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

American Board of Medical Specialties
353 North Clark Street, Suite 1400
Chicago, IL 60654
T: (312) 436-2600
F: (312) 436-2700 www.abms.org

November 17, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3321-NC
7500 Security Boulevard
Baltimore, MD 21244-1850

REF: CMS-3321-NC
Request for Information Regarding Implementation of the Merit-based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models

Dear Mr. Slavitt:

On behalf of the American Board of Medical Specialties (ABMS), thank you for this opportunity to submit suggestions for the implementation of the Merit-based Incentive Payment System (MIPS). The ABMS Member Boards have a strong interest in aligning federal quality reporting with their programs of Maintenance of Certification (MOC). Specifically with respect to the identification of appropriate Clinical Practice Improvement Activities (CPIA) and attestation that the physician has been meaningfully engaged in the activity, the ABMS Member Boards can serve as "responsible reporting agents", with the permission of their diplomates, to attest to and validate these activities.

We limit our responses to select questions relating to the Quality Performance category and CPIAs since these are the performance areas that relate directly to MOC.

QUALITY PERFORMANCE CATEGORY

Should we maintain all PQRS reporting mechanisms under MIPS?

ABMS encourages CMS to maintain all reporting mechanisms at the present time. Changes in legislation and rules over the past several years have created an incentive to develop Qualified Clinical Data Registries (QCDRs) to support quality improvement and federal reporting, but it may take some time for these to become fully operable in all specialties. In the meantime, those specialties currently reporting through claims or other registries should retain the ability to do so.

Moreover, we suggest retaining the registry reporting option through which physicians can report measure groups. This approach to reporting is most directly aligned with the "practice biopsies" performed by some of the ABMS Member Boards as part of their programs for MOC.

We also suggest, as we have suggested in the past, that CMS create an option for reporting on measure groups through QCDRs using the same sampling and other requirements that apply to measure group reporting through other registries. The development of measure groups describing broadly the treatment for a medical or surgical condition is desirable; measure group reporting provides useful information to consumers (and other physicians) about the performance of a physician, and the sampling requirements for measure group reporting align with the MOC practice biopsies. Once a measure group is defined, it would be possible to generate a composite measure describing general trends and performance for the group.

Should we maintain the same or similar reporting criteria under MIPS as under the PQRS? What is the appropriate number of measures on which a MIPS EP's performance should be based?
It would be prudent to keep reporting expectations stable for the current time. As the Measures Application Partnership has pointed out in several reports to CMS, many specialties still lack measures on which to report, even at the current level of reporting requirements. At present, the science of measurement is too rudimentary to answer the question, "how many measures should be reported in order accurately to assess the performance of an individual physician?" The answer to that question would depend on what types of services a physician provides and the mix of conditions he or she treats, and we don't have these data to work with today.

Current reporting requirements set an arbitrary standard to encourage the development of measures and begin to understand what those measures say about the nature of a physician's practice. Even with the current standard, we need a better understanding of the relationship between the measures of physician performance to patient experience and outcomes. Significant investment in measure development and evaluation of the real utility of measures is necessary before increasing requirements.

Should we maintain the policy that measures cover a specified number of National Quality Strategy domains?

ABMS has recommended in previous comment letters that measure development for physicians prioritize the assessment of the full range of physician competencies, which reflect different elements of physician performance that are important to physicians and patients and map well to the priorities of the National Quality Strategy (NQS) gaps even in basic process measures for many specialties. A workable system of performance incentives, transparency, and rewards

must provide an opportunity for participation by physicians in every specialty, and should reflect all domains of performance that are commonly understood to constitute good medical practice.

Current PQRS reporting requires measures addressing at least three of the NQS priorities. It would be more appropriate to require that measures address at least three of the six core physician competencies, which map to the NQS priorities. The competencies are interpreted and understood universally for physicians in all specialties. The NQS priorities are written in ways that do not speak to the clinical focus of each physician.

Should we require that certain types of measures be reported? For example, should a minimum number of measures be outcomes-based? Should more weight be assigned to outcomes-based measures?
Each type of measure has advantages and disadvantages. Process measures are easier to measure, don't need to be risk adjusted, and can be attributed to individual physicians, but may not map to patient outcomes, are often narrowly task oriented, and tend to focus improvement effort on tasks rather than patient results. Outcome measures matter more to patient but are often difficult to attribute to specific physicians, need to be risk adjusted, and may not be entirely clear what actions physicians can take to improve performance on outcome measures.

