Washington Report – March, 2012

MedPAC Releases 2012 Recommendations

The Medicare Payment Advisory Commission (MedPAC) is an independent Congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. Historically, many of MedPACs recommendations find their way into law or regulation.

On March 12th, the Commission released its annual review of the Medicare program to Congress. The report, entitled, "Medicare Payment Policy", provides Congress with a review of the current Medicare payment policies and their recommendations regarding the fee-for-service payments for 2013. MedPAC's recommendations are based on an assessment of payment adequacy for each sector of the healthcare delivery system.

In regards to physicians and other health professionals, the Commission's recommendation is a classic good news/bad news conundrum. The good news is that the Commission recommends that Congress repeal the sustainable growth rate (SGR) formula. The bad news is that in lieu of the SGR, MedPAC recommends a 10 year freeze in the Medicare Conversion Factor (CF) for primary care and a nearly 18% reduction in the CF for non-primary care over the next three years, followed by a seven-year freeze in the CF.

The Commission made the following specific recommendations to Congress:

- The Congress should repeal the sustainable growth rate (SGR) system and replace it with a 10-year path of statutory fee-schedule updates. Specifically, the Commission recommends a 10 year freeze in current Medicare Fee Schedule Conversion Factor for primary care services. This would lock-in the Conversion Factor at $33.98 for primary care services. For all other services, MedPAC proposes annual payment reductions of 5.9 percent per year for three years, followed by a freeze. This would result in a CF of $28.34 for non-primary care after the three years of reductions.

- MedPAC recommends that Congress direct the Secretary of Health and Human Services to reduce payment rates for evaluation and management office visits provided in hospital outpatient departments so that total payment rates for these visits are the same whether the service is provided in an outpatient department or a physician's office.

- The Congress should direct the Secretary to regularly collect data – including service volume and work time – to establish more accurate work and practice expense values.

- The Congress should direct the Secretary to identify overpriced fee-schedule services and reduce their relative value units (RVUs) accordingly.

- Under the 10-year update path, the Congress should direct the Secretary to increase the shared savings opportunities for physicians and health professionals who join or lead two-sided risk Accountable Care Organizations (ACOs). The Secretary should compute spending benchmarks for these ACOs using 2011 fee-schedule rates.

Repealing the scheduled SGR cuts would result in an increase in Medicare expenditures over the next 10 years of approximately $300 Billion. Freezing the primary care CF, or reducing and then freezing the non-primary care CF as recommended by MedPAC, would not offset the full cost repealing the SGR. The repeal/replace approach described by MedPAC would reduce outlays by about $100 Billion over 10 years, leaving an additional $200 billion in cuts necessary to fully pay for the SGR repeal.

MedPAC offered a list of options for the Congress to consider if it decides to offset the cost of repealing the SGR system within the Medicare program. As you will note, the options are drawn from a variety of provider types, not just physicians. Some of the offset options are:

MedPAC Options	10-year savings (Billions)
Co-payment for home health	$4
Hospital update of 1% (instead of projected update)	$14
Competitive Bidding for DME	$7
Rebase Home Health Payments and subsequent freeze	$10
Require Manufacturers to provide	$75

Medicaid-level rebates for dual eligibles	
Impose excise tax on Medigap plans	$12
Reduce clinical lab payments by 10%	$10
Rebase SNF payments	$23
Part D cost-sharing to encourage generic substitution	$17
Total savings if all were enacted	**$172 Billion**

The savings options offered by MedPac to Congress must be limited to the Medicare program. However, the Commission suggests that Congress look outside the Medicare program for additional offsets.

The entire list of Medicare offset options identified by MedPAC can be found on page 400 of the report.
Return To Top

Ways and Means Committee Announces Release of the Green Book

Beginning in 1981, long before it was fashionable to refer to something as "green" to convey environmental sensitivity, the House Ways and Means Committee began producing a document referred to as the Green Book. Officially titled "Background Material and Data on the Programs within the Jurisdiction of the Committee on Ways and Means," the Green Book, is a compilation of key health, welfare, retirement, and related programs under the jurisdiction of the Committee on Ways and Means (Social Security, Medicare, Welfare, Unemployment Insurance, etc.). The book also contains data and a discussion on issues within the jurisdiction of the Ways and Means Committee, including federal policy affecting low-income households, non-citizen eligibility for federal benefit programs, and social welfare programs. There is a chapter dedicated to the Medicare Program that provides a tremendous amount of historical information about the program, along with data about expenditures based upon provider type.

