June 15, 2015

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

RE: RIN 0938-AS58 – Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Modifications to Meaningful Use in 2015 Through 2-17

Dear Administrator Slavitt:

The American Academy of Pediatrics (AAP), a non-profit professional organization of more than 64,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of all infants, children, adolescents, and young adults, appreciates the opportunity to comment on the proposed rule for Electronic Health Record Incentive Program, Modifications to Meaningful Use in 2015 Through 2017.

The AAP is committed to the meaningful adoption of health information technology (HIT) for improving the quality of care for children and commends the comprehensive approach being taken by the Centers for Medicare and Medicaid Services (CMS) to streamline and improve the Meaningful Use reporting requirements for Medicare and Medicaid EHR incentive programs. There is tremendous potential for HIT to facilitate patient safety and quality improvement, specifically quality measurement and reporting through efficient data collection, analysis and information exchange.

The AAP has been involved in programmatic activities aimed to improve pediatric functionality in EHRs over the course of the last decade. We are one of the founding organizations of the Continuity of Care Record (CCR) effort that was the original way that interoperability was achieved. The Academy has published pediatric specific requirements for ePrescribing as well as inpatient and outpatient HIT systems. The AAP also worked with Agency for Healthcare Research and Quality (AHRQ) and CMS as a subcontractor to develop the Model Pediatric EHR Format. We continue to be involved in subsequent ongoing work to identify and enhance critical pediatric EHR functionality outlined within the original format. Finally, the AAP is also working closely with the Centers for Disease Control and Prevention (CDC) on how to best incorporate immunizations and developmental screening into EHRs.
Pediatricians have been early and ambitious adopters of health information technology. As the AAP has stressed in all of our prior comments and communications with CMS, children have different needs than adults, and therefore, pediatricians also have specific needs when it comes to health information technology, especially in terms of data collection, reporting, and functionality. The AAP would like to provide the following suggestions on the Notice for Proposed Rule Making for Modifications to Meaningful Use in 2015 through 2017.

II.B.b.(3): EHR Reporting Periods in 2015 Through 2017

The AAP strongly advocates for a 90 day reporting period for all reporting years. Although we appreciate CMS’ intent to create a less burdensome reporting structure, it is important to remember that meeting requirements throughout an entire 365 day reporting period without any tolerance for downtime, system upgrades, personnel interruptions, and other workflow challenges sets a bar that simply will discourage providers from participating in the Meaningful Use program. We believe that a 90 day, or at least a reporting period much shorter than 365 days, provides the flexibility for providers to be able to manage these types of challenges. For example, a 90 day reporting period will allow time for providers to improve their performance after a vendor upgrade, which typically causes declines in performance, without having to meet higher levels of requirements for the remainder of the year in order for the average to meet the Meaningful Use requirement. This concept is much more in line with the “Learning Healthcare System” that enhances the development and application of evidence in health care decision making that we are trying to create.

However, if CMS is intent on a 365 day reporting period, the AAP supports CMS’ proposal that this period be aligned with the calendar year. We would also advocate for more leniency for practices who are currently upgrading or switching their EHR technology. A 90 day reporting period provides needed flexibility during these times.

II.B.c.(1): Considerations in Defining Meaningful Use

The AAP agrees with the measures that CMS has identified as redundant, duplicative, or topped out. Many of these measures have become burdensome on pediatricians. With respect to the Family Health History measure (42 CFR § 495.6(m)(6)(i) and (ii)), AAP does not feel that CMS should define the parameters of what this type of measure should entail at this time.

AAP/ONC Collaboration on Meaningful Use for Pediatrics

Although vendors, insurers, and the federal government each have important roles to play in setting standards for the Meaningful Use of health information technology for children, the American Academy of Pediatrics is best suited to coordinate and fulfill this role. According to a recent study published in Pediatrics, pediatricians’ adoption of electronic health records lags behind other groups of physicians, despite initially being early and ambitious adopters. In addition, data from the Office of the National Coordinator of Health IT (ONC) revealed that pediatricians’ participation rates in the Medicaid EHR Incentive Program are also quite low, with only 17.2% of eligible pediatricians participating nationally. Concerns about cost and loss of productivity and lack of pediatric specificity and design are preventing pediatricians from

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adoption of currently available EHRs. The AAP and ONC should continue their collaborative efforts to improve EHR usability for pediatricians.

Additional barriers to use exist; for example, a recent editorial in *Pediatrics*\(^2\) pointed out how Meaningful Use participation is much more challenging for pediatricians than for other specialists. Unlike most other specialists, pediatricians are eligible for Meaningful Use through the Medicaid program. Barriers to Meaningful Use include low Medicaid panels due to low and unreliable Medicaid payments, exclusion of CHIP patients in the Medicaid threshold requirement in several states (those with separate CHIP programs), varying reporting requirements by state and territory burdening pediatric vendors, delayed opening of incentive programs in some states, and a brief but arbitrary non-payment of Meaningful Use monies by Florida. For more than a year, the AAP has been warning that pediatricians will fall behind in the adoption of Meaningful Use unless some changes are made to the program.

