



**American Board
of Medical Specialties**

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Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

REF: CMS-5517-P

Merit-Based Incentive Payment System and Alternative Payment Model Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Dear Administrator Slavitt:

The American Board of Medical Specialties (ABMS) is pleased to submit comments on the Notice of Proposed Rule Making implementing the Quality Payment Program (QPP) for physicians.

ABMS represents 24 Member Boards which certify over 840,000 physicians in one or more of 37 primary specialties and 85 subspecialties. ABMS Board Certification signifies that a physician has completed formal training and demonstrated the knowledge, skill and professionalism to practice in a specialty. ABMS Member Board Programs for Maintenance of Certification (MOC) combine learning, assessment, and improvement to help physicians demonstrate to their patients that they are keeping up in their disciplines and are actively engaged in improving care.

The ABMS Member Boards have a strong interest in aligning federal quality reporting requirements and the Boards' MOC programs so that physician efforts to improve clinical skills and engage in medical practice improvement can be leveraged to satisfy federal quality requirements.

CMS must implement a law that applies to physicians practicing in a wide variety of specialties and subspecialties. ABMS is pleased to see a greater recognition of the variable state of measurement across the many specialties and an acknowledgement that physicians in non-patient-facing practices may need special consideration. ABMS continues to be concerned, however, that reporting requirements may not always reflect the real differences in specialized medical practice. The general perspective on clinical practice outlined in the proposed rule still seems more focused on a model of primary care practice, despite the fact that more than sixty percent of physicians practice in a non-primary care specialty or subspecialty. In order to provide appropriate incentives for performance improvement, the basket of measures available to each clinician must be generally descriptive of that physician's practice. This is particularly true of the reputational incentives created by postings on Physician Compare.

Having said that, ABMS supports several provisions in the proposed rule:

- **Consistent support for the National Quality Strategy** – CMS has been steadfast in its support of the National Quality Strategy (NQS) and continued alignment of federal

programs around the NQS strategic priorities. This has helped to reduce competing demands for physicians' time and attention and could help to reduce administrative burden and increase the yield of quality improvement programs.

- **Reduction in physician reporting burden** – Sec. 414.1335 of the proposed rule would reduce from nine to six the number of measures required to be reported, and would no longer require that physicians report in each of the three NQS priority areas. Sec. 414.1335(a)(1) specifies that physicians would report a single outcome measure and a cross cutting measure, or a high-priority measure if an outcome measure is not available in the specialty. ABMS supports these changes, which will help to assure that more physicians can meet reporting expectations. Reducing the number of reportable measures will be helpful, because many physician specialists still lack measures relevant to their practices. Moreover, because many of the Clinical Practice Improvement Activity (CPIA) options address population health, communication, patient engagement, and care coordination, these NQS priorities will be addressed through other means.
- **Promotion of Qualified Clinical Data Registries (QCDR)** – ABMS supports the continued emphasis on QCDRs as a reporting option and appreciates the many ways that the rule reinforces and encourages the use of QCDRs for quality measurement and reporting, and also for supplying CPIA options. These provisions will promote participation in QCDRs by physicians and encourage the QCDRs to increase their functionality.
- **Single-source reporting** – ABMS supports provisions that would allow physicians to use a single source – a QCDR, for example – to report on all performance areas, including quality, CPIA, and Advancing Care Information. This will reduce the administrative burden to clinicians and might encourage greater participation in a QCDR.
- **Maintenance of multiple data reporting options** – ABMS also supports the continued maintenance of multiple reporting options including claims, EHRs, and web-based reporting. Although ABMS believes participation in a registry will be more conducive to quality improvement and will generate more meaningful data and benchmarks, registry reporting options are not available for many specialties. Maintaining alternative reporting options will give these specialties time to develop registry reporting options.
- **Broad choice of CPIAs** – ABMS has some concerns about the low level of support for important and impactful improvement activities (about which more below) but appreciates the broad set of choices available to clinicians to satisfy the CPIA performance area, especially options for leveraging the QCDR to satisfy multiple goals.
- **Special provisions for non-patient-facing physicians** - ABMS supports provisions exempting certain non-patient-facing specialties from reporting and the use of presumptive eligibility for diagnostic radiologists, anesthesiologists, pathologists, and nuclear medicine physicians. Physicians in other specialties also should be able to declare by exception that they deserve a similar exemption, which can be confirmed by CMS through coding analysis.

