September 6, 2013

Marilyn Tavenner, 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

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014 [CMS-1600-P]

Dear Administrator Tavenner:

On behalf of the American Board of Medical Specialties (ABMS), thank you for the opportunity to comment on proposed rules revising federal quality reporting requirements and other provisions related to physician payment under Medicare. ABMS represents 24 medical specialty boards that certify physician competence to practice in a specialty. The ABMS Member Boards issue 37 primary certificates and 123 subspecialty certificates to nearly 750,000 physicians licensed and practicing in the United States.

Because the ABMS Member Boards are concerned exclusively with the quality of physician care, we confine our comments to matters relating to how physician quality is defined and reported, and how the payment and accountability mechanisms being implemented in these rules may affect physician-level quality improvement initiatives and in particular medical specialty certification. We will comment on the specific proposals, with special attention to areas on which CMS has requested comment. Before doing so, however, we want to make a few general observations and suggestions.

First, we are gratified that CMS has exhibited a willingness to align federal quality reporting requirements, both across federal programs and with private sector programs like medical specialty certification. The ABMS Member Boards have an interest in reducing the administrative burden that physicians face due to multiple quality reporting requirements, and in assuring that programs of quality measurement and reporting add real value to physicians’ clinical practices.
Operational alignment between federal quality reporting and the professional assessment and improvement activities sponsored by the Boards creates an opportunity both to reduce administrative burden and to increase the likelihood that physicians will be meaningfully engaged in measurement and improvement.

Secondly, as CMS develops its policies we encourage you to be mindful of the heterogeneity of the physician community in the US. Most physicians practice in specialties or subspecialties. Even most of the primary care specialists practice in a subspecialty. In the field of internal medicine, our largest primary care board, nearly two-thirds of diplomates practice in one of the 20 subspecialties, covering a wide range of practices from Adolescent or Geriatric medicine, to Cardiology, to Medical Oncology to Transplant Hepatology. If accountability and rewards programs are to be successful, they must be supported with measures that are practice-relevant, descriptive of physician practices, and amenable to improvement. Unfortunately, despite years of work in this area, medicine is not well endowed with measures across all the subspecialties, especially outcome measures, sufficient to support these programs. CMS needs to establish rules that can apply to all physicians.

Related to this, we encourage CMS to think about whether the accountability and rewards programs directed to individual physicians can be implemented in a meaningful way for some specialties that do not see patients or do not see patients on an individual basis. Different rules might need to apply to physicians who practice in disciplines that are not patient-facing or are hospital-based (e.g., anesthesiology, diagnostic radiology, nuclear medicine, pathology), or whose practices are team based and rarely entail a 1:1 relationship with patients (e.g., transplant surgery, trauma surgery, hospital medicine, emergency medicine). For some specialties a level of group measurement and accountability is inevitable.

Third, the accountability and rewards programs are built on the hypothesis that measuring performance and employing incentives – financial rewards or patient demand – will induce physicians to improve care. Hence, PQRS serves both as a channel for delivering data to support a program of public accountability expressed through Physician Compare, and a program of financial rewards for high performance. Given today’s state of measurement, we are concerned that the link between reporting and actual improvement based on PQRS measurement and reporting is tenuous. We respectfully suggest that CMS consider rewarding improvement activity and improvement in practice directly through Maintenance of Certification (MOC) activities sponsored by the 24 specialty boards of the ABMS. These activities are designed to engage physicians in an explicit cycle of measurement and intervention that can yield measurable improvement. If improvement through MOC is demonstrable, wouldn’t it be more efficient for PQRS to capture, display, and reward it directly?

Lastly, we believed, when the new registry reporting option was adopted, that alignment with board certification activity would be more likely. Unfortunately, several provisions in the proposed rule may work against that goal. We address these issues directly below.
1. PHYSICIAN COMPARE

In the coming year, CMS proposes to enhance Physician Compare with identifying data about physicians who have earned the MOC incentive for participating “more frequently” in MOC, along with similar identifiers of successful PQRS reporting, successful EHR reporting, and reporting of the Cardiovascular Prevention measures group in support of the CDC’s “Million Hearts” campaign. CMS has also asked for comments on whether to indicate professional participation in initiatives like “Choosing Wisely.” We question whether this sort of information will be helpful or can be interpreted meaningfully absent significant contextual information. The MOC incentive program does indeed reward individual physicians who are participating “more frequently” in MOC than required by their boards; on the other hand, the Board has to qualify to offer this program, and so far only half of the Boards have chosen to participate. Would it say anything about the physician without a check in that box if her Board had not yet qualified to offer the program? Similarly for the “Million Hearts” campaign, some physicians will report these data because they are directly relevant to their practices. If these measures are not relevant to their practices, is it meaningful that they don’t report them?

