Washington Report – January, 2017
(Covers activity between 1/1/17 and 1/31/17)

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State of the Affordable Care Act

It has become a widely accepted conclusion that the Affordable Care Act (ACA), as we know it, is going to change. The fate of the ACA has been one of the most partisan issues since it was passed in 2010. Now that the Republicans control both Chambers of Congress as well as the White House, they have been eager to begin repealing and replacing the law with their own health reform plan.

However, repealing and replacing the ACA cannot happen overnight. It will be a process that takes at least a few months and could possibly take over a year. President Trump has already begun taking action by issuing an Executive Order that require the Agencies that oversee the ACA (IRS, HHS, CMS, etc.) to reduce the regulatory burden of the ACA. Meanwhile, Congress has begun the legislative process of repealing the ACA while continuing to work on the details of their replacement proposal.

But until then, ACA remains the law of the land.

On January 31st, the Open Enrollment period for the 2017 plan year for ACA coverage obtained through the federal health insurance exchange came to a close. According to the Centers for Medicare and Medicaid Services (CMS), 9.2 million people purchased coverage through the federal exchange, healthcare.gov, for 2017. According to the data, 3 million of these enrollees are new customers. This is down from the 9.6 million who purchased insurance on the federal exchange in 2016. This announcement does not include enrollment from the state exchanges. That data will be released in March.

This is the first year that enrollment through the federal exchanges has declined. Several factors have been attributed to the decline. According to CMS, this year's selections were made from a market that experienced a

25 percent increase over the previous year in the average premium for the benchmark second-lowest cost silver plan. In addition, there was a 28 percent decline in the number of issuers participating over the past year. Finally, some ACA supporters argue that the Trump Administration's scaling back of ACA marketing in the final week of the open enrollment period had an adverse impact on enrollment.

Despite these challenges and the likelihood of wholesale change, the rulemaking process for the 2018 plan year has progressed on schedule and insurers are preparing to file their rate proposals for the next plan year in a few months. Republicans are still deciding on a timeline for a replacement and it is possible they will build a transition year into their plan. This could mean that the ACA will continue to exist in 2018 with an expiration date at the end of 2018.

It was also recently announced that the Trump Administration is preparing to release a proposed rule that could make some Health Plan sought changes or "repairs" to the ACA.

HBMA has learned that the proposed rule (which may be released the week of February 13th) seeks to assuage many concerns raised by Health Plans, including:

1. Limitations on the Special Enrollment Periods for people seeking to enroll outside the open enrollment period;
2. Modifying the Guaranteed Issue requirements;
3. Change in the length of the 2018 open enrollment period;
4. Revisions to the Network Adequacy Standards;
5. Changes to the Essential Community Provider thresholds;
6. Changes to how plans should calculate the "actuarial value" of alternative benefit packages;
7. Changes in how you calculate the age-related rate bands (premium ratio between highest and lowest premiums based on age).

Although this will have to be published and available for public comment, the public comment period and move to publish this rule in final form could be on a very fast track.

With regard to a Republican alternative to the ACA, much is known but many key details have yet to be worked out. Timing is one of the details that has yet to be determined. Congressional Leaders are hoping to introduce legislation by the end of March; however, President Trump has said that it could take until next year for a replacement to happen.

Recall, Congressional Republicans intend to use the Budget Reconciliation process to repeal and replace key provisions of the ACA. Under Budget Reconciliation, both Chambers of Congress must first pass a unified budget (which they did in January). They then issue reconciliation instructions to specific congressional committees to identify a specific amount of savings. In this case, the committees with jurisdiction over the ACA were instructed to each identify $1 billion in savings (a drop in the bucket for the federal budget). This was done as part of the aforementioned Budget Resolution.

Given their jurisdiction over the ACA, the committees will be able to recommend eliminating parts of the ACA as a means to achieve the required savings. Further, the committees can propose new policies as long as the net effect is the required savings and the new policies comply with budget reconciliation rules.

Why this route?