ABMS has specific recommendations for several provisions of the proposed rule:

1. ***Credit a physician's participation in a certifying Board's Maintenance of Certification (MOC) program as a high-value CPIA*** - MOC is an ongoing, multi-modal approach to improving the ability of physician specialists to optimize patient

outcomes and improve patient safety. ABMS MOC is a coherent program of self-assessment and self-directed learning, external assessment of knowledge, judgment, and skills, and improvement in medical practice. ABMS Member Boards develop MOC programs with each of these three elements in an effort to improve all six of the "core competencies" that constitute good medical practice.

The "improvement in medical practice" element of MOC recognizes both personal professional development activities and system improvement activities. Both should be recognized and rewarded under the QPP. Personal professional development activities would include improvement activities designed specifically to increase physician knowledge of improvement science as applied to their own practices (e.g., direct continuing education in improvement and safety science, or participation in an improvement collaborative like the primary care collaborative, Improving Performance in Practice) as well as activities to improve patient care and technical skills. This may involve structured peer review of a sample of medical records to ascertain the appropriateness of patient care decision-making and clinical protocols; "Practice Audits" to compare practice on a variety of metrics for a population of patients with specific conditions against clinical or peer benchmarks; high-fidelity simulation exercises to practice and develop patient care and procedural skills; or participation in clinical data registries.

ABMS Member Board Programs for MOC also encourage participation in organizational quality and safety improvement activities, which may include training for effective communication, evaluation and improvement of teamwork and care coordination, or participation in the implementation of safety systems (e.g., participation in root cause analysis, development and management of error reporting or other safety systems). All of these individual and system-level activities should receive credit as CPIAs.

To recognize participation in organizational improvement activities, ABMS Member Boards created the ABMS Multi-specialty Portfolio Approval Program (Portfolio Program). Member Boards assign MOC credit for meaningful participation in quality and safety activities undertaken by Portfolio Program sponsoring organizations, all of which meet high standards for the maturity of their quality improvement support systems. Improvement priorities are established by Portfolio Program sponsors; individual physicians attest to their intimate participation and personal reflection as part of the improvement activity. Sponsoring organizations include hospitals and health systems, group practices, medical societies, and community collaboratives. In addition, program sponsors now include other organizations that provide performance improvement opportunities such as state medical societies, community health improvement collaboratives, AHRQ's EvidenceNow collaborative, and the CMS Innovation Center's Practice Transformation Initiative.

ABMS makes the following recommendations for revisions to Table H, the inventory of Clinical Practice Improvement Activities acceptable to satisfy that component of a physician's quality score:

- Recognize participation in MOC as a high-value clinical practice improvement activity;
- Recognize other forms of assessment and feedback, including peer review and practice assessments through on-line Performance Improvement modules;
- Recognize high-fidelity simulations, which are effective mechanisms for assessment, learning, and improvement of technical and procedural skills;
- Recognize continuing professional development activities as "Clinical Practice Improvement Activities" as long as they are practice relevant; accredited by ACCME; involve assessment and improvement of patient outcomes or care quality, as demonstrated by clinical data or patient experience of care data, such as PI-CME or QI-CME;
- Recognize CME that involves instruction in quality and/or safety science to improve the ability of physicians to participate fully in quality and safety improvement activities; and,
- Recognize activities completed and authenticated under the auspices of the ABMS Multi-Specialty Portfolio Approval Program.

