COMMENTS
Notice of Proposed Rulemaking
Medicare and Medicaid Incentives: Electronic Health Record Incentive Program—Stage 2
Submitted on behalf of the American Academy of Pediatrics

**Meaningful Use Criteria – Stage 2 Key Comments**

Approximately 46% of pediatricians\(^1\) are have a Medicaid panel below the 20% threshold (even though they may provide uncompensated or CHIP care) and thus are not eligible for Meaningful Use. These practices will face significant financial hardship to adopt and implement an EHR. It was noted that there is no patient panel threshold in the Medicare program; any provider who accepts Medicare can qualify without minimum Medicare panel requirements. Since pediatricians generally do not accept Medicare, a significant proportion of pediatricians will be excluded from eligibility for the incentive program.

- The Academy whole-heartedly supports:
  - allowing States the option for their providers to calculate total Medicaid or total needy individual patient encounters in any representative, continuous 90-day period in the 12 months preceding the EPs attestation
  - allowing for the calculation of the total Medicaid patients assigned to the EPs panel in any representative, continuous 90-day period in either the preceding calendar year, as is currently permitted, or in the 12 months preceding the EPs attestation when at least 1 Medicaid encounter took place with the Medicaid patient in the 24 months prior to the beginning of the 90-day period.
  - expanding the current definition of "encounter" to also include any service rendered on any one day to an individual "enrolled" in a Medicaid program.
  - allowing some children who are enrolled in the Children’s Health Insurance Program (CHIP) to qualify for the eligibility threshold. Specifically, the proposed Stage 2 regulation will allow children who are enrolled in CHIP programs in States that have Medicaid expansion programs (7 States) or in States that have a combined Medicaid and CHIP program (26 states) to now count towards the patient volume threshold. AAP appreciates this expanded eligibility threshold and encourages CMS to allow all CHIP enrollees, regardless of the State and program, to qualify for the eligibility threshold.

|Meaningful Use Criteria – Stage 2 Core Set|

**CORE Objective #1:** Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order.

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\(^1\) 2008 American Academy of Pediatrics (AAP) Socioeconomic Survey of Pediatric Practices.
The Academy is concerned that:
- many of the routine labs for pediatric check ups are templates and entered by ancillary staff prior to the MD seeing the patient as per protocol. Requiring the EP to enter them (or enter on behalf of a provider requiring cosignature) would add tremendous inefficiency and delay to the practice of pediatrics.
- the majority of pediatricians do not have in-house laboratories or x-ray facilities.
- pediatricians in community practice may not have access to laboratory and radiology systems and will be unable to enter orders electronically.

CORE Objective #2: Generate and transmit permissible prescriptions electronically (eRx).

OTC medications play a much larger role in the care of children than adults. Part of the pediatricians anticipatory guidance involves writing instructions/ prescriptions for OTC meds to assure proper dosing and administration. Further, pediatric patients receive a large number of compounded medications that complicate eRX.

The Academy believes that:
- controlled substances should be excluded from any metrics.
- OTC medications should be excluded from the definition of a prescription.

The Academy is concerned that:
- because eRx is dependent upon individual state laws it will be very difficult to compare performance for all EPs across states
- there is no clear eRx technology to support the Drug Enforcement Agency ruling for controlled medications.
- eRx is problematic for pediatricians because there is no standard for transmitting compounded medications.
- eRx is problematic for pediatrician because there is poor adaptability to transmitting doses that are different at varied times of day (a frequent occurrence for seizure medications or ADHD medications for children).
- SureScripts (the only vendor on the market managing the transmission of these messages) will only allow a physician to e-prescribe from ONE institution so metrics will be very skewed.

CORE Objective #3: Record the following demographics: preferred language, gender, race and ethnicity, and date of birth.

The Academy believes that:
- disability status, gender identity, and sexual orientation data should not be collected as demographics.

The Academy is concerned that:
- there are many variations of “disability” including, physical, cognitive, emotional, an impairment and/or a medical condition. Certification of disability must be done at the physician level not at the “record demographic” level by a non-medical staff member.
- gender identity and sexual orientation have no relevance to most pediatric patients and would not be appropriate for pediatricians. Further collecting this information may lead to privacy breeches with parents and guardians.
CORE Objective #4: Record and chart changes in the following vital signs: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0-20 years, including BMI.

The Academy believes that:
- measuring BMI is not appropriate for children under the age of 2 years. This is supported by the fact that the CDC BMI percentile curves do not go below 24 months.
- measuring height/length and blood pressure on an annual basis should be enough to meet the core requirement.
- Recording height may be inappropriate for pediatric subspecialty EPs as it is generally the primary care provider who monitors overall growth.
- the measure could be improved by requiring weight for 80% of hospitalized patients and wt/ht/length/BMI for all primary care preventative visits (well child checks) only.
- the measure could be modified to say that growth charts are required at 50% of all well-child or primary care visits for children age 0-20 years and that BMI is required at 50% of all well-child or primary care visits for children age 2 years and older.

