



**American Board
of Medical Specialties**

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Marilyn Tavenner, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3276-NC
Mail Stop S3-02-01
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: Medicare Program; Request for Information on the Use of Clinical Quality Measures (CQMs) Reported Under the Physician Quality Reporting System (PQRS), the Electronic Health Record (EHR) Incentive Program, and Other Reporting Programs

Dear Administrator Tavenner:

On behalf of the American Board of Medical Specialties, I am grateful for the opportunity to submit comments on the above referenced Request for Information regarding the use of quality measures reported under the Physician Quality Reporting System and other reporting programs.

The ABMS Member Boards have been working with CMS to achieve better alignment of public and private sector quality measurement and improvement activities for several years. We think that ABMS Maintenance of Certification (ABMS MOC) has the potential to enable many more physicians to participate in federal reporting programs, but, more importantly, we believe that leveraging ABMS MOC will provide an improvement infrastructure otherwise lacking in reporting programs.

Our detailed comments to the questions raised in the RFI are attached. If you have any questions about them or wish to explore any of the issues in greater detail, please let us know.

Sincerely,

Lois Margaret Nora, MD, JD, MBA
President and Chief Executive Officer

Member Boards of the American Board of Medical Specialties

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American Board of Emergency Medicine | American Board of Family Medicine | American Board of Internal Medicine | American Board of Medical Genetics
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ABMS Response CMS Request for Information on the use of clinical quality measures to satisfy federal quality reporting requirements

ABMS welcomes this opportunity to respond to CMS's request for information (RFI) about the use of ABMS Maintenance of Certification (ABMS MOC®), registries, and other performance measurement and improvement activities to satisfy federal quality reporting requirements. We understand that the RFI is motivated by three goals:

- Increase participation in federal quality reporting programs and ease the reporting burden to participating physicians
- Better align quality programs both within the federal government (e.g., the Physician Quality Reporting system and Meaningful Use requirements) and between public and private quality measurement and reporting activities (including ABMS MOC® and specialty registries)
- Implement Sec. 601(b) of the American Taxpayer Relief Act of 2012, which provides that physicians can satisfy federal reporting requirements by satisfactorily reporting data to a qualified clinical data registry.

The ABMS Member boards are hopeful that CMS will use ABMS MOC® as a foundational element of its measurement and improvement strategy. The Boards are committed to raising standards and improving care, and will work toward better alignment with PQRS and other reporting requirements to the extent that the two programs serve the same ends.

Recognition of Maintenance of Certification as a Performance Measure

A first step toward alignment of PQRS with private sector quality measurement and improvement activity would be to recognize the portfolio of quality measurement and improvement activities that comprise ABMS Member Board "Maintenance of Certification" and the completion of a practice assessment, a component of ABMS MOC®, as reportable performance measures. We encourage CMS to take advantage of the authority granted in Sec. 1848(k)(4) of the Social Security Act, as amended by Section 3002(c)(3) of the Affordable Care Act, to incorporate "participation in a Maintenance of Certification Program and successful completion of a qualified Maintenance of Certification Program practice assessment" both to satisfy PQRS reporting and for use in computing the value-based payment modifier.

ABMS Maintenance of Certification is a system of specialty specific assessment and professional development activities that require medical specialists to reflect on their practice performance, identify gaps, and adopt new practices to improve care. The performance practice assessment itself involves measuring a dimension of practice over time in an improvement framework.

These activities lend themselves to three potential measures: 1) individuals perform all the professional development activities defined by the certifying boards to maintain certification; 2) individuals complete a practice performance assessment that includes a performance improvement project; and 3) the practice performance project shows either that performance is consistent with professional norms or that care practices have improved.

In contrast to PQRS, which addresses a single domain of physician performance, the ABMS MOC® addresses several different dimensions of physician performance. These are summarized in six competencies or domains that are becoming accepted by the profession as fundamental to good specialty practice:

- Professionalism
- Knowledge
- Patient care and procedural skill
- Interpersonal communication
- Lifelong learning
- System-based practice or “system thinking”

Adopted 14 years ago by the ABMS and the American Council on Graduate Medical Education, this competency framework is currently being integrated into the training and continuous professional development of physicians throughout their careers. The American Osteopathic Association has adopted a parallel set of competencies for Doctors of Osteopathy.

These competency domains encompass a wide range of performance issues that map to the priorities of the National Quality Strategy and Meaningful Use domains, including patient engagement, safety, care coordination and patient care management, clinical appropriateness and effectiveness, and efficient use of health care resources.

