HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION

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(Covers activity between 3/1/18 and 3/31/18)

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HBMA GR Committee Holds Conference Call with ONC to Discuss EHR Burden Reduction

On April 3rd, the HBMA Government Relations Committee participated in a conference call with the Department of Health and Human Services (HHS) Office of the National Coordinator (ONC). The purpose of this call was for HBMA to provide feedback to ONC on its effort to reduce the clinical, financial and administrative burdens of electronic health records (EHR).

Leading a group of five high-level ONC attendees was Dr. Tom Mason, Chief Medical Officer for ONC. HBMA Executive Director, Andre Williams and Director of Government Relations,

Bill Finerfrock, held an in-person meeting with Dr. Mason a few weeks prior to this call to introduce HBMA and begin this conversation.

Title IV of the 21st Century Cures Act requires HHS to issue a report on how to reduce EHR burdens including how to reduce information blocking and achieve greater EHR interoperability. ONC is collaborating with CMS on this report.

ONC has hosted public stakeholder listening sessions and has also hosted individual meetings with certain stakeholders to hear their concerns and proposed solutions. This call was an opportunity for the HBMA Government Relations (GR) Committee to provide direct feedback to ONC on these issues.

HBMA GR Committee Chair, Arthur Roosa, introduced HBMA and raised the importance of interoperability to the healthcare revenue cycle management (RCM) industry. He described how many systems are not adhering to standards set by HIPAA or the HITECH act. Chairman Roosa also described how there can also be a lack of compliance with regard to HL7 formatted transactions. Finally, he emphasized the need for consistency in transaction formatting as well as the need for true interoperability.

Lack of interoperability leads to a number of administrative and financial burdens. Other Committee Members shared how EHRs will often charge significant interface fees to allow their systems to work with other systems. Further, the process for using the interface is extremely labor intensive.

The GR Committee discussed how many EHR vendors also charge huge transfer fees when practices switch to a different vendor. ONC mentioned that it cannot intervene on contracts signed between providers and vendors. However, ONC is trying to help providers understand contracts and negotiate these provisions on their own. ONC's Health IT Playbook is an example of an educational resource ONC developed for this purpose.

The HBMA representatives pointed out that education can only go so far because current law places the incentive on the provider to have an EHR, meaning the EHR vendors have leverage in contract negotiations. It was further noted that there is little to no government enforcement of these rules and no business incentive for EHR companies to follow the standards.

Enforcement of Administrative Simplification policies has been a key part of the HBMA Government Relations Committee's 2018 Strategic Plan. There is little government enforcement of HIPAA electronic transaction standards and rarely any financial penalties associated with infractions – especially compared to how the HHS Office of Civil Rights (OCR) enforces HIPAA privacy and security violations.

ONC has heard similar concerns about interoperability and information blocking from other stakeholders. However, ONC had not heard much from stakeholders about administrative

simplification. This is probably because ONC does not have direct authority over HIPAA Administrative Simplification. This authority lies with CMS.

HBMA suggested that ONC – and HHS as a whole – should stop looking at interoperability and administrative simplification as separate issues. Both are directly related to each other in that the root of both issues is a lack of standards and enforcement of those standards. The Committee expressed its belief that HHS can and should play an active role in developing and enforcing standards.

ONC was interested in this idea and asked HBMA to propose an approach for addressing these two issues as a single topic. The GR Committee is in the process of developing written feedback to ONC on how to combine these issues into one.

ONC leaders also mentioned that the 21st Century Cures Act gave HHS the authority to levy fines of up to $1 million per infraction with regard to EHRs such as information blocking. ONC is actively working on reducing information blocking and will introduce a proposed rule for how it will police such activity. However, the information blocking proposed rule has not yet been promulgated so no fines have been levied under this authority. ONC does not know when the proposed rule will be issued. The HHS Office of Inspector General (OIG) will publicly report the issuing of fines under this authority.

Finally, the Committee discussed how EHRs are placing a financial burden on RCM companies by charging them to access certain data. It was pointed out that it does not make sense that RCM companies, who are HIPAA Business Associates (BA) of the practice, are charged by the EHR companies to access information that the practice itself entered into the EHR.

ONC was also very interested in formal written comments with proposed solutions to the issues the Committee highlighted on the call. ONC asked for specific examples of issues HBMA members are addressing for their clients. ONC also offered to help direct those problems to the appropriate staff in HHS where appropriate.

