CHANGE HEALTHCARE REGULATORY AND STANDARDS UPDATE

Q4 2019 Update Published: November 15, 2019
Q1 2019 Update Available: February 14, 2020
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS New Medicare Card Project</td>
<td></td>
</tr>
<tr>
<td>ASC X12N Version 7030™ Public Review and Comment Period</td>
<td></td>
</tr>
<tr>
<td>Attachments NPRM</td>
<td></td>
</tr>
<tr>
<td>CAQH® CORE® Operating Rules</td>
<td></td>
</tr>
<tr>
<td>NCVHS Draft Recommendations Predictability Roadmap</td>
<td></td>
</tr>
<tr>
<td>21st Century Cures Act</td>
<td></td>
</tr>
<tr>
<td>Proposed Rules Supporting Provisions of the 21st Century Cures Act</td>
<td></td>
</tr>
<tr>
<td>Policy Update – Price Transparency and Data Privacy</td>
<td></td>
</tr>
<tr>
<td>MACRA</td>
<td></td>
</tr>
<tr>
<td>Health Plan Identifier (HPID)</td>
<td></td>
</tr>
<tr>
<td>CMS Compliance Review Program</td>
<td></td>
</tr>
<tr>
<td>Change Healthcare Accreditations &amp; Certifications</td>
<td></td>
</tr>
</tbody>
</table>

7030™ is a trademark of X12. All rights reserved.
CORE®, the CORE-certification/Endorser Seals and logo are registered trademarks of CAQH®, copyright 2010, Council for Affordable Quality Healthcare®. All rights reserved.
## Timeline

<table>
<thead>
<tr>
<th>2016-2017</th>
<th>2018</th>
<th>2019</th>
<th>2020+</th>
</tr>
</thead>
<tbody>
<tr>
<td>21st Century Cures Act enacted.</td>
<td>CMS launches Compliance Review Program for Health Plans and Clearinghouses.</td>
<td>HICN (SSN) – MBI transition period ends. Entities must support MBI only.</td>
<td></td>
</tr>
<tr>
<td>1/1/2017</td>
<td>3/28/2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MACRA Final Rule.</td>
<td>CMS launches Compliance Review Program for Health Plans and Clearinghouses.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

##### Withdrawals

| 10/28/2019 |
| Final Rule Rescinding the Adoption of the Standard Unique Health Plan Identifier (HPID) and Other Entity Identifier (OEID) |
| Rule rescinds and deactivates the HPID and OEID as of December 27, 2019. |
CMS NEW MEDICARE CARD PROJECT
CMS New Medicare Card Project – the transition period is almost over!

• All new Medicare cards have been issued.
• The CMS transition from HICN to MBI in electronic transactions and on print claim forms began April 1, 2018 and extends through December 31, 2019, after which Medicare will accept MBI only (with some exceptions).

Change Healthcare is successfully receiving, processing, and routing transactions containing MBI.

See www.hipaasimplified.com for additional information.

Important Dates
➢ June 1, 2018 – CMS MBI Lookup Tool available to providers via their MAC.
➢ October 1, 2018 – CMS began returning the MBI on the Claim Payment/Advice (835) as a Corrected Identifier, when a HICN has been submitted on the claim.
➢ January 1, 2020 – MBI must be used in all transactions and print forms.
MBI Provider Adoption Trend

- Change Healthcare has been tracking provider use and adoption of the Medicare Beneficiary Identifier (MBI) in Medicare claim transactions flowing through our network to the MACs.

- The chart to the right shows the trend and percentage of Medicare claim transactions of total that included an MBI for part A and B claims to all MACs.

- Change Healthcare’s October metric of **81.3%** closely aligns with the CMS reported metric of 80% of fee for service claims for the week ending October 4th.

Source: Change Healthcare Medical Network
The Medicare Access and CHIP Reauthorization Act (MACRA) mandates the removal of the Social Security number-based Health Insurance Claim Number (HICN) from Medicare cards.

As a result, the Centers for Medicare & Medicare Services (CMS) has initiated their New Medicaid Card Project wherein all beneficiary Medicare cards will be reissued with the new Medicare Beneficiary Identifier (MBI), and all Medicare systems will be remediated to accept and process the new identifier.

The primary goal of the New Medicare Card Project is to decrease Medicare beneficiaries' vulnerability to identify theft and fraud by removing the HICN from all Medicare ID cards and systems and replacing it with a randomly-generated MBI.
Regulatory Roadmap – Transition to MBI

- CMS has conducted a phased issuance of new ID cards which will include the MBI.
- All systems, applications, and operational processes must be able to accept, process, and transmit both the HCIN and MBI from April 1, 2018 through December 31, 2019.

⚠️ During the transition period:
- CMS will accept, use for processing, and return to stakeholders either the MBI or HICN. CMS will return the same beneficiary number submitted on the incoming transaction.
- CMS will return a message segment (MSG) in the eligibility transaction when the beneficiary has been mailed their MBI card. Providers may also ask patients if they have received their new card with their assigned MBI.
- For claims submitted using the HCIN identifier, CMS will return the MBI on the remittance advice starting October 2018.
- CMS recommends that providers use the beneficiary’s MBI in transactions once the beneficiary has received their new card.

