August 21, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-5522-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-5522-P CY 2018 Updates to the Quality Payment Program – Proposed Rule

Submitted electronically via www.regulations.gov

Dear Administrator Verma,

The relationship between CMS's value-based payment programs and the physician burn-out rate grows stronger every day. Accordingly, our general remarks here echo comments from years past – in order to fully implement the Quality Payment Program (QPP) and relieve the frustrations of a beleaguered and administratively burdensome Meaningful Use (MU) program, CMS must first improve access to its own data, focus on outcomes based measures, and stop mandating the design of health IT through regulation. This administration must seize this opportunity to redress years of consternation for physicians by correcting course on the transition to value based payments under MACRA.

For twenty years, athenahealth ("athena") has been committed to removing the obstacles that prevent clinicians from focusing on patient care. As a partner to hospital and ambulatory clients, we provide medical record, revenue cycle, patient engagement, care coordination, and population health services to a cross-section of clinicians. Our single instance, multi-tenant, platform allows us to combine insights from our network of over 106,000 clinicians and 88 million patients to infuse knowledge—from clinical guidelines to Medicare rules—directly into clients' workflows. To enable our clients to focus on high-value patient care, we perform administrative work at scale on behalf of our clients, including all of the back-office work needed for success under CMS's various quality and value-based payment programs.

General Remarks

An August 2017 survey conducted by the Medical Group Management Association (MGMA) found that 73% of physicians see MIPS as a government program that does not support their clinical quality priorities. athena shares that view. We don't believe the hurdles are too high, but we believe the complexity in the program undercuts the potential for better care and lower costs.

We know from the experience of the more than 100,000 providers on our network that clinicians could focus more on patient care if less time was spent box-checking and chasing a series of fluctuating and often opaque requirements just to get paid.

To avoid repeating the pitfalls of the MU program and save physicians from needless frustration, we encourage CMS to consider the following:

1. Improve data access for clinicians participating in CMS programs.

It is unreasonable to hold clinicians accountable for the cost and quality of care delivered to their patients while the data on such cost and quality remains locked in a vault. To achieve the shared goal of better care at lower costs, CMS should implement information systems that support QPP participants and their technology partners with the data necessary to succeed. At a minimum, CMS beneficiary claims data should be more readily available in real-time to clinicians caring for those beneficiaries. The federal government cannot pursue providers who refuse to share patient information as "information blockers" while it engages in exactly the same behavior to the detriment of over 58 million patients.

Broader access to CMS claims data would help clinicians participating in QPP identify clinically effective treatments, coordinate care with other providers treating the same patient, improve population health, and more accurately and efficiently document quality measures. Current CMS policy creates unnecessary barriers to obtain paid claims data, leaving a valuable resource to control healthcare costs untapped.

We recognize that real-time feedback may not be feasible in the near term and suggest that CMS strive to give clinicians digestible feedback on at least a quarterly basis. Aided by timely data, clinicians will be more likely to embrace APMs and contribute to a successful QPP. Without the near real-time access to this data for providers and their technology partners, providers will be hamstrung and forced to operate with incomplete information.

2. Further reduce complexity and uncertainty.

It is clear this administration desires to reduce complexity and uncertainty for clinicians. We applaud the efforts thus far and urge CMS to go further to alleviate the burden placed on clinicians participating in the QPP.

CMS must fully embody its stated mission to reduce regulatory burden, control costs, and improve care quality. To achieve this goal CMS should not mandate a base set of behavioral requirements, but rather focus on the desired outcomes. Measures should be limited to demonstrating outcomes that are directly linked to improved patient care and empower clinicians to apply their training to best meet the needs of their unique patient population. For example, we know that our providers successfully use a number

of communication channels to engage with their patients. Yet, CMS constrains its patient engagement measure to the use of an online portal that can actually impede the personalized care that might befit certain patients. CMS should not punish clinicians for communicating with patients in a manner different from that which is prescribed in a program measure.

Additionally, we recommend CMS continue to remove uncertainty in the rulemaking process by establishing consistent scoring calculations and performance metrics well in advance of the reporting period. CMS's goal should be a program that enables any clinician—from a solo practitioner to an employee of a large health system—to feel confident that they know what needs to be done to avoid a negative payment adjustment.

