Medicare Update hfma Central Texas Regional Meeting

October 15 | 2010

Medicare Update

The FFY 2011 IPPS Final Rule, CY 2011 OPPS Proposed Rule, Healthcare Reform Legislation

Medicare Update

The FFY 2011 Inpatient Prospective Payment System Final Rule

Medicare Update

- NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR IF WAGE INDEX IS LESS THAN 1

FFY 2010 (Full update)		FFY 2011 (Full update)	
Labor	Non Labor	Labor	Non Labor
$3,238.35	$1,984.79	$3,552.91	$1,611.20

- CAPITAL STANDARD FEDERAL PAYMENT RATE

FFY 2010	FFY 2011
$430.20	$420.01

- OUTLIER FIXED-LOSS COST THRESHOLD

FFY 2010	FFY 2011
$24,240	$23,075

Medicare Update

- WAGE INDEX, GEOGRAPHIC ADJUSTMENT FACTOR, AND BASE PAYMENTS

	AWI		GAF		Base Payment	
CBSA	2010	2011	2010	2011	2010	2011
Killeen-Temple-Fort Hood	0.8757	0.8833	0.9131	0.9185	$ 5,213.43	$ 5,222.55
Waco	0.8608	0.8609	0.9024	0.9025	$ 5,160.57	$ 5,143.41
Austin-Round Rock	0.9515	0.9480	0.9665	0.9641	$ 5,481.87	$ 5,450.85
Rural Texas	0.7944	0.7976	0.8542	0.8565	$ 4,924.82	$ 4,919.46

Medicare Update

FY 2011 Inpatient Hospital Update:

- The market basket update for FY 2011 for hospitals paid under the IPPS is 2.6%.
- This update amount will be reduced by 0.25%, as required by the PPACA.
- The applicable percentage increase to the standardized amount for FY 2011 is 2.35% for hospitals that submit quality data in accordance with the RHQDAPU requirements.
- The penalty not submitting quality data in accordance with the RHQDAPU requirements is -2%.

Medicare Update

Prospective Adjustment to the Average Standardized Amounts Required by Section 7(b)(1)(A) of Pub. L. 110-90

- Implementation of the MS–DRG system resulted in changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 or FY 2009 that are different than the prospective documentation and coding adjustments applied under section 7(a) of Pub. L. 110-90, the Secretary is required to make an appropriate adjustment.

	Required Prospective Adjustment for FYs 2008-2009	Required Recoupment Adjustment for FYs 2008-2009	Total Adjustment	Recoupment Adjustment to FY 2011 Payments	Remaining Adjustment
Level of Adjustments	3.9%	5.8%	9.7%	2.9%	6.8%

Medicare Update

Standardized rates decrease from 2010 to 2011

- After factoring in the -2.9% adjustment to partially account "Behavioral offset" related to the conversion from CMS-DRGs to MS-DRG the standardized amount drops by -0.55% from the current level.
- Remember that FFY 2010 rates were already reduced by 0.25%, as required by the PPACA.
- For the first time in a long time Medicare operating payments to acute care hospitals for inpatient services occurring in FY 2011 are projected to decrease by $440 million.

Medicare Update

3-day Payment Window

- The Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (Pub. L. 111-192) Section 102 pertains to Medicare's policy for payment of outpatient services provided on either the day of or during the 3 days prior to a Medicare beneficiary's inpatient admission.
- Under the 3-day payment window, a hospital must include on the claim for a Medicare beneficiary's inpatient stay, the charges for all outpatient diagnostic services and admission-related non-diagnostic services provided during the payment window.

Medicare Update

3-day Payment Window

- Outpatient services furnished on or after June 25, 2010, all nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital on the date of a beneficiary's inpatient admission are deemed related to the admission and, therefore, must be billed with the inpatient stay.
- Outpatient services furnished on the first, second, and third calendar days preceding the date of a beneficiary's admission are deemed related to the admission and, therefore, must be billed with the inpatient stay, unless the hospital attests that services as unrelated to the hospital claim (services are clinically distinct or independent from the reason for the beneficiary's admission).

