HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION

Washington Report – December, 2017

(Covers activity between 12/1/17 and 12/31/17)

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Second MIPS Reporting Year Has Begun

On December 31st, about one-million people flocked to Times Square in New York City to watch a 12-foot ball drop which marks the beginning of the new reporting year for the Merit-based Incentive Payment System (MIPS). Perhaps the New Year's impact on Medicare payment policy was not truly the reason most of those people chose to brave below freezing temperatures, but regardless of their reason for attending, the second MIPS reporting year began on January 1st.

Data reported in 2018 will affect Medicare Part B payments in 2020. Eligible Clinicians (i.e. those physicians, PAs and NPs who are not otherwise exempt from MIPS) who fail to achieve the minimum benchmark score of 15 points will have their Medicare fee-for-service (FFS) payments reduced by five percent in 2020. Eligible Clinicians (ECs) can earn up to five percent in positive payment adjustments depending on their reporting performance.

ECs were able to avoid negative payment adjustments in 2017 by reporting any amount of data for any amount of patients (at least one patient). This threshold score was increased for 2018 but should still be relatively achievable. There is a separate pot of bonus money that is available for the highest performing ECs.

Eligible clinicians (EC) should be aware of several important changes to the MIPS reporting requirements for the new reporting year. In fact, one of these changes results in over half of ECs being exempt from MIPS reporting.

Specifically, the Centers for Medicare and Medicaid Services (CMS) increased the low-volume threshold to ECs who bill $90,000 or less in Medicare Part B allowed charges or 200 or fewer Medicare patients. ECs who fall below the threshold are exempt from MIPS reporting and there is no option for exempt ECs to voluntarily participate. The low-volume provider threshold in 2017 was $30,000 or less in Medicare Part B allowed charges or 100 or fewer patients.

ECs can also be exempt from MIPS if they qualify as a partial or full participant in Advanced Alternative Payment Models (Advanced APM). There are also circumstances which result in reduced MIPS reporting requirements such as ECs who are non-patient facing and ECs who are hospital-based.

ECs can check their participation status using their NPI number on the Quality Payment Program website (www.qpp.cms.gov).

Individual ECs and small practices can also form virtual groups in 2018. Virtual groups allow smaller practices to pool their resources to report (and receive payment adjustments) as a single entity.

As a reminder, those providers who qualify for MIPS participation will be evaluated on four factors which will make up the ECs Composite Performance Score (CPS). These are:

Category	**Percent of Total CPS score**
Quality Measure Performance	50%
Resource Use	10%
Advancing Care Information	25%
Clinical Practice Improvement	15%

Resource Use was excluded from MIPS scores in 2017 but CMS still collected data and provided feedback reports to ECs based on their performance in this category. Beginning in 2018, Resource Use will now be included in the ECs overall MIPS score.

ECs should note that the quality and cost categories will measure performance across the entire 2018 performance year while other categories such as the Advancing Care Information (ACI)

category will only require a 90-consecutive-day reporting period to satisfy the reporting requirement.

For 2018, small practices will be eligible for a five point bonus to their MIPS score. CMS is also allowing improvement to factor into an EC's CPS. CMS is also providing up to a five point adjustment for ECs who treat a significant number of complex patients.

Eligible clinicians have until March 31, 2018 to submit data for the 2017 reporting year, unless they are part of a group reporting via the newly announced CMS Web Interface in which case they must report by March 16th.

Additional resources on MIPS are available for HBMA members on the association's website.

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Historic Tax Overhaul Signed Into Law

On December 22nd, President Trump signed into law the massive tax overhaul bill, passed by Congress just days earlier. Final passage of the Conference Report by Congress never seemed in doubt during the lead-up to the party-line vote. No Democrats in either chamber voted for the final version while a handful of House Republicans voted against the bill due to the elimination of certain tax exemptions which were popular in their districts.