3. **Improve coordination between HHS programs, specifically aligning the ONC Certification Program with CMS's work to streamline pay-for-performance programs and transition to APMs.**

ONC's Certification Program no longer concerns itself with the EHR functionality necessary to succeed under MIPS, and it is even further attenuated from the functionality conducive to successful APM participation. Simply put, this lack of alignment is the single biggest threat to QPP success. None of CMS's goals can be realized if providers are using technology designed to meet unrelated federal requirements first and the needs of their practice second.

For the first several years of the MU program, certification criteria were tied to MU measures. Though burdensome, certification was directly related to the functionality clinicians needed to successfully meet MU requirements. CMS has recognized the clear benefits of simplifying MU and now the ACI category of MIPS, but unfortunately ONC has not followed suit in the Certification Program. As a result, certification drains health IT developer resources without any corresponding improvement in patient care. It is imperative that any investment required of vendors to facilitate physicians' success in the program be guided by the same principles of increased efficiency and improved patient outcomes. Yet the lack of coordination within HHS forces partners like athena to substitute innovative improvements on its product roadmap—exactly the kind requested by clients to promote more efficient and better care—with certification requirements that have strayed too far from the original program goals.

APM participants need innovative technology solutions to help them track population health and coordinate care with other clinicians, not uniform box-checking systems that simultaneously establish both a floor and a ceiling. CMS should not be deceived into thinking that EHRs bloated with certification-required functionality will help to usher in a new wave of value-based care. In fact, it is difficult to see a nexus between the two at all.

The approach to certifying software should be consistent across all of HHS' agencies. FDA Commissioner Gottlieb recognized we can build better tools and promote better health outcomes by pulling back on the government's inclination to micromanage innovation. We have been encouraged by his agency's efforts to begin the shift toward certifying software developers instead of approving individual software product functionality and each iterative improvement made thereto.

Although we understand the FDA regulatory framework has meaningful differences from ONC and CMS, and we support the 21st Century Cures Act's exclusion of EHRs from FDA oversight, Dr. Gottlieb's views on the FDA's regulation of low-risk software should nevertheless resonate in the development of EHRs. As he posited: "Certification could be used to assess . . . whether a company consistently and reliably engages in high quality software design and testing (validation) and ongoing maintenance of its software products."

Under that paradigm, the market forces that push companies like athena to responsibly and efficiently innovate would also contribute to our successful certification, rather than force a choice between innovation and certification. We urge CMS to ensure that agencies across HHS adopt a likeminded approach, which would allow vendors like athena to help providers and patients realize the promise of EHRs that prompted the establishment of a certification program in the first place.

Specific Comments

With these recommendations in mind, we offer the following specific suggestions for improvement to the Proposed Rule:

1. **MIPS Program Details: Eligibility, Exclusions, Group Reporting**

We applaud CMS for improving access to the MIPS Participation tool on the QPP website. However, the current tool requires searching exclusions on a case-by-case basis. As a health IT vendor supporting more than 30,000 clinicians in QPP, this process is not scalable and hinders our ability to support the same clinicians CMS aims to help by providing this tool. Performance and status data should be available in a format that is usable and scalable for both individual clinicians and group practices. Large data sets of NPIs that include 'special status' designation should be available upon request in a downloadable format like .xls, .xlsx, .csv, or .xml.

We ask that the following information be returned in these files:

- Low volume threshold
- APM QP
- First year billing Medicare
- Special status: Hospital-based, small practice status, HPSA, rural, non-patient facing status, and any additional finalized criteria

2. Virtual Groups

We support CMS's proposed implementation of the virtual group option. CMS is wise to not over-orchestrate the virtual group option or attempt to provide the entire end-to-end infrastructure for this optional program, as others have suggested. As proposed, virtual groups will enable third-party service providers, like consultants or health IT vendors, to create new solutions that assist independent clinicians in forming virtual groups, pooling resources, reducing administrative burden, and performing and reporting together.