⚠️ All systems and processes must use only the MBI beginning January 1, 2020. There may be limited exceptions for use of the HICN after transition, such as appeals, adjustments, and other scenarios.
Medicare Beneficiary Identifiers (MBIs) – Next Step Actions to Avoid Impact

- You should be using MBIs in health care transactions now.

You must submit all HICN-based transactions by the 12/31/19 transition period end date. Starting 01/01/20, with a few exceptions, Medicare will no longer accept, or process transactions submitted using the HICN identifier.

- Additionally, CMS has provided an MBI Lookup Tool available to providers via their MAC portal. Patient MBIs can be obtained using the patient's Social Security number, first and last names, and date of birth.

- More info @ https://www.cms.gov/Medicare/New-Medicare-Card/
ASC X12N VERSION 7030™ PUBLIC REVIEW AND COMMENT PERIOD
Public review and comment periods for version 7030™ of the X12N Type 3 Technical Reports (TR3s) began in the fall of 2016.

- Initial reviews of all but four TR3s (both HIPAA-adopted and non-mandated) and one Technical Report Type 2 (TR2)*, have been completed.
- Initial review of three TR3s will close on November 30, with one TR3 remaining.
- Six TR3s have been published, or have been finalized with anticipated publication dates in late 2019/early 2020.
- Based on substantive comments received during the initial review, many TR3s will undergo a second review period. Second review periods are in progress or will begin later in 2019.

* entitled Code Value Usage in Eligibility Benefit Inquiry and Subsequent Response; instructs on proper usage of external code sets designated in the 270/271.
X12N Version 7030™ – Reviews In Progress/Upcoming

Remaining Initial Reviews

• Health Care Request for Additional Information (277RFAI): October 1 – November 30, 2019
• Additional Information to Support a Health Care Claim or Encounter (275): October 1 – November 30, 2019
• Additional Information to Support a Health Care Services Review (275): October 1 – November 30, 2019
• Application Reporting for Insurance (824): TBA

Second Public Reviews

• Health Care Claims (837P/I/D): October 15 – November 30, 2019
• Health Care Service: Data Reporting (837R): October 30 – November 29, 2019
• Health Care Claim Status Request and Response (276/277): November 15, 2019 – January 15, 2019
• Health Care Claim Acknowledgment (277CA): November 15, 2019 – January 15, 2019
• Health Care Services Request for Review and Response (278RR), Review Inquiry and Response (278IR), and Notification and Acknowledgment (278NA): Anticipated December 15, 2019
• Health Care Eligibility Benefit Inquiry and Response (270/271) plus TR2: TBA
• Implementation Acknowledgment for Health Care Insurance (999): TBA

For X12’s summary of the status of version 7030 public comment periods, see the X12 PUBLIC COMMENT TIMELINE at http://www.x12.org
X12N Version 7030™ – Completed Initial Review Cycles

**Cycle 1** September 1 through October 31, 2016
- Payroll Deducted and Other Group Premium Payment for Insurance Products (820)
- Health Insurance Exchange Related Payments (820)
- Benefit Enrollment and Maintenance (834)
- Health Insurance Exchange: Enrollment (834)

**Cycle 2** October 1 through November 30, 2016
- Health Care Claim Status Request and Response (276/277)
- Health Care Claim Acknowledgment (277CA)
- Health Care Claim Pending Status Information (277P)
- Implementation Acknowledgment for Health Care Insurance (999)

**Cycle 3** November 1, 2016 through January 30, 2017
- Health Care Claim Payment/Advice (835)

**Cycle 4** February 1 through June 1, 2017
- Health Care Claim: Professional (837P)
- Health Care Claim: Institutional (837I)
- Health Care Claim: Dental (837D)
- Health Care Service: Data Reporting (837R)

**Cycle 5** September 1 through January 31, 2018
- Health Care Services Request for Review and Response (278RR)
- Health Care Services Review Inquiry and Response (278IR)
- Health Care Services Review – Notification and Acknowledgment (278NA)

**Cycle 6** October 1 through November 30, 2016
- Health Care Claim Status Request and Response (276/277)
- Health Care Claim Acknowledgment (277CA)
- Health Care Claim Pending Status Information (277P)
- Implementation Acknowledgment for Health Care Insurance (999)

- Health Care Eligibility Benefits Inquiry and Response (270/271)
- Code Value Usage in Eligibility Benefit Inquiry and Subsequent Response (TR2)
X12N Version 7030™ – Final

Published

- Benefit Enrollment and Maintenance (834)
- Health Insurance Exchange: Enrollment (834)

Ready for Publication 2019/2020

- Health Care Claim/Payment Advice (835)
- Health Care Claim Pending Status Information (277P)
- Payroll Deducted and Other Group Premium Payment for Insurance Products (820)
- Health Insurance Exchange Related Payments (820)
X12N Version 7030™ Informational Forums

• X12N holds public Informational Forums for each draft TR3 once the public comments received during their public comment periods have been adjudicated.

• Each Informational Forum gives an overview of the number of comments received and how the comment was adjudicated.

• Resolution of substantive comments are discussed in detail.

• All Informational Forum presentations are available to X12 members at https://x12.imeetcentral.com in the X12N Insurance Workspace. To gain access to this site, email info@X12.org.