The final version is the result of negotiations by the Conference Committee made up of a bipartisan group of lawmakers from both Chambers who were appointed to reconcile the differences between the House and Senate versions of the bill. The Conference Committee produces a Conference Report which includes a description of the differing provisions and an explanation for the decision that was made regarding each provision.

This bill has far reaching effects for both the individuals and businesses. The non-partisan Congressional Budget Office (CBO) estimates that the bill could reduce federal revenues by about $1.4 trillion over ten years. However proponents of the legislation believe that as a result of the new economic growth that they believe will occur as a result of this legislation, federal revenues will be considerably higher than what CBO projects.

Most of the bill's provisions are effective beginning with the 2018 tax year.

Although the bill does not technically repeal the Affordable Care Act's individual mandate, the tax bill does eliminate the individual mandate's penalty for not maintaining qualified health insurance. Beginning January 1, 2019, the ACA penalty for failure by an individual to demonstrate coverage by a qualified health plan will be $0.

The bill maintains seven individual tax brackets but adjusts the tax percentages and income thresholds for each bracket. It also lowers the corporate tax rate from 35 percent to 21 percent beginning in 2018.

In addition to reducing the tax rates, a major goal of the Congress and President was to reform the tax code by eliminating or reducing many of the itemized deductions that individuals can claim on their tax returns. It is estimated that for 2017, approximately 80 percent of taxpayers will file a simple tax return and 20 percent will file an itemized tax return.

As a result of the simplification and raising of the standard deduction from $6,350 to $12,000 for individuals and from $12,700 to $24,000 for joint filers the number of individuals filing an itemized return is expected to drop to 10% in 2018.

Trying to assess the impact of the tax reform plan on those taxpayers who do itemize is more difficult because it is impossible to know what tax deductions a taxpayer might take on their itemized return. Most of the more popular tax deductions were retained in the new law but there were some significant modifications. For example, the new law lowers the cap on the home mortgage interest deduction for NEW homebuyers from $1 million to $750,000 in mortgage. Existing homeowners will continue to have the $1 million cap. The bill also caps the state and local tax deduction at $10,000 per year.

In addition to eliminating or modifying some existing deductions, the bill also raises or expands some popular tax incentives. For example, the child tax credit was increased to $2,000 per child with no limit on the number of children for whom you can claim the credit. The credit is also made "refundable" – up to $1,400 per child – meaning that even families who have no tax liability against which the credit can be claimed can get a refund in the amount of the credit up to the cap.

Finally, the new tax law expands the medical expense deduction by lowering the qualifying threshold for medical expenses from medical expenses that exceed 10 percent of income to medical expenses that exceed 7.5 percent of income.

The final version of the bill does not include several controversial provisions from previous iterations of the bill such as a provision that would have eliminated the student loan interest deduction.

With regard to some business-related provisions, the bill ends the corporate alternative minimum tax (AMT). It also changes how executive compensation in the form of stock options and performance-based pay are taxed. It also lowers the pass-through tax deduction.

HBMA has made a summary of some of the key individual tax provisions available to members on the website.

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Update to HBMA Members on CMS Social Security Number Removal Initiative

Beginning in April 2018, the Centers for Medicare and Medicaid Services (CMS) will begin issuing new Medicare ID cards to beneficiaries as part of a congressionally mandated initiative to replace the Health Insurance Claim Number (HICN) with a new Medicare Beneficiary Identifier (MBI). The HICN, which is the beneficiary's Social Security Number (SSN), was viewed by Congress as a threat to program integrity and exposed Medicare beneficiaries to identity theft that could give criminals access to a wide-range of personal information linked to the individual's SSN.

Congress therefore included a provision in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requiring CMS to remove and replace SSNs on Medicare cards with a new, alphanumeric MBI similar to what commercial insurance cards use. These MBIs will not be "smart" numbers meaning that there is no information embedded in the ID number. Individuals will be discouraged from using this number for anything other than the Medicare program. The MBI will be a randomly generated number assigned to the individual.

