HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION

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2019 Medicare Physician Fee Schedule Final Rule Scales Back Proposed E/M Coding Changes

- CMS is finalizing a revised version of its proposed changes to its E/M reimbursement and documentation policies. These changes will not take effect until 2021.
- CMS proposed to collapse the five existing E/M visit levels into two levels (levels 2-5 would be one, standard reimbursement). CMS is finalizing a modified version of this proposal. CMS will collapse E/M levels 2 and 3 into one reimbursement and levels 4 and 5 into another reimbursement, resulting in three E/M visit level reimbursements.
- CMS is also finalizing a number of changes to the documentation requirements for justifying an E/M visit level. These changes are intended to reduce the administrative burden of correctly documenting E/M visit levels.

On November 1st, the Centers for Medicare and Medicaid Services (CMS) published the 2019 Medicare Physician Fee Schedule (PFS) final rule.

HBMA submitted comments to CMS on the proposed rule. The HBMA GR Committee is still reviewing the 2,300-plus page document. The GR Committee will distribute a more detailed analysis of the final rule after completing its review.

In the proposed rule, CMS put forward a drastic change in how it would pay evaluation and management (E/M) codes as well as the documentation requirements for E/M services. CMS proposed to collapse the existing five E/M codes for both new and existing patients into only two codes. CMS' proposal would have maintained E/M level 1 payments but would have collapsed levels 2 through 5 into a single reimbursement amount. The proposal also included several add-on payments for complex patients and prolonged visits.

The provider community overwhelmingly opposed CMS' proposal. CMS is finalizing changes to the Medicare E/M coding and reimbursement policies but has scaled back from its initial proposal and delayed implementation to give industry time to prepare for the new E/M policy.

Instead of collapsing E/M codes into two reimbursements, CMS is finalizing three E/M payment levels. E/M levels 1 and 5 will remain but levels 2, 3 and 4 will be collapsed into a single reimbursement. CMS is maintaining add-on payments for complex and prolonged visits. CMS originally proposed for the new E/M codes to take effect as soon as 2019, but the final rule delays implementation. The new codes will not take effect until 2021.

CMS is also moving forward with some of its proposed changes to the documentation requirements for E/M visit levels beginning in 2019 while delaying implementation of others until 2021.

Beginning in 2019, providers will be able to document relevant information about what has changed for information that is already in the medical record rather than having to re-document everything. CMS will only require that a provider reviews information entered by ancillary staff rather than require the provider to re-enter this information personally.

Beginning in 2021, CMS will allow providers to use time or medical decision making (MDM) to justify E/M visit levels in addition to the 1995 and 1997 guidelines. The new collapsed payment for levels 2, 3 and 4 will require minimum documentation necessary for a level 2 visit.

CMS believes reducing the number of codes and increasing flexibility for documenting a visit level will relieve burden on practices.

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Medicare Physician Fee Schedule Finalizes Many Provisions from Proposed Rule

- CMS is finalizing many provisions of the proposed rule. CMS is increasing the 2019 PFS conversion factor by $0.05, which is $0.01 less than the proposed conversion factor.
- CMS is also adopting policies related to the use of appropriate use criteria for advanced imaging services and is maintaining the 40 percent relativity adjuster for services provided in hospital off-campus provider base departments.
- CMS is not finalizing a proposal to require provider offices to publicly display the prices they charge for the services they provide. CMS also is not finalizing any change to the Medicare conditions of participation that would make the use of an interoperable EHR system a condition of participation.

The 2019 Medicare Physician Fee Schedule (PFS) Final Rule includes a number of important changes for 2019 Medicare policy in addition to finalizing changes to the Evaluation and Management (E/M) code documentation requirements and reimbursements.

CMS is finalizing a 2019 PFS Conversion Factor $36.04, a slight increase above the 2018 PFS conversion factor of $35.99. The finalized 2019 CF is $0.01 less than the proposed 2019 CF of $36.05.

CMS is finalizing newly proposed codes for use of technology to communicate with a patient. These new codes are:

- Brief communication technology-based service, e.g. virtual check-in (HCPCS code G2012) and
- Remote evaluation of recorded video and/or images submitted by an established patient (HCPCS code G2010).

CMS is also finalizing two new telehealth service codes: HCPCS codes G0513 and G0514 (Prolonged preventive service(s)).

