the National Retail Federation.

The coalition’s principles include:

- Patients Should Be Protected from Surprise Medical Bills Through Federal Legislation. The organizations support federal legislative action to end surprise medical bills.
- Patients Should Be Informed When Care Is Out of Network. Patients have a right to know about the costs of their treatment and options.
- Federal Policy Should Protect Consumers from Surprise Medical Bills While Restraining Costs and Ensuring Quality Networks. Putting patients first means enacting policies that protect consumers from surprise bills, while ensuring that those policies do not simultaneously increase premiums or other costs for consumers.
- Payments to Out-of-Network Doctors Should be Based on a Federal Standard. More than 100 million Americans are enrolled in a self-funded health plan. Protecting them requires a federal standard that reduces complexity while ensuring they cannot be surprise-billed.

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CMS Office of the Actuary Publishes National Health Expenditure Data

- The CMS Office of the Actuary published its annual report analyzing national healthcare expenditures for the most recent year.

- According to the report, national healthcare spending growth decelerated in 2017. According to CMS, overall national health spending grew at a rate of 3.9 percent in 2017, almost 1.0 percentage point slower than growth in 2016.
- The slower growth in spending on hospital and physician services for 2017 is mainly attributed to slower growth in the use and intensity of services.

The Centers for Medicare and Medicaid Services (CMS) Office of the Actuary published its analysis of overall national health expenditures for 2017. This annual report analyzes the spending growth rate, aggregate health spending by consumers and payers and breaks down spending by types of health services.

According to CMS, overall national health spending grew at a rate of 3.9 percent in 2017, almost 1.0 percentage point slower than growth in 2016. The 3.9 percent growth in healthcare spending was slightly slower than growth in the overall economy (4.2 percent) in 2017. Healthcare spending represented 17.9 percent of Gross Domestic Product (GDP) compared to 18 percent in 2016. Total health spending was $3.5 trillion in 2017, up from $3.4 trillion the year before.

CMS attributes the slowdown in health spending to an across the board decrease in utilization of healthcare services.

Aggregate spending on medical services decreased across hospitals, physician offices and retail prescription drugs. According to CMS, hospital spending, representing 33 percent of total healthcare spending, decelerated in 2017, growing at a pace of 4.6 percent to $1.1 trillion compared to 5.6 percent growth in 2016. Physician and clinical services spending, representing 20 percent of total healthcare spending, increased 4.2 percent to $694.3 billion in 2017. This increase followed more rapid growth of 5.6 percent in 2016 and 6.0 percent in 2015. Retail prescription drug spending, representing 10 percent of total healthcare spending, slowed in 2017, increasing 0.4 percent to $333.4 billion.

The slower growth in spending on hospital and physician services for 2017 is mainly attributed to slower growth in the use and intensity of services.

The data is further broken down by how much was spent by each type of healthcare payer. According to CMS, private health insurance spending, representing 34 percent of total healthcare spending, increased 4.2 percent to $1.2 trillion in 2017, which was slower than the 6.2 percent growth in 2016.

Medicare spending, representing 20 percent of total healthcare spending, grew 4.2 percent to $705.9 billion in 2017, which was about the same rate as in 2016 when spending grew 4.3 percent. In 2017, slower growth in fee-for-service Medicare (Medicare FFS) spending (1.4 percent in 2017 compared to 2.6 percent in 2016) offset faster growth in spending for Medicare private health plans (10.0 percent in 2017 compared to 8.1 percent in 2016). The trends in Medicare FFS and Medicare private health plan spending are attributed in part to an increasing share of all Medicare beneficiaries enrolling in Medicare Advantage.

Medicaid spending, representing 17 percent of total healthcare spending, growth slowed in 2017, increasing 2.9 percent to $581.9 billion following growth of 4.2 percent in 2016.

Out-of-pocket spending by consumers, which includes direct consumer payments such as copayments, deductibles, and spending not covered by insurance, represented 10 percent of

total healthcare spending. Out-of-pocket spending grew 2.6 percent to $365.5 billion in 2017, which was slower than the 4.4 percent growth in 2016.

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Nancy Pelosi Elected Speaker of the House

- The 116th Congress was sworn-into office on January 3rd. The House of Representatives elected Nancy Pelosi (D-CA) as Speaker of the House for the new Congress.
- Pelosi returns to the Speakership after serving as Speaker from 2007-2010.
- In exchange for securing the support of some House Democrats, Pelosi agreed to endorse internal rule changes for the House Democratic Caucus that potentially limits her to serving only one more term as Speaker.

On January 3rd, the 116th Congress convened for the first time. Every member of the House of Representatives and those senators who were elected in 2018 were sworn into office. The day culminated in the House of Representatives electing Nancy Pelosi (D-CA) to serve as Speaker of the House in the new Congress.

