November 17, 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-3321-NC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-3321-NC; Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models

Submitted electronically through www.regulations.gov

Dear Administrator Slavitt,

athenahealth, Inc. ("athenahealth") appreciates the opportunity to respond to the Request for Information regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models ("RFI").

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 67,000 healthcare professionals who serve over 60 million patients 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.

General Remarks

The passage of the Medicare Access and CHIP Reauthorization Act of 2015 ("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 and providers to be less heavy-handed in its approach, adopt and 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 the Merit-Based Incentive Payment System ("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.

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.

Specific Comments

A. THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

1. MIPS EP IDENTIFIER AND EXCLUSIONS

CMS Question: Should we use a MIPS EP's TIN, NPI or a combination thereof? Should we create a distinct MIPS Identifier?

athenahealth response: Based on our experience working with different provider identifier mechanisms through a variety of CMS programs, we recommend that CMS use NPI to identify MIPS EPs.

The problem with identifying providers by each unique TIN/NPI combination, as is done in PQRS, is that providers practicing under multiple TINs are challenged to report multiple instances of PQRS data, likely through multiple methods and EHR vendors. Also, providers who move from one TIN to another mid-year are also unlikely to report their quality data recorded under their former TIN since they are no longer accountable for that information. By identifying EPs at the NPI level, as is the case under the MU program, providers are expected to report and be successful even if they move organizations throughout the year and their performance data follows them more easily from one group to another.

Additionally, importing records from multiple TINs for a given NPI requires EHR vendors to support multiple data aggregation processes. By using NPI to identify EPs, EHR vendors only need to support one data aggregation process, which is easier to implement and allows these vendors to focus more development time on innovations that have a more direct impact on patient care.

Using NPI to identify EPs can also make it easier to identify which providers qualify for exclusions in the MIPS program for reasons such as low patient thresholds.

CMS Question: What are the advantages/disadvantages associated with creating a distinct MIPS identifier?

athenahealth response: We do not believe that a separate MIPS identification number needs to be created as there is no benefit to the provider. Instead, it adds another layer of complexity and forces CMS to release the distinct identifier far enough in advance for EPs to prepare to report. CMS would also need to support a way for EHR vendors to easily access this information, which places an additional burden on CMS that would not be present with an alternative method like the NPI.

However, if CMS decides to use a distinct MIPS identifier, please consider the lessons learned from the Provider Enrollment, Chain and Ownership System (PECOS). PECOS requires all impacted entities to maintain the most up to date information and version of PECOS. This can subject providers to unwanted penalties and burdens if other providers are not up to date in the system. Providers should not be burdened or penalized due to the inaction of other providers. Like PECOS, a list of the new MIPS identification number should be available to all entities so that technology vendors supporting providers may access these files without having to log into a web portal. If a new identification number must be created, we request that CMS find alignment across CMS programs and enrollment in an effort to reduce administrative burden on providers and allow them to focus their energy on patient care.

CMS Question: How should we calculate performance for MIPS EPs that practice under multiple TINs?

athenahealth response: We recommend calculating quality performance at the NPI level, across TINs, as this encourages consistent performance from EPs, regardless of the group under which they are billing.

2. PERFORMANCE IN VIRTUAL GROUPS

As a prefatory matter, the Congressional intent behind the virtual group option is to help independent providers 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 option to participate in a virtual group should provide all of those same benefits for providers wishing to remain organizationally independent, so it would be inappropriate to place additional burdens on virtual groups that do not exist in other reporting options. We urge CMS to take this opportunity to enable innovative care delivery models and not arbitrarily burden the virtual group performance option with unnecessary restrictions aimed at addressing unsubstantiated risks.

CMS Question: How should eligibility, participation, and performance be assessed under the MIPS for voluntary virtual groups?

athenahealth response: Eligibility, participation, and performance assessment for virtual groups should be the same as for any other MIPS EP or group.

CMS Question: Assuming that some, but not all, members of a TIN could elect to join a virtual group, how should remaining members of the TIN be treated under the MIPS, if we allow TINs to split?

athenahealth response: The remaining members should be allowed to submit as individual EPs or as a TIN, excluding the virtual group EPs.

