December 15, 2015

The Honorable Sylvia M. Burwell
Office of the Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Attention: CMS-3310 &3311-FC

RE: Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 through 2017

Dear Secretary Burwell:

The American Academy of PAs (AAPA), on behalf of the more than 104,000 certified PAs (physician assistants) throughout the United States, appreciates the opportunity to provide comments on the Medicare and Medicaid Program's Electronic Health Record (EHR) Incentive Program—Stage 3 and Modifications to Meaningful Use (MU) in 2015 through 2017 final rule. We applaud CMS' solicitation of stakeholder perspective regarding the direction and ongoing implementation of the MU program. AAPA has a particularly strong interest in the CMS MU policy as PAs routinely utilize health information technology (HIT) as part of their daily patient care activities, and will soon report MU requirements under the MIPS program. It is within that context that we draw your attention to our comments regarding CMS' Meaningful Use Stage 3 Rule.

Concerns Regarding the Pace of Implementation

AAPA believes EHRs have the ability to substantially enhance care delivery, increase operational efficiencies and improve the health of patients. PAs fully support the use of health information technology (HIT) as we move toward the realization of the Triple Aim. However, a serious and overarching concern regarding the transition to MU generally, and the Stage 3 requirements in particular, include the timeline for implementation of this final stage of MU. CMS indicates that, regardless of prior participation in MU, all health professionals must participate in Stage 3 and use 2015 Certified EHR Technology (CEHRT) by 2018. It should be pointed out that many health professionals have yet to successfully achieve Stage 2 MU status.

AAPA believes CMS' Stage 3 MU implementation is rushed. Consequently, we recommend CMS immediately reach out to associations representing health professionals, such as AAPA, to engage in a more detailed discussion regarding a more appropriate implementation timeline and to resolve usability issues that currently limit the effective use of EHRs. If CMS continues to hear legitimate concerns from those who are expected to implement Stage 3 requirements, AAPA requests that CMS announce a complete or partial delay of Stage 3.

We all recognize the importance of health professionals being proficient in the use of HIT, but it is in the best interest of all stakeholders to execute its adoption and utilization properly, without setting unrealistic or unduly burdensome expectations and requirements. The issues surrounding the implementation of Stage 3 MU are even more severe for smaller and rural practices that likely already function with more limited resources.

Positive Steps Forward

One way the rule constructively advances MU is through a commitment to a simplified reporting process. Examples of this include a reduction in the number of objectives that health professionals must report on for the 2015-2017 reporting periods, the alignment of EHR reporting periods to the calendar year and the establishment of a single set of MU objectives and measures to be met from 2018 onward. AAPA believes that a simplified, easier to understand reporting methodology will reduce the administrative burden on health professionals and increase participation of health professionals who meet MU reporting standards.

A second way the rule attempts to advance MU is the increased focus on interoperability, which has been one of the primary stumbling blocks of EHR systems. AAPA has long supported interoperable EHR systems that benefit patient care coordination and facilitate the sharing of important health information. Consequently, we find interest in CMS' emphasis on this issue by making more than 60 percent of the Stage 3 metrics relate to interoperability, up from 33 percent previously, as well as its focus on Application Programming Interfaces (APIs) to connect systems and allow patients increased access to their records. However, increasing the reliance on and importance of interoperability when EHR technology is not fully capable of achieving that goal places health professionals in a very precarious position.

The rule also attempts to constructively advance MU through certain commitments to flexibility. AAPA believes that flexibility in a program such as MU is essential, as one-size-fits-all approach rarely suits all types of health professionals. The ability of each professional to meet Stage 3 MU guidelines is likely to differ based on patient mix, fiscal outlook, type and size of practice, etc. Consequently, allowing for flexibility in MU reporting benefits the program by maintaining core goals, but allowing health professionals to reach those goals in a manner amenable to them and beneficial to their patients. Some of the provisions that stand as an example of this are increased choice in measures reported, allowing 2017 to be an optional year for Stage 3 reporting, and the utilization of hardship exceptions for payment adjustments based on circumstances beyond a health professional's control.