It would be desirable to move to a measurement system that focuses on patient outcomes, including patient-reported outcomes. However, in doing so, CMS should assign the outcome to an appropriately accountable entity, which may not be the individual physician.

For the CAHPS for PQRS reporting option specifically, should this still be considered as part of the quality performance category or as part of the clinical practice improvement activities performance category? What considerations should be made as we further implement CAHPS for all practice sizes? How can we leverage existing CAHPS reporting by physician groups?

The CAHPS family of survey instruments is by far the most thoroughly vetted and studied set of patient surveys and captures important domains of patient experience. That does not necessarily mean that the instruments will be an effective basis for individual physician assessment. The surveys may over-emphasize system properties that are not under the control of the physicians, and under-emphasize crucial competencies that require more rigorous assessment (e.g., communications skills).

While ABMS supports the continued use of CAHPS surveys for practices and organizations, we suggest three issues for consideration by the CAHPS Technical Advisory Panel to expand the utility of CAHPS:

1. Leverage new technologies to simplify administration, increase response rates, and capture more robust feedback from patients. Response rates are low and survey administration protocols are burdensome for physician practices. We understand the need to maintain rigorous standards for survey administration and to assure the integrity and validity of the CAHPS data, but new technologies need to be leveraged to increase reach, response rates, and timeliness of data.

2. Develop specialty-specific survey modules that capture more specifically the performance relevant to individual physicians in each type of physician practice. It is possible that more nuanced and discriminating surveys can be developed by practice type (the practice context when services are rendered based on the nature of the relationship during the clinical encounter between the treating physician and the patient) without having to define different surveys for each specialty. But the feedback from patients must speak to physician behaviors and competencies that are relevant to every specialty if patient experiences are going to be meaningfully improved.
3. Consider adding select patient-reported outcome questions to the CAHPS surveys. The opportunity to capture feedback from patients is precious. The ABMS Member Boards that have examined the use of patient reports have found that patient-reported outcomes are highly regarded by physicians and stimulate reflection and change in clinical practice.

What are the potential barriers to successfully meeting the MIPS quality performance category?

We would suggest re-framing this question: what are the potential barriers to improving care through MIPS quality reporting?

Priority must be given to developing measurement methods to assess difficult to measure competencies like communication and care coordination and filling measure gaps so that all physicians have access to a sufficient number of reporting options that are descriptive of the care they actually provide. We suggest prioritizing measures that are most likely to eliminate preventable errors and complications from care, patient-physician communication, and team communication. We continue to urge CMS to work with the medical community to align the NQS priorities with clinical performance competencies that resonate with what physicians actually do in practice.

Because of the current inadequacy of data, the persistent analytic problem of small numbers in the calculation of performance rates, and the difficulty attributing outcome and safety measures to individual physicians, we urge CMS to work with the medical specialty societies and Member Boards to identify specific improvement practices that are linked by evidence to improved patient outcomes that can become the focus of improvement activity.

We are very encouraged by the registry movement and its promise to create an opportunity for physicians to measure their practices, study the results, identify performance benchmarks and standardize performance. This will take some time to develop and there is significant work to be done so that physicians can focus their efforts on improving their practices rather than data collection and analysis. Resources need to be devoted to improving the functional use of data electronically captured to reduce redundant data collection.

Most importantly, we believe that physicians need supportive structures to help them focus their efforts on identifying opportunities for improvement in care rather than on measuring and reporting data. This could occur through their specialty societies and Member Boards, their hospitals and health systems, or their practice organizations to support practice based learning

and improvement. As long as physicians are pulled out of their work to capture and analyze data, they will resent the process as an intrusion and distraction from the work they were trained to do, they will not be engaged in the process, and the process will not yield better care.

Data Accuracy

What thresholds for data integrity should CMS have in place for accuracy, completeness, and reliability of the data? For example, if a QCDR's calculated performance rate does not equate to the distinct performance values, such as the numerator exceeding the value of the denominator, should CMS re-calculate the data based on the numerator and denominator values provided? Should CMS not require MIPS EPs to submit a calculated performance rate (and instead have CMS calculate all rates)? Alternatively, for example, if a QCDR omits data elements that make validation of the reported data infeasible, should the data be discarded? What threshold of errors in submitted data should be acceptable?

While we understand the need for CMS to verify the accuracy and validity of the submitted data, we believe an overly regulatory approach will alienate physicians and set CMS up for technical challenges.