Unlike most other legislation, a reconciliation bill is not subject to a filibuster. A Senate filibuster takes 60 votes to override and the Senate Republicans only control 52 seats in the Senate. If the GOP were to use the normal legislative process to repeal and replace the ACA, that legislation would be subject to an almost certain Democratic filibuster.

By using a reconciliation bill to repeal and replace the key components of the ACA, the GOP denies the Democrats of the filibuster option. It should be noted that when the Democrats controlled the Senate in the early days of the Obama Administration, they used the same reconciliation process to pass key parts of the ACA after they lost their filibuster-proof majority in 2010.

Although the Budget Reconciliation process is a powerful legislative tool, it does have its limitations. For example, budget reconciliation bills must be strictly limited to changing policies that have to do with the raising or spending of money.

Repealing key aspects of the ACA (individual mandate, employer mandate, taxes and subsidies for low-income individuals) would be possible under reconciliation. But other policies that cannot be changed through reconciliation (i.e. health insurance exchanges, pre-existing condition exclusions) would have to be dealt with through the normal legislative process.

Due to the limitations of reconciliation, Republicans will have to get creative with how they implement their own health reform plan. The same rules governing what can be repealed via a reconciliation bill would also apply to the inclusion of provisions to replace the ACA. Republicans have floated several alternatives to the ACA. Some are newly introduced ideas while others have been around for years.

Readers of the Washington Report may recall that Republicans successfully passed a reconciliation bill that repealed the ACA at the end of 2015. The bill was sponsored by Rep. Tom Price (R-GA), President Trump's nominee for Secretary of Health and Human Services (HHS). This largely symbolic vote sent a repeal bill to President Obama's desk for the first (and only) time which – to nobody's surprise – he vetoed. There were not enough votes in Congress to override the presidential veto. This bill essentially eliminated all of the taxes, fees and penalties in the ACA. It is likely that this same framework, if not the same language, will be used.

In 2015, Rep. Price also introduced his own replacement bill to the ACA, H.R. 2300 - Empowering Patients First Act of 2015. His bill relies on high deductible health plans linked to tax-advantaged health savings accounts (HSA), a foundational Republican policy ideas for health reform. It would also allow associations, such as HBMA, to create their own health plans that it could make available to member companies and their employees. The proposal would eliminate the minimum benefit requirements built into all Health Plans sold on the exchanges. Finally, the Price Plan would create high-risk pools for insuring the sickest beneficiaries.

With Rep. Price poised to serve as the Secretary of HHS, key pieces of his health reform plan could be included in the legislation replacing the ACA.

Other notable policy proposals, such as Speaker of the House, Paul Ryan's (R-WI) A Better Way reform plan, is very similar to Rep. Price's plan. A Better Way also relies on high-deductible health plans and HSAs as the foundation of the plan. The argument for this form of health insurance is to empower consumers to pay for what they actually consume by lowering premiums while helping them build up financial reserves to pay for care when they need to spend it on their higher deductibles. Ryan's plan would also preserve several popular provisions of the ACA such as protecting consumers from being denied coverage for pre-existing conditions but with an added requirement that consumers maintain continuous coverage to be eligible for the protection.

In the early days of the 115th Congress, Senator Bill Cassidy (R-LA) and Susan Collins (R-ME) introduced a health reform bill that appears to be more of a compromise than the plans put forth by their colleagues. The Cassidy/Collins bill, the Patient Freedom Act, proposes an alternative to the ACA but it gives each state the option to keep the ACA exchanges and financial assistance mechanisms. It also allows states the option to develop their own innovative system. Included in the option to keep the ACA is funding for the ACA Medicaid expansion.

The House Energy and Commerce Committee is holding hearings on four smaller bills that would strengthen existing ACA provisions for the 2018 plan year such as creating a new eligibility verification process for consumers enrolling in plans during special enrollment periods. One of the bills would reduce the 90-day grace period for which insurers must cover beneficiaries who do not pay their premiums to only one month. Some of these provisions could be included in a Republican alternative.