CORE Objective #5: Record smoking status for patients 13 years old or older.

The Academy believes that:
- the term “smoking status” should be broadened to “tobacco use” to include other tobacco products such as cigars, chewing tobacco and hookah.
- secondhand smoke exposure is relevant to everyone and can lead to or exacerbate chronic health conditions and other health and development problems and as such, should be included as a separate objective beginning at birth, including prenatal exposure to maternal smoking.
- this is relevant primarily for primary care and possibly inpatients, but not relevant or meaningful for most ambulatory specialties.

The Academy is concerned that:
- the smoking status recodes from the CDC/NHIS are targeted toward adults are not appropriate for adolescents.
- The “frequency choices” typically used for adults (i.e. 1 pack/week) are not appropriate for adolescents.

CORE Objective #6: Use clinical decision support to improve performance on high priority health conditions.

Drug-Drug alerting systems designed by vendors of CPOE systems are non-functional. When implementing a commercial system at Johns Hopkins University. 97.4% of alerts were ignored by providers. Vague instructions, inability to consider the route (ophthalmic drops) when constructing alerts, and long incomprehensible warnings resulted in no patient benefits. Of the 2.6% of alerts responded to, providers introduced new errors in 2/3 of cases resulting in possible harmful medication discontinuation.

The Academy believes that:
- If CMS plans to specify which drug-drug interaction checks, it is recommended that they look to the list that is being compiled by Marvin Harper from Boston Children’s Hospital as the “minimum approved set” for pediatric DDI-checking.

The Academy is concerned that:
- the definition of a “CDS Rule” is too narrow and doesn’t include things like medication dosing support, clinical pathways, and care protocols.
- there may not be 5 pediatric clinical quality measures that are appropriate targets for a “CDS Rule” (depending on how that is defined).

**CORE Objective #7: Provide clinical summaries for patients for each office visit.**

The Academy believes that:
- the requirement for clinical summaries in pediatrics should be limited to serious acute illness and chronic illness only.

The Academy is concerned that:
- due to the high volume of pediatric visits, providing clinical summaries of every visit is a burden on the pediatrician and of little value.
- providing summaries within 24 hours may not be realistic in many cases as results from throat or urine cultures may alter the plan of action, thus altering the clinical summary.
- there are adolescent privacy issues that might prevent a clinical summary from being provided.

**CORE Objective #8: Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.**

*No significant comments received.*

**CORE Objective #9: Incorporate clinical lab-test results into Certified EHR Technology as structured data.**

While considered but not included in the NPRM, the Academy believes that the following hospital objective and measure should be incorporated into Stage 2:
- Objective: Provide structured electronic lab results to eligible professionals.
- Measure: Hospital labs send (directly or indirectly) structured electronic clinical lab results to the ordering provider for more than 40% of electronic lab orders received

Pediatricians will be required to report on a number of quality measures that are based on laboratory testing and laboratory results. Many of these laboratory tests will be ordered electronically. The current NPRM excluded the requirement for hospital laboratories to provide laboratory test results to EPs in an electronic format. For pediatricians, who have to report on these results, the only solution will be manual entry of laboratory results into their EHRs.

It is the academy's position that the reprise given specifically to hospitals places an undue burden on primary care providers, who need these results for their reporting.

The academy proposes that EH be required to report at least 40% of laboratory tests (that were ordered electronically) in an electronic format using HL7 and LOINC standards, where pediatricians are able to receive these messages.

**CORE Objective #10: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.**

The Academy believes that:
• generating condition-specific reports is an important step in quality improvement and is essential for transforming the health care system from a procedure/visit-based system into a quality-based system.
• the requirement of generating one report for stage 2 is appropriate.

Core Objective #11: Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care.

No significant comments received.

Core Objective #12: Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

The Academy believes that:
• it is unrealistic to expect 10% of patients to view, download and transmit their health information and that the responsibility on the provider side should end with making the information available.
• additional scenarios exist where patients would lack access to the technology needed to view and download information (i.e. no access to a computer/broadband, non- or limited English speakers, etc.).
• a consideration for Stage 3 is the possibility of providing patients with access via their mobile phones/devices. Many more people have mobile phones than have computers including people in remote areas and inner cities. In fact, through the USAC Lifeline and Link Up programs, low-income households in the US can be eligible to receive a subsidy to offset the costs of monthly wired or wireless telephone service. Link Up provides a one-time subsidy for phone set up and installation costs. This program is available in most states for people on some type of low income assistance service such as Medicaid or food stamps.
• Significant concerns for the privacy of adolescent must be considered. Making information available online must be accompanied by policies discussing when parental access to this information is not possible or what data elements (such as STDs, sexual activity and preference) must be excluded from such an online portal.

The Academy is concerned that:
• holding EPs accountable for patient/family compliance is not appropriate and may have a negative impact on an EPs ability to meet the objective.

