March 10, 2010

Charlene M. Frizzera

Acting Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS–1413–P

Room 445–G, Hubert H. Humphrey Building

200 Independence Avenue, SW

Washington, DC 20201

**Re: Medicare and Medicaid Programs; Electronic Health Record Incentive Program; RIN 0938-AP78**

Dear Ms. Frizzera:

On behalf of the American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS), I am pleased to submit the following comments on the “Medicare and Medicaid Programs; Electronic Health Record Incentive Program” published in the Federal Register as a proposed notice on December 30, 2009. Our comments will begin with general observations, and then we will address specific meaningful use criteria, followed by remarks on the clinical quality measures.

We applaud CMS’s efforts in crafting this proposed rule for meaningful use. We are highly supportive of the adoption of EHRs and are aware of the benefits of implementing these systems to the delivery of high quality healthcare. **However, we agree with the American Medical Association’s (AMA) assertion that the stage 1 meaningful use criteria are too aggressive and may dissuade physicians, especially those in small practices, from adopting EHRs.** We suggest that similar to the Medicaid EHR incentive program, the Medicare EHR incentive program should allow incentive payments to Eligible Professionals (EPs) during the first year for adopting, installing, or implementing a certified EHR. After the first year after EPs have trained their staff and become more accustomed to utilizing their EHRs, CMS should then require compliance to certain aspects of the stage 1 criteria. We believe that in order to achieve widespread adoption of EHRs, physicians must be comfortable with the interface; therefore, systems should aid their clinical workflow rather than impede it, and the adoption of EHR systems should be a gradual process.

Because most of our members fall under the category of owning small practices (an average of 3 physicians or less per practice), we strongly agree with the AMA’s recommendation that such specialists be represented on the HIT Policy and Standards committees to provide realistic and accurate feedback about their implementation of EHRs and their abilities to use these systems meaningfully. The realistic feedback that such physicians provide would be very relevant and helpful to CMS as it proposes later stages of meaningful use in subsequent rule making.

In addition, we propose that CMS adopt a system to hold EHR vendors accountable if clinicians use certified EHRs appropriately and still are unable to meet the meaningful use criteria due to limitations of the EHR or vendor. This can be done by stripping the vendors of their certification status and/or incentivizing the EHR vendors based on the number of practices or EPs that purchase their certified EHRs. By doing so, CMS will encourage them to create systems that are user-friendly, inexpensive, and useful to providers in order to encourage more widespread adoption.

**Meaningful Use Criteria and Measures**

*Criterion: Generate and transmit permissible prescriptions electronically.*

*Measure: At least 75 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.*

*Recommendation:* We support the use of e-prescribing, but we do not support the 75 percent threshold. We are skeptical that many physicians will be able to meet this level of e-prescribing. Because surgeons typically prescribe medication in diverse settings (emergency room, surgical centers, hospital inpatient and outpatient, etc.), and because a universally coordinated computer network does not currently exist, this will pose a greater challenge for EPs in certain settings. Also, e-prescribing has limited use due to an inability to dispense controlled substances. In addition, many patients prefer hand-written prescriptions so they can do comparison shopping, and therefore this might prevent EPs from reaching the 75% goal. **We recommend that CMS reduce this threshold to 25% and defer it until stage III to allow for advancements in technology that are required to reach this level of compliance.**

*Criterion: Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT®.*

*Recommendation:* We are concerned that limiting the diagnoses to ICD-9-CM and SNOMED might inadvertently stifle innovation and exclude other useful tools from being adopted in the future. **We recommend that CMS include other alternatives such as MEDCIN® to encourage future improvements in documentation and decision support.**

*Criterion: Record and chart changes in the following vital signs: height, weight and blood pressure and calculate and display body mass index (BMI) for ages 2 and over; plot and display growth charts for children 2-20 years, including BMI.*

*Measure: For at least 80 percent of all unique patients age 2 and over seen by the EP, record blood pressure and BMI; additionally, plot growth chart for children age 2 to 20.*

*Recommendation:* We believe that recording all vital signs might be appropriate for primary care physicians but may not be applicable to specialists like otolaryngologist – head and neck surgeons. For example, it would not necessarily be relevant for our members to report growth charts, BMI, etc. when unrelated to the presenting problem, especially as these are functions that are primarily performed by primary care physicians. Therefore, to allow specialists to maintain appropriate work flows and our unique requirements for functionality, we recommend that CMS modify this criterion to state, “*Record and chart changes in the appropriate vital signs* ***(based on EP’s specialty).***

*Criterion: Provide clinical summaries for patients of each office visit (not meant to apply to telephone or web visits).*

*Measure: Clinical summaries provided to patients for at least 80 percent of all office visits. The clinical summary can be provided through a personal health record, patient portal on the web site, secure email, electronic media such as CD or USB fob, or printed copy.*

*Recommendation:* Although we applaud the effort to inform and empower patients by providing clinical summaries for patients, the degree to which patients might desire summaries of their clinical visits is unknown. Hence, this requirement has the potential to become an administrative burden to physicians and increases the risk of patient confidentiality breaches or even opposition from patients. Furthermore, this objective is redundant since the Health Information Portability and Accountability Act (HIPAA) has already noted that every patient has the right to request medical records. Our recommendation is that CMS revise the criterion to state, “*Provide clinical summaries for patients* ***(only upon request)*** *of each office visit*.”

*Criterion: Implement five clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules. CMS proposes to describe clinical decision support as HIT functionality that provides persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care.*

*Measure: Implement five clinical decision support rules relevant to the clinical quality metrics the EP is responsible for.*

*Recommendation:* We strongly oppose this measure because implementing decision support (DS) for five criteria in any specialty requires the development of EHR hardware and software and should be a criterion for vendors of EHRs. Once a platform adequate for a specialty exits, it is still a formidable task and cumbersome to document even with the best systems. We believe that good DS measures for all specialties are not currently available, and the technology does not currently exist to efficiently record and report DS and other quality measures. **We recommend that these measures be excluded from the meaningful use criteria until a more appropriate time.**

**Clinical Quality Measures**

First, we support data registries as a potential alternative within which to report the required clinical quality measures. In addition, we support the exemption of otolaryngologist – head and neck surgeons from reporting specialty clinical measures that were identified in the proposed rule because no specialty group is applicable. We observed that out of the ninety proposed Clinical Quality measures included in Table 3 of the proposed regulation, ten, at most, of these measures could be applicable for *some* otolaryngology reporting. In addition, the proceduralist measures outlined in Table 9 are not applicable to many otolaryngologists. Therefore, we recommend that CMS exclude otolaryngologist – head and neck surgeons from reporting these quality measures until more substantial and relevant measures specific to our specialty are developed. By doing so, these specialists would not be penalized for not being able to report on measures that are unrelated to our specialty. Finally, we recommend that CMS include the quality measures included below for Acute Otitis Externa and Otitis Media with Effusion and provide language within the rule which outlines the process for approving the addition of new measures as they become available.

Acute Otitis Externa (AOE)

91.  Topical Therapy

92.  Pain Assessment

93.  Systemic antimicrobial therapy – avoidance of inappropriate use

Otitis Media with Effusion (OME)

94.  Diagnostic evaluation – assessment of tympanic membrane mobility (OME)

**Conclusion**

The American Academy of Otolaryngology—Head and Neck Surgery appreciates the opportunity to provide these comments and recommendations of behalf of our members. If you require further information, please contact Udo Kaja, Program Manager, Health Policy by telephone at (703) 535-3727 or through e-mail at Ukaja@entnet.org.

Sincerely,



David R. Nielsen, MD

Executive Vice President and CEO