

AMERICAN ASSOCIATION OF
NEUROLOGICAL SURGEONS

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July 21, 2014

Marilyn B. Tavenner
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Washington, DC 20201

Karen B. DeSalvo, MD, MPH
National Coordinator for HIT
Office of the National Coordinator for HIT
U.S. Department of HHS
Hubert H. Humphrey Building, 729D
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Re: Medicare and Medicaid Programs; Modifications to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs for 2014; and Health Information Technology: Revisions to the Certified EHR Technology Definition

Dear Administrator Tavenner and Dr. DeSalvo,

On behalf of 4,000 practicing neurosurgeons in the United States, the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS) appreciate the opportunity to comment on proposed modifications to the Electronic Health Records (EHR) Incentive Program.

Overall Concerns

The AANS and CNS support the goal of a national health information infrastructure and recognize the potential value of EHRs to improve the quality of patient care. Nevertheless, there are considerable barriers to widespread adoption of EHRs, including high cost, lack of functionality (especially for specialists, who require much more tailored EHR systems), lack of relevant measures in the incentive program, and interoperability challenges. Physicians, their practices, and their EHR needs are not homogenous. Many specialists have adopted EHRs into their practice, but still choose not to participate in the EHR Incentive Program due to a lack of relevant measures. Furthermore, many EHR products do not work in a way that meets their patient's needs and many meaningful use measures do not result in the collection of data that is important to those providing specialty care.

On the vendor side, vendors may be inclined to avoid the added expense of extensive customization, focusing on building models solely based on program requirements. This results in systems that only collect information on a limited set of measures that are not applicable to all specialties, which decreases the value of the products on the market for specialists.

In terms of interoperability, problems persist not just between physician practices and hospital systems, but also between EHR systems and clinical data registries. We believe that CMS and ONC can, and should, play a greater role in facilitating the use of clinical data registries by encouraging the development of standards for sharing/transmitting data between EHRs and registries. Presently,

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practices are forced to manually enter data into a registry because no streamlined process exists and because of the proprietary nature of EHR products. This is particularly challenging for solo and small practices, who do not necessarily have the resources to hire additional staff for data entry, thus preventing many from participating in registries.

Although not specifically addressed in this rule, the AANS and CNS support the expanded use of specialty registries as part of federal quality programs. Specialty registries may be useful in helping to streamline the exchange of health information for quality improvement and patient safety purposes, and measures from these registries are often more relevant, clinically appropriate, and actionable for specialists. Registries require a significant investment of resources and it often takes several years of data collection and analysis before improvement in practice can be documented. However, we believe that aligning registry participation with the EHR Incentive Program is one way to help facilitate strategic health information exchange and more focused quality improvement, while reducing the reporting burden on the physician community. Allowing specialists to participate through registries that are validated, relevant, and developed and run by specialists will increase, and result in more meaningful, participation in these programs.

Provisions Related to 2014 Edition CEHRT availability

Multiple EHR vendors have voiced concern that they are unable to certify their EHR products to the 2014 Edition of EHR certification due to the short time span between the Stage 2 final rule and the beginning of Stage 2. This has resulted in a backlog of eligible professionals (EPs) and hospitals that are interested in but unable to upgrade to the 2014 Edition CEHRT. As such, we appreciate that CMS and ONC are proposing in this rule to allow EPs, eligible hospitals (EHs), and critical access hospitals (CAHs) that could not fully implement the 2014 Edition CEHRT for the 2014 year due to delays in the availability of the upgraded software to continue to use the 2011 Edition CEHRT, or a combination of 2011 Edition and 2014 Edition CEHRT for the 2014 EHR reporting period.

More specifically, the three proposed options for the use of CEHRT editions are as follows:

1. Using the 2011 Edition CEHRT only. Under this option, EPs, EHs, and CAHs that use 2011 Edition CEHRT for the 2014 EHR reporting period would have to meet the 2013 Stage 1 meaningful use objectives and associated measures regardless of their current stage of meaningful use.
2. Using a combination of 2011 and 2014 Edition CEHRT. In this option, all EPs, EHs, and CAHs using a combination of 2011 Edition CEHRT and 2014 Edition CEHRT for their EHR reporting period in 2014 may choose to meet the 2013 Stage 1 objectives and measures or the 2014 Stage 1 objective and measures, or the 2014 Stage 2 objectives and measures.
3. Using the 2014 Edition CEHRT for 2014 Stage 1 Objectives and Measures in 2014 for providers beginning Stage 2. In this option, providers who were scheduled to begin Stage 2 in 2014 and were unable to begin due to delays in the implementation of the 2014 Edition CEHRT, would have the option to report on Stage 1 objectives and measures for 2014.

For any of these three options, the proposed rule notes that EPs who were unable to fully implement the 2014 CEHRT due to delays in its availability would need to attest to this when they submit their attestation for the meaningful use objectives and measures.

While we welcome these changes, we are concerned that these modified requirements may not be easily understood by practicing physicians and may result in further diversion of time away from direct patient care. In your continuing efforts to ease the regulatory burden on physicians, we urge CMS and ONC to provide clear and concise educational materials and other tools that can easily assist physicians with

understanding what stage of meaningful use they fall into each year and the specific requirements associated with that stage.