At the April 7, 2015 HIT Policy Committee meeting new federal data showed that the AAP warning is becoming reality. Dawn Heisey-Grove, Public Health Analyst at the Office of the National Coordinator for Health IT, presented the most recent registration and attestation data. Registration to Meaningful Use indicates the intent to participate. After receiving the Adopt-Implement-Upgrade (AIU) payments, which are paid once a provider implements a fully certified Electronic Health Record (EHR), the next step to more Meaningful Use incentive payments requires attestation of Meaningful Use.

With 176,000 registrants, more providers have registered for Medicaid than anticipated; however Medicaid eligible providers (pediatricians) have a lower Meaningful Use attestation rate than providers eligible under Medicare (Figure 1 below). Less than half of Medicaid eligible providers (EPs) attest to Meaningful Use in the year following AIU payment. More than half (56%) of all Medicare-registered providers were scheduled for stage 2 in 2014 compared to eight percent of all Medicaid-registered EPs. While providers eligible under Medicaid have more time to implement (Table 1 below), this delay is more than can be explained by the schedule differences. Of all providers scheduled to attest to Stage 2 of Meaningful use, 93% are eligible under Medicare.

This data shows pediatricians are falling behind in the attestation of Meaningful Use and in the advancement of higher levels of adoption. If this trend is not reversed pediatricians will forfeit billions in dollars intended to incentivize the use of certified EHRs in pediatric offices. These funds could be used to improve EHRs to serve pediatricians and children better by providing pediatric functionalities currently found in only 8% of office based EHRs.

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Children are not just little adults, and their providers are responsible for ensuring that they are receiving appropriate care; care that is at times quite different from the adult standards set by Medicare. The AAP is experienced in pediatric functionality of EHRs and stands to improve the overall processes and level of care for pediatric health information technology. The AAP can work with ONC and CMS to better tailor the Meaningful Use program to pediatrics, thereby improving the lives of children everywhere. As such, the AAP strongly recommends a robust and formal collaboration between AAP and ONC to significantly improve the levels of participation and attestation by pediatricians in the Medicaid EHR Incentive Program.

II.B.2.a: Protect Electronic Health Information
This measure requires that a practice conducts or completes a risk analysis annually. The AAP believes that this is onerous on small practices because the elements of what constitutes a risk analysis are not necessarily clear. For example: an auditor may conduct a risk assessment on a provider’s system, but may not complete all of the elements necessary to meet the requirement. The AAP suggests that this measure be required once every three years, or in conjunction with an upgrade. Additionally, the AAP suggests that risk assessments and HIPAA security risk assessments be combined into one assessment. This will relieve some of the burden on providers.

II.B.2.b: Clinical Decision Support
Currently, there are five Clinical Decision Support (CDS) interventions that correspond to four or more Clinical Quality Measures. The AAP suggests that CMS de-couple CDS from CQMs, so that there are simply five stand-alone CDS interventions. This provides freedom for practices to...
choose CDS tools that help their practice, and to implement CQMs in a way that is more meaningful to them.

II.B.2.c: Computer Provider Order Entry (CPOE)
The AAP would like to emphasize that CPOE measures for outpatient systems are not valuable because they are not connected to entities like labs, radiology, etc. that they normally would be in hospitals. The AAP therefore believes that this measure is topped out for Eligible Providers (EPs) and should therefore be retired for this group.

II.B.2.d: Electronic Prescribing
Making Transmission of weight and height mandatory with ePrescribing
The health and well-being of the children in our country depend on safe and reliable health care processes, including safe e-prescribing. Although the National Council for Prescription Drug Programs (NCPDP) supports the transmission of patients’ weight, body surface areas, and instructions to pharmacies, these important data do not get routinely transmitted. Further, there has been a lack of necessary pressure on vendors of EHRs and on retail pharmacies to send and receive these critical data. Explanations provided include unpreparedness of retail pharmacies to send and receive these data.

Despite the clearly described and endorsed best practice of including weights in pediatric prescriptions (where most medical decisions are weight-based for safety and efficacy) and the availability of a standard, current practice does not include routine transmission of the patient’s weight to pharmacies because EHR vendors are not willing to provide the information. Physicians utilizing certified EHRs have been forced to adopt workarounds for e-prescribing. For example, in order to share a patient’s weight with a pharmacy, a physician may have to manually transcribe a weight into a “special comments” section. Others have resorted to developing their own functionalities to auto-populate this section with weight. These workarounds bypass safety measures in the EMR such as weight-based dose checking. However, many pediatricians are unable to safely include weight in the prescription and thus have not adopted e-prescribing at all.

By not transmitting weight and body surface area, EHR vendors are not meeting the basic prescribing needs of pediatricians and their patients. As a result, our patients are denied the promise of improved safety and efficiency that e-prescribing offers.

