Washington Report – May, 2017

(Covers activity between 5/1/17 and 5/30/17)

Bill Finerfrock, Matt Reiter, Nathan Baugh, Josh Mendelson, Carolyn Bounds

Return to Top

AHCA Update: Where does the AHCA stand in the Senate?

On May 4th, the House of Representatives passed the American Health Care Act (AHCA) which effectively repeals and replaces the Affordable Care Act (ACA). The bill passed by a vote of 217 - 213. No Democrats supported the bill and a handful of Republicans also voted against the bill.

The bill now goes to the Senate where the Senate Leadership has indicated that they will consider the House bill as part of their deliberations but the Senate will likely take a very different approach to repealing and replacing the ACA.

Similar to what happened in the House, perhaps the biggest hurdle to passing a healthcare bill is reaching a consensus among Republican Senators. House Republican Leadership struggled to achieve a consensus on the AHCA among the conservative and moderate wings of the party in the same way that the Obama Administration struggled to achieve consensus among liberal and moderate Democrats. If a repeal and replace bill is going to pass the Senate it will also have to satisfy these same competing interests.

Leading the effort to write the Senate's iteration of the bill is a team of 13 Republican Senators. Staff for these Senators began drafting an outline of the Senate's bill during the Memorial Day Congressional recess.

Republicans in the Senate intend to use the budget reconciliation process which allows for a bill to be passed in the Senate with 51 votes. Budget reconciliation bills also cannot be subject to a filibuster – a procedural obstruction tactic that Democrats would likely employ were a repeal and replace bill come to the Senate floor under "regular" order. It takes 60 votes in the Senate to overcome a filibuster and Republicans do not have enough seats to override a filibuster without Democratic support.

Return to Top

CBO Releases Analysis of Amended American Health Care Act

Although the House of Representatives passed the AHCA by a vote of 217-213 on May 4th, the House vote occurred before the CBO had completed its analysis of the amended version of the bill. All Democrats and some Republicans voted against the bill.

The CBO is a non-partisan arm of Congress that performs budgetary and economic analysis of legislation pending before the Congress. This document projects the impact the AHCA will have on the federal budget and on insurance markets and replaces the earlier CBO report on the earlier version of the AHCA (see April WR for information on the original CBO report).

After failing to secure enough Republican support to vote on the AHCA in March, Speaker of the House Paul Ryan (R-WI) and the White House continued negotiating with House Republicans who were withholding support for the bill. House Leadership was able to secure enough support for passage after introducing two amendments to the AHCA.

One change added $8 billion for high risk pools to help protect the sickest enrollees from unaffordable health insurance. In addition, the bill allows states to apply for waivers from several ACA insurance regulations such as the essential health benefits requirements and the requirement that plans must community rate enrollees in one risk pool. Finally, the new version includes several new spending initiatives such as $15 billion to states for maternity care, and care for those with mental illness or substance abuse disorders and $15 billion to states for the Federal Invisible Risk Sharing Program.

As reported in the April Washington Report, the original CBO analysis of the AHCA was that the bill would have reduced the federal budget deficit by $337 billion over ten years. With the addition of the changes noted above, CBO now projects that the AHCA will reduce federal spending by $119 Billion over the course of 2017-2026.

The CBO is predicting that in 2018, 14 million more people would be uninsured under the AHCA than if the ACA remained the law of the land. This is the same projection as the initial score. This number increases to 19 million in 2020 and 23 million in 2026. The initial version of the AHCA was projected to result in 24 million fewer people having health insurance in 2026.

The CBO attributes much of this decreased insurance coverage to individuals choosing not to purchase insurance or voluntarily disenrolling from Medicaid as opposed to attributing the coverage loss to financial inability to purchase insurance. This voluntary decision is due to the elimination of the penalties in the ACA for failure to purchase insurance.

