



May 28, 2015

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3310-P
P.O. Box 8013
Baltimore, MD 21244-8013

**Medicare and Medicaid Programs; Electronic Health Record Incentive Program—
Stage 3**

Dear Acting Administrator Slavitt:

The American Academy of Physician Assistants (AAPA), on behalf of the more than 100,000 nationally certified physician assistants (PAs) throughout the United States, appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' Electronic Health Record (EHR) Incentive Program - Stage 3 proposed rule dealing with the advanced use of EHR technology to promote improved health outcomes for patients. The proposed rule would establish guidelines and requirements for eligible professionals, such as PAs and physicians, to substantiate meaningful use compliance and qualify for Medicare and Medicaid EHR Incentive Program incentive payments. The proposed rule also seeks to establish criteria that would increase flexibility in the EHR incentive program while encouraging interoperability and a focus on patient outcomes in the meaningful use program.

With limited exceptions, eligible providers are expected to conform to the new requirements by 2018 and to begin reporting on a full calendar cycle in 2017. Program participants have the option to start Stage 3 in 2017 or 2018, but all participants must use the Stage 3 standards by 2018. PAs, physicians, and other eligible providers who do not meet the requirements of Stage 3 meaningful use as established by the Centers for Medicare and Medicaid Services (CMS) will lose incentive pay eligibility and face payment penalties.

AAPA is in agreement that the appropriate use of EHRs can have a significantly positive impact on patient outcomes, and this impact will only continue to grow as more health professionals adopt EHR systems and expand their use. Like physicians and nurse practitioners (NPs), PAs are heavy users of EHR systems across virtually all medical settings and specialties. In fact, in many rural or medically-underserved areas, PAs may be the sole healthcare provider. However, the current EHR incentive program excludes the majority of PAs from the Medicaid EHR incentive, essentially penalizing medical practices and clinics in which PAs provide a high volume of care. This implicit penalty creates two undesirable results: a financial disincentive for Medicaid-heavy practices and clinics to hire and retain

PAs, and a decrease in access to this technology for some of the nation's most vulnerable patients.

Because of this near exclusion from the EHR incentive program, serious questions remain as to how PAs will be incorporated into Stage 3 meaningful use and whether expectations to meet Stage 3 criteria extend to those PAs beyond the limited subset deemed eligible for the incentive. Clarity on this matter becomes even more important with the Stage 3 proposed provision intending to further align EHR incentive programs with other quality reporting programs such as PQRS and the Hospital IQR, as such programs continue to trend toward becoming more supportive and interdependent in reporting requirements, process, and mechanism. If all PAs are expected to meet Stage 3 meaningful use requirements, limitations on the profession under the Medicaid EHR incentive program should be removed, allowing all PAs to act as eligible professionals. Any such decision should be made explicit well in advance of 2018 to permit proper PA preparation in a program in which most have been told they are not able to participate.

Overarching Issues

AAPA appreciates CMS' proposal to streamline the meaningful use adoption process by condensing the number of core program objectives from seventeen in Stage 2 down to eight objectives in Stage 3, and permitting provider flexibility within these objectives to meet meaningful use criteria. In addition, changing the EHR reporting period away from the government's fiscal year to a calendar year beginning in 2017 is a positive step that brings simplicity to the program.

However, serious concerns and questions remain regarding the intersection between meaningful use criteria and the upcoming value-based payment models such as the Merit-based Incentive Payment System. There is an interdependent relationship between these two concepts, but the critical details surrounding implementation have not yet been made apparent by CMS.

In addition, we continue to find that some of the specific requirements proposed for Stage 3 are extremely challenging. For example increasing the percentage of Unique Patients who "actively engage" with their EHR through the use of an Office of the National Coordinator-certified application- programming interfaces from 5 percent in Stage 2 to 25 percent in Stage 3 may prove to be overly onerous, especially in light of the fact that an eligible provider has only marginal control and input over whether a patient will engage in this activity.

Another proposed Stage 3 measure of similar concern requires that eligible providers engage in secure messaging with 35 percent of patients, instead of the 5 percent required under Stage 2. The sharp increase in expectation for these patient engagement measures may be excessively burdensome, and still beyond the control of providers who can only influence, and not control, patient actions.

In order to assure reasonable compliance with EHR guidelines and avoid unfair provider penalties, it is imperative that CMS requirements be reasonably based upon the resources that practices have at their disposal and to assure that practices and eligible professionals be responsible for those behaviors and actions that are clearly within their control. New

methods of patient engagement may require drastic shifts in both the perspective and methods that patients and providers use in care interaction. While providers can modify their behavior, they are only half of the required parties necessary to meet these ambitious goals. Consequently, we would recommend a more phased approach to increasing the expectations for patient engagement measures, allowing for providers and patients to become more aware of, and comfortable with, expected shifts in the provider-patient relationship.

Sub-Optimal Data Collection

The CMS EHR Stage 3 rule fact sheet articulates three goals for the incentive program:

- 1) Increased coordination of care
- 2) Increased access to health information
- 3) Support for data collection in a format that can be shared across multiple organizations

AAPA is supportive of these three goals and believes that the first two are enhanced by this rule. However, current policies of the EHR incentive program are counter to the ambition of the third goal — the collection of data. Regardless of format, data is only as strong as the validity and usefulness of what is collected. Unfortunately, not requiring states to report on providers such as PAs in quarterly reports or not collecting information from PAs who do not qualify for the EHR incentive only exacerbates data concerns under the current program structure, as data is not being captured as comprehensively as possible and the accuracy of determinations and conclusions based on such data will be diminished.

Conclusion

To achieve meaningful use of EHRs, and HIT in general, there must be appropriate incentives for those practitioners who provide care to the intended populations. Such properly designed incentives would further promote widespread adoption and utilization, accountability, best practice adherence, fair reimbursement, system improvement, and strengthened data.

For these reasons, AAPA recommends a modification to the EHR incentive program to designate PAs in all settings as eligible professionals under Medicaid. AAPA knows that CMS does not have the ability to make this change by regulatory means and thus any such alteration would require modification of the program through legislation. We ask that CMS work with members of both parties in Congress who have expressed an interest in this change to impress upon them the importance of such a modification to the integrity of EHRs, a historically bipartisan supported tool of health reform.

AAPA has reached out to congressional leaders to recommend the amendment of section 4201(a)(3)(b) of the Health Information Technology for Economic and Clinical Health (HITECH) Act to extend EHR Medicaid incentive payments to PAs whose patient population is at least 30 percent Medicaid recipients. We would also hope that CMS would be supportive of the appropriate full inclusion of PAs in current and future government-sponsored HIT programs.

Thank you for the opportunity to provide feedback on the proposed rule. AAPA welcomes further discussion with CMS on the issue of EHRs, meaningful use and the incentive program. For any questions you may have in regard to our comments and recommendations please do not hesitate to contact Michael Powe, AAPA Vice President of Reimbursement & Professional Advocacy, at 571-319-4345 or michael@aapa.org.

Sincerely,

A handwritten signature in black ink, appearing to read "John McGinnity". The signature is stylized and cursive, with a large initial "J" and "M".

John McGinnity, MS, PA-C, DFAAPA
AAPA President