The GR Committee is in the process of writing a response to ONC and will publicize this document to the HBMA membership once it is finalized and submitted to ONC.

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Congress Passes FY 2018 Omnibus Appropriations Bill

Shortly before the March 23rd expiration of the short-term Continuing Resolution (CR) which kept the federal government funded since February, Congress passed a $1.3 trillion omnibus appropriations bill which funds the federal government for the remainder of the 2018 fiscal year (September 30, 2018).

This bill is the product of weeks of intense negotiations by both parties in both the House and Senate. The $1.3 trillion package reflects the new spending caps adopted as part of the bipartisan budget agreement that was passed by Congress last month.

The omnibus boosts funding for many HHS agencies and initiatives. The Centers for Medicare and Medicaid Services (CMS) received a $56.7 billion increase and the National Institutes of Health (NIH) received a $3 billion increase.

To help offset the cost of this spending bill, Congress extended budget sequestration from FY 2025 until FY 2027. This extends the two percent cuts to mandatory spending, including Medicare reimbursements, to providers for two additional years.

The bill provides funding across HHS to address the opioid crisis – a key priority of both Congress and the Administration for 2018. The bill provides $1 billion in State Opioid Response grants and $500 million for NIH to fund research on opioid addiction.

Despite many important initiatives such as the opioid crisis making it into the bill, notably absent from the bill is a bipartisan Affordable Care Act (ACA) stabilization bill sponsored by Sen. Lamar Alexander (R-TN) and Sen. Patty Murray (D-WA). Republicans eliminated the individual mandate penalty in the tax reform bill but the ACA otherwise remains intact and is still the law of the land.

The lack of an individual mandate penalty will allow healthy people who do not feel they need insurance to leave the market at no cost; leaving only the sickest (and more expensive) consumers in the market. This will also make participating in the exchanges much less attractive to insurers. This will likely lead to fewer choices and increased premiums for the plans that are sold in 2019.

The GOP remains committed to repealing and replacing the ACA but it is becoming less and less likely that they will make a new attempt in 2018. Assuming the ACA is successfully repealed and replaced, there would almost certainly be a transition period for stakeholders to prepare for the change in which the ACA would remain the law of the land before the replacement takes effect. This means that no matter what Congress chooses to do, the ACA will likely continue to exist for at least the 2019 plan year.

Should the make-up of the Congress change as a result of the 2018 elections, then the future of the ACA will either be more in doubt – or less secure.

The stabilization bill would authorize funding for the cost sharing subsidies (CSR) for three years and fund a $30 billion reinsurance program for three years.

The Administration stopped making CSR payments to insurers until Congress appropriates the money for these payments. Beginning with the Obama Administration, the Administration repurposed money within the Department of Health and Human Services (HHS) to make the

CSR payments. A lawsuit brought against the Obama Administration by the Republican-led House of Representatives resulted in a ruling that the administration did not have the authority to make the CSR payments. The Trump Administration therefore stopped making the CSR payments to insurers pending Congressional authorization. Insurers anticipated this happening and raised premiums in 2018 to help offset the lack of CSR payments.

The bill's proposal to restore CSR payments to insurers along with funding an invisible high-risk pool at $10 billion a year for three years would help lower premiums on the exchanges by as much as 40 percent, according to the bill's sponsors. States would also be granted a greater ability to use the waiver process to exempt themselves form certain ACA requirements.

Despite being excluded from the omnibus, there is still a chance Congress considers an ACA stabilization bill this year however it is unclear how much support the bill has in either Chamber. It is also unlikely that Congress votes on this bill as a standalone measure. Now that Congress has passed a government funding bill for the remainder of the fiscal year, there are fewer must-pass bills that could serve as a legislative vehicle for an ACA stabilization bill.

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CMS Announces New Patient Data Initiatives

The Centers for Medicare & Medicaid Services (CMS) has announced two new initiatives that are intended to give patients greater control over their health data. These initiatives are the Blue Button 2.0 and MyHealthEData. The purpose of these projects is to empower patients by giving them more control of their healthcare data, and make it easier for the data to follow them through their healthcare journey.

This government-wide initiative is led by the White House Office of American Innovation with participation from the Department of Health and Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS), the Office of the National Coordinator for Health Information Technology (ONC), and the National Institutes of Health (NIH). The Department of Veterans Affairs (VA) will also be a key contributor to this effort.