Because the report is prepared by the non-partisan Congressional Research Service (CRS) the Green Book has served as a valuable reference for legislators and the public since it was first published in 1981.

In releasing the latest version of the Green Book, Ways and Means Chairman Dave Camp (R-MI) said, "I am proud to announce the release of this latest version of the Ways and Means 'Green Book,' which has helped policymakers and the public better understand the background and impact of U.S. social policy for over three decades."

The latest version of the Green Book is only available electronically.

According to a press release issued by the Ways and Means Committee, "The release of this version, which is technically the 2011 Green Book since work on its chapters was largely completed last fall, has been delayed due to technical issues related to its publication on the Committee's website. It is expected that, beginning with this year, revised versions of the Green

Book will be available on a more frequent basis, significantly increasing its utility for readers."

Return To Top

Whither IPAB?

On March 22nd, the Republican-controlled House passed a bill (H.R. 4) to abolish the Independent Payment Advisory Board (IPAB) established as part of the Patient Protection and Affordable Care Act (ACA). Although the bill, was largely approved along partisan lines by a vote of 223 to 181 (most Republicans voted for repeal and most Democrats voted against), the bill did have some Democratic support and some GOP critics.

According to statements made on the floor of the House of Representatives just prior to the final vote, it appears that many who would have voted to repeal IPAB ended up voting against the measure because H.R. 4 also included Tort Reform proposals that many Democrats found objectionable. Typical of this view was Representative Allyson Y. Schwartz, (D-PA), a staunch critic of IPAB within the Democratic Caucus. In announcing her vote against H.R. 4, Representative Schwartz complained that Republicans had destroyed any hope of bipartisanship by "linking repeal of the board to tort reform."

It is considered highly unlikely that the Senate will follow the House and support the repeal of IPAB. However, should anything change and the Senate pass IPAB repeal legislation, the President has indicated that he would veto the bill. Based upon current vote counts, it does not appear that there would be sufficient votes to override a Presidential veto.

A White House spokesman reiterated the President's support for IPAB stating, "(IPAB) will help reduce the rate of Medicare cost growth responsibly while protecting beneficiaries."

Opponents of IPAB argue that the independent board has far too much power and effectively eviscerates Congressional authority to determine the future direction of the Medicare program. One oft heard phrase by IPAB opponents is, "if you like the SGR, you'll love IPAB."

How will IPAB work?

IPAB was modeled after the Independent Military Base Closure Commission established in the late '90s to facilitate the closure of military bases around the U.S. Although the Base Closure Commission's recommendations were technically advisory, the only way Congress could overturn a recommendation made by the Commission was to substitute another facility for the one identified by the Commission for closure.

Beginning with Calendar Year 2015, IPAB can make specific binding recommendations to reduce short-term and long-term Medicare spending. Whether recommendations will be binding or not depends upon the short-term and long-term fiscal outlook for the Medicare program. If the Board determines that the Medicare program is facing a budgetary shortfall (considered highly likely) then the Board's recommendations are binding.

The IPAB spending reduction recommendations will be sent to Congress by the Spring of each year. If Congress doesn't like the proposals, Congress can reject the IPAB proposal BUT, in rejecting the IPAB proposal, Congress must pass alternative cuts -- of the same size -- by August of that year.

If Congress fails to act, the Secretary of Health and Human Services is required to implement the cuts recommended by IPAB.

Who will serve on IPAB?

The Board will consist of 15 **full-time** members, and by law, most will not be health care providers. Individuals serving on the Board will be paid and will be prohibited from having any outside employment. Board members will serve six-year terms and based upon the current federal pay scale, are slated to be paid a salary of $165,300 per year.

Although all Board members will be appointed/selected by the President, 12 of the 15 Board members will come from names submitted by Congressional leaders from both parties in both houses. All Board Members must be confirmed by the Senate.

Many physicians are concerned that given the statutory restrictions on the types of recommendations the Board can make, physicians will bear the brunt of payment reductions expected from the Board because hospitals and nursing homes are exempted from IPAB's cost-cutting recommendations for several years.