ABMS suggests that CMS encourage physician reporting through a responsible reporting agent that would be held responsible for running edits and validation routines on the data and attesting to their integrity. These might include QCDRs, other registries, certifying boards, or other entities that collect practice data, calculate performance measures, and benchmark and report to physicians. As these systems begin to use technologies for integrating data from multiple sources, implementing new measures, and making complex calculations, we expect that errors will occur. We suggest a feedback and warning system rather than a penalty system for dealing with these issues, and reserving more punitive measures for patterns of insufficiency or abuse.

CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY

Should EPs be required to attest directly to CMS through a registration system, web portal or other means that they have met the required activities and to specify which activities on the list they have met? Or alternatively, should qualified registries, QCDRs, EHRs, or other health IT systems be able to transmit results of the activities to CMS?

ABMS strongly suggests that there be multiple ways to communicate compliance with these activities. These may be among the most difficult to measure and report.

MACRA Section 1848(q)(2)(C)(v)(III) defines "clinical practice improvement activities" as those activities "relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, are likely to result in improved outcomes." "Relevant eligible professional

organizations" are defined as a "professional organization as defined by nationally recognized specialty boards of certification or equivalent certification boards."

Through this framing, Congress instructed HHS to utilize the role and expertise of certifying boards as independent entities to which physicians are professionally accountable for maintaining and improving their medical knowledge and practice. ABMS recommends that MIPS credit a physician's participation in a certifying board's MOC program as a clinical practice improvement activity and allow the ABMS Member Boards to serve as the responsible reporting agent attesting to (and verifying) completion of the activity.

MOC is an ongoing, multi-form approach to improving physician capabilities to provide high quality care through assessment and improvement of their personal knowledge and practice skill and of the systems in which they practice. The ABMS Standards for MOC conceive of the MOC program as a coherent program of self-assessment and self-directed learning, external assessment of knowledge, judgment, and skills, and improvement in medical practice. The 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.[1]

The ABMS Member Boards recognize a wide variety of improvement activities that could improve the quality and safety of patient care. The competencies framework can be viewed as an organizing framework for the variety of activities that might be credited as CPIAs under MACRA. Each improvement activity speaks to the development of a specific competency which diplomates in all disciplines are encouraged to master.

Practice-based Learning and Improvement. Some improvement activities are designed specifically to cultivate physician knowledge of improvement science as applied to their own practices. This might include participation in an improvement collaborative like the primary care collaborative, Improving Performance in Practice.

Patient care and procedural (technical) skill. Activities may include: structured peer review of a sample of medical records to ascertain the appropriateness of patient care decision-making and clinical protocols; "Practice Audit" of a sample of medical records to compare practice 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 Boards verify a physician's personal engagement in these clinical practice improvement activities.

System-based practice. ABMS Member Boards encourage participation in organizational quality and safety improvement activities, which may include strategies for effective communication, participation in a TeamSTEPPS evaluation of teamwork and care coordination,

[1] In 1999 the Accreditation Council for Graduate Medical Education and the ABMS adopted a joint competencies framework for residency training and certification. The six competency domains include professionalism, medical knowledge, practice and procedural skill, interpersonal communication, system-based practice, and practice-based learning and improvement.

or participation in the implementation of safety systems, including conducting a root cause analysis of a safety error, setting up or managing error reporting or other safety systems, or otherwise addressing system-level safety problems. To recognize and encourage physician participation in organizational quality improvement activities, the ABMS Member Boards have created the Multi-specialty Portfolio Approval Program (MSPP) (www.mocportfolioprogram.org), through which Member Boards assign MOC credit for participation in quality and safety activities undertaken by their sponsoring organizations, including hospitals and health systems, group practices, medical societies, and community collaboratives. Improvement priorities are established by the sponsors, but individual physicians are expected to attest to their intimate participation and personal reflection as part of the improvement activity. Henry Ting, MD, and his colleagues at the Mayo Clinic have described the success of this program as an opportunity to engage physicians in practice improvement activities.[2] In addition to its health system sponsors, which include Mayo, Kaiser, and Johns Hopkins, the MSPP is now reaching other types of supporting organizations, including state medical societies, the Network of Regional Health Initiatives, through its grantfrom the CMS Innovation Center's Practice Transformation Initiative.

It is important to engage physicians in a wide range of activities that will improve patient care and reduce the risk of error. These may include activities to improve individual patient care skills, but should also activities that develop physician expertise in improvement science as well as activities focused on the improvement of the effectiveness and efficiency of individual or group practices or health care organizations.