Medicare Update

Reclassifications under Section 508 of Public Law 108-173

- Allowed certain qualifying hospitals to receive wage index reclassifications and assignments that they otherwise would not have been eligible to receive under the law.
- Section 508 originally was scheduled to expire after a 3-year period, however Congress extended the provision several times.
- Section 3137(a) of the PPACA (as amended), extended through FY 2010, section 508 reclassifications.
- The latest extension of these provisions expires on September 30, 2010, and will not be applicable in FY 2011.

Medicare Update

Processing of Diagnosis & Procedure Codes on Hospital Inpatient Claims

- Claims submitted on the 5010 format beginning January 1, 2011, CMS will increase the capacity to process diagnosis and procedure codes on hospital inpatient claims from the current 9 diagnoses and 6 procedures up to 25 diagnoses and 25 procedures.

Medicare Update

Additional Payments For Hospitals With Low Per Enrollee Medicare Spending

- PPACA provides for additional payments totaling $400 million to “qualifying hospitals” for FYs 2011 and 2012. A “qualifying hospital” is a “subsection (d) hospital” that is located in a county that ranks, based upon its per enrollee Medicare spending under parts A and B, adjusted for age, sex, and race, within the lowest quartile of counties in the United States.
- CMS will distribute $150 million in FY 2011 to qualifying hospitals.

Medicare Update

Medicare Add on Payments

- No changes to GME and IME formulas for calculating payments
- Revised SSI % determination to be applied by CMS
- Clarification issued on Medicare Advantage/ “shadow billing”
- Clarification issued on Nursing Allied Pass through payments

Medicare Update

The FFY 2011 Outpatient

Prospective Payment

System Proposed Rule

Medicare Update

CY11 Outpatient PPS Proposed Rule

- Provides updates on APC weights and classifications
- Provides updates on ASC payment rates and groupings
- No new Quality measures added for CY 2011
- Implements provisions of the Affordable Care Act related to GME and IME payments

Medicare Update

GME & IME Provisions

- For cost reporting periods after 7/1/09 hospitals allowed to count time for didactic time in non hospital setting for GME only.
- Allows for counting of resident vacation, sick and other approved leave for both GME and IME.
- Amends requirements for counting residents in non-hospital setting (Effective 7/1/10).
- Provides for reallocation of resident cap slots for both GME and IME.
- 65% of most unused residency slots will be lost and redistributed
- Detailed rules and points system included in the proposed rule.

Medicare Update

GME Residents Training in Non-Hospital Settings

- Section 5504 of the PPACA changes policy
- Hospital must incur the expense of the resident salary and fringe benefits for the time the resident trains at non-hospital sites.
- No longer required to incur other training costs at the nonhospital site.
- If more than one hospital incurs the resident cost, then hospitals will be required to split the time based on a written agreement.
- CMS to track resident time at non-provider sites annually.

Medicare Update

Healthcare Reform

Medicare Update

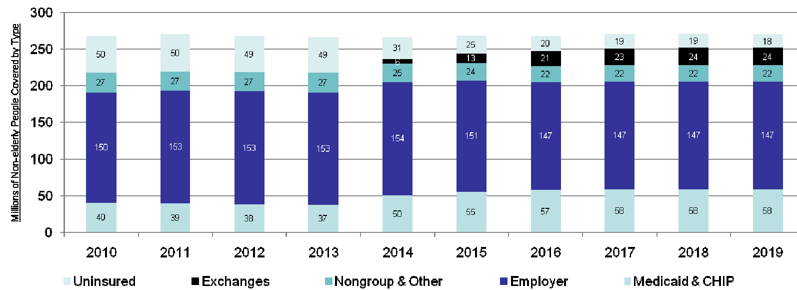
Health Reform Background

- President Obama signs:
  - Patient Protection and Affordable Care Act - March 23, 2010
  - Health Care and Education Reconciliation Act (a.k.a “reconciliation” or “fix it bill”) - March 30, 2010
- Most substantial change to the health system since passage of Medicare
- Expanded access implemented and paid through new mandates, fees, regulatory and reimbursement reform, health exchanges, and new incentives
- Provider will benefit from more patients with insurance through coverage expansions and expansion of existing government programs
- Legislation contains nearly $500 billion in Medicare cuts, more than$156.6 billion in payment reductions

Medicare Update

Health reform reduces the number of uninsured by 32 million by expanding Medicaid and creating Exchanges

