June 25, 2018

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1694-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems and Proposed Policy Changes for Fiscal Year 2019 Rates Proposed Rule ("Proposed Rule")

Submitted electronically through www.regulations.gov

Dear Administrator Verma,

Recognizing that data flow is critical in the healthcare ecosystem, athenahealth has been a leading voice committed to interoperability in the health IT community. Over the last twenty-one years, we have built a network of over 114,000 clinicians who care for patients in both the acute and ambulatory settings. Consistent with our model in which all of our customers use a single instance of our cloud-based application, we have aspired to connect with partners across the care continuum to enable our providers to improve the quality of care they provide to the more than 110 million patients on our network. Because we are in the trenches with our customers, we observe firsthand the administrative burden imposed on clinicians, who must devote precious resources to navigating complicated reimbursement systems. Because we collaborate with other technology companies to advance our customers' interests, we are also positioned to know that ever-improving technology exists to exchange meaningful information.

We are pleased to see that CMS intends to "promote interoperability," but we caution that it should not transform its goal to "prescribe interoperability." Historically, government programs stemming from the HITECH Act have too frequently stifled private sector innovation by mandating the means by which technologists help their customers deliver results. The cost to the industry is real, and it is imperative that CMS, ONC, and all the agencies that set the rules of the road for electronic health records and related reimbursement paradigms refrain from over-orchestrating the process. We encourage simplicity, consistency, and predictability across all of HHS so that healthcare IT companies like athenahealth can help them deliver quality care and free them from unreasonable burden.

We applaud CMS's espoused commitment to focusing on only those measures that translate to value, eradicating redundancy, and ameliorating the burdens that tax the healthcare industry. Similarly, athenahealth is committed to freeing our customers up to do what matters. We

provide our services—revenue cycle management, electronic health record, patient engagement, care coordination, population health, and Epocrates point-of-care medical applications—by utilizing our network to harness and share billing and clinical knowledge with medical practices, health systems, and hospitals. Moreover, we perform administrative work at scale on their behalves, allowing clinicians to focus on delivering high value patient care. We have aligned our incentives with and supported customers throughout the evolution of payment programs from Meaningful Use Stage 1 through MIPS, and as a result we are uniquely positioned to identify how CMS can avoid a recurrence of the pitfalls that hampered prior iterations on the path to Promoting Interoperability.

Given our unique support model for the Electronic Health Record (EHR) Incentive Program, Inpatient Quality Reporting Program (IQR), and Quality Payment Program, we find ourselves in a position similar to a large health system, needing to review and reconcile the change that CMS makes to those programs through the various fee schedule and other rules. This model for rulemaking leads to inconsistent and often confusing requirements and is not sustainable. We urge CMS to ensure that changes to payment programs are consistent across all programs and that rulemaking around those changes be done in a centralized manner to ensure consistency.

In addition, while we agree with CMS that empowering patients is a vital component of the path forward, we must reconcile the burdens that might become an unintended consequence of that effort. As CMS explores initiatives such as Blue Button 2.0 to address patient data access, athenahealth recommends that CMS contemporaneously consider ways to ensure that the providers caring for those patients likewise have timely access to critical Medicare claims data. Ensuring that providers have a more complete picture of how and where patients receive care, *without relying on the patient to mediate the provision of such a picture*, will allow clinicians to make more informed medical decisions and stand to improve their performance in value-based care models.

It is with that context that we provide the following specific comments and requests for clarification on the Proposed Rule:

1. CMS's commitment to flexibility should extend to the Public Health and Clinical Data Exchange objective.

We appreciate the many instances in the Proposed Rule in which CMS demonstrated its commitment to flexibility and burden reduction. We support the proposal to allow reporting for any continuous 90-day period in 2019 and 2020. We also support allowing hospitals to self-select the quarter during which they must report on four eCQMs.

With respect to the Public Health and Clinical Data Exchange objective, however, we ask that CMS offer more flexibility. Specifically, we ask CMS to consider allowing reporting on any two public health measures, rather than mandating Syndromic Surveillance and providing flexibility only with respect to the second public health measure. Requiring Syndromic Surveillance causes undue burden for many hospitals, as there are varying factors that can impact a hospital's

eligibility, as well as substantial readiness variability among each state's local public health agencies.

Furthermore, hospitals with no emergency department, or that are using a different emergency department software, fall into an ambiguous status with respect the Syndromic Surveillance measure; namely, they are unable to meet the measure but do not fall within the current exclusion criteria. We request that CMS clarify that such hospitals meet the exclusion criteria.

2. CMS should optimize the removal of eCQMs to avoid the inefficient outcome in which vendors unnecessarily support measures that are marked for removal, and it should prioritize streamlined alignment of measures across all payment programs.

We enthusiastically support CMS's efforts to reduce reporting burden by examining measures through a lens that identifies meaningful, outcome-based measures. That rigorous review process should continue to guide measures that are proposed in the future. To the extent that new measures are introduced prospectively, athenahealth supports making those measures optional to further ease burden.

