June 17th, 2022

Honorable 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 #2022-08268 Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation

Submitted electronically via www.regulations.gov

Dear Honorable Brooks-LaSure,

athenahealth, Inc. ("athenahealth" or "athena") appreciates the opportunity to respond to the proposed changes outlined in the FY 2023 IPPS Proposed Rule.

Over the past 25 years, athenahealth has built a network of approximately 390,000 providers in both the ambulatory and acute settings. 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. 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 the burden of cumbersome regulatory requirements and red tape facing healthcare providers today.

It is with that context that we offer the following comments to CMS:

1. **Reduce Burden on Proposed Changes to the Public Health and Clinical Data Exchange Objective** athenahealth shares in CMS's vision of the widespread electronic transmission of high-quality production level data. However, the proposal to require hospitals to move from one level of active engagement to the next in consecutive reporting periods is problematic. In many circumstances, the ability to move from testing and validation to production is outside of the hospital's control. State registries can be overburdened, under resourced, and technologically out of date resulting in long registry wait times, arduous testing procedures, and interface connectivity issues.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 hospital's control and limit their ability to progress. Enforcing arbitrary timeframes that limit the duration a hospital can be in a particular level of active engagement will unintentionally penalize faultless hospitals and providers and undermine the spirit of the objective.

2. **Maintain consistency and alignment across all measures.**
   We encourage CMS to align the exclusion options of the (f)(6) Antimicrobial Use and Resistance (AUR) measure to meet the Public Health Objective with exclusion options from other previous measures. Specifically, we recommend the AUR measure provide a similar exclusion option as the Electronic Case Reporting measure provided for 2022, for those hospitals that may not have implemented a (f)(6) certified module or whose current EHR does not make one available: "(For 2022 only) The MIPS eligible clinician uses CEHRT that is not certified to the electronic case reporting certification criterion at § 170.315(f)(5)." We fully support both of these measures and the increased sharing of public health information. However, consistent with our previous feedback to CMS, we ask for exclusion options that account for the wide range of health system priorities and needs over the next several months. We believe it is more important to implement this measure properly and sustainably to continue to improve our nation's public health infrastructure, than to punish health systems working with limited resources and time to implement the measure for 2023.

3. **Reportable Data Elements Must be Structured Relevant to a Declared Public Health Emergency**
   athenahealth acknowledges that there are uncertainties in planning for future emergencies and understands that there are many incentives and pathways to consider with regard to preparedness. As CMS evaluates how to best monitor preparedness, we discourage the collection of extraneous unstructured data elements. Unstructured data, such as the amount of personal protective equipment or staffing shortages, are monitored in disparate systems in disparate formats. Hospitals must be able to prioritize patient care without the additional burden and cost of manually tracking and reporting these fields. athenahealth strongly recommends allowing flexibility in reporting requirements, and encourages the use of structured data fields that follow HL7 standards to enable automation.

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

Regards,

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