According to a CMS press release, the MyHealthEData initiative is designed to empower patients around a common aim - giving every American control of their medical data. CMS believes MyHealthEData will help break down the barriers that prevent patients from having electronic access and true control of their own health records from the device or application of their choice.

When completed, patients will be able to control their health data, allowing them to share personal health information with trusted partners, such as their doctors and hospitals. Some believe this could lead to greater competition and reducing costs. Proponents of this initiative hope that this will put the patient at the center of the healthcare system.

Blue Button 2.0 will be a secure way for Medicare beneficiaries to access and share their personal health data in a universal digital format. Blue Button 2.0 is the newest iteration of the Blue Button initiative started during the Obama Administration.

This will enable patients who participate in the traditional Medicare program to connect their claims data to the secure applications, providers, services, and research programs they trust. It will also allow a patient to access and share their healthcare information, previous prescriptions, treatments, and procedures with a new doctor which can lead to less duplication in testing and provide continuity of care.

According to CMS, more than 100 organizations, including some of the most notable names in technological innovation, have signed on to use Medicare's Blue Button 2.0 to develop applications that will provide innovative new tools to help these patients manage their health. To learn more about the MyHealthEData and Blue Button 2.0, please read the fact sheet CMS has developed for these initiatives.

Although few details were forthcoming in this announcement, according to the CMS fact sheet, this initiative will also streamline Medicare documentation and billing requirements ensuring that clinicians will spend less time inputting codes and information into EHR systems, and more time with their patients.

The HBMA Government Relations Committee will be monitoring this initiative closely and will be scheduling meetings with CMS staff involved in this program when the Committee makes its annual visit with CMS officials in June.

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MedPAC Recommends Eliminating MIPS but Congress is Unlikely to Act on Proposal in 2018

In its March Report to Congress, the Medicare Payment Advisory Commission (MedPAC) formally recommended that Congress should repeal and replace the Merit-based Incentive Payment System (MIPS). The Commission voted 14-2 (with one abstention) to include this recommendation in the report.

The MedPAC recommendation left many MIPS-eligible clinicians (EC) wondering about the long-term viability of the program. While MedPAC's recommendations are influential, it is unlikely that Congress will act to replace the MIPS program – at least for the next few years.

MedPAC provides two primary reasons for disliking MIPS:

1. It does not meaningfully measure for quality, and
2. It is overly burdensome on providers to the point where the administrative burden cost outweighs the potential financial savings of the program.

Most ECs would likely agree with MedPAC's assessment of the program.

MedPAC is recommending that Congress replaces MIPS with a new "Voluntary Value Program" (VVP) that would automatically withhold a percentage of every provider's Medicare fee-for-service (FFS) payments each year. Providers would join together to form reporting groups and would be measured as a group on a small set of population health measures for which data would be automatically collected through claims. Providers could earn back their withheld amount and potentially earn a bonus payment based on their group's performance. Unlike MIPS, this program would not be budget neutral although it would be designed to be as close to budget neutral as possible.

MedPAC's true goal is to drive providers towards Advanced Alternative Payment Model (Advanced APM). As is the case with MIPS, the VVP is intended to be less-attractive to clinicians than Advanced APMs because Advanced APMs would have a higher potential for positive payment adjustments than the VVP. Providers who participate in Advanced APMs would automatically earn back their withheld amount.

The Commission's recommendations are more of a framework rather than a fully formed policy proposal. Almost every Commissioner supports the framework of the VVP although they acknowledge that many of the details for the VVP still need to be finalized. MedPAC still needs to agree on which population health measures it will use, the criteria for forming a participation group, what percentage of FFS payments will be withheld, what are the potential positive payment adjustments beyond earning back the withheld amount under the VVP, will the measures be risk adjusted, etc.

Despite overwhelming support among the Commissioners, a similar level of support has yet to emerge in Congress. Therefore it seems unlikely that there will be a serious attempt by Congress to adopt this recommendation this year. The law that created MIPS, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), was passed with significant bipartisan support which it still enjoys in Congress.

Some of the lawmakers who supported MACRA have taken issue with how the Centers for Medicare and Medicaid Services (CMS) has implemented certain parts of the statute. However their concerns are matters that can be fixed and do not require Congress to tear everything down and start from scratch.

In response to the concerns expressed by the provider community, Congress granted CMS additional flexibilities to implement MIPS in the 2018 budget deal that was passed in February.