Choosing Wisely, an initiative of the American Board of Internal Medicine Foundation with participation by over fifty specialty societies, is an important effort to begin dialog between patients and physicians about marginally beneficial services, but we don’t yet have agreement on what participation entails. For all of these programs, as for any data, some context would be important to understanding the information.

Plan for Phased Improvements to Physician Compare

In the proposed rule, CMS outlines its intent to pursue a phased approach to publicly reporting physician quality data via Physician Compare. ABMS is fully supportive of this phased approach.

As we noted in our introductory comments, we believe CMS should consider alternative measurement and reporting approaches for physicians practicing in specialties where the consumer choice accountability model will not readily apply. The consumer choice model that underlies Physician Compare is not relevant to at least a quarter of practicing specialists, because of the nature of the discipline and how the specialty is practiced. Anesthesiology, Emergency Medicine, Nuclear Medicine, Pathology, Preventive Medicine, and Diagnostic Radiology all fall into this category, along with many subspecialties, including Trauma Surgery, Transplant Surgery, Hospital Medicine, Transplant Hepatology, and many more. As CMS moves forward with its plans to enhance Physician Compare, we believe it would be prudent to think about having different approaches for different kinds of specialty practices. It may be that for these specialties, group or departmental data might be useful to some users (more likely hospitals, health plans, and other organizational users) than to individual consumers because consumers' choice of physician is generally not at issue.

CMS seeks comment on expanding the scope of performance information posted on Physician Compare to include measure data for individual physicians. With full understanding of the statutory constraints under which CMS operates, we would be cautious about displaying
individual performance data on the measures currently available through PQRS. The small number of measures reported through PQRS will not adequately describe a physician's practice, rendering the reporting unlikely to support effectively either the accountability mechanism or the rewards mechanism. The Measure Applications Partnership has noted the significant gaps in measures available for public reporting. Before proceeding with such a significant increase in the number of measures that physicians would be expected to report, we suggest that CMS evaluate the current portfolio of measures and identify which are relevant to which specialty and how well the measures map to the NQS domains. We would welcome a chance to work with you to do this. We believe that very few physicians will be able to meet the new reporting standard.

**Reporting Patient Experience Data**
Where ABMS Member Boards have implemented patient surveys, they have found that condition-specific or specialty-specific surveys are more useful to patients and yield information more helpful to quality improvement by clinicians. As we have previously recommended, we strongly encourage CMS to recognize customized surveys administered by individual physicians at the specialty level alongside the standardized CAHPS surveys that will be conducted at the organizational level. How specialty or condition-specific surveys might be nested in organizational CAHPS surveys might require some research. We would welcome a chance to talk with CMS about how this might best be accomplished.

**Information about the Certification Process**
In addition, as we have suggested previously, we believe that users of the site would benefit from some contextual information about ABMS Board Certification. While we have found that people are generally interested in certification and feel it is important that physicians be certified, many people are unaware of what certification entails. Few people understand the transformation in certification over the last decade through the implementation of the competencies framework, which has broadened and deepened the assessment of physician performance, and signifies a real commitment on the part of physicians to quality improvement. Material from the ABMS website ([www.certificationmatters.org](http://www.certificationmatters.org)) would help users to understand the certification process and the competencies that certification is designed to address. We are happy to share this information for inclusion on Physician Compare.

**Additional Certification Information**
We are pleased that CMS is including information about current certification status, including whether the individual is certified by an ABMS Member Board. We suggest as an enhancement that the ABMS certifying Board be identified, not just the specialty for which the physician is certified.

CMS has indicated its willingness to include information on whether physicians meet Board MOC requirements when that information is reported by all Boards. We look forward to discussion with CMS in 2014 about the inclusion of information about physicians meeting the requirements of Maintenance of Certification that is currently being prepared by the ABMS Member Boards. We expect this information to be available for reporting in 2014 and would
welcome an opportunity to discuss the addition of this dimension of certifying information next year.

2. PQRS REPORTING
Significant changes in PQRS reporting are proposed that have the potential to foster further alignment of PQRS with Member Board Part IV activities. Some of the particulars are problematic, however, for many specialties.

We appreciate the effort CMS has made to align the reporting requirements across its many physician reporting programs so that individuals may satisfy different programmatic reporting requirements at the same time and direct quality improvement effort to priorities of the National Quality Strategy. However, we believe the new requirements are likely to work against CMS’s current interest in increasing physician reporting, may generate reports on measures of marginal relevance to physician practices, and may have the perverse effect of diluting concerted efforts to address specific domains of the NQS by requiring physicians to report on measures addressing at least three domains.