Change Healthcare Encourages Your Participation

• Change Healthcare is actively participating in the v7030™ Public Review and Comment process and we encourage all entities to participate

• See the Change Healthcare Version 7030™ Customer Communication and Version 7030™ FAQs on www.HIPAAASimplified.com

• To view and comment on the TR3s, go to forums.x12.org

For updates to the public-comment period timeline, watch: www.x12.org
ATTACHMENTS NPRM
The Administrative Simplification provisions under the ACA include adoption of transaction standards and operating rules for Attachments.

Electronic Attachments are electronic transactions that support claims and preauthorizations transactions:
- Health Care Claims/Encounters (837)
- Health Care Services Review-Request for Review and Response (278)
- Health Care Services Review-Notification and Acknowledgment (278)

A proposed rule establishing Attachment Standards and Operating Rules is anticipated as early as December 2019, per the Unified Agenda of Regulatory and Deregulatory Actions (RIN 0938-AT38).
Attachments – Publications

• HL7 Publications:
  – HL7 CDA® R2 Attachment Implementation Guide: Exchange of C-CDA Based Documents, Release 1 Standard for Trial Use
  – HL7 CDA® Release 2 Implementation Guide: Exchange of C-CDA Based Documents; Periodontal Attachment, Release 1

• X12, HL7, and the Workgroup for Electronic Data Interchange (WEDI) White Paper:

CDA is a registered trademark of Health Level Seven International. All rights reserved.
Attachments – Recommendations

On February 16, 2016, the National Committee on Vital and Health Statistics (NCVHS), advisory body to HHS, conducted hearings on the Attachment standards. The following summary recommendations were made by NCVHS to the Secretary of Health and Human Services in a letter dated July 5, 2016:

• Adopt one standard definition of “Attachment”, and establish the scope of the transaction.
• Adopt a set of mature, implementable electronic standards for the health care industry to execute the Attachments transaction.
• Define a series of transaction process requirements, including consistency with adopted privacy laws and regulations.
• Take an incremental, flexible implementation approach in no less than five years inclusive of rulemaking.
• Broaden the testing, education, outreach and compliance efforts.
• Ensure alignment of the Attachment standard’s regulatory requirements with those adopted for use with Electronic Health Records under the Office of the National Coordinator (ONC) for Health Information Technology’s 2015 Edition Certification of Health Information Technology program (i.e., Meaningful Use) and the Medicare Access CHIP Reauthorization Act of 2015 (MACRA)/Merit-Based Incentive Payment System (MIPS).

To see the NCVHS Letter to the Secretary – Recommendations for the Electronic Health Care Attachment Standard, click here.
Attachments – Regulatory Roadmap

- NCVHS hearing was held on February 16, 2016, with NCVHS Letter of Recommendation sent to HHS on July 5, 2016.

- Unified Agenda (RIN 0938-AT38) indicate that a proposed rule is anticipated as early as December 2019, with Public Comment Period.

- Proposed Rule is expected to:
  - Adopt standards for health care attachments transactions and electronic signatures to be used in conjunction with health care attachments transactions.
  - Adopt operating rules that require acknowledgments to be used for the eligibility for a health plan, health care claim status, and health care electronic funds transfers (EFT) and remittance advice transactions.
  - Adopt acknowledgments transactions standards for the health care claim status, enrollment and disenrollment in a health plan, health plan premium payments, coordination of benefits, referral certification and authorization, and health care attachments transactions.
  - Modify the standard for the referral certification and authorization transaction from ASC X12 version 5010 to ASC X12 version 6020.
CAQH® CORE® OPERATING RULES
# CAQH® CORE® Final Operating Rules - Summary

<table>
<thead>
<tr>
<th>Phase</th>
<th>Applicable Transactions</th>
<th>Rules Define:</th>
<th>HIPAA-Adopted*</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>270/271</td>
<td>Infrastructure, connectivity, response time, companion guide, acknowledgments, and data content</td>
<td>Y</td>
</tr>
<tr>
<td>II</td>
<td>270/271, 276/277</td>
<td>270/271: Expanded data content, AAA error reporting, name normalization. 276/277: Infrastructure, connectivity, response time, companion guide, acknowledgments</td>
<td>Y</td>
</tr>
<tr>
<td>III</td>
<td>835 EFT</td>
<td>835: Infrastructure, connectivity, response time, companion guide, acknowledgments; provider enrollment form standardization and online support; 835/EFT reassociation</td>
<td>Y</td>
</tr>
<tr>
<td>IV</td>
<td>Remaining HIPAA transactions</td>
<td>Infrastructure, connectivity, response time, companion guide, acknowledgments</td>
<td>N</td>
</tr>
<tr>
<td>V</td>
<td>278 Request for Review and Response</td>
<td>Data content, proprietary web portal standardization See next slide</td>
<td>N</td>
</tr>
</tbody>
</table>

* Regulations exclude acknowledgment-related requirements.
New Phase V Operating Rules – Prior Authorization

- CAQH® CORE® has completed development of the Phase V rules for the Prior Authorization transaction (005010X217 278 Health Care Request for Review and Response), which is a HIPAA adopted transaction.
  - Rules address data content requirements for the 278 as well as proprietary web portal prior authorization standardization.
  - Phase V Operating Rules were approved by member ballot in April, 2019.
Phase IV Rule Revisions – Prior Authorization Final Determination Timeframe

