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June 12, 2015

Honorable Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health & Human Services
Attention: CMS-3311-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically to http://www.regulations.gov

Re: **Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Modifications to Meaningful Use in 2015 Through 2017; Proposed Rule. 42 CFR Part 495 (April 15, 2015). CMS–3311–P/RIN 0938–AS58**

Dear Acting Administrator Slavitt:

The American Nurses Association (ANA) welcomes the opportunity to provide comments to the proposed rule on the Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Modifications to Meaningful Use in 2015 through 2017(42 CFR Part 495; [CMS-3311-P]; RIN 0938-AS58), which was published in the Federal Register on April 15, 2015.

As the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses (RNs), ANA is privileged to speak on behalf of its state and constituent member associations, organizational affiliates, and individual members. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. RNs provide screening, assessments, and coordinate patient-driven evidence-based care. RNs engage and educate patients, their families, other caregivers, and even the public in self-care for prevention, maintaining wellness, and managing various health conditions. Finally, RNs provide emotional support to patients and their family members.[1] ANA members also include the four advanced practice registered nurse (APRN) roles: nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists.[2]

ANA is committed to the goal of advancing the quality and safety of patient care in a rapidly changing and transforming health care system. Steps to achieve this include utilizing health information technology (IT) and Electronic Health Records (EHRs) to improve care

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[1] Nursing Alliance for Quality Care Whitepaper (2013), Fostering Successful Patient and Family Engagement: Nursing's Critical Role.
http://www.naqc.org/Main/Resources/Publications/March2013-FosteringSuccessfulPatientFamilyEngagement.pdf (accessed June 12, 2015).

[2] The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

coordination; standardizing the electronic capture of nursing's contributions to care (including the electronic capture of quality measures that reflect nursing's contributions to improving patient outcomes); and promoting interoperability and standardized representation of nursing in EHRs, including the attribution of nurses. We believe it is also essential that meaningful use support incentives for APRN-led practice.

ANA has worked collaboratively to develop comments on this proposed rule with support from APRN member feedback, informatics nurse specialists, and the Healthcare Information and Management Systems Society (HIMSS). ANA has evaluated these complex proposed regulations using the lens of the nation's tri-part aim (i.e., better care, healthier people/communities, and lower cost) to improve healthcare through achieving the goals related to the six priorities articulated in the National Quality Strategy (NQS) and the Measure Application Partnership (MAP) recommendations as the overarching evaluation criteria.

ANA supports the Centers for Medicare and Medicaid Services (CMS) proposed rule's vision to align Stage 1 and Stage 2 objectives and measures with long-term proposals for Stage 3 in order to "reduce reporting burden, eliminate redundant and duplicative reporting" and "ensure future sustainability of the Medicare and Medicaid EHR Incentive Program."[3]

ANA comments on this proposed rule focus on:

- 90-Day EHR Reporting Period for All Providers in 2015
- Changes to Patient Engagement Requirements for 2015 through 2017
    - Patient Electronic Access (Action to View, Download, or Transmit (VDT) Health Information)
    - Secure Electronic Messaging Using Certified EHR Technology (CEHRT)
- Clinical Quality Measurement
- Demonstration of Meaningful Use for 2015 through 2017

<u>90-Day EHR Reporting Period for All Providers in 2015</u>

ANA supports the proposal to change the 2015 Meaningful Use Program reporting requirements to any continuous 90-day period within the calendar year to allow providers time and flexibility to plan for the changes proposed in this rule.

<u>Patient Electronic Access (VDT)</u>

ANA is supportive of the CMS goals of "reducing the burden on providers to account for patient actions while still continuing to encourage IT supported patient engagement."[4] ANA does have concerns regarding the proposal to remove the 5 percent threshold for Measure 2 from the the Eligible Professional (EP), eligible hospital, and Critical Access Hospital (CAH) Stage 2 Patient Electronic Access (VDT) objective and to instead require that at least one patient seen by the

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[3] Medicare and Medicaid Programs; Electronic Health Record Incentive Program--Modifications to Meaningful Use in 2015 through 2017. 80 Fed. Reg. 20,347 (April 15, 2015).