With regard to insurance premiums, the CBO believes that this bill will cause dramatic changes in premiums based on an individual's age. Under the ACA, there is a 3 – 1 rate band for community rated health plans. The AHCA changes this to a 5 – 1 rate band. This means that under the ACA's 3 – 1 rate band, the highest premium charged an can be no more than 3 times the lowest premium charged for that plan (the youngest purchasers). Moving to a 5 – 1 rate band would allow insurers to charge 5 times the lowest premium they charge for the same health plan.

Under the ACA and the AHCA, Health Plans can only vary premiums due to age, geographic location or smoking status.

ACA	Premium
21 years old	5,100
64 years old	15,300
AHCA	
21 years old	3,900
64 years old	19,500

As you can see, in this example, under the ACA, rate bands are 3 – 1 (oldest to youngest) and the AHCA rate band is 5 – 1.

The AHCA clearly achieves significant budgetary savings for the federal government. However, the amendments do little to assuage concerns over projected coverage losses. Many House Republicans withheld support for the AHCA over the projected coverage losses. The amendments to the AHCA were largely motivated to address this concern. However, the CBO indicates that the amendments would only decrease coverage losses by 1 million over ten years.

The Senate might include some provisions from the AHCA in its version of a repeal/replace bill but Senate Majority Leader Mitch McConnell (R-WI) has indicated that the Senate will essentially start from scratch with its bill. The Senate will have to address the same concerns over coverage losses while also finding a way to reduce federal spending. The CBO score gives

the Senate some insight into the effect of the AHCA's provisions and could help the Senate decide which provisions it will include in its own version.

Return to Top

CMS Posts MIPS Participation Status Determinations

The Centers for Medicare and Medicaid Services (CMS) has sent letters to each eligible clinician (EC) which states if they have to participate in the Medicare Merit-based Incentive Payment System (MIPS) in 2017. The letters will also state if ECs are exempt from some of the reporting requirements or from the program entirely for the 2017 reporting year.

These letters were originally supposed to be sent by the end of 2016.

CMS has also created a tool on its official Quality Payment Program (QPP) website where ECs can look up their participation status by their national provider identifier (NPI) number.

For those required to participate, data reported under MIPS in 2017 will affect Medicare payments by as much as -4 or +4 percent in 2019. Some providers will have their reporting requirements reduced for reasons such being a non-patient-facing clinician or being a hospital-based provider. Others will be completely exempt from MIPS if they fall below a low volume threshold.

EC provider types required to participate in MIPS in 2017 are:

- Physicians
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified nurse practitioners

ECs are required to participate in MIPS in 2017 **if** they:

- Bill Medicare Part B more than $30,000 a year **AND**
- See more than 100 Medicare patients a year.

Falling below either of those figures will exempt an EC from MIPS in 2017. Participation determinations will be made each year. The low-volume exemption threshold applies the same regardless of whether an EC participates individually or as a group.

CMS is exempting almost two thirds of ECs from MIPS reporting in 2017 under the low-volume threshold. To be exact, 806,879 ECs will be exempt while 418,849 will be required to report.

2017 is the first year ECs have to report under MIPS. CMS has made 2017 a transition year which gives ECs several participation tracks. ECs can elect to report minimal data to avoid a negative payment adjustment or report for longer periods of time during the reporting year to be eligible for a larger portion of the maximum possible positive payment adjustment of +4 percent. ECs who are required to report who fail to report any data will receive the maximum negative payment adjustment of -4 percent.

The MIPS payment adjustments are budget neutral meaning that the negative payment adjustments fund the positive payment adjustments. The transition year greatly reduces the number of ECs projected to receive a penalty which means that there will likely be very little money available for positive payment adjustments in 2017.

If these assumptions hold true, the only way for ECs to earn a substantive positive payment adjustment will be if they qualify for the bonuses that are available to the highest performers. This bonus money is not subject to the budget neutrality of MIPS.

CMS officials have stated that they intend to hold a second round of eligibility determinations which would only add to the list of ECs receiving an exemption and will not remove an exemption that has already been determined.

ECs who do not agree with their participation status determination can contact the CMS support desk by emailing QPP@cms.hhs.gov or by calling 1-866-288-8292.

