Washington Report – April, 2017

(Covers activity between 4/1/17 and 4/30/17)

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House Republicans Pass AHCA

On May 4th, by a vote of 217-213, the House of Representatives passed the American Health Care Act (AHCA), which effectively repeals and replaces the Affordable Care Act (ACA).

After failing to secure enough support for a scheduled vote in March, House Republicans had continued their efforts to find a way to bring the holdout members onboard. After the cancelled vote, President Trump indicated that he would press Congress to move on to other priorities such as infrastructure and tax reform. At that time, it was unclear when Congress would circle back to the AHCA.

Although a significant majority of Republicans in the House supported the AHCA, two ideological factions of the party, the moderate Tuesday Group and the conservative House Freedom Caucus (HFC) both opposed the AHCA in its original form. Each group had enough votes to prevent House Republicans from reaching the votes necessary to pass the bill because it was clear from the beginning of the new Congress that Democratic support for repealing and replacing the ACA would not be forthcoming. Although House Leadership and the White House tried to negotiate support from each group, it became almost impossible to appease one of the holdout groups without losing the necessary support of the other.

For both political and policy reasons, House Republicans could not afford to hold up the AHCA for very long.

Since the ACA was passed in 2010, almost every (if not all) Republican in both the House and Senate has campaigned on repealing and replacing President Obama's signature healthcare law. Over the intervening years, the GOP controlled House has passed dozens of bills repealing the

ACA. But these were always done with the knowledge that President Obama would veto the legislation.

For the first time since the ACA was passed, Republicans now control both chambers of congress as well as the White House; thus providing them with their best opportunity to date to repeal the ACA and replace it with their own alternative. Most political observers agree that failing to repeal and replace the Affordable Care Act would result in consequences in the midterm elections. Indeed, many argue that repealing and replacing the ACA could have a significant impact on the midterm elections, just as passage of the ACA contributed to the Democrats losing the House in the 2010 midterm election.

The White House, led by President Trump, was largely responsible for this latest push to pass the AHCA. Like all new administrations, President Trump was eager to have a successful "first 100 days." Even though the House vote occurred after the first 100 days of the Trump presidency had elapsed, the White House was aggressively trying to find enough support for the bill ahead of the 100 day mark.

Two amendments were introduced to try to gain the support of the holdouts. The first of these amendments allows states to apply for waivers from certain ACA standards including the essential health benefit requirements and some of the community rating rules. Under the AHCA health plans would still be prohibited from refusing to sell insurance to any individual with a pre-existing condition and plans would be prohibited from "risk rating" enrollees based on gender; however, a state could request a waiver of the "community rating" requirement if certain protections were in place.

In order to waive the community rating requirement and instead, base premiums on actuarial "risk", states must have in place a high risk pool program to provide subsidized coverage for individuals who are being charged higher premiums due to the plan classifying the individuals as "high risk". The AHCA provides $130 Billion in federal grants to states to fund these high risk pools.

In applying for the waivers, states must also attest that the purpose of the waiver is intended to achieve one of the following:

- reduce premium costs,
- increase coverage, or
- advance another benefit to the public interest in the state, such as the guarantee of coverage for pre-existing conditions.

Although this amendment was negotiated by Rep. Tom MacArthur (R-NJ), a leader of the moderate-leaning Tuesday Group many of his fellow moderates opposed this amendment and continued to withhold support for the AHCA. Members of the Freed Caucus agreed to support the AHCA with this amendment.

The second amendment includes an extra $8 billion to help subsidize insurance for people with preexisting conditions. The funding, which is authorized from 2018 until 2023, is available for

states that have obtained a community rating waiver (from the first amendment). These states also have to establish high risk pools. This brings the total funding available for high risk pools to $138 billion.

The AHCA now goes to the Senate where it will undoubtedly face some changes. The Senate will also be passing the AHCA under a special procedure known as budget reconciliation which allows the bill to be passed with a simple majority. This allows Senate Republicans to avoid an expected filibuster by Senate Democrats. Reconciliation bills must be budgetary in nature and therefore can only include provisions that have to do with the raising and spending of federal money. All provisions of the AHCA will be subject to review under this rule during the vote.