ABMS suggests that CMS:

- Recognize multiple types of individual activities that will improve performance, reduce the risk of error, or improve the effectiveness and efficiency of practice, including personal skills development, the adoption of quality and safety practices, and organizational or system analysis and improvement
- Recognize the Member Boards as "responsible reporting agents" with the physician's approval, and rely on the Member Boards to attest to and verify meaningful participation of individual physicians in the activities.
- Recognize all activities conducted under the auspices of the Multi-Specialty Portfolio Approval Program, which also captures and verifies attestations of meaningful physician participation in system, practice, or community improvement initiatives
- Expect an attestation of personal engagement in the quality improvement activity

[2] Henry Ting, MD, et al. Integrating Maintenance of Board Certification and Health Systems' Quality-Improvement Programs. Harvard Business Review blog 11.11.2013; accessed at https://hbr.org/2013/11/integrating-maintenance-of-board-certification-and-health-systems-quality-improvement-programs/ on 09.08.2015.

What information should be reported and what quality checks and/or data validation should occur to ensure successful completion of these activities?

ABMS recommends avoiding a reporting system for CPIA that is redundant of requirements for MOC. We recommend negotiating with certifying boards for what CMS feels is adequate, accountable CPIA performance and reporting to enable physicians to report to their Member Boards and Member Boards to attest on behalf of physicians. Building alignment with recertification improves synergy and would recruit the certifying boards into providing tools and processes to meaningfully support CPIA.

DEVELOPMENT OF PERFORMANCE STANDARDS

How should we define improvement and the opportunity for continued improvement? For example, section 1848(q)(5)(D) of the Act requires the Secretary, beginning in the second year of the MIPS, if there are available data sufficient to measure improvement, to take into account improvement of the MIPS EP in calculating the performance score for the quality and resource use performance categories.

ABMS suggests rewarding three levels of improvement:

1. Meaningful Engagement: Reflection - the process of critically thinking about the activity, the results of the activity, and the impact of the activity on the physician, the physician's practice, and the affected patient population – is key to this process. At this time, the improvement process is not well understood, practice improvement skills are not highly developed, measures are inadequate, data systems are developmental, and participation in data collection relatively low. Meanwhile, the whole process is not well-integrated into practice, which takes physicians out of their clinical role, interferes with their practices, and adds to the sense of burden. We must help physicians meaningful engage in improvement activities.
2. Measurable Improvement: This might involve adoption of a quality or safety practice that is known to be effective or improvement in reducing a performance gap between actual and best achievable performance. This will require sufficient data reporting to generate a benchmark that can identify "best achievable" and an analysis of what "best" performers do differently.
3. Attainment of "best achievable performance": physicians demonstrate that they have fully adopted the improvement practices and/or reached the performance benchmark.

CONCLUSION

ABMS Member Board continuing certification programs contain a variety of opportunities for assessment and learning across a spectrum of clinical competencies that will improve care and experience for Medicare beneficiaries. Quality and safety improvement activities have been vetted and approved by the ABMS Member Boards, are structured around conventional quality improvement practices, and the physician's personal engagement is verified. We urge CMS to

align MACRA reporting and improvement with Maintenance of Certification, and work with the ABMS Member Boards to report physician improvement activities. We believe that the Multispecialty Portfolio Improvement Program, in which 21 of the 24 ABMS Member Boards participate, should be an especially valuable partner.

Finally, CMS should take an expansive view of what constitute creditable "Clinical Practice Improvement Activities." These might involve skills development on practices that are not easily measured. For example, a recent report on Improving Diagnosis in Medicine from the Institute of Medicine of the National Academy of Sciences, suggests that certifying boards emphasize improvement in diagnostic reasoning, including the adoption of "meta-cognitive" practices that may reduce cognitive biases that can impede diagnosis. Practices to improve diagnostic reasoning get to the core of what physicians do, yet they do not fit into the narrow framework of performance measurement that prevails today. Likewise, there is evidence that improving physician communication skills can improve diagnostic accuracy, patient outcomes, and organizational resilience, and efforts to improve these skills should be credited even in the absence of scalable, practice-relevant measures today. Finally, physician engagement in the adoption of safety systems and system improvements is critical to the achievement of CMS's overall quality goals. All of these activities should be viewed as "Clinical Practice Improvement Activities" under MACRA.

The ABMS Member Boards continue to be eager to work with CMS to make care better for Medicare patients. We look forward to further dialog.

Sincerely,

Tom Granatir
Senior Vice President, Policy and External Relations