Return to Top

President Trump Selects Medicare Director

As rumored, President Trump has selected Demetrios Kouzoukas to be the Director of the Center for Medicare at the Centers for Medicare and Medicaid Services (CMS). Kouzoukas will also serve as Principle Deputy Administrator for CMS making him second in command to CMS Administrator Seema Verma.

From 2003-2009 Kouzoukas served as the Principal Associate Deputy Secretary of the Department of Health and Human Services (HHS) and Deputy General Counsel for HHS under President George W. Bush. After leaving HHS Kouzoukas went into private legal practice before becoming General Counsel for United Health Care's Medicare and Retirement division.

While at HHS, Kouzoukas was responsible for regulatory policy across the Department and at various times collaborated with or advised every division of HHS. Kouzoukas graduated with a degree in political science and public policy from George Washington University before going on to receive his J.D. from the University of Illinois. He is originally from Chicago.

Return to Top

184 Representatives Sign Letter Asking HHS to Allow Third-Party Premium Payments

A bipartisan group of 184 Members of the House of Representatives signed a letter to Health and Human Services (HHS) Secretary Tom Price asking the Department to allow charitable organizations to provide financial assistance to consumers for the purchase of their health insurance. In 2014, the Obama Administration prohibited many non-profit charitable organizations from providing third-party premium assistance.

The signatories on this letter believe that third parties should be allowed to assist consumers in paying for health insurance. According to the letter, prohibiting the practice means that more individuals end up on the government's insurance rolls either through Medicare of Medicaid. It is unclear if HHS will take action in response to this letter.

In December, the Centers for Medicare and Medicaid Services (CMS) issued an interim final rule to prevent dialysis facilities from steering Medicare or Medicaid-eligible patients to commercial health plans. According to CMS, in some cases the dialysis facilities were connecting patients with charitable non-profit organizations that provide financial assistance to patients to help pay the premiums for private health insurance. Opponents of this rule argue that CMS went too far.

CMS concluded that rather than making these referrals for humanitarian or compassionate reasons, these dialysis facilities were pushing patients to commercial insurance plans because these plans generally pay more generous reimbursement rates than Medicare and Medicaid and these non-profit organizations often had a connection to the dialysis facility.

The interim final rule prohibited dialysis facilities from making direct or indirect payments to consumers or on their behalf for health insurance. Further, dialysis facilities are also required to inform patients on all coverage options including Medicare and Medicaid if they are eligible. Opponents of this rule argue that CMS went too far.

The Representatives signing the letter ask that CMS amend the policy to allow certain third-party organizations to provide assistance if the third party is one of the of following:

1. a nonprofit charitable organization;
2. a place of worship; and,
3. local civic organization

Furthermore, to ensure that the mission of the third-party is not compromised, the entity must "maintain compliance with all applicable federal laws including the False Claims Act" (section 2739 through 3733) and these entities must ensure that patients are empowered to select the plan that works best for the patient's needs, including the health as well as financial needs.

Return to Top

Return to Top

Uncertainty Over ACA Cost Sharing Reductions Continues

When people discuss the Affordable Care Act's (ACA) financial subsidies for purchasing health insurance, they often are thinking of the premium support tax credits which are available for individuals who earn up to 400 percent of the federal poverty line (FPL). These tax credits are money that goes directly to the individual/family in the form of a lower federal tax liability. In fact, the debate over ACA plan affordability often focuses on a plan's premiums. However, the ACA also includes an invisible subsidy to help some individuals afford their plan's out-of-pocket spending obligations.

The ACA's cost sharing reduction subsidies (CSR) has become an increasingly contentious issue. CSRs are a direct payment from the government to insurers to lower the out-of-pocket (deductible, co-insurance or copayment) component of a health plan for qualified enrollee. The CSR is available to enrollees earning between 100 percent and 250 percent of the FPL. Individuals with an income below 100% of FPL do not qualify. Enrollees qualify for a CSR if they receive premium tax credits and if they select a "silver plan."

Opponents of the Affordable Care Act have long complained about these payments as they represent a direct payment to health plans for expenses that would normally have been paid by patient to providers. For the patient, the CSRs represents a cap on the individual's out-of-pocket expenditures making healthcare more affordable.

