athenahealth

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1701-P
P.O. Box 8013
Baltimore, Maryland 21244-8013

Submitted electronically to www.regulations.gov

Dear Administrator Verma:

Thank you for the opportunity to provide athenahealth's perspective on the Medicare Shared Savings Program (MSSP) "Pathways to Success" proposed rule.

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 support CMS's efforts in the MSSP proposed rule to foster a more accountable healthcare marketplace, while promoting interoperability through the wider adoption of EHR technology. Our healthcare ecosystem must incentivize the seamless exchange of information and financial responsibility to achieve meaningful cost reduction.

As CMS continues to identify opportunities to overhaul the status quo in healthcare, we believe that the agency should continue its effort to reduce physician burden, focus on outcomes and promote interoperability. To advance these goals, we encourage CMS to consider the following:

1. **Increase alignment across quality reporting requirements**

athenahealth believes CMS should examine all rulemaking with an eye towards reducing physician documentation burden and enabling innovative technologies to enter the market to support that mission. We believe that replacing Meaningful Use electronic health record quality measures with ACO attestation that the majority of eligible clinicians use CEHRT will add value to ACO participants. However, CMS should also be cognizant of the fact that, while the adoption of CEHRT is certainly important to the success of ACOs, technologies falling outside of the scope of CEHRT also contribute to success in two-sided risk programs. As CMS continues to develop MSSP quality measures as part of the Meaningful Measures initiative and those that would assess opioid utilization, we request that CMS streamline these requirements with other Medicare programs – and non-Medicare programs when possible – to reduce data collection and duplicative physician work. We also propose that CMS avoid selecting a quality measure that is prohibitively difficult to calculate and track, particularly if such measures have not been proven to drive meaningful improvement in patient outcomes.

2. **Reduce financial barriers for low-revenue ACOs to participate in MSSP**

CMS has indicated that low-revenue, physician-led ACOs generate more savings for Medicare, on average, than high-revenue ACOs. As the agency seeks to ensure that MSSP remains accessible and attractive for smaller and lower-revenue ACOs, we encourage the agency to minimize financial barriers to entry. Below are several recommendations to streamline CMS's data-sharing and reporting processes to lower costs incurred by ACOs and their technology partners.

As athenahealth has experienced firsthand, the necessary investment in healthcare IT systems is not an insignificant business decision for these low-revenue ACOs, which often exist on razor-thin margins. From athenahealth's experience, financial hurdles for forming an ACO have often deterred prospective groups from participating in MSSP. Alternatively, we have also experienced low-revenue ACOs successfully join MSSP and demonstrate a real value add to patient outcomes amidst constraining financial situations. CMS should continue to identify ways to allow private sector innovation to lower barriers of participation for physicians and technology vendors who partner with ACOs to demonstrate savings.

Currently, the operational complexity of CMS's data sharing and reporting processes, as well as a lack of consistency in data formats, requires that technology vendors significantly invest in understanding and adjusting to changes. There is a real opportunity cost associated with this. Every dollar that is spent untangling the complexities of MSSP is routed away from innovation which improves outcomes at a lower cost – the explicit purpose of this program. Together, the following recommended changes would increase efficiency for vendors to ingest, render, and extract data on behalf of MSSP ACOs and enable improved outcomes and greater cost savings.

- **Streamline CMS data-sharing**
  Today, CMS sends a quarterly package of information, including beneficiary assignment files (QASSGNs) and financial reporting, which is distinct from the monthly claim and claim line feed files (CCLFs). We recommend that CMS send the quarterly beneficiary package with updated eligibility each month with the CCLF set. This change would enable vendors to manage a single set of data per cycle, allow for a more thorough and timely review of eligibility and client metrics, and eliminate the work of maintaining a member month creation model that infers membership based on a variety of factors.

- **Improve transparency and consistency of standards for CMS data files**
  Current ambiguity around CMS's logic for certain reports, such as the QEXPU reports, creates substantial work for providers and vendors who are required to "back into" CMS calculations. We recommend that CMS either provide the reports monthly and/or provide ACOs with the necessary information to calculate this independently (e.g. non-claims-based payments, non-data-sharing financials, substance abuse claims).

  Additionally, CMS does not share documentation of the CCLF and beneficiary eligibility data model with data vendors. We request that CMS provide a schema diagram, entity relationships, and detailed description of data elements before they are combined or calculated, which would provide vendors more insight into how key fields and calculations are related and derived, which would allow more efficient and accurate mapping and reporting.