For example, Congress is allowing CMS the authority to set the MIPS performance threshold for the first five reporting years of MIPS. CMS only had the authority to set the performance threshold for the first two reporting years. Beginning in year three, CMS would be required to

use either the mean or median MIPS composite performance score (CPS) as the performance threshold. This would likely be much higher than the 2018 performance threshold of 15 points.

Congress is still requiring CMS to raise the threshold each year but CMS can now increase the performance threshold much more gradually which will make participation much easier for eligible clinicians.

Clinicians who score below the performance threshold are subject to the MIPS negative payment adjustments which will be a five percent downward adjustment for payments in 2020 based on 2018 reporting. CMS used the low-volume provider threshold to exempt almost half of all eligible clinicians from MIPS.

Congress has also given CMS further discretion on how to weight the Resource Use (cost) category. The original statute required CMS to weight Resource Use as 30 percent of a clinician's CPS beginning with the third reporting year. This category was weighted at 0 percent in the first reporting year and 10 percent in the second. 30 percent would be a significant increase in weighting. CMS now has the ability to weight Resource Use at less than 30 percent in year three and additional years.

Congress is unlikely to make changes to MIPS unless they hear from a significant number of ECs who are facing negative payment adjustments. CMS is already shielding many ECs from negative payment adjustments through the low-volume provider exemption threshold and by setting a relatively achievable benchmark MIPS Composite Performance Score (CPS) for both the 2017 and 2018 reporting years. Between CMS' ability to shield providers using the low-volume provider exemption and its newly granted flexibility to implement MIPS, most providers should be able to avoid negative payment adjustments under MIPS. It is therefore unlikely that Congress hears enough complaints from the provider community to act on MedPAC's recommendations.

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CMS Holds Listening Session on Updating Evaluation and Management Guidelines

In the 2018 Medicare Physician Fee Schedule (PFS) proposed rule, the Centers for Medicare and Medicaid Services (CMS) indicated that it would like to update the two guideline documents that are used to help providers understand and appropriately use evaluation and management (E/M) codes. CMS ultimately did not take any action in the final rule, instead stating that it would solicit stakeholder feedback before attempting to update the E/M guidelines.

As part of this effort, on March 21st, CMS held a stakeholder listening session during which CMS posed six broad questions/topics for stakeholders to respond to with feedback and suggestions. The call was hosted by Marge Watchorn, Deputy Director of CMS' Division of Practitioner Services.

The topics CMS requested feedback on were:

1. Broadly, ways to reduce burden associated with documentation of patient E/M visits.
2. Other payer approaches to E/M visit payment and documentation.
3. Role of each currently required item (history, physical exam, and medical decision-making).
4. Addressing documentation through changes to the underlying E/M code set itself.
5. Duplicative data entry regarding visits in the medical record.
6. Specialty-specific changes.

In general, the stakeholders recommended that CMS reduce some of the documentation requirements such as requiring a medical history with each claim. To be clear, the stakeholders who responded did not recommend eliminating medical history. Their point was that some of the medical history requirements are redundant and overly time consuming. For example, electronic health records (EHR) make it easier to maintain and access medical history information.

Another widely-supported recommendation was for greater consistency in coding and documentation requirements across payers. There are already too many gray areas within each payer not to mention the inconsistencies that exist across each payer.

Other recommendations that were made by individual stakeholders but not supported (or opposed) by others included combining E/M levels four and five and to reduce the number of E/M codes from five codes to three. Another recommendation was to provide greater E/M reimbursements for providers who address multiple chronic conditions in one visit.

Lastly, one stakeholder mentioned that CMS' policies with regard to E/M guidelines can affect specialties that rarely bill Medicare such as pediatrics. This stakeholder asked CMS to consider the effect revisions to the E/M guidelines will have on specialties that do not often bill Medicare.

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Reminder: CMS Will Begin Issuing New Medicare Cards to Beneficiaries in April

Beginning in April, CMS started mailing newly-designed Medicare cards with the new Medicare Beneficiary Identifier (MBI) to beneficiaries in pre-selected states and U.S. Territories. These new cards will replace the old cards that use the beneficiary's Social Security Number (SSN) as their identification number, which is also referred to as the Health Insurance Claim Number (HICN).

CMS has several resources on its website for this effort, called the Social Security Number Removal Initiative (SSNRI) including a "landing page" for providers.