CMS Question: Should there be a maximum or a minimum size for virtual groups? For example, should there be limitations on the size of a virtual group, such as a minimum of 10 MIPS EPs, or no more than 100 MIPS EPs that can elect to be in a given virtual group?

athenahealth response: There should not be a minimum or maximum size for virtual groups. Such a limitation would be arbitrary and unnecessarily restrict collaboration among independent providers for better outcomes.

CMS Question: Should there be a limit placed on the number of virtual group elections that can be made for a particular performance period for a year as this provision is rolled out? We are considering limiting the number of voluntary virtual groups to no more than

100 for the first year this provision is implemented in order for CMS to gain experience with this new reporting configuration. Are there other criteria we should consider? Should we limit for virtual groups the mechanisms by which data can be reported under the quality performance category to specific methods such as QCDRs or utilizing the web interface?

athenahealth response: For the reasons stated above, there should be no limit on the number of virtual group elections. All eligible data reporting mechanisms should be supported for virtual groups.

CMS Question: If a limit is placed on the number of virtual group elections within a performance period, should this be done on a first-come, first-served basis? Should limits be placed on the size of virtual groups or the number of groups?

athenahealth response: See above. We strongly encourage CMS to not place arbitrary limitations on virtual group participation.

CMS Question: Should there be limitations, such as that MIPS EPs electing a virtual group must be located within a specific 50 mile radius or within close proximity of each other and be part of the same specialty?

athenahealth response: CMS should not impose limitations around geography or specialty, or any other limitations that hinder EPs voluntarily electing a virtual group. Again, such limitations would arbitrarily limit participation in and innovation among virtual groups. If providers can successfully collaborate across specialty or geographies, there is no legitimate reason to limit that collaboration.

3. QUALITY PERFORMANCE CATEGORY

a. Reporting Mechanisms

CMS Question: Should we maintain all PQRS reporting mechanisms noted above under MIPS?

athenahealth response: The existing PQRS reporting mechanisms should be simplified and streamlined under MIPS. There should be fewer choices for reporting mechanisms that all support the same measures and reporting requirements. Currently, there are seven reporting mechanisms under the PQRS program, and technology vendors have to spend development resources to support all of them. Simplified reporting mechanisms would enable vendors to spend more development resources on customer requests and innovations that have a more direct impact on patient care. Therefore, we recommend that only the EHR and Qualified Clinical Data Registry (QCDR) reporting mechanisms be maintained from PQRS in the MIPS program. This will maintain provider choice in reporting options while reducing complexity.

CMS Question: Should we maintain the same or similar reporting criteria under MIPS as under the PQRS? What is the appropriate number of measures on which a MIPS EP's performance should be based?

athenahealth response: However many reporting mechanisms are supported, the criteria should be consistent.

CMS Question: Should we require that certain types of measures be reported? For example, should a minimum number of measures be outcomes-based? Should more weight be assigned to outcomes-based measures?

athenahealth response: Whenever providers are held accountable for outcomes-based measures, we encourage CMS to implement risk-adjustment to ensure that providers who provide care to sicker populations are not unfairly disadvantaged.

CMS Question: How do we apply the quality performance category to MIPS EPs that are in specialties that may not have enough measures to meet our defined criteria? Should we maintain a Measure-Applicability Verification Process? If we customize the performance requirements for certain types of MIPS EPs, how should we go about identifying the MIPS EPs to whom specific requirements apply?

athenahealth response: We support maintaining the Measure Applicability Verification (MAV) Process in MIPS as we think it provides the right balance of flexibility and accountability for certain specialties. However, MAV should be expanded to allow providers reporting through the EHR method to report on fewer than nine measures across three domains when there are not nine measures that apply.