The premium associated with that plan would reflect the publicly identified deductible and applicable copays and/or co-insurance. The Exchange website would then calculate the premium for the individual based upon his/her income. Later, as the individual worked his or her way through the application process, they could be flagged as eligible for the additional cost-sharing reduction. The individual would be informed that based on income, out-of-pocket expenses would be capped.

Absent the CSR program, a qualifying individual choosing a health plan with a $5,000 deductible would have to meet that out-of-pocket threshold before the health plan would begin making payments for the individuals qualified health expenses. In addition, the individual wold be eligible for lower co-pays and/or co-insurance on allowable charges. Due to the CSR, the Health Plan would begin making payments for the individual health expenses far sooner than would have occurred under normal circumstances.

There is also some question over the legality of the CSR payments to insurers. The legal debate stems from a lawsuit brought by the Republican-led U.S. House of Representatives against the Obama Administration. The lawsuit claims that federal money was being unconstitutionally distributed by the Administration. The House lawsuit argues that Congress never formally

appropriated the money for the CSRs and that the Administration is therefore not authorized to make the payments.

The federal judge hearing the case ruled in favor of the House of Representatives. However, the Obama administration appealed the original verdict and the judged "stayed" the ruling pending the outcome of an appeal. Ironically, the lawsuit is now the Republican-controlled House suing a Republican Administration. The appeal is still ongoing but the Trump Administration could drop its appeal if it chooses. The Trump administration further delayed a decision on CSRs when it filed a request to delay for 90 days its decision on continuing or dropping the appeal.

Because the Administration is responsible for distributing the CSR payments, the Trump Administration has threatened to stop making CSR payments to insurers as a tactic to bring supporters of the CSR to the negotiating table on this and other issues. The Trump Administration has committed to a short-term funding extension of CSRs and the issue could resurface as a political bargaining chip in future legislation.

Insurers have been aggressively lobbying to preserve the CSRs. At the very least, they want certainty over the future of CSRs in anticipation of their rate filings for the coming plan year. The deadline for insurers is June 21, which is when they will set premium rates for 2018. If the Trump administration chooses to discontinue making the payments, insurers would likely decide that it would be too costly to remain in the individual market, prompting them to either exit the market or drastically raise premiums.

Return to Top

eClinical Works Fine Will Not Impact Provider Customers

In late May, electronic health record (EHR) vendor eClinical Work (ECW) agreed to a settlement with the U.S. Department of Justice (DOJ) in which it will pay $155 million to settle False Claims Act allegations. The DOJ filed a lawsuit arguing that ECW "misrepresented the capabilities of its software" and "paid kickbacks to certain customers in exchange for promoting its product."

The complaint filed by the DOJ asserts that ECW, a Certified EHR Technology, did not meet several requirements of the Meaningful Use (MU) Program but inappropriately marketed its products as being compliant. According to the complaint, "ECW falsely represented to its certifying bodies and the United States that its software complied with the requirements for certification and for the payment of incentives under the Meaningful Use program."

The DOJ also found the alleged referral scheme to be inappropriate.

CMS was quick to offer clarification that ECW's shortcomings will not result in penalties for its customers who attested to meeting the requirements of the MU program with technology which according to the DOJ complaint "was unable to satisfy certain certification criteria."

CMS published an FAQ that clarifies that ECW customers will not be held responsible for their vendor's flaws. According CMS,

> CMS does not plan to conduct an audit to find providers who relied on flawed software for their attestation information. We realize that providers relied on the software they used for accuracy of reporting, and we believe that most providers who were improperly deemed meaningful users would have met the requirements of the EHR Incentive Programs using the updated certified EHR technology

ECW did not admit guilt as part of the settlement.

Return to Top

Senate Committee Approves Regulatory Reform Legislation

Earlier this month the Senate Homeland Security and Governmental Affairs Committee approved six bills that would make reforms to the regulatory process. Some of the bills were passed with significant bipartisan support while others were passed along party lines.