Recent media reports and press statements from Congressional leaders indicate that Congress intends to introduce its alternative to the ACA in late February or early March.

It remains to be seen when a replacement plan would take effect and how long of a transition period there will be between the ACA and the Republican alternative. Further, like all major pieces of legislation, the Agencies will have a large role to play as they develop the granular details for implementing the plan through the rule making process. With Rep. Tom Price as an architect of a potential replacement plan, Congress could delegate greater authority to HHS for developing their reform plan.

Although a lot is still unknown, expect answers to many of these questions in the coming weeks.

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Senate Committees Hold Confirmation Hearings for HHS Secretary Nominee

The confirmation process for Rep. Tom Price (R-GA), President Trump's nominee to serve as Secretary of Health and Human Services (HHS), is well underway.

On January 18th, the Senate Health, Education, Labor and Pensions Committee (HELP) held its confirmation hearing. The Senate Finance Committee followed with a hearing on January 24th. These hearings present an opportunity for the Senators on the Committees to question Rep. Price on his qualifications, policy positions and other matters related to his ability to lead HHS.

In both hearings, Rep. Price faced questions on his controversial stock holdings in several medical device companies. Critics of his nomination felt these holdings presented a conflict of interest. Price has already sold or has promised to sell his holdings in these companies if he is confirmed. Democrats also scrutinized one of his stock trades in which they feel he was offered the stock at a private stock offering at a discounted price. This offering was arranged by a fellow Congressman who was on the Board of that company.

Rep. Price's nomination was approved by the Senate Finance Committee; however, the vote was not without drama. Just prior to the Committee vote, the Democrats on the Committee staged a walkout which caused the vote to be delayed. Finance Committee rules require at least one member of each party to be present for a quorum. With no Democrats present, the Committee didn't have a quorum and therefore could not hold a vote. The next day, the GOP majority again scheduled a vote and again, the Committee Democrats refused to

participate. Rather than delay the vote, Republicans temporarily suspended the rules of the Committee and advanced Price's nomination to the full Senate without a Democrat being present.

Secretary-designate Price's nomination is now pending on the Senate floor awaiting a final confirmation vote.

Rep. Price has served in Congress since 2005. Price was an orthopedic surgeon in Georgia before entering politics first at the state level and eventually to the US House of Representatives. He is a conservative thought leader, especially on healthcare issues. He most recently served at Chair of the House Budget Committee.

Rep. Price has been a vocal critic of the Affordable Care Act (ACA) since it was introduced in Congress in 2009. He has authored a bill that would repeal and replace the ACA with his own alternative plan. He received many questions on his position regarding the ACA during the hearing. If confirmed, he expressed his desire to ensure that all Americans continue to have access to affordable health insurance coverage in any replacement to the ACA. He stopped short of offering details but he did state his belief that a replacement plan should maintain protections for people with pre-existing conditions. He also expressed his support for high risk pools.

There is no information at this time to suggest that Rep. Price's nomination is in jeopardy and his full Senate confirmation vote confirming him as Secretary of HHS is expected to be largely along party lines.

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President Trump Takes Swift Action on Many Issues with Executive Orders

In keeping with the tradition, President Trump has issued a series of high-profile Executive Orders (EO) on topics ranging from government regulation to the Affordable Care Act (ACA). Executive Orders allow the president to change or make policy within the jurisdiction of the federal agencies under existing statutory authority. EOs are not subject to Congressional review or approval and are generally among the first actions taken by a newly inaugurated President.

Almost immediately after taking the oath of office, President Trump issued a "regulatory freeze pending review." This is typically one of the first actions a new president takes, particularly when the newly sworn-in President is of a party different from the departing Chief Executive. This allows the new administration to review and approve pending regulations from the previous administration. Further, the order delays the effective date of any already finalized regulation that is not yet effective by 60 days. Agencies are still allowed to work on forthcoming regulations, however, the order prohibits these regulations from being published before the Trump Administration can review them.