During an initial transition period, CMS will accept claims that use either the HICN or the MBI from April 2018 until the end of 2019. **CMS has asked that HBMA make our members aware that CMS will begin including the new MBI on remittance advice.** Beginning on January 1, 2020, CMS will only accept the new MBI.

Eligibility transaction responses

Beginning in April 2018, through the end of the transition period, if you submit a HICN on the 270 eligibility transaction request, we'll tell you in the message field on the 271 response when we've mailed a new Medicare card to each individual with Medicare. The message will say, "**CMS mailed a Medicare card with a new Medicare Beneficiary Identifier (MBI) to this beneficiary.** Medicare providers, please get the new MBI from your patient and save it in your system(s)."

271 Loop 2110C, Segment MSG

Your eligibility service provider can give you this information. Beginning on January 1, 2020, you must use the MBI to get a valid response.

Beginning in April 2018 through the end of the transition period, you can also submit either a HICN or MBI through the Common Working File (CWF) eligibility transaction request to get information; we're aligning all primary eligibility search criteria, regardless of the system you use to request information as required by the X12 standard. Beginning on January 1, 2020, you must use the MBI to get a valid eligibility response.

We won't send you the MBI in eligibility transaction responses when you give us a HICN. We're aware some providers find the HICN by using a combination of the Social Security Number and Beneficiary Identification Code until they find a match; returning the MBI when providers submit a HICN gives a higher risk of medical identity theft. Therefore, **beginning in October 2018, through the transition period, we'll also return the MBI only through the remittance advice in the same place you get the "changed HICN", "Corrected Patient/Insured Name, Identification Code" field, for all claims you submit with a valid and active HICN.** This is consistent with our policies to reduce medical identity theft.

HBMA has expressed to CMS that this transition poses operational challenges to the healthcare revenue cycle management (RCM) process. CMS has been engaging with stakeholders such as HBMA to provide education and obtain feedback on how it will effectively implement the transition.

Beginning in April 2018, Medicare beneficiaries will be able to look up their new MBI numbers and in June 2018, providers will also be able to look up their patients' new MBI numbers through secure web interfaces that will support quick access to the MBI. These web interfaces will be available through each Medicare Administrative Contractor's (MAC) secure portal.

HBMA will continue to work with CMS to make the transition to the new MBI as smooth as possible for the healthcare RCM industry.

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Congress Punts on Reauthorizing CHIP Funding and Avoids Medicare Cuts in Short-Term Spending Bill

Right before leaving Washington for the holidays, Congress passed another short-term Continuing Resolution (CR) which funds the federal government through January 19th. Failure to pass the CR would have resulted in a government shutdown.

Congress often includes provisions that are unrelated to government spending in must-pass spending bills. This CR was seen as an opportunity to reauthorize funding for the popular Children's Health Insurance Program (CHIP) which technically expired at the end of September, 2017. Both parties are eager to reauthorize this funding. However, there remains significant disagreement between Democrats and Republicans over how to pay for the reauthorization.

Republicans control both Chambers of Congress and are therefore in the driver seat for making determinations on funding mechanisms. However, Democratic votes will be necessary to pass the bill in the Senate. Senate Democrats have been withholding their support for a CHIP reauthorization bill until they get a funding mechanisms more to their liking.

The GOP wants to offset the cost of CHIP reauthorization by reallocating money from a fund established by the Affordable Care Act and by raising Medicare premiums on high-income beneficiaries. Democrats want the program funded through a dedicated funding stream to prevent future disruptions.

Given that neither side wants to see the CHIP program run out of money, some sort of compromise will have to be made for CHIP reauthorization. Congress did not have enough time to negotiate such a compromise before the previous CR was set to expire which resulted in another short-term funding patch for CHIP.

Although the new federal money to operate the CHIP program ended on September 30th, most states had built up reserves of unspent CHIP money that could carry them through the end of December. The short-term funding for CHIP included in the CR should be sufficient to sustain the program through the end of March, 2018.