Putting together an ACA repeal/replace bill in the Senate will prove every bit as challenging as it was in the House.

Once the Senate passes its repeal/replace bill, the two bodies must then negotiate a compromise between two bills that may bear very little resemblance to one another.

Finally, it should be noted that legislative effort to repeal and replace the Affordable Care Act is only one part of a three-part strategy. The Trump Administration has, literally, hundreds of ACA related regulations it can rewrite over the next four years that would address those provisions the GOP controlled Congress cannot address legislatively.

The AHCA is only the first phase. Stay Tuned!

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CMS Issues ACA Exchange Market Stabilization Final Rule

When Tom Price was confirmed as Secretary of Health and Human Services (HHS), he was very eager to oversee the government's transition away from the Affordable Care Act (ACA) and the implementation of its replacement. Ironically, he has actually been spending the first months of his tenure trying to stabilize the ACA's Healthcare Exchange market for 2018.

On April 13th, the Centers for Medicare and Medicaid Services (CMS) published a final rule intended to strengthen the individual and small group health insurance exchanges established by the ACA. The final rule adopted most of the provisions of the proposed rule that was issued in February of this year.

The Final Rule makes many insurer-friendly changes to the ACA marketplaces to try to keep the exchanges viable in the 2018 plan year. The ACA insurance markets are dealing with declining enrollment, rising premiums, and insurers exiting the exchanges. Each market has experienced these challenges to varying degrees. Some areas have experienced dramatic 100 percent premium increases and other markets are down to having only one insurer selling plans in 2018.

The Republican-controlled Congress is in the process of trying to repeal and replace the ACA. Although the repeal and replace process has been slower than many in the GOP base might have hoped, there remains a strong likelihood that Congressional Republicans will eventually come together to deliver on their seven-year-plus campaign promise to repeal and replace the ACA.

Because the replacement provisions being debated would generally not take effect until 2020, the ACA market will have to function in place during the transition. This Final Rule is intended to address some of the challenges facing the exchanges for these transition years.

Some of the changes in the final rule are:

1. Shortens the 2018 open enrollment period to six weeks: November 1, 2017 – December 15, 2017.
2. Tightens the requirements for enrolling in a plan outside of the open enrollment period through a special enrollment period (SEP). Insurers have long-held that consumers "game" the system by taking advantage of SEPs to avoid enrolling in a plan until it is necessary.
3. Allows insurers to require additional verification documents for SEP enrollments.
4. Allows insurers to charge beneficiaries for past due premiums before enrolling in a plan for the new plan year.
5. Eases some of the network adequacy and essential community provider standards that insurance products must meet to be sold on the exchanges.

CMS is also adjusting the actuarial value (AV) requirements which dictate what average percentage of medical costs a plan is required to cover. Prior to this Final Rule, the ACA assigned "metal" tiers for plans based on their minimum AV. Platinum plans had a minimum AV of 90, Gold had a minimum AV of 80, Silver had a minimum AV of 70 and Bronze had a minimum AV of 60.

The Final Rule changes the minimum AV of each metal level. For example, a silver plan can now have an AV as low as 66 percent. An AV of 60 percent is still the lowest-allowable AV.

It remains to be seen if these changes will lead to the desired improvements in enrollment and competition.

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Congress Reaches Deal on $1.1 Trillion Spending Bill

On April 30th Congressional leaders announced they had reached a bipartisan agreement on an omnibus appropriations bill to fund the government through the remainder of the fiscal year (September 30th). The agreement lacked the drama that was expected when the negotiations began several weeks ago. Many in Washington expected both parties to dig in on contentious

issues that could have jeopardized this must-pass legislation. However, bipartisanship prevailed as both parties refrained from poison-pill provisions that could have jeopardized the negotiations.

Congress has been passing short-term Continuing Resolutions (CR) to fund the government since the end of last year. The most recent CR that was passed in December expired on April 28th. Congress was closing in on an agreement and passed a one week CR on that date to give themselves time to complete the bill.