CMS should expect and demand that the convener of each virtual group assume the burden of facilitating participating clinicians' performance while providing visibility into individual and group performance metrics. However, this will take time. As CMS acknowledges, the timeline for virtual group participation in 2018 is ambitious.

athena has long supported care models that enable success for small and independent practices that may lack the resources of a larger health system, and we support the virtual group option CMS proposes. While we intend to convene interested clinicians in virtual groups, we may use 2018 to plan and ensure we can arm virtual groups for success. We advise CMS to account for the initial start-up time in the private sector and not judge the success of the program based on initial 2018 results and participation. This will be a long-term success for independent practices. We look forward to working with CMS on this initiative.

3. Cost Performance Category

As mentioned in our general remarks, CMS must continue to provide clarity on scoring methodology and improve performance feedback well in advance of reporting period start dates. As CMS removes 10 of 12 measures for cost, the new measures must be published sooner than they have historically been announced. They must be set prior to the end of the 2018 reporting period. Further, the current data supplied via the QRUR is not helpful to control costs. The data is not consumable and is delivered far too late to make a significant impact on cost during a given year.

4. Improvement Activity Criteria

CMS requested comment on whether it should establish a minimum threshold for clinicians (NPIs) to complete an activity for the entire group to get credit. athena does not favor establishing a minimum threshold. All program requirements should advance clinicians toward the long-term goal of participating in an APM. A minimum threshold is an unnecessary complication in an already confusing program that does not help clinicians succeed in early stages of QPP to later advance to APMs.

5. Advancing Care Information

athena is pleased that there is a proposed exclusion for HIE in 2017 and 2018 to help eligible clinicians who do not transition or refer enough patients to meet the base score

requirements. Additionally, we believe a simple way to further reduce clinician burden in QPP is for CMS to automatically exclude clinicians if the denominator reported is less than 100. No further action should be required by the clinician to ensure exclusion.

6. **Review and Correction of MIPS Final Score Data Validation and Auditing**

CMS requests comments whether it would be helpful to provide more frequent feedback on the cost performance category using a rolling 12-month period, or quarterly snapshots of the most recent 12-month period. athena believes that monthly, or quarterly, rolling 12-month feedback is essential to successful participation in cost and quality measures. Additionally, this data is critical to prepare clinicians for the 2019 performance year when the weighting of the cost category increases along with the associated negative adjustments.

This feedback should be disseminated in a format other than the QRURs. The PDF format of QRURs is not easily digestible for clinicians or scalable for health IT vendors to present and coach clients to improve in the program. The feedback must be in machine, and human, readable formats (such as .xls or .csv) so that health IT vendors can provide full transparency and clear status updates into performance.

7. **Third Party Data Submission**

As clinicians have questioned the value of the QPP, third parties try to take on as much work as possible to support them. We encourage future rulemaking to seek alternatives to the current state QRDA3 format for the QPP program and other quality programs. QRDA3 has several drawbacks, and multiple other submission methods are proven, such as PQRS registry XML format, QPP XML format, MU attestation portal, and the new QPP Submissions API.

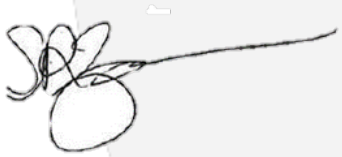
We request clarification in response to the proposal that CMS add a requirement for a third-party data submitter to certify that data submitted is true, accurate, and complete. We ask CMS to clarify that this certification is an acknowledgement or attestation that the data is true, accurate, and complete, rather than a separate set of certification criteria. As stated in our general remarks, HHS and CMS should consider a program that certifies entities, and not every detail of a specific product.

CMS should not create an additional incentive model based on EHR vendor access to comprehensive data. We share the administration's goal for widespread interoperability and another incentive program will ensure that the health IT industry remains years behind similar information technology industries. As evidenced by the baseline standards and incentives set through the MU program, the majority of health IT vendors perform the minimum amount of work to comply with the requirements and innovate no further. Under QPP, clinicians are held accountable for cost and quality of care, regardless of where the patient has been seen. There is a mutual interest to have timely access to relevant patient information among the vendors whose physicians share patients across multiple platforms. CMS's focus is better directed to improve

access to its own data so that vendors can compete on the quality of services they deliver with that data, and not the mere access to data.

We look forward to continued dialogue with your office and would be happy to discuss any of our input with you or your staff.

Sincerely,



Stephanie Zaremba
Director, Government Affairs
athenahealth, Inc.