athenahealth

September 12, 2025

Mehmet Oz, M.D.
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-1832-P Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Submitted electronically via www.regulations.gov

Dear Administrator Oz,

athenahealth Inc. ("athenahealth" or "athena") appreciates the opportunity to respond to the proposed changes outlined in the Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program Proposed Rule.

Over the past 28 years, athenahealth has delivered data-driven insights from across the company's connected network of more than 160,000 providers serving nearly one-fourth of the U.S. population. Our healthcare providers serve in both 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. 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 in that context that we offer the following comments.

CY 2026 Physician Fee Schedule Rate Setting and Conversion Factor

athenahealth commends CMS for proposing the first positive update to the Medicare Physician Fee Schedule conversion factor in several years, representing a meaningful step toward recognizing the real costs of delivering care. The proposed 3.8% increase for physicians participating in Advanced Alternative Payment Models (APMs) and 3.3% increase for other clinicians marks an important reversal of the long-standing trend of declining reimbursement. This progress reflects a significant achievement for the provider community and a strong signal of CMS's commitment to strengthening value-based care models while addressing the financial challenges facing physicians.

At the same time, we emphasize that this update cannot be the final step in ensuring long-term, sustainable reimbursement. Many independent physicians are already feeling the financial strain of

keeping their practices open. A recent survey conducted by the Harris Poll on behalf of athenahealth found that more than half of physicians (53%) feel concerned at least once per week about reimbursement rates from payers, and nearly one-third (31%) worry weekly that they may not be able to continue serving Medicare or Medicaid patients due to low reimbursement levels[1]. These pressures put small and independent practices at particular risk of instability, which in turn threatens patient access. We strongly encourage CMS to build on this positive proposal to preserve practice viability, safeguard access to care, and support a sustainable care delivery system.

Ambulatory Specialty Model (ASM) Eligibility and Transparency

athenahealth encourages CMS to improve transparency into program eligibility to enable technology vendors to better serve their clinicians. We urge CMS to establish a mechanism to exchange clinician ASM eligibility data directly with health IT vendors. We welcome the opportunity to collaborate with you as you lead the healthcare sector towards common solutions that support patients, promote burden reduction for clinicians, and foster innovation within our health care system.

With respect to CMS's proposal to use ASM participants' final scores across the four performance categories to determine if they receive positive, neutral or negative payment adjustments on future Medicare Part B claims for covered services, we strongly encourage CMS to improve transparency for payment adjustments under the Ambulatory Specialty Model by introducing designated payment codes or a clear identifier for these adjustments. Currently, adjustments applied at the claim level without distinct codes make it challenging for providers to track and reconcile payments accurately. We request that CMS establish a designated adjustment code or consistent remittance advice indicator specific to ASM adjustments and publish the format and file specifications that identify which remittance codes will be used, including CARCs and RARCs. This additional transparency will support accurate financial reconciliation, compliance tracking, and facilitate better operational planning for participating organizations.

Core Elements Request for Information

athenahealth appreciates CMS's efforts to streamline MVP participation through the proposed "Core Elements" policy and strongly encourages CMS to extend this same flexibility to Qualified Registries (QRs) and other third-party intermediaries. Requiring QRs to support every applicable quality measure within an MVP rather than the core measures or a sufficient subset to meet reporting requirements, creates significant operational burden and leaves no business discretion to invest in measures pertinent to provider interests. Because the number and composition of measures within each MVP can fluctuate, a universal support mandate forces QRs into continual reconfiguration, limiting their ability to provide consistent, high-quality services to clinicians.

Granting QRs the discretion to support a targeted subset of measures within an MVP would allow intermediaries to focus on measures most relevant to the specialties they serve, allocate resources more efficiently, and expand support across a larger number of MVPs. This flexibility would better align measure availability with provider needs and directly advance CMS's goal of promoting broad MVP adoption while ensuring reporting remains clinically meaningful and administratively feasible.