The relatively "clean" spending bill lacks many of the politically controversial policies that are often expected with appropriations bills. The $1.1 billion bill boosts defense spending, a priority of the Trump Administration, by $15 billion. The Department of Health and Human Services (HHS) received a $2.8 billion increase from the last fiscal year and will be funded at a total of $73.5 billion. The Centers for Medicare and Medicaid Services (CMS) received a $44 billion increase. It also gives the National Institutes of Health (NIH) an extra $2 billion.

Although the negotiations came together without much drama, the weeks leading up to the agreement had some in Washington worrying that a deal couldn't be reached and the government would shut down. President Trump originally threatened to withhold funding for the Affordable Care Act's (ACA) health insurance cost-sharing subsidies (CSRs) unless Congress provided funding for a border wall with Mexico.

Insurers as well as patient and provider groups all lined up in support of the CSRs. President Trump ended up agreeing to fund the cost-sharing subsidies. Although Congress is not funding the border wall, the bill does provide $1.5 billion in additional spending for other border security efforts.

The cost-sharing reduction subsidies are available to consumers who purchase health insurance on the exchanges who earn up to 250 percent of the Federal Poverty Line (FPL). These subsidies are separate from the premium assistance that is available to individuals earning up to 400 percent of the FPL and are intended to assist with the health plan's out-of-pocket spending obligations such as copays, coinsurance and deductibles.

The CSRs have been the subject of a high-profile lawsuit. The House of Representatives, under former Speaker John Boehner's (R-OH) leadership, voted along party lines to sue the Administration for overreaching its authority in funding of the CSRs. The lawsuit argues that Congress is the branch of government with the authority to fund the CSRs, not the executive branch. The previous Congress refused to appropriate the money for the CSR subsidies so the Obama Administration repurposed money Congress approved for a different purpose, to fund the CSR initiative.

The Federal Judge hearing the case ruled in favor of the House of Representatives but that ruling was appealed by the Obama Administration. That appeal is pending.

The lawsuit dynamic shifted when President Trump took the oath of office. It is now the Republican-controlled House suing the Republican-controlled Administration.

This appropriations bill was a rare display of legislative bipartisanship. However, Congress will have to go through this process again before this funding bill expires in September. It remains to be seen if this bipartisanship will continue or if the political fights of old will reappear.

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HBMA Testifies Before NCVHS on Health Plan IDs

On May 3rd, HBMA Government Relations Committee Member, Dave Nicholson presented testimony to the National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards on the issue of restarting Health Plan ID implementation.

In 2014, the Centers for Medicare and Medicaid Services (CMS) delayed implementation of regulations requiring the adoption of HPIDs due to industry opposition. The purpose of the hearing was to seek further input from industry stakeholders, such as HBMA, as CMS and NCVHS consider how (or if) to proceed with HPIDs implementation.

The NCVHS Standards Subcommittee was joined by several CMS staff members from the Division of National Standards.

In addition to HBMA, the hearing featured testimony from health insurers, the Department of Defense/Veterans Administration, provider groups (represented by MGMA), clearinghouses, and standards development organizations.

Almost all of the witnesses at the hearing testified against adopting HPIDs. They either expressed satisfaction with the current system or argued that adding HPIDs would not result in any meaningful improvement to the current system.

HBMA articulated that HPIDs must be used in conjunction with a policy identification number. HBMA put HPIDs in the context of a sports metaphor: The Health Plan ID is generally sufficient to get you into the ball park but the policy identification number is what gets you to the right section, row and seat. This metaphor resonated well with the Committee members.

HBMA will have another opportunity to discus HPIDs when the Government Relations Committee holds its annual meeting with CMS in June.

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MIPS Participation Letters Being Sent

The Centers for Medicare and Medicaid Services (CMS) announced that the official Quality Payment Program (QPP) participation letters will be sent to eligible clinicians in late April

through May. The letters will be sent by the Medicare Administrative Contractor (MAC) that processes the clinician's Medicare Part B claims.

These letters will inform clinicians if they are required to participate in the Merit-based Incentive Payment System (MIPS) in 2017 or if they are exempt from MIPS because they fall below the low-volume provider threshold.