CMS Question: What are the potential barriers to successfully meeting the MIPS quality performance category?

athenahealth response: In light of CMS' recent announcement that the 2014 PQRS benchmarks will not be released until after the end of the 2015 performance year, we urge CMS to recognize that the biggest barrier to successful quality performance is a lack of *timely* performance information. It is unacceptable to ask providers to perform against a benchmark that is unknown through part or all of a performance year. Before implementing MIPS, CMS should endeavor to revise its internal systems so that provider performance can be measured and assessed against benchmarks in as close as real-time as possible.

b. Data Accuracy

CMS Question: What should CMS require in terms of testing of the qualified registry, QCDR, or direct EHR product, or EHR data submission vendor product? How can testing be enhanced to improve data integrity?

athenahealth response: All CMS testing tools should be up-to-date with all file format requirements (e.g., format for XML checks) and distinct programmatic requirements (e.g., numerator count cannot be greater than denominator count, performance rates cannot be negative). Additionally, testing tools should be available early in the performance year to allow for multiple rounds of validation and updates prior to the official submission window. Using a current program example, the SVET testing tool for PQRS Registry XML submission in 2015 will not be available with updated information until mid-way through December, 2015. This leaves little room for improvement and iteration.

CMS Question: Should registries and qualified clinical data registries be required to submit data to CMS using certain standards, such as the Quality Reporting Document Architecture (QRDA) standard, which certified EHRs are required to support?

athenahealth response: Yes, by requiring all reporting mechanisms to use a single data submission method, CMS will reduce the burden on technology vendors that support more than one reporting mechanism while reducing its own burden in keeping multiple testing and submission systems up to date.

CMS Question: What feedback from CMS during testing would be beneficial to these stakeholders?

athenahealth response: To ease the burden of testing, feedback reports should be clearly defined, and any component producing an error should be able to be quickly identified.

CMS Question: What thresholds for data integrity should CMS have in place for accuracy, completeness, and reliability of the data? For example, if a QCDR's calculated performance rate does not equate to the distinct performance values, such as the numerator exceeding the value of the denominator, should CMS re-calculate the data based on the numerator and denominator values provided? Should CMS not require MIPS EPs to submit a calculated performance rate (and instead have CMS calculate all rates)? Alternatively, for example, if a QCDR omits data elements that make validation of the reported data infeasible, should the data be discarded? What threshold of errors in submitted data should be acceptable?

athenahealth response: CMS should not take on the burden of re-calculating the data if there are errors as this would lead to challenges if an EP was audited under MIPS. It would also fail to create a closed feedback loop as providers and their technology vendors would never know that they needed to adjust their files. If a submitted file does

not include sufficient information for validation, the data should be discarded, an error report should be generated, and providers should have the ability to re-upload the file following adjustments.

c. Use of Certified EHR Technology (CEHRT) under the Quality Performance Category

CMS Question: Under the MIPS, what should constitute use of CEHRT for purposes of reporting quality data?

athenahealth response: We urge CMS to not impose any new or additional requirements for CEHRT for the purposes of reporting quality data.

CMS Question: Instead of requiring that the EHR be utilized to transmit the data, should it be sufficient to use the EHR to capture and/or calculate the quality data? What standards should apply for data capture and transmission?

athenahealth response: CMS should enable EHR vendors to easily submit quality reporting data directly to CMS on behalf of providers by using simple, standardized formats, such as the QRDA Category III, and providing sufficient technical support.

4. RESOURCE USE PEFORMANCE CATEGORY

We urge CMS to share provider performance on resource use and any other measures in as close to real-time as possible directly with providers and their technology vendors. This will allow this information to be incorporated into clinical workflows, enabling continuous performance improvement. As we noted in our comments to the 2016 Physician Fee Schedule Proposed Rule, providers are most likely to be successful when they are armed with timely, usable, accessible, and meaningful feedback on their performance.

While CMS has taken steps to expand the availability of its claims data, much more is needed in order for providers to understand the complete cost and quality profile of their patients. Without this information, providers will be held accountable for the costs of care patients incur without the adequate transparency into these costs. This will not allow providers to take the appropriate actions at the point of care or over the course of a performance period to better manage utilization of resources.

In providing performance feedback and data on resource use and other MIPS categories, we ask that CMS focus on the following priorities:

- Timeliness: 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 be able to give providers at least quarterly feedback once MIPS is implemented.

