June 27, 2016

Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-5517-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Merit-Based Incentive Payment System and Alternative Payment Model Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models Proposed Rule

Submitted electronically through www.regulations.gov

Dear Administrator Slavitt,

athenahealth, Inc. ("athenahealth") appreciates the opportunity to respond to the Merit-Based Incentive Payment System ("MIPS") and Alternative Payment Model ("APM") Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models Proposed Rule ("Proposed Rule").

We provide electronic health record ("EHR"), practice management, care coordination, patient communication, data analytics, and related services to physician practices and hospitals, working with a network of over 78,000 healthcare professionals who serve over 60 million patients in all 50 states. All of our clinicians access our services on the same continuously-updated, network enabled, cloud-based platform. 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.

General Remarks

As we noted in our November, 2015 comments to the Centers for Medicare and Medicaid Services ("CMS"), the passage of the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") represents a significant opportunity for CMS to implement the changes necessary to achieve the goal set by the Department of Health and Human Services ("HHS") to tie ninety percent of Medicare fee-for-service payments to value or quality by 2018. To capitalize on this opportunity, we encouraged CMS to further reduce the heavy-handed bureaucracy has plagued related agency programs to-date.

We appreciate the good faith effort by CMS to respond to feedback from stakeholders reflected in the Proposed Rule. But the road to bloated, complex, and unpopular regulatory regimes is paved with good intentions. Whatever the intention, in a rule totaling nearly one thousand pages, clinicians participating in the Medicare program will find a Quality Payment Program ("QPP") that is more complex than the programs it replaces.

athenahealth clients are proof that clinicians can jump through the hoops erected by CMS to achieve Medicare payments. Our MU attestation rate is more than twice the national average, and almost 99 percent of our clients will avoid penalties under the Physician Quality Reporting System ("PQRS") and Value-Based Modifier ("VM") programs in 2016. Therefore, our criticism is not that the existing or proposed programs create hurdles that are too high. Rather, we question whether the increasingly complex burdens associated with program participation result in better care. To the contrary, our experience tells us that clinicians could focus more on patients if less time was spent box-checking and trying to understand the ever-changing rules of the reimbursement game.

To reduce the likelihood of yet another decade of complexity and stagnation, we recommend that CMS consider the following three major thematic recommendations as it finalizes the rules for MIPS and APMs:

1. **CMS should ensure that in giving clinicians flexibility, it is not drowning them in excessive and opaque choices with thousands of attached strings.**

   In finalizing the Proposed Rule, we encourage CMS to identify areas where it can continue to simplify. In heeding stakeholder calls for flexibility, CMS has created excessive complexity. The result, as many observers have commented, could well be the end of private practice in healthcare. Provider frustrations with the MU program clearly demonstrate that a one-size-fits-all approach is insufficient, but options should be transparent and easy to navigate.

   For example, the Advancing Care Information ("ACI") category still includes a menu of options falling into three different components of the composite score for that category. The Quality category will include over 200 possible measures, and clinicians will need to ensure that they are choosing the right number of different types of measures, which changes based on practice size, type, and the availability of applicable measures. Under this Proposed Rule, clinicians will struggle to determine which measures they should choose, and the proposed process for "topping out" measures will leave clinicians with no insight into how they are performing against the goal within a given reporting period.

   CMS's goal should be a program that enables any clinician—from a solo practitioner to the employee of a large health system—to feel confident that they know what needs to be done to avoid a negative payment adjustment. Unfortunately, CMS's own estimation that 87 percent of clinicians in small practices will see a negative payment adjustment in 2019 is proof that CMS is establishing a regime with such complexity that only clinicians armed with incredible administrative and technical resources can succeed.

2. **Before it focuses its attention on QPP implementation, CMS *must* address the lack of transparency and data access for clinicians participating in its programs.**

   Success under QPP depends on clinicians' ability to become increasingly accountable for the cost and quality of the care they deliver. This level of accountability, in turn, depends on real-time access to data; from an individual patient's medical record to aggregated data on

the health of an entire patient population, clinicians can only improve outcomes if they know at all times where they stand.