We also seek clarification from CMS regarding why measures marked for removal in 2020 must persist in 2019. Given that vendors are obligated to support eCQMs as part of 2015 Edition certification criteria, it seems wasteful to require those vendors to maintain support for measures that will not be maintained as part of the Inpatient Quality Reporting Program prospectively. This lame duck period in 2019 would conscript vendor resources to supporting deprecated program elements instead of permitting vendors to invest those same resources in innovations that help customers improve performance and quality.

athenahealth appreciates CMS's interest in stakeholder feedback relating to the challenges posed by eCQM use. The total number of programs and measures, and versions of specific measures, continues to be a challenge to support from a vendor perspective. Continued analysis of measure enrollment and effectiveness in support of Meaningful Measures and other initiatives to reduce complexity and simplify programs would enable better overall vendor support and reduce provider and hospital overhead in supporting these programs. We also believe that the expanded use of CQL-based measures and earlier, longer draft periods could enable hospitals and vendors to perform more testing and provide more feedback. Additionally, athenahealth believes that updates to Cypress and other tools in line with measure draft availability, such as support for 2019 measures, would be valuable for both hospitals and vendors.

Finally, as we have with past CMS initiatives, athenahealth is an interested participant in any pilots or feedback sessions to explore and discuss alternative approaches to quality measurement.

3. CMS should clarify its rationale with respect to linking a patient's right to access health information with Medicare CoPs.

athenahealth appreciates CMS's well-intentioned policy goal of ensuring that patients can access and direct their medical records when they choose to do so. Liberating data is necessary to advance widespread interoperability, so CMS is right to focus on access. We recognize that many patients may need to be better educated about their existing rights of access, but it is premature to impose consequences such as exclusion from participation. The 21st Century Cures Act charged ONC to promulgate rules related to information blocking, and it is vital that stakeholders have a comprehensive view of all the coordinated efforts across HHS.

CMS asked in its Request for Information whether it should:

> propose new CoPs/CfCs/RfPs for hospitals and other participating providers and suppliers to ensure a patient's or resident's (or his or her caregiver's or representative's) right and ability to electronically access his or her health information without undue burden? Would existing portals or other electronic means currently in use by many hospitals satisfy such a requirement regarding patient/resident access as well as interoperability?

We appreciate and understand that electronic access is likely to lead to greater interoperability, but CMS should be careful to avoid disqualifying non-electronic access, which may be necessary under certain circumstances. While we agree that requests to provide information electronically should be fulfilled electronically, there is still value in exchanging information through non-electronic means if the receivers (including, in many instances, patients) either prefer non-electronic copies or lack the capability to do anything meaningful with the electronic copy.

HHS (ONC, CMS, and OIG) should focus its efforts first on abhorrent behavior in the industry by those who seek to hoard patient data for improper purposes. After addressing that behavior and better educating patients, it may then be appropriate to hone in on the mode of access.

4. CMS should provide more information about its objective-based scoring approach so that stakeholders can comment on whether the objective-based or measure-based approach would better satisfy CMS's stated goals of flexibility and burden reduction.

athenahealth agrees that hospitals should be able to focus their efforts on performance attributes that are most meaningful to their patients, communities, and care delivery models. Although CMS mentioned and invited comment on a scoring methodology deployed at the objective level, it failed to address the objective-level scoring as granularly as the proposed measure-level scoring methodology. In order to more fully consider and provide the requested feedback, athenahealth requests additional, equivalent detail regarding the objective-level scoring methodology under consideration.

Regardless of the scoring methodology CMS ultimately adopts, we also encourage it to align scoring feedback systems across MIPS and Promoting Interoperability. Vendors that have utilized an API for MIPS scoring would benefit from the efficiencies that would come with leveraging those same APIs for all programs.

5. CMS should take into account the complexities associated with PDMP-EHR integrations and clarify related exclusions.

Although the efforts of the federal government to advance PDMPs are laudable, athenahealth has first-hand experience trying to integrate with those PDMPs that suggests those programs have more to do. In our experience, states vary in their PDMP integration capabilities, willingness to integrate, and contractual gymnastics to enable integrations. Often, the preference is for point-to-point integrations that are anathema to our model and stand to block our efforts to build and scale interoperability across our network. Given the nascent state of PDMP-EHR integrations, CMS should proceed deliberately and heed the lessons learned in prior stages of Meaningful Use—that disparities across state capabilities can exacerbate burden and drain and distract vendors. While we acknowledge that integration is not explicitly called for in the Proposed Rule, CMS must recognize that vendors will be pressured to provide that integration, but neither hospitals nor vendors should bear the burden of state PDMPs not being ready to integrate.

6. CMS should ensure alignment so that vendors like athenahealth can meaningfully contribute to the success of this and other payment programs.

Given that the Proposed Rule reflects a sincere effort to isolate the most meaningful elements among past iterations of the included programs, streamline and clarify those elements, and pave the way for hospitals to deliver without unreasonable burden, it is disappointing that CMS allowed ambiguity to persist. Clearly, CMS favors Promoting Interoperability over Meaningful Use. The shift is not merely a superficial rebranding. However, should states not elect to adopt measure changes and the performance-based scoring methodology, then "Medicaid-only" hospitals will not be freed from the administrative burdens in the same way. To the extent it can, CMS should encourage states to adopt the finalized scoring methodology and measures so that vendors can focus on helping their customers succeed at scale instead of assisting different customers in programs with diverging requirements. This should extend to include both the ambulatory and hospital Medicaid Promoting Interoperability programs.

Looking ahead to the forthcoming QPP rule, we also hope that CMS will ensure consistency between scoring methodologies and measures. If MIPS similarly transitions to Promoting Interoperability, it is imperative that, aside from distinctions that are required by care settings, the programs are aligned and consistent.

In summary, athenahealth appreciates the opportunity to provide input on the Proposed Rule, and we look forward to continuing to work with you and your staff in reducing the burden facing

clinicians today and maximizing our customers' flexibility to meaningfully advance interoperability.

Sincerely,

Greg Carey
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athenahealth, Inc.