The final rule maintains current Medicare reimbursement reductions for services provided in hospital outpatient departments (HOPD) to achieve a site-neutral payment policy. CMS will continue to apply a 40 percent relativity adjuster to hospital outpatient prospective payment system (HOPPS) services performed at HOPDs that were constructed after this site-neutral payment policy took effect in 2015. CMS is also expanding this policy to new services.

CMS is finalizing its updates to the Appropriate Use Criteria (AUC) requirements for advanced imaging services that require the furnishing professional to document on claims that the ordering professional consulted AUC using a qualified Clinical Decision Support Mechanism (CDSM). The final rule expands this requirement to Independent Diagnostic Testing Facilities (IDTF). Beginning in 2019, CMS will allow clinical staff under the supervision of the ordering professional to perform the CDSM consultation. CMS will also grant hardship exemptions from this requirement under certain circumstances.

The final rule also adopts CMS's proposal to use G-codes with modifiers to document AUC/CDSM consultation. In finalizing this policy, CMS acknowledged several specific concerns HBMA raised in our comments on the proposed rule. For example, HBMA highlighted that it will not be possible for CMS to match up a G-code with a modifier to a specific service on claims that include multiple imaging services. In the final rule, CMS agreed that this will not be possible and expressed it will continue to explore ways to address this issue.

CMS has some time to figure out these issues. CMS will not begin to reject claims that fail to document AUC/CDSM consultation until 2021.

In the proposed rule, CMS included a request for information (RFI) on if/how to require providers to publicly display the price of their services. CMS issued a similar price transparency RFI in the 2019 Hospital Inpatient Prospective Payment System (IPPS) proposed rule and ultimately finalized a requirement that hospitals display their "standard charges" on a publicly available website. This led to speculation that CMS would adopt a similar requirement in the 2019 PFS final rule. However, CMS is not finalizing any price transparency policy for PFS services in the 2019 PFS final rule.

The 2019 PFS proposed rule also included an RFI on adding ownership of an interoperable EHR as a condition of participation (CoP) in the Medicare program. This would be a drastic increase in the EHR requirements for provider offices. A similar RFI was issued in the 2019 IPPS proposed rule. CMS did not finalize any change to the Medicare CoP with regard to interoperability in either the 2019 IPPS or 2019 PFS final rules.

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CMS Finalizes 2019 MIPS Requirements

- CMS is finalizing most of its proposed changes to the Medicare Quality Payment Program's Merit-based Incentive Payment System for the 2019 reporting year and corresponding 2021 payment year.
- This includes an expansion of the low-volume provider threshold but also the addition of an opt-in mechanism for providers who fall below the low-volume provider threshold to voluntarily participate in MIPS.
- Providers who fall below the finalized performance threshold of 30 points will be subject to a seven percent downward payment adjustment in 2021.

The Medicare Physician Fee Schedule final rule also finalizes the requirements for the 2019 reporting year for the Medicare Quality Payment Program's (QPP) Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APM) participation tracks. CMS is finalizing most of its proposed changes to the QPP participation and reporting requirements.

Several new provider types will be required to participate in the QPP beginning in 2019. These new MIPS Eligible Clinician (EC) provider types include physical therapist, occupational

therapist, qualified speech-language pathologist, qualified audiologist, clinical psychologist, and registered dietitian or nutrition professionals.

Data reported in 2019 will affect Medicare payments in 2021. Providers who are not exempt from MIPS and who do not meet the MIPS performance threshold score of 30 points will receive a seven percent Medicare payment reduction in 2021. ECs can earn up to a seven percent positive payment adjustment based on their performance above the performance threshold. ECs who score above the 75 point exceptional performance threshold will be eligible for additional positive payment adjustments that are not subject to the budget neutrality of MIPS payment adjustments.

CMS is finalizing its proposal to broaden the MIPS low-volume provider exemption threshold while also allowing exempt providers to voluntarily participate in MIPS if they choose. CMS is maintaining the $90,000 or less in Part B allowed charges or 200 or fewer Medicare Part B patients treated low-volume provider threshold. CMS is adding 200 or fewer covered services as a third basis for the low-volume threshold. Falling below at least one of the three threshold limits will exempt an EC from MIPS reporting and payment adjustments for the 2019 reporting/2021 payment year.

However, starting in 2019, MIPS ECs can opt-in to MIPS, if they meet or exceed at least one, but not all three, of the low-volume threshold criteria.

