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September 6th, 2022

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: FR Doc #2022-0113 Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs To Provide Refunds With Respect to Discarded Amounts

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 FY 2023 MPFS Proposed Rule.

Over the past 25 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.

CMS and Congress must take action to avert the 4.4% reduction to the conversion factor as proposed in the 2023 Medicare Physician Fee Schedule. Healthcare providers are not immune to economic uncertainty. The front door of healthcare is experiencing record inflation rates as the country barrels towards the three-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 provider 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 2023, it is imperative that action is taken to provide both short and long-term solutions to this challenge.

It is with that context that we offer the following specific comments.

CMS Must Continue the Expansion of Telehealth Flexibilities

Telehealth is here to stay and CMS's action for permanent change can set a foundation that will improve patient outcomes and empower health systems to survive and adapt to a new era in healthcare. athenahealth appreciates CMS's action to temporarily extend the coverage of codes covered during the PHE to align with the Consolidated Appropriations Act extension of telehealth flexibilities beyond 151 days post PHE. However, this temporary extension provides little to no certainty about the future of telehealth as providers weigh investments and methods to promote further access to care via virtual platforms. The recent proposal to eliminate coverage for audio-only modalities for every service except mental health services will result in a technology devolution in healthcare. While some types of services may be more appropriate with video, some services can be delivered effectively using audio only. With varying access to broadband and video technology, the decision to have an audio-only visit should remain with the provider and patient.

Additionally, we urge CMS to make permanent an appropriate reimbursement structure based on the provider's clinical guidance and expertise, and not based on the arbitrary patient or provider. Reducing telehealth reimbursement rates and limiting access points to care as the country recovers from a pandemic will negatively impact adoption and use at a time when Americans need certainty in continuity of care.

<u>Request for Information on Third Party Intermediary Support of MVPs</u>

Should third party intermediaries have the flexibility to choose which measures they will support within an MVP?

athenahealth strongly supports the flexibility for a third-party intermediary to choose which measures to support within MVP.

a. The quantity of quality measures in an MVP can vary significantly even after an MVP is finalized making the requirement to support every measure challenging for intermediaries. For example, the previously approved Advancing Care for Heart

Disease MVP had 8 quality measures. In the 2023 proposed rule, an additional 5 measures were proposed for addition for CY 2023 performance period, for a new total of 13 quality measures. Allowing intermediaries to support a subset of the measures in an MVP would provide increased flexibility and greater opportunities to support additional MVPs.

b. Supporting all measures in an MVP minimizes the bandwidth that an intermediary can support for a larger number of the MVPs relevant to their client's specialties.
c. Many quality measures in an MVP have multiple collection types: claims, eCQMs or CQMs. Since CMS already collects the claims data to score these quality measures, we suggest that measures that include a collection type of claims be calculated by CMS like the cost and population health measures. It would allow intermediaries to support a greater number of MVPs and reduce the burden of support.
d. Greater flexibility for third party intermediaries to choose which measures they support within an MVP allows electronic health record vendors to make optimal selections to cater to provider needs. Furthermore, third party intermediaries can better utilize resources to support a wider set of MVPs.

What are the barriers/burdens that third-party intermediaries face supporting all measures within an MVP?
New electronic Clinical Quality Measure (eCQM) implementation requires extensive time to successfully execute. First, electronic health record vendors must analyze and implement workflows to capture the required clinical and supplemental data points to support the measure specifications. They must then test eCQMs using real-world data and data derived from testing tools. Finally, new eCQMs must obtain certification to meet C1 – C3 ONC HIT criteria. Furthermore, there is no limit to the number of quality measures included in an MVP and intermediaries have no flexibility in choosing the quantity and/or selection of measures. For example, between the November 2021 Medicare Physician Fee Schedule final rule and the July 2022 proposed rule, six new quality measures were added to a single MVP. This volume of new measures is neither realistic nor sustainable to implement in a tight turnaround time.

Additionally, the CQM Measure Quality ID 483: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM) is included in two MVP's (Promoting Wellness MVP and Optimizing Chronic Disease Management MVP). This new measure was introduced by CMS for CY 2022 performance period and includes a set of workflows for clinicians to survey patients outside an encounter/visit workflow to solicit feedback. While we appreciate and support the end goal of increased patient experience feedback, the workflow for clinicians or third-party intermediaries leaves room for improvement. As this measure was not a mandatory requirement for traditional MIPS, making third party intermediaries mandatorily support all measures within an MVP creates a shift in requirements and presents a barrier to offer these two MVPs to clinicians. We support CMS allowing third party intermediaries the flexibility to choose which measure they will support within an MVP.

What type of technical educational resources would be helpful for QCDRs, qualified registries, and health IT vendors to support all measures within an MVP?
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. We urge CMS to account for the administrative and financial burden that will be placed on health IT developers and the clinicians they support in their ability to serve their communities, particularly in a healthcare landscape already taxed by the COVID-19 pandemic.

In summary, athenahealth appreciates the opportunity to provide comments and input on the Proposed Rule. We look forward to continued collaboration with CMS in improving interoperability, and quality of care while reducing the burden faced by clinicians today.

Sincerely,

Greg Carey
Director, Government & Regulatory Affairs