September 11, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1678-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs Proposed Rule

Submitted electronically via www.regulations.gov

Dear Administrator Verma,

For twenty years, athenahealth ("athena") has been committed to removing the obstacles that prevent clinicians from focusing on patient care. As a partner to hospital and ambulatory clients, we provide medical record, revenue cycle, patient engagement, care coordination, and population health services to a cross-section of clinicians. Our single instance, multi-tenant, platform allows us to combine insights from our network of over 106,000 clinicians and 88 million patients to infuse knowledge—from clinical guidelines to Medicare rules—directly into clients' workflows. To enable our clients to focus on high-value patient care, we perform administrative work at scale on behalf of our clients, including all of the back-office work needed for success under CMS's various quality and value-based payment programs.

Given our unique support model for the Electronic Health Record (EHR) Incentive Program, we find ourselves in a position similar to a large health system, needing to review and reconcile the changes that CMS makes to those programs through the complex combination of the fee schedule and other rules. This model for rulemaking leads to inconsistent and often confusing requirements and is not sustainable. As CMS has stated its goal to reduce the burden on clinicians and simplify complex program rules, we urge CMS to ensure that changes to payment programs are consistent across all programs and that rulemaking around those changes be done in a centralized manner to ensure consistency.

It is with that context that we provide the following specific comments and requests for clarification on the Proposed Rule:

Appropriate Use Criteria (AUC) Program, MPFS and OPPS CY 2018 Proposed Rules

athena appreciates CMS's measured approach to AUC consultation requirements. For the AUC Program to drive more appropriate ordering of advanced imaging services, consultation with the Clinical Decision Support Mechanism (CDSM) must be embedded in the provider's EHR workflow. Supporting an embedded integration that minimizes the burden these requirements place on providers requires time and effort by both EHRs and CDSMs to ensure the success of the initiative. Thus, the delay of the consultation start date by one year and the stepwise implementation is a welcomed proposal that better addresses the desire to test the program requirements before consultation is mandatory. The private sector will effectively identify and implement the best solutions to this challenge. The inclusion of CDSM consultation as a MIPS high-weight improvement activity provides incentive to early adopters of the program in 2018. Additionally, the operational testing period through the first year of the program assuages many of the concerns providers have in meeting these impactful requirements.

athena requests additional clarification regarding the appropriateness ratings from CDSMs,. Given that each Provider-Led Entity (PLE) may have its own appropriateness rating system for AUC (some may use a scale between 1-9, others 1-3, still others a color-coded rating system), we request that CMS confirms that the CDSM needs to provide the ordering provider an explicit "is appropriate" versus "is not appropriate" indication to eliminate any ambiguity in the rating. This is especially important as the proposed use of G-codes and HCPCS modifiers requires the furnishing provider to understand whether the consultation did or did not adhere to AUC. These explicit guidelines enable providers to make correct coding decisions and allow EHRs to easily determine whether to interrupt the provider with consultation details. We believe that providers may wish to be presented with consultation details only in those instances where the study is deemed inappropriate.

MACRA Patient Relationship Categories and Codes, MPFS CY 2018 Proposed Rule

athena acknowledges that there is a need to report patient relationship categories for MACRA. However, it is important to consider the burden introduced when requirements are implemented for the sake of reporting. We ask CMS to consider the least burdensome process for providers in this requirement so that they can focus on providing patient care above all else. Regarding the currently proposed reporting method of HCPCS level II modifiers, we request clarification as to whether the modifiers would be required at the individual charge level, or as a one-time claim level modifier. Additionally, we request clarification as to whether this will be required on all claims, or for only a subset of visits. Based on the currently available information, we would advocate for the utilization of CPT procedure codes, rather than HCPCS level II modifiers, to indicate patient relationship information on claims. These steps would lower the reporting burden on providers.

New Medicare Card

Finally, athena notes that the New Medicare Card initiative, formerly known as the Medicare Social Security Removal Initiative (SSNRI), was omitted from the CY 2018 proposed rules. Given the uncertainty around the change, we request a timeline of the initiative's impact on crossover claims. Additionally, we encourage CMS to publish the data file for Health Insurance Claim Number (HICN)-Medicare Beneficiary Identifier (MBI) mapping for use by third-party vendors. This would allow technology partners, such as athena, to better assist physicians for a smooth transition from HICN to MBI.

We look forward to continued dialogue with your office. If you or your staff have any questions, please do not hesitate to contact us.

Sincerely,

Stephanie Zaremba
Director, Government Affairs
athenahealth, Inc.