• In April 2019, CAQH® CORE® formed a task group to revise Rule 452 Health Care Services Review-Request for Review and Response Infrastructure Rule.
  – Rule 452 is part of the CAQH® CORE® Phase IV rule set, which defines infrastructure, connectivity, and companion guide requirements for Health Care Claims (837), Health Care Services Review – Request for Review and Response (278), Benefit Enrollment and Maintenance (834), and Premium Payment (820) transactions.
• The purpose of this task group was to strengthen Rule 452 to include a response time requirement for a final preauthorization determination.
• Combined meetings of the Rules Work Group and Technical Work Group convened to review the recommendations of the task group per CORE® voting protocol. These combined groups approved the Phase IV Rule Revisions by ballot in November, 2019.
• Ballot for final approval is expected to be distributed to CORE® participating organizations by the end of 2019.
Phase IV and V Operating Rules – Regulatory Roadmap

- On July 6, 2016, NCVHS sent a letter to the HHS secretary recommending that the Phase IV Operating Rules not be adopted under regulatory mandate and supporting voluntary industry adoption.

- Recommendations also included; addressing inconsistencies in authentication and connectivity requirements, regulatory adoption of the acknowledgement standard as HIPAA-mandated, and transaction-specific findings and recommendations.

- To see the NCVHS Letter to the Secretary – Recommendations for the Proposed Phase IV Operating Rules, click here.

- No regulatory action has occurred surrounding Phase V rules.
Change Healthcare Operating Rules Readiness

Change Healthcare clearinghouse services are **CORE Phase III Certified**. To become CORE Phase III certified entities must be CORE-certified on the earlier phases. Our CORE Phase III certification serves as Change Healthcare’s exhibit of Operating Rule readiness.

The CAQH Committee on Operating Rules for Information Exchange (CAQH® CORE®) certifies and awards CORE® Certification Seals to entities that create, transmit or use the administrative transactions addressed by applicable Operating Rules. CORE Certification means an entity has demonstrated that its IT system or product is operating in conformance with a specific phase(s) of the Operating Rules.

- Change Healthcare is CORE® Phase I, Phase II, and Phase III certified, as evidenced by our Phase III seal.
- Link to Change Healthcare’s **CORE Phase III Seal**.
- Link to our **CORE Voluntary Certification** (Clearinghouses tab).
- Additional information regarding the Change Healthcare Operating Rules program can be found on [www.HIPAA Simplified.com](http://www.HIPAA Simplified.com).

CORE®, the CORE-certification/Endorser Seals and logo are registered trademarks of CAQH®, copyright 2010, Council for Affordable Quality Healthcare®. All rights reserved.
Future Operating Rule Development – Attachments

• In their April 24, 2019 webinar, Delivering Value through Electronic Healthcare Attachments, CAQH CORE presented its Attachments initiative

• The ACA mandated the development of operating rules for Attachments

• In 2018 CAQH CORE launched an environmental scan of the industry relating to attachments

• CAQH CORE published a white paper on May 7, 2019, entitled, CAQH CORE Report on Attachments: A Bridge to a Fully Automated Future to Share Medical Documentation, which captures the results of their environmental scan and identifies five rule opportunity areas

• Operating-rule development will begin following federal Attachment rulemaking
Future Operating Rule Development – Value-Based Payments Subgroup

CAQH® CORE® has established a Value-Based Payments Subgroup, an outgrowth of its Value-Based Payments Advisory Group which:

• Evaluated the challenges encountered across the traditional revenue cycle workflow for value-based payments, and
• Prioritized three opportunity areas for further operating rule development.

The scope of the Subgroup’s work is to develop operating rules to support the exchange of provider attribution information prior to the point of service.

For additional details, contact core@caqh.org.
CAQH® CORE® and HL7 have announced collaboration to improve interoperability between administrative and clinical systems.

The two organizations will initially collaborate in three areas:

1. Prior Authorization: collaboration to move the industry towards end-to-end automation of the prior authorization process.
2. Exchange of Medical Documentation: collaboration to align their respective efforts to support the electronic exchange of clinical information and medical documentation.
3. Value-Based Payments: collaboration to address the interoperability challenges causing administrative burden for innovative payment models.
NCVHS DRAFT RECOMMENDATIONS PREDICTABILITY ROADMAP
The Patient Protection and Affordable Care Act (ACA) of 2010 authorized the Secretary of the Department of Health and Human Services (HHS) to establish a Review Committee responsible for evaluating the adopted transaction standards and operating rules. The Secretary designated the National Committee on Vital and Health Statistics (NCVHS), advisory body to HHS, to act as the Review Committee.

June 2015 testimony gathered from industry stakeholders – including the Standards Development Organizations (SDOs) and the Operating Rules Authoring Entity (ORAE) – indicated that that HIPAA named transaction standards and operating rules are significant steps towards achieving greater administrative efficiencies.

However, concerns expressed resulted in a letter to HHS with a set of recommendations including the need to:

- Explore the feasibility of expanding the definition of HIPAA covered entities.
- Broaden education.
- Ensure consistency.
- Enforce compliance.
- Adopt the acknowledgment transaction.
- Provide predictability in the adoption of standards, code sets, identifiers and operating rules.
- Ensure responsiveness to evolving changes in health care.