[4] Medicare and Medicaid Programs; Electronic Health Record Incentive Program--Modifications to Meaningful Use in 2015 through 2017. 80 Fed. Reg. 20,358 (April 15, 2015).

provider during the EHR reporting period views, downloads, or transmits his or her health information to a third party reduction.

ANA stated in our previous comments, that having the provider held accountable for a patient's use of technology would be challenging in situations where the patient is either unwilling or unable to participate electronically with their provider. There may be a myriad of reasons for the patient not being able to communicate electronically with their EP (e.g. language barriers, limited or lack of access to technology). ANA respectfully asked CMS to consider flexibility in these scenarios and provide further guidance to providers with these concerns.

We do not want to mitigate the progress being made towards patient engagement. Therefore, we encourage CMS to consider an incrementally phased-in approach towards measure thresholds to balance the challenges facing providers with the need to promote patient engagement. A gradual, incremental increase towards measure thresholds from year-to-year may foster fewer burdens on providers to successfully achieve the patient electronic access objective.

Secure Electronic Messaging Using Certified EHR Technology

ANA is principally supportive of the CMS proposed changes to "allow providers to work toward meaningful patient engagement through health IT using the methods best suited to their practice and their patient population."[5] ANA have concerns with the proposal to convert the measure for Stage 2 EP Secure Electronic Messaging objective from the 5 percent threshold to a yes/no attestation to the statement: "The capability for patients to send a secure electronic message was enabled during the EHR reporting period."[6]

We again encourage CMS to consider an incrementally phased-in approach towards measure thresholds to balance the challenges facing providers with the need to promote patient engagement.

Clinical Quality Measurement

As previously stated in ANA's Electronic Health Record Stage 3 comments, ANA supports the efforts by CMS to align quality measure reporting between quality programs such as MU, IQR, and PQRS to reduce the existing reporting burden. ANA supports the concerns expressed by an ANA member who is expert in eMeasure development, reporting, and certification that often the language within a CQM does not lend itself to being built in a CEHRT. The expert expressed concerns that eCQMs are not being updated as frequently as needed to be in alignment with evidenced-based practice. As a result, the measures would require a provider to meet standards that are no longer considered best practice. CMS should ensure that CQMs are accurate and

[5] Medicare and Medicaid Programs; Electronic Health Record Incentive Program--Modifications to Meaningful Use in 2015 through 2017. 80 Fed. Reg. 20,358 (April 15, 2015).

[6] Medicare and Medicaid Programs; Electronic Health Record Incentive Program--Modifications to Meaningful Use in 2015 through 2017. 80 Fed. Reg. 20,358 (April 15, 2015).

valid, and that the review process is agile enough to incorporate best practices within a reasonable time to support a Learning Health System.[7]

Demonstration of Meaningful Use for 2015 through 2017

ANA has been concerned since the passage of the ACA about the uneven treatment of APRNs who are enrolled as Part B providers and/or Medicaid providers. Although NPs, in particular, have been found to be more likely than physicians to accept dual eligible patients, many of the Medicare provisions of the ACA omit mention of APRNs or only include one or two of the APRN roles rather than all four. It makes little sense to provide EHR incentives for some but not all of the clinicians who provide and coordinate health care.

ANA requests that if CMS adds additional place of service codes or settings, that all APRN providers be eligible for the EHR incentive payment, not only under Medicaid, but also under Medicare.

We appreciate the opportunity to share our views on this matter and welcome the opportunity to discuss these issues in greater detail. If you have questions, please contact Kelly Cochran at kelly.cochran@ana.org or 301.628.5040.

Sincerely,

Debbie D. Hatmaker, PhD, RN, FAAN
Executive Director

cc: Pamela Cipriano, PhD, RN, NEA-BC, FAAN, ANA President
Marla Weston, PhD, RN, FAAN, ANA Chief Executive Officer

[7] IOM (Institute of Medicine). 2012. Best care at lower cost: The path to continuously learning health care in America.