February 4, 2016

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS—3323—NC

Submitted electronically to: http://www.regulations.gov

Re: Certification Frequency and Requirements for the Reporting of Quality Measures under CMS Programs

Dear Mr. Slavitt,

On behalf of children’s hospitals across the country, the Children’s Hospital Association (CHA) appreciates the opportunity to provide comments on the certification of health information technology (HIT) including electronic health records (EHR) products used for reporting certain Centers for Medicare and Medicaid Services (CMS) quality reporting programs. CHA shares the federal government’s commitment to utilizing HIT to improve clinical care, care coordination, information provided to patients, and the overall quality of health care for children and their families in our country.

Although children’s hospitals account for only 5 percent of hospitals in the United States, they provide 47 percent of the hospital care required by children covered by Medicaid. Children’s hospitals are regional centers for children’s health, providing care across large geographic areas and serving Medicaid children across state lines. Children’s hospitals serve the majority of children with serious illnesses and complex chronic conditions and most children in need of major surgical services.

CHA appreciates that CMS is seeking input on whether the agency should require HIT developers to ensure that they are certified to the types of measures that are most relevant to their client base. We were particularly pleased to see that CMS specifically inquires whether the pediatric core set that is currently recommended – but not required – for HIT developer certification should be required. CHA believes that, at a minimum, HIT requirements should include those requirements that ensure data are consistently collected and maintained in HIT so that measures assessing child health and the quality of child health services are valid. We believe that uniform standards would allow pediatric providers the ability to benchmark with their peers. This will also be important with Stage 3 of Meaningful Use, which is focused on outcomes. Normalizing data that is captured nationally with required core quality measures, including pediatrics, provides the foundation for measuring success in the program.

CHA does have some concerns about using the 2014 clinical quality measures (CQMs) pediatric recommended core measures that were linked to in the Federal Register. Many of the recommended measures are related to ambulatory care and do not include measures appropriate for dealing with very sick or complex pediatric patients that receive care at children’s hospitals. Therefore, we believe that the HIT requirements and the core set of measures should include relevant data and measures derived from the “Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP” to assess
quality of care for children in acute care settings. Further, similar to the review of adult HIT requirements and core measure sets, HIT requirements should be regularly aligned so that as new measures are developed and adopted (e.g., clinical and patient reported outcomes), HIT systems are able to support their implementation. Since CMS reviews and updates electronic CQMs on an annual basis, we encourage CMS to also review pediatric measures on an annual basis. As CMS is aware, the federal investment in measurement development for individuals under the age of 18 significantly lags behind the investment for adults and, particularly, the Medicare population. The Pediatric Quality Measures Program (PQMP) supported by CMS and the Agency for Healthcare Research and Quality has been the first significant step in closing the gap. Thanks to the PQMP, new measures have been developed and are being tested, refined, and/or endorsed. Therefore, we believe it is important that the required core set be reviewed and updated as appropriate as new measures are ready for use. Moreover, when the core set is updated, we urge CMS to require vendors to update the certified EHR technology (CEHRT) to reflect the changes.

In addition, we ask that CMS clarify for vendors that including the data elements to measure child health, starting with those in the pediatric core set, should be seen as a “floor.” In other words, vendors and providers should continue to work together to make sure the CEHRT reflects the needs of the providers and the patients they serve.

CHA also believes that CMS should consider the unique needs of the adolescent population. It would be helpful for CEHRT to support settings that allow for appropriate filtering of information that is protected under confidentiality provisions in most state laws related to reproductive and mental health. As a recent Health Affairs article notes, it is important that we invest in mental health for children and adolescents, but we also need the certified technology that allows for easy communication with adolescents as patients and parents as proxies without compromising these confidentiality requirements.

Again, we appreciate that CMS is requesting information about whether the pediatric core set should be required for CEHRT. Measures that have been developed for the adult population do not always work for the pediatric population, and we applaud CMS for this recognition. Requiring HIT developers to certify all the measures in the pediatric core set is an important first step. Continuous monitoring to ensure the most appropriate measures are included in CEHRT is equally important. Children's hospitals look forward to continuing to work with CMS and vendors to ensure that the CEHRT has the most appropriate and up-to-date measures.

If you have any questions or comments, please contact Liz Parry at 202-753-5392 or liz.parry@childrenshospitals.org.

Sincerely,

M. James Kaufman, PhD
Vice President, Public Policy