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Senate Committee Passes Bill to Improve Health IT

On February 8, the Senate Health, Education, Labor and Pensions Committee (HELP) passed the *Improving Health Information Technology Act* (S. 2511). The legislation was a result of months-long bipartisan collaboration between HELP Committee Members and staff. The AAP did not endorse the legislation in its entirety, but is pleased to see that it contains a system for transparent rating on usability and security of health IT, that are designed to help providers choose better health IT products. It also gives the US Department of Health and Human Services Office of the Inspector General the authority to investigate and establish deterrents to information blocking practices that interfere with appropriate sharing of electronic health information and requires a GAO study on patient matching. In addition, the bill included one provision specific to pediatrics, regarding certified health information technology. The provision’s text states that:

“Not later than 18 months after the date of enactment of this subparagraph, the HIT Advisory Committee, in consultation with relevant stakeholders, shall make recommendations for the voluntary certification of health information technology for use by pediatric health providers to support the health care of children. Not later than 24 months after the date of enactment of this subparagraph, the Secretary shall adopt certification criteria (under section 3004) to support the voluntary certification of health information technology for use by pediatric health providers to support the health care of children.”

The bill has not yet been taken up by the full Senate, and it does not have a companion bill in the House.

AAP Comments on CMS Request for Information on Certification Frequency and Requirements for the Reporting of Quality Measures

On February 9, AAP submitted comments in response to the Center for Medicare and Medicaid Services Request for Information on Certification Frequency and Requirements for the Reporting of Quality Measures Under CMS Programs. As AAP has stressed in all of our prior comments and communications with CMS, these comments emphasized that 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.

In the comments, the Academy pointed out that any discussion about the frequency of certification for electronic health records must include the fact that the vast majority of office based pediatricians are not using EHRs with pediatric functionalities. A survey conducted in 2012 found that only 8% of pediatricians were using fully functional EHRs in 2012 that
included pediatric functionalities.\(^1\) As a result, pediatricians’ adoption of electronic health records lags behind other groups of physicians, despite initially being early and ambitious adopters. The letter also pointed out that, in general, pediatric functionality is more likely to be found in products associated with smaller vendors, who have made pediatrics their primary focus and who support pediatric providers and their patients with tailored EHR products. As such, the Academy shared its concern that adding a recertification requirement—which would require CEHRT products to be recertified when a new version of the CEHRT is available—would be of great concern for pediatricians.

Further pressures on the market place that would result in additional consolidation would, in the opinion of the Academy, lead to increased pressure on vendors supporting specialty specific EHRs. Rather than issue new recertification requirements, the AAP would instead suggest usability testing that includes specialty specific needs significantly more important and critical to better patient care than a recertification process.

In terms of CMS’ proposal to increase the number of Clinical Quality Measurement (CQM) certifications required, the Academy noted that it is wary that the proposed CQM requirements will result in meaningless certification of CQMs not used by pediatric providers but added to the EHR to comply with an arbitrary measure. Again, this burden will be disproportionately harder for the vendors specializing in pediatrics. In addition, while AAP supports the notion of pediatric specific core set certification, the AAP is also concerned about the bandwidth levels and limited resources of pediatric specific vendors and would be in favor of starting with a limited set of CQMs.

Finally, in regards to CQM testing and certification, the comments stated that the AAP again is concerned that this requirement will unduly burden EHR vendors focused on the specialty market. Further, as discussed previously, measuring something precise is welcome as long as the object of the measure is meaningful; as such, the AAP is of the opinion that the pediatric CQMs can and should be improved.

Instead, the AAP would favor the development of automatic data loading tools that would allow a vendor to automatically load a predefined data set from CMS. These data would then be used for validation since the desired output for the CQM would be known in advance. Such a process would minimize the work load to vendors and would allow testing in vitro (at the vendor’s offices), minimizing the impact on providers.

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AAP Comments on the Final Rule for Meaningful Use Stage 3 and Modifications to Meaningful Use Stage 2

In November 2015, the Department of Health and Human Services (HHS) and the Office of the National Coordinator for Health Information Technology (ONC) released the final rule for Meaningful Use Stage 3 and modifications to Meaningful Use Stage 2 through 2017. While these are final rules, HHS and ONC included a comment period for interested stakeholders to provide feedback on the new requirements.

The Academy commented on both rules respectively in May and June of this year, strongly advocating for a 90-day reporting period for all reporting years and emphasizing the need for a more formal collaboration between AAP and HHS/ONC to significantly improve the levels of participation and attestation by pediatricians in the Medicaid EHR Incentive Program. In addition, AAP’s comments also highlighted the need for adequate privacy protections for the adolescent population, the need for ONC to use certification to make the sending of weight and body-surface area a requirement for EHR vendors, and support for bidirectional exchange with immunization registries, among numerous recommendations.