The ABMS Member Boards use a variety of assessment approaches and tools to address these competency domains, including peer review, cognitive tests, patient and peer surveys, and practice performance assessments. ABMS believes that all of these assessment methods enhance the performance of physicians as medical specialists. All the competency domains are important to patient care, and address a wide range of performance issues, including many issues that cannot currently be captured in conventional measures – issues like diagnostic skill, care transition management, procedural skill, surgical outcomes, assessment and application of safety knowledge.

ABMS believes the ABMS MOC® provides a strong foundation for improving patient care. We encourage CMS to adopt a measurement strategy that rewards the knowledge, behaviors and skills inherent in the competency domains physicians are being trained to develop and demonstrate. Taken together, these performance domains are more descriptive of what physicians actually do – and what they are being asked to improve throughout their clinical careers – than the discrete performance measures currently in use. We believe that a reward system that focuses on the behaviors, skills, and competencies that we want to see all physicians embrace, rather than specific clinical actions, will be much more likely to lead to the improvements in care that Medicare’s quality programs are meant to induce.

Redundancy and opportunity for alignment

- 1. How are the current reporting requirements for the PQRS and the EHR Incentive Program similar to the reporting requirements established by the ABMS boards? How are they different? In what ways are these reporting requirements duplicative and can these reporting programs be integrated to reduce reporting burden on eligible professionals?*

As we note above, the overall assessment structure and approach embodied in ABMS MOC® is quite different from the discrete measurement approach in PQRS. ABMS MOC® is conceived as a comprehensive program of professional development across all six competency domains, and we believe the whole of ABMS MOC® should be rewarded through federal quality programs.

Having said that, all ABMS MOC® programs include a practice performance assessment (Part IV of MOC) that can map to PQRS. Some of our Boards will allow diplomates to use PQRS measures – generally measure groups rather than individual measures to satisfy Part IV performance practice assessment requirements of ABMS MOC®. This sort of alignment will have the advantage to physicians of reducing their reporting burden, since a single measurement activity will satisfy both certification and federal reporting requirements, and it will have the additional advantage to CMS that measurement will be conducted in a quality improvement framework.

However, we believe that if CMS hopes to engage all physicians across all the specialties in measurement and improvement activity, it would be best to adapt PQRS to ABMS MOC®.

Although federal quality reporting requirements apply to all physicians, current measure sets and measurement priorities focus on the provision of primary care, particularly chronic care. There are good reasons for this, but it may be worth noting how diverse physician practices can be across the 24 specialty areas. The three primary care boards, plus the conjoint board of Allergy and Immunology (a subspecialty of both Internal Medicine and Pediatrics), represent about half of certified physicians. But there are also surgical specialties (including general, plastic, thoracic, and colorectal surgery, neurological surgery, OB/GYN, ophthalmology, orthopedics, otolaryngology, urology), hospital-based specialties (including anesthesiology, nuclear medicine,

pathology, radiology, and emergency medicine), and other specialty practices with unique clinical qualities (including dermatology, medical genetics, physical medicine, preventive medicine, and psychiatry/neurology). This diversity of practice requires diversity in assessment.

The Boards respect this diversity in their standards for ABMS MOC®. Since 2009, ABMS has set specific expectations for performance practice assessment as part of MOC that allows for differences in approach based on each specialty's judgment about what is most appropriate to the clinical practices within the discipline. The Boards are expected to base their requirements on a complete cycle of assessment, improvement activity and re-assessment (using AMA PRA Category I Practice Improvement as a model) provided all stages are completed.

Evidence of participation in assessment of performance in practice and quality improvement includes the following, which must be Member Board approved:

- Use of a registry with a learning collaborative (like the registry maintained by the Society for Thoracic Surgeons),
- Completion of a self-administered clinical evaluation module (generally a method for abstracting data from medical records on key metrics related to the treatment of specific conditions)
- Verification through attestation of individual participation in a group quality measurement and improvement activity (like hospital quality improvement activities or regional improvement collaborations like IPIP: Improving Performance in Practice);
- Other activity judged to be of comparable value in practice assessment and quality improvement.

Because of the differences in specialty practices and differences in the clinical contexts of the specialty disciplines, each specialty has specified the type of measurement activity that is most relevant to its discipline. The ABMS Member Boards recognize that assessment strategies must vary according to the different contexts of clinical practices, and each Board's assessment protocols reflect the needs and practices of its medical specialists (diplomates). Although the approaches differ, the basic structure of MOC Part IV is the same across all the boards: a measure-intervention-measure cycle with feedback and opportunity for reflection and improvement. The identification of performance gaps is followed by additional education or some form of system practice change that is expected to improve capabilities or improve actual performance.