The SSNRI was required by Congress in the Medicare Access and CHIP Reauthorization Act of 2015. The motivation behind the new MBI is to reduce fraud and identity theft by taking the

beneficiary's SSN off of their Medicare card. However, scammers have been using the transition as a new scam opportunity, prompting the Federal Trade Commission (FTC) to issue an alert to help beneficiaries avoid these scams. According to the FTC, scammers are calling Medicare beneficiaries to try to charge them for their new card and asking for their personal information for where to send their card.

CMS will accept claims with either an MBI or a HICN through a transition period which begins in April with issuance of the new cards and ends on December 31, 2019. Beginning on January 1, 2020, CMS will only accept claims with the MBI.

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MedPAC Analysis: Physician Payment Rates and Access to Care are "Adequate"

In its annual March Report to Congress, the Medicare Payment Advisory Committee (MedPAC), reports on an analysis of Medicare fee-for-service (FFS) payments they conducted to determine if Medicare payment rates are adequate and if payment rates are affecting access to care for beneficiaries.

MedPAC is an independent, non-partisan agency of Congress established to provide research, analysis and policy recommendations on Medicare payment policy. The March Report is the first of their two annual reports to Congress with their formal recommendations of changes Congress should make to Medicare payment policy. Congress is not required to act on MedPAC's recommendations.

According to MedPAC, Medicare FFS payments for 2018 are adequate, and MedPAC has not observed a significant change from prior years. The report also found that access to "timely, appropriate care" was adequate however some challenges exist.

Beneficiaries reported that overall, they had an easier time accessing care under Medicare than private insurance, but under Medicare, specialty care was easier to access than primary care. Minorities also have reported a more difficult time accessing care as well as higher rates of foregoing care. There was also no reported difference in access to care in rural versus urban areas.

According to a MedPAC phone survey, 88 percent of Medicare beneficiaries reported that they were very or somewhat satisfied with their care compared with 82 percent reported by beneficiaries who had private Medicare coverage (Medicare Advantage). These results are consistent with past years.

Medicare enrollment has been increasing over the past several years. MedPAC has found that the supply of health professionals who are billing Medicare has increased at an appropriate pace to provide access to care for this growing Medicare population.

It was difficult for MedPAC to measure changes in volume for specific services because of an observed shift in site-of-service for many Medicare services. Many services are shifting away from hospitals and towards free-standing and outpatient facilities.

One issue highlighted in the report was the growth of low-value care in Medicare FFS. According to MedPAC, "low-value" is defined as care where there is little-to-no health benefits but a greater health risk.

However, MedPAC criticized many of the measures used to help assess quality and value of care. MedPAC does not believe the existing quality measure set in the Physician Quality Reporting System (PQRS) or the Merit-based Incentive Payment System (MIPS) actually measures for quality of care because most measures are process-based rather than outcomes-based. MedPAC favors a quality measurement program built around population health measures.

MedPAC's recommended update for physicians and health services attempted to balance three main factors: maintain beneficiary access to care, minimize the burden on taxpayers and beneficiaries who finance the program, and ensure adequate payments for the efficient provision of services.

With these considerations in mind, the Commission recommended Congress maintains scheduled payment increases under current law. It should be noted that Congress reduced a 0.5 percent payment update instituted under the Medicare Access and CHIP Reauthorization Act (MACRA) to 0.25 percent under the budget bill that was passed in February.

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Administration Releases Initial 2018 ACA Enrollment Report

According to an April 3rd announcement from the Centers for Medicare and Medicaid Services (CMS), 11.8 million consumers were enrolled, or re-enrolled in an exchange plan during the 2018 open enrollment period for the individual and small group markets created under the Affordable Care Act (ACA). The 39 states using healthcare.gov accounted for 8.7 million of the enrollees, while state-based exchanges made up 3 million of the enrollees.

While this number shrunk from 12.8 million in 2017, the 2018 enrollment period was shorter than the previous year and there was a much lighter push to market open enrollment than the previous year. However, CMS views this enrollment figure as an increase in efficiency for its enrollment program. In 2017, CMS spent on average, $11 per enrollee for marketing and outreach, compared to the $1 spent per enrollee this year while maintaining similar enrollment rates.

Twenty-seven percent of the enrollees were new customers, with the rest re-enrolling in a plan from the previous year. Data from the Federal Health Insurance Exchange call center shows that

the consumer satisfaction rate increased to 90 percent. The consumer satisfaction rate was 85 percent in 2017.