In addition to the regulatory freeze, President Trump also issued an Executive Order on reducing government regulations in general. The EO requires that for every new regulation issued by an agency, two existing regulations must be eliminated. The EO also directs the heads of all agencies to ensure that the total incremental cost of all new regulations finalized throughout the year be no greater than zero.

Many of the fine details of this order are still unclear. For example, it is unclear if the Trump Administration will calculate "total incremental cost" based on the cost the rules impose on the private sector, or based on the cost the new rules pose to the federal government, or perhaps the cost for both. Also called into question was the definition of "regulation" for purposes of this order.

The Office of Information and Regulatory Affairs (OIRA) issued an interim guidance document to help clarify details on this order. The guidance offers greater detail on what level of significance a regulation must be in

order to be impacted by this order. Additionally, it states that the savings of the two deregulatory actions are to fully offset the costs of the new significant regulatory action.

The OIRA guidance clarifies that the Order does not apply to rules that implement Medicare spending policy. However, the order requires agencies to account for costs that new regulations impose through reporting and recordkeeping requirements to non-Federal entities in the regulatory relief offsets.

President Trump also issued a relatively broad Executive Order on "Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal." This order directs the Secretary of Health and Human Services and all other relevant authorities to:

> waive, defer, grant exemptions from, or delay the implementation of any provision of the [ACA] that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of health care services, purchasers of health insurance, or makers of medical devices, products, or medications.

In the event that a repeal/replace effort gets delayed, this executive order could be used to halt enforcement of the taxing authorities built into the ACA, such as the so-called Cadillac Tax or medical device tax, or tanning booth tax, from going into effect. It could also be used to effectively eliminate the individual mandate penalty. Such actions would be done under the same executive authority the Obama administration used to delay the effective date of certain aspects of the ACA.

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PQRS and Meaningful Use Updates

Although MACRA is now the official Medicare quality payment program, the Centers for Medicare and Medicaid Services (CMS) has announced important updates on the Physician Quality Reporting System (PQRS) and the electronic health record (EHR) Meaningful Use program. These two programs, which now make up part of the Merit-based Incentive Payment System (MIPS), are technically still in their final reporting year since eligible clinicians have a few months into 2017 to report 2016 data.

With regard to PQRS, CMS announced that they have had difficulty processing PQRS data because of the transition to the new ICD-10 coding system. Therefore,

> CMS will not apply the 2017 or 2018 PQRS downward payment adjustments, as applicable, to any individual eligible professional (EP) or group practice that fails to satisfactorily report for CY 2016 solely as a result of the impact of ICD-10 code updates on quality data reported for the 4th quarter of CY 2016.

This internal error at CMS will likely be resolved in time to process the first year of MIPS reporting.

In separate announcements, CMS also announced an extension for physicians and hospitals to report meaningful use data for the 2016 reporting year. The reporting deadline for EHR meaningful use is now March 13, 2017.

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HHS Allows Disclosure of PHI in Public Health Emergencies

The Department of Health and Human Services (HHS) Office of Civil Rights (OCR) has released a new fact sheet on when it is permissible for HIPAA covered entities to share protected personal health information (PHI).

This document is largely in response to recent public health emergencies such as the Zika virus outbreak as well as large medical emergencies such as the terrorist attack on the Pulse nightclub in Orlando.

This fact sheet is intended to help authorities monitor and respond to outbreaks of highly contagious diseases that pose a serious threat to public health. Also, in the aftermath of the Pulse shooting, the hospitals treating the victims were not sure if they could disclose PHI to loved ones of the victims because it could be seen as a violation of the HIPAA privacy laws.

The fact sheet does not make new policy. Rather, it features specific, clarifying scenarios as examples of when it is or is not permissible for a HIPAA covered entity to share PHI. For example, OCR is saying that it is permissible for covered entities, such as hospitals, to share PHI of patients diagnosed with the Zika virus with the Centers for Disease Control and Prevention (CDC) to help CDC track and monitor the contagious disease.

It should be noted that the fact sheet specifies that any electronic transfer of PHI must be done using Certified EHR Technology.

