American Board of Medical Specialties
Higher standards. Better care.®

American Board of Medical Specialties
222 North LaSalle Street, Suite 1500
Chicago, IL 60601
T: (312) 436-2600
F: (312) 436-2700 www.abms.org

January 27, 2014

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244–1850

REF:
CMS-1600-FC; Final Rule; Medicare Program Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule and Other Revisions to Part B for CY 2014

Dear Administrator Tavenner:

The American Board of Medical Specialties appreciates this opportunity to submit comments on the Final Rule governing Medicare payment policies for CY2014.

The 24 ABMS Member Boards together certify more than 800,000 physicians in 37 primary and 123 subspecialty areas of medical practice to assure the public that physicians have had the training, and possess the knowledge, skill, and professional competency to practice safely and effectively in their chosen area of specialization. For over a decade, the Boards have implemented programs for Maintenance of Certification (MOC), offering a broad range of opportunities for continuous professional development of the six competencies that are core to physician training and so important to the provision of high quality care. Nearly sixty percent of certified physicians currently participate in these programs, and about 50,000 physicians join the programs each year.

ABMS Member Boards are firmly committed to alignment of Federal quality reporting requirements with their Maintenance of Certification program requirements. We believe we share this alignment goal. The imposition of redundant or competing measurement and reporting requirements on physicians adds cost and waste to the system and is extremely confusing and dissatisfying to professionals in practice. We will likely have more success engaging physicians in quality improvement if the data and measures used are trusted to be valid, relevant, and reliable, and if physicians are supported by systems that help them to examine and

improve their practices. This is what Maintenance of Certification offers to participating physicians. CMS's best chance to engage physicians in quality improvement is by aligning federal quality reporting with the improvement activities they undertake to maintain their expertise and their credentials as practicing physicians.

ABMS supports several changes in the Final Rule that respond to comments made on the Proposed Rule. We believe these changes will increase the opportunity for alignment with the MOC programs of ABMS Member Boards:

- *The measure group reporting option through traditional registries has been retained.* The Proposed Rule left us unclear about the status of the measures group reporting option. Though not dealt with directly in the text, this is clarified in one of the tables.
- *Physicians can report on 1-8 measures if 9 measures are not available to report.* As has been repeatedly affirmed by the National Quality Forum and the Measure Applications Partnership, there are enormous gaps across the specialties in measures available to report.
- *CMS will accept into PQRS some important measures that have not yet been endorsed by the National Quality Forum* (as CMS has done with the Optimizing Patient Exposure to Ionizing Radiation measures group for 2014). ABMS supports the NQF and values stakeholder input on measures used in public programs, but the priority, at this time, should be to put measures to use and develop effective feedback on the utility, burden, and impact of the measures as they are put into practice.
- *QCDRs will have some flexibility on the timing of feedback reports to physicians.* We share your expectation that physicians receive feedback from their registries, but we believe that feedback should be proximate to data input or produced on demand by participating physicians.
- *The minimum number of participants in a qualified QCDR will be 50 rather than 100.* This will support incipient registries in smaller specialties.
- *QCDRs will not have to report data publicly.* ABMS supports transparency of performance information but it is not appropriate to impose this requirement on all registries, most of which have been created principally to support quality improvement, not public reporting. These purposes are different and the capabilities of the registries to satisfy these two goals will differ.

CMS's effort to align all the physician quality reporting and incentive programs has been a massive effort, given the diverse statutory authorities, and it will help enormously to reduce redundancy and send consistent signals through the physician community.

These positive steps notwithstanding, the Final Rule is disappointing in the way the new option Congress introduced last year for reporting through Qualified Clinical Data Registries (QCDR) has been implemented. We believed that this new reporting option promised a new

opportunity for alignment. We thought it would bring more physicians into reporting compliance, accelerate the development and deployment of measures to fill the specialty measure gaps, and link to an infrastructure that creates an opportunity for physicians to reflect on and compare their performance. As structured, the QCDR option will not fulfill that promise. Few of the practice improvement activities currently approved for Maintenance of Certification will be able to meet the requirements, and most of the best and most sophisticated registries usable for MOC will not qualify.

