AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY

December 19, 2012

Marilyn Travenner, RN
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1590-FC
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and other Revisions to Part B for CY 2013

Dear Administrator Travenner:

On behalf of the American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS), I am pleased to submit the following comments on the final rule titled "Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2013" published in the *Federal Register* on November 16, 2012. Our comments will address the following issues: (1) the sustainable growth rate (SGR); (2) potentially misvalued codes under the Medicare Physician Fee Schedule (MPFS); (3) primary care and care coordination efforts; (4) physician compare website; (5) quality reporting initiatives; and (6) implementation of the physician feedback and value-based payment modifier programs.

1. Sustainable Growth Rate (SGR)

Over the past decade, the AAO-HNS and others in the physician community have repeatedly advocated for the reform and full repeal of the unstable and unsustainable Medicare Sustainable Growth Rate (SGR) formula. The failure to enact permanent reform has created an instability and uncertainty that undermines the ability of physicians to plan for the future, to provide for their employees, and to make investments to help improve the quality and efficiency of the care they provide. In the final rule, the Centers for Medicare and Medicaid Services (CMS) estimate that under current law, the conversion factor for CY 2013 would be reduced by 26.5 percent to $25.0008 (compared to the CY 2012 conversion factor of $34.0376), but emphasizes that the Agency is committed to working with Congress to permanently reform the SGR methodology for MPFS updates. The negative impact associated with a steep 26.5 percent cut would only be exacerbated when coupled with a potential 2 percent additional cut to physician payments under the budget sequestration process. *The Academy applauds CMS for recognizing that the SGR must be fixed, and we appreciate CMS' commitment to work with Congress to resolve the issue. The Academy continues to advocate for permanent repeal of the SGR, and we welcome the efforts by CMS to advocate for the same.*

2. Potentially Misvalued Services Under the Physician Fee Schedule

A. Interim Final Rule Relative Value Units (RVUs) for CY 2013

Overall, the Academy is extremely grateful to CMS for accepting, and implementing as interim for CY 2013, the majority of the AMA RUCs valuation recommendations for physician work and direct practice expense inputs related to services provided by otolaryngologist-head and neck surgeons. Specifically, we thank the Agency for accepting the RUC recommendations for physician work relative value units (RVUs) for CPT codes 31231 Nasal Endoscopy; 13132 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm; 13151 Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm; 40490

Biopsy of lip; 69200 Clear outer ear canal; and 69433 Create eardrum opening. There were several codes, however, for which CMS either declined to accept the RUC recommended physician work RVUs, or made significant modifications to the direct practice inputs recommended by the AMA RUC; for those procedures, the Academy would like to provide the following comments:

i. Changes to Physician Work Time for CPT 31231 Nasal Endoscopy

Within the final rule, CMS stated that for CPT code 31231, they:

> "[B]elieve that some of the activities furnished during the pre- and post-service period of the procedure code and the E/M visit overlap. We believe that the AMA RUC appropriately accounted for this overlap in its recommendation of pre-service time, but failed to account for the overlap in post-service time. To account for this overlap, we reduced the AMA RUC-recommended post-service time for this procedure by one-third, from 5 minutes to 3 minutes. We believe 3 minutes accurately reflects the post-service time involved in furnishing this procedure, and is more in line with similar services."

During its deliberations, the RUC reviewed Medicare billed together claims data showing that code 31231 is typically billed with an E/M service on the same date of service. The RUC carefully reviewed the survey data and discussed this with our Academy physician experts and determined that 5 minutes of post-service work accurately accounts for the immediate post-service work for this code, independent of any E/M work. Furthermore, CMS does not state which physician activities they believe overlap with the E/M, or which similar services necessitate the removal of 1/3 of the code's post-service time. Given these incorrect assumptions and CMS' vague explanation for this modification to the post service time for CPT 31231, the Academy urges CMS to accept the original RUC recommendation of 5 minutes of immediate post-service time for CPT code 31231.