Clinicians who bill less than $30,000 in Medicare Part B allowed charges **or** who provide care for 100 or fewer Medicare Part B enrollees during either of the two previous years, are exempt from MIPS under the low-volume provider exception. This threshold is the same regardless if the clinician reports individually or as a group. The letters were originally supposed to be sent in December.

In future years, CMS intends to send the letters in December so that providers will know in advance whether they are exempt for the upcoming reporting year.

If you do not want to wait for your letter, CMS has set up a web page where you can check to see if you need to submit data to MIPS. You will need to enter your 10-digit NPI in order to make the inquiry.

Because CMS has made 2017 a transition year for MIPS, the sense of urgency that would normally attach to knowing in advance whether a clinician was exempt became less significant.

Under the transition year, eligible clinicians have several participation tracks they can choose from ranging from partial participation to full participation. Eligible clinicians who participate in almost any form will avoid negative payment adjustments in 2019. The 2019 payment adjustments – positive or negative – will be based on data reported in 2017. Only eligible clinicians who do not report any data will receive the maximum negative four percent payment adjustment.

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Trump Administration Continues to Fill Key HHS Positions

President Trump has filled many key positions in his Administration; however, many vacancies continue to exist at the "subcabinet" level. For example, the Trump Administration has yet to fill hundreds of sub-cabinet level positions within the Department of Health and Human Services (HHS). One position of note that has yet to be filled is the director of the Medicare program. These nominations and appointments will serve key advisory and administrative roles for Secretary of HHS Tom Price.

In early April, President Trump nominated Brett Giroir to be the HHS Assistant Secretary for Health. Giroir is currently the president and CEO of ViraCyte, a biopharmaceutical company. He previously led the Texas A&M Health Science Center and has held several administrative roles

for the federal government. Giroir Chaired the blue ribbon commission that was behind the Veterans Choice Act of 2014 which allows veterans to seek care outside of the VA system. Readers may recall that Congress passed this bill in response to the appointment scheduling scandals within the VA.

Economist Stephen Parente was nominated to be the HHS Assistant Secretary for Planning and Evaluation (ASPE). In this position, Parente will be one of the principal policy advisors and researchers for Secretary Price. Parente, who has publicly criticized the ACA, is currently a professor at the University of Minnesota.

President Trump has also nominated Elinore McCance-Katz to be the HHS Assistant Secretary for Mental Health and Substance Abuse, a new position created by the 21st Century Cures Act. In this role McCance-Katz will lead the Substance Abuse and Mental Health Services Administration (SAMHSA). McCance-Katz was the Chief Medical Officer for SAMHSA from 2013-2015. She publicly criticized the Agency's approach to addressing mental health issues when she left that role. She is currently the Chief Medical Officer for the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals.

Sean Hayes has been appointed as the HHS Deputy Assistant Secretary for Oversight and Investigations. He previously worked as a Congressional Staffer for the House Oversight and Budget Reform Committee and the House Energy and Commerce Committee.

President Trump has also appointed Charmaine Yoest as the HHS Assistant Secretary of Public Affairs. In this position, Yoest will lead the Agency's public messaging efforts. Yoest most recently served as president and CEO Americans United for Life, a pro-life advocacy group. Yoest was also a speech writer for President George H. W. Bush.

Finally, George Sigounas was appointed as the Administrator for the Health Resources and Services Administration (HRSA), a sub agency of HHS that focuses on providing access to healthcare to underserved and disadvantaged people. Sigounas is a cancer researcher who most recently worked as a professor at East Carolina University.

In late April, the Senate Health, Education, Labor and Pensions (HELP) Committee voted to advance the nomination of Scott Gottlieb to be the Commissioner of the Food and Drug Administration. Gottlieb's nomination now goes to the full Senate for a final confirmation vote.

Gottlieb is a physician who served as a Deputy Commissioner at FDA in President George W. Bush's Administration. During his confirmation hearing, Gottlieb faced a great deal of criticism from HELP Committee Democrats over his financial ties to several drug and device companies. Gottlieb has promised to recuse himself from decisions affecting those companies. Gottlieb is expected to push for streamlining the FDA's drug approval process.