The final rule for Meaningful Use Stage 3 and Stage 2 modifications did include the 90-day reporting period recommendation, but many other comments from AAP were not included in the final rules. This new comment period for the final rules provided another opportunity for AAP to again reiterate our need for a more formal collaboration between AAP and HHS/ONC to significantly improve the levels of participation and attestation by pediatricians in the Medicaid EHR Incentive Program. In addition, the new comments also allowed AAP to remind HHS/ONC about the importance of capturing weight and body-surface data for the pediatric population and the need for adequate privacy protections for the adolescent population.

AAP Submits Comments on Implementation of the Merit-Based Incentive Payment System (MIPS), Alternative Payment Models and Incentive Payments

On November 17, 2015, AAP submitted comments to the Centers for Medicare and Medicaid Services (CMS) regarding a Request for Information (RFI) on the implementation of the Merit-Based Incentive Payment System (MIPS), promotion of Alternative Payment Models (APM), and incentive payments for participation in eligible Alternative Payment Models. The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, which repealed the sustainable growth rate (SGR) formula for updating the Medicare physician fee schedule (PFS), established a new payment methodology which ties annual PFS payment adjustments to value through MIPS for MIPS eligible professionals. MACRA also created a separate incentive program to encourage participation by eligible professionals in APMs. CMS released a RFI for comments regarding certain aspects of MIPS and more broadly on APMs in general.

MIPS combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-based Payment Modifier), and the Medicare Electronic Health Record (EHR)
incentive program into one single program based on quality, resource use, clinical practice improvement, and meaningful use of certified EHR technology. By 2022, physicians can receive up to a 9% Medicare “bonus,” but also may have their payments cut 9% depending on MIPS factors. APMs like patient-centered medical home qualify a practice for a 5% increase with no risk of penalty.

Much of the RFI has no obvious relation to pediatrics. Nevertheless, pediatricians have repeatedly experienced that changes in Medicare are often adopted and applied to Medicaid programs and in private payer arrangements. Thus, even though few children are enrolled in Medicare, the program has the potential to affect the entire US child population.

In our comments, the Academy noted that the most immediate way to improve the care for children through MIPS will be through adoption of child-friendly quality measures when those measures could be applied to non-adult populations as a result of MIPs. Congress recognized that children are not little adults when the Children’s Health Insurance Program Reauthorization Act (CHIPRA) was passed, including close to one-quarter billion dollars investing in pediatric quality improvement systems. The Academy has endorsed the CHIPRA core set of pediatric quality measures and urges CMS to use that set when developing systems under MIPS that could impact children.

In addition, when discussing electronic health records, the Academy noted that, as CMS is aware, eCQMs are challenging to design and implement. The AAP believes that instead of simply releasing them, it would be beneficial to test them before their initial release. The old approach of designing measures and releasing them without any testing their implementation should be abandoned, as it has placed an enormous burden on providers.

The AAP recommended that CMS transition from the eminence-based development of measures to a more scientific approach that uses evidence to develop measures that have been proven to be beneficial in the care of patients. Developing eMeasures around proven evidence, such as clinical alerts to reduce antimicrobial use, is desirable from a child health care view.

The AAP also noted that there should be a common set of standards which certified EHRs are required to support. Additionally, the Quality Reporting Document Architecture (QRDA) standard has the potential to lead to consistency and reliability if CMS devotes resources to improve that standard.

Finally, the Academy pointed out that the Meaningful Use program, while well-intentioned, has reduced innovation and the responsiveness of vendors to customer requests. Current EHR systems are not pediatric friendly, and they miss pediatric functionalities such as weight-based dosing and immunization forecasting. Currently, only 8% of pediatricians are using an EHR with full pediatric functionality. Many pediatricians have been left behind in the Meaningful Use program. Therefore, the Academy noted that, should MIPS be applied to Medicaid at some point, many pediatricians could fail to satisfy this requirement because many of the Meaningful Use requirements cannot be met by pediatricians.
AAP Comments on the 2016 Interoperability Standards Advisory

On November 6, 2015, the AAP submitted comments in response to the Office of the National Coordinator for Health Information Technology’s (ONC) earlier release of its 2016 Interoperability Standards Advisory (ISA). While AAP applauded the ONC’s effort in producing these interoperability standards, the comments also pointed out some gaps in the standards that needed to be addressed. The Academy noted that appropriate interoperability standards can make care for children more effective, safer, and less costly, and, as a result, drew the ONC’s attention to the following elements of the ISA:

- **Transfer of birth and newborn data to the medical home:** It is important that interoperability standards include the ability to transfer birth data from a mother’s medical record and a newborn nursery record, including newborn screening, to the medical home. The AAP noted that this functionality should be mandatory, and should be addressed in the ISA.

