January 14, 2013

Farzad Mostashari

Chair, Health IT Policy Committee  
National Coordinator for Health Information Technology

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Washington, DC 20201

Dear Mr. Mostashari,

On behalf of the American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS), I am pleased to submit the following comments on the Health Information Technology (HIT) Policy Committee’s vision of Stage 3 of the Electronic Health Record (EHR) Incentive Program. Our comments focus on the objectives proposed for the Core and Menu Measures and the proposed options for reporting Clinical Quality Measures (CQMs). The AAO-HNS represents over 12,000 physicians in the United States who diagnose and treat disorders of the ears, nose, throat, and related structures of the head and neck. The medical ailments treated by this specialty are the most common that afflict all Americans, old and young, including hearing loss, balance disorders, chronic ear infection, rhinological disorders, snoring and sleep disorders, swallowing disorders, facial and cranial nerve disorders, and head and neck cancer.

**Stage 3 High Thresholds and Penalties**

The AAO-HNS is supportive of the stated goals of the Health Information Technology (HIT) Policy Committee’s vision of Stage 3 which includes a “collaborative model of care with shared responsibility and accountability, building upon previous Meaningful Use (MU) objectives.” However, as the Academy has stated in comments to CMS on previous stages of Meaningful Use, the Academy has concerns that specialists such as otolaryngologists- head and neck surgeons will continue to have difficulty meeting the increased thresholds in Stage 3. Accompanying these higher objective thresholds are increased penalties, which will only increase pressure on small specialty practices such as ours that have had problems successfully meeting Meaningful Use. Stage 3 is scheduled to begin in 2016 and we believe that when coupled with decreasing reimbursement and other potential penalties, these increased thresholds could continue to hinder HIT adoption and patient access to quality care.

In the Stage 2 final rule, CMS indicated that unless 75 percent of all eligible physicians successfully participate in the EHR incentive program by 2016, penalties will increase from 3 to 4 percent in 2018 and from 4 to 5 percent from 2019 on. ***Therefore, due to the high thresholds set by CMS and increased penalties from 2016 on, we believe that Stage 3 of the EHR Incentive Program should be delayed until it is clear physicians, including specialists like otolaryngologists- head and neck surgeons, are able to meet the proposed thresholds to meet CMS’ stated goals of participation.***

**Specialty Participation in Meaningful Use**

In 2011, only 14 percent of all eligible otolaryngologist- head and neck surgeons were awarded EHR incentive payments. Much of this can be attributed to difficulty meeting thresholds because many objectives are not designed for specialists. Many of the objectives in Stage 3 present higher thresholds than Stage 1 and 2 in order to successfully achieving Meaningful Use, which will make it more difficult for otolaryngologist- head and neck surgeons to achieve. The Policy Committee proposes increases in thresholds for 12 core and menu objectives, many of which our physicians have had trouble reaching in Stage 1. Further increases in many of these thresholds will make successful reporting harder for specialty physicians like otolaryngologist- head and neck surgeons. Additionally, the committee proposes retiring objectives that have “topped out” and cannot have higher reporting criteria and introduces new objectives and measures. This presents additional obstacles for physicians as they must learn how to properly report these new objectives and modify their practice accordingly to ensure they are meeting the reporting criteria for Stage 3.

In the request for comment, the committee asks stakeholders to address a question stating, “Is there flexibility in achieving a close percentage of the objectives, but not quite achieving all of them.” ***In response to this question, as thresholds continue to increase through subsequent stages of meaningful use, flexibility on successful reporting criteria from CMS would increase the probability that specialists, such as otolaryngologist- head and neck surgeons, could successfully report objectives and attest to meaningful use.*** One way CMS could achieve increased flexibility in the Meaningful Use program is through the creation of alternative reporting options to avoid payment adjustments, mirroring the intent of alternative reporting options used in the Physician Quality Reporting System (PQRS) 2015 and 2016 penalty adjustment periods. Specifically, the creation of the Administrative Claims-based reporting option, or the ability to report on applicable measures or measures groups, allows greater participation in the PQRS program. Additional flexibility and reporting criteria in the Meaningful Use program would allow more physicians to meaningfully participate in the program and CMS to continue to achieve the stated goals of the program without penalizing providers based on high reporting thresholds and burdensome reporting requirements.

**Increased Costs Associated with Stage 3**

In 2016, physicians participating in Stage 3 will not be eligible for incentive payments, leaving them financially responsible for the upkeep, maintenance, and necessary training for the proper operation of the EHR system. This does little to help physicians cope with the total cost of the EHR system and IT systems management. Additionally, as new requirements are implemented for both certification and objective requirements in Stage 3, physicians must purchase updates to their system or upgrade their system to meet the new Stage 3 requirements and they and their staff must receive training to properly operate their system. In addition to the costs of the system a physician’s practice must cover, expenses associated with core, menu, and clinical quality objectives must also be considered by the HIT policy committee in Stage 3. For example, proposed objective SGRP 206 states EPs must provide at least 80% of patient specific materials in at least one of the top five non-English languages spoken nationally, based upon the local population demographics. These materials must be purchased or developed by the physician’s office at their own expense. These materials must be printed in multiple languages due to the top fivenon-English language requirements, which will lead to increased prices of educational materials and subsequently an increased cost and burden to physicians participating in the Meaningful Use program.

**CQMs Limit Specialty Reporting Options**

QMWG04 discusses the inclusion of a core set of clinical quality measures (CQM) for high priority health conditions; with controlling hypertension as the cited example. To improve the applicability of CQMs to otolaryngology- head and neck surgerons and specialists in general, we would request not limiting reporting, and hence participation, to core CQM sets related to high priority health conditions. It is unlikely that any core set will be applicable to all medical specialties and additional program flexibility will allow our members to participate in the MU program. Further, we would emphasize the need to allow physicians to choose all the CQMs required for reporting purposes, allowing them to identify CQMs most applicable to their practice.

**Align CQMs with Other Quality Initiatives**

QMWG01 discusses the expansion of the eCQM measure set and asks how this can be done in ways to minimize costs and reduce the burden on health care providers. We would recommend that this be achieved by continuing to align CQM reporting across quality initiatives, such as MU and PQRS. This alignment will greatly reduce the burden on providers to collect and report CQM data. Further, we would also suggest that measures be retooled, wherever possible, for electronic reporting.

The American Academy of Otolaryngology—Head and Neck Surgery appreciates the opportunity to provide these comments and recommendations on behalf of our members. If you require further information, please contact Joe Cody, MA at (703) 535-3729 or [jcody@entnet.org](mailto:jcody@entnet.org). Thank you.

Sincerely,

David R. Nielsen, MD, FACS

Executive Vice President and CEO

CC: Paul Tang, Vice Chair, HIT Policy Committee

Robert Anthony, Centers for Medicare and Medicaid Servicers, Office of E-Health Standards and Services