The enrollment report found that premiums continued to grow, averaging $621 in 2018 which is a significant increase from the $476 reported for the previous year. Eighty-three percent of enrollees had some of their premiums reduced by federal premium assistance tax credits. The 2018 average tax credit was equal to 86 percent of premiums, resulting in an average premium of $89 a month.

The number of those enrolled in exchange plans is expected to decrease over the course of the year. Every enrollment year has seen a decrease in the number of consumers who maintained coverage throughout the entirety of the plan year.

In addition, the Trump Administration is offering several alternatives for consumers to purchase health insurance coverage. The administration recently issued proposed rules for expanding short-term limited-duration insurance (STLDI) plans. It also proposed a rule that would allow associations to offer health plans to their members similar to how an employer offers coverage for their employees.

Congress eliminated the individual mandate penalty beginning with the 2019 plan year. Rising premiums, fewer plans participating on the exchanges and alternatives to the exchanges in the form of association health plans and STLDIs will likely lead to another enrollment decrease in 2019.

Congress is considering several legislative proposals to help stabilize the ACA markets. Most of these proposals rely on a federally subsidized reinsurance program and expanding state innovation waiver authorities which allow states to be exempt from several ACA requirements. These proposals could help reduce premiums and mitigate at least some of the projected enrollment decrease.

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CMS Will Automatically Reprocess Claims Impacted By Bipartisan Budget Act of 2018

On February 9th, Congress passed the Bipartisan Budget Act of 2018, which contains provisions that extend certain Medicare Fee-For-Service (FFS) policies. These provisions include:

- Extending the ambulance add-on payment.
- Extending the Work Geographic Practice Cost Index Floor.
- Extending the three percent Home Health Rural Add-on Payment.
- Eliminating Medicare therapy caps while still requiring the appropriate modifier.

Due to the retroactive effective dates of these provisions, each Medicare Administrative Contractor (MAC) will automatically reprocess Medicare FFS claims impacted by this legislation. Providers do not need to take any action.

MACs are reprocessing CY 2018 outpatient therapy cap claims, which contain the KX modifier for services in excess of the prior cap amounts. Additional information is available via MLN Matters® Article #10531.

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House Health Subcommittee Holds Hearing on MACRA and Physician Payments

On March 21st, the House Ways and Means Committee's Subcommittee on Health held a hearing on the implantation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and how it is impacting physician payments. MACRA repealed the Medicare Sustainable Growth Rate Formula (SGR) and replaced it with the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (Advanced APM) program. MACRA also included many other policies such as requiring CMS to replace the Social Security Number (SSN) as the Medicare beneficiary number on Medicare Cards.

The Committee heard testimony from two witnesses, Demetrious Kouzoukas, Deputy Administrator of the Centers for Medicare and Medicaid Services (CMS) and Kate Goodrich, Chief Medical Officer at CMS.

After the witnesses presented their testimony, the Committee Members were provided an opportunity to ask them questions related to the topic of MACRA and physician payments. The questions were, for the most part, broad and conceptual and generally did not take a deep dive into the weeds of MIPS and APMs.

Among the important takeaways from the hearing is that the witnesses reaffirmed CMS' commitment to the transition to value-based healthcare. MIPS and APMs will be a major part of this transition. A common theme throughout the hearing was the Committee's desire to see private innovation in healthcare as a main driver towards value-based system. These Committee Members do not think that CMS should be driving this transition alone and see the private sector as an important player in this effort.

The Committee asked if the Trump Administration shares the Obama Administration's goals goal for 50 percent of all healthcare to be delivered under a value-based payment system by the end of 2018. The witnesses expressed a commitment to the broad goal of transitioning to value-based but they would not commit to the 50 percent number.

The Committee also asked about how CMS is providing flexibility for physicians with regard to data reporting under MIPS. Deputy Administrator Kouzoukas cited two past provisions, the

increase to the low volume thresholds, and virtual groups, as steps that have been taken to decrease the burden of reporting, especially on physicians who care for underserved populations.

CMS intends to provide additional flexibilities in the 2019 reporting year such as allowing multiple reporting mechanisms to be used within each of the four MIPS reporting categories. The Committee also wanted to know what CMS is doing to make it more feasible for physician led groups of all sizes to participate in Advanced APM that require downside risk. Deputy Administrator Kouzoukas responded that the creation of more APMs and a greater variety of options would eventually lead to greater participation in two-sided risk models.