ii. Changes to Practice Expense Direct Inputs for CPT 31231 Nasal Endoscopy

As the primary providers of nasal endoscopy services and the sole participant in the 2011-2012 RUC survey of CPT 31231, the Academy would like to provide specific comments in response to CMS' changes to the direct practice expense inputs for this service. To outline our concerns, we have prepared a table included at the end of our comments, labeled Addendum A, which outlines the CMS, modified PE inputs, the AMA RUC approved values, and the Academy's recommended values and accompanying rationale. We also note that there are several inconsistencies between the 2013 Direct Input PE file posted on the CMS website and the tables published in the 2013 Final MPFS. *We have noted those discrepancies in our rationale contained in addendum A, and urge CMS to carefully review and resolve these areas of inconsistency between the two documents to ensure the final direct PE inputs are accurate for this CPT code.*

iii. Changes to Physician Work RVUs for Pediatric Polysomnography CPT codes 95782 and 95783

The Academy is disappointed that CMS elected not to accept the AMA RUC recommended values for the new pediatric polysomnography codes, CPT 95782 and 95783. We believe the RUC recommendations of 3.00 and 3.20 physician work RVUs respectively were appropriate given the difficulty of performing sleep studies in children. Specifically, we believe children require significantly more effort than adults in order to obtain an accurate polysomnogram. They frequently pull leads off, require more attention, and may even require mild sedation. Additionally, they are even more complex to titrate due to their resistance to accepting the CPAP mask. Therefore, the minimal increase in work value over the adult polysomnography codes which are finalized as interim by CMS for CY 2013 does not accurately capture the additional work required when conducting these studies on children. *Thus, we believe the RUC values for physician work for CPT 95782 and 95783 are more appropriate and urge CMS to reconsider the valuation for these new codes in future rulemaking.*

iv. CMS Reduction of the Physician Work RVU for CPT code 13152 Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm

The Academy strongly objects to CMS' decision to reject the AMA RUC's recommendation for physician work for CPT 13152. We believe CPT 13152 is more intense and complex to perform than its comparator code within the family, CPT 13132 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm. CPT 13152 has a higher risk of complication, requires finer smaller sutures in a delicate area, is more challenging to repair with underlying tissue planes and adjacent structures, and has a more cosmetic impact and involves repair on mobile areas. We believe this additional work and complexity

should be accurately reflected in the physician work RVU for CPT 13152, thus, an increment of only 0.12 RVUs from CPT 13132 to CPT 13152 is not appropriate. In addition, utilizing the 4.90 work RVU for CPT 13152 results in a rank order anomaly within the family of codes when compared to the less intense 13132. *Therefore, we urge CMS to reconsider this interim assignment of a 4.90 work RVU for CPT 13152 and reiterate our support for the AMA RUC recommended physician work RVU of 5.34.*

B. Improving Valuation of the Global Surgical Package

Within the proposed rule, CMS outlined their concerns regarding the accuracy of valuing the number of evaluation and management (E/M) visits associated with global surgical procedures which range from 0, 10, or 90 days of post-operative care. In response, they requested input from the public regarding the best methods for validating the number of visits actually provided during the global surgical period, including whether or not they should pursue a claims-based reporting requirement for post operative visits within the global surgical period. Within the final rule, CMS notes they received hundreds of comments related to this topic which they will continue to take into consideration. While the Agency did not make any policy changes for CY 2013 in this realm, the rule was clear that CMS intends to implement policy changes in this area for CY 2014.

The Academy appreciates the fact that CMS is proceeding cautiously in this area and is taking the time to thoroughly vet and consider all comments regarding how best to proceed in order to validate visits provided during the post operative global period. We continue, however, to have serious concerns regarding a claims based reporting requirement in order to track these visits. We believe that this work is already appropriately surveyed, vetted, and valued by the AMA RUC during their ongoing reviews of surgical procedures, and therefore, claims based reporting is unnecessary in order to verify that the number of visits assigned to surgical procedures is accurate. Second, we believe requiring providers, or their billing staff, to document and submit claims for these E/M visits simply to track their usage will result in unnecessary administrative burden and additional costs on physician practices. Therefore, we urge CMS to work with the AMA RUC to address their concerns regarding the allocating of visits within a global surgical package, and discourage any requirement of tracking visits via administrative claims.

