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Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O Box 8013
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Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule for CY 2015

The American Board of Medical Specialties (ABMS) appreciates this opportunity to submit comments on the Notice of Proposed Rule Making revising Medicare Payment Policies for CY2015, including changes to the federal quality reporting requirements.

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 (ABMS 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 welcomes this opportunity to comment on the following issues:

- Public Reporting of Physician Information on Physician Compare
- Federal Quality Reporting
- Patient Experience of Care Surveys
- Qualified Clinical Data Registries
- Measure Applicability Validation
- Value Modifier for Physician Reimbursement

Physician Compare

CMS has significantly improved the Physician Compare site. The new site is very readable and easily navigable. We are pleased to see that ABMS Board Certification data are available and that individuals participating in the Physician Quality Reporting System (PQRS) MOC Incentive program will be identified.

We have some observations and suggestions.

First, although Physician Compare identifies whether an individual is certified and in what discipline, it does not identify the name of the certifying Board. Because there are many boards with varying standards, we suggest that ABMS Boards be identified as such, preferably by the name of the certifying Board.

Second, ABMS currently makes available, through the channel partner used by CMS, information from the Boards on whether individual physicians are participating in the MOC Program. We suggest that this information could be easily added, perhaps graphically.

CMS states that it will only publish on Physician Compare those measures that are statistically valid and reliable as a necessary principle to assure that the data will actually be helpful to consumers. We support this principle. Although CMS proposes to make individual-level data publicly available in the near future, we expect that given the difficulty of analyzing small numbers of cases data may be more likely aggregated to the practice level.

CMS also states that it will subject the data to be displayed on Physician Compare to consumer concept testing. ABMS supports this provision as well.

CMS seeks comment on its plan to test the development and display of composite measures which would be statistically constructed out of clusters of related measures. We support the proposed plan, assuming a statistically reliable and medically meaningful composite can be constructed. One of our Member Boards, the American Board of Internal Medicine, has used composite measures to provide a summary of condition-related measures. Physicians find this sort of summary measure useful and consumers will too. We assume the individual components would also be available.

Finally, CMS seeks comment on whether it should post on Physician Compare the data from non-PQRS measures that may be collected in Qualified Clinical Data Registries (QCDR), including measures developed by specialty societies. Many of the measures collected in these registries were selected for quality improvement purposes and have not been vetted for public reports. We do not believe it would be appropriate for CMS to require the registries to publish their data at this time. However, if CMS proceeds to require that the data be published:

- We would expect the society-sponsored non-PQRS measures to be subjected to the same reliability and validity testing and consumer testing that CMS promises for other information on Physician Compare.
- We believe the registries themselves should retain the responsibility to determine in what manner these data should be displayed and at what level.
- We would suggest that QCDRs be given the choice of reporting either on Physician Compare or on their own.
- We strongly support the proposal that the QCDR have the option to report data at an appropriate aggregate level, even for sets of physicians who are not registered as a group practice for the purposes of PQRS reporting.

Federal Quality Reporting Options

ABMS believes that performance measurement and assessment are an integral part of individual and organizational performance improvement, and we continue to be interested in aligning federal quality reporting requirements with the data gathering and analysis that physicians conduct to meet their ABMS MOC performance practice assessment requirements. We are confident that such alignment can reduce the reporting burden borne by physicians, increase physician engagement in meaningful clinical self-assessment and quality improvement, and link CMS reward systems to measurable improvement in patient care.

Measure Group Reporting - We are pleased that CMS has retained the option to report on measure groups through traditional registries rather than on a selection of independent, unrelated individual measures. We believe that measure groups will 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 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 are disappointed at the reduced number of measure groups available for reporting, and urge CMS to encourage the development of measure groups for a wider range of specialties.

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 some process measures that are clearly attributable, directly actionable, and less susceptible to risk adjustment issues. We would encourage CMS to assure that selected outcome measures are properly risk adjusted and are attributable to and actionable by the reporting physician.

Claims Reporting – For some years, CMS has indicated an intention to move away from claims-based reporting in favor of registries and Electronic Health Records (EHRs). We understand that this is driven in part by the high level of reporting error in claims that resulted in large numbers of reporting physicians unable to obtain their incentive payments in the early years. We also expect that eventually registries and EHRs will be able to deliver data more timely and result in fresher data flows. However, for some specialties, claims-based reporting has resulted in consistent and reliable reporting. Emergency physicians, in particular, use claims-based reporting very successfully. We also note that claims-based reporting is still the most widely used reporting method for certain specialties. We urge CMS to allow for a transition away from claims to other reporting methods to give these physicians time to develop alternative methods of data collection.

Qualified Clinical Data Registries (QCDR) – As we suggested in our comments last year, we continue to believe that CMS should entitle 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.

We also suggest that CMS allow QCDRs to use a smaller sampling frame. The requirement that QCDRs obtain 50 percent of all cases is burdensome, costly, and unnecessary. One day data will move into the registry directly from an electronic record, but for now, registries depend on time consuming, resource intensive data input that depends on sampling records on a smaller scale. 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.