In addition to filling many of these key positions, President Trump created one new vacancy by asking Surgeon General Vivek Murthy to resign. Murthy, who was appointed by President Obama, was asked to resign as part of the Trump Administrations overall efforts to replace the remaining Obama appointees with its own people. Deputy Surgeon General Real Admiral Sylvia

Trent-Adams will serve as Acting Surgeon General on an interim basis until President Trump chooses a replacement for Murthy.

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Trump Lifts Federal Hiring Freeze But Orders Agencies to Reorganize

Upon taking office, President Trump issued an Executive Order placing a hiring freeze for all federal agencies. In early April, President Trump not only lifted the freeze, he also proposed a two percent pay increase for federal employees next year. In looking beyond a short term hiring freeze, President Trump also ordered a reorganization of the federal agencies.

It is unclear exactly what this reorganization will look like. Specifically, President Trump is ordering the Office of Management and Budget (OMB) to propose a plan to reorganize governmental functions and eliminate unnecessary agencies, components of agencies, and agency programs.

In writing this plan, OMB is to consider:

- Whether some or all of the functions of an agency, a component, or a program are appropriate for the Federal Government or would be better left to State or local governments or to the private sector through free enterprise;
- Whether some or all of the functions of an agency, a component, or a program are redundant, including with those of another agency, component, or program;
- Whether certain administrative capabilities necessary for operating an agency, a component, or a program are redundant with those of another agency, component, or program;
- Whether the costs of continuing to operate an agency, a component, or a program are justified by the public benefits it provides; and
- The costs of shutting down or merging agencies, components, or programs, including the costs of addressing the equities of affected agency staff.

Departments and Agencies are also required to begin taking immediate actions to achieve near-term workforce reductions and cost savings, including planning for funding levels specified in the President's Budget Request to Congress. It should be noted that Congress reached a deal on a spending bill that allocates funding in a way which disregards almost all of the President's Budget Request.

OMB has 180 days to publish its proposed plan in the Federal Register for public comment. The Administration will also be hosting a website that allows the public to submit their ideas for how to reorganize the government.

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New CMS Mailbox for Beneficiary Notices Initiative Questions

Under the Medicare program, beneficiaries are entitled to formal notifications from providers regarding certain benefits, denials, or coverage status. These include Advance Beneficiary Notices of Non-coverage and Skilled Nursing Facility Advance Beneficiary Notices.

Additionally, under a law passed by Congress in 2015 called the NOTICE Act, hospitals are now specifically required to provide written and oral notification to inform patients when they are in observation status as opposed to being an admitted inpatient of the hospital.

Patients who spend significant time in a hospital (more than 24 hours) but are not technically admitted as inpatients are considered to be under outpatient observation status. These notices, called Medicare Outpatient Observation Notices (MOON) are intended to address concerns that many patients who are under outpatient observation status believe they are actually inpatients.

Patients have different financial obligations depending on if they are inpatients or outpatients. The specific status of the patient can also affect their ability to obtain Medicare covered placement in a Skilled Nursing Facility. Further, there are certain benefits that are exclusive to inpatients that are not available to outpatients. For example, patients often cannot qualify for several types of rehabilitation services unless they are an admitted inpatient for a specified amount of time.

Effective April 13, 2017, CMS has created a new email address for questions regarding any of the Fee For Service Beneficiary Notice Initiative (BNI) notices. The email address is: BNImailbox@cms.hhs.gov.

CMS wants members of the public to continue submitting questions regarding the MOON to MOONMailbox@cms.hhs.gov.