- **Add certain data elements in CMS-shared data files**
  CMS currently does not include a one-to-one relationship between a beneficiary and a responsible provider, but instead provides the top three providers without indication of priority on a quarterly basis on the QASSGN. We recommend that CMS include the

responsible provider associated with the beneficiary for the month in the CCLF8 file and QASSGNs. This change would eliminate the work of determining and maintaining an attribution model that attempts to mimic CMS' suggestions.

Additionally, CMS should provide beneficiary addresses in either the QASSGN or CCLF files, which it currently does not, to improve efficiency in patient matching and reduce the need for manual patient merges.

- **Update GPRO processes**

  - **Extend File Format Lead Time**
    We request that CMS send the file format specifications and sample data with more lead time - a minimum of 12 weeks before receipt of clients' files - to ensure that vendors have adequate time to plan for changes without disrupting client-facing initiatives, update systems to accommodate changes to file formats, and adjust operational processes that support clients' reporting needs.

    Additionally, we request that CMS offer a testing environment in which vendors may upload submission test files and test the GPRO UI to ensure compliance with the required specifications, rather than relying on clients to test submission files with PHI after the reporting period has begun.

    We also ask that CMS minimize year-by-year changes to GPRO, only providing updates that offer clear, demonstrable benefit for participating providers and their technology partners. This will help drastically reduce the hours dedicated to explaining the interpretations of these measures and last-minute resource diversion. When changes are made, we ask that CMS communicate them in a consistent and well-publicized manner to all stakeholders.

  - **Adopt a Consistent, Clear Measure Specification Format**
    Today, CMS has defined at least three different versions of each of their measures: machine-readable (eCQM), claims-based, and user reported (Web Interface/GPRO). While we believe the eCQM is the source for the Web Interface specification, there are differences between the versions that suggest human error is at play. Additionally, because CMS sends measure specifications in a narrative format, both vendors and participating ACOs must interpret the narrative. This requires substantial effort to translate into code in order to enable tracking and monitoring on the measures, which makes it, too, prone to human error.

    We ask that the Web Interface stay true to the eCQM version of each measure, rather than provide a separate, narrative version of the specification. This will ensure that vendors supporting ACOs can code the measures accurately and avoid ambiguous, time-intensive work of interpreting and coding the measures. Using the eCQM version would make automated reporting possible for provider organizations. Automation would help providers eliminate administrative work (staff are needed to validate each measure and input) and reduce human error. In turn, fewer errors will reduce work needed during the reporting period to make corrections and other changes.

  - **Allow Claims Data in the Reporting Process**
    The current GPRO submission process accepts exclusively clinical data. While valuable in its current form, capturing holistic data offers a more complete picture of patient care. For example, athenahealth aggregates data from claims, EHRs, labs, user entry, and commercial payers in order to better inform physicians on

patient-level care gaps and empower them to provide higher quality of care. CMS should encourage a more comprehensive perspective of patient health by incorporating data from all valid sources in the GPRO submission process.

- **Allow Health Technology Vendors to Submit ACO Clients' GPRO Data** Currently, technology vendors are not provided access to submit data to the GPRO interface on behalf of their ACO clients. This results in either time-intensive effort of the clients themselves and/or the payment for temporary staff and service agencies to complete the submission. To relieve this undue burden on ACO participants, CMS should allow technology vendors to easily send quality measure data directly to the agency via industry-standard API.

- **Adopt Standard Formats for Export Data and Ingesting Patient Data** The unique data ingestion format required for the GPRO reporting process creates a substantial amount of work for vendors to reformat our exported data into a format that can be submitted. We recommend that CMS use an industry-standard format for ingesting patient data. This should not be limited to MSSP participants, but ideally apply to all Medicare reporting programs.

3. **Share prescription drug cost data to enabling more comprehensive cost tracking and reporting**

CMS does not currently share information about prescription costs (e.g. ingredient cost, dispensing fee, coinsurance, copay, deductible, allowable, etc.). To further increase transparency in healthcare, we request that CMS add prescription cost fields to the existing Part D CCLF file, including beneficiary payment information. This transparency would allow for improved analysis of pharmaceutical spending and the deployment of cost saving measures across ACO participants, enabling them to achieve greater Medicare savings.

In closing, we believe the proposed MSSP changes are a logical next step in the transition to value based care. We urge CMS to use caution when implementing changes quickly and consider the role that technology vendors play as partners to their clients who participate in a variety of agency programs. Technology vendors sit in a unique position to greatly lower the costs and improve the quality of care their physician clients deliver when they are free to innovate and compete on value of services delivered. 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.