Pelosi successfully secured the nomination of the House Democratic Caucus but she faced considerable opposition from a handful of Members heading into the final vote by the full House. With House Republicans guaranteeing to oppose her nomination, Pelosi could only afford to lose a handful of Democratic votes to achieve the simple majority needed to be elected Speaker. She was ultimately able to secure enough support from concerned Democrats after agreeing to some reforms on how the House Democratic Caucus is internally organized.

Some House Democrats opposed her Speakership bid primarily because they want her to guarantee opportunities for younger Members to hold Leadership positions. As it stands, the same House Democrats who filled the top three Leadership positions in the Democratic Caucus since 2007 are seeking to return to those posts in 2019. They appear likely to win back those positions.

In addition to Pelosi's return to the Speakership after serving as Speaker from 2007-2010, Rep. Steny Hoyer (D-MD) and Rep. Jim Clyburn (D-SC) are returning to the top leadership positions they held during those years in the new Congress. Rep. Hoyer will serve as House Majority Leader and Rep. Clyburn will serve as Majority Whip.

To assuage concerns from House Democrats over a lack of Leadership opportunities, Pelosi agreed to support a new system of term limits within the House Democratic Caucus. The new internal House Democratic Party rules will impose a limit of three two-year terms for key positions. A Member will be allowed to seek a fourth term but a higher vote threshold will be needed. Most importantly, the term limits are retroactive meaning Pelosi will begin her third term should she win the Speaker election. The new system allows Members to seek a fourth and final term but will require a higher threshold of votes for the fourth term.

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Partial Government Shutdown Continues Over Border Wall Disagreement

- Parts of the Federal Government have been shut down since December 22nd due to a lapse in Congressional appropriations for those agencies.

- Funding for a wall or barrier along our southern border is the central issue behind the shutdown.

Among the most pressing issues the new Congress must address is passing legislation that funds parts of the federal government that are currently shutdown due to a lapse in federal appropriations for those agencies.

Congress had been using short-term legislation to extend funding for part of the Federal Government. The most recent short-term bill expired on December 21st, thus resulting in a government shutdown for the agencies funded by these bills. The federal agencies that are shutdown are those funded by the Interior-Environment, Financial Services, Transportation-Housing and Urban Development (HUD), Agriculture-Food and Drug Administration (FDA), Homeland Security, Commerce-Justice-Science, or State and Foreign Operations appropriations bills.

Last year, Congress passed legislation that fully funds the Department of Health and Human Services (HHS) and its sub agencies including the Centers for Medicare and Medicaid Services (CMS) for the full fiscal year (10/1/18 – 9/30/19). HHS and CMS are not affected by this shutdown.

The partial shutdown of the federal government began on December 22nd and has yet to be resolved with both parties digging in on their positions over the issue that is central to the shutdown: a wall along our southern border with Mexico.

President Trump is insisting that the bill funding the Department of Homeland Security (DHS) provide $5 billion in funding specifically for a border wall. Republicans and Democrats in Congress previously agreed to provide $1.6 billion to DHS for “border security” and specified that the funds cannot be spent on a border wall.

Speaker Pelosi has refused to provide any funding or a border wall. Among its first actions upon being sworn into office on January 3rd, the House of Representatives passed legislation – largely along party lines – that would extend funding for the currently shutdown agencies. Senate Majority Leader Mitch McConnell (R-KY) is refusing to consider legislation that the President will not sign and therefore does not intend to bring these bills up for a vote in the Senate.

Both sides have shown little willingness to compromise. It is not immediately clear how this impasse will ultimately be resolved.

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HHS Requests Feedback from Stakeholders on how to Change HIPAA Privacy Rules to Promote Data Sharing

- HHS is requesting recommendations from stakeholders on how to reform the HIPAA privacy rules to promote data sharing.
- Data sharing is an essential part of many value-based payment models. However, HHS has heard concerns from stakeholders that HIPAA presents a barrier to the type of data sharing needed for new models.

One of the goals of the transition to a value-based healthcare system is to improve care management and break down some of the silos that make it difficult for multiple health care professionals to provide care to a patient with many conditions. Improving care management typically requires healthcare providers to share data with each other. HIPAA's strict privacy rules on protecting patient information can pose a barrier to sharing health information for care management purposes.

The Department of Health and Human Services (HHS) Office of Civil Rights (OCR) recognizes this challenge and is requesting feedback from industry stakeholders to identify provisions of the HIPAA Rules that may present obstacles to these goals without meaningfully contributing to the privacy and security of protected health information (PHI) and/or patients' ability to exercise their rights with respect to their PHI.

In addition to requesting broad input on the HIPAA Rules, the RFI also seeks comments on specific areas of the HIPAA Privacy Rule, including:

- Encouraging information-sharing for treatment and care coordination
- Facilitating parental involvement in care
- Addressing the opioid crisis and serious mental illness
- Accounting for disclosures of PHI for treatment, payment, and health care operations as required by the HITECH Act
- Changing the current requirement for certain providers to make a good faith effort to obtain an acknowledgment of receipt of the Notice of Privacy Practices

Public comments on the RFI will be due by February 11, 2019.