The full list of BNI notices are:

- FFS Advance Beneficiary Notice of Non-coverage (FFS ABN)
- FFS Home Health Change of Care Notice (FFS HHCCN)
- FFS Skilled Nursing Facility Advance Beneficiary Notice (FFS SNFABN) and SNF Denial Letters
- FFS Hospital-Issued Notices of Non-coverage (FFS HINNs)
- FFS Expedited Determination Notices for Home Health Agencies, Skilled Nursing Facility, Hospice and Comprehensive Outpatient Rehabilitation Facility (FFS Expedited Determination Notices)
- Important Message from Medicare (IM) and Detailed Notice of Discharge (DND) (Hospital Discharge Appeal Notices)
- FFS Notice of Exclusion from Medicare Benefits - Skilled Nursing Facility (FFS NEMB SNF)

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Anthem Loses Appeal – Merger Attempt with Cigna Suffers Major Setback

Insurance giant, Anthem, lost its appeal of a Federal Judge's February decision to block its attempted $54 billion merger with Cigna. A three-judge panel rejected Anthem's appeal 2-1. The Department of Justice (DOJ) successfully blocked the merger in U.S. District Court due its projected effect on competition in the insurance markets.

Anthem had argued that the merger would create administrative efficiencies that would result in reduced premiums for consumers. Thus far, neither the U.S. District Court nor the U.S. Court of Appeals has agreed with that argument.

It is expected that Anthem will continue to pursue the merger by appealing the ruling to the full appeals court. After the initial ruling blocking the merger, Cigna sued Anthem for almost $15 billion in contractual breakup fees and compensation for damages to its shareholders.

The DOJ also successfully blocked Aetna from merging with Humana on the same anti-competitive grounds. Aetna and Humana are not appealing their blocked merger attempt. It has been reported that Aetna had to pay Humana a $1 billion contractual break-up fee as a result of the failed merger.

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CMS Creates New Administrative Simplification Fact Sheet and Infographic

The Centers for Medicare and Medicaid Services (CMS) is actively trying to strengthen its online presence on the topic of HIPAA Administrative Simplification. A few months ago, CMS launched a new website dedicated to administrative simplification. The website features educational material on electronic business transaction standards, information on covered entities and an FAQ page among other resources.

The most recent addition to the website are a fact sheet and an infographic on administrative simplification. These materials are intended to help educate providers on the administrative simplification issue while also highlighting the resources available to providers from CMS.

CMS solicited feedback from the HBMA Government Relations Committee on what information to include and how to structure the documents. HBMA was pleased to see several of our recommendations adopted in the final version of these documents. This collaboration speaks to the success of HBMA's relationship building efforts with CMS. HBMA will continue to look for opportunities to collaborate with CMS on similar types of educational materials.

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Senate Finance Committee Reintroduces Chronic Care Bill

The Senate Finance Committee has reintroduced a bipartisan bill that is intended to improve care for the chronically ill Medicare population. The bill was originally introduced in 2015 but, as with all bills not adopted, expired when the 114th Congress adjourned in December. The bill never received a Senate vote in the 114th and it is unclear how far it will advance in the 115th Congress.

Much of the bill focuses on the Medicare Advantage (MA) program. For example, it allows MA plans to offer a wider array of supplemental benefits to chronically ill enrollees beginning in 2020. The Medicare program pays MA plans a per-beneficiary monthly rate to cover a package of required benefits. However, plans can offer additional supplemental benefits as well such as counseling, enhanced disease management or acupuncture. Medicare places some limitations on these supplemental benefits.

Additionally, the bill allows MA plans to offer telehealth benefits that are beyond the services currently covered under traditional Medicare fee-for-service. MA plans have some leeway to determine what telehealth services to cover but the bill specifically allows for MA plans to cover telehealth services for stroke care.

The bill also focuses a great deal on Accountable Care Organizations (ACO). The bill allows ACOs to voluntarily make incentive payments directly to all of its assigned beneficiaries to encourage them to receive preventive primary care services. This program is intended to help manage chronic conditions. These payments can be up to $20 per qualifying services. ACOs would not be provided additional Medicare reimbursement to cover the primary care incentive payment costs.

The bill also requires the Government Accountability Office (GAO) to conduct several new studies. This includes a study for the development of a payment code describing the formulation of a comprehensive plan of longitudinal care for a Medicare beneficiary diagnosed with a serious or life-threatening illness. It also requires a study on improving medication synchronization and a study on the impact of obesity drugs on patient health and spending.