We appreciate the flexibility afforded to allow physicians to report on 1-8 measures when fewer than nine measures are available. Although not explicitly stated, we expect the same flexibility with respect to the NQS domains if measures addressing those domains are similarly unavailable. In the interest of alignment, we recommend that this exception be carried through all reporting options, including claims, traditional registries, and Qualified Clinical Data Registries.

Claims-based reporting

CMS proposes to retain claims-based reporting for individual measures, but would eliminate measure group reporting via claims, since so few physicians took advantage of this reporting option. While we understand that only a few thousand physicians currently report on measure group option through claims, we wonder at the wisdom of closing off a reporting option at this time when less than a third of physicians are currently reporting. Furthermore, we are persuaded that measure group reporting can be more usefully descriptive of condition management and ought to be encouraged. We suggest retaining measure group reporting through claims at least for a few more years until registry reporting is more prevalent and available.

In the long run, CMS wonders whether it should retain claims-based reporting, given the large (nearly 30 percent) error rate, even though it is still the most widely used reporting option. Given the importance of claims-based reporting to the majority of currently-reporting physicians, especially the hospital-based disciplines, we think it prudent to continue to accept reporting through claims and try to reduce the error rate. Some hospital-based specialties, especially emergency medicine, are likely to continue to report through claims for some time. As EHRs and registries become more prevalent, claims reporting may naturally be displaced.
We would encourage CMS to revisit this issue in 2-3 years, once these other options become more established.

**Traditional Registry Reporting**

*Individual Measures* - CMS proposes to increase from three to nine the number of required measures (allowing for reporting fewer measures if fewer than nine measures are available for reporting), including an outcome measure; to require measures to address at least three domains of the National Quality Strategy; and to report on at least 50 percent of Medicare patients served with the condition. For claims reporting, CMS provides an exception for individuals practicing in disciplines underserved with appropriate measures. Where an insufficient number of measures is available for reporting via registries, physicians should be able to report on 1-8 measures as applicable, just as the rule provides for claims-based reporting.

As many as half of physicians participating in Medicare will have fewer than three measures available to report that are meaningfully related to their scope of practice. At the present time, given the paucity of meaningful measures for most physicians practicing outside of primary care — by far the majority of physicians — an exception is warranted. Where insufficient measures are available, we would also urge an exception to the requirement to cover three of the six NQS domains. **We are not persuaded that measures exist in all the domains.**

Moreover, although we think it is appropriate that measures map to one or more of the NQS domains, it may be counterproductive to specify that three domains be addressed at the individual physician level. A focus on a single domain — patient safety, for example — may produce the most far-reaching impact on patients even if it doesn’t address all the NQS priorities. We suggest that depth of impact might be more desirable than breadth of effort.

Reducing the percentage of cases reported from 80 percent to 50 percent for individual measures will better align with other reporting requirements. **We support it. However, we would point out that there is no magic to the reporting of a large sample of cases. The real issue is whether the sample is statistically reliable and will yield confident estimates on the chosen measures.**

*Measure Groups – Sampling* - The option to report for a measure group on a select sample of records appears to have been stricken from these rules. In past years, physicians reporting on a measure group could select a sample of 20 patient records, of which more than half must be Medicare patients, and report the data on all the measures in the group. We strongly urge that CMS retain this reporting option. Unless this provision is restored, many physicians will not be able to report and any hope of aligning with professionally driven Maintenance of Certification programs will be dashed.

Most of the Boards have or are developing “Performance Improvement Modules” — registry-based platforms through which physicians select a sample of records to investigate performance
on a specific condition and then work to improve identified performance gaps through a classic Perform-Do-Check-Act improvement cycle. Whether reporting through a traditional registry or taking the path of a Qualified Clinical Data Registry as provided for elsewhere in these rules, this method of assessment and improvement is the dominant form and offers the most promising opportunity for CMS to obtain clinical measure data and support clinical quality improvement through certification activity.

Measure Groups – Composition — CMS proposes that the minimum number of measures be fixed at six measures rather than four, and the maximum number of measures reportable from a measure group be set at 20. We respectfully suggest that the appropriate number of measures in a group should be determined by what's required to assess appropriate management of the condition. Increasing the number of measures in a group from four to six may not be a burden for most conditions; measure groups are meant to capture the important dimensions of care for that condition, and most contain at least six measures. On the other hand, adding to the required minimum number of measures in a measure group makes sense only if the two additional measures add materially to our understanding of the physician's performance with respect to the clinical condition. If the condition is well described with four or five measures, does it really make sense to add one or two more to maintain the measure group?