Opponents of IPAB argue that the Board will have too much power

Supporters of IPAB maintain that the law bars the Board from rationing care, restricting benefits or changing eligibility criteria. While this assurance may be comforting to beneficiaries, it only adds to the anxiety of providers because it only serves to increase the likelihood that IPAB's recommendations will result in significant payment reductions for providers.

What if Medicare's projected spending doesn't exceed the targets?

It is always possible that Medicare spending won't exceed the targets and the Board won't be required to make any binding recommendations. IPAB supporters point to a Congressional Budget Office analysis that says that it is possible that Medicare spending will remain below the threshold for IPAB action in the early years. It should be noted, however, that this report assumes that the projected SGR cuts (>30% for CY 2013) will take effect.

Where to from here?

For the time being, IPAB appears safe from repeal. Should there be a change in who controls both houses of Congress after this Fall's elections as well as a change in who sits in the White House, things could look different. But given the current make-up in Congress and the President's stated support for IPAB, nothing will change in the near-term.

Return To Top

Health insurance rate hikes deemed excessive by HHS

HHS Secretary Kathleen Sebelius announced in mid-March that health insurance premium increases in nine States were "unreasonable" based upon a rate review conducted by the agency. Sebelius called upon the insurance companies cited for these unreasonable rate increases to voluntarily reduce their rate hike requests.
Under the Affordable Care Act, the Secretary is authorized to review any rate increase in excess of 10 percent to determine whether it is justified. Although the law authorizes the Secretary to conduct these rate hike reviews, the law does not give the Secretary any authority to do anything about rate hikes her agency deems "unreasonable."

In making the announcement, Secretary Sebelius also released a report stating that six months after HHS began reviewing proposed health insurance rate increases, health insurers have proposed fewer double-digit rate increases. The report is not able to determine, however, whether there is a cause and effect relationship between the rate review process and the fewer than expected double-digit rate increases or if other factors (such as a sluggish economy) affected rate hike requests by insurance companies.

For example, the HHS report highlights Nevada, a state whose economy has been particularly hard hit by the economic downturn, as a state in which health insurance premiums declined over the past year. Unfortunately, the report is unable to state whether the reduction in health insurance premiums was due to increased oversight and transparency or a reflection of the harsh economic times being experienced by the people of Nevada.

Insurers cited in the report said the higher rates were justified by rising medical costs in those markets.

Individuals interested in examining the HHS report or state and company specific information can go to the HHS website and review the rate review information available.

Return To Top

Supreme Court hears challenge to the Individual Mandate and Medicaid Expansion

The long-awaited Supreme Court review of the cases challenging the Constitutionality of two provisions of the ACA finally took place the week of March 26th.

The oral arguments are available for download. If you would like to listen to the deliberations, go to: http://www.supremecourt.gov/oral_arguments/argument_audio.aspx and click on any of the four sessions (titled either Department of Health and Human Services Vs. Florida or National Federation of Independent Businesses Vs. Sebelius or Florida Vs. Department of Health and Human Services).

There were four issues the Court considered over the three days of deliberations. The Court scheduled 4 oral arguments over three days (March 26th, 27th and 28th) with each session dedicated to one of the issues.

They are:

1. **Is a lawsuit challenging the Individual Mandate even permissible at this time because the "penalty" for failure to show evidence of having health insurance is a "tax" under federal law?**
2. **Is the Individual Mandate constitutional?**
3. **Is the Medicaid expansion an unreasonable encroachment by the federal government on state autonomy?**
4. **Are the Individual Mandate and Medicaid expansion provisions "severable" from the remainder of the law?**

A summary of the three days of Supreme Court proceedings on this issue is available for HBMA members to review.

Return To Top

What If the Supreme Court rules the Mandate Unconstitutional?

An obvious question in light of the Supreme Court hearing oral arguments on the Constitutionality of the individual mandate included in the Affordable Care Act is – What If? What if the court rules the individual mandate unconstitutional?

Legally there are various paths the Court could take if the individual mandate is ruled unconstitutional. Those are explored in the summary memo referenced in the previous article.

But beyond the legal issues associated with the Supreme Court's decision, there is the larger question of what this might mean for healthcare reform.

Would a determination by the Supreme Court that the individual mandate is unconstitutional, derail healthcare reform altogether?

