May 11, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services

U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: Social Security Number Removal Initiative

Dear Administrator Verma:

The undersigned organizations are writing to express concern over the Centers for Medicare & Medicaid Services' (CMS) planned enactment of the Social Security Number Removal Initiative (SSNRI). As explained below, this initiative has the potential to significantly disrupt patient care and physician payment. **Accordingly, we recommend that CMS pursue this change through the traditional notice and comment rulemaking process so that valuable industry feedback may be considered. We further ask that CMS develop a mechanism for providers to quickly and securely access Medicare beneficiary identification numbers to avoid disruptions in access to care.**

Background

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 included a provision requiring CMS to remove the Social Security Number (SSN) from Medicare cards due to concerns of identity theft. The process CMS has developed to implement this requirement is referred to as the SSNRI. CMS currently uses a Health Insurance Claim Number (HICN), based on an individual's SSN, as a patient's Medicare beneficiary identification number. To implement the SSNRI, CMS will create new Medicare Beneficiary Identifiers (MBIs), first for the 60 million active Medicare beneficiaries and then for 90 million deceased beneficiaries, to replace the HICN on beneficiary identification cards.

Starting in January 2018, CMS plans to conduct outreach and education to beneficiaries to alert them of the transition from the HICN to the MBI. New identification cards displaying the MBI will be sent to beneficiaries in phases over a twelve-month period beginning April 1, 2018. CMS, however, does not plan to disclose the details of how the cards will be sent (e.g., alphabetically, by state or region, etc.). While CMS will accept both HICNs and MBIs in administrative transactions during the transition period (April 1, 2018 – December 31, 2019), providers' systems must be ready to accept the MBI by April 2018 and must exclusively use the MBI starting January 1, 2020. CMS will provide MBIs in remittance advice for part of the transition period (beginning in October 2018), but there will be no mechanism for providers to obtain a patient's MBI after January 1, 2020 – even if a patient's first appointment with a particular

provider after being assigned an MBI occurs after the transition period. This scenario is particularly likely for patients receiving new cards towards the end of the issuing cycle and for provider types, such as specialists, from whom the patient may not seek frequent care.

As explained in more detail below, we are concerned about a provider's inability to access a patient's MBI both during and following the transition. If a patient does not bring his or her MBI to his or her appointment, significant delays in patient care or provider reimbursement could result due to the lack of a mechanism for the provider to look-up the patient's MBI.

Transition Concerns

While we understand the importance of protecting Medicare beneficiaries from identify theft by replacing SSNs with new MBIs on Medicare identification cards, we have concerns about patient and physician awareness of this change and backup plans to mitigate potential problems. In a September 23, 2016 letter responding to providers' request for traditional rulemaking concerning the SSNRI, CMS characterized the majority of needed changes as being "operational in nature", making a regulatory review and comment process unnecessary. We respectfully note that this change will impact all Medicare beneficiaries and that all systems and business processes will need to be able to accept and process the new MBI. We therefore urge CMS to work with stakeholders to avoid significant problems and again recommend that CMS instead pursue this change through the traditional notice and comment rulemaking process so that valuable industry feedback on SSNRI implementation may be obtained and considered.

Furthermore, multiple provider groups have expressed overwhelming concern regarding the lack of a contingency system that will allow medical practices to obtain the MBI for a patient who arrives at an appointment without a new Medicare card. This lack of a provider look-up system may strain a practice's ability to conduct administrative transactions and delay patient care in the event that a patient does not present his or her card at the time of service. In addition, family members managing the patient's care and affairs may not have access to the new card. Providers have offered a range of potential solutions—including look-up databases, providing MBIs in electronic eligibility responses, and secure phone systems—to both protect sensitive MBI data and allow practices to access the information needed to continue providing timely care to Medicare patients. **An SSNRI transition plan that is totally dependent upon patient presentation of new Medicare cards to providers will result in delayed treatment and claim payment.**

We have the following additional concerns about the SSNRI transition process:

Beneficiary confusion about new cards: We are concerned that beneficiaries will not understand why they are getting a new card and will throw it away or misplace it, especially since CMS does not plan to initiate outreach and education to the Medicare population until January 2018—just three short months before the beginning of the SSNRI transition. We believe that this short window for educational outreach will be insufficient to prepare the large and vulnerable Medicare population for this major transition, and we urge CMS to initiate an extensive communications campaign to beneficiaries at a much earlier date.

Lack of knowledge of phased rollout of new cards: CMS has said that, for security purposes, it will not provide information on when new identification cards will be sent to beneficiaries, which means practices will not know when to ask their patients for their new card. Through targeted notification to impacted providers, CMS could inform practices of new card distribution and still avoid the broadcast communications that could potentially alert fraudsters.

MBI not provided in eligibility responses: CMS' plan to include the MBI in remittance advice during the transition period is not the optimal solution within the current provider workflow. Inclusion of the patient's MBI in the eligibility response would be of far greater utility to practices, as the information would be available at the beginning of the care episode, when and where providers routinely seek and obtain benefit and coverage information. Existing patient intake and scheduling systems will be disrupted if the MBI is not available via the eligibility response, and time and resources spent ascertaining MBIs will lead to practice inefficiencies that could reduce the hours available for direct care of Medicare patients. Patients would also benefit from inclusion of the MBI in eligibility responses, as this would reduce confusion and apprehension about eligibility for services at the earliest point in care.

Insufficient industry education and preparation: The conversion to the MBI will require significant workflow and system changes for providers, practice management system vendors, and secondary payers. Discussions at CMS-organized listening sessions and forums about the SSNRI suggest widespread confusion and lack of readiness throughout the industry for this major transition. We urge CMS to increase education and outreach efforts to all affected stakeholders to ensure adequate industry preparation for SSNRI implementation.

In an age of increased identity theft and fraud, the Medicare patient population deserves the improved security that will be achieved with the SSNRI. This protection should not, however, come at the expense of prompt patient care or provider payment. We urge CMS to consider adjusting the implementation of the SSNRI as outlined above to protect care access for our nation's seniors. We appreciate your attention to this matter.

Sincerely,

American Medical Association
American Academy of Allergy, Asthma & Immunology
American Academy of Dermatology Association
American Academy of Emergency Medicine
American Academy of Family Physicians
American Academy of Otolaryngology—Head and Neck Surgery
American Academy of Orthopaedic Surgeons
American Academy of Physical Medicine and Rehabilitation
American Association of Neurological Surgeons
American Association of Otolaryngic Allergy
American College of Emergency Physicians
American College of Physicians
American College of Rheumatology
American College of Surgeons

American Congress of Obstetricians and Gynecologists
American Gastroenterological Association
American Orthopaedic Foot & Ankle Society
American Osteopathic Association
American Psychiatric Association
American Society for Clinical Pathology
American Society for Dermatologic Surgery Association
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Dermatopathology
American Society of Hematology
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
American Academy of Ophthalmology
Association of American Medical Colleges
College of American Pathologists
Congress of Neurological Surgeons
Infectious Diseases Society of America
Medical Group Management Association
National Association of Medical Examiners
North American Spine Society
Obesity Medicine Association
Renal Physicians Association
Society of Critical Care Medicine
Society of Nuclear Medicine and Molecular Imaging
Spine Intervention Society

Medical Association of the State of Alabama
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association Inc
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society

Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
Wisconsin Medical Society
Wyoming Medical Society