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Aetna- Humana Merger Blocked by Federal Judge

The attempted merger between health insurance giants Aetna and Humana appears to have reached the end of the line. Judge John Bates from the district court for the District of Columbia ruled on the side of the federal government and blocked the merger. The Department of Justice (DOJ) under the Obama administration challenged the merger as well as the attempted merger of Anthem and Cigna. The latter case is still awaiting a ruling.

Judge Bates agreed with the government that Aetna's purchase of Humana would "substantially…lessen competition" in violation of federal anti-trust statutes. Judge Bates concluded that the proposed $37 billion merger would substantially harm competition in both the Medicare Advantage and commercial insurance markets and is not in the best interests of consumers.

Aetna and Humana argued that the merger would combine two companies to create more efficiency which would translate into lower prices for consumers. The judge did not agree, "the Court is unpersuaded that the efficiencies generated by the merger will be sufficient to mitigate the transaction's anticompetitive effects for consumers in the challenged markets."

Bates also determined that Aetna withdrew from competing in several ACA exchange markets in 2017 to avoid judicial scrutiny of the merger.

The Aetna-Humana merger received increased scrutiny in the media after a letter from Aetna to the DOJ in which Aetna threatened to exit the health insurance exchanges established by the Affordable Care Act (ACA) if the Obama Administration's DOJ challenged the merger. Aetna did in-fact exit almost all of the exchanges in 2017.

The companies did prepare for the possibility their merger would not happen as Aetna agreed to pay Humana a $1 billion fee if the merger did not occur before February 15, 2017.

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OIG Review of MACs Shows Improvement but Also Persistence of Security Gaps

According to a recently issued report, Medicare Administrative Contractors (MAC) have sufficient information security programs in place but there is still room for improvement. The report, issued by the Department of Health and Human Services (HHS) Office of Inspector General (OIG), is an annual evaluation of each MAC's performance on cyber security based on a set of eight measures. These measures include a periodic risk assessment, risk reduction procedures, system security plans, staff training and periodic testing of procedures.

This report, which analyzes data from FY 2015, added privacy as a ninth performance area.
The report found an overall adequacy of information security across all nine MACs. However, the findings also indicate that there is room for improvement.

The report found a total of 149 security gaps, of which 22 were high-risk gaps, 46 were medium-risk gaps, and 81 were low-risk gaps. The report points out that very few of the high- and medium-risk gaps were repeat gaps from the previous year. No MAC had fewer than 11 security gaps. The results of the report also showed a 16 percent increase in total security gaps however some of this increase is attributed to the addition of a new performance area.

Examples of security gaps that did not meet CMS requirements include, inadequate policies and procedures for mobile device encryption and inadequate policies and procedures related to external information system connections.

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Federal Judge Indefinitely Delays Patient Steering Rule

In early January, a U.S. District Court Judge in Texas granted an indefinite delay of the implementation of an Interim Final Rule released by CMS in December that is intended to prevent dialysis facilities from steering Medicare- or Medicaid-eligible patients to commercial plans.

The Interim Final Rule, which was to take effect on January 13, 2017, addressed concerns from the Obama Administration that dialysis facilities would withhold information on Medicaid and Medicare eligibility and instead direct uninsured patients to obtain commercial coverage through the exchanges. The motivation for such actions by the facilities was that commercial plans generally reimburse dialysis providers at better rates than Medicaid and Medicare. The rule also sought to prevent dialysis facilities from making payments of premiums for individual market health plans directly, through a parent organization, or through a third party.

The Interim Final Rule did not ban the practice outright, rather, it requires Medicare-certified dialysis facilities to disclose information on these practices to insurers.

Several large dialysis organizations challenged the law in Federal Court. The Judge in the case has issued an order that indefinitely delays the effective date of the rule to allow sufficient time for the legal process to play out.