Congress also used the must-pass CR as an opportunity to waive the so-called "Pay-as-you go" or "Paygo" requirement enacted a few years ago. Under Paygo, any legislation that results in reduced revenue or higher spending that raises the federal deficit must be offset by cuts in federal spending. These mandatory cuts can be avoided if Congress votes to "waive" the Paygo requirement – as they have now done. Absent a waiver, Congress would have been required to offset a portion of the cost of the recently enacted tax reform legislation through cuts in mandatory spending programs such as Medicare. With the Paygo waiver now in place, no mandatory cuts to Medicare spending will be necessary.

Congress now has until January 19th to pass legislation that either funds the government for the remainder of the fiscal year or adopt another short-term CR. Should a deal on long-term CHIP funding be reached, the next CR will also be a likely legislative vehicle for this compromise.

Finally, there are also a number of Medicare "Extenders" that need to be enacted in order to continue payments for various provider services. Members from both political parties have expressed support for the Medicare Extenders package but as with CHIP, identifying spending offsets that enjoy bipartisan support has been elusive.

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2018 ACA Enrollment at 8.7 Million

The ACA open enrollment period for the 2018 ended on December 15, 2017. Preliminary reports indicate that 8.7 million people enrolled in Qualified Health Plans (QHP) for 2018. This is slightly lower than last year's enrollment number of 9.2 million.

Of the 8.7 million total, about 2.4 million were new consumers while about 6.3 million were consumers who renewed coverage. However, this also means that roughly 2.9 million people who purchased insurance in 2017 did not purchase insurance for the 2018 plan year through the federal exchanges.

It is not known officially what happened to the 2.9 million people who had ACA insurance in 2017 who did not sign up for coverage for 2018 but it is widely believed that many of these individuals may have gotten health insurance coverage through another means such as from an employer or Medicaid.

Thirty-nine states use the federal exchange (healthcare.gov) while the remaining 11 states facilitate their own exchanges. The state-run exchanges can set their own enrollment periods and not all are aligned with the federal exchange. Data on state exchange enrollment likely will not be available for a few months.

Based on trends from previous years, the 8.7 million number is expected to decrease over the course of the year as people choose not to maintain coverage.

As previously reported, Congress eliminated the individual mandate penalty beginning in 2019 as part of the 2017 tax overhaul bill. Some fear that this could lead to additional drops in coverage in 2018.

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CMS Creates New Program to Settle Low Volume Claims Appeals

The Department of Health and Human Services (HHS) Office of Medicare Hearings and Appeals (OMHA) is currently mired in a massive backlog of appealed claims at the administrative law judge level. Many of these appealed claims are Medicare Part A (inpatient) claims that were challenged by Recovery Audit Contractors (RAC) that believed these claims should have been submitted as Medicare Part B (outpatient) claims. Hospitals have been appealing the RAC determinations and OMHA does not have the resources to adjudicate the number of appealed claims in a timely manner.

Plenty of non-inpatient vs. outpatient determination claims have been caught up in this backlog. To reduce the number of appeals cases, HHS is offering settlements to providers for many of these claims.

HHS recently announced that the Centers for Medicare and Medicaid Services (CMS) will make available a new settlement option for providers and suppliers (appellants) with appeals pending at OMHA and the Medicare Appeals Council (the Council) at the Departmental Appeals Board. The new "low volume appeals settlement option (LVA)" will be limited to appellants with a low volume of appeals pending at OMHA and the Council.

Specifically, appellants with fewer than 500 Medicare Part A or Part B claim appeals pending at OMHA and the Council, combined, as of November 3, 2017, with a total billed amount of $9,000 or less per appeal could potentially be eligible, if certain other conditions are met. CMS will settle eligible appeals at 62 percent of the net allowed amount.

Separately, OMHA will be expanding the Settlement Conference Facilitation Process for certain appellants that are not eligible for the LVA option. More information will be available on the OMHA website.

