

September 11th, 2023

Administrator Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS–1784–P Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

Submitted electronically via www.regulations.gov

Dear Administrator Brooks-LaSure,

athenahealth, Inc. (“athenahealth” or “athena”) appreciates the opportunity to respond to the proposed changes outlined in the CY 2024 Payment Policies Under the Physician Fee Schedule Proposed Rule.

Over the past 26 years, athenahealth has built a network of approximately 385,000 healthcare providers in both the ambulatory and acute settings in all 50 states. We provide electronic health record (EHR), practice management, care coordination, patient engagement, data analytics, revenue cycle management, and related services to physician practices and hospitals. More than 140,000 providers utilize our single instance, continuously updated, cloud-based platform. We also support on-premise software solutions. In both hosting paradigms, athenahealth seeks out and establishes connections with partners across the care continuum, enabling our clinicians to improve the quality of care they deliver.

athenahealth’s vision is to create a thriving healthcare ecosystem that delivers accessible, high quality, and sustainable healthcare for all. We work towards this vision partially by reducing burdensome administrative tasks for providers so that they can focus on improving patient outcomes. It is with that context that we offer the following comments.

1. CMS and Congress Must Take Action to Avert the Proposed 3.36% Reduction to the Conversion Factor

Healthcare providers are not immune to economic uncertainty. The front door of healthcare is experiencing record inflation rates as the country barrels towards the four-year anniversary of the start of the COVID-19 Public Health Emergency (PHE). Our nation’s healthcare providers confront economic uncertainty and financial jeopardy daily as they continue to care for vulnerable patients and communities.

We share the deep concerns of our clinician customers about the impact of the sizable budget cuts this update will impose on many physicians and healthcare professionals. These proposed payment reductions come at a time when physician practices and other stakeholders are navigating provider burnout caused by the effects of the pandemic, rising costs due to the inflation rate, staffing shortages and significant challenges to meet additional regulatory burdens.

The rate cuts surface the larger issue of budget neutrality. Under existing Medicare law, any changes to the Medicare Physician Fee Schedule cannot increase or decrease expenditures by more than \$20 million without triggering automatic budget neutrality adjustments. The \$20 million threshold was established in 1994 and has not been adjusted for inflation or changes in healthcare delivery. There are very few aspects of our lives that look the same today as they did close to 20 years ago and healthcare should not be the exception. With payment reductions of this magnitude proposed again for 2024, it is imperative that action is taken to provide both short and long-term solutions to this challenge.

2. Reduce Burden on the Public Health and Clinical Data Exchange Objective

athenahealth shares in CMS's vision for the widespread electronic transmission of high-quality production level data. However, requiring clinicians to transition to active engagement level two by PY2025 is problematic. In many circumstances, the ability to move from the "pre-production and validation" level to "validated data production" is outside of the clinicians' control. State registries are overburdened, under resourced, and technologically out of date resulting in long registry wait times, arduous testing procedures, and interface connectivity issues. These factors lay outside a clinician's control and limit their ability to progress. Enforcing arbitrary timeframes that limit the duration a clinician can be in a particular level of active engagement will unintentionally penalize faultless providers and undermine the spirit of the objective.

3. athenahealth Supports Implementation of Telehealth-Related Flexibilities

athenahealth applauds CMS for the proposal to implement several telehealth related provisions of the Consolidated Appropriations Act (CAA). Flexibilities such as expanding the scope of a telehealth originating site, expanding the definition of telehealth practitioners, and the continued payment for telehealth services furnished by Rural Health Centers and Federally Qualified Health Centers will continue to improve access to care.

4. CMS Must Allow Reasonable Time to Adopt Changes to MIPS Value Pathways (MVPs)

athenahealth recognizes CMS's forward-thinking approach to expand MVP's is tied to specific specialties, clinical conditions, and episodes of care. However, CMS must balance the strict timeline to implement new MVPs with bandwidth against other competing and time-sensitive MIPS and MVP requirements. Improving digital healthcare requires clinicians to work with their technology vendors and policymakers as partners to iterate and re-imagine resource intensive processes. Net new quality measures proposed for an MVP in July are not finalized until mid-November, creating challenges for measure development, testing, and establishing workflows by January 1st of the performance year. Given the newness of MVPs, we urge CMS to account for the administrative and financial burden that will be placed on health IT developers and the clinicians they support as they work to comply with regulatory requirements.