C. Validation of Relative Value Units (RVUs) for Potentially Misvalued Codes

CMS notes within the potentially misvalued codes section of the final rule, that under Section 1848(C)(2)(K)(ii) of the ACA, the Secretary of Health and Human Services (HHS) is directed to validate a sampling of RVUs for services identified by the seven categories of potentially misvalued codes. In response to this statutory requirement, CMS announced during the public AMA briefing on payment policies within the final 2013 MPFS that they have entered into two research contracts, with RAND and Urban Institute respectively, to further this goal.

While the Academy is appreciative of CMS' attempts to provide additional detail in this area to the public, and understand that CMS is statutorily obligated to develop a method to validate potentially misvalued codes based on the language in the ACA, *we are disappointed at their lack of transparency within the final rule in this regard. Specifically, we believe CMS should have announced the names of the contractors and provided a brief outline of the research projects they will be undertaking within the final 2013 MPFS rather than announcing this at a public briefing which is only attended by a handful of medical specialties. In addition, we remain generally concerned about the Agency's engagement of outside contractors to perform this function.* As stated in previous comment letters, the Academy believes the AMA RUC process is a sound and reliable process for evaluating and valuing physician services to Medicare beneficiaries. Notably, the AMA RUC process ensures relativity across services and allows for physician involvement and expertise to play a role in valuing the medical services they provide on a daily basis.

Based on the aforementioned concerns, the Academy strongly urges CMS to ensure that these research projects are conducted in an open and transparent manner to keep specialty societies informed on the process and methodology that will be used to validate the RVUs for these services. Further, we believe it is not sufficient for CMS to hold all detail regarding these validation projects until formal reports have been finalized. Instead, we encourage CMS to be open about these projects as they develop and include input from practicing physicians who are knowledgeable about the specific services being reviewed. Finally, we encourage CMS to exercise restraint in the utilization of the data resulting from the work of these outside contractors and respectfully request that the Agency continue the use of the AMA RUC as the sole method of validating physician work RVUs time for physician's services.

3. Primary Care and Care Coordination

A. Payment for Transitional Care Management

The Academy would like to thank CMS for considering and implementing, our previous comments and recommendations regarding reimbursement for transitional care management (TCM) services. Specifically, rather than implement the proposed G codes put forth by CMS in the 2013 proposed rule, we requested that CMS implement the transitional care management codes developed by the AMA RUC's Chronic Care Coordination workgroup (C3W). We are extremely appreciative that CMS accepted our recommendation in this regard.

Despite this appreciation, we continue to urge CMS to consider the AMA RUCs previous comments that additional work should be done via the CPT Editorial Panel process to create coding structures which recognize instances where specialists are providing transitional care management that goes above and beyond the typical discharge management work and therefore, they should be able to code and bill for this additional time and effort, We encourage CMS to remain open to reimbursement for all physician work aimed at coordinating care for Medicare beneficiaries, regardless of whether it is performed by a specialist or a primary care physician.

4. Physician Compare Website

The Physician Compare website was launched in December 2010 and originally included data on eligible professionals (EPs) who successfully reported for PQRS in CY 2009. The website also presently includes physicians' primary and secondary specialties, practice locations, group practice and hospital affiliations, education, foreign language skills, gender, and names of EPs who are successfully reporting for the eRx and PQRS quality programs. Statute requires that by January 2013, CMS must have a plan in place to make information related to physicians' quality performance and patient experience publicly available.