CMS should not begin to implement a program as complicated as the QPP if it does not have the information systems in place to support QPP participants with the data necessary to perform and succeed. Where CMS holds information such as claims data, benchmarks, and reports like the Quality and Resource Use Reports ("QRUR"), it should endeavor to provide that information to clinicians in as close to real time as possible.

3. **The Office of the National Coordinator for Health Information Technology ("ONC") Certification Program is increasingly disconnected from CMS's work to streamline pay-for-performance programs and transition to APMs. CMS should not rely on ONC's 2015 Edition Health IT Certification Criteria as a requirement for success under QPP.**

   ONC's Certification Program no longer concerns itself with the EHR functionality necessary to succeed under MIPS, and it is even further removed from the functionality necessary for successful APM participation. For the first several years of the MU program, certification criteria were tied to MU measures. Though burdensome, certification was directly related to clinicians' successfully meeting MU requirements. CMS has made progress toward simplifying MU and now the ACI category of MIPS, but unfortunately ONC has not followed suit in the Certification Program. As a result, certification is an incredible drain on health IT developer resources with no incremental gain to patient care. Increasingly, the vast majority of provider complaints about EHRs stem from functionality required by certification and the fact that each year significant developer time is diverted from projects to improve interoperability and usability so that certification can be maintained.

   In our November 2015 comments, we reminded CMS what the American Medical Association and 110 state and national medical societies stated about MU in a letter to Congress in late 2015: "the success of the program hinges on a laser-like focus on promoting interoperability and allowing innovation to flourish as vendors respond to the demands of physicians and hospitals rather than … ill-informed check-the-box requirements of the current program." We applaud CMS for its efforts to heed that advice, but note that the Certification Program continues to threaten that progress.

   As a direct result of the 2015 Edition Health IT Certification Criteria, the rapidly growing momentum toward achieving the shared goal of widespread interoperation will be ground to a halt. Vendors have finite resources, and developer time will be taken away from collaborations like the CommonWell Health Alliance, the Argonaut Project, and Carequality to participate instead in another round of baseline compliance demonstrations. Innovation will cease in favor of proving basic capabilities, like electronic prescribing, even though CMS no longer requires clinicians to demonstrate their ability to use such functions. Clinicians now expect these basic functionalities to be a part of any EHR, and these market expectations—not over-regulations—are sufficient to ensure that health IT vendors will continue to include and support the things that no longer need to be a part of certification.

   Perhaps more importantly, an EHR certified under the 2015 Edition Health IT Certification Criteria in more likely to hinder clinicians participating in an APM than it is to enable their

success. APM participants need innovative technology solutions to help them track population health and coordinate care with other clinicians, not an automated box-checking system. CMS should not be deceived into thinking that EHRs that are bloated with certification-required functionality will help to usher in a new wave of value-based care.

We urge CMS to work with ONC on a Certification Program that focuses on the basic functionality needed for success under QPP. The 2015 Edition Health IT Certification Criteria is not the answer.

Specific Comments

With these general themes in mind, we make the following specific recommendations for improvements to the Proposed Rule:

1. *MIPS Advancing Care Information Performance Category*

The proposed structure and scoring of the ACI category demonstrates that CMS listened to stakeholder feedback, and we applaud that effort. The "all or nothing" scoring of MU was a major source of frustration for clinicians, and the scoring in the Proposed Rule is a more accurate reflection of a clinician's performance. We support the elimination of measures to demonstrate use of basic functionality, such as Clinical Decision Support and Computerized Provider Order Entry, in favor of measures more appropriately focused on information exchange.

However, the proposed ACI measures still do not accurately represent activities that will meaningfully move the needle on interoperation, and we do not believe that provider time is well-spent demonstrating these measures. As we have previously highlighted, the shared goal of all health IT stakeholders is widespread interoperability. Very significant progress toward fully interoperating health systems has been made in the private sector, independent of federal efforts to address the issue. Multi-stakeholder initiatives driven by market demand have begun the difficult process of tying together disparate vendor platforms and care settings. The degree of real, functioning interoperability today is orders of magnitude greater than a year ago, and the pace of progress is accelerating. It is crucial, therefore, that in its efforts to "fix the interoperability problem," CMS does not implement policies that inadvertently impede or slow this private sector progress.