We also note that net new measures do not have benchmarks, ultimately impacting scoring. In the programs first year, two distinct MVPs were merged and replaced with a net new MVP with new measures. Changes like this result in considerable UX modifications in the product as well as MVP identifiers required at submission.

5. CMS Must Not Remove Health Information Technology Vendors from the Definition of Third-Party Intermediary

athenahealth is passionate about helping healthcare organizations reduce administrative burdens and freeing up providers and their staff to focus on their most valuable work. In part, we accomplish this by supporting our clinician customers through quality payment program submissions. We discourage CMS's proposal to remove non-registered health IT vendors from the definition of third-party intermediary. By doing so, the burden of quality data submission is unnecessarily placed on the clinician. As a health IT vendor that acts as a trusted partner and offers a Qualified Registry (QR) solution in addition to a non-registered solution, we understand the complexities and challenges that come with being a QR. For example, the CMS technology infrastructure is not currently set up in a way that enables vendors to support clinicians at scale under QR requirements (O-Auth is assigned to a person, not a TPI). Revoking a non-registered health IT vendors ability to support customers by directly submitting data to CMS is counterproductive to CMS's goal of reducing clinician burden and does not change the quality of data being submitted, as it is the same data generated by the health IT vendor. If CMS finalizes the decision to remove health IT vendors from the definition of third-party intermediary, we ask that the 2025 timeline be extended to allow sufficient time for health IT developers to become QRs.

6. Clarification Needed on Expanded Coverage for Community Health Integration (CHI) and Principal Illness Navigation (PIN) Services

athenahealth seeks clarification on the proposed expanded coverage for community health integration and principal illness navigation service. If CHI Services and PIN Services are to be "included" in the general care management payment for G0511 how should CHI and PIN services be billed? For example, should they be suppressed from the claim and if so, should they still be included in the cost report? Are those services paid in addition to the G0511? If not, should they be treated as incidental services and have their charge amounts changed to \$0 or \$0.01? Should they influence any changes to the amount billed on G0511?

7. Clarification Needed on Qualified Registry Attestation Requirements

athenahealth seeks clarification on CMS's proposal to require that qualified registries attest that each MIPS eligible clinician provide the registry with all documentation necessary to verify the accuracy of the data on "quality measures" submitted. We ask that CMS clarify the definition of 'quality measures'. Are quality measures limited to Electronic Clinical Quality Measures (eCQMs) and clinical quality measures, or does it collectively reference quality, Promoting Interoperability (PI) and Improvement Activities (IA) measures? In the case of PI and IA, it is not feasible for third party intermediaries to provide CMS documentation verifying the accuracy of the data submitted for attestation measures performed outside of the electronic health record (e.g. Security Risk Analysis, SAFER guides).

8. Clarification Needed on Support for Both a 12 Month and Nine Month eCQM Submission

athenahealth appreciates CMS's acknowledgment that eCQM measures cannot be truncated. CMS's proposal to offer both a 12- and nine-month measure specification will effectively double the number of eCQMs offered by electronic health record vendors. Doubling an already large set of measures leaves developers with less capacity to support current eCQMs or add additional e-measures. This additional burden ultimately leads to developers supporting fewer measures across the industry. Is the expectation that CMS will require health IT developers to support both 12- and 9-month measure specifications? As noted above, we urge CMS to account for the administrative and financial burden that will be placed on health IT developers and the clinicians they support when adding new regulatory reporting requirements.

athenahealth looks forward to supporting this work and encourages CMS to continue to consider industry feedback to develop standardized approaches that reduce burden and ensure lasting value for patients and providers.

Regards,

A handwritten signature in black ink that reads "J. Michaels". The signature is written in a cursive style with a large, looped initial "J" and a stylized "M".

Jennifer Michaels
Senior Manager, Government & Regulatory Affairs
athenahealth, Inc.