In the narrow sense, the individual mandate is an attempt to ensure that more people purchase insurance thereby expanding the pool of insured individuals, and significantly decreasing the likelihood that people will show up at the hospital emergency room without any means of paying for the healthcare they will receive. It attempts to deal with what some view as flaws in the health insurance marketplace.

But the ACA is far more than the insurance reforms such as the individual and employer mandates, prohibitions on pre-existing conditions and community rating. Throughout the ACA are changes intended to encourage a redesign of how healthcare is delivered and paid for. While the individual mandate has received the lion's share of public attention, it may just be that the delivery system reforms encouraged by the ACA could have a longer lasting and more

significant impact on the future of healthcare in America than anything having to do with the mandate.

Delivery system reforms are not dependent on anything in the Affordable Care Act to survive. Indeed, many of the delivery system reforms encouraged by the ACA were already being undertaken in the private sector and the ACA merely served as a means of "legitimizing" or promoting some of the changes the marketplace was already embracing. Primary care medical homes; paying for quality, not volume; shifting from a payment system based upon discrete services rather than bundled payments; shifting financial risk from the payer to the provider, were all being tested in one or more markets around the country.

Arguably Medicare was lagging behind some of the private sector changes that were taking place and the ACA expanded the ability of CMS to test innovative care delivery models. But that authority would likely have been granted by Congress regardless of the passage or failure of the ACA. The ACA merely attempts to accelerate the pace of change; it did not require any changes in federal law to allow delivery system reforms to take place.

Opponents and supporters of the Patient Protection and Affordable Care Act have invested a great deal of political capital in the outcome of the Supreme Court's decision and there's no question that the decision could have a profound affect on the future role of the federal government as it relates to health insurance and government mandates. But in terms of reforming the healthcare delivery system, the marketplace will have more to say about what healthcare delivery will look like in the future, than will the scholarly legal opinions of the nine Justices that make up the Supreme Court.

Return To Top

Internists Form Group to Propose Payment Reforms

The Society of General Internal Medicine (SGIM) has announced plans to establish an independent commission to assess how physicians are paid, and how pay incentives are linked to patient care. Called The National Commission on Physician Payment Reform, the group plans to issue recommendations in 2013 on how to reform the physician payment system, "…in an effort to restrain health care costs while at the same time optimizing outcomes for patients."

According to the group's website, SGIM was founded in 1978 by a national group of academic general internists committed to promoting research and education aimed at improving healthcare for the whole patient. The organization has approximately 3,000 members.

In a press release announcing the group's formation, it states, "Physician payment issues and health care costs are at the forefront of discussion in health policy circles, in the halls of hospitals, and at home around the dinner table. Congress continues to grapple with adjusting the sustainable growth rate (SGR) that determines physician Medicare payment rate cuts, uncertainty continues to surround implementation of the Affordable Care Act, and physicians and policymakers alike agree the continued increases in cost to provide health care services cannot continue."

In assessing the reasons why healthcare costs continue to escalate at a rate far faster than the rest of the economy, the group has concluded:

1. The current fee-for-service system rewards doctors for quantity not quality. Physicians are paid more to perform more procedures and order more tests, instead of better overall care.
2. The lack of care coordination among providers. This results in duplication of services and tests, over-treatment, errors, and excessive administrative costs.
3. An increasing number of patients accessing the health care system more often. They are older, have more chronic diseases, and often have more complex health problems.
4. Physicians and patients continue to utilize high tech interventions that may or may not be necessary.

Former U.S. Senate Majority Leader Bill Frist (R-TN), himself a physician, will serve as the Honorary Co-Chair of the group. Frist had this to say about the reason behind the group's formation, "This Commission couldn't come at a better time, given political realities and a desperate need to rein in health care costs while maximizing quality." "We want to continue to provide the best care possible, but the need to constrain costs can no longer be dodged. We are taking away money from nursing homes, schools and other public services to pay for ever-escalating health care expenses."