CMS is reweighting two of the four MIPS categories to gradually increase the weight of the Resource Use (cost) category. The Quality category's weight will be reduced from 50 percent to 45 percent of an EC's total MIPS score while Resource Use will increase from 10 percent to 15 percent. The Promoting Interoperability (F.K.A. Advancing Care Information) category will remain at 25 percent and the Clinical Practice Improvement Activity category will remain at 15 percent.

ECs will also be allowed to report data using multiple submission mechanisms for each category. Previously, ECs could only use one mechanism per category. If the same measure is submitted using multiple collection types, the one with the greatest number of measure achievement points will be selected for scoring.

The measures for each category are generally remaining the same except for the Promoting Interoperability (PI) category. CMS is restructuring this category to eliminate base, performance, and bonus scores. CMS will instead structure the PI measure set similar to the Quality category in that each measure will be scored at the individual measure level.

CMS is maintaining the five-point complex patient population add-on payment and is folding the small practice bonus into the Quality category instead of having it added to an EC's total MIPS score.

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Open Enrollment Begins for ACA Exchanges

- Open enrollment for health plans sold on the exchanges established under the Affordable Care Act began on November 1st and ends on December 15th.
- CMS has published important information on exchange website maintenance downtime.
- Enrollees are encouraged to shop around for a new plan as subsidies for every plan change from year to year. Enrollees who take no action will be automatically renewed with their current plan or will be automatically enrolled in a new plan if their current plan is no longer offered.

The 2019 open enrollment period for health plans sold on the federal health insurance exchange established under the Affordable Care Act (ACA) began on November 1st and ends on December 15th. Consumers who are currently enrolled in plans through the exchange will automatically be re-enrolled in the same or a similar plan if they do not take any action. Consumers are encouraged to compare all available plans during every open-enrollment period as the financial assistance for exchange plans is subject to change each plan year. Consumers will be notified if their plan will not be offered in 2019.

2019 will be the first plan year for which there will be no individual mandate penalty for failing to maintain qualified health insurance for the plan year. Consumers will also have new alternatives to ACA plans. Earlier this year, the Administration finalized regulations to expand access to short-term limited duration health insurance (STLDI) plans and association health plans (AHP).

Data released by the Centers for Medicare and Medicaid Services (CMS) indicates average premiums for the second-lowest-cost sliver plans will decrease by 1.5 percent in 2019. Premiums for these plans increased by an average of 37 percent last year. The second-lowest-cost silver plan is used as the benchmark plan for determining the premium assistance subsidies for plans in each market.

This data also shows that insurers are expanding their presence in the ACA markets. Twenty-nine health insurers are expanding into new markets. In total, there are 23 more health insurers offering plans than there were during last year's open enrollment. Only five states will have one insurer in 2019, down from 10 in 2018.

CMS is also notifying consumers about periods of scheduled maintenance that will temporarily bring the exchanges off-line during the enrollment period. This maintenance will occur on Sundays from 12:00 a.m. to 12:00 p.m. except on December 9, 2018.

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OPPS Final Rule Expands Site-Neutral Payment Policy

- CMS issued the Hospital Outpatient Prospective Payment System (OPPS) final rule that expands its site-neutral payment policy to new types of services.
- CMS will continue to reimburse services covered by this policy performed in hospital off-campus provider base departments at 40 percent of the OPPS rate.
- CMS is not finalizing a proposed expansion of this policy to exempt facilities that offer services in new clinical families.

In addition to publishing the 2019 Medicare Physician Fee Schedule (PFS) final rule, the Centers for Medicare and Medicaid Services (CMS) also released the 2019 Medicare Hospital Outpatient Prospective Payment System (OPPS) final rule.

The OPPS final rule updates payment rates for hospital outpatient services and ambulatory surgical center (ASC) services.

Among the most notable provisions, the final rule adopts CMS' proposal to expand the types of OPPS services covered under the Medicare site-neutral payment policy.

The Bipartisan Budget Act of 2015 (BBA) required CMS to implement a site-neutral payment policy for off-campus provider based departments (PBD) that opened after November 2, 2015. Off-campus PBDs subject to this policy still bill Medicare using the OPPS, but CMS applies a relativity adjuster to align these OPPS payments with the PFS reimbursement rate.