Some examples of what the Boards are developing for their Part IV assessment activities may help to show how the different approaches capture different dimensions of performance and offer opportunities for improvement in clinical skill that are beyond the reach of conventional methods of measurement.

The American Board of Family Medicine was the first to arrange a Part IV practice assessment solution for its diplomates to satisfy PQRS reporting requirements. ABFM uses fully specified

NQF-endorsed measures captured from medical records and compared to performance benchmarks. ABFM focuses its MOC program on high priority quality issues identified by the Institute of Medicine, and has chosen to align with PQRS around the diabetes measurement group.

For the surgical boards, case logs and outcome registries are the norm. The registry developed by the Thoracic Surgeons has been providing feedback to surgeons on high-impact procedures for twenty years. It has not only shown dramatic influence on clinical practices, but it has generated scores of research papers that have transformed clinical practice. The American Board of Surgery, in association with the American College of Surgeons, is developing a surgeon-specific registry that will provide detailed outcome feedback for surgeons in several subspecialties of general surgery. The American Board of Neurological Surgery, along with its specialty society, is currently developing a registry of key clinical factors and patient outcomes.

Since 2011 The American Board of Radiology has been working with the American College of Radiology on Dose Index Registry (DIR) in which 463 facilities are now enrolled, contributing dose index data on over 3 million exams spanning 5.4 million irradiation events. In June 2012, the registry began to collect localizer images that enable estimation of patient size and size-adjustment of dose index measures. The registry is in the process of developing a pilot test for including Radiography dose indices.

Several boards have developed on-line "Practice Improvement Modules," through which data are collected from a selection of records to compute a set of measures related to the treatment of a specific condition. Participating physicians get feedback from the Boards about their performance, which forms the basis for the expected reflection and improvement cycle. The Board of Ophthalmology has embraced this approach, developing over the last two years over 200 metrics in 23 sub-disciplines of ophthalmologic practice that will be mounted in these sorts of on-line assessment exercises. In recent years, the primary care boards of Internal Medicine and Pediatrics have turned to areas of patient engagement and patient management that cannot be assessed through conventional approaches, including patient experience of care, health literacy, and care transition management.

Other approaches involve the peer review of clinical observations from medical records examined against clinical standards through a peer review process and clinical simulations. Two of the Boards have focused on the development of simulations. The American Board of Family Medicine has developed a simulation to assess clinical management skills, and the American Board of Anesthesiology has developed simulations to help anesthesiologists to master specific procedural skills.

Certainly, this variation in approaches presents operational challenges. However, the ABMS Member Board experience demonstrates that it is possible to create a universal assessment program with enough flexibility to allow for these differences in assessment approaches. We believe this approach will yield better engagement and more improvement in practice.

2. *What are the benefits and shortcomings of allowing third-party entities to report quality data to CMS on behalf of physicians and other eligible professionals?*

Despite CMS's best efforts over the last five years to engage physicians in PQRS reporting, we understand that only about 31 percent of eligible practitioners currently submit data. By contrast, physician adoption of ABMS MOC® has been growing at an accelerated pace during the same period, currently exceeding 415,000 physicians.

The best way for CMS to increase physician participation in its quality programs would be to link to the professional activities that physicians commit to for their professional development. Doing so will increase physician confidence in the validity of the data and the fairness of the assessment, reduce redundant data collection activities by clinicians, and create an improvement framework that will increase the likelihood that CMS's payment and accountability programs will actually lead to improvements in care.

3. *How should the CMS quality reporting programs change/evolve to reduce reporting burden on eligible professionals, while still receiving robust data on clinical quality? In aligning with non-federal reporting, should CMS reporting change or should non-federal reporting be forced to align with CMS requirements.*

The current approach to performance measurement has undeniable limitations. Measures don't exist for many specialties; even where measures exist they capture only a fraction of what physicians do in their practices; small numbers make statistical inferences about performance uncertain at best; and even for the best specified, most reliable measures, we know little about how they perform in practice – whether they reveal meaningful and remediable differences in performance. In the short term, the variety of approaches used in MOC will have much more impact on quality improvement at the physician level than the current approach to physician quality reporting.

ABMS recommends that CMS consider a measurement and reporting strategy that unfolds in stages, as measures are developed, put to use, and shown through experience that they can be usefully deployed.

