June 15, 2015

311 Arsenal Street
Watertown, MA 02472

Marilyn Tavenner, R.N.
Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically via www.regulations.gov

Re: CMS-3311-P; Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Modifications to Meaningful Use in 2015 through 2017

Dear Administrator Tavenner,

athenahealth, Inc. ("athenahealth") appreciates the opportunity to provide comments on the proposed Modifications to Meaningful Use in 2015 through 2017 ("Proposed Rule").

As you know athenahealth provides electronic health record ("EHR"), practice management, care coordination, patient communication, data analytics, and related services to physician practices, working with a network of more than 60,000 healthcare professionals who serve over 60 million patients in all 50 states. We envision and work to establish a nationwide health information backbone that makes healthcare work as it should by connecting patients and care providers with the information they need to seek and provide high-quality, cost-effective, efficient care. All of our providers access our services on the same instance of continuously-updated, cloud-based software. Our clients' successes, exemplified by a Meaningful Use ("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.

As we noted in our comments to the Electronic Health Record Incentive Program, Stage 3 proposed rule, we appreciate the extent to which the Centers for Medicare and Medicaid Services ("CMS") has incorporated stakeholder calls for reform, flexibility, and simplification of the MU program. We believe that certain aspects of the Proposed Rule, such as the shift to a 90-day reporting period for 2015, will alleviate some of the administrative burden associated with the MU program. However, we urge CMS to resist easing Stage 2 requirements in a way that undermines the goals of meaningful use. Program modifications that reduce the administrative complexity of MU compliance are welcomed relief for care providers already struggling under the cumulative burden of many overlapping government programs. Modifications that allow inferior technology products to maintain certification despite falling woefully short of provider expectations, however, do neither providers nor the healthcare system any favors in the long term.

We understand that many changes are 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 high standards necessary to enable their clients to achieve the reasonable goals of MU Stage 2. Over 98 percent of our eligible provider clients attested to Stage 2 in 2014, proving that the Stage 2 bar can be met by a wide range of providers using technology that enables, not hampers, their success in the program. While we feel strongly that the providers who have requested relief from the Stage 2 requirements should not be punished for the shortcomings of their vendors, relief for providers does not need to constitute a free pass for industry laggards.

Specific Comments

Reporting Periods

athenahealth supports the proposed 90-day reporting period for 2015, not because the reversion is necessary for our clients' success in the program, but because it will allow other providers to transition from EHRs that are incapable of enabling success in the MU program to 21st century technologies that can actually improve patient care. We urge CMS to revise its proposal for a full-year reporting period in 2016 to include some leeway for providers—particularly those who declared their EHR the basis of a hardship exemption—to transition to a new EHR. Simply put, a full-year attestation period leaves no time for a provider who is unsatisfied with her EHR to make a change. If CMS maintains a full-year reporting period in 2016 with no exceptions for providers switching EHRs, many providers will be forced into an unacceptable choice: forego participation in the MU program and accept the corresponding penalties, or continue to be locked into use of inferior technologies that do not sufficiently support their success in MU.

Many of our clients who are generally pleased with the proposed changes to Stage 2 have nevertheless expressed concern about the administrative impact of a mid-stream course change. We therefore request that CMS work expeditiously to make the necessary system changes so that 2015 and 2016 MU attestations can proceed without disruption. CMS should accept 2015 attestations beginning no later than October 1, 2015 to alleviate administrative burden on attesters. It is unreasonable for CMS to expect providers to adjust in real time to mid-year rule changes when its own systems cannot be adjusted as quickly.

Additionally, athenahealth requests that CMS clarify how it will treat Medicare and Medicaid eligible providers who demonstrated Meaningful Use before the finalization of the Proposed Rule. Our recommendation is that Stage 1 Year 1 providers who meet the current program objectives before the Proposed Rule is finalized should be able to attest using current program requirements. Further, we recommend that providers in Year 2 and beyond should be able to attest to the proposed updated program requirements from any 90 day period in 2015 (as opposed to restricting their attestations to a 90 day period after the Proposed Rule is finalized). We also request guidance on whether states will be required to take an approach consistent with CMS on this issue.