Within the CY 2013 final rule CMS finalizes a reduction to the patient sample size required for posting information from 25 patients down to 20. They also approve posting, for CY 2013, the following: 2012 PQRS GPRO measure information for measures that meet the minimum sample size (20 patients), whether physicians are accepting Medicare, and physician board certification information. CMS is also undergoing a full website redesign to improve usability and functionality in 2013 and are specifically working to improve the information provided on language skills and hospital affiliation. *The Academy has continued concerns regarding the reduced patient threshold for posting information on physicians' quality performance and patient experience survey data. As was stated in our comments on the proposed rule, we believe a higher threshold should be used to ensure a statistically valid sample size is available for both types of data. Larger samples will result in more meaningful data which can be better used by patients to inform their medical decision making and will more accurately represent the physicians' practice patterns and quality of care.*

For CY 2014, CMS is aiming to post information on the website which illustrates physicians' performance rates on measures for CY 2013 reported by groups or ACOs via the GPRO web interface. They will have 30 days to review this information before it is posted publicly. In addition, CMS is hoping to post patient experience survey data for groups and ACOs participating in the PQRS GPRO reporting method. This will only apply to groups of 100 or more and the patient experience data will be derived using the CG-CAHPS survey mechanism for groups and ACOs meeting the size requirement. CMS also hopes to post information on providers who obtain PQRS maintenance of certification incentives. *We appreciate CMS' decision to delay the posting of this information until CY 2014. We believe this will allow physician groups and ACOs more time to implement these quality programs in their practices, resulting in more meaningful data being available to the public once the information is posted. In addition, we appreciate CMS' implementation of a 30 day review period prior to making this information publicly available on the Physician Compare website. We believe a review period is essential to ensuring accuracy of data and personal information which is a critical piece to creating a set of useful resources and information for patients to access via the Physician Compare website. Finally, we have concerns regarding the use of the CG-CAHPS survey mechanism to derive patient experience data. These concerns are outlined in detail in the PQRS comment section below.*

In 2015, CMS is considering posting individual EP's performance measure data and discuss posting measures developed by specialty societies, which will be subjected to the MAP process, in the future. CMS rationalizes the need for specialty developed measures by stating that working with specialty societies to identify quality measure data that are already collected and available reduces the reporting burden on specialties and provides an opportunity to expand public reporting to specialties and types of physicians not currently represented. They state this will be discussed in future rulemaking. They also discuss continued alignment with PQRS and

the VBP modifier measure performance as a means of minimizing the reporting burden on EPs by linking these programs and reporting performance on these measures publicly.

CMS also stresses in the final rule that they are concerned about ensuring data accuracy and while they are still pulling physician information from PECOS, they are working to identify other data sources to validate the information from PECOS. In addition, they are allowing a 30 day review period for physicians before this information is public, to ensure the information is accurate. CMS is also working on disclaimer language for the Physician Compare website in response to comments on the proposed rule.

5. Quality Reporting Initiatives

A. Physician Quality Reporting System

The Academy appreciates CMS' continued willingness to enhance the Physician Quality Reporting System (PQRS). We recognize and support CMS' efforts to increase the participation rate of EPs to 50% by 2015. In regards to this goal, the Academy has several comments below which address questions and issues in the final rule regarding PQRS.

a. Eligible Professional Participation in PQRS

In general, the Academy is pleased that CMS has taken steps to increase EPs participation in PQRS. For example, we support the reduction in number of patients for reporting measures groups needed to satisfactorily report in 2013 and 2014. We also commend the continued alignment between CMS quality initiatives. Allowing EPs to report PQRS quality measures to satisfactorily report for both PQRS and the clinical quality measure requirement of the proposed Stage 2 Meaningful Use will reduce the burden placed on EPs to report quality measure data across multiple quality programs.

In 2012, only a limited number (31 of 210) of PQRS individual quality measures were generally applicable to otolaryngology. Of those measures, an even smaller number are directly applicable to our subspecialties. The Academy continues to believe that for CMS to meet their goal of increasing the participation rate of EPs to 50 percent by 2015, the adoption of new quality measures applicable to all specialty societies is required. However, as we stated in our comments on the proposed rule in order to meet this goal, CMS needs to increase the number of PQRS individual quality measures directly applicable to otolaryngologists. The alignment of the approval process for quality measures available for reporting, such as those endorsed by National Quality Forum (NQF), AMA-Physician Consortium for Performance Improvement (PCPI), specialty societies and CMS would greatly increase the number of measures applicable to otolaryngology and boost participation by 2015. An example of such alignment is the development and approval of a set of quality measures focused on adult sinusitis which will be undergoing MAP review during CY 2013 and are under consideration for use in PQRS reporting for CY 2014. ***Therefore, we strongly urge CMS to streamline the timeframe and approval process for quality measures physicians can report as part of the PQRS program.***

To support participation of our members in PQRS, the Academy continues to strongly encourage CMS to include a set of quality measures focused on adult sinusitis. These measures, outlined below, were developed by the AMA-Physician Consortium for Performance Improvement (PCPI) with the support of the AAO-HNS Foundation (AAO-HNSF).