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Cigna Acquiring Express Scripts

On March 8th, Cigna announced that it is acquiring Express Scripts for $67 billion. The acquisition is expected to be finalized by the end of the year. Cigna, a health insurance company, and Express Scripts, a pharmacy benefit manager (PBM), will combine to offer "a full suite of medical, behavioral, specialty pharmacy and other health engagement services."

The stated goal of the merger is to drive greater choice and align each company's respective skills to provide a streamlined healthcare approach.

This merger is subject to regulatory approval. Cigna had previously attempted a merger with fellow insurance giant, Anthem, but that deal was blocked by regulators.

Cigna's acquisition of a PBM does not necessarily raise the same anti-competitive red flags as its attempted vertical deal with Anthem. However, these are two very large companies and it will be interesting to see how regulators approach this merger.

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Arkansas Becomes Third State to Implement Medicaid Work Requirements

Arkansas is joining Kentucky and Indiana as the first states that will implement a work requirement for able bodied, working age recipients of Medicaid. In January, the Trump Administration provided states with increased authority to use Section 1115 Waivers to implement Medicaid work requirements among other healthcare system reforms.

Approximately 22 percent of Arkansas' population are Medicaid beneficiaries. The work requirement program will require that people of working age (but below 50 years old) provide documentation that proves they are working, or doing related activities to find work if they are unemployed. Medicaid beneficiaries who are disabled, full-time students, care-takers, pregnant, or in a rehabilitation program are exempt from the requirements.

The goal of the work requirement initiative is to increase the personal responsibility for beneficiaries enrolled in the Medicaid program.

Critics of the policy claim that most people who are on Medicaid already work, and all it is doing is creating unnecessary red tape for participants to go through.

The National Health Law Program has already filed a legal challenge to Kentucky's work requirements. A similar suit is expected in Arkansas. It remains to be seen if other states will exercise this authority to implement similar work requirements.

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CMS Transmittals

Transmittal Number	Subject	Effective Date
3968CP	Consumer Friendly Spanish Descriptors for the Current Procedural Terminology (CPT) / Level 1 Healthcare Common Procedure Coding System (HCPCS) Codes and a Correction to the Part A Spanish Medicare Summary Notices (MSNs)	2018-07-02
R785PI		2018-05-07
R4017CP	Increased Ambulance Payment Reduction for Non-Emergency Basic Life Support (BLS) Transports to and from Renal Dialysis Facilities	2018-10-01
R4018CP	New Waived Tests	2018-07-02
R2051OTN	Claims Processing Actions to Implement Certain Provisions of the Bipartisan Budget Act of 2018	2018-04-02
R2050OTN	Modifications to the Implementation of the Paperwork (PWK) Segment of the Electronic Submission of Medical Documentation (esMD) System	2018-07-02
R206NCD	Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)	N/A
R4016CP	Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)	N/A
R784PI	Reviewing for Adverse Legal Actions (ALA)	2018-04-30
R783PI	Proof of Delivery Exceptions for Immunosuppressant Drugs Paid Under the Durable Medical Equipment (DME) Benefit	2018-04-30
R782PI	Update to Chapter 15 of Publication 100-08 - Medicare Enrollment Deactivation Policies	2018-04-30
R4011CP	Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN)	2018-04-30

R4013CP	Institutional Billing for No Cost Items	2018-06-29
R2049OTN	National Supplier Clearinghouse (NSC) Numbers Shortage for Walgreen TIN	2018-04-02
R4014CP	Revised and New Modifiers for Oxygen Flow Rate	2018-04-02
R302FM	Removal of Contractor Reporting Requirements for the Physician Scarcity Area (PSA), the Health Professional Shortage Area Surgical Incentive Payment Program (HSIP) and the Primary Care Payment Incentive Program (PCIP) Quarterly Reports	2018-07-02
SE18001	Proper Coding for Specimen Validity Testing Billed in Combination with Drug Testing	
R4010CP	Revisions to Medicare Claims Processing Manual for End Stage Renal Disease	2018-06-26
R4009CP	Update to the Internet Only Manual (IOM) Publication 100-04 - Medicare Claims Processing Manual, Chapter 27 - Contractor Instructions for Common Working File (CWF)	2018-04-23
R4008CP	Notification of Change in Instructions for Handling IRF Active Provider List	2018-04-23
R2048OTN	Fiscal Intermediary Shared System (FISS) Internal Crosswalk Modification	2018-07-22
R4007CP	Consumer Friendly Spanish Descriptors for the Current Procedural Terminology (CPT) / Level 1 Healthcare Common Procedure Coding System (HCPCS) Codes and a Correction to the Part A Spanish Medicare Summary Notices (MSNs)	2018-07-02
R4004CP	April Quarterly Update for 2018 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule	2018-04-02
R4006CP	April 2018 Integrated Outpatient Code Editor (I/OCE) Specifications Version 19.1	2018-04-02
R4005CP	April 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS)	2018-04-02
R2047OTN	Claims Processing Actions to Implement Certain Provisions of the Bipartisan Budget Act of 2018	2018-04-02
R301FM	The Fiscal Year 2018 Updates for the Centers for Medicare and Medicaid Services (CMS) Internet Only Manual (IOM) 100-06 The Medicare Financial Management Manual, Chapter 7 - Internal Control Requirements	2018-06-19
R114GI	Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF) (2018)	2018-06-19
R242BP	Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF) (2018)	2018-06-19