After further information gathering, the Standards Subcommittee of the NCVHS developed the Draft Recommendations for the Predictability Roadmap, presented to the full committee on September 14, 2018.

*See Roadmap Narrative
Timeline

- **October-November 2018:** Industry stakeholders reviewed the Draft Recommendations for the Predictability Roadmap.
- **December 13-14, 2018:** The NCVHS Standards Subcommittee conducted a hearing to hear testimony on these recommendations.
- **December 2018 through January 2019:** The Standards Subcommittee incorporated feedback from comments and testimony.
- **February 6-7, 2019:** The full NCVHS reviewed and approved revised draft recommendations.
- **February 13, 2019:** NCVHS issued letter of recommendation to HHS.
- **June 4, 2019:** CMS issued response to the NCVHS recommendations.
- **July 10-11 2019:** The NCVHS Standards Subcommittee conducted a visioning session to further discuss barriers to adopting and implementing updated versions of standards and operating rules on a predictable, reliable, and timely basis.
- **November 13-14 2019:** Full committee meeting.
Documents

Draft Recommendations for the Predictability Roadmap, October 2018

Improving Health Care System Efficiency by Accelerating the Update, Adoption, and Use of Administrative Standards and Operating Rules: A Brief History and Draft Recommendations (Roadmap Narrative), September, 2018
21st CENTURY CURES ACT
About the 21st Century Cures Act

• On December 13, 2016, the 21st Century Cures Act was enacted into public law “to accelerate the discovery, development, and delivery of 21st century cures, and for other purposes.”

• The legislation includes 18 sections under 3 divisions:
  - DIVISION A—21ST CENTURY CURES
    o TITLE I—INNOVATION PROJECTS AND STATE RESPONSES TO OPIOID ABUSE; TITLE II—DISCOVERY; TITLE III—DEVELOPMENT; TITLE IV—DELIVERY; TITLE V—SAVINGS
  - DIVISION B—HELPING FAMILIES IN MENTAL HEALTH CRISIS
    o TITLE VI—STRENGTHENING LEADERSHIP AND ACCOUNTABILITY; TITLE VII—ENSURING MENTAL AND SUBSTANCE USE DISORDERS PREVENTION, TREATMENT, AND RECOVERY PROGRAMS KEEP PACE WITH SCIENCE AND TECHNOLOGY; TITLE VIII—SUPPORTING STATE PREVENTION ACTIVITIES AND RESPONSES TO MENTAL HEALTH AND SUBSTANCE USE DISORDER NEEDS; TITLE IX—PROMOTING ACCESS TO MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE; TITLE X—STRENGTHENING MENTAL AND SUBSTANCE USE DISORDER CARE FOR CHILDREN AND ADOLESCENTS; TITLE XI—COMPASSIONATE COMMUNICATION ON HIPAA; TITLE XII—MEDICAID MENTAL HEALTH COVERAGE; TITLE XIII—MENTAL HEALTH PARITY; TITLE XIV—MENTAL HEALTH AND SAFE COMMUNITIES
  - DIVISION C—INCREASING CHOICE, ACCESS, AND QUALITY IN HEALTH CARE FOR AMERICANS
    o TITLE XV—PROVISIONS RELATING TO MEDICARE PART A; TITLE XVI—PROVISIONS RELATING TO MEDICARE PART B; TITLE XVII—OTHER MEDICARE PROVISIONS; TITLE XVIII—OTHER PROVISIONS
21st Century Cures Act – Title IV-Delivery (focused breakdown)

- Sec. 4001. Assisting doctors and hospitals in improving quality of care for patients
- Sec. 4002. Transparent reporting on usability, security, and functionality
- Sec. 4003. Interoperability
- Sec. 4004. Information blocking
- Sec. 4005. Leveraging electronic health records to improve patient care
- Sec. 4006. Empowering patients and improving patient access to their electronic health information
- Sec. 4007. GAO study on patient matching
- Sec. 4008. GAO study on patient access to health information
- Sec. 4009. Improving Medicare local coverage determinations
- Sec. 4010. Medicare pharmaceutical and technology ombudsman
- Sec. 4011. Medicare site-of-service price transparency
- Sec. 4012. Telehealth services in Medicare
Assisting doctors and hospitals in improving quality of care for patients

- **4001(a)** Amends the HITECH Act to require HHS to establish a goal, develop a strategy, and make recommendations to reduce regulatory or administrative burdens relating to the use of EHRs.

- **4001(b)** ONC must encourage, keep, or recognize the voluntary certification of health IT for use in medical specialties. HHS must solicit stakeholder input and make criteria recommendations, adopt certification criteria, and support voluntary certification to support health IT for pediatric health providers.