In a similar vein, CMS also proposes to limit to 20 the number of measures that can be reported through a measures group. Although we understand the concern about reporting on over-large groups of measures, the measure groups need to offer as complete as possible a picture of care for the condition or procedure under investigation. We do not think an arbitrary limit is necessary or prudent until we know more about what measures will be included in condition registries.

Qualified Clinical Data Registries (QCDR)

Under a new provision of law passed earlier this year, physicians can satisfy their federal reporting requirements by "satisfactory participation" in "Qualified Clinical Data Registries" (QCDR). CMS views registries as a vehicle to advance PQRS' evolution into a force for quality improvement and as a potentially useful link to Meaningful Use in Stage 3. We agree. We also believe the new provision for complying with reporting through "satisfactory participation" in QCDRs is the best hope for enhancing physician engagement in measurement and improvement activity and the most direct opportunity to align with MOC Part IV practice assessment activities, but only if significant changes are made to the structural, functional, and reporting requirements.

Definition of a QCRD — CMS has proposed to define a Qualified Clinical Data Registry for the purposes of PQRS as an entity that "collects medical and or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care furnished to patients." This describes the prevalent research registries, but would exclude many of the types of registries that CMS would like to leverage to engage physicians more broadly in quality measurement,
improvement, and reporting, including the medical specialty boards and community collaboratives. These entities set up data registries to support reflection and quality improvement. In the case of the Performance Improvement Modules used for performance practice assessment, clinical data are abstracted from medical records sufficient to enable the physician to reflect on performance, based on benchmarking and feedback from the registry, and identify practice gaps that might be amenable to improvement. Physicians are then expected to pursue interventions to bridge the gaps and to measure again to test the effectiveness of the chosen intervention. We believe this is precisely the kind of process that CMS hopes to engage physicians to undertake.

We suggest the definition of registry be revised to eliminate the modifying clause so that more types of data bases can participate, including the practice improvement modules developed by the specialty Boards.

**Structural requirements** — QCDRs must meet structural and functional requirements, some of which may be problematic for Boards. QCDRs must have and implement a data validation strategy, demonstrate HIPAA compliance, maintain data privacy and security, and provide access to practice data by CMS. These requirements are reasonable, and we also understand why CMS requires that registries be in existence for at least a year so that they can demonstrate the capability to manage the data securely.

We question the requirement that the registry must have enrolled at least 100 participants. Why 100 and not 50? We see no particular magic to the number of participants, and fear that an arbitrarily high number will disqualify registries in highly specialized fields. The real issue is whether the registry can demonstrate its ability to manage the data, verify its accuracy, protect its privacy, comply with HIPAA, and report feedback to physicians. We would challenge the assumption that 100 registrants would be necessary to demonstrate these capabilities.

**Functional requirements** — We support the requirements that registries be completely transparent about measures that can be derived from their practice data, including risk adjustment methods, where appropriate, and that they be able to benchmark data so that physicians can compare their performance to that of other physicians and to support quality improvement.

**Measures** — Under the new registry participation standard established by Congress, physicians would be deemed to meet their reporting requirements by "satisfactorily participating" in a qualified clinical data registry. CMS is proposing that registry sponsors show evidence of a physician's "satisfactory participation" by submitting his or her practice data to the agency. We note that CMS does have the authority to accept attestation in lieu of measures as evidence of a physician's satisfactory participation in a QCDR, and indeed seeks comment on whether to use this authority in 2014. We believe that is simply a practical necessity. In addition, we believe that it is a program strategy that CMS should consider for certain types of registries whose purpose is to identify and guide physicians through opportunities to improve their individual
clinical practice performance as part of their ongoing professional certification, which would mean supplying practice data and receiving reports on measure data to analyze and compare performance. CMS has interpreted broadly its statutory authority to collect information from the registries and to impose standards on the registries such that the registries would be required to meet the same reporting criteria that would apply to other methods of quality reporting. The rules would require that QCDRs have available at least 9 measures in three NQS domains, of which one must be an outcome measure.

We appreciate the flexibility to report on measure data that may have been developed by specialty societies or certifying boards or by regional quality collaboratives, but we suggest, for consistency and for the benefit of physicians practicing in disciplines without sufficient measures, that physicians reporting through QCDRs have access to the same exception provided elsewhere.