CMS will be holding a national provider call on the LVA on January 9th from 1:30 – 2:30 p.m. ET. Questions can be submitted in advance to MedicareSettlementFAQs@cms.hhs.gov.
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Finance Committee Chairman Orrin Hatch to Retire from Senate

Senator Orrin Hatch (R-UT), who chairs the powerful Senate Finance Committee, announced that he will not seek reelection when his current term expires at the end of this year. First elected in 1976, Senator Hatch, who is 83 years old, is currently the longest-serving Senator and is the longest-serving Republican senator in history.

The Senate Finance Committee has jurisdiction over the Medicare and Medicaid programs as well as tax policy in the Senate. The vacancy as the leader of this powerful Committee will be

among the most sought-after position in the Senate but it is too early to say who will succeed Hatch atop the Finance Committee.

Hatch will leave behind a legacy as a healthcare policy leader. He is known as a conservative Republican who at times "digs in" on conservative positions but also has a history of reaching across the aisle to work with Democrats to pass bipartisan legislation. He is known for collaborating with the late Senator Ted Kennedy (D-MA) to lead the legislative efforts to create the Children's Health Insurance Program (CHIP) and pass the Americans with Disabilities Act.

Although a number of potential Democratic and Republican candidates to replace Senator Hatch may emerge over the next few months, the most interesting name being mentioned is that of Mitt Romney, the former Governor of Massachusetts and the 2008 Republican presidential nominee. Ever since rumors of Senator Hatch's potential retirement began surfacing a few months ago, Romney has been the most consistently named person as a potential successor.

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Total National Health Spending Growth Decelerated in 2016

The total overall spending by patients and payers on healthcare grew at a slower pace in 2016, according to an annual report from the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary (OACT). In 2016, national health expenditures grew by 4.3 percent, which is less than the 5.8 percent growth seen in 2015.

This data represents spending by commercial and government payers on reimbursements for healthcare services as well as spending by individuals on health insurance premiums, out-of-pocket healthcare costs and prescription drugs. The data is further explained and analyzed in a *Health Affairs* post.

According to the report, healthcare spending grew 1.5 percentage points faster than the overall economy in 2016, resulting in a 0.2 percentage-point increase in the health spending share of the economy – from 17.7 percent in 2015 to 17.9 percent in 2016.

In 2016, the federal government and households accounted for the largest shares of spending (28 percent each) followed by private businesses (20 percent), state and local governments (17 percent), and other private revenue (7 percent).

As has been previously reported by OACT, Medicare spending growth slowed in 2016 from about five percent growth in 2014 and 2015 to 3.6 percent growth in 2016. Medicare spent a total of $672.1 billion in 2016.

However, Medicaid spending grew at a faster rate in 2016. State and local spending on Medicaid increased by 3.2 percent while the federal share of Medicaid spending grew by 4.4 percent in 2016 translating to total Medicaid spending of $565.5 billion.

Perhaps the most significant spending trend change was for retail prescription drugs which only increased by 1.3 percent in 2016 after 12.4 percent growth in 2014 and 8.9 percent growth in 2015. Total retail prescription drug spending was $328.6 billion in 2016. According to OACT, this slowdown in spending was due to fewer new drug approvals, slower growth in brand-name drug spending and a decline in spending for generic drugs as price growth slowed. Additionally, there was a decline in spending on expensive drugs such as the new treatment for hepatitis C.

Out-of-pocket spending by consumers grew 3.9 percent to $352.5 billion in 2016, faster than the 2.8 percent growth in 2015. Private health insurance spending on benefits increased 5.1 percent to $1.1 trillion in 2016, which was slower than the 6.9 percent growth in 2015.

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HHS ONC Creates Patient Demographic Data Collection Best Practices Framework

The Department of Health and Human Services (HHS) Office of the National Coordinator for Health Information Technology (ONC) has developed a framework of best practices for healthcare provider organizations to use to improve the collection of patient demographic information. ONC hopes that healthcare provider organizations will use this framework to assess their patient demographic collection processes to identify strengths and areas for improvement.