The Commission will be chaired by Dr. Steven Schroeder, the former president of the Robert Wood Johnson Foundation and distinguished professor of health and health care at the University of California, San Francisco. Some of the other members of the Commission include:

Kavita Patel, MD, Managing Director for Clinical Transformation and Delivery at the Engelberg Center for Health Care Reform of the Brookings Institution and a former member of the Obama administration;

Troy Brennan, MD, Executive Vice President and Chief Medical Officer of CVS Caremark and CVS Pharmacy, Inc.;

Suzanne Delbanco, PhD, Executive Director of Catalyst for Payment Reform and founding CEO of the Leapfrog Group;

JudyAnn Bigby, MD, Secretary of the Executive Office of Health and Human Services of the Commonwealth of Massachusetts; and,

Lisa Latts, MD, Vice President of Public Health Policy for WellPoint, Inc. Dr. Latts is responsible for directing WellPoint's public health strategy.

Meredith Rosenthal, PhD, Professor of Health Economics and Policy in the Department of Health Policy and Management at the Harvard School of Public Health.

The Commission will look at efforts to incorporate quality into the current pay system and assess the opportunities and risks of the healthcare payment configurations being implemented as part of the Affordable Care Act, as well as those currently in place. The Commission will also likely consider incentives and safeguards surrounding physician payment, as well as assess forms of physician payment that maximize good clinical outcomes.

The Commission plans to meet several times over the course of one year, producing an analysis and full recommendations in early 2013. Funding for the Commission comes, in part, from the Robert Wood Johnson Foundation; the California Healthcare Foundation; and the Sergei Zlinkoff Fund for Medical Education and Research.

Return To Top

CMS Proposes then Suspends new Place of Service (POS) policy

On February 12th, CMS announced the release of a Program Transmittal (2407) re-establishing CMS policy on Place of Service codes. The Transmittal was intended to revise and clarify national policy for POS code assignment. Instructions were included regarding the assignment of place of service (POS) for all services paid under the Medicare Physician Fee Schedule and for certain services provided by independent labs. In addition to establishing a national policy for the correct assignment of POS codes, instructions were provided for the interpretation or professional component (PC) and the technical component (TC) of diagnostic tests.

Almost from the moment the policy was announced, concerns were expressed by the provider community. Initially, the concerns were over the quick implementation schedule CMS announced with the issuance of the new policy. The policy was slated to become effective on April 1, 2012, giving providers less than six weeks to make all of the necessary changes in their systems to reflect the new policy.

Over time, substantive questions began to be raised, particularly among Emergency Department providers.

HBMA, along with many other organizations, expressed concerns to CMS staff about the quick implementation schedule even as members were raising the more substantive issues.

In response to industry concerns, CMS announced in late March that it was postponing the effective date of the new POS policy until October 1, 2012 to give the agency more time to review the concerns raised by the industry and also allow the industry time to make the necessary technical adjustments to comply with the new policy. The summary sheet for Transmittal 2435 indicates the change in the effective date; however, as of the writing of this report, there was an error when you tried to link to the actual transmittal.

HBMA has formed a technical workgroup to review the new CMS POS policy, drawing expertise from the various specialties that could be affected by this policy. After completing its review, the group will make a recommendation to the HBMA Government Relations Committee on how best to proceed.

Return To Top

HBMA submits comments on new CMS EFT/RA policy

In early January, 2012, CMS announced what is called an "interim final" rule on new standards governing Electronic Fund Transfers and Remittance Advice. Specifically, the new policy would require third party payers, to include additional information in the EFT/RA information that is electronically transmitted to the provider in order to reduce the burden providers (and billing companies) experience attempting to connect EFT payments with the RA explaining for whom and what those payments are for.

Unlike a Proposed Rule, which is just that, a proposal, an interim final rule is just that, final. Typically the interim final rule nomenclature is used to allow the agency to move quickly to a final rule due to a looming statutory deadline. In this case, the law mandated that CMS issue a final rule by January, 2012 and had the agency used the normal rulemaking process, they would have failed to meet that deadline. Although the rule is technically final, the agency is required to give the public an opportunity to comment on the interim final rule and make subsequent changes if comments received convince the agency that changes are warranted.

Unlike most business-to-business electronic transactions, a health plan rarely pays a provider the exact amount a provider bills the health plan for a health care claim. A health plan adjusts the claim based on a variety of factors: contract agreements, secondary payers, benefit coverage, expected co-pays, co-insurance, etc. These adjustments are described in the remittance advice. Therefore, in order for the system to work efficiently, it is critical that there be a way to efficiently link the EFT to the RA so the provider (or billing company working on behalf of the provider) knows what was being paid, for what and for whom.