Measure Title	**PCPI Recommended Data Source**	**Specifications included in call for measures**
Adult Sinusitis: Accurate Diagnosis of Acute Sinusitis: Distinguishing Viral vs. Bacterial Sinusitis	Claims, EHR or Registry	Claims/registry specifications; Data requirements table for EHR
Adult Sinusitis: Plain Film Radiography for Acute Sinusitis (overuse)	Claims, EHR or Registry	Claims/registry specifications, Data requirements table submitted for EHR consideration
Adult Sinusitis: Computerized Tomography for Acute Sinusitis (overuse)	Claims, EHR or Registry	Claims/registry specifications, Data requirements table for EHR
Adult Sinusitis: Appropriate Diagnostic Testing for Chronic Sinusitis (underuse)	Claims, EHR or Registry	Claims/registry specifications, Data requirements table for EHR
Adult Sinusitis: More than 1 Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse)	EHR or Registry	Data requirements table for EHR/Registry

Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Appropriate Use)	EHR or Registry	Data requirements table for EHR/Registry
Adult Sinusitis: Watchful Waiting for Acute Bacterial Sinusitis: Initial Observation Without Antibiotics for Patients With Mild Illness (Appropriate Use)	EHR or Registry	Data requirements table for EHR/Registry
Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)	EHR or Registry	Data requirements table for EHR/Registry
Adult Sinusitis: Premature Changing of Initial Antibiotic for Acute Bacterial Sinusitis (Overuse)	EHR or Registry	Data requirements table for EHR/Registry

One of the primary sources of evidence supporting the measures development was the AAO-HNSF clinical practice guideline on adult sinusitis. The adult sinusitis measures were developed for all clinicians who care for adult patients with either acute or chronic sinusitis and emphasize overuse, appropriate use, and patient-reported health status. In past rulemaking, CMS has made it clear that in order to obtain approval of new quality measures societies must identify quality gaps that need to be addressed. We believe the development of adult sinusitis measures would do just that as current quality gaps in the treatment of sinusitis indicate the need to develop and enhance specific processes demonstrated to improve outcomes, including accurate diagnosis, appropriate diagnostic testing, appropriate antibiotic prescribing, and reducing antibiotic resistance and unnecessary exposure to radiation. *The AMA-PCPI submitted these measures, which were supported by a separate Academy letter to CMS, during the most recent PQRS public call for measures. As such, we strongly encourage CMS to adopt these measures in CY 2014 rulemaking for inclusion in future PQRS reporting periods to enable otolaryngologist-head and neck surgeons to meaningfully participate in the PQRS program.*

b. Satisfactorily Reporting for the 2015 and 2016 Penalty Adjustments

The Academy greatly appreciates and strongly supports CMS' reduction of the reporting requirements to satisfactorily report for the 2015 and 2016 penalty adjustments. Allowing EPs and group practices to report on either one individual measure or measures group will improve the ability of our membership to avoid future payment adjustments. Additionally, the Academy appreciates that physicians attempting to report quality measures in 2013, but not reaching the required thresholds, will not be penalized by the 2015 payment adjustment. By making this policy change, CMS encourages a greater number of physicians, specifically otolaryngologist-head and neck surgeons, to participate in the program.