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CMS Transmittals

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

Transmittal Number	Subject	Effective Date

Transmittal Number	Subject	Effective Date
R3760CP	July Quarterly Update for 2017 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule	N/A
R3761CP	Screening for Hepatitis B Virus (HBV) Infection	N/A
R1831OTN	Introductory Letters for Suppliers and Providers Related to the Prior Authorization for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items	2017-05-30
R195NCD	Screening for Hepatitis B Virus (HBV) Infection	N/A
R1833OTN	Implementing the remittance advice messaging for the 20-hour weekly minimum for Partial Hospitalization Program services.	2017-10-02
R1839OTN	Implementation of Section 1557 for Medicare Redetermination Notices (MRNs) by Adding a Notice and Tagline Sheet	2017-10-02
R1837OTN	Shared System Enhancement 2015: Identify Inactive Medicare Demonstration Projects within the Fiscal Intermediary Shared System (Analysis Only)	2017-10-02
R3763CP	Payment for Moderate Sedation Services Furnished with Colorectal Cancer Screening Tests	2017-10-02
R1832OTN	Update FISS Editing to Include the Admitting Diagnosis Code Field	2017-10-02
R283FM	New Physician Specialty Code for Advanced Heart Failure and Transplant Cardiology, Medical Toxicology, and Hematopoietic Cell Transplantation and Cellular Therapy	2017-10-02
R1834OTN	Analysis and Design Working Sessions for the Development of a Pre-Payment Common Additional Documentation Request (ADR) Letter	2017-10-02
R3762CP	New Physician Specialty Code for Advanced Heart Failure and Transplant Cardiology, Medical Toxicology, and Hematopoietic Cell Transplantation and Cellular Therapy	2017-10-02
R1835OTN	Reason Codes 36233 and 36330 Bypass for Claims Submitted on the 72x Type of Bill for Services Provided to Beneficiaries with Acute Kidney Injury (AKI) and edits related to not separately payable drugs	2017-10-02
R1836OTN	Analysis Only-Provider Number Validation Update for the Shared Systems Maintainer (SSM)	2017-10-02
R1838OTN	Part B Detail Line Expansion - Common Working File (CWF)	N/A
R3764CP	Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System	N/A
R711PI	Update to Pub. 100-08, Chapter 15	2017-05-15
R30QIO	QIO Manual Chapter 16 – “Healthcare Quality Improvement Program”	2017-04-21
R3751CP	Two New “K” Codes for Therapeutic Continuous Glucose Monitors	2017-07-10

Transmittal Number	Subject	Effective Date
R3754CP	Implementation of New Influenza Virus Vaccine Code	2017-07-03
R3750CP	New Fields in the Fiscal Intermediary Shared System (FISS) Inpatient and Outpatient Provider Specific Files (PSF)	2017-07-03
R3747CP	Payment for Moderate Sedation Services	2017-05-15
R3748CP	Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) Edits, Version 23.2, Effective July 1, 2017	2017-07-03
R710PI	Update to Pub. 100-08, Chapter 15	2017-05-15
R282FM	Notice of New Interest Rate for Medicare Overpayments and Underpayments -3rd Qtr Notification for FY 2017	2017-04-18
R1815OTN	Common Working File (CWF) to Archive Inactive Part B Consistency Edits	2017-10-02
R1818OTN	Annual Updates to the Prior Authorization/Pre-Claim Review Federal Holiday Schedule Tables for Generating Reports	2017-10-02
R1819OTN	Update to Common Working File (CWF) Blood Editing on Medicare Advantage (MA) Enrollees' Inpatient Claims for Indirect Medical Education (IME) Payment	2017-10-02
R1817OTN	Enrollment Data Base (EDB) and Common Working File (CWF) Data Resync - Analysis and Design	2017-10-02
R3746CP	July 2017 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files	2017-07-03
R119MSP	Implement the International Classification of Diseases, Tenth Revision (ICD-10) 2018 General Equivalence Mappings (GEMs) Tables in the Common Working File (CWF) for Purposes of Processing Non-Group Health Plan (NGHP) Medicare Secondary Payer (MSP) Records and Claims	2017-10-02

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