Congress passed the BBA's site-neutral payment policy in response to recommendations from influential groups, such as the Medicare Payment Advisory Commission (MedPAC), that believed it did not make sense for Medicare to pay a higher reimbursement for a service delivered an off-campus provider base department than Medicare paid for an independent physician office.

These groups were concerned hospitals were taking advantage of the Medicare reimbursement system structure by purchasing medical practices that billed Medicare under the Physician Fee Schedule (PFS). The change in ownership would categorize the practice as an off-campus PBD of the hospital thus allowing that location to bill Medicare under the higher OPPS reimbursement rates despite there being no significant change to the practice beyond its ownership.

To achieve site-neutrality, CMS applies a relativity adjuster to OPPS payments for services performed in PBDs subject to the site-neutral payment policy. The relativity adjuster is 40 percent of the OPPS rate. The 2019 PFS final rule maintains the 40 percent relativity adjuster.

The 2019 final rule expands site neutral payment policy by applying the relativity adjuster to HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of a patient) with modifier "PO." This code is paid under APC 5012 (Clinic Visits and Related Services). This commonly billed code has not previously been subject to the relativity adjuster. CMS believes this will save Medicare $380 million in 2019.

Hospitals are not happy about this significant expansion of the site-neutral payment policy. In its immediate response to the final rule, the American Hospital Association (AHA) announced its intent to sue the Administration to stop the expansion of this policy.

CMS stopped short of finalizing a different expansion of the site-neutral payment policy that would have applied the relativity adjuster when facilities exempt from the policy furnish services in new clinical families. This proposal would limit the exemption to services within the clinical families the facility offered at the time it was grandfathered from the policy. CMS is concerned this can be exploited as a loophole in that exempt facilities can expand into other clinical families and receive a complete exemption from the relativity adjuster.

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Senators Introduce New Surprise Billing Legislation

- The issue of surprise out-of-network medical bills for care provided at in-network facilities is continuing to gain traction on Capitol Hill. Two new pieces of legislation were introduced by the two Democratic Senators from New Hampshire. These bills build on legislation introduced by Sen. Bill Cassidy (R-LA) last month to address this issue.
- One of the new bills would create a binding arbitration process for determining the reimbursement from the patient's health plan to the out-of-network provider. The other would cap all out-of-network charges for health plans sold under the ACA exchanges.

Last month, Senator Bill Cassidy (R-LA) introduced legislation to create a federal patient protection from "surprise" out-of-network medical bills. Surprise medical bills refer to patients receiving medical bills for out-of-network care that was provided at an in-network facility under the patient's health plan. This is not a new issue, but it has been gaining attention in the media and on Capitol Hill.

Surprise bills are generally regulated at the state level. A number of states have some protection in place, but the type of laws vary. Sen. Cassidy, as well as two other senators, have introduced legislation that would provide a federal protection where state laws either do not exist or are inadequate.

Sen. Cassidy's bill, the Protecting Patients from Surprise Medical Bills Act, would prohibit the ability of out-of-network providers to balance bill patients for care provided at an in-network facility under the patient's health plan. The patient's cost-sharing obligation would be limited to their in-network cost-sharing amount. The bill also establishes a process for determining reimbursement to the provider for the out-of-network service. The reimbursement would be the greatest of:

- The geographic average payment, defined as median in-network amount negotiated by health plans and health insurers for the service provided by a provider in the same or similar specialty and provided in the same geographical area, or

- The "usual, customary and reasonable" rate which is defined for purposes of this bill as 125 percent of the average allowed amount for all private health plans and health insurance issuers for the service provided by a provider in the same or similar specialty and provided in the same geographical area.

Cassidy's bill defers to state laws when state laws are in place. His bill would apply to states that have not enacted their own surprise billing protections.

Earlier this month, two additional pieces of legislation were introduced. The first bill, the No More Surprise Medical Bills Act of 2018, was introduced by Sen. Maggie Hassan (D-NH). This bill takes a less prescriptive approach to Sen. Cassidy's bill with regard to determining reimbursement for the out-of-network provider. This bill would establish a binding arbitration process for determining the reimbursement. If the health plan and provider cannot agree on a reimbursement, the two parties would submit a reimbursement offer to an arbiter who would choose which bid to select.

The second bill, introduced by Sen. Jeanne Shaheen (D-NH), goes even farther. Her bill, the Reducing Costs for Out-of-Network Services Act of 2018, only applies to health plans purchased through an exchange established under the ACA but would cap out-of-network charges *in any situation*, not just what typically qualifies as a "surprise" bill. These options are:

- 125 percent of the Medicare Rate,
- 80 percent of the Usual and Customary rate,
- The insurer's in-network rate.