Finally, we urge CMS to allow first-time meaningful users to attest for any 90-day reporting period in 2016 and not impose the arbitrary October 1 deadline. The October 1 deadline imposes a significant administrative burden on practices, because it requires them to separately track providers attesting to MU for the first time and ensure that this subset of attestations are submitted on a different timeline

than the rest of the practice. We request that CMS make additional adjustments on its end to enable an attestation deadline that is consistent across all providers.

Patient Engagement

athenahealth does not support easing the patient engagement measures in MU Stage 2. We understand that successful completion of these measures is not easy, but our eligible providers—over 98 percent of whom successfully attested to MU in 2014—prove that the challenge is not insurmountable. More importantly, our clients, many of whom complained about these new measures initially, have told us that while meeting them was initially difficult, the resulting improvement in patient engagement was worth the effort. According to athenahealth client Dr. John Kulin, the increased patient engagement resulted in better quality care that was more easily coordinated with patients:

> "While the secure messaging requirement was tough to meet in the urgent care setting, we saw an increase in patient engagement due to it. For example, we saw a decrease in the number of patients requesting antibiotics for upper respiratory infections due to the increased connectivity to our practice and ability to contact us back via secure messaging at their convenience."
>
> Dr. John Kulin
> The Urgent Care Group
> Manahawkin, New Jersey

We urge CMS to keep Stage 2 focused on activities, like patient engagement, that will produce truly meaningful improvements in the quality of care. MU measures should be eased and simplified to align with a more focused approach, not merely because they are challenging.

Structured Labs & Imaging

athenahealth urges CMS to reevaluate the removal of the structured lab results and imaging measures, which were identified as redundant, duplicative or topped out. Keeping these measures will help to ensure that the right incentives exist to enable electronic or discrete access to this data within a patient chart. The removal of these measures from the Meaningful Use program will be viewed in the industry as the dismissal of the endorsement of these types of electronic exchange. However, much of this data, particularly discrete lab result values, are essential for appropriately tracking a patient's progress against evidence-based clinical quality measures such as those found in the Physician Quality Reporting System ("PQRS") program. Although other programs benefit from the existence of discrete lab result data, it was not until MU Stage 2 that we experienced a dramatic uptick in interest and support from our providers and lab vendors in developing additional lab result interfaces. Since we began supporting the MU Stage 2 program, we have implemented 50% more lab result interfaces on behalf of our clients participating in MU Stage 2 than for the rest of our provider population. These interfaces would not have been established without willingness on the part of the lab system software vendors.

Since the Proposed Rule was published, we have already experienced several vendors eliminate their support of lab result and PACS Link interfaces. Both interface types are valuable to providers and

promote patient care. Within athenahealth's EHR, interfaced lab result data is significant for patient care because it results in better-labeled result documents for a provider's review, automatically highlights abnormal values for better transparency to urgent results, automatically ties a result to its order, and promotes real-time data exchange, all of which allow providers to have the clinical information they need to make decisions at the point of care while minimizing time spent sorting through result documents.

Summary of Care

We recommend that nationwide health information network ("NwHIN") governance mechanisms, such as Direct, should continue to be an acceptable baseline standard for information exchange. While governance mechanisms must remain flexible to allow for the development of future standards, backsliding away from the Direct standard and allowing the Summary of Care objective to be accomplished through any electronic means, without a required baseline capability, could increase the need for investment in point-to-point integration without any clear functional benefit.