Legislation passed by Congress rarely includes all of the details necessary to implement a new policy or program. Congress often gives the federal agencies broad authority to fill in those details. Depending on how much authority a piece of legislation gives the agencies, the regulatory process can be just as important as the legislative process.

One of the more notable bills passed by the Committee, the Regulatory Accountability Act (RAA) was co-sponsored by both a Republican and a Democrat. The RAA would require the agencies to issue rules that have more scientific data backing them. Additionally, the agencies would be required to undertake major financial reviews of regulations every 10 years. According its sponsors, this bill pushes the government to create the most cost-effective rules.

Another bill that advanced was the Midnight Rules Relief Act, sponsored by Ron Johnson (R-WI). This bill would make it easier to simultaneously reverse multiple regulations. With a single vote, congress could strike down many Obama-era regulations. This bill was passed along party lines.

The Early Participation in Regulations Act, sponsored by Senator James Lankford (R-OK) would require the government to issue some sort of notice before a major rule is proposed. The agencies currently publish a general schedule throughout the year for the rules it expects to publish however there is no formal advanced notice for when a proposed rule will be published.

The Regulations from the Executive in Needs of Scrutiny (REINS) sponsored by Senator Rand Paul (R-KY), grants congress additional power to reject regulation. Under REINS, federal agencies would need congressional approval before any major regulation could go into effect.

This bill was also passed along party lines. If passed into law, this bill would give Congress a tremendous amount of authority over the rule making process.

The Providing Accountability through Transparency Act would require federal agencies to include a 100 word plain language summary of each proposed rule.

These bills now go to the full Senate where it is unclear if or when they will receive a vote. If passed, the House would also have to approve these bills before they can be signed into law.

If passed, these bills could have a significant implications for federal health policy – much of which is made through the regulatory process. Every year the Centers for Medicare and Medicaid Services (CMS) publish rules that make updates to the Medicare reimbursement methodologies such as the Physician Fee Schedule and Hospital Outpatient Prospective Payment System. CMS also passes rules to implement the Medicare Access and CHIP Reauthorization Act (MACRA) as well as annual updates for the Affordable Care Act exchanges.

Return to Top

Massive Cyber-Attack Hits Health Systems Abroad

A recent worldwide ransomware attack exposed vulnerabilities on computer networks in 100 countries. The ransomware, dubbed "WannaCry", locks users out of their computers and demands a bitcoin payment as ransom. Healthcare systems and providers who depend on the accessibility of their files in order to make life saving decisions are at particular risk. Notably, the United Kingdom's National Health Service (NHS) was hit particularly hard by the attack.

Those who use Windows and did not undergo the security update released last month by Microsoft were vulnerable to the attack. That security update is free and still available from Microsoft.

The attack could have been much worse. The victims were fortunate that someone observing the attack was able to identify a "kill switch" which prevented the attack from spreading.

Several government agencies have issued responses and made cybersecurity suggestions moving forward. The FBI recommends strong spam filters to avoid phishing emails. All anti-virus and anti-malware software should be up to date and set to automatically conduct scans. They also suggest training employees to recognize scams and malicious links. Finally, they propose that "penetration tests" should be run annually against the network.

Computers should be backed up to some type of external hard drive in order to protect files and data. A full summary of the FBI's statement can be found here: FBI statement on WannaCry.

HHS has issued a similar statement detailing cybersecurity recommendations: HHS cybersecurity update.

According to the Institute for Critical Infrastructure Technology, the healthcare industry is one of the most frequent targets of malicious attacks. In a report done by SANS institute, they noted that with the rise of electronic health records, more attacks are being waged on the healthcare field.

The costs associated with a cyberattack for a healthcare provider are huge. Large HIPAA compliance fines can be imposed on companies. Additionally, there are costs to handling the incident and notifying victims, as well as lost opportunities, legal costs, new security investments, and the cost of recovering data.