This issue will likely continue to receive increased attention. The HBMA Government Relations Committee will be closely tracking federal efforts to regulate surprise billing situations.

All three of these bills need to be passed by both the Senate and the House and be signed into law by the President before the end of the year. Otherwise, the bills will need to be reintroduced in the new Congress – which is very likely to happen.

Industry organizations are responding to the increased attention Congress is paying to surprise bills. For example, The American Hospital Association (AHA), America's Health Insurance Plans (AHIP), and the Healthcare Financial Management Association (HFMA) published a guide for consumers on surprise billing. This document is intended to help consumers understand surprise billing and recommends steps consumers can take to avoid surprise bills.

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Trump Administration Revises Guidelines for ACA Section 1332 Waivers

- The Administration released updated guidelines for how CMS will evaluate Section 1332 Waiver Requests. This process allows states to seek permission to implement alternatives to ACA requirements.
- The updated guidelines make it easier for states to submit waiver requests by removing the requirement for state legislators to approve waiver requests.
- CMS will also allow states to seek waivers to use ACA subsidy funding for non-ACA plans.

The Trump Administration released a revised version of the guidelines used by the Centers for Medicare and Medicaid Services (CMS) to evaluate state requests for waivers from Affordable Care Act (ACA) requirements. Section 1332 of the ACA allow states to request an exemption from certain ACA requirements in conjunction with the state proposing an alternative to the requirements.

States can use the Section 1332 Waiver Process to request a change in how it implements almost any part of the ACA's requirements. There are a number of statutory limitations as well as guidance from CMS that regulate these Waivers. The statutory requirements cannot be changed without an act of Congress. However, the Administration has significant discretion in how it evaluates and approves waiver requests.

Perhaps the most notable change being made is that beginning with the 2020 plan year, the states will be allowed to use federal premium assistance subsidies for health plans not sold through the federal or state health insurance exchanges established under the Affordable Care Act (ACA).

Using the ACA's Section 1332 Waiver process, States will be able to request permission from CMS to direct federal funding that is used for subsidizing plans sold on the ACA exchanges to subsidize non-ACA-compliant plans such as Association Health Plans (AHP) or Short-term Limited Duration Health Insurance (STLDI) plans. These types of plans do not have to meet many of the ACA's health plan requirements such as offering essential health benefits.

This policy does not eliminate or replace the ACA's subsidies for ACA plans. Instead, the policy allows states to offer subsidies for other types of plans in addition to ACA plans.

In announcing the new policy, CMS Administrator Seema Verma clarified that the new waiver authority will not undermine the ACA's protections for pre-existing conditions.

In addition to changing the requirements for how states can spend subsidy funds, the guidance removes the requirement that State Legislatures approve waiver requests before they can be approved by CMS. This gives governors greater authority to shape Section 1332 waiver requests.

The new version of the guidance also removes the requirement that Waiver requests prove that the changes being sought will not lead to a decline in insurance coverage. The guidance expresses the Administration's belief that Waiver requests should be evaluated based on the

"nature of coverage" that is available to consumers (access to coverage) rather than how many people purchased coverage.

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Trump Administration Announces Proposed Overhaul Part B Drug Payment Methodology

- The Trump Administration is proposing a drastic reform of how Medicare Part B reimburses providers for administering drugs in an office setting.
- This proposal picks up torch from past efforts to reform the Part B drug reimbursement methodology. The Obama Administration proposed but ultimately withdrew their proposed revision to Part B drug reimbursements. However, the Trump Administration's proposal goes even farther than that of his predecessor.
- CMS is proposing to replace the current Part B drug reimbursement system with one that pegs the price to the international prices of the drug.

In his first visit to the Department of Health and Human Services (HHS) headquarters in Washington, D.C., President Trump announced his Administration's plan to completely overhaul how Medicare reimburses providers for administering drugs to patients in an office setting. These drugs are paid under Medicare Part B at 106 percent of the average sales price (ASP) of the drug. This incentivizes the most expensive drug despite the existence of a cheaper, yet equally efficacious drug in the market (six percent of a $1,000 drug is more than six percent of a $500 drug).