As billing companies know all too well, the RA and the EFT information are typically sent in different electronic formats through different networks, contain different data that have different business uses, and are often received by the billing company or health care provider at different times. Matching up this data (reassociation) is costly and time consuming.

Some billing companies have long complained that because of the disjointed and haphazard way claim payment information is electronically transmitted from the payer to the provider, they are less automated in 2012 than they were prior to the enactment of HIPAA. The new policy is intended to send payment and RA information as a "packet" of information, eliminating the necessity on the part of the provider and billing company to "reassociate" the information after it has been received separately by the provider.

HBMA strongly supported the CMS initiative, however, the organization's comments did express concern that CMS was postponing enforcement of the new policy until January 2014. HBMA encouraged CMS to begin enforcing the new policy in 2013.

Return To Top

CMS Transmittals

The Centers for Medicare & Medicaid Services uses transmittals to communicate new or changed policies or procedures that will be incorporated into the CMS Online Manual System. The cover or transmittal page summarizes and specifies the changes. The following Transmittals were issued in the month of March.

Transmittal Number	Subject	Effective Date
R2434CP	Quarterly Update to the Correct Coding Initiative (CCI) Edits, Version 18.2, Effective July 1, 2012	07/02/2012
R412PI	General Update to Chapter 15 of the Program integrity Manual(PIM)-Part I	04/30/2012
R84MSP	Correspondence Referral System (ECRS) Web Enhancements Phase I	04/02/2012
R2436CP	Claims Status Category and Claims Status Codes Update	07/02/2012
R2435CP	Revised and Clarified Place of Service (POS) Coding Instructions	10/01/2012
R2433CP	Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse	N/A
R2431CP	Screening for Depression in Adults	N/A
R2432CP	Intensive Behavioral Therapy for Cardiovascular Disease	N/A
R2427CP	2012 Durable Medical Equipment Prosthetics, Orthotics, and Supplies Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction	04/23/2012
R5QRI	Medicare Quality Reporting Incentive Programs Manual Update	06/25/2012
R2429CP	April Update to the CY 2012 Medicare Physician Fee Schedule Database (MPFSDB)	04/02/2012
R81SOMA	Revisions to State Operations Manual (SOM), Appendix A, Hospitals	03/23/2012
R104MCM	Chapter 13, Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs), (collectively referred to as Medicare Health Plans)	03/23/2012
R2425CP	April 2012 Update of the Ambulatory Surgical Center (ASC) Payment System	04/02/2012
R2424CP	Influenza Virus Vaccine Annual Payment Limit Effective Date	08/01/2012

R1058OTN	Emergency March 2012 Update (MCTRJCA) to the CY 2012 Medicare Physician Fee Schedule (MPFS) Database	03/15/2012
R2423CP	April 2012 Integrated Outpatient Code Editor (I/OCE) Specifications Version 13.1	04/02/2012
R1056OTN	Revision of Medicare Summary Notice (MSN) for Non-Competitive Bid Claims	07/02/2012
R1057OTN	Implementation of a Correction of Initial Default Values for Medically Unlikely Edits (MUEs)	N/A
R206FM	Processing of Recovery Audit Program Error Files	04/09/2012
R1055OTN	Medicare Fiscal Intermediaries Shared System (FISS), HealthCare Integrated General Ledger Accounting System (HIGLAS), and Change of Ownership Process Revisions for IRS Form 1099 Reporting	07/02/2012
R1054OTN	Use of Revised Remittance Advice Remark Code (RARC) N103 When Denying Services Furnished to Federally Incarcerated Beneficiaries	07/02/2012
R2421CP	Intensive Behavioral Therapy for Obesity	N/A
R2418CP	April 2012 Update of the Hospital Outpatient Prospective Payment System (OPPS)	04/02/2012
R410PI	Instructions for Processing Form CMS-855O Submissions	06/04/2012
R1043OTN	Delayed Work from CR 7589: Request to Require Hours for Research and Conference Calls with Maintainers, MACs, and EDCs and Additional Requirements for IDR Shared Systems	07/02/2012
R1052OTN	Analysis and Design of Edits to Correct Recovery Auditor Identified Improper Payments in MCS	07/02/2012
R80SOMA	Revised Exhibit 286, Hospital/CAH Database Worksheet	03/01/2012