Core Objective #13: Use clinically relevant information from Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient.

No significant comments received.

Core Objective #14: The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

The Academy is concerned that:
• the 65% threshold is too high because of “breakages” in the supply of information (i.e. parents not knowing the names, doses, concentrations for medications) that don’t allow the reconciliation to happen in a timely fashion.
Core Objective #15: The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.

The Academy believes that:
- the problem list should be extended to “when applicable, functional and cognitive limitations.”
- the better place to address these issues is in the certification criteria for vendor products, rather than putting the burden on providers to locate partners with different EHRs.

The Academy is concerned that:
- current technology does not have the necessary level of interoperability to transfer data between systems.
- resultingly, summaries will be paper-based with little hope of incorporation into the EHR and thus of little value
- until there are data standards for secure encrypted exchange of information and a standard format, this will not be successful.

Core Objective #16: Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.

The Academy believes that:
- the submission of electronic data to immunization registries or immunization information systems, except where prohibited, is appropriate.
- interoperability between state registries is crucial and should be required.
- bi-directional functionality is necessary.

The Academy is concerned that:
- the variability in state systems is a barrier that may prohibit many EPs from meeting this objective.
- the variability in state requirements allowing parents to “opt-out” of participating in registries is a barrier that may prohibit many EPs from meeting this objective.

Core Objective #17: Use secure electronic messaging to communicate with patients on relevant health information.

No significant comments received.

### Meaningful Use Criteria – Stage 2 Menu Set

Menu Objective #1: Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.

The Academy is concerned that:
- many public health agencies may not have currently have the capability for this type of interoperability.

Menu Objective #2: Imaging results and information are accessible through Certified EHR Technology.
The Academy believes that:
- many pediatricians rely on the interpretations of images and rarely access the direct images themselves.
- it is most important for pediatricians to have electronic access to image reports, not the actual images themselves.
- this measure will be hard for EPs to meet and that many may not choose it as part of their menu set.

The Academy is concerned that:
- if it is only necessary to have links to images and image results, it may be difficult to track and record the accessing of things stored on a 3rd party system.
- storing and having access to images in an EPs system puts them at risk from a medical legal standpoint.
- Storing data dense images on duplicate systems is a waste of data space and could overwhelm and bring down EP systems.

Menu Objective #3: Record patient family health history as structured data.

The Academy believes that:
- patients with no known “first degree relative” should be excluded from the denominator.

The Academy is concerned that:
- the requirement of “structured data entry for one or more first-degree relatives” is not defined. Does this mean mothers blood type, race of parents or that mother is healthy with no significant medical problems?

Menu Objective #4: Capability to identify and report cancer cases to a State cancer registry, except where prohibited, and in accordance with applicable law and practice.

The Academy believes that:
- this is not widely applicable to pediatrics.

Menu Objective #5: Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.

No significant comments received.

Meaningful Use Criteria – Stage 2 Clinical Quality Measures

Pediatricians will be required to report on a number of quality measures that are based on laboratory testing and laboratory results. Many of these laboratory tests will be ordered electronically. The current NPRM excluded the requirement for hospital laboratories to provide laboratory test results to EPs in an electronic format. For pediatricians, who have to report on these results, the only solution will be manual entry of laboratory results into their EHRs. The Academy believes that the reprise given specifically to hospitals places an undue burden on primary care providers, who need these results for their reporting.

Therefore, the academy proposes that eligible hospitals be required to report at least 40% of laboratory tests (that were ordered electronically) in an electronic format using HL7 and LOINC standards, where pediatricians are able to receive these messages.
The Academy also believes that:

- option 1b: EPs reporting on 11 "core" clinical quality measures plus 1 "menu" clinical quality measure is the best choice of reporting options.
- States should be allowed to establish the method and requirements, subject to CMS approval, for electronic reporting.
- while some pediatricians may see patients age 21 years and beyond, particularly when a patient has special healthcare needs that make the transition to adult care more challenging, pediatricians generally do not see patients aged 21 years and older and thus clinical quality measures applicable to patients age 0-21 must be included in the list of “core” measures.
- EPs who do not have sufficient patients in the denominator for the core measures that apply to patients age 65 and older should not be required to report on those measures.
- only clinical quality measures that have appropriate payment codes should be chosen for the “core” set.
- measures involving atrial fibrillation/flutter are truly adult-based; we really don't see this in significant numbers in the pediatric/adolescent population.
- measures involving lipids are not reliable in adolescents, as their numbers routinely drop in mid-adolescence and then come back up. As well, unlike adults, children and adolescents are not routinely placed on lipid-lowering medications unless truly indicated.
- myocardial infarction in children and adolescents is extremely rare and is not routinely managed enough to be able to come up with standards.
- co-morbid diabetes and cardiac disease is extremely rare in the pediatric population.
- there is minimal data for management of CHF in pediatric and adolescent patients, and adult data cannot be extrapolated to pediatric patients.