Shifting Costs

A further concern that AAPA has with the MU final rule relates to new capabilities that will be required of CEHRT in order to meet the standards set by the rule. AAPA supports the idea of utilizing technology that is properly designed to meet the needs of patients and health professionals alike, but worries that the magnitude of the changes to vendor products and the ambitious timeline in which those changes must take place may lead to significant costs to developers that could be passed on to health professionals.

AAPA requests that CMS find opportunities to mitigate EHR implementation costs to health professionals though relaxed CEHRT requirements, an extended amount of time for implementation of necessary changes, or financial assistance to health professionals to offset any increases in charges received from vendors for product updates.

AAPA would be remiss if we did not take this opportunity to remind CMS that PAs were not fully included in the Medicaid EHR incentive program. Only PA-led rural health clinics and federally-qualified health centers were eligible for the EHR incentive payments. PAs in other practice settings, despite treating the requisite percentage of Medicaid patients, were not eligible for the incentive. The lack of access to EHR incentive dollars placed an additional economic burden on PA practice as it relates to EHR implementation.

The Impact on Rural Health Professionals

While many health professionals are concerned about new requirements, the associated financial obligations and the target dates for meeting such obligations are often magnified for those working in rural and underserved communities. PAs know firsthand about the challenges of delivering care in underserved and rural communities as over 20 percent of PAs practice in these areas .[1] Rural health professionals already face unique economic challenges of caring for patients in remote and underserved communities. To impose additional financial obligations on these practices is particularly detrimental. If the administrative and financial burdens imposed by MU requirements cause rural practices locations to close due to an inability to meet the standards as set, access would be further limited in localities that already suffer from a relative lack of healthcare professionals.[2] AAPA encourages CMS to consider lower thresholds for certain measures for health professionals in these practice settings or a protracted window for implementation. We also encourage additional financial and technical assistance be made available to these underserved practices.

Considerations in Measure Development and Appropriate Thresholds

AAPA believes that as CMS continues to update and modify the MU program, it is important for the agency to be mindful that the various participating health professionals will have different patient care responsibilities and patient mix, and consequently have varying opportunities to meet specific metrics. This must be accounted for when CMS determines which measures must be met for successful implementation of MU and appropriate thresholds for program participation.

AAPA recommends CMS review MU requirements to assure that the metrics used for evaluating eligible professionals are appropriate based on the scope of practice of participating eligible health professionals. If these metrics are to be the method by which successful attainment of MU is scored, participating health professionals must be able to perform all required activities. Otherwise, a practitioner may be unfairly punished for limitations that are beyond their control.

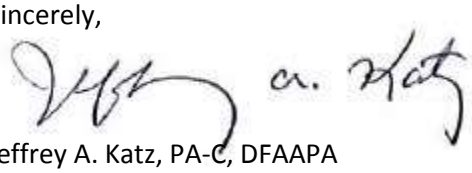
Meanwhile, due to the importance of collected data in determining low volume thresholds for program participation, there is additional concern that much information currently collected as to the volume of services delivered by PAs is incomplete. A substantial percentage of the services provided by PAs are not submitted under their name or National Provider Identification (NPI) number and consequently not attributed to the actual provider of care. A PA may treat a high volume of eligible patients, but if a substantial number of those services are billed under the physician, data may indicate that the PA provided a low volume of care, potentially leading to exclusion from the MU program. It is imperative that

[1] American Academy of Physician Assistants. 2013 AAPA Annual Survey Data Tables. Accessed November 2, 2015.
[2] http://www.ruralhealthweb.org/go/left/about-rural-health

CMS determine a solution to the problem of "hidden" healthcare services in order to gather data that is an accurate reflection of the actual care that is being provided.[3]

We appreciate the opportunity to provide feedback on the MU Stage 3 Final Rule. AAPA welcomes further discussion with CMS regarding our thoughts, suggestions and concerns. 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,



Jeffrey A. Katz, PA-C, DFAAPA
President and Chair of the Board of Directors

[3] See AAPA Comments to CMS regarding Merit-based Incentive Payment System and Alternate Payment Models https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=2147486775