- **Inclusion of preventive health schedules:** In response to ONC’s intent to include surveys and data entry templates in future work, the Academy suggested that this should be generalized to include preventive health schedules, including AAP’s Bright Futures, as well as individual state Early and Periodic Screening, Diagnostic, and Testing (EPSDT).

- **Privacy and confidentiality of patients:** The AAP noted its concern about the privacy and confidentiality needs of adolescents, children in foster care, and children with special needs. These privacy needs should always be an important part of considerations for security of interoperability and these children should never be excluded from benefiting from health information exchange because of lack of security and privacy protection they require.

- **Lack of harmonization between internal and external data:** The Academy noted that the adoption and benefit from interoperability may be limited by the lack of harmonization between the external representation of information in standard messages and documents, and the internal representation of the same information within the EHR. This makes it difficult or impossible to incorporate and use data sent using standards without manual transcription and re-keying of data. The AAP recommended using the HL7 FHIR approach to standard data objects and resources as a strategy for overcoming this problem.

- **Lack of incorporation of data into EHRs:** The Academy suggested that assessments of adoption of interoperability standards should include a separate assessment of whether the standards are sent and received, and whether the data transmitted has been discretely imported into an EHR and used for computations. Too much of the interoperability we see in use today does not really advance electronic data transmission beyond what was achieved in the past using paper and fax machines with data scanned into an EHR as a document. The comments noted it is not enough to simply send an Emergency Department visit note, or transmit a previous growth chart. Rather, pediatricians must be able to see
new medications on a medication list, or see old height and weight measurements plotted on the same growth chart as new measurements.

The comments also responded to some general quests that ONC asked regarding each standard and implementation specification, vocabulary and code set, content and structure of data capturing, and sources of security standards.

**Budget and Appropriations**

**Fiscal Year 2016 Appropriations**

**Congressional Action on FY 2016 Appropriations and Budget**

In late October of 2015, congressional leadership and the White House agreed to the Bipartisan Budget Agreement of 2015 (H.R. 1314). The agreement was a product of weeks-long negotiations among President Barack Obama, Senate Majority Leader Mitch McConnell (R-Ky.), House Speaker John Boehner (R-Ohio), and other democratic leaders. The two-year agreement provided $33 billion in non-defense discretionary (NDD) sequestration relief for Fiscal Year (FY) 2016, and $23 billion in FY 2017. In addition to lifting the budget caps, the deal also maintained the parity principle between defense and non-defense discretionary spending, meaning that both spending categories received the same amount of increases. The deal also extended the debt ceiling until March 5, 2017.

On December 18, the President signed a $1.1 trillion omnibus spending bill to fund the federal government until September 30, 2016. The bill passed overwhelmingly, and was combined with a $680 billion package of tax cuts. The omnibus contained numerous increases for child health programs, preserved funding for others, and was largely free of harmful policy riders that would have negatively impacted child health. Some of the highlights of the bill include:

- Increases in funding for important children's health programs made possible by lifting across-the-board budget caps set in 2011
- A significant increase in research funding at the National Institutes of Health, as well as funding for child poverty research at the Administration for Children and Families
- Rejection of a proposal to eliminate the Agency for Healthcare Research and Quality
- Increases in funding for early childhood education and care, graduate medical education at children's hospitals, combatting antimicrobial resistance, reducing birth defects and developmental disabilities, and emergency preparedness, disease prevention and research at the Centers for Disease Control and Prevention
- Increased funding at the U.S. Agency for International Development in the areas of immunizations, nutrition and maternal and child health
- Preserved funding for WIC, the National Children’s Study, the Emergency Medical Services for Children program, and HIV/AIDS funding for children, youth, and families
- Prevention of harmful policy riders that would have jeopardized children’s health by:
  - rolling back school nutrition standards and politicizing dietary guidelines development,
  - defunding Planned Parenthood,
exempting e-cigarettes from federal regulation, and
preventing implementation of the Environmental Protection Agency’s Clean Power Plan to address climate change and newly strengthened ozone standards

Fiscal Year 2017 Appropriations

Though the Bipartisan Budget Agreement of 2015 set top-line budget numbers for FY 2016 and FY 2017, some Republicans are interested in drafting and passing a budget for FY 2017. Budgets are symbolic in nature and do not carry the weight of law. It remains to be seen if the Republican caucus will be able to come to an agreement on a budget.