Policymakers from both parties have been trying to reduce Medicare Part B drug spending by reforming how Medicare reimburses for these drugs. The Obama Administration sought to reform reimbursements for Part B drugs to lower the ASP add-on percentage and pay a flat fee per drug. This proposal received significant industry pushback and ultimately was not finalized. Rather than reform the existing formula for calculating Part B reimbursements, the Trump Administration is proposing a completely new reimbursement methodology that will replace the current system.

Under the new system, HHS will index Part B drugs to international prices under what is being called the "International Pricing Index" model (IPI Model). The IPI Model would be tested in select geographic areas through the Center for Medicare and Medicaid Innovation (CMMI) before it is expanded to the full Medicare program. The model would be mandatory in the selected geographic areas. CMS would compare the results of the IPI Model to the existing model which would remain in effect in the geographic areas not selected for participation. CMS believes this new model will save Medicare $17 billion over the five-year demonstration.

The IPI Model will select vendors to negotiate prices on drugs and procure them on behalf of provider. The vendors would submit claims to Medicare for reimbursement and then would enter into separate arrangements with providers to supply them with Part B drugs. Vendors would charge providers for distribution costs.

Medicare would reimburse vendors according to a target price that would be determined using several factors. One such factor will be the international price index for the product. The target price methodology would be phased in over five years so that providers in the model are reimbursed using a blend of the target price and the current methodology. The percentage of the payment based on the new target price would increase each year.

The Administration has not officially proposed this new reimbursement system. It published a pre-proposal soliciting input on the idea with the goal of incorporating the feedback it receives into an official proposed rule in early 2019. If all goes according to plan, the new demonstration would take effect in late 2019 or early 2020.

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CMS to Host National Provider Enrollment Conference in March

- CMS will host its second in-person National Provider Enrollment Conference in March of 2019. The conference will take place in Nashville, TN.
- CMS had previously told the HBMA GR Committee it was planning to hold a second conference, but CMS had not yet finalized the details of the conference.

The Centers for Medicare and Medicaid Services (CMS) announced it will hold a National Provider Enrollment Conference on March 12 and 13, 2019 at the Nashville Music City Center in Tennessee. CMS held the first such conference in April of this year in San Diego. Registration is not open yet, but CMS will make registration available soon.

CMS spoke very highly about the 2018 conference at the HBMA Government Relations (GR) Committee's visit to CMS headquarters in June. CMS informed the GR Committee that it was planning to hold another Provider Enrollment Conference in 2019 but had not yet picked a date or location for the conference.

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Trump Administration Targets Drug Prices in Series of Actions

- President Trump is proposing to require drug manufacturers to display their list price in television advertisements for their products.
- The President also signed legislation to ban the use of "gag" clauses that prevent pharmacies from informing patients if a drug is cheaper if they pay out-of-pocket than if they pay through their health plan.

With Congress out of D.C. to spend the final weeks of the midterms campaigning, most of the policy news out of Washington has come from the Administration. October has seen a number of Medicare reimbursement final rules released, updates to Affordable Care Act (ACA) guidelines and the beginning of the ACA open enrollment period.

The Administration has also been hard at work on another important health policy priority of the President: prescription drug prices. The Administration has taken three separate actions in the month of October on this issue. President Trump signed legislation, issued a proposed rule, and issued a notice of intent to publish another proposed rule for which it is seeking stakeholder input.

President Trump signed two bills into law that seek to lower drug prices for consumers. The first bill, S. 2554, the Patient Right to Know Drug Prices Act prohibits the use of "gag clauses" that prohibit pharmacists from informing a customer if their prescription drug would be cheaper if they paid out-of-pocket than if they paid through their health insurance plan. The second bill, S. 2553, the Know Lowest Price Act would do the same for Medicare Advantage and Medicare Part D plans. Gag clauses have been receiving a lot of attention in the media and on Capitol Hill however drug manufacturers and pharmacy benefit managers claim these clauses are rarely used.

The Administration also issued a proposed rule that, if finalized, will require drug manufacturers to display their list price in television advertisements for their products. All drugs that are covered by Medicare and Medicaid would be subject to this requirement. The Administration believes requiring manufacturers to list their wholesale acquisition cost (WAC) will provide transparency to consumers to compare the list price against what they pay at the pharmacy. The Administration hopes this will put downward pressure on prices as consumers would likely be angry if they see a substantial price markup at the pharmacy counter.