As CMS prepares the next generation of federal quality reporting requirements we urge you to consider the following suggestions:

1. ***Consider introducing differences in reporting for different kinds of clinical practices.*** Alignment does not require that all specialties be treated identically. There are big differences in clinical context, both in terms of clinical practices and in terms of the relationships physicians have with their patients. These differences are very important to the evaluation of clinical performance and they will become very important to the eventual performance of the accountability and incentive programs. We know that this issue will be addressed by the Measure Applications Partnership Clinician Workgroup in the coming year and look forward to seeing some meaningful distinctions between clinical contexts in the next round of rulemaking.

2. ***Preserve the measures group reporting option for traditional registries.*** Our sense is that this reporting option may fall victim to CMS's enthusiasm for large patient samples. Yet we believe strongly that this reporting option provides a meaningful snapshot of physician performance and can form the basis of a successful exercise in reflection and improvement, as has been shown by the many ABMS Member Boards that have formed performance practice improvement activities based on small but statistically significant patient samples of a clinically related cluster of measures. We urge CMS to keep this option available for the next few years as EHR and registry adoption grows.

3. ***Create a measure group reporting option through QCDRs that parallels the measures group reporting option via traditional registry.*** In our comments on the proposed rule, we suggested that CMS create a measure group reporting option through QCDRs, which would encourage the development of measure groups in a manageable sampling frame that mirrors the sampling frame for traditional registry reporting. CMS agrees that the creation of measure groups through QCDRs is a good idea but puzzlingly requires that they be collected and reported as individual measures. In the spirit of consistency and alignment, we reiterate our suggestion to allow QCDRs to create measure groups such that all measures are reported on a small but statistically meaningful sample of patients. This would parallel the measures group reporting option

for traditional registries. You may see this as a transitional approach, but we believe it is an important option that must be kept open in the short term.

4. ***Encourage the development of measure groups.*** We believe that measure groups are likely to be significantly more useful to physicians and patients than a handful of individual measures: they will be more generally descriptive of performance in a clinical area or procedure, they will be likely to contain a balance of process and outcome measures, and they can be summarized in composite measures that are accessible and meaningful to patients. We understand that CMS has a preference for a small number of more outcome-oriented measures. While we think outcome measures are important, we think it is equally important to capture measures that are directly actionable and less susceptible to risk adjustment issues, which is generally the case with process measures.

5. ***Consider imposing the Measure Applicability Validation process on a sample basis rather than on all physicians who report fewer than the expected number of measures.*** We understand why CMS expects physicians who report fewer than the required number of measures to submit to a validation process. However, we do not believe it is necessary in all cases. First, like most validation processes, this one could be more efficiently accomplished by sampling. Second, CMS already knows that many specialties are not well served with measures. All physicians practicing in Nuclear Medicine, for example, have available a single PQRS measure to report that is relevant to their specialty. The PQRS measure set can be mapped to the specialties and some presumptions may guide where and when to validate the appropriateness of reduced reporting. This would seem to be less burdensome to both physicians and to CMS than the process that has been proposed.

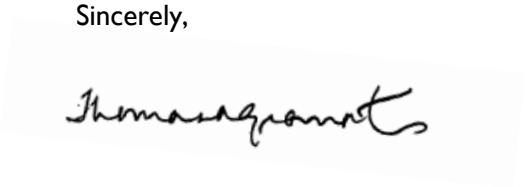
6. ***Allow Qualified Clinical Data Registries to use a smaller sampling frame.*** The requirement that QCDRs contain 50 percent of all cases for each measure may make sense one day in an environment where data can be imported into the registry directly from an electronic record, but that day is far from here. For now, registries depend on time consuming, resource intensive data input that depends on sampling records on a smaller scale. Some may believe that this requirement will encourage organizations and individuals to move more quickly to electronic records. But given the current state of EHR adoption, and the difficulty of extracting data from existing record systems, the requirement to collect such a large sample is more likely to keep promising and even well-established registries from becoming qualified.

7. ***Provide protection from discovery for data collected by Boards and registries to support quality improvement.*** As we have suggested in earlier letters, we believe the

quality of data and engagement of physicians will increase if their practice data can be collected and analyzed without the threat of legal discovery. This would in no way compromise the reporting of measure data that summarizes individual performance, but would protect the patient-level practice data. We would welcome a conversation about how to create a more secure data environment as the expectations for data collection, analysis, and reporting increase.

ABMS appreciates this opportunity to comment on the Final Rule and looks forward to a future conversation about reporting expectations that are clinically relevant to all specialties so that we can increase physician engagement and improve patient care.

Sincerely,



Tom Granatir
Senior Vice-President for Policy and External Relations