- **4001(c)** HHS must publish attestation statistics for the Medicare and Medicaid EHR Incentive Programs to assist in informing standards adoption and related practices.
  - CMS is renaming the EHR Incentive Programs to the Promoting Interoperability (PI) Programs.
Title IV-Delivery - Section 4002

Transparent reporting on usability, security, and functionality

• 4002(a) Requires HHS, through notice and comment rulemaking, to require as a condition and maintenance of certification, that the HIT developer or entity “does not take any action that constitutes information blocking” (as defined in Section 3022(a) of the Public Health Service Act, as amended), or “any other action that may inhibit the appropriate exchange, access, and use of electronic health information”
  – HealthIT.gov Usability and Provider Burden page & Strategy on Reducing Burden draft
• 4002(b) A health care provider whose adopted health IT is decertified is exempted from the application of a payment adjustment
• 4002(c) HHS must support the convening of stakeholders to develop reporting criteria
Title IV-Delivery - Section 4003

Interoperability

• 4003(a) Defines Interoperability:
• The term ‘interoperability’, with respect to health information technology, means such health information technology that:
  A. Enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user
  B. Allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law
  C. Does not constitute information blocking as defined in section 3022(a) of the Public Health Service Act (PHSA) as amended
Title IV-Delivery - Section 4003

Interoperability (continued)

- 4003(b) directs the National Coordinator to convene appropriate public and private stakeholders to develop or support a trusted exchange framework for trust policies and practices and for a common agreement (TEFCA) for exchange between health information networks.
  - A User’s Guide to Understanding the Trusted Exchange Framework (ONC HealthIT.gov)
  - Timeline:

  ![Timeline Graphic from A User’s Guide to Understanding the Trusted Exchange Framework, Office of the National Coordinator for Health Information Technology.](image-url)
Title IV-Delivery - Section 4003

• **Interoperability** (continued)

• 4003(c) requires that HHS establish an index of digital contact information for health professionals, health facilities, and others to encourage the exchange of health information
  – The Center for Program Integrity (CPI) in CMS will be responsible for implementing the provision. CPI is working with ONC on implementation of the provision.

• 4003(e) replaces the Health IT Policy Committee and the Health IT Standards Committee with the Health IT Advisory Committee (HITAC)
  – The ONC must periodically convene the HITAC to report on priority uses of health IT and standards and implementation specifications that support the implementation of a health information technology infrastructure that advances the electronic access, exchange, and use of health information.

*ONC 2018 Report to Congress*
Interoperability (continued)

- The TEFCA outlines a common set of principles, terms, and conditions to support the development of a Common Agreement that would help enable a nationwide exchange of electronic health information (EHI) across disparate health information networks (HINs).

**Trusted Exchange Framework and Common Agreement (TEFCA) Draft 2**

- For more information, including a user’s guide and market-specific information sheets, see [https://www.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement](https://www.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement).
Title IV-Delivery - Section 4004

Information blocking

• 4004(a) defines information blocking as a practice that:
  A. “except as required by law or specified by the Secretary pursuant to rulemaking under paragraph (3), is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information.”
  B. “(i) if conducted by a health information technology developer, exchange, or network, such developer, exchange, or network knows, or should know, that such practice is likely to interfere with, prevent, or materially discourage the access, exchange, or use of electronic health information; or (ii) if conducted by a health care provider, such provider knows that such practice is unreasonable and is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information.”
Title IV-Delivery - Section 4004

**Information blocking** (continued)

- 4004(b) The Inspector General of HHS is authorized to investigate claims of information blocking
  - A health information technology developer or other entity offering certified health information technology, or a health information exchange or network, may be penalized for engaging in information blocking, up to $1M per violation.
  - Providers determined by the Inspector General to have committed information blocking shall be referred to the appropriate agency to be subject to appropriate disincentives using authorities under applicable Federal law, as the Secretary sets forth through notice and comment rulemaking.

- 4004(d) The National Coordinator must implement a standardized process for the public to submit reports on claims of information blocking
Title IV-Delivery - Sections 4005 & 4006

Leveraging electronic health records to improve patient care

- 4005(a) To be certified, electronic health records must be capable of transmitting to, and where applicable, receiving and accepting data from, registries certified by the ONC
- 4005(c) HHS must report on best practices and current trends provided by patient safety organizations to improve the integration of health IT into clinical practice

Empowering patients and improving patient access to their electronic health information

- 4006(a) instructs HHS to:
  - Encourage partnerships between health information exchanges and health care providers, health plans, and others with the goal of offering patients access to their electronic health information
  - Issue guidance to health information exchanges on best practices
  - Educate providers on leveraging health information exchanges
  - Promote policies to facilitate patient communication with providers and others, given patient consent
  - Update education on accessing and exchanging personal health information
  - Develop and prioritize standards, implementation specifications, and certification criteria required to support patient access to electronic health information and usability
GAO Study on Patient Matching

- 4007(a) instructs the Comptroller General to conduct a study to review ONC HIT and other relevant stakeholder policies and activities to ensure appropriate patient matching to protect patient privacy and security of electronic health records (EHR) and the exchange of electronic patient information.

- 4007(b) outlines areas of concentration to evaluate current methods used for patient matching and taking steps to improve matching.

- 4007(c) requires a report concerning the findings of the study be reported to Congress.
  - The report “Approaches and Challenges to Electronically Matching Patients’ Records across Providers” was published on January 19, 2019.
    - Web link @ https://www.gao.gov/products/GAO-19-197
    - Full Report
Title IV-Delivery - Section 4008

GAO Study on Patient Access to Health Information

- 4008(a) instructs the Comptroller General to conduct a study to review patient access to their own protected health information, including barriers to such patient access and complications or difficulties providers experience in providing access to patients.

- 4008(b) outlines areas of concentration to consider.