- Usable format: Performance data should be disseminated in a format that is usable and scalable for both individual providers and group practices. For example, data that is provided in a downloadable format like .exl is preferable to sending .pdf documents.
- Accessibility: Performance data should be easily available not just to providers but also to their third-party partners, particularly technology vendors. The implementation of MIPS will bring a new wave of change and administrative complexity for providers, and they will need to increasingly rely on strong business partners to thrive through that change. CMS should seek to enable provider success by thinking about working with providers' partners as much as with providers themselves.
- Meaningful data: As providers are increasingly held accountable for the cost and quality of patients' care, including care rendered by other providers, CMS should ensure that it provides all of the data that providers need to make meaningful performance improvements. This should include cost and quality data for attributed patients, as is provided to Medicare Shared Savings Program ACOs, as well as benchmark data so that providers can gauge their performance relative to their peers.

CMS Question: CMS has received stakeholder feedback encouraging us to align resource use measures with clinical quality measures. How could the MIPS methodology, which includes domains for clinical quality and resource use, be designed to achieve such alignment?

athenahealth response: We believe that aligning resource use measures with CQM measures makes practical sense because improving workflows for a domain or measure will naturally benefit both clinical quality and resource use.

5. CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY

As noted above, we suggest that many objectives and measures that are currently part of the MU program should be more appropriately placed in the clinical practice improvement activities category. Congress's intent in establishing the MIPS program was clear: streamline and simplify existing pay-for-performance programs. Particularly with respect to the six subcategories that Congress directed be included in clinical practice improvement activities, including timely communication with patients, timely exchange of clinical information with other providers, and beneficiary engagement, such measures no longer need to be part of the EHR use category.

Additionally, CMS and other groups have already established many measures in other programs that we recommend be reused in the six subcategories of clinical practice improvement activities. For example, chronic care management, comprehensive primary care initiative, patient centered medical home, and

accountable care organization ("ACO") programs already define measures for activities that should be classified as clinical practice improvement activities. CMS should reuse existing measures whenever possible to increase consistency across programs, which will in turn increase the number of activities that are supported through EHR workflows and encourage provider participation.

With respect to performance and attestation for the clinical practice improvement activities, CMS should enable providers to partner with third parties, such as technology vendors, just as they do in existing programs like MU. This will allow providers to outsource some of the more administrative functions of clinical practice improvement and rely on the expertise that others might have in areas such as patient engagement, care coordination, and care management, thus maximizing provider time spent on direct patient care.

CMS Question: Should EPs be required to attest directly to CMS through a registration system, web portal or other means that they have met the required activities and to specify which activities on the list they have met? Or alternatively, should qualified registries, QCDRs, EHRs, or other health IT systems be able to transmit results of the activities to CMS?

athenahealth response: EPs should not be required to attest directly to CMS. The same reporting mechanisms should be supported across all MIPS programs. Additionally, we urge CMS to recognize the importance of maintaining the ability of EHR vendors to transmit results to CMS on behalf of providers, as this helps reduce the administrative burden of program participation, particularly for small, independent practices.

CMS Question: How often providers should report or attest that they have met the required activities?

athenahealth response: Providers should be required to report no more frequently than annually that they have met the required activities. Annual reporting will allow increased flexibility and reduced administrative burden for providers.

CMS Question: What threshold or quantity of activities should be established under the clinical practice improvement activities performance category? For example, should performance in this category be based on completion of a specific number of clinical practice improvement activities, or, for some categories, a specific number of hours? If so, what is the minimum number of activities or hours that should be completed? How many activities or hours would be needed to earn the maximum possible score for the clinical practice improvement activities in each performance subcategory? Should the threshold or quantity of activities increase over time? Should performance in this category be based on demonstrated availability of specific functions and capabilities?

athenahealth response: Instead of a set of required activities, we recommend that CMS use an approach similar to that used in the Comprehensive Primary Care Initiative (CPCI) program, where providers select two out of three activities to track and support. This is also similar to the menu measures required under the MU program. The flexibility of this approach will best enable provider success in clinical practice improvement activities.