ONC, the office responsible for most health IT policy within HHS, collaborated with the CMMI Institute (no relationship to the Center for Medicare and Medicaid Innovation within CMS), to develop this framework called the Patient Demographic Data Quality (PDDQ).

According to ONC, "The goal of the PDDQ Framework is to help organizations ensure that the formulation, agreement, approval, and implementation of adopted standards and processes will be effective and sustainable and support the minimization of the number of duplicate records across the industry, ultimately improving patient safety."

This framework was developed in reaction to issues such as those identified in a 2016 National Patient Misidentification Report, released by the Ponemon Institute which found that 86 percent of healthcare providers surveyed are aware of medical errors caused by patient misidentification.

According to ONC, "Accurately and consistently matching patient data both within and across organizations is pivotal to ensuring safe and effective care to patients. When patient data is not accurately matched, treatment and diagnosis decisions are made in the absence of valuable information, and patients could be subject to adverse events and significant harm."

The PDDQ Framework is intended to help organizations evaluate themselves against key questions designed to understand how effective their patient demographic information processes are compared to what ONC believe should be the benchmark. It is also intended to help stakeholders improve.

Similar to how most HHS frameworks of this nature are structured, the PDDQ includes five primary categories, each with their own process areas. The five primary categories are data governance, data quality, data operations, platform & standards, and supporting processes. There are a total of 19 process areas across these five categories.

Category	Process Area
Data Governance	Governance Management
	Communications
	Data Management Function
	Business Glossary
	Metadata Management
Data Quality	Data Quality Planning
	Data Profiling
	Data Quality Assessment
	Data Cleansing & Improvement
Data Operations	Data Requirements Definition
	Data Lifecycle Management
	Data Provider Management
Platform & Standards	Data Standards
	Data Management Platform
	Data Integration
	Historical Data, Archiving & Retention
Supporting Processes	Measurement & Analysis
	Process Management
	Process Quality Assurance

The framework includes a point scoring system for each category that is meant to show a participant's current state and help identify where improvements are needed.

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GAO Assesses CMS Program Integrity Efforts

In a December report, the Government Accountability Office (GAO) conducted an assessment of the Centers for Medicare and Medicaid Services (CMS) program integrity efforts. The GAO specifically examined CMS' adherence to the GAO's Fraud Risk Framework. The report concludes that CMS is making progress but could be doing a better job in certain areas.

The GAO considers the Medicare and Medicaid programs to be at particularly high risk for fraud and improper payments. In FY 2016, GAO estimated improper payment for these programs totaled about $95 billion. Improper payments include payments for incorrectly coded claims and claims for excessive or unnecessary services. Improper payments can be unintentional billing mistakes or intentionally fraudulent billing practices.

CMS has been working to educate providers on proper billing practices so that the unintentional mistakes can be fixed and CMS can better focus anti-fraud resources on those bad actors who are intentionally defrauding the programs.

GAO first issued the Fraud Risk Framework in July 2015 as a way to provide a comprehensive set of key components and leading practices that could serve as a guide for federal agencies to use when developing efforts to combat fraud. The Fraud Risk Framework describes best practices in four components: commit, assess, design and implement, and evaluate and adapt. GAO believes CMS is doing well on some of these components but could be doing better on others.

GAO believes that CMS has met the *commit* component in part by establishing a dedicated entity—the Center for Program Integrity—to lead anti-fraud efforts. Furthermore, CMS is offering and requiring anti-fraud training for stakeholder groups such as providers, beneficiaries, and health-insurance plans.

However, the report criticizes CMS for not requiring fraud-awareness training on a regular basis for employees and feels that there is room for improvement within the *assess, design and implement,* and *evaluate and adapt* components of the framework.

GAO made three recommendations on how to improve fraud prevention. HHS agreed with all three recommendations. The recommendations are for CMS to:

1. provide and require fraud-awareness training to its employees,
2. conduct fraud risk assessments, and
3. create an antifraud strategy for Medicare and Medicaid, including an approach for evaluation.