In regards to existing exemptions, the proposed rule does not appear to extend the current July 1 hardship exemption deadline. This presents a problem for physicians working on meeting meaningful use requirements after July 1. If it is determined that the requirements under meaningful use cannot be met, the physician will have missed the hardship exemption deadline and could be unfairly penalized in 2015. We urge you to extend or otherwise address this deadline during the current rulemaking process.

Extension of Stage 2

CMS and ONC are proposing a one-year extension of Stage 2 so that Stage 3 will begin in 2017 for EPs. While the AANS and CNS welcome this delay, we strongly recommend that CMS and ONC carefully analyze participation data from both Stages 1 and 2 of the program before finalizing requirements in Stage 3. We have expressed concern in previous comments regarding measures with onerous or irrelevant requirements. For example, one Stage 2 core measure requires using clinically relevant information to identify and send patient reminders for preventive/follow-up care, which may not be appropriate for all specialists. While it makes sense for a primary care physician to send reminders to his or her patients with one or more chronic conditions, surgeons often treat a patient for an acute, time-limited condition and should not be penalized for failing to comply with this measure. Another Stage 2 measure requires that clinical summaries are provided to patients within one business day for more than 50 percent of office visits. We continue to believe that the threshold for this measure is too high and that the one business day requirement is burdensome for physicians.

In talking with neurosurgical practices that have participated in the program, even those who have been successful with Stage 1 still do not feel like compliance has done much to help their patients. Others, who are in the process of upgrading for Stage 2, are finding that even their certified EHRs are missing many critical features necessary for reporting and supporting work flow processes associated with the meaningful use program, and ultimately chose to apply for a hardship exemption. Furthermore, our members tell us that there are still very few clinical quality measures (CQMs) that apply to neurosurgery or any other subspecialty for that matter. For the past five years, these practices feel as if they are putting more time and resources into complying with federal regulations rather than practices that would truly promote efficiency and quality of care for neurosurgical patients.

A delay of Stage 3 addresses only part of the problem by ignoring many of the issues still associated with Stage 2 (and Stage 1) in regards to the relevancy of measures to specialists. Furthermore, the AANS and CAN continue to have serious concerns about the rapid pace at which CMS and ONC have been proposing criteria for future stages of meaningful use without first considering provider performance in earlier stages. We understand that extending the timeline for Stage 2 through 2016 will allow the agencies to consider and analyze data from Stage 2 in development of criteria for Stage 3. However, to date there has been a paucity of evidence regarding the feasibility of Stage 1 criteria and the effect of these criteria on physician practices-- specialties, in particular-- and overall patient care and safety. We urge CMS and ONC to collect and carefully analyze data on how physicians are performing and to what extent the measures are feasible and relevant to their practice before making recommendations for new criteria or increasing reporting thresholds in Stage 3.

Clinical Quality Measure (CQM) Submission in 2014

The proposed rule states that due to limitations in the EHR Registration and Attestation System, clinical quality measure (CQM) submission will be dependent on the edition of the CEHRT a physician chooses to use for the 2014 EHR reporting period:

- An EP who elects the 2011 Edition CEHRT would be required to report on the set of 44 measures finalized in the Stage 1 final rule. EPs reporting for the first time would have to report for 90 consecutive days and report on **three core or alternate core measures** and **three additional CQMs**.
- An EP who reports using a combination of 2011 and 2014 Edition CEHRT and attests to the 2014 Stage 1 objectives and measures or the Stage 2 objectives and measures would have to report CQMs using the criteria finalized in the Stage 2 final rule- **nine CQMs covering at least three National Quality Strategy (NQS) domains**.
- Those EPs who are able to use the 2014 Edition CEHRT would also be required to report on **nine CQMs regardless of which stage they are in**.

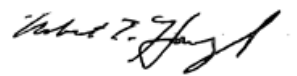
As noted earlier, these varying reporting requirements will likely result in confusion and frustration among physicians who are simultaneously required to meet increasing complex requirements for other quality reporting mandates, such as the Physician Quality Reporting System (PQRS). We request that CMS and ONC streamline requirements or, at the very least, provide the public with tools to help them better understand these multiple requirements. We also remind CMS and ONC that the CQM component of the program has been particularly challenging for surgeons. There are not enough relevant and meaningful measures for surgeons to report. CMS should work with specialty societies to develop more specialty-specific clinical quality measures for the EHR Incentive Program.

Concluding Remarks

Overall, CMS and ONC must make interoperability a top priority, as sharing health information across EHRs and with registries is key to reducing costs, improving efficiency and quality, and increasing patient safety. CMS also must make the EHR Incentive Program more flexible for specialists such as surgeons who may not be able to satisfy all of the current objectives and measures of the program. This is especially critical given the all-or-nothing nature of the program (i.e., failure to satisfy even one objective or measure will result in an automatic penalty). CMS should give providers more flexibility to choose reporting options that are most relevant to their practice by emphasizing menu options over core requirements. Finally, CMS and ONC must streamline reporting requirements both within the EHR Incentive Program and among other federal quality reporting programs, and provide physicians with the tools needed to more easily navigate this increasingly complex maze of reporting requirements.

The AANS and CNS appreciate the opportunity to comment on this proposed regulation and look forward to working with both CMS and ONC to make improvements to the EHR Incentive Program and to work toward the overall goal of a nationwide interoperable HIT infrastructure that improves patient quality. In the meantime, if you have any questions or need further information, please feel free to contact us.

Sincerely,



Robert E. Harbaugh, MD, President
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