September 13th, 2021

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: Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements.

Submitted electronically via www.regulations.gov

Dear Administrator Brooks-LaSure,

athenahealth, Inc. ("athenahealth" or "athena") appreciates the opportunity to respond to the changes outlined in the CY 2022 Medicare Physician Fee Schedule and Quality Payment Program (QPP) Proposed Rule.

Over the past 23 years, athenahealth has built a network of approximately 385,000 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. More than 140,000 clinicians 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.

Below please find our specific comments and requests for clarification on the proposed rule:

Ensuring Access to Telemental Health Services Must Continue Post Pandemic

athenahealth applauds Congress for acting at the end of 2020 to pass the Consolidated Appropriations Act, which was a step in the right direction to ensure access to telemental health services. However, in the proposed rule, the Center for Medicare and Medicaid (CMS) considers an arbitrary requirement for the patient to have an in-person mental health visit every six months. We strongly urge CMS to remove the continual six month in-person visit requirement. Such a provision will have the unintended consequence of hindering patient access to telemental services. We encourage the agency to use their regulatory authority and establish that no additional in-person visits be required for a provider to furnish telehealth services to an eligible patient.

In response to CMS's question about the need for additional documentation in the patient's medical record to support the clinical appropriateness of audio-only telemental health, athenahealth urges CMS to avoid creating requirements that burden clinicians and unnecessarily detract from the provider's ability to care for a patient.

athenahealth praises CMS for the recommendation that Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) offer mental health services through interactive, real-time telecommunications technology. We support CMS's proposal to align FQHC and RHC patient access with other telemental health services, and strongly recommend that CMS avoid adding the same unnecessary in-person requirement to remote services for these patients.

All Medicare Covered Telehealth Codes Should Continue Through 2023 to Evaluate the Need for Permanency

athenahealth commends CMS for extending the Category 3 telehealth service list through 2023, and further believes Category 3 could be a useful framework to maintain beyond 2023 and the COVID-19 pandemic. However, the bifurcation of codes into those that extend through 2023 and those that expire at the end of the public health emergency will hinder much of the progress that has been made. We urge CMS to recognize the need for telehealth services to continue for a period not dependent on the public health emergency and ask that all 160 temporary telehealth codes be extended through 2023 to allow additional time to measure effectiveness.

Patients Should Have Prompt Access to their Data with Minimal Effort

athenahealth supports the principle that patients should have prompt access to their data with minimal effort. However, as recognized in the FY 2022 Hospital Inpatient Prospective Payment Systems final rule, CMS must clearly define what an "indefinite" timeline entails and define what specific data should be included in "all patient health information" prior to finalizing this proposal. Additionally, we encourage CMS to partner with ONC to clearly distinguish between USCDI and the larger set of electronic health information as defined in the ONC Information Blocking rules.

MIPS Quality Measure Benchmarks for 2022 Must Allow Organizations to Monitor Performance Throughout the Reporting Period

athenahealth appreciates CMS's consideration of the COVID-19 impact on MIPS Quality measure benchmarks for PY 2022. However, the proposal to benchmark for the 2022 performance period based on data submitted during 2022 would both limit electronic health record vendors' ability to provide timely scoring feedback to customers, and hinder provider insight into performance during the reporting period. As providers continue to be measured on the quality and cost of care they deliver and take on more risk, it is essential that they have real-time or near real-time access to their performance data. We agree with CMS's recognition that "this option would allow clinicians to continue to receive advance notice for quality performance category measures so that MIPS eligible clinicians can set a clear performance goal for these measures for the CY 2022 performance period/2024 MIPS payment year" and encourage the agency to seek solutions that enable performance insight against benchmarks in real time.

The Transition to Outcomes-Based Administrative Claims is Not a Complete Assessment of Patient Care

athenahealth applauds CMS's effort to create a more cohesive and meaningful participation experience in MIPS that improves both value and reduces clinician burden. The proposal to utilize outcomes-based administrative claims measures to reduce reporting burden is a step in the right direction. However, as proposed, measuring claims data alone is not reflective of the complete

patient chart. While claims data relies on billing codes, it does not capture the SNOMED or LOINC codes needed to assess the quality of care delivered. Until claims data captures all necessary information, the agency risks assessing performance with incomplete information.

Standardization is Needed Across State Public Health Registries

athenahealth recognizes CMS's forward-thinking approach to create a more integrated case reporting and immunization network and agrees that investments in public health are vital to modernizing the nation's healthcare infrastructure. With respect to the Public Health and Clinical Data Exchange Objective, we ask that CMS explore a national registry and/or standardization as a way to consolidate the current piecemeal approach of connecting to fifty individual jurisdictional registries. The different standards across states cause extreme burden and administrative work for providers and electronic health record vendors. We urge CMS to encourage standardization amongst state registries and/or explore a national registry.

Opportunity to Exchange Clinician MVP Participation Data with Health IT Vendors

athenahealth appreciates CMS's recognition that the transition to MIPS Value Pathways (MVP) will take time as the agency evaluates the readiness of clinicians. As the agency prepares for upcoming changes, we encourage CMS to improve transparency into program eligibility and participation to enable technology vendors to better serve their clinicians. We urge CMS to establish a mechanism to exchange clinician MVP participation 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.

Enable TIN Level Reporting and Sampling for eCQMs/MIPS CQMs by Health IT Vendors

athenahealth supports CMS's effort to address ACO eCQM/ MIPS CQM data aggregation across multiple TINs with multiple EHR systems. We encourage the agency to afford the same opportunity to health IT vendors. By allowing vendors to aggregate the TIN level quality data to create an ACO level score, this would offer ACOs insight into their performance, while enabling submission if they choose to centralize their data with one vendor.

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
Manager, Government & Regulatory Affairs
athenahealth, Inc.