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2016 CAQH Index Shows Continued but Slow Adoption of Electronic Transactions

The Council for Affordable Quality Healthcare (CAQH) has released its annual report that measures the adoption of HIPAA standard electronic business transactions compared to manual, non-electronic transactions. CAQH is a non-profit organization comprised of health plans and related stakeholders that works to improve the business of healthcare.

This annual report, called the CAQH Index, measures the transition from manual business processes (paper and phone) to electronic, standardized transactions between healthcare providers and health plans. The recently released 2016 CAQH Index measures data collected in 2015. The data collected is from commercial health plans.
The 2016 Index shows an overall increase in adoption of electronic transactions in 2015. The transactions studied include claim submission; eligibility and benefit verification; claim status inquiries; claim payment; coordination of benefit (COB) claims; remittance advice; prior authorization; and referral requests.

With regard to commercial health plans, the report found that COB claims had the greatest increase in utilization, rising seven percent in 2015 to a total utilization rate of 56 percent. Claim submission continues to be the most widely adopted electronic process with a 94 percent utilization rate in 2015. Referral requests were the least-adopted transactions with a utilization rate of seven percent. Claim status inquiries also had a notable six percent increase in utilization with an adoption rate of 63 percent. All of the transactions studied saw at least a one percent increase.

Depending on the transaction type, the cost-per-transaction for electronic transactions ranges from $0.49 to $1.93 while the cost-per-transaction for manual transactions ranges from $2.64 to $11.18. Prior authorization happens to be the most expensive transaction for both electronic and manual but the difference is almost ten dollars.

CAQH estimates that the healthcare industry could save $9.4 billion a year by switching to electronic transactions. According the Index, providers stand to gain $7.9 billion of these savings by adopting electronic transactions. The Index estimates that providers could gain $4.3 billion within the eligibility and benefit verification transaction alone.

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President Trump Nominates Neil Gorsuch for the US Supreme Court

On January 31, 2017, President Trump announced his pick to fill the vacant seat left by the late Justice Antonin Scalia on the US Supreme Court. The president nominated Judge Neil Gorsuch, an appellate judge for the 10th circuit. The 49 year old judge who hails from Colorado is no stranger to Washington. His mother, a Reagan appointee, served as the Administrator of the Environmental Protection Agency in the early 1980s.

Justice Scalia was a “strict constructional” jurist who interpreted the Constitution based on the clear interpretation of how it is written. If confirmed Gorsuch’s nomination would mark the success of Republicans in the Senate to replace Justice Scalia with a justice of similar ideological principles.

President Obama nominated Merrick Garland, a moderate republican justice, to fill the seat after Scalia’s death. Senate Republicans, who controlled the Senate, never held confirmation hearings or a confirmation vote on Garland. His nomination expired when President Trump was inaugurated.

Gorsuch replacing Justice Scalia would leave the court in the same ideological balance that existed before Justice Scalia's passing with four conservative and four liberal justices with one justice considered a swing vote.

In the announcement ceremony, Gorsuch revealed how he would view his role as a justice by criticizing judicial activism. He stated that judges should "apply the law rather than alter the law." Conservative politicians are praising the nomination of Gorsuch as he has taken conservative positions on many social issues such as opposing right-to-die laws and allowing employers a religious exemption from providing health insurance to their employees that covers birth control.

Although they disagree with him on many of his positions, several notable Democrats in the legal field have praised Gorsuch's qualifications for the Bench. Neil Katyal, who served as US Solicitor General under President Obama, was one such Democrat who supports Gorsuch.

Gorsuch has clerked for not one but two Supreme Court Justices. He has worked for Supreme Court justice Anthony Kennedy and Justice Bryon White. After his clerkships, Gorsuch worked in private practice for 10 years before being appointed by George W. Bush to the 10th circuit in 2006.

Gorsuch is certain to face opposition from Senate Democrats who are angry over Garland not receiving a hearing or vote on his nomination. Democrats could filibuster Gorsuch on the Senate floor, which requires 60 votes to overcome instead of a simple majority of 51 votes.

Republicans control 52 seats so they will need eight Democrats to join them to advance his nomination if the filibuster is employed.

