June 27, 2016

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS -5517-P
P.O. Box 8016
Baltimore, MD 21244-8016

We submit the following comments on the Centers for Medicare Medicaid Services (CMS) Notice of Proposed Rule (NPRM) on the Medicare Program: Merit-Based Incentive Payment System and Alternative Payment Model Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Background on the Healthcare Administrative Technology Association (HATA)

The Healthcare Administrative Technology Association (HATA) is a non-profit trade association to provide a forum for the Practice Management (PM) Vendor industry and other affiliated stakeholders. The association serves as the representative voice to advocate and influence key stakeholders and government representatives on PM Vendor issues.

Our Practice Management members, AdvancedMD, AllMeds, AzaleaHealth, Clinix, e-MDs, HealthPac, Medinformatix, NextGen, OfficeAlly, Optum, and PracticeAdmin represent over 500,000 providers.

Formal representation of such an important piece of the healthcare ecosystem is critical to the advancement of the industry. HATA represents a key stakeholder, PM Vendor and affiliate vendors in the $40 billion physician revenue cycle industry and is an active and influential voice promoting goals and values on behalf of its members to drive administrative efficiencies for its clients, which mainly consist of providers and billing services.

The PM Vendor industry has more than 400 companies providing a variety of technology solutions for the full range of healthcare professionals. The industry represents nearly 100 percent of all initial claims submitted on behalf of hospitals, physicians and allied healthcare professionals. Administrative simplification of the claims revenue cycle, which includes claim submission and payment processing, is a key factor in reducing the excessive cost of healthcare in the United States

COMMENTS

Although the actual reimbursement will now be adjusted up or down based on MACRA scores, payments will continue to be 'fee for service," meaning that current functionality still works but tracking may become more difficult. Revenue cycle companies who have agreements based on a percentage of reimbursement might have a difficult time projecting revenue for those clients impacted by scores and should consider the long term business implications.

CAHPS

CMS has indicated that groups of two (2) or more providers can use CAHPS surveys to earn extra bonus points, it had previously been 100. This would allow CMS to count surveys as a crosscutting measure or patient experience measure. This only applies to CMS approved survey vendors. Also the proposal at first suggests that this be voluntary and then asks for comments as to whether groups of 100 or more be required to submit CAHPS surveys or if it should remain voluntary.

RECOMMENDATION: HATA recommends that this remain voluntary allowing vendors time to add this functionality and allowing providers to include this as a reportable measure or not depending ontheir specific situation

Timing – Preparation by the Practice Management (PM) Vendor

The Proposed Rule states that new quality measures be in place by November of each year based upon interim reports of performance by July. With fee schedule adjustments announced no later than December (one month before payment adjustments implemented), leaves the timing for claims submissions only 90 days after performance year. First full year on which they will be judged will be 2017, and so if the rule isn't finalized in November, then have it on a 90 day period so they are not penalized rather than a full year for which they really didn't have time to prepare.

RECOMMENDATION: HATA recommends that implementation be pushed back from the January 1, 2017 by two years.

RECOMMENDATION: HATA recommends that the first year be for a 90 day period not the full calendar year.

Right now, PM Vendors are working with their provider clients on implementing Meaningful Use 3. There is currently no information in the Proposed Rules for technical departments to discuss internally (only at a high level), that programmers cannot even get the developing code stage. If there are any major changes that would require new codes or change in codes (even CARC/RARC), then the industry will need two years for testing and training.

Definitions for "small providers"

Billing $10,000/year and less than 100 Medicare patients, makes it tough to be considered a small provider.

RECOMMENDATION: HATA recommends keeping it at the dollar amount of $10,000 per year.

Unanswered Questions

There are still a number of questions that need to be answered by CMS before final rules can be released:

1. TIN/NPI is being used – will it make a difference if they are submitting as a group or an individual. How are they treated?
2. CMS/Medicare processing of claims – how is it reported back? How can the provider confirm what Medicare is stating is their payment? Are you adjusting the fee schedule or are you adjusting the payment? There needs to be some reconciliation between what Medicare provides (either an incentive or a penalty) and what the provider knows to be true within their own accounting system. Will need a way to substantiate the payment.
3. Patient attribution and trigger events – are these easily identifiable
4. Information to rebut resource or other measures (auditing/appeals)
5. Do risk criteria for APMs seem reasonable?

6. Will the adjustments be a change to the providers 'fee schedule' meaning that the fees under which allowables are calculated?
7. Under the new formulas for payment adjustments will there be a reason code to reflect the adjustment?
8. Does the patient coinsurance and copay get adjusted as well based on the physicians reimbursement?
9. Do supplemental payments get adjusted?
10. Since these adjustments are for services in 2017 and adjusted in 2019 will patients be affected in 2019 by scores in 2017?
11. Reporting mechanisms – will there be changes to definitions?
12. It would seem that at first glance a patient would pay less for a provider that did not score well. How will CMS account for this?

RECOMMENDATION: HATA recommends that CMS use reason codes per line item for adjustments rather than change fee schedules (i.e. do it the same way you did with PQRS). This will allow providers to use existing systems and more easily track the reason for changes in payments without major changes to their core EPM applications.

Medicare Advantage

There are parts of the regulation which suggest that Medicare Advantage (MA) plans might adopt the models being used by CMS. It's not clear to what extent any adoption might actually take place and whether this might establish precedents for MA plans globally or going forward into future updates on the legislation.

Prohibition of SSN on Medicare Cards

While this is a different Initiative embedded in a footnote of the proposed rule, a two year implementation is still needed. The proposal does not suggest what the new number format might be, and the relevance for Practice Management Vendor is that they must prepare the formats for these numbers within their systems. Depending on the system it may not require a change, if system has rules by payers for allowed format (i.e. current numeric with alpha suffix to possibly all numeric it might be a master file change). However, it is possible that some systems have a hard coded format that might require an update. In any case all systems will have to clearly understand format and length of newly published Medicare ID's to communicate what must be done for patients within each system.

It is also not clear if there will be a transition period where both id formats are used or an effective date where all Medicare recipients will be issued new ID's. Either implementation plan may present challenges to vendor i.e. multiple formats and/or effective dates. Clarity on the implementation strategy must be clearly communicated.

Summary

We look forward to working with CMS and other stakeholders as they move to a value-based healthcare system, supported by Practice Management System (PMS) vendors and their partners.

Respectfully Submitted,

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