December 15, 2015

311 Arsenal Street
Watertown, MA 02472

Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-3310 & 3311-FC
P.O. Box 8013
Baltimore, MD 21244-1850

Re: CMS-3310 & 3311-FC; Medicare and Medicaid Programs: Electronic Health Record Incentive Program -- Stage 3 and Modifications to Meaningful Use in 2015 through 2017

Submitted electronically through www.regulations.gov

Dear Administrator Slavitt,

athenahealth, Inc. ("athenahealth") appreciates the opportunity to provide comments on the Medicare and Medicaid Programs: Electronic Health Record Incentive Program -- Stage 3 and Modifications to Meaningful Use in 2015 through 2017 Final Rule relative to the implementation of the Merit-Based Incentive Payment System ("MIPS") established through the Medicare Access and CHIP Reauthorization Act ("MACRA").

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 72,000 healthcare professionals in all 50 states. 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.

The passage of MACRA represents a significant shift in payment and delivery models. It also represents a significant opportunity for the Centers for Medicare and Medicaid Services ("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. Achieving this goal will require both CMS to be less heavy-handed in its approach, make better use of modern technology, improve interoperability of systems, and promote flexibility and innovation throughout all CMS programs.

We encourage CMS to do the following three things that are, in our view, essential to achieving HHS's goal:

1. *Recognize that interoperation among health IT platforms is fundamental to the success of MIPS and Alternative Payment Models ("APMs") and heed calls from provider groups to refocus existing CMS programs around actual information exchange*.

Provider groups and policymakers have correctly pointed out in recent months that, despite substantial investment in the adoption of health IT, the healthcare industry is not nearly far enough along in achieving ubiquitous information exchange. Without the ability to coordinate care across care settings that may use different health IT platforms, providers will not be successful under MIPS or APMs, placing in jeopardy the entire MACRA reform effort. As the American Medical Association and 110 state and national medical societies recently stated in a letter to Congress, "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."

Stage 3 of MU, as recently finalized by CMS, should *not* be incorporated into MIPS. Instead, CMS should take this opportunity to significantly revise the program to be finally meaningful by focusing it on two simple requirements: use of certified EHR technology ("CEHRT") and actual interoperation. Any current MU objectives and measures that are not focused on the outcome of requiring information exchange among providers or patients should be removed from the MIPS program entirely or re-categorized into a more appropriate MIPS category, as discussed below.

Very significant progress toward the goal of widespread interoperability 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.

2. *Follow Congress's clear intent under MACRA that MIPS be used as an opportunity to simplify and streamline existing pay-for-performance programs*.

The increase in the number of voluntary and mandatory CMS pay-for-performance programs over the past few years has led to an unsustainable level of complexity and administrative burden for providers. Satisfaction and success among the provider community with these programs continues to decline. Recognizing this reality, Congress clearly established its intent under MACRA that programs measuring quality, resource use, EHR use, and clinical practice improvement activities should be consolidated and simplified under MIPS.

We urge CMS to respond to stakeholder feedback and reduce the complexity, redundancy, and burden of the programs that are to be consolidated into MIPS. If MIPS is merely a repackaging of existing programs, CMS will have wasted a tremendous opportunity. Every measure in the Physician Quality Reporting System ("PQRS"), Value-Based Modifier program ("VM"), and MU program should be evaluated to determine whether it should be eliminated, more appropriately moved to another category (particularly the clinical practice improvement activity category), or combined with another similar and duplicative measure.

Additionally, CMS should address stakeholder requests that it transition away from process-based and toward outcomes-based measures. For example, an outcomes-focused interoperation requirement that measures providers on whether they are actively exchanging clinical information will still implicitly capture many of the activities, such as recording data consistently and in a standardized format while reducing administrative burden on providers and increasing flexibility for the future.

3. *Consider not just how CMS can best partner with care providers, but how it can also partner with the service providers, such as health IT vendors, that are working to enable provider success in new, value-based payment arrangements*.

The health care industry is in the midst of a period of enormous change, and independent physicians in particular are struggling to keep up with the pace of that change while maintaining their independence. The administrative burden required to participate in new care and payment models leave independent physicians with little choice but to accept employment with a hospital or large health system—in the past several years up to one-third of physicians have moved from independent practice to employment. Data shows that physician employment leads to a significant drop in productivity, which over time will reduce access to care.

CMS should ensure that the MIPS and APM programs encourage new, innovative models that enable independent physicians to utilize non-traditional resources and partnerships to take on risk without close affiliation with or employment by a large health system. We urge CMS to allow third parties, such as health IT vendors, to take on administrative tasks within MIPS and APMs on behalf of providers and to provide these third parties with access to the data and feedback reports necessary to take on that work.

We appreciate the opportunity to share our thoughts on the MU program in light of the value-based environment envisioned by MACRA. We look forward to continuing to work with you and your staff to ensure a successful transition and would be happy to discuss any of our input with you or your staff.

Sincerely,

Stephanie Zaremba
Senior Manager, Government & Regulatory Affairs
athenahealth, Inc.