2. Include ABMS Member Boards as Reporting Agents for CPIAs – Section 414.1325 provides that CPIAs can be submitted via qualified registry, QCDRs, EHRs, or by personal attestation, but does not provide for other third-party submission. Although the ABMS Member Boards are referenced in the preamble as eligible reporting agents, presumably provided they meet the requirements for qualified registry or QCDR, the Member Boards are not referenced in Section 414.1400, which sets forth requirements for third party data submission. ABMS recommends that the Member Boards be eligible to serve as reporting agents for CPIAs on behalf of eligible individual physicians, without having to meet the requirements of a registry. Because the Member Boards are capturing, auditing, and vetting learning and improvement activities, they can make annual submissions on behalf of their diplomates without needing the full functionality of a data registry. ABMS recommends that the Member Boards be included as reporting agents for CPIAs under Sections 414.125 and 414.1400.

3. Reduce data completeness criteria – The rule would increase from 50% to 90% the number of patient records required for inclusion in a data registry in order to meet "data completeness" criteria. This is an unreasonable and unnecessary requirement that will vastly increase the data entry burden for those registries that require some manual data entry. A time may come when registries can be populated exclusively with data extracted from EHRs, but most registries in use today include data that are not captured routinely in EHRs. For these registries, sampling methods make it possible to achieve reliable results while making the data collection burden manageable. This requirement may dissuade some

clinicians from participating in registries. ABMS urges CMS to enable the registry to achieve a data reliability target without specifying the number or percentage of records that need to be abstracted.

- 4. Reduce requirements for EHR surveillance** - ABMS supports efforts to facilitate data mobility by preventing data “blocking” from EHR vendors, but is concerned about the level of participation required of physicians to police EHRs in Section 495.40. Imposing these surveillance requirements on physicians – rather than focusing on the functionality of the EHRs themselves - is inappropriate and unnecessary.

The following issues are not specifically addressed in the proposed rule, but ABMS believes that they should be addressed in future rule making:

- 1. Provide access to Medicare claims data** – MACRA provides that CMS can make Medicare data available for use in clinical data registries, yet the rule is silent about this. Incorporation of claims data would greatly increase the capability of the QCDR to provide longitudinal assessments of clinical performance and would capture some elements of performance from outside the clinical record that can improve performance analytics. ABMS urges CMS to provide Medicare data for integration with QCDRs.
- 2. Develop specialty-specific patient experience instruments** – ABMS supports the use of patient experience data to provide feedback to clinicians on important areas of clinical performance that patients are best able to report. Yet, as noted in ABMS’ response to the CMS Measure Development Plan, the general experience of survey instruments currently in use do not provide feedback useful to specialty physicians for quality improvement. Compelling physicians to use existing survey instruments will only undermine physician confidence in patient experience feedback. ABMS encourages CMS to fulfill the promise announced in the Measure Development Plan and work with the specialty physician community to develop specialty-specific patient experience surveys. In addition, new survey administration protocols should simplify administration and improve patient response rates and experience surveys should be bundled with condition-appropriate patient-reported outcome measures to capture more fully the patient’s experience of care.
- 3. Report MOC participation on Physician Compare** – CMS includes certification data on Physician Compare. ABMS supports the use of certification as a quality metric and urges CMS to incorporate data on participation in MOC as well. Participation in ABMS programs of continuing certification helps to assure consumers that specialists practice up-to-date, evidence-based medicine. Patients should be able to identify participating physicians through Physician Compare. These data are already available to CMS through its current data provider and should be noted in the certification data field.
- 4. Develop practice profiles to help contextualize information on Physician Compare** – To help beneficiaries understand the relevance and completeness of reported measures, ABMS recommends 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.

CMS has expressed a desire to work with the physician community to implement the QPP. ABMS is committed to working with CMS to align the QPP with the professional development and practice improvement requirements of the ABMS Member Board Certification programs, professionally-led programs of assessment, learning, and improvement that set standards for the practice of specialty medicine. The ABMS Member Boards are dedicated to improving the care patients receive and develop their programs to address core competencies that are important to patients and reflect both the art and the science of medicine.

ABMS appreciates this opportunity to express its views on the proposed rule. If you have any questions about any of the issues raised above, please contact me at tgranatir@abms.org or 312-436-2683.

Sincerely,

A handwritten signature in black ink, appearing to read "Tom Granatir", written over a light gray rectangular background.

Tom Granatir
Senior Vice-President, Policy and External Relations