R4001CP	Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF) (2018)	2018-06-19
R780PI		2018-05-16
R14P240	Provider Reimbursement Manual Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Form CMS-2552-10	2018-03-16
R300FM	The Fiscal Year 2018 Updates for the Centers for Medicare and Medicaid Services (CMS) Internet Only Manual (IOM) 100-06 The Medicare Financial Management Manual, Chapter 7 - Internal Control Requirements	2018-06-19
R4000CP	Internet Only Manual Update to Pub 100-04, Chapter 16, Section 40.8 - Date of Service Policy	2018-07-02
R18P232	Medicare Provider Reimbursement Manual - Part 2, Provider Cost Reporting Forms and Instructions, Chapter 32, Form CMS-1728-94	2018-03-16
R778PI	Updates to Payment Suspension Notice	2018-05-16
R2042OTN	Adjustments to Qualified Medicare Beneficiary (QMB) Claims Processed Under CR 9911	2018-12-11
R2043OTN	The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2016 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCH)	2018-04-16
R2044OTN	National Correct Coding Initiative (NCCI) Add-on Codes for Non-Outpatient Prospective Payment System (OPPS) Institutional Providers Implementation	2018-04-02
R2045OTN	Identifying and Eliminating Discrepancies in Shared System Enrollment Data and Provider Enrollment Chain and Ownership System (PECOS) Data	2018-07-02
R3999CP	Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment	2018-04-02
R2041OTN	Redesign of Flu Vaccines in Fiscal Intermediary Shared System (FISS)	N/A
R8P241	Medicare Provider Reimbursement Manual Part 2, Provider Cost Reporting Forms and Instructions, Chapter 41, Form CMS-2540-10	2018-03-09
R2P244	Medicare Provider Reimbursement Manual Part 2, Provider Cost Reporting Forms and Instructions, Chapter 44, Form CMS-224-14	2018-03-09
R3996CP	April 2018 Update of the Ambulatory Surgical Center (ASC) Payment System	2018-04-02

R3994CP	April Quarterly Update for 2018 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule	2018-04-02
R3995CP	Correction to Pub. 100-04, Chapter 5	2018-06-11
R3998CP	File Conversions Related to the Spanish Translation of the Healthcare Common Procedure Coding System (HCPCS) Descriptions	2018-02-05
R3997CP	Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - April 2018 Update	2018-04-02
R3993CP	Reinstating the Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System from CR 9911	2018-03-06
R774PI	Comprehensive Error Rate Testing (CERT) Program Dispute Process	2018-03-19
R3985CP	Instructions for Downloading the Medicare ZIP Code File for July 2018	2018-07-02
R2040OTN	Appropriate Use Criteria for Advanced Diagnostic Imaging – Voluntary Participation and Reporting Period - Claims Processing Requirements – HCPCS Modifier QQ	2018-07-02
R3989CP	April 2018 Integrated Outpatient Code Editor (I/OCE) Specifications Version 19.1	2018-04-02
R3988CP	April 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS)	2018-04-02
R3987CP	Indian Health Services (IHS) Hospital Payment Rates for Calendar Year 2018	2018-04-02
R205NCD	Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)	2018-07-02
R3992CP	Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)	2018-07-02
R3990CP	Diagnosis Code Update for Add-on Payments for Blood Clotting Factor Administered to Hemophilia Inpatients	2018-07-02

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