In 2013, former Senate Majority Leader, Harry Reid, a Democrat, changed the Senate rules to eliminate the filibuster for confirmation votes (excluding Supreme Court nominees). Changing Senate rules to eliminate the filibuster is a very big deal in the Senate. It is colloquially referred to as the "nuclear" option as it is essentially getting rid of a Senate tradition that has been around for decades. If Democrats attempt to filibuster Gorsuch's nomination, many Republicans, including President Trump, will pressure Senate Majority Leader Mitch McConnell (R-KY) to "go nuclear" on Supreme Court nominees. Leader McConnell is personally a supporter of the filibuster and was the chief critic of former Majority Leader Reid going nuclear in 2013.

Democrats might not actually filibuster Gorsuch. They might instead choose to unanimously vote against him – knowing they will lose the simple-majority vote – to paint his nomination as a partisan issue.

Regardless of the opposition tactics, Senate Republicans should be able to confirm Gorsuch to the Bench. It is just a matter of how dramatic the confirmation process will be.

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CMS Transmittals

The following Transmittals were released by CMS during the month of January.

Transmittal Number	Subject	Effective Date
SE17002	Additional Guidance for Clinical Laboratories as Data Reporting Begins	
SE17004	Revised Centers for Medicare & Medicaid Services (CMS) 855S Application – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers	
R3688CP	Update to the Federally Qualified Health Centers (FQHC) Prospective Payment System (PPS) - Recurring File Updates	2017-01-03
R3689CP	2017 Durable Medical Equipment Prosthetics, Orthotics, and Supplies Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List	2017-01-24
R1768OTN	Shared System Enhancement 2015: Reslove Operating Report (ORPT) Issues - Development and Implementation	N/A
R165DEMO	Shared System Enhancement 2015: Archive/Remove Inactive Medicare Demonstration Projects - Common Working File Analysis Only	2017-07-01
R1767OTN	Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) Front End Updates for July 2017	2017-07-03
R1769OTN	eMSN and Alternate Format MSN Service Improvements	N/A
R1770OTN	Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process	2017-04-03
R1771OTN	Fraud Prevention System (FPS) 2 Edit Migration Testing	2017-02-21
R1772OTN	Common Working File (CWF) Reorganization of Daily Beneficiary Extract Files	N/A
R280FM	Notice of New Interest Rate for Medicare Overpayments and Underpayments -2nd Qtr Notification for FY 2017	2017-01-19
R1774OTN	Shared System Enhancement 2014 – Identification of Fiscal Intermediary Standard System (FISS) Obsolete Reports - Analysis Only	N/A
R3691CP	Changes to the Laboratory National Coverage Determination (NCD) Edit Software for April 2017	2017-04-03
R3692CP	April 2017 Quarterly Average Sales Price (ASP) Medicare Part B Drug	2017-04-03

Transmittal Number	Subject	Effective Date
	Pricing Files and Revisions to Prior Quarterly Pricing Files	
R166DEMO	Affordable Care Act Bundled Payments for Care Improvement Initiative - Recurring File Updates Models 2 and 4 April 2017 Updates	2017-04-03
R3693CP	Medicare Physician Fee Schedule Database (MPFSDB) 2017 File Layout Manual	2017-01-03
R3695CP	Medicare Outpatient Observation Notice (MOON) Instructions	2017-02-17
R698PI	The Process of Prior Authorization	2017-02-21
R3696CP	New Waived Tests	2017-04-03
R1775OTN	Updated Editing of Professional Therapy Services	2017-07-03
R1776OTN	Instructions to Hospitals on the Election of a Medicare-Supplemental Security Income (SSI) Component of the Disproportionate Share (DSH) Payment Adjustment for Cost Reports that Involve SSI Ratios for Fiscal Year (FY) 2004 and earlier, or SSI Ratios for Hospital Cost-reporting Periods for Patient Discharges Occurring before October 1, 2004.	2017-01-19
R3698CP	Medicare Outpatient Observation Notice (MOON) Instructions	2017-02-21

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