- 4008(c) requires a report concerning the findings of the study be reported to Congress.
  - The report “Fees and Challenges Associated with Patients’ Access” was published on May 14, 2018.
    - Web link @ https://www.gao.gov/products/GAO-18-386
    - Full Report
PROPOSED RULES SUPPORTING PROVISIONS OF THE 21st CENTURY CURES ACT
CMS and ONC Issue Proposed Rules

- On February 11, 2019, the U.S. Department of Health and Human Services (HHS) proposed new rules to support seamless and secure access, exchange, and use of electronic health information. The rules, issued by the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC), would increase choice and competition while fostering innovation that promotes patient access to and control over their health information. The proposed ONC rule would require that patient electronic access to this electronic health information (EHI) be made available at no cost.

  - CMS Fact Sheet - https://go.cms.gov/2E3dp5v
  - Public comments were accepted through June 3, 2019 (extended from original deadline of May 3, 2019).

- In addition to the policy proposals, CMS released two Requests for Information (RFIs) to obtain feedback on interoperability and health information technology (health IT) adoption in Post-Acute Care (PAC) settings, and the role of patient matching in interoperability and improved patient care.
NPRMs Published in the Federal Register

- **CMS-9115-P / RIN 0938-AT79** - Medicare and Medicaid Programs: Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans in the Federally-facilitated Exchanges and Health Care Providers


Associated CMS RFIs

The following Requests for Information (RFIs) are also included in CMS-9115-P / RIN 0938-AT79:

- **Interoperability and Health Information Technology (Health IT) Adoption in Post-Acute Care (PAC) Settings**
  - See NPRM Section XI. Request for Information on Advancing Interoperability Across the Care Continuum

- **The Role of Patient Matching in Interoperability and Improved Patient Care**
  - See NPRM Section XIII. Request for Information on Policies To Improve Patient Matching
  - Specifically there are 7 questions posed in part B. Solicitation of Comments.

Click on the links above to review the NPRMs as published in the Federal Register.
POLICY UPDATE – PRICE TRANSPARENCY AND DATA PRIVACY
Federal Transparency Initiatives
Cost/Quality Transparency – Federal Overview

• **Moving Parts**
  - White House Executive Order (EO)
  - Bipartisan legislative packages in both House and Senate

• **Common Threads**
  - Mandating payments for out-of-network providers when consumer had no choice, knowledge (benchmark rate setting and/or arbitration)
  - Consumers must have estimated price information at point of care, in advance to support care choices (i.e., elective care)
Overview of June 24th Executive Order

• Push to make healthcare more transparent
  – Eliminate unnecessary barriers to price/quality transparency
  – Increase availability of meaningful price/quality information for patients
  – Enhance patients’ control over own resources, including through tax-preferred medical accounts (i.e., expanding HSA use)
  – Protect patients from surprise medical bills
Overview of Executive Order - Timeline

- **Within 60 days:** proposed rule requiring hospitals to post negotiated charges in an “easy-to-understand”, machine readable format *(CMS rule imminent)*

- **Within 90 days:** HHS, Treasury, DOL – proposed rule requiring providers, payers, and self-insured plans to provide or facilitate access to information about expected out-of-pocket costs for items or services to patients *before they receive care*

- **Within 180 days:** proposal for federal health programs (HHS, VA, DoD) will increase access to de-identified data to facilitate the development of tools that empower patients to be better informed

- **Within 120 – 180 days:** Treasury issues additional guidance for changes to HSAs and use (more flexibility); HHS report on Surprise Medical Billing
House Legislative Highlights

- Prohibit surprise medical bills and hold patients harmless in emergency situations
- Increase transparency and empower patient choice
- Prohibit surprise medical bills from providers that patients cannot reasonably choose
- **Disagreement in policy: arbitration or benchmarks**
- Encourage the development of state all-payer claims databases
Senate HELP - Lower Health Care Costs Act of 2019

- **Ends surprise billing** – sets benchmark rates w/ arbitration backstop
- Changes insurance contracts (no “gag clauses”)
- Non-profit entity to build national claims database
- Consumers must receive more information on cost and quality
- More accurate provider directories
- Requires facilities and providers to **furnish all adjudicated bills** to the patient as soon as practicable but **no later than 45 calendar days** after discharge or visit
- Requires commercial health insurers to make information available to patients via APIs
“Compromise” Bill: House Ways and Means (in progress)

• Committee leadership formulating an alternative bill (aka “defer responsibility to a committee”)

• Would sidestep siding with either providers or payers re: out-of-network rates
  – “Negotiated rule making” model
  – Does not pre-empt state laws
  – Creates stakeholder committee to formulate a proposal in one year, then goes to rulemaking process (18 months)
State Transparency Initiatives
State Measures Introduced – 2019

• **Over 140 bills** introduced regarding price transparency
  
  – **Type of bills**
    
    o **Shop and reward** - allows patient to shop for services, compare costs, and rewards them for choosing lower-cost service; usually requires payer to provide a web-based mechanism to pay patient
    
    o **Advance notice/surprise billing** – requires facilities and/or providers to provide patients, in advance, an explanation of charges; or notify and obtain consent prior billing uncovered costs. Others, prohibit balance billing
    
    o **Data reporting** – establishes reporting requirements and centralized source for healthcare charges/expenditures for use by State authorities, employers, providers, and/or the public
State Laws Enacted

• Approximately **18 bills signed into law in 13 states** related to price transparency

• By type of bill

  – **Shop and reward**: Florida, Tennessee and Virginia

  – **Advance Notice/Surprise billing**: Colorado, California, Texas, New Mexico, Utah, Vermont, Virginia, Vermont, Missouri, Nevada, and Washington

  – **Data reporting**: Colorado and Virginia
Data Privacy
Why Broad State Data Privacy Policy Now?