- **32 million Americans gain insurance coverage at a cost of $214 billion in 2019**



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Medicare Update

Key Components of Health Care Reform: Extending Coverage

Immediate Insurance Market Regulations

- Dependent coverage to age 26 beginning first plan year after 9/23/2010
- Premiums in the exchange may not vary by more than 3 to 1, based on age
- Plans must meet 85% medical loss ratio for large group market and 80% medical loss ratio for small group market
- Uninsured eligible for temporary high risk pools
- No annual or lifetime limits or pre-existing condition exclusions

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Medicare Update

Key Components of Health Care Reform: Extending Coverage

Medicaid

- Supports up to 133% of FPL from current 100% of FPL
- Feds pay 100% of the cost for new Medicaid patients from 2014 to 2016, and then decreasing down to 90% through 2019, with states paying the balance

Medicare Update

Key Components of Health Care Reform: Extending Coverage

Pilot Programs

- Creates a bundled payment pilot program by 2013 to test more efficient ways of paying hospitals, doctors, nursing homes and other providers who care for Medicare patients from admission through discharge
- Beginning in 2012, accountable care organizations (ACO's) of physicians and hospitals, they could participate in shared savings programs
- Create Medicaid medical home program to better coordinate care for those with multiple chronic conditions

Medicare Update

Key Components of Health Care Reform: Extending Coverage

Individual Mandate

- Income surtax penalty ranging from $695 (single) per year up to a maximum of $2,085 per family or 2.5% of household income, whichever is higher, by 2016 (low income exempt)
- Penalties will be phased in beginning in 2014
- Refundable premium credits (that can also be advanced to the consumer) to individuals and families with incomes between 133-400% FPL to purchase insurance in the exchanges

Medicare Update

Key Components of Health Care Reform: Extending Coverage

Employer Penalties

- In 2014 imposes penalties on employers who do not provide coverage for full-time employees, as well as on employers whose coverage is inadequate or unaffordable for low-income employees
- Employers with fewer than 50 FTE's exempt from penalties
- If at least one full-time employee enrolls in a qualified health plan under an exchange and receives a premium tax credit, the penalty is $2,000 times the total number of fulltime employees, excluding the first 30 full-time employees
- The penalty for employers who do offer minimum essential health insurance coverage, but where at least one full-time employee has enrolled in an exchange and qualified for a premium tax credit, is $3,000 for each such employee, but not more than $2,000 times the number of full-time employees
- Limits waiting periods to 90 days beginning in 2014 (non-grandfathered plans)

Medicare Update

Persons in Family	100% FPL	133% FPL	400% FPL
	Current Medicaid Limit	PPACA Medicaid Limit	PPACA Exchange Subsidy Limit
1	$10,830	$14,404	$43,320
2	$14,570	$19,378	$58,280
3	$18,310	$24,352	$73,240
4	$22,050	$29,327	$88,200
5	$25,790	$34,301	$103,160
6	$29,530	$39,275	$118,120
7	$33,270	$44,249	$133,080
8	$37,010	$49,223	$148,040
For families with more than 8 persons	*Add $3,740 for each additional person*	*Add $4,974 for each additional person*	*Add $14,960 for each additional person*

Medicare Update

Key Components of Health Care Reform: Reducing Costs

Medicare

- Restructures payments to Medicare Advantage plans
- Closes the Medicare Part D prescription drug 'donut hole' gradually over the next decade
- Reduces Medicare spending over the next 10 years by almost $500 billion
  - Decreases market basket update for providers - $157 billion
  - Medicare Disproportionate Share (DSH) payment and home health adjustments - $55 billion
  - Medicare Advantage payments - $132 billion
  - Establishes Medicare Independent Payment Advisory Board to make recommendations to reduce Medicare spending by 2014.
  - Creates Center for Medicare and Medicaid Innovation to test payment and service delivery models.