Measure Applicability Validation Process (MAV)
We support provisions that permit physicians to report fewer than the required number of measures if an insufficient number of measures are available in their specialty. We understand why a validation process is required, to verify that other reportable measures were not available, but we do not understand why this process needs to be performed on all physicians. We suggest that CMS consider imposing the MAV process on a sample basis rather than on all physicians who report fewer than the expected number of measures. CMS already knows that many specialties are not well served with measures and could presumptively accept fewer measures by these reporting cohorts. All physicians practicing in Nuclear Medicine, for example, have available a single PQRS measure to report that is relevant to their specialty, as the MAV guidelines already show. 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 be less burdensome to both physicians and to CMS than the process that has been proposed.

Patient Experience of Care Surveys
The eventual reporting of patient experience will require some level of survey standardization, both in terms of content and survey administration. It appears that for medical groups, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) family of surveys will be the standard.

Some ABMS Member Boards have integrated patient experience and outcome feedback into their practice audit programs but the Boards tend to blend communication issues with other condition-specific patient-reported functional data. Physicians report that these data can be very useful to identify opportunities for additional education or training or changes to their clinical practices. However, preliminary experience with these surveys suggests that the more clinically specific surveys may be more useful to patients and physicians from an improvement perspective and also may be more differentiating about levels of performance at the level of the individual physician.

In light of Boards' early experience, we suggest CMS direct the CAHPS Technical Expert Panel to examine ways to annex specialty-specific survey questions that may be more clinically relevant to physician specialists. The aim is to obtain feedback that is meaningful to patients and useful to physicians; one size may not suit all.

Implementation of the Value Modifier
The Affordable Care Act authorizes CMS to use participation in an ABMS MOC program and completion of a performance practice assessment (Part IV of ABMS MOC) into the composite of measures used to calculate the Value-Based Payment Modifier. These are structural

measures that reflect the ongoing learning, external assessment by the certifying board, and performance practice assessment and improvement required to maintain professional certification by a Member Board of the ABMS. We urge CMS to take advantage of this authority and incorporate these two measures into the calculation of the value modifier. This would send a strong signal that CMS supports and values professional certification, and acknowledges the ambition of the Boards to improve physician performance across six comprehensive competency domains.

Conclusion

ABMS continues to be concerned about the narrow quality framework that guides federal quality reporting requirements. First, CMS views physician practices through a narrow lens of primary care practice, which is simply not appropriate for large numbers of physicians practicing in other specialties or subspecialties. (Even in the primary care specialties like Internal Medicine, the majority of physicians are practicing in subspecialties.) Second, PQRS measures focus on technical patient care and procedural issues, excluding other physician competencies – communication, teamwork, and system-thinking - that ABMS believes are essential to good medical practice. We therefore recommend that CMS consider two broad conceptual changes to federal reporting requirements:

1. ***Consider introducing differences in reporting for different kinds of clinical practices.*** While we respect all that CMS has done to align federal reporting requirements, we do not believe that alignment requires that all specialties be treated identically. Differences in clinical context, both in terms of clinical practices and in terms of the relationships between physicians and patients, are very important to the evaluation of clinical performance and these differences become very important to the eventual success of accountability and incentive programs. We urge CMS to ask the Measure Applications Partnership Clinician Workgroup to explore meaningful distinctions between clinical contexts for the next round of rulemaking.

2. ***Adopt the Competencies Framework for Physician Excellence.*** Fifteen years ago, the Accreditation Council for Graduation Medical Education (ACGME) and ABMS adopted a framework for good medical practice that has been used to guide the development of residency training programs, specialty certification and maintenance of certification. Last year, under the auspices of the Coalition for Physician Accountability, all major organizations that together take responsibility for educating, training, assessing, licensing, and certifying physicians, in both the allopathic and osteopathic medical traditions, have endorsed this competency framework. The Six Competencies describe domains of expertise that need to be considered together to assess the quality of physicians: Professionalism, Knowledge, Patient Care and Procedural Skill, Learning and Improvement, Interpersonal Communication, and Systems-based Practice. These "competencies" represent broad domains of behavior and skill that are teachable, measurable, and improvable. The Association of American Medical Colleges (AAMC) and the ACGME have been working out the behavioral expectations that demonstrate expertise in each of these areas to guide undergraduate and graduate medical teaching.

> The competency domains undergird certification and continuing education as well. By focusing physician quality reporting exclusively on practice and procedural skills, CMS undervalues other domains of performance that we believe are important to patients, families, and their communities and essential to good results for health systems.

ABMS appreciates this opportunity to comment on the Proposed 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. We would welcome continued opportunity to work with CMS to create a physician quality program that physicians believe in and that reflects accurately what physicians do.

Sincerely,

Tom Granatir
Senior Vice-President for Health Policy and External Relations