We also recommend that CMS follow an approach that has been successful in PCMH and CPCI by using subcategories (e.g., social, preventive, behavioral, pharmacology integration, chronic condition support, etc.) and requiring providers to perform activities in a number of these categories (for example, require performing at least 3 activities across at least 2 subcategories).

6. MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY PERFORMANCE CATEGORY

In light of the mounting criticism against the MU program, we urge CMS to use MIPS implementation as an opportunity to finally reform the program into something truly meaningful. To that end, we recommend that the MU category be streamlined into two simple measures: 1) use of CEHRT, measured as a binary pass/fail based on whether a provider has implemented CEHRT for a reporting period; and 2) actual interoperation, measured and weighted more heavily based on demonstrated information exchange with patients and other providers, particularly those in other health systems and using different IT platforms.

This simplified approach would respond to calls for a MU program that is refocused on interoperation without losing any of the progress made to date in improving care through the use of health IT. By measuring providers on whether they are actively exchanging clinical information, CMS will still capture many of the activities required under the MU program today. To exchange care summaries or discrete data on patients, providers must record that data consistently and in a standardized format, so the finer requirements in the current MU program would be included implicitly, while focusing on outcomes, reducing administrative burden on providers, and increasing flexibility for the future.

CMS Question: Should the performance score for this category be based be based solely on full achievement of meaningful use? For example, an EP might receive full credit (for example, 100 percent of the allotted 25 percentage points of the composite performance score) under this performance category for meeting or exceeding the thresholds of all meaningful use objectives and measures; however, failing to meet or exceed all objectives and measures would result in the EP receiving no credit (for example, zero percent of the allotted 25 percentage points of the composite performance score) for this performance category.

athenahealth response: Performance in the MU category should be based on full achievement.

CMS Question: Should CMS use a tiered methodology for determining levels of achievement in this performance category that would allow EPs to receive a higher or lower score based on their performance relative to the thresholds established in the Medicare EHR Incentive program's meaningful use objectives and measures? For example, an EP who scores significantly higher than the threshold and higher than their peer group might receive a higher score than the median performer. How should such a methodology be developed? Should scoring in this category be based on an EP's under- or over-performance relative to the required thresholds of the objectives and measures, or should the scoring methodology of this category be based on an EP's performance relative to the performance of his or her peers?

athenahealth response: We recommend that CMS adopt a tiered methodology that would allow EPs to receive a higher or lower score based on their performance relative to established thresholds. Providers across our network exceed MU thresholds today and we believe that this should be reflected in their MIPS scores. Furthermore, incentivizing providers and EHR vendors to exceed the thresholds would help to improve interoperation outcomes in the industry.

CMS Question: How should hardship exemptions be treated?

athenahealth response: If CMS refocuses the MU program around our suggested CEHRT and interoperation measures, we believe that the need for hardship exemptions will decrease dramatically. Removing the workflow and quality measures from MU will result in less need for provider exemption categories. For example, surgical specialists struggle to meet certain program requirements today (like secure messaging and electronic access) because of their scope of practice, but a refocused program would increase their participation.

Additionally, we continue to believe that vendors, not providers, should be penalized when a provider claims a hardship exemption due to vendor issues or implementation delays. CMS should publish the frequency with which EHR vendors' systems are the basis for a hardship exemption. The availability of this information would increase transparency and assist providers in future EHR purchasing decisions.

8. DEVELOPMENT OF PERFORMANCE STANDARDS

CMS Question: Which specific historical performance standards should be used? For example, for the quality and resource use performance categories, how should CMS select quality and cost benchmarks? Should CMS use providers' historical quality and cost performance benchmarks and/or thresholds from the most recent year feasible prior to the commencement of MIPS? Should performance standards be stratified by

group size or other criteria? Should we use a model similar to the performance standards established under the VM?

athenahealth response: We recommend using the prior year's performance data to create national benchmarks, as is the current process under VM. However, as noted above, benchmarks need to be released as close to the start of a performance year as possible and absolutely no later than half way through the performance year. Having insight into peer benchmark performance in a timely manner is essential for providers to understand, gauge, and improve their own performance.