Proposal To Modify the Security Risk Analysis

athenahealth supports CMS's goal of aligning the Security Risk Analysis measure more closely with the requirements of the HIPAA Security Rule. However, we recommend that CMS maintain this as a

[1] 2025 Physician Sentiment Survey of 1,001 physicians nationwide, commissioned by athenahealth and fielded by Harris Poll, Jan 2025.

single, comprehensive attestation rather than splitting it into two separate "Yes/No" responses. Since clinicians are already required to conduct a security risk analysis and implement security risk management activities to be compliant with HIPAA, dividing the measure into two separate attestations introduces additional clicks and workflow steps without providing meaningful differentiation in compliance or oversight.

Even small increases in attestation steps create added burden for both clinicians and health IT vendors, who must build, support, and maintain reporting infrastructure. We encourage CMS to prioritize streamlining the Promoting Interoperability measures in ways that support efficiency while preserving program integrity. A single comprehensive attestation would reinforce the requirement for both analysis and mitigation, while reducing unnecessary administrative complexity.

Digital Quality Measurement in CMS Quality Programs

athenahealth strongly supports a unified approach to patient data as CMS transitions to Digital Quality Measures (dQMs). To reduce complexity and promote consistency, we recommend that CMS, HRSA, and AHRQ align future versions of the U.S. Core Data Interoperability (USCDI) with the HL7 FHIR QI-Core implementation guide. Currently, USCDI is aligned with FHIR US-Core; however, QI-Core is conducive to support clinical quality measurement. Adopting a QI-Core as the standard for dQMs will reduce the burden on health IT developers, who would otherwise need to support multiple FHIR profiles.

In particular, HRSA should prioritize alignment with QI-Core over creating a separate, purpose-built UDS+ FHIR specification. Leveraging a single, widely accepted standard across federal programs will facilitate interoperability, minimize redundancy, and streamline implementation efforts for EHR vendors.

We also offer the following observations regarding the dQM roadmap as outlined on the Electronic Clinical Quality Improvement (eCQI) Resource Center. The dQM roadmap, as published at https://ecqi.healthit.gov/dqm?qt-tabs_dqm=dqm-strategic-roadmap, relies heavily on a FHIR-based measure calculation tool. However, CMS is now proposing to move away from this model without identifying a clear alternative. Certified health IT developers need guidance on CMS's new direction, particularly regarding the architecture and processes required for data submission.

Moreover, the transition to FHIR based electronic Clinical Quality Measures (eCQMs) necessitates clarity on how patient data will be migrated and aggregated across disparate EHR systems. While the Quality Data Model (QDM) and QRDA 1 serve as interoperability standards, their role within the FHIR ecosystem remains uncertain. Developers require clear, actionable guidance on how these changes will impact migration, along with revised certification requirements for FHIR based eCQMs.

We recommend that CMS allow for a two-year transition period to give vendors sufficient time to upgrade systems and meet certification requirements, contingent on timely and detailed guidance. As developers continue to invest in USCDI, clarity around certification pathways, measure calculation, and data submission processes will enable more targeted, modular investments aligned with the FHIR transition.

Finally, the proposed rule encourages health IT developers to use the Measure Authoring Development Integrated Environment (MADiE), however, current access limitations require a U.S.

Social Security Number (SSN) for login. By restricting access to MADiE based on SSN requirements, CMS will inadvertently hinder broader engagement and ultimately slow progress in the advancement of quality measure development. athenahealth strongly encourages CMS to consider alternative access solutions that accommodate a wider range of contributors. An alternate solution is for CMS to consider implementing administrative or organizational-level accounts for MADiE. Under this approach, organizations manage access, assigning internal accountability, and oversight for user activity. Implementing a more inclusive access policy would not only enhance the utilization and adoption of MADiE but also support the overall goal of improving healthcare quality through diverse perspectives and expertise.

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

Regards,

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athenahealth, Inc.