AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

November 25, 2013

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SUBMITTED VIA ELECTRONIC MAIL AND REGULAR MAIL

Marilyn Tavenner, RN
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

Re: Proposed Clinical Quality Measures for Use in Stage 3 of the EHR Meaningful Use Incentive Program

Dear Administrator Tavenner:

On behalf of the American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS)[1], I am pleased to submit the following comments on the Centers for Medicare & Medicaid's (CMS) proposed clinical quality measures (CQMs) for use in Stage 3 of the EHR Meaningful Use (MU) Incentive Program. We appreciate the opportunity to provide comment on these important proposed measures, specifically, the proposed Stage 3 measure on *Overuse of Diagnostic Imaging for Uncomplicated Headache*. We are also providing comment on Stage 2 timing; and concerns related to Stage 3 thresholds and penalties for the agency's consideration as you work towards implementation of Stage 2 and ultimately, Stage 3.

I. Proposed Measure *Overuse of Diagnostic Imaging for Uncomplicated Headache*

The Academy's clinical quality experts, as well as the Chair of our Imaging Committee, have reviewed the proposed CQM related to the *Overuse of Diagnostic Imaging for Uncomplicated Headache.* They agree it is appropriate and reasonable as proposed by CMS. While the focus is on CT and MRI of the brain for headache alone, and does not reference any sinonasal related complaints or pathology or imaging, the Academy felt the measure was appropriately structured and support the measure as proposed. They particularly agreed with the premise that brain imaging for simple headache, without other worrisome clinical features, is unnecessary and should be avoided, which is reflected in the measure, and that in the event a worrisome clinical indicator (history or clinical finding) presents itself, neuroimaging would be justified. Overall, our reviewing experts felt the measure itself, as well as the evidence cited, are sound and appropriate.

[1] 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.

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II. Stage 2 Timing

Given the timing of this comment letter, we also wanted to take the opportunity to provide CMS with feedback regarding Stage 2 timing. While the Academy applauds the role the EHR Meaningful Use Incentive Program has played in advancing and promoting adoption of the health information technology (HIT) across the country, we remain extremely concerned about the timing requirements of Stage 2. Therefore, we respectfully request an extension of Stage 2 for providers who need extra time to meet the new requirements.

As you know, at the start of 2014 participating eligible hospitals and professionals must progress to the next stage in order to demonstrate growth in the use of EHR technology. All eligible hospitals and professionals will have to demonstrate achievement of Stage 2 MU objectives for any quarter-based 90-day period of either FY 2014 for hospitals or CY 2014 for physicians in order to avoid penalties in 2016. This requirement applies to those who began Stage 1 in 2012 or earlier, but also to providers that began Stage 1 in 2013, or will attest for the first time in 2014 and must use the 2014 Edition Certified EHRs to satisfy the revised set of Stage 1 objectives.

Many of our members are under significant time pressures to meet these 2014 requirements, resulting in progression to Stage 2 being potentially unfeasible. In one year, over 500,000 hospitals and physicians are required to upgrade their existing technology to demonstrate new standards of "meaningful use" by the end of 2014 in order to be eligible for the corresponding incentive payment. This significant pressure and lack of feasibility is especially prevalent for small and rural specialists who lack the resources of large practices, and who are likely not vendors' top priorities. These concerns reflect those expressed by 17 U.S. Senators in a letter to Secretary Sebelius and CMS regarding the timing and readiness of physicians for Stage 2.[2]

Therefore, a delay of Stage 2 for providers, who need extra time to meet the new requirements, would further the goals of the EHR program, whereas a failure to extend may have the unintended effect of stifling innovation and increasing medical error. Allowing for sufficient time to ensure a safe and orderly transition through Stage 2 is critical to the long-term success of EHR MU Incentive Program and is of great importance to our specialists.

III. Stage 3 Thresholds & Penalties

A. Stage 3 Thresholds

Similarly, the Academy is concerned that specialists, such as otolaryngologists – head and neck surgeons, will continue to have difficulty meeting the increased thresholds in Stage 3. As previously stated, while we are supportive of the stated goals of HIT, and the vision of Stage 3 which includes a "collaborative model of care with shared responsibility and accountability, we are concerned that Stage 3 includes higher objective thresholds with increased penalties, which will only increase pressure on small specialty practices that have encountered problems successfully meeting MU Stage 1 and/or 2 requirements. 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.

The Stage 2 final rule 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 onward. 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

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[2] To view the Hill letter dated September 24, 2013, please visit http://www.entnet.org/Practice/CMS-News.cfm.

otolaryngologists-head and neck surgeons, are able to meet the proposed thresholds to meet CMS' stated goals of participation.

Further, as thresholds continue to increase through subsequent stages of MU, 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 MU 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.

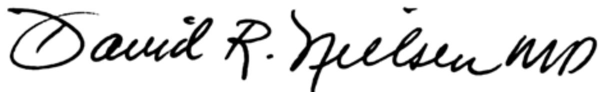
B. Increased Costs Associated with Stage 3

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 for Stage 3. Thus, we encourage CMS to carefully consider these potential roadblocks to successful implementation of the coming phases of the EHR MU Incentive program as you plan for the coming stages.

IV. Conclusion

The American Academy of Otolaryngology—Head and Neck Surgery appreciates the opportunity to provide these comments and recommendations on behalf of our members. Thank you in advance for your consideration of our recommendations and comments. If you require further information, please contact Jenna Kappel, MA, MPH, Director of Health Policy, at (703) 535 -3724. Thank you.

Sincerely,



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