athenahealth

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 8013
Baltimore, Maryland 21244-8016

Submitted electronically to www.regulations.gov

Dear Administrator Verma:

Thank you for the opportunity to provide athenahealth's perspective 2019 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rules.

Over the last twenty-one years, athenahealth has built a network of over 115,000 providers who care for 110 million patients in both the acute and ambulatory settings. We provide electronic health record ("EHR"), practice management, care coordination, patient communication, data analytics, and related services to physician practices and hospitals. Consistent with our model in which all of our customers use a single instance of our cloud-based application, we have aspired to connect with partners across the care continuum to enable our clinicians to improve the quality of care they deliver while demonstrating success in CMS programs.

We applaud CMS's efforts in the PFS and QPP proposed rules to take impactful steps towards alleviating physician reporting burden by removing unnecessary measures and emphasizing outcome-based measures. For too long, government payment programs have asked physicians to take time away from direct patient care to perform administrative tasks that often do not directly contribute to improved patient outcomes.

As you recently wrote in a blog, "CMS fully acknowledges that we cannot operate in a 'way-we-have-always-done-it' manner and hope for different results."[1] We believe this logic can be applied across CMS programs to continue building on the agency's effort to reduce physician burden, focus on outcomes and promote interoperability. To advance these goals, we encourage the agency to consider the following:

1. **Improve access to CMS claims data for clinicians participating in CMS programs.**

In the 2019 QPP proposed rule CMS aims to increasingly hold physicians accountable for the cost of care and access to patient information from care settings besides their own. To fully implement the Quality Payment Program (QPP) and successfully transition to a payment model that improves clinical outcomes and lowers costs, CMS must first improve access to its own data.

CMS claims data is tremendously valuable in coordinating care, improving quality, reducing duplication of healthcare services, and managing costs. Today, these benefits are only realized by Accountable Care Organizations (ACOs). Current CMS policy renders paid claims data unnecessarily difficult to obtain and unavailable to many clinicians. Patient-identifiable

[1] https://www.cms.gov/blog/cms-doubling-down-health-it-patients

claims data is shared with ACOs, but not more broadly. Yet under MACRA's Merit-based Incentive Payment System (MIPS), clinicians are reimbursed based on their ability to perform essentially the same functions as ACOs, but without the benefit of the claims data that ACOs receive.

While there are existing pathways for access to CMS claims data outside of the ACO context (namely, the Virtual Research Data Center and Qualified Entity Program), those pathways are directed toward research and public reporting purposes, making them ill-suited for use in direct patient care. As a result, most clinicians lack a means to access updated patient-identifiable claims data that would help them deliver better care.

We believe that improving access to real-time or near real-time CMS claims data for MIPS and APM participants will promote interoperability and equip clinicians with valuable information they often lack when making care decisions. In addition to the clear benefits of identifying clinically effective or appropriate treatments, CMS claims data will help clinicians more efficiently and accurately document quality measures, coordinate care with other providers treating the same patient, and free patients from the error prone routine of filling out a medical history at every visit by pre-populating charts in advance of a visit.

We urge CMS to improve data access to clinicians in the same way the agency has focused on improving patient access via API through the Blue Button 2.0 initiative.

2. Increase alignment and consistency across all CMS programs.

It is clear this administration is acting in a manner that will reduce complexity and uncertainty for clinicians. As a technology partner to our physician clients, we consistently hear that CMS should go further to alleviate the burden placed on clinicians participating in all quality programs by continuing to focus on desired outcomes and applying the principles of Patients Over Paperwork initiative to all of its programs.

As the agency works to remove uncertainty in the rulemaking process by establishing consistent scoring calculations and performance metrics well in advance of the reporting period, they should do so in a manner that empowers clinicians in any practice size to have all the tools to successfully demonstrate performance to CMS while also maintaining the flexibility to improve their own individual practice in areas that reach beyond CMS payment rule purview. The technology partners clinicians use to participate in CMS programs are often the guiding force behind helping clinicians succeed in these programs. As more information is made available to clinicians and patients, the impact can often be more immediate and widespread if those resources are designed to scale and empower a technology company to better support its own customers participating in CMS programs.

In addition to these general remarks, we offer the following specific comments for the Physician Fee Schedule and Quality Payment Program 2019 Proposed Rules.

Evaluation & Management (E/M) Visits

athenahealth is glad to see CMS's efforts to reduce burden associated with E/M visits and we support changes that result in more efficient clinicians. However, we urge CMS to reconsider the way the agency plans to reduce coding burden. The introduction of new add-on G-codes to distinguish additional resources and complexities not covered in the new single payment rate will result in undue coding burden due to a lack of code-set alignment between Medicare and other payers. CMS should work for consistency across the industry and instead consider utilizing CPT codes before introducing HCPCS G-codes. Utilizing CPT codes and aligning with the AMA is a more sustainable, long term solution that relies on private sector best

practices and will minimize variation and confusion for clinicians and payers on cross-over claims.

Request for Information on Potentially Misvalued Services under the PFS
athenahealth encourages CMS to consider moving away from a claims-based data collection approach. Instead, CMS should pursue reporting through an EHR in alignment with the current MIPS reporting procedure. This reduces the coding burden on clinicians, better suits the shift to value-based payments and increases efficiency for both clinicians and their technology partners.

MIPS Promoting Interoperability Category – Public Health and Clinical Data Exchange Objective
We praise CMS for the flexibility of reporting on any two public health measures for the Public Health and Clinical Data Exchange objective. However, we ask CMS to provide greater clarity around the satisfaction criteria for this objective. The proposal states that a clinician may receive the full ten points for reporting two "yes" responses, or for submitting a "yes" for one measure and claiming an exclusion for another. In the latter scenario, there is ambiguity around whether an exclusion may be claimed as one of the two measures to report on when the clinician qualifies for reporting on a third measure. We ask CMS to clarify whether clinicians are obligated to first report on two measures for which they qualify (regardless of whether they would satisfy as a "yes" or not satisfy through a "no"), or whether clinicians may choose to report on an exclusion when they would have qualified for another measure. We believe that allowing clinicians to claim an exclusion when they would otherwise qualify for, but not satisfy, another measure gives the greatest level of flexibility and reduces burden associated with this objective.

MIPS and Advanced APMs
Consistent with our comments from previous proposed and final rules, athenahealth encourages the agency to improve transparency into program eligibility and participation to enable technology vendors to better serve their clinicians. As a health IT vendor supporting more than 35,000 clinicians in QPP, athenahealth finds the current process to search the CMS Participation tool on a case-by-case basis is not scalable and the tool hinders any technology vendor's ability to support the same clinicians that CMS aims to help through this tool. CMS should make a program eligibility API available to provide vendors' insight into clinician eligibility at a batch level rather than querying for individual eligibility. In addition to decreasing clinician burden, the bulk data will allow companies to better support their clients and ensure that no one is left behind.

In closing, we remain convinced that this Administration has an opportunity to set in motion a wave of innovation and efficiency in healthcare to lower costs, improve quality, and reduce the burden on clinicians. athenahealth looks forward to working together with you on these important issues. Please do not hesitate to reach out via email at gcarey@athenahealth.com or phone at 617-402-8516.

Sincerely,

Greg Carey
Director, Government & Regulatory Affairs
athenahealth, Inc.