c. Reporting Mechanisms for Group Practices of 100+ EPs

In the proposed rule, CMS limited large group practices of 100+ professionals to reporting via the GPRO web interface to satisfactorily report for the 2013 and 2014 payment incentive, and added the reporting option of administrative claims to satisfactorily report for the 2015 and 2016 payment adjustment. *The Academy appreciates that CMS did not finalize these limited options and instead, finalized four options for groups of 100 or more professionals to report. This includes the two proposed options as well as via qualified registries in 2013 and via EHR based reporting in 2014.* Although AAO-HNS has few members practicing in large practices of this size, these changes will allow large group practices meaningful choice as to how best to participate in PQRS which we believe will foster more widespread adoption of quality reporting.

d. Inclusion of S-CAHPS into PQRS GPRO Web Interface

The PQRS GPRO Web interface and the Physician Compare Web site provisions (commented on above) include use of the Consumer Assessment of Healthcare Providers Clinician and Group Survey (CG-CAHPS) as the sole patient experience of care survey measure. The Academy expressed concerns regarding the exclusive inclusion of CG-CAHPS into the PQRS and GPRO Web interface in a joint letter with the American College of Surgeons sent to CMS on November 30, 2012. We take this opportunity to reiterate points made in the letter. Namely, that the CG-CAHPS is not equally meaningful to all members of a multi-specialty group, such as surgeons. The Surgical Consumer Assessment of Healthcare Providers and Systems (S-CAHPS), was developed by ACS in partnership with other surgical and anesthesia organizations and the Agency for Healthcare Research and Quality's (AHRQ) CAHPS Consortium to assess and to adequately identify opportunities to improve quality of care, surgical outcomes, public reporting, and patient experience. The S-CAHPS survey was developed using the same methodology and scientific rigor applied in the development of all CAHPS surveys.

Therefore, to better meet the needs of the surgical patient, we strongly recommend that CMS reconsider the inclusion of the S-CAHPS in addition to the CG-CAHPS for the PQRS GPRO Web interface and Physician Compare.

We have additional apprehension regarding the administration of the CG-CAHPS survey on behalf of the group practices participating in the 2013 and 2014 PQRS GPRO reporting periods. As stated in the joint letter, we are concerned about how CMS will standardize the administration of the survey. The current CG-CAHPS and S-CAHPS administration methods have been tested and validated by a team of experts at AHRQ. The validated administration modes include: mail only, telephone only, and mixed mode (mail and telephone; e-mail and mail; or e-mail and telephone). *We strongly urge CMS to adhere to the AHRQ recommended modes of administration to ensure the survey's validity and reliability.*

In addition, we continue to seek clarification on whether the process to standardize survey administration can be applied to other patient experience of care surveys, including other CAHPS surveys. We are concerned that if CMS does not incorporate S-CAHPS into the PQRS GPRO Web interface and standardize a low cost way to implement CG-CAHPS, that surveys which are more meaningful to a patient and provider populations, such as S-CAHPS, could be cost-prohibitive to implement in comparison to the CG-CAHPS.

e. Administrative Claims Reporting

The Academy appreciates CMS' inclusion of the administrative claims reporting option for CY 2013. This option allows individual EPs and groups to satisfactorily report for the 2015 PQRS payment adjustment based on an analysis of their claims. We also appreciate CMS providing physicians until October 15, 2013 to elect to the administrative claims-based reporting mechanism. This date will allow physicians additional time to determine the best method of reporting for their practice. For a more detailed discussion of our recommendations regarding availability of the administrative claims reporting option for future years, see the value based payment modifier comments below.

f. PQRS Reporting in 2013 and 2014

The Academy strongly supports the additional six month reporting period (July 1- December 31) for the reporting of measure groups via registry for 2013 and 2014. Additional reporting periods are extremely helpful in allowing EPs to successfully report quality measures to avoid payment reductions in 2015 and 2016 and we appreciate CMS' inclusion of this new reporting period.

g. Changes to EHR Reporting

The Academy disagrees, however, with CMS' decision to eliminate the qualification of EHR products beyond 2013, or post a list of qualified EHR vendors and their products. However, we are supportive of CMS' decision to continue to require that the Office of the National Coordinator (ONC) certify a direct EHR product as Certified Electronic Health Record Technology (CEHRT) and meet the definition of CEHRT in ONC's regulation to submit PQRS measures. *We believe it is essential that CMS continue to provide valuable guidance and expertise to providers and their staff on qualified EHR systems to ensure that the administrative burden placed on providers for participation in PQRS and the EHR Incentive Program is not excessive.*