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CMS Scrutinizing Facility Accreditors for Conflicts of Interest

- CMS is soliciting public feedback on the appropriateness of the practices of some Medicare-approved Accrediting Organizations (AOs) to provide fee-based consultative services for Medicare-participating providers as part of their business model.
- CMS is concerned that this practice poses a conflict of interest.

The Centers for Medicare and Medicaid Services (CMS) has put out a request for information (RFI) seeking information about Accrediting Organizations that also offer consulting services.

CMS is soliciting public comment regarding the appropriateness of the practices of some Medicare-approved Accrediting Organizations (AOs) to provide fee-based consultative services for Medicare-participating providers as part of their business model. CMS hopes to determine whether AO practices of consulting with the same facilities which they accredit under their CMS approval could create actual or perceived conflicts of interest between the accreditation and consultative entities.

CMS is concerned that "this dual function may undermine, or appear to undermine, the integrity of the accreditation programs and could erode the public trust in the safety of CMS-accredited providers and suppliers."

According to CMS Administrator Seema Verma, “Our data shows that state-level audits of healthcare facilities are uncovering serious issues that AOs have missed, leading to high ‘disparity rates’ between the two reviews. We are taking action across-the-board to ensure the quality and safety of patient care through strengthened CMS oversight of AOs, and today’s RFI is a critical component of that effort.”

The Joint Commission is the largest AO and is likely the main target of this RFI. The Joint Commission accredits about 80 percent of hospitals and has its own consulting arm. Recently, media reports have scrutinized the Joint Commission’s high accreditation rate.

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CMS Transmittals

CMS issued the following transmittals in December.

Transmittal Number	Subject	Effective Date
R4189CP	Updates to Immunosuppressive Guidance	2019-04-03
R4190CP	Home Health Rural Add-on Payments Based on County of Residence	2019-01-07
R4191CP	January 2019 Update of the Ambulatory Surgical Center (ASC) Payment System	2019-01-07
R4187CP	Ensuring Only the Active Billing Hospice Can Submit a Revocation	2019-07-01
R2215OTN	Analysis of the Combined Common Edits/Enhancements Module (CCEM) and MSSQL and Oracle Relational Data Base Management Systems	2017-07-01
R2216OTN	Clarification of Part B Recovery Audit Contractor (RAC) Appeals Case File Sharing Process	2019-07-01
R4188CP	Medicare Claims Processing Manual Chapter 23 - Fee Schedule Administration and Coding Requirements	2019-01-30
R2217OTN	Multi-Carrier System (MCS) Prepayment Review File	2019-04-01
R852PI	Update to Chapter 12 (The Comprehensive Error Rate Testing (CERT) Program) of Publication (Pub.) 100-08 (Medicare Program Integrity Manual)	2019-01-24
R4183CP	Claim Status Category and Claim Status Codes Update	2019-04-01
R479PR1	Medicare Provider Reimbursement Manual - Part 1, Chapter 28, Prospective Payments	N/A
R122GI	Updated Instructions for the Change Request Implementation Report (CRIR) and Technical Direction Letter (TDL) Compliance Report (TCR)	N/A
R4185CP	January 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.0	2019-01-07
R4186CP	January 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS)	2019-01-07

R216DEMO	Next Generation Accountable Care Organization (NGACO) Model Post Discharge Home Visit HCPCS	2019-04-01
R4184CP	New Physician Specialty Code for Undersea and Hyperbaric Medicine	2019-01-07
R309FM	New Physician Specialty Code for Undersea and Hyperbaric Medicine	2019-01-07
R4181CP	Calendar Year (CY) 2019 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule	2019-01-07
R253BP	Updates to the Inpatient Psychiatric Facility Benefit Policy Manual	2019-01-16
R4182CP	Calendar Year (CY) 2019 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment	2019-01-07
R2213OTN	Implementing the Revised Patient's Request for Medical Payment Form CMS-1490S, Version 01/18	2019-01-07
R2214OTN	Transitioning the Pricing, Data Analysis and Coding (PDAC) to the New Contractor	2019-01-14
R850PI	Medical Review of Diagnostic Laboratory Tests	2018-12-17
R851PI	Updates to Chapter 4 of Publication (Pub.) 100-08	2018-10-22
R211NCD	National Coverage Determination (NCD) 20.4 Implantable Cardiac Defibrillators (ICDs)	2019-02-26
R254BP	Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2019	2019-01-17
R2210OTN	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Update	N/A
R848PI	Update to Chapter 4, Section 4.18.1.4 and Exhibit 16 in Publication (Pub.) 100-08	2018-10-22
R252BP	Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update	2019-01-02
R4179CP	Combined Common Edits/Enhancements Modules (CCEM) Code Set Update	2019-04-01
R2209OTN	Analysis and Implementation for First Coast Service Options (FCSO) and Novitas for the CMS Enterprise Identity Management OKTA/Saviynt Migration	2019-08-30

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