On February 9, the President released his budget. This budget, which is not legally binding and will not be voted on by Congress, represents the president’s priorities for funding throughout his final year in office. The $4.23 trillion proposal includes increased funding for the National Cancer Institute to help spur the “moonshot” initiative to cure cancer, announced during last month’s State of the Union speech, as well as funding to combat opioid abuse and the Zika virus. It also included proposals aimed at reducing the price of prescription drugs in Medicaid and Medicare. A more comprehensive breakdown of the president's budget is available here, but key areas relevant to children's health supported by the AAP include:

- New emergency funding to help combat the spread of the Zika virus, as well as spur the rapid development of new vaccines and diagnostic tests;
- Increased funding for global health initiatives like the Maternal and Child Health program and the GAVI Vaccine Alliance at the U.S. Agency for International Development, and the Polio Eradication program at the Centers for Disease Control and Prevention (CDC);
- Continued funding for the Children's Health Insurance Program through 2019;
- Improved funding for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) breastfeeding peer counseling program;
- Expansion of the Summer Electronic Benefit Transfer Demonstrations that provide monthly food assistance to low-income children in the summer;
- Increased funding for the Title X Family Planning Program, a crucial funding source for reproductive health care services for adolescents;
- Additional funding to meet the rising administrative costs of the National Vaccine Injury Compensation Program;
- Increased funding for Head Start and Early Head Start, including more opportunities to offer full school-day, full school-year services for low-income infants, toddlers and preschool age children and their families;
- Renewed efforts to include funding for gun violence prevention research at the CDC;
- Increased funding to expand the ability to detect, respond to, and prevent antibiotic resistant infections;
- Shifting from discretionary to mandatory funding for the Children’s Hospital Graduate Medical Education (CHGME) Program, an important recognition that CHGME deserves a consistent source of funding.

In addition to the initiatives listed above, other important programs like Emergency Medical Services for Children, the National Center for Birth Defects and Developmental Disabilities, the
Pediatric Device Consortia Program, the *Eunice K. Shriver* National Institute of Child Health and Human Development and the National Children’s Study follow-up efforts were all proposed to receive the same amount of funding as the previous fiscal year.

While these proposals represent the president’s priorities for the next fiscal year, it is unlikely that the budget will be accepted in its entirety by Congress; there has already been public resistance by the chairmen of the budget and appropriations committees in both the House and the Senate. Looking ahead, AAP will work with Congress to advocate for many of the programs listed above, as well as others, that are important to the health and safety of America’s children.

The Department of Federal Affairs is now focusing on the FY 2017 appropriations process. DOFA staff are urging Congress to put children first in federal spending by meeting with appropriators and submitting programmatic funding requests.
Grassroots Advocacy: AAP Key Contact Program

Key Contacts are AAP members who are interested in receiving advocacy opportunities and timely policy updates from the AAP Department of Federal Affairs on federal legislation and other issues important to the Academy.

Through regular e-mail communication with specific requests for action, the Department of Federal Affairs keeps Key Contacts informed of the latest legislative developments affecting children and pediatricians.

**How to become a Key Contact:**
E-mail kids1st@aap.org with your name, AAP ID if known, and your preferred e-mail address. If you have questions about federal advocacy, contact AAP Department of Federal Affairs at 800-347-8600.

FederalAdvocacy.aap.org: Dept. of Federal Affairs Online Resource Center

The Academy’s newly-designed federal advocacy website, [federaladvocacy.aap.org](http://federaladvocacy.aap.org), gives AAP members access to numerous resources and educational tools on federal policy priorities affecting children and pediatricians, including featured issue snapshots, legislation summaries and media advocacy tips. By visiting the website’s Advocacy Action Center, AAP members are able to directly contact their federal legislators on timely child health topics, with access to email templates and talking points to help guide outreach.

About the Department of Federal Affairs

The American Academy of Pediatrics Washington, DC office—the Department of Federal Affairs—is the Academy’s voice on federal issues impacting children and the pediatricians who care for them. For four decades, the Department has cemented the Academy’s credibility and visibility on national child health issues through lobbying Congress, building coalitions and raising public awareness. Utilizing the Department’s resources and expertise, pediatricians within the Academy are given the information and tools necessary become effective advocates, encouraging members of the U.S. Congress, the Administration and/or federal agencies to prioritize children’s health issues on the national policy agenda.
There are many issues on Academy's current federal legislative agenda, including, but not limited to: health reform implementation, childhood obesity prevention, immunizations, disaster preparedness, tobacco control, adolescent health and child nutrition. The Department also actively advocates for the needs of pediatricians, tracking and impacting federal legislation and regulations dealing with physician payment and education, ethics, biomedical research and environmental health. For more information, please visit http://federaladvocacy.aap.org.