Supporting safe prescribing for pediatric patients requires collaboration from EHR vendors, pharmacies, and health information networks. We urge ONC to use certification to make the sending of weight and body surface area (when available in the EHR) a mandatory requirement with every electronic prescription independent of age since patients with renal or hepatic failure or very low weight adults can benefit from this requirement.

II.B.2.e: Summary of Care
In regard to the transmission of the summary of care, the AAP believes that the measure, as written by CMS, places too much reliance on EHR technology in that it requires the EHR to both generate and send the summary. We believe that the physician should be able to use the EHR technology to generate the summary of care, but then transmit that summary using whatever
method works for each specific practice whether that is to a Health Information Exchange (HIE) or other entity. The AAP also believes that simply sending the summary of care document should count toward this measure. Providers cannot control whether the person they sent the document to opens it or looks at it, and therefore providers should not be held accountable for this.

II.B.2.f: Patient Specific Education
This measure states that the problem list, medication list, or laboratory test results must be used by the CEHRT to identity patient-specific education resources. The AAP believes that this excludes the fact that many pediatricians use other parts of the CEHRT, specifically documentation, to identify the need for educational materials. For example, a physician may learn that a patient is exposed to secondhand smoke. This issue generally would not appear on the problem list. If the pediatrician documents in their note that secondhand smoke is a problem that should be accepted as a trigger for educational resources.

It is impossible for all of the issues that doctors, and in particular, pediatricians, address with their patients to be listed in a problem list. Another prominent example is gun safety. Gun safety would likely never appear in a problem list, but pediatricians regularly provide information to parents on gun safety in the home. They should receive credit for this if the CEHRT uses their documentation to identify that education is needed.

II.B.2.h: Patient Electronic Access (VDT)
As CMS is aware, on their summary of care documents Eligible Hospitals are required to include every test and lab result that has been performed. For hospitals it is indeed onerous because the sheer number of tests performed during any one stay can be voluminous and irrelevant. For example, a baby in the Neonatal Intensive Care Unit (NICU) may be getting blood gas tests every 15 minutes during their stay. Over the course of their stay in the NICU, that baby may have well over 1,000 tests, the documentation of which is not useful to future providers. Receiving this volume of information is overwhelming and irrelevant for future care. It only leads to what is already referred to as HIE “Chart Bloat” and makes it more difficult for providers to find relevant, pertinent information. Therefore, the AAP suggests that CMS pare down the required amount of information on summary of care documents to include only information that is relevant to future care.

In this same vein, the AAP believes that “vital signs” should be changed to read “recent vital sign” with a definition of recent or “last vital signs.” As mentioned before, future providers do not need to receive the entire history of vital signs for one patient.

EP Measure 2:
The AAP believes that the 50% threshold for this measure is too high. We suggest that the measure simply be that one patient must view, download, or transmit their data. Though we agree that this technology is useful, and believe that providers should have to demonstrate ability to perform these tasks, we believe that any future efforts to define particular percentages of patients that have to perform these actions interferes with the relationship of the patient and pediatrician. Not all patients are ready to be fully electronic, and it should be left to the patient provider relationship to determine how best to do this.
II.B.2.j: Public Health and Clinical Data Registry (CDR) Reporting
The AAP believes that any reporting to Accountable Care Organizations (ACOs), etc. should count toward this requirement. Sharing data with a research registry, such as the electronic Pediatric Research in Office Settings (ePROS) database, the larger Comparative Effectiveness Research through Collaborative Electronic Reporting (CER) database (both overseen by the Pediatrics Research in Office Settings group at the AAP) or with other research registries, should also count toward this threshold. Participation in such registries is one way to use EHR data to meaningfully improve care and should be encouraged.

Active Engagement Option 3 – Production
The AAP believes that physicians should be able to get credit for this measure if they connect to an HIE, and the HIE then connects to immunization registries, public health databases, etc. We believe that physicians whose HIEs do this should be offered full credit for each measure that is supported by HIE reporting. The measure as written encourages point-to-point connections and does not support HIEs, which could be a key part to the future of our health care information systems.

Measure 1: Immunization Registry Reporting
CMS should support the desire for bidirectional exchange with immunization registries.

Exclusions
The AAP suggests that physicians should be eligible for an exclusion if they have submitted the required information, but the registry failed to respond.

II.D.5 Hospital-Based Eligible Professionals
The AAP supports the inclusion of Place of Service (POS) 22, which covers an outpatient hospital place of service, to help define hospital-based eligible providers.

AAP appreciates the opportunity to provide comments on CMS’ proposed rule for the Electronic Health Record Incentive Program, Modifications to Meaningful Use in 2015 through 2017. The Academy is committed to the meaningful adoption of HIT for improving the quality of care for children and looks forward to continuing to work with CMS to ensure that Meaningful Use is implemented in a way that promotes the goals of improving the quality, safety and cost-effectiveness of care. If we may provide further information or assistance, please contact Patrick Johnson in our Washington, DC office at (202) 347-8600 or pjohnson@aap.org.

Sincerely,

Sandra G. Hassink, MD, FAAP
President

SGH/arp