July 18, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-0052-P
P.O. Box 8013
Baltimore, MD 21244

Re: Medicare and Medicaid Programs; Modifications to the Medicare and Medicaid Electronic Health Record Incentive Programs for 2014; and Health Information Technology: Revisions to the Certified EHR Technology Definition

Dear Ms. Tavenner:

The Children’s Hospital Association (the Association) appreciates the opportunity to comment on the proposed changes to the requirements for the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program for 2014. The Association is a tax-exempt organization of over 220 children’s hospitals, including freestanding children’s hospitals, children’s hospitals that are part of larger hospitals and systems and hospitals that provide ongoing specialty care to children and their families. Although they account for less than 5 percent of hospitals in the United States, children’s hospitals care for almost one half of children admitted to hospitals and, together with major teaching hospitals, children’s hospitals provide almost all care for children requiring highly specialized and complex care, such as cardiac surgery and organ transplantation.

Overall, the Association would like to express our appreciation for the increased flexibility the Centers for Medicare and Medicaid Services (CMS) and Office of the National Coordinator for Health Information Technology (ONC) have proposed for eligible hospitals, critical access hospitals, and eligible professionals (EPs) in 2014. Given that the comment period for the proposed rule closes on July 21, which is after the final reporting period for FY 2014 has begun, the Association urges CMS and ONC to finalize the proposals as quickly as possible.

While the Association is supportive of the flexibility, there are a few outstanding questions that we hope CMS and ONC will address in the final rule:

- First, we ask that the agencies provide clarification for what certified EHR technology (CEHRT) modules are required if an eligible hospital or EP is attesting to a mix of 2011 and 2014 technology. Specifically, are providers required to have all of the technology to meet the 2014 base level, even if not attesting to all of the 2014 relevant measures? If a provider is attesting to a mix of 2011 and 2014 CEHRT, do the agencies expect providers to meet the 2014 EHR definition? For example, if a hospital is unable to fully implement the 2014
CEHRT for summary of care at transition of care, will that hospital be able to generate an ONC Certified Health IT Product List number to meet the 2011 and 2014 mix?

- In addition, we request that the agencies provide clarification for EPs that work at multiple locations that choose different strategies for attesting in 2014 and how EPs should calculate the general requirements. For example, how should an EP calculate their encounters if 50 percent of them are at locations with 2014 CEHRT and the other 50 percent of encounters are at locations with either 2011 CEHRT, or a combination of 2011 and 2014?

- It would also be helpful for the agencies to provide additional clarification on aggregating data across locations and how to report on clinical quality measures. For example, how should an EP calculate the percent of measures if the various locations select different measures?

Finally, while the proposed rule does not address the definition of Stage 2, the Association believes it is important that eligible hospitals have increased flexibility around some of the requirements outlined in Stage 2. In particular, the transition of care summary exchange requirement should be relaxed. Many children’s hospitals have been early adopters of health information technology and are successfully using EHRs to improve the quality of patient care. However, the rate of adoption among other care settings has not been as robust. As a result, even if a hospital has installed 2014 edition software and can send transition of care summaries, the hospital cannot always find a physician or other care setting that is equipped to receive the information. Consequently, the lack of widespread implementation of information exchange infrastructure makes it difficult to meet this requirement. Moreover, it is unlikely that this issue will be resolved within the next 90 days for the start of the Oct. 1 reporting period. Therefore the Association recommends that either the transition of care summary exchange requirement is relaxed or the 2015 reporting period should be 90 days to enable more time for implementation.

Again, the Association appreciates the opportunity to respond to this proposed rule. If you have any questions or need additional information, please contact Liz Parry, associate director, policy analysis (liz.parry@childrenshospitals.org or 202-753-5392).

Sincerely,

M. James Kaufman
Vice President, Public Policy