Lastly, the Administration announced a notice of proposed rulemaking stating its intent to formally issue a proposed rule that would institute a new methodology for reimbursing providers for drugs administered to patients in an office setting under Medicare Part B. The new methodology would replace the current system of paying providers for administering Part B drugs at 106 percent of the average sales price (ASP) with a new methodology that pegs the price to the international price index (IPI) for the drug. The Administration is seeking comments from stakeholders before issuing the official proposed rule.

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CMS Announces 2019 Medicare Premiums and Deductibles

- CMS announced updates to the premiums and deductibles for Medicare Parts A and B for 2019.
- Both Parts will see a slight increase in premiums and deductibles in 2019, especially compared to recent years.

The Centers for Medicare and Medicaid Services (CMS) announced the premiums and deductibles for Medicare Parts A and B in 2019. Premiums and deductibles for both Parts A and B are set to increase slightly.

All eligible Medicare beneficiaries automatically receive Medicare Part A benefits. There are no premiums for 99 percent of Medicare Part A beneficiaries. However, beneficiaries who did not

pay into the Medicare program through payroll taxes for at least 40 quarters will have to pay premiums. All Medicare Part A beneficiaries have a deductible. Medicare Part A beneficiaries will see their deductibles rise by $24 to $1,364 for 2019.

Eligible Medicare beneficiaries can choose to enroll in Medicare Part B. All beneficiaries enrolled in Medicare Part B have a monthly premium and an annual deductible similar to commercial health insurance plans. Part B premiums vary based on income.

For 2019, the lowest Medicare Part B monthly premium will increase from $134 to $135.50. This premium amount applies for individual beneficiaries who earn less than or equal to $85,000 or beneficiaries with a joint income less than or equal to $170,000. The Part B deductible will increase from $183 to $185. Beneficiaries who earn at least $500,000 per year will have to pay $460.50.

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CMS Transmittals

The following transmittals were issued by CMS in October.

Transmittal Number	Subject	Effective Date
R213DEMO	Next Generation Accountable Care Organization (NGACO) Model Post Discharge Home Visit HCPCS	2019-04-01
R2156OTN	Update to Common Working File (CWF) Edit of Medicare Advantage (MA) Enrollees' Inpatient Claims from Approved Teaching Hospitals Billed with Indirect Medical Education (IME) or Coverage with Evidence Development (CED)	2019-04-01
R2154OTN	Shared System Enhancement 2018: Streamline National Provider Identifier (NPI) Processing in the VIPS Medicare System (VMS)	2019-04-01
R4150CP	Update to Bone Mass Measurements (BMM) Code 77085 Deductible and Coinsurance	2019-04-01
R2158OTN	Shared System Enhancement 2018: Establish Beneficiary Data Streaming (BDS) Log Files	2019-04-01
R2157OTN	Systems Changes to Address Acute Kidney Injury (AKI) Claims and Outlier Payments	2019-04-01

R2159OTN	Shared System Enhancement 2018: Remove Remaining Obsolete Access Restriction by Granular User Services (ARGUS) Processing	2019-04-01
R2160OTN	Shared System Enhancement 2018: Eliminate action code logic	2019-04-01
R2161OTN	Shared System Enhancement 2018: Remove Default Automated Development System (ADS) and Field ADS Questions	2019-04-01
R2162OTN	Modify Common Working File (CWF) Editing to Apply Code G0476 to Female Beneficiaries Only	2019-04-01
R2164OTN	Shared System Enhancement 2018: Enhance Common Working File (CWF) Data Extract Process	2019-04-01
R2165OTN	Fiscal Intermediary Shared System (FISS) AGILE Development and Implementation of Application Programming Interface (API) for Medicare Administrative Contractors (MACs)	2019-04-01
R4152CP	Redesign of Hospice Periods – Additional Requirements	2019-04-01
R2163OTN	Shared System Enhancement 2018 ViPS Medicare Systems (VMS): Streamline the use of Assembler Language Code (ALC) Modules	2019-04-01
R2166OTN	Shared System Enhancement 2018: Enhance Common Working File (CWF) Internal Testing Facility (ITF) Response Records	2019-04-01
R4154CP	January 2019 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files	2019-01-07
R4153CP	Incomplete Colonoscopies Billed with Modifier 53 for Critical Access Hospital (CAH) Method II Providers	2019-04-01
R308FM	The Fiscal Year 2019 Updates for the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) Publication (Pub.) 100-06, Medicare Financial Management Manual, Chapter 7 - Internal Control Requirements	2018-11-27
R2167OTN	Decommissioning of the Client Letter Application within VIPS Medicare System (VMS)	2019-04-01