In the current early stage, the priority should be on increasing participation in measurement and learning how to use measures to improve care. As measures are developed, CMS should create an expectation that participating registries collect feedback from measure users about the usefulness of a measure when it is deployed. With some empirical experience, CMS and NQF will be in a better position to identify the important few measures that have the most impact on improvement. Meanwhile, we should be focusing on creating a supporting infrastructure that provides opportunity for reflection, benchmarking, and improvement. This should be a pre-requisite, and not an afterthought, to a reporting program.

As experience grows, and descriptive measures relevant to all types of practices emerge, we will be able to identify which measures are most likely to yield improvement in care, and we will have mature support systems to help physicians use their data to improve their performance. Policies that are intended to be supported by quality reporting will yield robust benefits in the form of improved care.

Requirements for reporting entities

- 1. What types of entities should be eligible to submit quality measures data and what qualifications should be applicable? What functions should they possess? What criteria should they have to meet?*

ABMS encourages CMS to take a broad view of registry definitions to encompass a variety of registry types that enable clinicians to reflect on performance and conduct self-assessment and improvement. In particular, we would expect the definition of registry to encompass both a surgical registry like NSQIP, which may be used by our surgical boards, a Performance Improvement Module like those used by our primary care boards, or a regional improvement collaborative like the Wisconsin Collaborative for Healthcare Quality.

Whatever the reporting entity, we would expect that a qualifying registry would:

- Be able to report feedback to clinicians with benchmarks either to clinical standards (depending on the state of consensus around standards for expected clinical outcomes) or peer performance;
- Be completely transparent with respect to measure specifications, measure performance, and analytics of registry data;
- Audit data to assure its reliability and validity;
- Obtain feedback on the performance of the measures themselves in terms of their reliability and utility for improvement
- Protect the security of the data.

We would expect these criteria to apply equally to any type of registry.

Whether intended to support individual care decisions or to aggregate reflections on treatment of a population, the Boards would also expect a registry to support an individual physician to reflect on his or her performance, identify practice gaps, undertake an improvement project, and determine whether a chosen intervention helps to bridge that gap.

- 2. Should reporting entities have to self-nominate annually?*

Several ABMS Member Boards have been participating in the MOC Incentive Program available to eligible practitioners who successfully submit PQRS data. They have not found the requirement to self-nominate burdensome. ABMS has found that the opportunity to interact

with CMS staff and discuss relevant rule changes has some value. Although it creates some additional administrative burden for CMS, the process may have some additional value in the early phases of expanded reporting options, if only to reassure CMS that it will be able to receive the requisite data.

3. *Should reporting entities be required to post performance data publicly?*

ABMS does not believe it is appropriate for CMS to require participating registries or Boards to post performance data publicly. While CMS has a statutory obligation to report data publicly, this is not an obligation of the Boards or their participating registries, nor do we believe this requirement would be desirable. Most registries do not routinely report their registry information so that physicians will be encouraged to share their data honestly and completely. Requiring that the registries publicly report the information may, in fact, deter some clinicians from participating in their improvement activities. Nor do we think it is necessary. CMS is committed under the ACA to report on physician quality on Physician Compare. We, along with physicians submitting the data, fully expect that data will find their way to Physician Compare once CMS is satisfied that the comparisons are valid, reliable, and useful.

Maintenance of Certification is a voluntary activity. The Boards want to make it possible for participating physicians to repurpose the data reported to registries or through Maintenance of Certification to satisfy other reporting requirements, but would not preempt that choice or otherwise coerce physicians to use the MOC process for this purpose.

Selection of measures related to registry reporting

1. *Should CMS require that a certain portion of submitted measures have particular characteristics such as being NQF-endorsed or outcome-based?*

ABMS MOC® standards expect that NQF-endorsed measures will be used if available and appropriate. At this moment, considering the gaps in measures and lack of experience putting measures to use, the focus on NQF endorsement would be counterproductive. Such a requirement would reduce physician engagement in reporting at a time when policies should encourage wider engagement. At a point where performance data are used in public accountability programs, standardization and endorsement of measures will be necessary. But for now, given the state of the science of performance measurement, we do not believe the ranking and rating of performance in accountability and incentive programs can be effectively implemented. At this time the focus should be on measure development, deployment, and assessment, and on the development of support systems to help physicians use data to improve care.

The movement toward a more outcome-oriented measurement system is surely desirable, but there will need to be a balance of process and outcome measures. Process measures that are

proximate to and proven to be associated with desired outcomes have many advantages – they are measurable, actionable, and attributable – and shouldn't be discarded in the process of developing a system more focused on end results.