Medicare Update

Impact to one Central Texas System

	2010	2011	2012	2013	2014	
General Medicare Cuts	-452	-1,531	-4,241	-7,051	-11,531	
Medicare DSH Cuts	0	0	0	0	0	
Medicaid DSH Cuts	0	0	0	0	0	
SGR Adjustment	0	-11,681	-6,223	-1,679	-1,816	
Net	-452	-13,212	-10,464	-8,730	-13,347	
	2015	2016	2017	2018	2019	Total
General Medicare Cuts	-16,220	-20,814	-27,086	-33,315	-40,154	-162,395
Medicare DSH Cuts	-4,454	-4,800	-5,813	-4,957	-5,554	-25,578
Medicaid DSH Cuts	-924	-926	-2,783	-7,745	-8,677	-21,055
SGR Adjustment	-1,812	-1,812	-1,812	-1,812	-1,812	-30,459
Net	-23,410	-28,352	-37,494	-47,829	-56,197	-$239,487

000's omitted

Medicare Update

Key Components of Health Care Reform: Reducing Costs

Quality Initiatives

- In 2012, Medicare value-based purchasing (VBP) program will begin to measure hospitals on efficiency, patient satisfaction and the quality of care around five conditions and procedures. Beginning 2013 each Quality Initiatives hospital will receive its own performance score that will determine its incentive payment. Because this program is revenue neutral, higher scoring hospitals will receive higher payment and lower scoring hospitals will receive lower payment
- Also in 2012, Medicare will no longer pay for certain hospital readmissions and will begin to publish hospital readmission rates

Medicare Update

Key Components of Health Care Reform: State-wide Exchanges

Basic Logistics

- By 2014 states create their own insurance exchanges to sell insurance products which will include four tiers of benefit plan categories
- Exchanges to provide enrollment information through website and phone hotline
- Two multi-state health plans on each state exchange will be offered, at least one would be a non-profit plan

Medicare Update

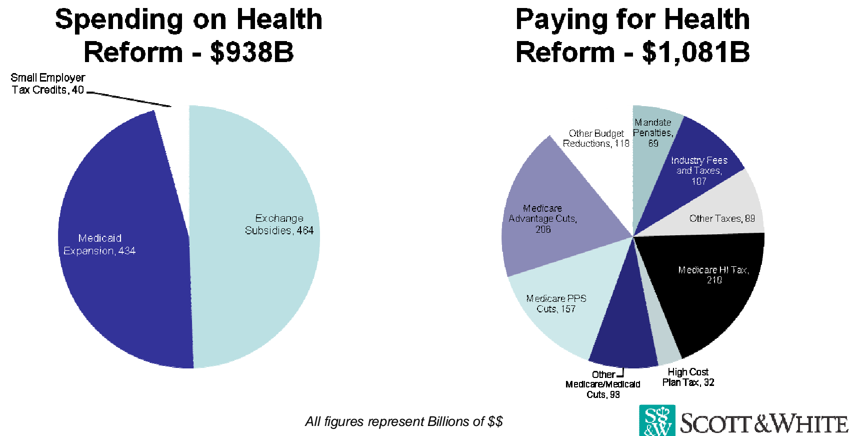
Key Components of Health Care Reform: State-wide Exchanges

Requirements for Participation

- Allows businesses of up to 100 employees to participate (although states will have the option to limit to 50 employees). Beginning in 2017, states may allow employers with more than 100 employees to use the exchange with Section 125 Plan
- Essential health benefits package required for all plans; four tiers; catastrophic policy for young adults or individuals exempt from coverage mandate
- Grandfathered plans prohibited from bans on annual and lifetime coverage, pre-existing conditions and must offer coverage to dependents until age 26
- Requires grandfathered plans to cover proven preventive services with no cost sharing starting in 2018

Medicare Update

Federal funding of coverage is paid for with new fees, taxes and payment reductions



All figures represent Billions of $$

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Medicare Update

Certain Tax Provisions

Excise Tax on High-value Health Plans

- The legislation imposes a 40-percent excise tax on "high-value" health plans, effective beginning in 2018. In general, plans with actuarial values in excess of specified thresholds ($27,500 for a family plan and $10,200 or a single plan) will owe the tax on amounts exceeding the thresholds. Higher thresholds apply for certain individuals age 55 and older, and for employees covered by an employer-provided plan in which the majority of employees covered by the plan are engaged in certain high-risk professions.
- • For 2019, the thresholds will be indexed for inflation (as measured by the consumer price index for urban consumers) plus one percent. In 2020 and thereafter, the thresholds will be indexed for general inflation.