A. Incentives and Payment Adjustments for Electronic Prescribing (eRx)

The Academy is extremely grateful to CMS for finalizing two additional hardship exemptions for use in the Electronic Prescribing (eRx) Incentive Program for CY 2013. These exemptions link the eRx program to the EHR Incentive Program by exempting physicians that demonstrate intent to participate in, or successfully attest to, Meaningful Use (MU) during 2013 and 2014 reporting periods. We believe that by doing so, EPs would not have to perform redundant work for both incentive programs, ensuring that their time treating patients is not diminished by administrative burdens such as these reporting requirements.

The Academy remains concerned, however, about the difficulty for otolaryngologists and head and neck surgeons to achieve MU of EHRs. We believe MU requirements are so onerous that many physicians are not participating in the EHR incentive program. Failure to enroll in the EHR incentive program results in the inability to qualify for the new eRx hardship exemptions. According to a 2012 GAO report, the 56,585 professionals who were awarded a Medicare EHR incentive payment for 2011 represented about 9 percent of the estimated 600,172 professionals eligible for the program[i]. Within otolaryngology, only 14.1 percent were awarded EHR Incentive payments in 2011. We believe stringent program requirements with high satisfaction thresholds will hinder health information technology (HIT) adoption. CMS must take into account the current technological realities and additional financial and administrative costs that will be incurred by physicians in order to meet all of the program requirements. These concerns are supported by the CMS

2010 PQRS and eRx experience report, which demonstrated that only 19 percent of otolaryngologists participated[ii]. *We encourage CMS to continue efforts to ease the administrative burden on physicians due to high, and in some cases unattainable, reporting thresholds for the EHR incentive program.*

Despite our concerns outlined above, we are appreciative of CMS' acceptance of several of our comments submitted on the proposed rule, including the addition of the reporting period from January 1, 2013 – December 31, 2013 for groups sized 2 to 24 EPs to qualify for the 2013 incentive payment and the establishment of a reporting threshold of 75 for practices with 2-24 EPs. This additional period works to ensure more otolaryngologists and head and neck surgeons (and other physicians) participate and become successful e-prescribers. Further, the lowered reporting threshold of 75 allows more EPs in small practices to successfully e-prescribe.

We also support CMS' implementation of an informal review process for 2013 and 2014 eRx payments. We believe aligning the review process with PQRS will make participating in the programs less burdensome for providers and reduce confusion surrounding circumstances where a provider believes they have been incorrectly penalized as an unsuccessful participant. We also believe that allowing requests for review to be submitted via an online tool will reduce administrative burden and streamline the review process.

6. Implementation of the Physician Feedback Program and the Value-Based Payment Modifier Program

The Academy greatly appreciates CMS' responsiveness to comments on this area of the proposed rule and their subsequent decision to modify the group of EPs who will be impacted by the value based payment (VBP) modifier program for performance year 2013. We believe applying this program to only groups of 100 or more EPs for 2013, with adjustments occurring in 2015, will allow groups most prepared and equipped for this program's requirements to pilot the program. This will also allow the public and individual, or small groups of EP's, to observe the program in the first year and learn from the experiences of the larger groups prior to penalties directly impacting them.

We also appreciate CMS allowing various methods of participation in the VBP modifier program, via PQRS reporting, which will allow large groups enough time to implement the PQRS reporting required to satisfy the quality requirements of the VBP modifier program. Notably, we appreciate CMS' decision to allow groups to elect the PQRS administrative claims reporting option for 2013 in order to avoid penalties from both PQRS and the VBP modifier in CY 2015. *We believe this option is essential to the successful transition of large practices into the VBP modifier program and urge CMS to consider the retention of this option for all EPs during the first year the VBP modifier program is rolled out to them. For instance, if CMS elects to lower the threshold of EPs impacted by the VBP modifier program in CY 2014, from 100+ EPs to smaller groups of EPs, we suggest that CMS allow the administrative claims option to those new groups impacted by the VBP modifier program for that year. Similarly, in 2015 when all EPs will be impacted by the VBP modifier, we urge CMS to offer the administrative claims option to new EPs who are incorporated in the program for that year. We believe this allows a transition year for all providers who are new to the VBP modifier program and will minimize the penalties to providers who have not had sufficient time to implement quality reporting in their practices and are still working to get up to speed with these requirements.*

