June 25, 2018

Seema Verma
Administrator
Centers for Medicare and Medicaid
Department of Health and Human Services
Attn: CMS-1694-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, Maryland 21244-1850

RE: CMS-1694-P - 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 2019 Rates (83 Fed. Reg. 20164, May 7, 2018).

The American Association of Nurse Practitioners (AANP), representing more than 248,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to provide comment in response to the fiscal year 2019 updates to the Hospital Inpatient Prospective Payment System (83 FR 20164).

NPs are advanced practice registered nurses who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and walks of life. Daily practice includes: assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities. NPs practice in nearly every health care setting including clinics, hospitals, Veterans Affairs and Indian Health Care facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), nursing homes, schools, colleges, retail clinics, public health departments, nurse managed clinics, homeless clinics, and home health. NPs hold prescriptive authority in all 50 states and the District of Columbia. It is important to note that 86.6% of NPs are certified in primary care, the majority of whom see Medicare and Medicaid patients. NPs complete more than one billion patient visits annually.

Removal of Hospital Inpatient Quality Reporting (IQR) Program Measures

We are concerned about the impact that removing certain "topped-out" measures will have on quality of care. Certain activities, such as safe surgery checklists, are very important to patient care and we believe it is important to continue to incentivize providers to report these measures. For measures such as the safe surgery checklist in which providers continually have high scores, we believe CMS should adopt an approach that improves upon the measure, as opposed to removing it from the reporting program entirely.

Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange Through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers

In this proposed rule, CMS included a request for information (RFI) on promoting interoperability and electronic healthcare information exchange by revising the conditions of participation (COP) for hospitals and other Medicare and Medicaid providers. We support the goals of interoperability and improving data exchange so that patients and providers have access to the patient's health information. We applaud the goals of the Trusted Exchange Framework which will help bridge gaps in care and improve our ability to leverage the data contained in heath records to improve patient care. In order for these initiatives to reach their potential, it is important that CMS take steps to ensure that all clinicians, including NPs, are involved in the development and implementation of the programs, and are able to participate and share health information.

Nurse Practitioner Inclusion: CMS has made many practical suggestions to improve the use of certified-electronic health record technology (CEHRT) for clinicians. However, there are barriers within many CEHRT systems that are still geared to the concept that only a physician documents the patient's condition and the services performed, particularly in hospital systems. We suggest that CMS require software products to be "nurse practitioner inclusive" to be certified by CMS. This will help improve the documentation and transmission of medical records by removing prompts within the CEHRT that unnecessarily request a physician signature.

CMS has made improvements in including NPs in their CEHRT initiatives, and it is vital that this trend continues. We encourage CMS to continue to incentivize providers, including NPs, to adopt CEHRT to continue to spur progress on CEHRT adoption and interoperability. CMS NPs should be included in the development and implementation of CEHRT initiatives and one step toward accomplishing this goal is including NPs on health technology advisory committees.

Clinician Burden: A number of the questions in this RFI focus on the issue of clinician burden, which is an important consideration as we increase the prevalence and usage of CEHRT. CMS recognized in the development of the Quality Payment Program (QPP) that NPs and other clinicians were excluded from participating in the Medicare EHR Incentive Program and may have less familiarity with the requirements of CMS EHR initiatives. While utilization of CEHRT has certainly increased among NPs, we still believe that CMS should provide technical assistance to providers and ensure that there is high-quality, free and low-cost CEHRT for all clinicians, particularly those in small practices, who may not have the financial ability to invest significant money on CEHRT.

Non-Electronic Medical Information Sharing: CMS asked if under revised COPs, non-electronic forms of communication should be allowed to be shared if the receiving provider cannot receive the information electronically. We believe that this should be allowed, particularly considering difficulties that continue to exist with CEHRT interoperability. Obtaining up to date patient health information is imperative for a clinician to provide appropriate treatment, and we do not want to create a scenario where that is jeopardized solely due to technical issues.

Program Alignment: CMS asked if hardship exceptions, such as those allowed under the QPP, should also be allowed under revised COPs. We believe that any new regulations should be aligned across programs. If COPs are inconsistent with participation requirements in the QPP and other CMS programs, that will result in confusion, administrative burdens, and significant compliance difficulties. In a similar vein, we are concerned that new COP requirements related to CEHRT will be burdensome on clinicians who are not eligible to participate in the QPP. We continue to encourage CMS to lower the low-volume

threshold and create an opt-in option for the QPP, so that clinicians who invest in CEHRT and meet CMS requirements have an opportunity to participate and receive payment bonuses for their efforts.

We thank you for the opportunity to comment on this proposed regulation and request for information. We look forward to discussing these issues with you. Should you have comments or questions, please direct them to MaryAnne Sapio, V.P. Federal Government Affairs, msapio@aanp.org, 703-740-2529.

Sincerely,

David Hebert
Chief Executive Officer