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Medicare Update

Certain Tax Provisions

Medicare Part D Retiree Subsidies

- Employers are eligible for a subsidy under the Medicare Part D program if they sponsor drug coverage meeting certain standards for their Medicare-eligible retirees. The subsidy is calculated as 28 percent of the drug spending by eligible retirees within certain ranges.
- When enacted in 2003, the subsidy was made tax-deductible to encourage employers to continue to offer retiree drug coverage. The legislation eliminates the deductibility of this subsidy, beginning in 2013.
- The elimination of deductibility has an immediate impact on the income statements of companies receiving the subsidy.

Medicare Update

Certain Tax Provisions

Health Industry Taxes

- Assessments on pharmaceutical companies
- Assessment on health insurance companies
- Tanning salons
- Medical device excise tax
- Deduction limit for insurance company compensation

Medicare Update

Certain Tax Provisions

Individual Tax Provisions

- Medicare tax on wages
- Increase in AGI floor on medical expense deductions
- Limits on flexible savings accounts (FSAs)
- Health savings account penalties
- Conform definition of medical expenses
- New tax on investment income

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Medicare Update

Certain Tax Provisions

- Increased Reporting Requirements: W-2 Reporting
- The legislation requires an employer to report on each employee's annual Form W-2 the value of the employee's health insurance coverage provided by the employer.
- The employer must include the value of all employer-sponsored plans in which the employee enrolls, including medical insurance, dental, and vision coverage. To determine coverage value of employer-sponsored health coverage, the employer would calculate the value of the plan using the rules for COBRA coverage.
- The provision is effective for tax years beginning after December 31, 2010.

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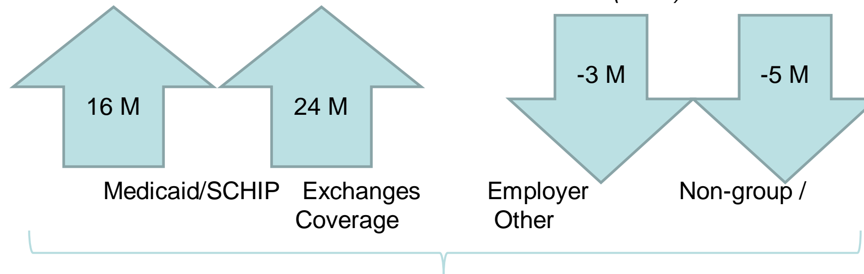
Medicare Update

Health reform expansions reduces the number of uninsured by 32 million

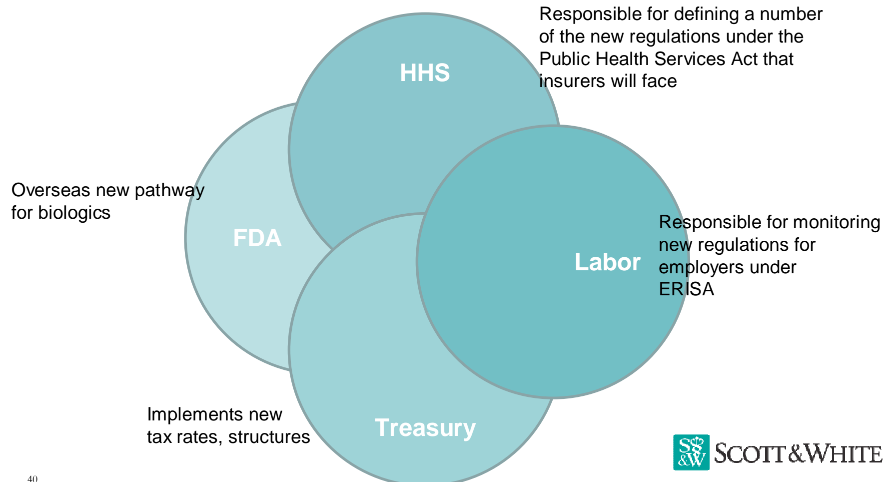
CBO Estimate of the Reconciliation Bill (2019)



32 million individuals gain insurance coverage at a cost of $214 billion in 2019
Uninsured drops from approximately 50 million to approximately 18 million 2019

Medicare Update

Expanded Role of Current Regulators



Medicare Update

4 Key Themes Emerge

	Theme	Components
1	How do you measure up?	-Quality performance/measures -Hospital Acquired Conditions (HAC) -Value Based Purchasing (VBP)
2	How do you think outside the box? Or the 4 walls of the hospital?	-Consolidation within markets -Alignment across the care continuum
3	How do you thrive on government reimbursement?	-Cutting costs to live on CMS rates -Billing and collecting payments due
4	How do you ensure you are doing the right things?	-Compliance

Medicare Update

How do you measure up?