Some Boards have developed or are developing extensive libraries of measures to be used for practice assessment. The American Board of Internal Medicine (ABIM), for example, has a very large library of measures, some of which are NQF endorsed, some not. Several specialties have had virtually no endorsed measures and many of the registry solutions being developed by the Boards contain scores of measures that will not be able to go through the endorsement process for some time. While the surgical specialties generally focus on outcome measures, for many specialties, there is a dearth of outcome measures, which would render it impractical to require a specific proportion of measures be outcome measures.

2. *Should CMS require that the quality measures data submitted cover a certain number of the six national quality strategy domains?*

While it is appropriate to ask physicians to report on data that relate to one or more of the priority domains, we do not recommend that CMS require reporting in all or a pre-determined number of domains.

Each of the 24 major specialty disciplines will be able to find a place for itself in one or more of the six priority domains, but we do not believe it will be possible or desirable to require physicians in each specialty to address all or some arbitrary number of them.

3. *How many measures should an eligible professional be required to report to collect meaningful quality data for both PQRS and MU? Should PQRS require reporting on a certain percentage of applicable patients or on a minimum number of patients rather than a percentage?*

CMS should base its reporting requirements on the types of measures and the number of cases that will fairly represent a physician's performance around the specific practice domain, condition, or procedure being studied.

CMS is raising two different issues here. The first is a policy question: how many measures are necessary to describe an important dimension of performance for the population of patients a physician serves? The second, more technical, question is whether there is a minimum number or percentage of patients that should be selected for reporting.

The answer to the first question depends on the condition and type of practice being evaluated. Physicians should be asked to report on a measure set that is relevant to their patient population. Whether this is one measure or a dozen will depend on the performance domain, the available measures, the potential level of impact of the measures, and the patient population treated. This will vary based on the clinical issue being assessed. It would generally be more

desirable to select a small number of high-impact measures that a larger set of broadly descriptive measures.

The second question is really one of the statistical confidence that the patient sample is a fair and accurate representation of the patient population (or population segment) being treated by the physician. There is a statistical answer, related to the level of error one wishes to accept in generalizing from the sample.

Alignment of PQRS with Meaningful Use Reporting

- 1. What entities have the capacity to report quality data similar to those reported under PQRS, Value-based Payment Modifier, and/or EHR Incentive programs? For CQMs that can be electronically submitted and reported under PQRS and the HER Incentive Program, should an entity's qualification to submit such measures be based on whether they have the technology certified to ONC's certification criteria for CQM calculations and/or electronic submission?*

We have suggested criteria above for reporting entities (including registries), including data security, transparency around methods, data management, analytics, feedback, and improvement. CMS certainly needs to specify its requirements to assure that measures are properly calculated and that data can be successfully transmitted, but we do not believe that ONC certification itself is necessary for all reporting entities. Such a requirement would probably end up being needlessly restrictive for entities – particularly registries – which will have the necessary analytic and data transmission capabilities but may not be able to meet all ONC certification criteria for EHRs. Nor would it necessarily assure successful reporting: we have heard that Meaningful Use-compliant EHRs sometimes will not be able to produce measures required by the HER Incentive Program. The American Board of Family Medicine, one of our Member Boards, is working to identify data extraction solutions that can produce quality measures for ABMS MOC as well as for PQRS.

We recommend that CMS consider another approach to EHR reporting whereby the vendor would enable data elements to be extracted from the records and transmitted to the registries or MOC programs, which would then calculate the CQMs and transmit the data. We have heard from some of the Boards that CQM-calculation and reporting tools are often sold as expensive add-ons to existing EHRs, that EHRs often lack exporting and reporting capabilities, and that the current approach binds physicians unhelpfully to the vendors. Freeing the user from the vendor might make possible a competitive market for applications that would extract and transmit data for a variety of purposes.

Concluding Remarks

The starting point for quality measurement must be some notion of what kinds of behaviors CMS hopes to induce with its payment and accountability programs. We have suggested a

framework based on the “competency domains” that were adopted by the medical education and assessment community over a decade ago.

Throughout this response to CMS’s RFI, ABMS has encouraged respect for the diversity of clinical practices. ABMS believes that CMS faces an operationally challenging task without a reliable proxy. ABMS MOC® and the society-supported registries and learning tools on which ABMS MOC® depends can be that proxy. Building federal reporting requirements on these activities will be more likely to create a quality infrastructure that will support improvement and will provide more useful data both to patients and physicians. ABMS and its Member Boards welcome the opportunity to work with you to create a pathway built on ABMS MOC®.