Public Health Reporting

athenahealth supports the increased emphasis of public health exchange in Stage 3 and appreciates that the proposed changes for 2015 to 2017 are designed to prepare providers for the Stage 3 requirements. However, a clearly stated goal of the proposed changes was to reduce provider burden. For many providers, the proposed changes for Stage 2 will require that they pursue additional public health measures, which would increase, not reduce the attestation burden on providers. For example, a Stage 2 provider that does not administer vaccines is currently excluded from the immunization registry core measure could currently be meeting the Stage 2 Final Rule criteria without "actively engaging" with a public health registry. There are also providers that do not administer vaccines but are currently meeting a single public health menu measure (Cancer or Specialized Registry). Providers will now need to scramble to establish active engagement with additional public health registries in order to meet the additional requirements under the Proposed Rule. The proposal is creating additional burden for providers by mandating that they seek out additional registries, which will be compounded by the short window that providers will be given to do this in 2015. It's also highly likely the public health agencies will not be able to support this sudden uptick in demand. We encourage CMS to modify this requirement to include a single public health objective per Stage 2 provider.

Measure 1 (Immunization Registry Reporting)

athenahealth supports the addition of a bi-directional requirement for the immunization registry reporting measure. We have successfully established bi-directional exchange with a number of state registries and agree that this functionality is important for patient safety. However, in our experience, 29 states and local registries (out of 55 total) are still not able to support bidirectional exchange. We suspect that if bidirectional exchange is mandated, most states and localities will either not be able to support at all or will not be able to keep up with the sudden demand of providers looking to establish bi-directional exchange. A clear and easily

administrable exclusion clause should be added to this measure for registries that are not ready to support bi-directional exchange.

Measure 2 (Syndromic Surveillance Reporting)

We agree with CMS's finding that few public health agencies have the ability to accept non-emergency or non-urgent care ambulatory syndromic surveillance data electronically. As a result, we have sought out other public health options for our providers because of the inability of public health agencies to work with our ambulatory provider population. The exclusion for eligible providers who operate in jurisdictions where public health agencies are not capable of receiving data electronically is appropriate for this measure.

Measure 3 (Case Reporting)

athenahealth seeks additional clarity on the proposed case reporting measure. Is the goal of case reporting not similar to that of syndromic surveillance reporting? We urge CMS to consider the applicability of case reporting for the broader eligible provider population before including it in the final version of this Proposed Rule. Including the functionality to both send and receive requests for case reporting information could require a significant investment without a clear benefit for our provider population, as we suspect that most would be excluded.

Measure 4 and 5 (Public Health & Clinical Data Registry Reporting)

athenahealth requests greater clarity and consistency around public health and clinical data registry reporting. We are concerned that the new definitions of public health registries and clinical data registries will generate confusion without further guidance provided by CMS. Further, in our experience, many states are selective in which clinical data registries (formerly specialized registries), they'll accept for eligible provider Medicaid Attestations. We support the creation of a centralized repository on public health readiness and think that this could eliminate confusion on the registry type definitions as well as help states standardize the registries that they'll honor for provider Medicaid attestations. As part of this effort, athenahealth requests that CMS work more closely with state Medicaid offices to ensure that they will accept all clinical data registries that record information about the health status of patients and the health care they receive over varying periods of time.

Requests for Clarification

In the Proposed Rule, under Active Engagement Option 3 of the Public Health and Clinical Data Registry Reporting objective, CMS stated that any prior action taken to meet the non-consolidated public health reporting objectives of MU Stages 1 and 2 would not count toward meeting the active engagement requirement. We request clarification that a test message executed by a provider participating in MU Stage 1 before the publication of this final rule will still be sufficient to meet the Immunization Registry Reporting measure.

Additionally, we request clarification on CMS FAQ #10754, which states that the security risk assessment may be completed outside of the EHR reporting period so long as it is after the start of the EHR reporting year and before the attestation date. We implore CMS to maintain this FAQ and officially recognize it in the final rule. Due to the change in program rules that will occur in 2015 once this Proposed Rule is finalized, a provider may have already completed their security risk assessment thinking their reporting period was the entire calendar year. If, once finalized, the 2015-2017 MU changes no longer recognize FAQ #10754, and require that the security risk assessment be completed during the reporting period, this may result in providers having to complete two security risk assessments in 2015. Such a result would be unnecessary and outside the intent of the MU program.

As always, we appreciate the opportunity to comment.

Sincerely,

Dan Haley
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Assistant General Counsel
athenahealth, Inc.