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Submitted electronically via www.regulations.gov

Re: Modifications to the Medicare and Medicaid Electronic Health Record Incentive Programs for 2014 Proposed Rule; CMS–0052–P

Dear Administrator Tavenner and Dr. DeSalvo:

athenahealth, Inc. ("athenahealth") appreciates the opportunity to provide comments on the proposed rule entitled "Medicare and Medicaid Programs; Modifications to the Medicare and Medicaid Electronic Health Record Incentive Programs for 2014; and Health Information Technology: Revisions to the Certified EHR Technology Definition" ("Proposed Rule").

We provide practice management, electronic health record ("EHR"), patient communication, care coordination, and related services to physician practices, working with a network of approximately 50,000 healthcare professionals nationwide. All of our providers access our services on the same instance of continuously-updated, cloud-based software. Our cloud platform affords to us and our clients a significant advantage over traditional, static software-based health IT products by enabling us to take an active role in assisting our clients in achieving Meaningful Use ("MU"). Our client's successes, exemplified by an MU attestation rate more than double the national average, underscore the very real potential of health IT to improve care delivery and patient outcomes while increasing efficiency and reducing systemic costs. In fact, approximately sixty percent of the MU Stage 2 attestations to date have been by providers using athenahealth's 2014 certified EHR.

Our point of view is that the sole indispensable measure of "meaningful use" of any information technology should be actual interoperation between and among vendor platforms. Unfortunately, this continues to be a measure on which the health IT industry as a whole falls woefully short, to the detriment of patients and providers everywhere.

As such, we are disappointed that this Proposed Rule would further delay MU timelines. We understand that this delay is intended to ensure that providers, especially those in rural areas and those caring for underserved populations, are not left behind in the transition to a digital healthcare system. However, our clients, many of whom serve those rural and underserved populations, are a testament to the fact that the digital divide will be closed more quickly if health IT vendors are held to the standards necessary to enable their clients to achieve the reasonable goals of

MU Stage 2. Providers should not be punished for the shortcomings of vendors, but relief for providers does not need to constitute a free pass for industry laggards.

Simply stated, the federal government currently subsidizes the purchase and implementation of EHRs that do not, cannot, and in some cases will never enable care providers to meet the most basic information technology standards of the information economy in which we all work and live. That fact is the result of a series of failures in implementation of the MU program, beginning with certification standards that put a government stamp of approval on sub-par technologies, and ending, for now, with the latest proposed delay. Another delay will not give providers time to catch up; it will simply extend for another year the period during which the government subsidizes technologies that will never meet the standards of later stages of the MU program. This will further impede achievement of the 10-year vision for health IT laid out by ONC leadership.

In fact, this Proposed Rule explicitly *disincentivizes* rapid progress toward the goal of a modernized, digital healthcare system. There are four distinct features of this Proposed Rule that create a disincentive to innovate:

1. Table 2 ("PROPOSED CEHRT SYSTEMS AVAILABLE FOR USE IN 2014") and the accompanying text, are inherently inequitable. According to Table 2, leading edge physicians and EHR vendors who had judiciously and expediently built and adopted a "2014 Edition" Certified EHR and were on track to attest to MU Stage 2 in 2014, will be required to meet the more taxing Stage 2 requirements in order to receive the same incentive as the clients of lagging vendors who could not be "2014 Edition" certified in time. Providers using EHRs developed by vendors not committed to previously published MU timelines, in the meantime, would only need to demonstrate the simpler and more familiar Stage 1 measures.

   To be clear, we are not suggesting here that the MU Stage 2 requirements are particularly wrong or unnecessary. However, they represent a tremendous sea-change in the behavior of the clinical practice, and any reasonable provider will view such requirements as burdensome and unfair when their peers "across the hall" are not held to the same standard.

2. The inequity created by the Proposed Rule is accentuated by the fact that the primary goal of MU Stage 2 is to (finally) achieve interoperability and break down data silos that hurt patients. Since this Proposed Rule lets a large subset of providers and vendors off the hook for implementing an interoperable, 2014 Certified EHR this year, the reality is that the early adopters have an altogether more significant challenge ahead of them: after all, how are they supposed to interoperate without another party with which to interoperate? This Proposed Rule prunes the community of potential health exchange partners and again disproportionately disadvantages the innovators.

3. The Proposed Rule discourages early adoption. Again, according to Table 2, if a provider were to adopt a 2014 Edition EHR in time for MU Stage 2 submission this year, they would be held to the higher Stage 2 standard (assuming they had not already attested earlier in the year to Stage 1 with their previous vendor/software). As such, the provider is incented *to hold off* on any such upgrades or investments to modernize their practices – exactly the opposite effect that the government was presumably seeking.

4. Finally, by delaying and changing the rules of the MU program five months ***after*** Stage 2 has already gone into effect – and long after the hardest work had already been done by both the EHR vendor community and the most conscientious physicians – this proposal accomplishes little except to give a free pass to those who could not keep up with the pace of change in healthcare. Coupled with the recent, similar (though more equitable) delay of the ICD-10 program, the signal emanating from the federal government is now a very clear "status quo is the way to go", which again defeats the goal of achieving a modernized healthcare system.

We urge CMS and ONC to reconsider this rule. In our view, the delay itself is unjustified. If hundreds of providers have already managed to attest to MU Stage 2, then govcernment should be incenting the entire community to achieve that higher standard and emulate the beacons of healthcare innovation and interoperability.

Again, providers stuck with EHR technology that cannot meet the 2014 requirements in time to attest to Stage 2 should not be penalized or left behind. The new hardship exemptions announced earlier this year for such providers were an acknowledgment of that fact. However, there should be greater transparency about the EHR vendors used by providers attesting to their inability to implement a 2014 Certified EHR in time to meet Stage 2 this year, whether that is through a hardship exemption or this Proposed Rule. We recommend that agencies publish information about vendors whose technology was the basis for such an attestation, including the number of times that such an attestation was made about their technology, so that providers can account for that information in future purchasing and upgrade decisions.

As always, we appreciate this opportunity to comment.

Sincerely,

Dan Haley
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athenahealth, Inc.