Value Based Purchasing (VBP)

Section 3001

- Beginning in FY 2013 based on hospitals' performance in 2012 (Oct 1 to Sept 30)
- The value-based purchasing program (VBP) will begin to measure hospitals on efficiency, patient satisfaction and the quality of care around five conditions and procedures:

1. Acute myocardial infarction (AMI)
2. Heart failure (HF)
3. Pneumonia
4. Surgery-associated infections (SCIP)
5. Hospital Consumer Assessment of Healthcare Providers and ystems (HCAHPS)

Value-based Payment Percentage by Year:

Year	2013	2014	2015	2016	2017
VBP%	1.0%	1.25%	1.50%	1.75%	2.0%

Medicare Update

How do you measure up?

Hospital Acquired Conditions (HAC)

Section 3008

- Beginning in FY 2015, the bill adds a 1% penalty to bottom quartile hospital's Medicare reimbursement for those hospitals with the poorest HAC rates
- Leads to reductions of $1.5 billion over 10 years.

Medicare Update

How do you measure up?

Re-Admission Rates

Section 3025

- Beginning in FY 2013, the bill imposes financial penalties on hospitals for so-called "excess" readmissions when compared to "expected" levels of readmissions based on the 30-day readmission measures for acute myocardial infarction (AMI), heart failure (HF) and pneumonia that are currently part of the Medicare pay-for-reporting program. A very complex methodology that is risk-adjusted.
- ***Exclusions: The bill excludes Critical Access Hospitals (CAHs) and post-acute care providers.***

Medicare Update

How do you think outside the box?

Patient Centered Medical Homes (ACOs)

Section 2717

- The Medicaid medical home program is designed to better coordinate care for people with multiple chronic conditions. Under this program, a designated provider or team of health professionals provide comprehensive care management, referrals, patient and family support and the use of health information technology.
- Providers participating in this program will receive a medical assistance payment and participating states will receive a 90% federal medical assistance percentage (FMAP) payment for two years.

Medicare Update

How do you think outside the box?

Bundled Payments & Episodes of Care

Section 3023

- Medicare will begin a bundled payment pilot program no later than 2013 for episodes of care through 30 days post discharge.
- The pilot program may cover the following: acute care inpatient hospitalizations; physician services delivered inside and outside of the acute care hospital setting; outpatient hospital services, including emergency department visits; services associated with acute care hospital readmissions; PAC services including HH, SNF, inpatient rehabilitation, long term care hospitals; continuing care hospitals; and other services as the Secretary determines.

Medicare Update

How do you thrive on Government Reimbursement?

Medicare Disproportionate Share Hospital (DSH)

Section 3133

- Effective FY 2014 and subsequent years.
- **Current DSH payment method * 25%, +**
- **The sum of :**
  - **Factor 1 Current DSH payment for all hospitals * 75%**

X

  - **Factor 2 1-%decrease in uninsured, under 65 age until**
    - FFY 2018 and then -% decrease in all uninsured - (in
    - FFY 2014 an additional 0.1% and in FFYs 2015 through 2019 and an additional 0.2%)

X

  - **Factor 3 Amount of uncompensated care for the hospital divided by the amount of uncompensated care for all hospital**

Medicare Update

How do you thrive on Government Reimbursement?

Payment for primary care physicians

Section 1202 of HCERA

Effective 2013 and 2014 only

- Require that Medicaid payment rates to primary care physicians for furnishing primary care services be no less than 100% of Medicare payment rates in 2013 and 2014.
- Provides 100% federal funding for the incremental costs to states of meeting this requirement.
- The term “primary care services” means evaluation and management services and services related to immunization administration for vaccines.

Medicare Update

How do you thrive on Government Reimbursement?

Expanding access to primary care and general surgery services.

