



March 1, 2016

Eric Gilbertson
CMS MACRA Team
Health Services Advisory Group, Inc.
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Dear Mr. Gilbertson:

I am pleased to submit comments on the CMS Measure Development Plan for the implementation of the Medicare Access and Chip Reauthorization Act of 2015 (MACRA) on behalf of the American Board of Medical Specialties (ABMS) and its 24 Member Boards. ABMS Member Boards certify nearly 800,000 physicians to practice in 37 primary specialties and 123 subspecialties.

The primary purpose of ABMS certification is to assure the quality of physician care. ABMS Member Boards take a special interest in implementation of MACRA and opportunities to align our quality improvement mechanisms and support many aspects of the proposed plan:

- **Strategic alignment with the national quality strategy.** We applaud CMS's constancy and clarity of vision in pursuing the three aims and six priorities of the National Quality Strategy (NQS). By creating a common vocabulary and clear aims for all quality programs, CMS is helping to create a more impactful quality improvement enterprise.
- **Alignment across federal, state, and private sector.** We appreciate CMS's resolve to align measures across all federal programs and also with private sector and state measurement initiatives. Alignment will reduce the burden to physicians from competing data demands; send more consistent signals to physicians and consumers about what is important to measure and reward; and reduce confusion for physicians and consumers from conflicting statements of quality based on differently assembled and defined measures.
- **Building on existing measure sets.** We support building on quality measures approved for use in the soon-to-sunset Physician Quality Reporting System, Value-based Payment Modifier, and Medicare EHR Incentive Program (Meaningful Use). Physicians

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and their organizations have invested heavily in the development of these measures and the capability to report them, and it will take some time to develop better measures that are more likely to achieve the goals of MACRA. We have measures to use today, from which we should be learning what is most effective with respect to improving both physician practices and patient decision-making. Nevertheless, as the Plan notes, massive measure gaps exist – there are too few measures for thousands of physician specialists, and too few of the types of measures – patient-centered and outcome-oriented – that CMS would like to be using in the Merit-based Incentive Payment System (MIPS) and APM programs, and we support additional measure development as noted below.

- **Use of non-endorsed measures.** We support CMS's decision to leverage the authority in MACRA to include measures that are not yet consensus-endorsed. While we recognize the need for broad consensus on measures across multiple users and stakeholders, and support the work of the National Quality Forum, we believe it is more important today to encourage data development and the use of metrics in organized quality measurement and improvement systems that can generate data physicians trust and help acculturate physicians to measurement and improvement practices.
- **Development of specialty measures.** ABMS has previously commented on the need to develop measures for all the specialties so that all physicians can participate fully in improvement programs. The Measure Applications Partnership has highlighted the gaps in measures for many specialties. We appreciate CMS's commitment to working with specialty professional organizations to identify measures that are important to clinicians and relevant to patients. For many specialists, the measures available for reporting are not relevant to their practices and therefore not helpful to beneficiaries making decisions about where to get their care. We need, for each physician, a basket of measures that are descriptive of the services they render, discriminating about actual care they provide, and actionable by physicians to improve results for patients.
- **Leveraging QCDRs –** ABMS strongly supports the development of registries as an essential component of quality measurement and improvement systems. Clinical registries can become the foundation for physician quality improvement by capturing data that physicians trust with the clinical richness to measure important dimensions of care. At present, claims data have insufficient clinical depth, and while it would be desirable to use the data from electronic health records for performance improvement, it is too difficult to export those data into a usable form. We believe that registries are an essential building block to the QI movement and should be supported. We have some specific suggestions for enhancements to current registries that require support by HHS, described below.
- **Development of specialty-specific patient experience surveys.** CMS asks for comment on the need to develop specialty-specific patient experience of care surveys. We believe it is essential to capture clinically-relevant data from patients that can be used by clinicians to improve their communication and other patient care

skills. ABMS has supported use of the CAHPS family of surveys. However, we believe that we need additional instruments for individual physician assessment. Existing surveys under-emphasize crucial competencies that require more rigorous assessment (e.g., communication skills). We encourage CMS to develop surveys that capture more specifically the performance relevant to individual physicians in each type of physician practice. Feedback from patients must speak to physician behaviors and competencies that are relevant to every specialty in order to meaningfully improve patient experience. In addition, we encourage CMS to simplify survey administration, increase response rates, and capture more robust feedback from patients. Massachusetts Health Quality Partners has developed a Roadmap for Advancing Ambulatory Patient Measurement and Reporting, which emerged from a meeting of many stakeholders convened in November 2014, outlining a number of specific recommendations to increase the relevance and reliability of patient experience surveys.¹

While ABMS supports the general direction and approach outlined in the Measure Development Plan, we offer the following recommendations to make the data and measurement environment more effective.