• States are introducing broad data privacy bills driven by:
  – Lack of progress at the federal level
  – Movement in UK (GDPR) and California (CCPA)
  – General concern with internet privacy surrounding social media, intrusive/targeted advertising, and an increase in data breaches (health and banking)
What Do These Bills Cover?

• Data privacy bills typically address:
  
  – Scope – internet service providers, data brokers, businesses meeting certain thresholds in terms of annual gross revenue or percent of revenue from the selling of information, etc.
  
  – Individuals rights regarding:
    
    o Know – what information is collected, how it’s used and how and if shared/sold
    o Consent – Opt-in/out of the collection, use, sale of data
    o Data access, correction, and right to delete
  
  – Exclusions - if any; e.g. HIPAA carve-outs, banking/credit, public information, employees, etc.
  
  – Enforcement – private right of action vs. AG enforcement action

• **Definitions are key** - some are clearly aligned with current state or federal laws others are very broad/sweeping (e.g., personal information, sale, de-identified data, etc.)
Key States We Will Watch Closely in 2020

- Broad data privacy bills introduced in 2019 but substituted or amended to establish a task force or study to making legislative recommendations for 2020*

- More amendments to CCPA will likely to be introduced; plus a potential ballot initiative

- Bills failed or stalled in 2019 and likely to be reintroduced in 2020

* Oregon’s workgroup will make recommendations for the 2021 session
MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015 (MACRA)
About MACRA

On April 16, 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) was enacted into public law. The MACRA amends the Social Security Act making changes to how Medicare pays those who provide care to Medicare beneficiaries and extends the CHIP program.

- Includes provisions for CMS to remove Social Security numbers (SSNs) from Health Care Insurance Numbers (HICNs) and Medicare Claims Numbers (MCNs). See CMS New Medicare Card Project (SSNRI).

- Required that CMS establish a classification code set for physician-patient relationships.

- On November 4, 2016, the MACRA Final Rule with Comment was published in the Federal Register. The rule establishes a unified framework called the CMS Quality Payment Program that rewards the quality and value of care in one of two ways:
  - Merit-based Payment System (MIPS),
    - MIPS Overview
  - Advanced Alternative Payment Models (APMs)
    - APMs Overview
  - Quality Payment Program Participation Status Tool
    - QPP Participation Status

- More information on the Quality Payment Program can be found in the Quality Payment Program Resource Library.
HEALTH PLAN IDENTIFIER (HPID)
Health Plan Identifier Rescission

• On October 28, 2019, the U.S. Department of Health and Human Services (HHS) issued a final rule that rescinds the adoption of the Health Plan Identifier (HPID) and Other Entity Identifier (OEID), as set forth in its original ruling Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier (45 CFR Part 162).

• This new regulation, entitled Administrative Simplification: Rescinding the Adoption of the Standard Unique Health Plan Identifier and Other Entity Identifier does the following:
  - Eliminates the requirements for health plans to obtain and use the HPID and eliminates the voluntary acquisition and use of the OEID.
  - Simplifies the process for deactivating HPIDs and OEIDs already issued.

• The effective date of this rule is December 27, 2019, at which time any active HPID or OEID will be automatically deactivated in the Health Plan or Other Entity Enumeration System (HPOES).

• Click here to view this regulation as published in the Federal Register.
CMS COMPLIANCE REVIEW PROGRAM
CMS Compliance Review Program

• In late 2017, CMS launched its Optimization Pilot in preparation for a full-scale Compliance Review program

Change Healthcare was selected to participate in the Optimization Pilot and was awarded our Certificate of Completion on October 4, 2018. See Change Healthcare Accreditations & Certifications for details.

• In April 2019, CMS began its formal Compliance Review program by selecting nine HIPAA-covered entities for compliance reviews. Any health plan or clearinghouse, not just those working with Medicare or Medicaid, can be selected

• Also in April, CMS launched a volunteer Provider Pilot Program to test the process for reviewing HIPAA Administrative Simplification rules compliance among providers.

For additional information, see https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Enforcements/Compliance-Review-Program.html
CHANGE HEALTHCARE
ACCREDITATIONS & CERTIFICATIONS
HHS Optimization Program Certification

- On October 4, 2018, The U.S. Department of Health and Human Services (HHS), Division of National Standards (DNS) within the Centers for Medicare & Medicaid Services (CMS), recognized Change Healthcare for successfully completing the HHS Optimization Program Pilot of Administrative Simplification transaction standards, code sets, unique identifiers, and operating rules.
- Visit the Change Healthcare Viewpoints blog post for additional information.
- Certificate of Completion
Change Healthcare Accreditations & Certifications

To demonstrate our continued commitment to assure that applicable Change Healthcare products and services meet industry and regulatory requirements and expectations, we maintain several industry recognized and trusted accreditations and certifications. Click HERE for more information.