Illustrative of the susceptibility of healthcare providers is the impact the attack had on the British NHS. Across England and Scotland there were reports of patient records becoming unavailable, operations cancelled, and ambulances diverted in the wake of the attack. Up to 40 NHS organizations were affected by the ransomware. Communication between doctors' offices and other providers were slowed or completely stalled as many computer systems were taken off line.

Among a growing list of cyberattacks on healthcare in the United States, some of the most notable have been the attack on Banner Health in which the information of nearly 3.7 million people was compromised, and the attack on 21st Century Oncology that affected over 2 million people.

Ultimately, providers and insurance companies must become increasingly vigilant. This will require increased investment in cybersecurity and creating more robust plans for when an attack occurs.

Return to Top

HBMA Goes to Washington

This 2017 HBMA Compliance Conference was held just a stone's throw from our nation's Capital in Alexandria, Virginia. HBMA was able to take advantage of the proximity the conference to Washington, DC to provide an opportunity for members to participate in an advocacy day on Capitol Hill.

The day after the official conference concluded, about 20 HBMA members travelled to Capitol Hill to meet with their Representative and Senate Offices. The meetings were an opportunity to educate the Members of Congress on the healthcare revenue cycle management industry and discuss important policy issues affecting the HBMA member companies and their clients. These meetings are also an opportunity to build relationships with Congress and strengthen the HBMA brand on Capitol Hill.

The meetings featured policy discussions on the need for Congress and the Federal Agencies to take HIPAA Administrative Simplification more seriously. It has been almost 21 years since HIPAA was enacted and the RCM industry has yet to realize many of the efficiencies that the Administrative Simplification section of the law promised.

The privacy and security sections of HIPAA have been heavily enforced. Reports of financial settlements with covered entities for HIPAA privacy and security violations happen on an almost weekly basis. These settlements almost always exceed fines in excess of $1 Million. HBMA would like to see a similar enforcement made for Health Plan violations of standard electronic transactions. HBMA would also like to see an expedited development of new standards such as claims attachments.

The Congressional offices were generally very receptive to this message. They recognize how improving the efficiency of the healthcare system with better standardized electronic transactions can save the system billions of dollars. Several offices expressed interest in working with HBMA to see what more can be done to improve HIPAA Administrative Simplification.

The attendees also discussed the prevalence of health plans with overly narrow networks. These plans can have a detrimental effect on patient access to care. Further, there needs to be better transparency since networks can change throughout a patient's plan year.

HBMA believes that if a Health Plan makes a change in the plan Network after the close of the open enrollment period, and physicians and hospitals previously identified as "in-network" are no longer in the Plan's network, patients affected by that plan decision should be permitted to re-enter the marketplace to choose another plan.

Finally, these meetings are intended to establish HBMA as a resource to Congressional offices as they engage in the policy making process. It is our goal to continue this advocacy effort on a regular basis. The HBMA Government Relations Committee plans to follow up with the offices that express significant interest in our issues.

HBMA will be publishing a more detailed report on these meetings for the membership in the form of a special bulletin.

Return to Top

CMS to Phase-Out SHOP Marketplace

Consistent with GOP plans to replace the Affordable Care Act (ACA), the Centers for Medicare and Medicaid Services (CMS) has announced significant changes to the Small Business Health Operations (SHOP). For small business owners, this means fewer regulations for how they provide health insurance plans for their workers.

CMS intends to issue a proposed rule that will allow employers to bypass the SHOP marketplace website and enroll directly with an insurance company offering SHOP plans, or with the

assistance of an agent or broker registered with the SHOP. This would take effect beginning with the 2018 plan year.

Under this approach, employers would still use the healthcare.gov website to obtain a determination of eligibility for the SHOP and the Small Business Healthcare Tax Credit that helps small business provide health insurance for their employees.

SHOP marketplaces were created to help streamline the process of obtaining health insurance for business owners. The SHOP is available to businesses or non-profit organizations that employ fewer than 50 full-time employees. The SHOP was intended to be a federally or state run marketplace in which subsidized health insurance could be purchased for employees. This provision required these small business owners purchase the plan through the SHOP marketplace instead of brokering a deal directly with the insurance company.