1. ***Aim for improvement*** - CMS states that the purpose of the plan is “to meet the requirements of the statute and serve as a strategic framework for ... future development ... of MIPS and APMs.” We respectfully suggest that this purpose statement focuses on the means and not the ends of both MACRA and the CMS Quality Strategy. It should provide a measurement framework that fairly assesses the performance of participating physicians and provides feedback to clinician and patients that will improve the quality of care. This framing has important implications for the way in which CMS contextualizes measures for use in quality programs both by patients and by physicians. If measures are to improve beneficiary choice, they should fairly represent the care physicians provide to Medicare beneficiaries. At the same time, in order for measures to be actionable, physicians need to see them as an honest reflection of the services they provide and within their power to change. We recommend that measures be evaluated by CMS in the context in which they are used.
2. ***Develop physician profiles to help contextualize measures*** – To help beneficiaries understand the relevance and completeness of reported measures, we recommend that CMS develop for each physician a profile that describes the clinical scope of their practices based on the claims submitted to Medicare. A profile of this sort would help beneficiaries to understand the context of the performance measures against which each physician is being judged, and would help CMS determine whether the measure sets are adequate to describe physician performance in a meaningful way.

¹ Advancing Ambulatory Patient Experience Measurement and Reporting Roadmap. Massachusetts Health Quality Partners, January 2016.

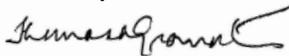
3. **Develop measures addressing all the core clinical competencies** - Priority must be given to developing measurement methods to assess difficult-to-measure competencies like communication and care coordination that are important to patients and to the professional practice of medicine. We suggest prioritizing measure development of competencies most likely to eliminate preventable errors and complications from care, patient-physician communication, and team communication. We urge CMS to work with the medical community to align the NQS priorities with clinical performance competencies that form the basis of advanced clinical training and which define the contours of good medical practice.²
4. **Support alternative approaches to measurement** – A number of experts in quality measurement and improvement have questioned the current approach to measurement at the individual physician level and called for new approaches to measurement.³ We encourage CMS to support new approaches that may yield the more parsimonious, patient centered, outcome-oriented measures that CMS is looking for but which are rare in today’s measure sets. The American College of Surgeons is developing a patient-centered measurement framework that could capture relevant measures throughout a patient’s episode of care and could potentially apply to all surgical disciplines. The International Consortium for Health Care Outcome Measurement is developing patient-oriented outcomes in a wide array of disciplines that could drive the system- and population-level change envisioned by the NQS . We should not approach measure development solely in terms of “filling gaps” with more of the kinds of measures we use today. We should be looking for new approaches that will be more representative of what physicians do and more implicitly meaningful to patients.
5. **Make Medicare claims data available to registries** – Medicare has been making claims data available for certain kinds of entities for reporting and analysis purposes. MACRA broadens CMS’s authority to release its data to further quality assessment and improvement. CMS should make its data available to QCDRs to supplement the clinically rich but somewhat isolated data in clinical registries. The longitudinal data available through claims will significantly enhance the analytic capabilities of the registries.
6. **Work with EHR vendors to liberate data from EHRs** – One of the biggest obstacles to the creation of clinical registries is the cost and difficulty of gathering the data. It would be desirable to be able to extract data from electronic records to reduce the cost and burden of data capture, but the EHR vendors have no incentive to facilitate data extraction for performance analysis. Where it has been possible to populate a registry from electronically captured data, participation rates have soared, as the

² Guide to Good Medical Practice USA. V. 1.1, March 9, 2009. Accessed at <https://gmpusa.org/> 02.29.2016.

³ See, for example, R. A. Berenson, P. J. Pronovost, and H. M. Krumholz, “Achieving the Potential of Health Care Performance Measures, published by The Urban Institute in May 2013, and E. A. McGlynn, M. C. Schneider, and E. A. Kerr, Reimagining Performance Measurement. *New England Journal of Medicine*, 371 (23)2150-53; December 2014.

- American Academy of Ophthalmology and the American College of Cardiology can attest. HHS should leverage its authority through the Office of the National Coordinator to encourage EHR vendors to simplify data extraction.
7. ***Develop a mechanism for collecting long-term functional outcomes from patients*** – The analysis of some conditions and treatments requires long-term functional outcomes, but because of the fragmentation of our health system, patients are often lost to follow-up, and with them, an understanding of the long-term impact of medical care. We recommend that CMS work with one or more patient-focused health data portals, such as PatientsLikeMe, to create a beneficiary portal for the collection of patient data. Some patient reported outcomes will be collected through provider registries, as is currently being done in rheumatology and neurological surgery. But it remains difficult to track patients for long-term follow-up. Medicare has a relationship with patients from the time they turn 65 until the end of their lives. A patient data portal, developed for patients voluntarily submitting their data, could help them to manage their conditions and, with their permission, help their clinicians understand the true results of care.
8. ***Qualify MOC activities as Clinical Practice Improvement Activities (CPIA) under MACRA*** - CMS mentions the CPIA requirements but declines to comment on what sorts of activities will be credited under MIPS. As we recommended at length in our comments to the Request for Information on the implementation of MACRA last autumn, we recommend that activities sanctioned by the ABMS Member Boards through their programs of Maintenance of Certification be considered acceptable improvement activities. It is a priority of the ABMS Member Boards to align certification and federal quality reporting requirements, and they will have mechanisms for approving activities that develop physician capabilities in practice-based learning and improvement, improve patient care and procedural skills, and engage physicians in systems-based practice improvement.

Sincerely,



Tom Granatir
Senior Vice President, Policy and External Relations