In finalizing its rules for the ACI category, CMS should focus on widespread "*interoperation*" (an activity) in health care, not mere "*interoperability*" (a capability). Any ACI measures that are not focused entirely on the *outcome* of actual information exchange among clinicians or patients should be removed from the ACI category.

CMS should seek ways to further incentivize results while empowering clinicians to determine specific areas to utilize technology to improve patient outcomes for their population. For example, while some clinicians find secure messaging to be a valuable method of engaging with patients, certain specialists that have limited patient interactions will find themselves forced to into generic, low-value communications with patients solely to maximize their ACI score. While we agree with CMS's intended goal in reforming the MU program, we believe that the proposed

ACI category is still another example of CMS imposing one-size-fits-all measures and box-checks instead of allowing clinicians to focus wholeheartedly on delivering quality care while incentivizing improved outcomes.

a. ACI Health Information Exchange (HIE) Requirements

CMS should not expand certification criteria to include participation in HIE and the use of specific standards. athenahealth remains convinced that the imposition of any "top down" government standard sets the bar far too low and will impede private sector interoperability progress. Given the rapid progress toward ubiquitous information exchange being made by private sector collaborations, it is imperative that future progress not be stifled by heavy-handed government requirements just as organically market-driven initiatives are getting off of the ground.

Furthermore, "health information exchange" should increasingly be a verb, not a noun. CMS should not pursue policies that prop up and provide life support to the largely struggling state and regional HIEs. When HIE is encouraged as a "thing" and not an activity, it incentivizes data siloes and additional layers of complexity for accessing information. We urge CMS to avoid a requirement of use of HIE and focus instead on the outcomes that inherently incentivize clinicians and health systems to share information.

b. ACI Reporting Period

While we understand CMS's intent in creating a reporting period that is consistent across all MIPS categories, we strongly urge that CMS reconsider a 90 day reporting period for the ACI category for 2017 to avoid unintended consequences as health IT vendors and clinicians transition from the MU program to MIPS. The MU Stage 3 Final Rule that was published by CMS late last year included a 90 day reporting period. Vendors allocated resources and clinicians began planning with an expectation that Stage 3 readiness would be required by October 2017 in order to successfully attest to Stage 3 measures over a 90 day period in 2017. If CMS finalizes a full year reporting period for ACI, it is very unlikely that many clinicians will be equipped with an EHR certified to the 2015 Edition Health IT Certification Criteria by January 1, 2017. As a result most clinicians will only be able to perform the six modified Stage 2 ACI measures, not the eight Stage 3 measures that potentially yield the maximum score.

Alternatively, if CMS keeps the full year reporting period requirement for the ACI category, it should revise its scoring methodology so that performance of the six modified Stage 2 measures can result in the same score as the eight Stage 3 measures. Again, while we understand CMS's intent to implement a scoring methodology that incentivizes clinicians to aspire to more difficult measures, doing so in the ACI category in 2017 will unfairly penalize clinicians for vendor certification timelines over which they have no control and that were reasonably resourced based on expectations set by CMS rulemaking in 2015.

c. ACI Scoring

The Proposed Rule states that the Secretary may reduce the ACI category weighting up to 15 percent in any year where 75 percent of eligible clinicians are deemed meaningful EHR users. We understand CMS's mission to promote continuous improvement through its

scoring methodology. However, this variable adjustment reduces scoring transparency for clinicians. To allow clinicians to make informed decisions and adequately prepare for future years, we suggest that CMS maintain the same weighting or set predictable adjustments year over year, similar to the design of the Resource Use weighting, well in advance of reporting period start dates.

2. *MIPS Quality Performance Category*

We support CMS's intent to tie performance to the actual care an eligible clinician provides in the Quality section of MIPS. The shift incentivizes improved health outcomes and seeks to make the measures more impactful. The reduction in required reporting measures from nine to six and the elimination of the domain requirement is an improvement over past programs.