Though this online marketplace has succeeded for some, it has fallen short of expectations. The CBO predicted that nearly 4 million people would enroll in health insurance through SHOP by 2017. However, according to CMS as of January 2017, approximately 27,000 employers have active coverage through SHOP Marketplaces, covering nearly 230,000 individuals. The true enrollment of 230,000 has fell notably short of the CBO's projection. Critics of SHOP also point to an inadequate choice of options and a lack of competition.

Shuttering this program means business owners would have to purchase health plans from insurance agencies directly. This change will not affect the 17 states who administer their own SHOP marketplaces.

The Trump administration has cited the low SHOP enrollment numbers as indicative of its failure. However, others have argued that lower than anticipated participation in the program does not negate the benefit it has served to small business owners.

The change is also meant to ease the perceived financial and time burden placed both on CMS in administering the program as well as small business owners. Though opponents have argued that brokering with an insurance company directly is more burdensome than enrolling in a program through SHOP.

Return to Top

CMS Releases Official Timeline for New Medicare Card Numbers

Included in the Medicare Access and CHIP Reauthorization Act (MACRA), is a provision which requires the Centers for Medicare and Medicaid Services (CMS) to remove Social Security numbers (SSN) from Medicare beneficiary cards by April, 2019. Medicare cards currently use SSNs as the beneficiary identification number, more formally known as the Health Insurance Claim Number (HICN).

The Centers for Medicare and Medicaid Services (CMS) has been actively working to replace the SSN on Medicare cards with a new unique beneficiary number similar to what is used on commercial insurance cards. CMS has been conducting education on its Social Security Number Removal Initiative (SSNRI) and this month has released its official timeline for the transition.

CMS will replace SSNs with a new Medicare Beneficiary Identifier (MBI). The MBI will be an alpha-numeric identifier.

CMS announced that it will begin mailing new cards in April 2018 and will be able to meet the April 2019 deadline.

There will be a 21 month transition period where Medicare will accept **either** the new MBI or the SSN (HICN) on claims. The transition period will begin no earlier than April 1, 2018 and run through December 31, 2019.

On May 23, The Ways and Means Social Security Subcommittee held a hearing affirming a federal commitment to reducing the use of Social Security Numbers to prevent fraud and abuse in various sectors of the government. CMS testified at this hearing on the SSNRI.

According to CMS, switching from SSN based HICNs to MBIs requires extensive coordination with beneficiaries as well as private sector, local, state, and federal stakeholders. MACRA allocated $320 million to CMS to support the changeover from SSNs and HICNs to MBIs.

Using an MBI grants more flexibility when faced with identity fraud. Now, if the MBI is compromised, it may be replaced with a new number. Under the SSN based program, this was impossible.

In addition to eliminating SSNs as primary identifiers, CMS testified that it is working to reduce the use of SSNs on other documents and mailings.

Return to Top

CMS Transmittals

The following Transmittals were issued b CMS during the month of May.

Transmittal Number	Subject	Effective Date
R104GI	Affordable Care Act Bundled Payments for Care Improvement Initiative - Recurring File Updates Models 2 and 4 October 2017 Updates	2017-10-02

Transmittal Number	Subject	Effective Date
R3782CP	Claim Status Category and Claim Status Codes Update	2017-10-02
R722PI	Clarifying Date and Timing Requirements for Certain Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS)	2017-06-27
R3786CP	Common Edits and Enhancements Modules (CEM) Code Set Update	2017-10-02
R1854OTN	ICD-10 Coding Revisions to National Coverage Determinations (NCDs)	N/A
R3781CP	Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE)	2017-10-02
R3784CP	Instructions for Downloading the Medicare ZIP Code File for October Files	2017-10-02
R3783CP	July 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS)	2017-07-03
R196NCD	Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)	2017-06-27
R3787CP	Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)	2017-06-27
R3780CP	Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update	2017-10-02
R719PI	Update to Reporting Requirements	2017-06-27
R3779CP	Instructions to Process Services Not Authorized by the Veterans Administration (VA) in a Non-VA Facility Reported With Value Code (VC) 42	2017-04-03
R3778CP	Screening for the Human Immunodeficiency Virus (HIV) Infection	2017-10-02
R3777CP	July 2017 Integrated Outpatient Code Editor (I/OCE) Specifications Version 18.2	2017-07-03