A. Physician Feedback Program

Regarding the rollout and distribution of physician feedback reports to physicians, we have continued concerns that these reports are not accompanied by sufficient education from CMS. *As such, we urge CMS to continue education efforts such as MLN Matters articles and national provider calls to inform physicians about the VBP modifier program and the role the physician feedback reports are intended to play as part of that program. This includes outlining what the reports will be utilized for in the future as the VBP program is rolled out to all EPs by CY 2015.*

B. Quality Tiering and Payment Incentives

Under the current program, as outlined by CMS in the final rule, groups of physicians who provide care in the high quality/low cost, average quality/low cost, or high quality/average cost tiers will be eligible for an additional +1.0x if the groups' attributed to the patient population has an average risk score in the top 25 percent of all risk scores. We strongly urge CMS to allow all groups of physicians who elect quality tiering to be eligible for the additional +1.0x across all quality/cost categories if the groups' attributed patient population has an average beneficiary risk score in the top 25 percent of all risk scores. *We believe that no physician group that takes on the risk of furnishing care to high risk Medicare beneficiaries should be penalized compared to other groups. In*

addition, uncertainty as to whether a group will receive the payment for taking on high risk patients could dissuade groups from electing quality tiering.

We are also concerned with CMS' decision to make the downward adjustment for groups of physicians who have not met the PQRS satisfactory reporting criteria (-1.0 percent) equivalent to the maximum downward adjustment for those groups who have met the PQRS satisfactory reporting criteria, but elected quality tiering and were high cost/low quality (also -1.0 percent*). Instead, we urge CMS to allow groups who have met the PQRS satisfactory reporting criteria, but elected quality tiering and were high cost/low quality to be penalized less than those who were not successful PQRS reporters at all. Specifically, we urge CMS to reduce the maximum downward adjustment for those groups who have met the PQRS satisfactory reporting criteria, but elected quality tiering and were high cost/low quality to -0.5 percent. This would also create an incentive for groups to meet the PQRS criteria and elect the quality tiering option.*

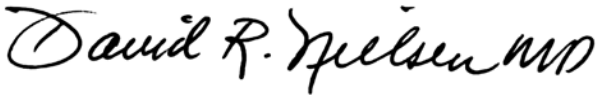
C. Quality Measures

The Academy thanks CMS for attempting to ease provider confusion by coordinating the various quality reporting program measures. While we appreciate the attempt to align the quality programs by using the PQRS measures as the means for measuring a provider's quality of care under the physician feedback and value based payment modifier programs, *we remain concerned regarding the limited number of measures relevant for our specialty to report on in both programs. Therefore, we encourage CMS to continue adding measures to the PQRS system which allow meaningful reporting options for all specialties and providers (see PQRS comments above for more detail). To this end, we would like to request an opportunity to meet with CMS in person to discuss the key issues confronting our specialty and to work with them to develop meaningful measures for otolaryngology-head and neck surgery and align these measures with the appropriate review/approval timeframes to make them available for use in quality reporting as soon as possible.*

Conclusion

The American Academy of Otolaryngology—Head and Neck Surgery appreciates the opportunity to provide comment and recommendations regarding these important policies on behalf of our members. If you have any questions or require further information, please contact Jenna Kappel, MPH, MA, Director of Health Policy at jkappel@entnet.org or 703-535-3724. Thank you.

Sincerely,



David R. Nielsen, MD, FACS
Executive Vice President and CEO

[i] GAO-12-778R Electronic Health Records**,** July 26th, 2012, http://www.gao.gov/assets/600/593078.pdf
[ii] 2010 PQRS and eRx Incentive Program Reporting Experience Appendix, February 22nd, 2012