CMS's recognition that certain categories have been "topped out" appropriately seeks to discourage repetitive submission of non-relevant data. While well-intended to drive continuous quality improvement, we have concerns that the downward scoring adjustment of "topped out" measures decreases physician choice and reduces reporting transparency. Clinicians invest limited resources to meet the program requirements. Setting the total potential points available for measures based on other clinicians' performance creates uncertainty and leaves clinicians unsure of their scoring potential when selecting measures. A clinician should be able to make clear, well informed decisions for resource investment in order to succeed in MIPS. Therefore, we recommend CMS allow new measures an initial one year reporting period to establish benchmarks before determining whether a measure has "topped out." In order to promote transparency, the total points available for each measure should be known at the start of the reporting period.

We are particularly concerned with the inclusion of "topped out" measures in the cross cutting requirement. Since the entire cross cutting category is nearly "topped out," clinicians will be forced to report on measures that will earn them fewer points. This directly contrasts CMS's goal to provide more flexibility and provider choice. The available options should be entirely transparent and easy to navigate. We recommend eliminating the cross cutting measure requirement or altering the scoring to allow the first cross cutting measure to be scored on an "all-or-nothing" scale.

3. *MIPS Resource Use Performance Category*

As proposed, the Resource Use category demonstrates CMS's resolve to learn from the VM program and implement a more sustainable set of rules. The utilization of proven cost measures from the VM program appropriately leverages past success. The weighting increase in the overall MIPS score year to year is an improvement that shows the long-term vision to improve costs. The recognition and incorporation of iterative progress gives vendors and physicians a clear path for preparation. Most importantly, CMS's proposal to release reporting thresholds in advance of the reporting period is a significant improvement in transparency.

The adjustments to the overall framework are positive, but we also believe there are clear and necessary improvements to the Proposed Rule to implement the Resource Use category successfully. As we have previously stated, CMS must improve physician feedback. CMS should recognize that the biggest barrier to successful Resource Use improvements is the lack of physician and vendor access to timely and usable performance feedback reports. In order to make impactful improvements in Resource Use, we make the following three recommendations regarding dissemination of the QRURs and other performance feedback:

- Ideally, feedback on performance could be provided by CMS in real-time. However, recognizing that this may not be feasible in the foreseeable future, we suggest that CMS strive to give clinicians all feedback on at least a quarterly basis.

- Performance data, and the QRUR in particular, should be easily available not just to clinicians but also to their third-party partners, particularly technology vendors. The implementation of MIPS and APM will bring a new wave of change and administrative complexity for clinicians. They will need to increasingly rely on strong business partners to thrive through that change. CMS should seek to enable provider success through third party innovations by thinking about working with clinicians' partners as much as with clinicians themselves.

- Performance data should be disseminated in a format that is usable and scalable for both individual clinicians and group practices. For example, data that is provided in a downloadable format like .xls, .xlsx, .csv, or .xml is preferable to sending .pdf documents.

The goal of feedback reports like the QRUR is to provide clinicians and practice managers with performance data that is critical to identifying areas for improvement and executing on development plans. Unfortunately, reports are released one and a half years after data submission. The delay in feedback makes an otherwise valuable report nearly useless.

In addition to the improving feedback reports, CMS should streamline access and improve uses of claims data. We applaud the steps taken by CMS to expand the availability of its claims data, but much more is needed in order for clinicians to understand the complete cost and quality profile of their patients. As currently proposed, the Resource Use category will hold clinicians accountable for the costs of care patients incur without receiving the adequate transparency into these costs that claims data can provide. This will not allow clinicians to take the appropriate actions at the point of care or over the course of a performance period to better manage utilization of resources. Meaningful access to CMS claims data needs to be an integral part of a transition to a value based system.

4. <u>MIPS Measure Reporting</u>

CMS has identified multiple options by category for data submission under MIPS. We urge CMS to further simplify the program by allowing health IT vendors to submit on behalf of clinicians any accepted file format across all reporting options. To successfully support the program, CMS

should act as a universal receiver of the approved data formats and not require various measure-specific formats.

Furthermore, athenahealth shares CMS's goal to manage performance and quality for both Medicare and non-Medicare patients. We recommend a rolled out approach to Quality Measure Reporting. The use of separate benchmarks for Medicare and non-Medicare patients adds an additional layer of complexity and does not ensure accurate baseline benchmarks for the first reporting period. To accurately determine benchmarks for future years, we suggest eligible clinicians report on 90 percent of all patients and CMS only use the Medicare patient data for scoring in the first year.