We welcome the flexibility under the Qualified Clinical Data Registry Option to use specialty- or board-defined measures in reporting. At this stage in the development of performance measurement, we think engaging more physicians in measurement is essential, and building on the measures developed and trusted by physicians for performance tracking and quality improvement will help to bring more physicians into quality work.

**Measure Group Reporting** — The proposed rules appear to envision reporting only on individual measures through Clinical Data Registries. However, we believe that because registry data are usually collected to assess a condition or a technology, they are likely to contain clusters of measures or Measure Groups much like the Measure Groups already adopted for use in PQRS. This has important consequences for patient selection rules and therefore on the potential to align with Maintenance of Certification. In fact, the majority of boards would not be able to participate in QCDRs if the option to use a 20 patient sample is removed as CMS seems to be proposing. Because registry data are generally condition- or procedure- specific, it should be possible to define measure groups for reporting purposes. All of the Performance Improvement Modules developed for and by the Boards for use in Maintenance of Certification can be characterized by condition- or treatment-specific measure groups. Reporting requirements should align with the Measure Group reporting requirements for traditional registry reporting. We urge CMS to create a parallel option through QCDRs for reporting of measure groups.

**Reporting on a calendar year basis** — One of the biggest challenges to performance measurement at the individual physician level is the problem of small numbers for any given clinical condition. Registries may need to draw records over longer periods to obtain sufficient numbers of records to analyze performance meaningfully. We suggest that CMS liberate reporting from the constraints of the calendar year.

**Feedback to Clinicians** — The proposed rules would require QCDRs to provide feedback to participating clinicians at least quarterly. The rationale offered for this requirement is that
physicians have demanded timely feedback on their performance. But because of the small numbers problem cited above, in many instances quarterly reporting might be meaningless because of the patient load. The Boards currently provide feedback to Diplomates within three months of completing a Performance Improvement Module so that the physicians can identify a practice gap or determine whether they have closed a practice gap. We recommend that the QCDR be required to provide timely feedback reports to physicians within three months of the submission of practice data, rather than requiring quarterly reporting.

**Public Reporting** -- We do not support the requirement that registries be required to report individual clinician data publicly. We believe that in some cases this may have a perverse effect on the quality of practice data reported by clinicians, which could undermine the very purpose of the registry. Most registries will be set up not to support public reporting but primarily to support improvement and research. For purposes of the Medicare incentive and payment programs, the responsibility to submit data to CMS should be located with the physician; boards and other entities that sponsor registry programs should be able to transmit those measure data to CMS at the request of the physician. Some physicians will be participating in multiple registries, and may be directing measure data to CMS from various sources to satisfy federal reporting requirements. Some of the certifying boards maintain non-disclosure policies with their diplomates and are not able to report measure data publicly or indeed submit measure data to public programs without the consent of the participating physician.

3. DATA DISCOVERABILITY

The proposed rule does not offer any protections for the discovery of clinical practice data reported to a Qualified Clinical Data Registry. ABMS has commented previously on the need to provide protection for practice data that may be obtained by the Boards to support quality improvement in a Part IV Performance Practice Assessment. We urge CMS to find a regulatory solution to protect practice data from discovery.

4. CONCLUSION

We have suggested elsewhere that CMS take a phased approach over the next five years to increase physician engagement, enable development of measures that matter for all the specialties, and create an infrastructure to support care improvement. Similar staging suggestions have been made by others.

Over the next two to three years, we expect intensive investment in measure and registry development and refinement of the improvement framework now in place in all the specialties. During this first phase, physicians should be credited with participation in registries when supplying practice data and using the feedback from the registries in an improvement framework like Part IV, Performance Practice Assessment, of Maintenance of Certification.

As the registries become more prevalent and participation more robust, registries would report to clinicians with benchmarks to identify practice gaps and stimulate improvement. Physicians would be expected to engage in improvement activities either independently or through their
organizations or improvement collaboratives. We would expect some of them to choose to report their results publicly.

Once registries are well established, measure data are routinely evaluated, benchmark data are available to participating physicians and the improvement framework of Maintenance of Certification widely used by practicing physicians, we expect MOC to become the dominant reporting pathway and support infrastructure for quality measurement and improvement. Given the time to identify practice gaps and implement interventions to improve practices, we expect physicians to be able to report improvement activities through MOC Part IV. We believe that this is the target of CMS’s reporting initiatives and would expect these improvement initiatives to become the basis for future reporting and rewards.

Engaging physicians in practice improvement and simplifying the reporting requirements they are expected to meet are goals our organizations share. ABMS looks forward to continuing to work with you to align federal reporting expectations with the professional development activities that physicians use through the certification process.

Sincerely

[Signature]

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