CMS Question: In the CY 2016 PFS proposed rule (80 FR 41812), the Secretary proposed to publicly report on Physician Compare an item-level benchmark derived using the Achievable Benchmark of Care (ABC™) methodology.2 We seek comment on using this methodology for determining the MIPS performance standards for one or more performance categories.

athenahealth response: We recommend that any benchmarking method for determining the MIPS performance standards should be risk-adjusted, maintain consistency with the ABC methodology that was just finalized under the CY 2016 PFS final rule, consider the reporting method used, and encourage testing to alleviate concerns around complexity.

9. FLEXIBILITY IN WEIGHTING PERFORMANCE STANDARDS

CMS Question: Generally, what methodologies should be used as we determine whether there are not sufficient measures and activities applicable and available to types of EPs such that the weight for a given performance category should be modified or should not apply to an EP? Should this be based on an EP's specialty? Should this determination occur at the measure or activity level, or separately at the specialty level?

athenahealth response: We recommend using the current VM methodology, which sets a minimum threshold of 20 patient cases before the measure is included in quality or cost calculations. This is a simple approach and continues an established, understood practice rather than creating some new threshold.

CMS Question: What safeguards should we have in place to ensure statistical significance when establishing performance thresholds? For example, under the VM one standard deviation is used. Should we apply a similar threshold under MIPS?

athenahealth response: We recommend maintaining the current VM national mean and standard deviation methodology. In addition to the benefits of using an established and understood methodology, it has become a way to differentiate between topped out measures where consistent high performance is expected versus those where an EP could rise above peers and be eligible for distinction and incentives.

10. MIPS COMPOSITE PERFORMANCE SCORE AND PERFORMANCE THRESHOLD

CMS Question: For the quality and resource use performance categories, should we use a methodology (for example, equal weighting of quality and resource use measures across National Quality Strategy domains) similar to what is currently used for the VM?

athenahealth response: Whatever methodology is selected for weighting quality and resource use measures, CMS should make this information readily and publicly available before the start of any given performance period. As stated above, providers need to understand the drivers of high quality, low cost care and be able to prospectively assess their performance in MIPS. This cannot be done successfully if the weighting methodology is not known at the outset of a performance year.

CMS Question: What minimum case size thresholds should be utilized? For example, should we leverage all data that is reported even if the denominators are small? Or should we employ a minimum patient threshold, such as a minimum of 20 patients, for each measure?

athenahealth response: We recommend using a 20 minimum patient threshold as currently used in the VM, as this does not disadvantage providers who may not have the opportunity to close a patient care gap within a given year.

12. FEEDBACK REPORTS

Please see our comments under Section 4 (Resource Use Performance Category).

B. ALTERNATIVE PAYMENT MODELS

As CMS begins to explore the criteria for assessing APMs, it should focus on the needs of independent physicians. As noted in our general remarks, independent physicians in particular are struggling to keep up with the pace of change in healthcare while maintaining their independence. CMS should ensure that its criteria for APMs 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.

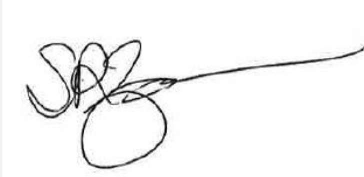
Athenahealth encourages CMS to avoid imposing EHR use requirements in APM criteria. APMs should be an outcomes-based alternative to MIPS, not a repackaging of the same requirements. APM criteria should focus on desired outcomes—lower costs and high quality performance—rather than the details of whether or not providers use an EHR in achieving those outcomes. Of course, in the 21st century, it is difficult (if not impossible) for providers to manage population health effectively without the aid of technology, but imposing specific regulatory requirements around EHR use will only stifle innovation in the development and use of that technology, limiting its potential effectiveness.

Further, certification of additional functions or interoperability requirements in health IT products is not necessary for APMs. Provider assumption of financial risk for the quality of care delivered through APMs is the single biggest potential driver of interoperability and effective use of health IT. CMS should allow these market forces to work, allowing health IT vendors to spend development resources innovating around client needs rather than the demands of an additional certification program.

Conclusion

We appreciate the opportunity to share our thoughts on how best to implement the requirements established under 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,



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