5. *Treatment of Federally Qualified Health Centers ("FQHCs") and Rural Health Centers ("RHCs") under MIPS*

The Proposed Rule is vague with respect to scoring and eligibility of clinicians serving an FQHC or RHC. While we understand that facility feeds from FQHCs and RHCs are exempt from MIPS, CMS should clarify whether clinicians practicing in these settings need to collect and submit data under MIPS.

6. *MIPS Virtual Group Option*

CMS should not delay the implementation of the virtual group performance option—a key component of helping small practices succeed under MIPS—due to the agency's own lack of readiness. The Proposed Rule sets rigorous requirements for the industry's readiness to an entirely new payment system on accelerated timelines, and if CMS expects industry to be ready for MIPS in 2017, it needs to put forth the same level of effort to be ready to support all aspects of the program.

The Congressional intent behind the virtual group option is to help independent clinicians thrive through payment reform without sacrificing their independence. Given the increasing administrative complexity of participating in payment reform programs, solo practitioners and small practices are increasingly being forced to affiliate with or become employed by larger health systems to take advantage of the infrastructure and risk stratification associated with performing in larger groups. The Proposed Rule estimates that 87 percent of solo practitioners will face penalties for 2017 performance. The option to participate in a virtual group will provide clinicians wishing to remain organizationally independent with a practical solution to take on more risk and alleviate some of the burden on their limited resources. If delayed, the virtual group option likely will not be needed because all eligible clinicians who would have benefitted will have either sold their practice to a larger group or gone out of business before virtual groups are implemented. We urge CMS to take this opportunity to enable innovative care delivery models at the start of the program and not delay implementation of the virtual group performance option.

7. *Certification of health IT for APM Participation*

We strongly recommend that CMS work with ONC to improve the Certification Program to focus on basic functionality needed for success in QPP. ONC and CMS continue to concurrently

vocalize the desire to encourage flexibility and spur innovation, but the current Certification Program directly conflicts with that rhetoric. The 2015 Edition Health IT Certification Criteria does not incentivize improved outcomes and instead provides vendors with a meaningless stamp of approval for painstakingly demonstrating fundamental EHR capabilities. In order to better partner with clinicians to improve outcomes, vendor resources should be freed to respond to physician client needs and to build tools that are capable of supporting complex and innovative APM programs. Further, groups that transition into APMs should not be led to believe that an EHR certified under the 2015 Edition Health IT Certification Criteria will ensure future success in the payment track.

8. Timing of Advanced APM Model Release

Advanced APM models will require a strong partnership between clinicians and their health IT vendors to ensure success and support. CMS should support this investment of time and resources by releasing clear expectations and program details. For example, the recent release of Comprehensive Primary Care Plus (CPC+) spurred interest and excitement for a new, innovative program, but it lacked many pertinent details. CMS has asked vendors to blindly submit a letter of intent to participate in a program where little information beyond a concept and program name was released. The HIT vendor community strongly desires to partner with clinicians and CMS to improve care and lower costs. We urge CMS to improve the quality and timeliness of releasing program details to empower the partnerships that support and improve innovative care models.

Similarly, CMS should consider using the prior year performance period to identify qualified and partially qualified Advanced APM participants. The Proposed Rule does not designate eligibility until after the reporting period. The delayed identification of qualified, or partially qualified, participants will force clinicians to make decisions that directly impact their workflows, financial and resource planning with extremely limited information. CMS should consider using the prior year's performance to identify eligibility.

9. Audits under QPP

In finalizing the Proposed Rule, CMS should clarify whether it will continue to conduct audits under QPP similar to those conducted under the MU program, and if so, what documentation clinicians and/or health IT vendors will need to provide in the event of an audit.

We appreciate the opportunity to comment on the MACRA proposed rule. We look forward to continued dialogue and would be happy to discuss any of our input with you or your staff.

Sincerely,

Stephanie Zaremba
Director, Government Affairs
athenahealth, Inc.