Section 5501 (as amended)

Effective CY 2011 through 2015

- 10% Medicare bonus on select evaluation and management codes
- The bonus shall be available to family medicine, internal medicine, geriatric medicine, or pediatric medicine (or APN and PA); and (2) furnish at least 60% of their services in the select codes.
- Qualifying practitioners providing care in a Health Professional Shortage Area (HPSA) also receive the 10% bonus on hospital visit codes that are typical of primary care medicine & major procedure codes for General surgeons.

Medicare Update

How do you thrive on Government Reimbursement?

Market Basket Updates

Section 3401 (as amended)

Effective upon enactment

- Inpatient and outpatient hospitals, inpatient rehabilitation facilities, and psychiatric hospitals. Reduces the annual Medicare payment update by 0.25 % in 2010 and 2011 by 0.1 % in 2012-2013, by 0.3% in 2014, by 0.2% in 2015-2016, and by 0.75% in 2017-2019.
- The reductions are applied after applicable adjustments for productivity, quality reporting and meaningful use.
- This could result in a negative update factor.

Medicare Update

How do you thrive on Government Reimbursement?

Distribution of Additional Residency Provisions

Section 5503

Effective not later than 2 years after passage of PPACA (3/23/2012)

- CMS shall calculate the number of unused resident slots over the last three Fys.
- 65% of unused slots shall be included in a pool for redistribution.
- Redistribution shall go 70% to hospitals located in states with resident to population ratios in the lowest quartile.
- The remaining 30% shall go to hospitals that is located in the top 10 states in terms of the ratio of the total population living in a health professional shortage area (HPSA) or finally to hospitals located in rural areas.

Medicare Update

How do you ensure you are doing the right things?

Limitation on Medicare exception to the prohibition on certain physician referrals for hospitals.

Section 6001 (as amended)

Effective 18 months from enactment and December 31, 2010 for a hospital to meet grandfathering provisions

- Medicare will not contract with any new physician-owned hospitals.
- Physician owners cannot increase their equity stakes.
- Only hospitals meeting certain requirements shall be exempt from the prohibition on self-referral.

Medicare Update

How do you ensure you are doing the right things?

Community Health Needs Assessments; Requirements for IRC 501(c)(3) Hospitals

Section 9007 (as amended)

Effective for taxable years beginning after 3/30/2012

- Each hospital facility must conduct a community health needs assessment for each of the hospitals operated by the organization every three years and adopt an implementation strategy.
- The health needs assessment must take into account input from persons who represent the broad interests of the community served by each of the organization's hospital facilities and make the assessment widely available to the public.

Medicare Update

How do you ensure you are doing the right things?

Additional Requirements for IRC 501(c)(3) Hospitals

Section 9007 (as amended)

3 additional requirements placed on Tax – Exempt Hospitals.

- Financial assistance policy — Clearly articulated criteria used to determine eligibility for financial assistance.
- Limitations on charges — For emergency and medically necessary care, no more than commercial rates and prohibits use gross charges.
- Billing and collections — "Reasonable effort" to determine eligibility criteria prior to "extraordinary" collection actions.
- Requires the Treasury Secretary to issue such regulations and guidance as may be necessary to carry out these provisions, including guidance relating to what constitutes reasonable efforts to determine the eligibility of a patient financial assistance policy.

Medicare Update

How do you ensure you are doing the right things?

Increased Funding for Waste, Fraud, and Abuse Prevention; More than 50 Sections of the law relate to new compliance requirements for Medicare, Medicaid, and CHIP

- Sec. 6003 – Disclosure of in-office ancillary exception to physician self-referral on imaging
- Sec. 6004 Prescription drug sample transparency
- Sec. 6005 – Pharmacy benefit managers transparency requirements
- Sec. 6101 – Required disclosure of ownership and additional disclosable parties information for nursing homes
- Sec. 6102 – Accountability requirements for SNFs and Nursing Facilities
- Sec. 6103 – Nursing home compare website
- Sec. 6401 – Provider screening under Medicare, Medicaid and CHIP
- Sec. 6402 – Enhanced Medicaid program integrity provisions
- Sec. 6404 – Maximum period for submission of Medicare claims
- Sec. 6411 – Expansion of the Recovery Audit Contractor program
- Sec. 6505 – Prohibition on payments to entities outside the U.S.
- Sec. 6507 – Mandatory state (Medicaid) use of national correct coding initiative

Medicare Update

Questions??