Transmittal Number	Subject	Effective Date
R173DEMO	Medicare Care Choices Model - Per Beneficiary per Month Payment (PBPM) - Implementation (eligibility updates and clarification)	2017-10-02
R174DEMO	Payment of G9678 (Oncology Care Model Monthly Enhanced Oncology Services) Claims for Beneficiaries Receiving Care in an Inpatient Setting	2017-10-02
R3776CP	Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2017 Update	2017-07-03
R718PI	Reviewing for Adverse Legal Actions (ALA)	2017-06-20
R3775CP	Two New “K” Codes for Therapeutic Continuous Glucose Monitors	2017-07-03
R1851OTN	Shared System Enhancement 2015: Identify Inactive Medicare Demonstration Projects Within the Common Working File (CWF)	N/A
R1852OTN	Update FISS Editing to Include All Three Patient Reason for Visit Code Fields	2017-10-02
R1850OTN	Common Working File (CWF) to Archive Inactive Part B Consistency Edits	2017-05-16
R3774CP	Changes to the Payment Policies for Reciprocal Billing Arrangements and Fee-For-Time Compensation Arrangements (formerly referred to as Locum Tenens Arrangements)	2017-06-13
R716PI	Clarifying Medical Review of Hospital Claims for Part A Payment	2017-06-13
R1847OTN	Common Working File (CWF) to reject CWF Provider Queries containing Health Insurance Claim Numbers (HICNs) starting with '9'	2017-10-02
R714PI	Comprehensive Error Rate Testing (CERT) File Layout for Social Security Number Removal Initiative (SSNRI)	N/A
R1849OTN	Implementation of Modifier CG for Type of Bill 72x	2017-10-02
R1846OTN	MCS Implementation of the Restructured Clinical Lab Fee Schedule	N/A
R3771CP	New Waived Tests	2017-07-03

Transmittal Number	Subject	Effective Date
R3772CP	Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July CY 2017 Update	2017-07-03
R172DEMO	Suppression of G9678 (Oncology Care Model Monthly Enhanced Oncology Services) Claims OCM Beneficiary Medicare Summary Notice	2017-10-02
R717PI	Update to Pub. 100-08, Chapter 15	2017-05-15
R715PI	Update to Pub. 100-08, Chapter 15	2017-06-13
R1845OTN	New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Liability Medicare Set-Aside Arrangements (LMSAs) and No-Fault Medicare Set-Aside Arrangements (NFMSAs)	N/A
R1843OTN	Analysis for Common Working File (CWF) to Medicare Beneficiary Database (MBD) Extract File Changes for Detailed Skilled Nursing Facility Data to Support HIPAA Eligibility Transaction System (HETS) 1002	2017-10-02
R3768CP	April Quarterly Update for 2017 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule	2017-04-03
R1841OTN	Medicare Fee-for-Service Recovery Audit Contractor (RAC) Data Centers	2017-06-06
R1844OTN	Modification to Two Fiscal Intermediary Shared System (FISS) Edits Created Through Change Request (CR) 9681	2017-08-07
R3765CP	Modifications to the Common Working File (CWF) In Support of the Coordination of Benefits Agreement (COBA) Crossover Process	2017-10-02
R1705OTN	Outlier Limitation on Outpatient Prospective Payment System (OPPS) Community Mental Health Centers (CMHC) Services	N/A
R1842OTN	Remove HSQLDB from the Combined Common Edits/Enhancements Module (CCEM)	2017-10-02
R3766CP	Screening for the Human Immunodeficiency Virus (HIV) Infection	2017-10-02
R713PI	Scribe Services Signature Requirements	2017-06-06
R1840OTN	Update FISS Editing to Include All Three Patient Reason for	N/A

Transmittal Number	Subject	Effective Date
	Visit Code Fields	