R2168OTN	Provider Enrollment Chain and Ownership System (PECOS) Data Source Change	2019-01-01
R2172OTN	Shared System Enhancement 2018: Remove Obsolete VIPS Medicare System (VMS) logic Related to the ViPS Medicare Automated Parameter (VMAP) Carrier Parameter Table	2019-04-01
R2171OTN	Analysis to Implement Changes to Regulations Allowing Inpatient Prospective Payment System (IPPS)-Excluded Hospitals to Operate IPPS-Excluded Units	2019-04-01
R2170OTN	Analysis of the Combined Common Edits/Enhancements Module (CCEM) and Intelligent Data Stream (IDS) Reporting Software to Ensure Effective Operation Under Java Version 8	2019-04-01
R2175OTN	Shared System Enhancement 2018: Establish a HMBI Query/Response Log	2019-04-01
R2174OTN	Correction to Common Working File (CWF) Informational Unsolicited Response (IUR) 7272 for Intervening Stay	2019-04-01
R2173OTN	Shared System Enhancement 2018: Renovate 2029 Serial Date Processing – Analysis Only	2019-04-01
R839PI	New Instructions for Home Health Agency Misuse of Requests for Anticipated Payments (RAPs)	2018-09-17
R2153OTN	Medicare Cost Report E-Filing (MCReF)	N/A
R836PI	Medical Review of Diagnostic Laboratory Tests	2018-11-21
R208NCD	Magnetic Resonance Imaging (MRI)	2018-12-10
R4147CP	Magnetic Resonance Imaging (MRI)	2018-12-10
R15P240	Provider Reimbursement Manual Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Form CMS-2552-10	2018-10-19
R184SOMA	Revisions to State Operations Manual, Chapter 2, Certification Process	2018-10-17
R183SOMA	Revisions to Medicare State Operations Manual (SOM) Table of Contents, Medicare SOM Appendix, SOM Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, SOM Appendix T-	2018-10-12

	Regulations and Interpretive Guidelines for Swing Beds in Hospitals, SOM Appendix W- Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs.	
R835PI	One-on-One Education	2018-11-13
R833PI	Templates in Medical Review	2018-11-13
R834PI	Order Requirements When Prescribing Practitioner is Also the Supplier and is Permitted to Furnish Specific Items of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	N/A
R2151OTN	Updating Calendar Year (CY) 2019 Medicare Diabetes Prevention Program (MDPP) Payment Rates	2019-01-07
R307FM	Notice of New Interest Rate for Medicare Overpayments and Underpayments -1st Qtr Notification for FY 2019	2018-10-17
R2152OTN	Procedures for Shared Systems to Handle Foreign (non US) Addresses	2019-01-07
R2144OTN	User CR: FISS to Add Location/Statuses to the 6H File Fix	2019-01-07
R2145OTN	Shared System Enhancement 2018: Implementation of the Medicare Summary Notice (MSN) Zip Code Analyzer Tool	2019-04-01
R4143CP	2019 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update	2019-01-07
R2146OTN	Update to Common Working File (CWF) Benefit Period Logic for Occurrence Code 22 on Skilled Nursing Facility (SNF) and Swing Bed Inpatient Claims	2019-04-01
R2147OTN	Update to the Long Description for Spanish Records on The Procedure Descriptor Master File for all Adds and Updates That Were Not Loaded with Change Request (CR) 10286	N/A
R832PI	Modification to Chapter 6, Section 6.3 (Medical Review of Certification and Recertification of Residents in SNFs) of Publication (Pub.) 100-08	2018-11-06

R2148OTN	Claim Based Incentive Programs - Non-Assigned Claim Update	2019-04-01
R2149OTN	Analysis to Implement the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)	2019-04-01
R210DEMO	Next Generation Accountable Care Organization (ACO) Model 2019 Benefit Enhancement	2019-01-07
R4144CP	Fiscal Year (FY) 2019 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes	2018-10-01
R829PI	Local Coverage Determinations (LCDs)	2019-01-07
R831PI	Update to Exhibit 16 - Model Payment Suspension Letters in Publication (Pub.) 100-08	2018-10-01

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