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CMS Transmittals

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

Transmittal Number	Subject	Effective Date
R3936CP	Updated Editing of Always Therapy Services - MCS	2018-01-02
R1991OTN	Method of Cost Settlement for Inpatient Services for Rural Hospitals Participating Under the Rural Community Hospital Demonstration	2018-01-29
R176SOMA	Revisions to State Operations Manual (SOM) Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals	2017-12-29
R1993OTN	Analyze the Common Working File (CWF) System and Identify Customer Information Control System (CICS) Screens Requiring Expansion	2018-04-02
R762PI	Update to Chapter 15 of Pub. 100-08	2018-01-29
R1994OTN	Suppression of the Standard Paper Remittance Advice (SPR) in 45 Days if Also Receiving Electronic Remittance Advice (ERA)	2018-01-02
R175SOMA	Revisions to State Operations Manual (SOM) Appendix J, Part II – Interpretive Guidelines – Responsibilities of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	2017-12-22
R3943CP	Correction to Prevent Payment on Inpatient Information Only Claims for Beneficiaries Enrolled in Medicare Advantage Plans	2018-04-02
R3940CP	January 2018 Integrated Outpatient Code Editor (I/OCE) Specifications Version 19.0	2018-01-02
R3941CP	January 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS)	2018-01-02

Transmittal Number	Subject	Effective Date
R3938CP	Summary of Policies in the Calendar Year (CY) 2018 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, and CT Modifier Reduction List	2018-01-02
R3942CP	Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens	2018-01-22
R3939CP	January 2018 Update of the Ambulatory Surgical Center (ASC) Payment System	2018-01-02
R3937CP	Changes to the Laboratory National Coverage Determination (NCD) Edit Software for April 2018	2018-04-02
R1990OTN	Suppression of the Standard Paper Remittance Advice (SPR) in 45 Days if Also Receiving Electronic Remittance Advice (ERA)	2018-01-01
R1989OTN	Fiscal Intermediary Shared Systems (FISS) Enhancements to the Mass Adjustment of Process Recovery Audit Contractor (RAC) Claims	2018-04-02
R3935CP	Instructions for Retrieving the 2018 Pricing and HCPCS Data Files through CMS' Mainframe Telecommunications Systems	2018-01-02
R1988OTN	National Provider Identification Crosswalk System (NPICS) Retirement Analysis Only - Engage Shared Systems Maintainers (SSMs) and Medicare Administrative Contractors (MACs) in Meetings and Correspondence Related to the NPICS Retirement with the Integrated Data Repository (IDR) Team	2018-01-02
R1987OTN	Archiving National Provider Identifier Crosswalk System (NPICS) System Logic in the Durable Medical Equipment (DME) Claims Processing System	2018-07-02

Transmittal Number	Subject	Effective Date
R3934CP	Calendar Year (CY) 2018 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment	2018-01-02
R1985OTN	Analysis Only- Medicare Reporting on the Return of Self-Identified Overpayments	2018-07-02
R174SOMA	Revisions to the State Operations Manual (SOM) Appendix P	2017-12-08
R3933CP	Revisions to the Home Health Pricer to Support Value-Based Purchasing and Payment Standardization	2018-01-02
R111GI	Update to Medicare Deductible, Coinsurance and Premium Rates for 2018	2018-01-02
R3932CP	Special Requirements for Immunosuppressive Drugs	2018-03-09
R1983OTN	Shared System Enhancement 2015: Identify Inactive Medicare Demonstration Projects within the Fiscal Intermediary Shared System - (Removing/Archiving demonstration codes 38, 42 and 43)	2018-04-02
R3930CP	Hospice Manual Update Only for Section 30.3	2018-03-01
R1982OTN	Line Level versus Claim Level Reporting – Analysis Only	2018-01-01
R3931CP	CY 2018 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule	2018-01-02
R1981OTN	Fiscal Year (FY) 2014 and 2015 Worksheet S-10 Revisions: Further Extension for All Inpatient Prospective Payment System (IPPS) Hospitals	2018-01-02

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