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Marilyn B. Tavenner **Acting Administrator** Centers for Medicare & Medicaid Services Department of Health and Human Services CMS-3276-NC P.O. Box 8013 Baltimore, MD 21244-8013

Re: CMS-3276-NC, 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 Acting Administrator Tavenner:

On behalf of the American Society of Hematology (ASH), thank you for the opportunity to offer the Society's input in response to the Medicare Program's Request for Information (RFI) on the Use of Clinical Quality Measures Reported under the Physician Quality Reporting System (PQRS), the Electronic Health Record (EHR) Incentive Program, and Other Reporting Programs.

ASH represents approximately 14,000 clinicians and scientists committed to the study and treatment of blood and blood-related diseases, including blood cancers such as leukemia, lymphoma and myeloma, and nonmalignant illnesses such as anemias, thrombosis and bleeding disorders. ASH's mission is to promote the understanding, prevention and treatment of blood disorders, and improve healthcare and patient outcomes with hematologic disease.

One of the Society's core values is to promote the highest quality care of patients with hematologic diseases. ASH is committed to ensuring that the practice of hematology is characterized by high professional standards and reliance on evidence, and to promoting awareness and appreciation of the contribution of hematologists in the health care system. To assist its members and other clinicians providing hematology care, ASH has developed evidence-based tools, including clinical practice guidelines, quick reference guides and webinars. The Society has also created performance measures and practice improvement modules to measure quality and gauge improvement in the care provided to patients with various hematologic diseases. Additionally, the Society convenes a quality session each year during its Annual Meeting, focusing on the successful implementation of quality improvement efforts in the field.

ASH greatly appreciates Medicare's interest in seeking ways that an eligible professional might use clinical quality measure data reported to specialty boards, specialty societies, regional health care quality organizations or other non-federal reporting programs to also report under the PQRS program. The Society recognizes the importance of providing

clinicians with ways to improve quality of care for patients, but, as described below, has struggled in how to best and most efficiently develop tools and participate in current federal and non-federal programs. ASH asks CMS to consider these concerns and offer flexibility as it looks to align its quality reporting system with other federal, nonfederal and/or state based quality reporting programs.

ASH and PQRS - Comments on the Current System

Working with AMA's Physician Consortium for Performance Improvement (PCPI), ASH has developed four quality measures in hematology that are endorsed by the National Quality Forum (NQF) and are included in Medicare's PQRS program. These measures include: #67 Myelodysplastic Syndrome and Acute Leukemias - Baseline cytogenetic testing performed on bone marrow; #68 Myelodysplastic Syndrome - Documentation of baseline iron stores in patients receiving erythropoietin therapy; #69 Multiple Myeloma - Treatment with bisphosphonates; and, #70 Chronic Lymphocytic Leukemia - Baseline flow cytometry. There have been limitations placed on ASH, however, in attempting to create new measures. Measures are expensive to develop and test; and, when ASH has submitted new measure topics to the entities that develop and approve measures, the topics have not been accepted. Like ASH, many specialty societies are under pressure to revise and develop new measures in order for their members to be able to comply with the PQRS program. This increase in the sheer volume of measures directly impacts the total number of measures that PCPI and NQF can efficiently manage, which limits and slows down the development and approval process. But, it is important to recognize that PCPI's measure development and testing expertise is still greatly needed by small subspecialty societies that do not have a robust infrastructure to develop and test measures.

Comments on Concept to Use CQM data Reported to Specialty Boards

ASH has developed products that could translate into a performance improvement/quality related reporting system. ASH-developed chart abstraction tools and Practice Improvement Modules or PIMs are web-based self-evaluation tools that guide board-certified physicians through medical record abstractions and a practice system inventory to establish a performance assessment for a chronic condition or preventive service. PIMS include "quality indicators," which are the key procedural steps expected to be performed in the routine diagnosis or treatment of a patient. The concept is that through this process, physicians can make substantial improvements in practice that will translate into higher quality of care for patients. The interactive PIM process allows a physician to reflect on detailed performance data, select areas for improvement and create an improvement plan with goals and strategies. Once the plan has been implemented and its effect measured, the board-certified hematologist reports the results to the American Board of Internal Medicine (ABIM) for its Maintenance of Certification (MOC) program. In addition to receiving MOC credit, physicians who complete a PIM earn 20 AMA Category 1 Continuing Medical Education (CME) credits. ASH believes that the PIMs process is one that could be further developed to meet the requirements of an aligned quality-related reporting system.

While PIMS may be an option for hematologists to participate in a quality-related reporting system, ASH notes some important considerations. Hematology as a field is comprised of many rare diseases. The existing PIMs reflect only a small number of disorders treated by hematologists and it will be difficult for ASH to develop PIMs to encompass all of the diseases and disorders that hematologists treat. Furthermore, a single hematologist typically sees 10 patients per rare hematologic disease each year, at best. For this reason, ASH strongly urges CMS not to require eligible professionals to report on a minimum number of patients, but rather, to maintain its current system to report on a percentage of Medicare patients. This would allow for flexibility for physicians who treat a smaller number of patients with rare diseases. Hematology chart abstraction tools developed by ASH focus on the following topic areas: myelodysplastic syndromes (MDS), multiple myeloma, perioperative anticoagulation management and immune thrombocytopenia (ITP). ASH is in the process of submitting

two PIMS on non-Hodgkin lymphoma and MDS to ABIM, but there are many additional diseases and areas covered by hematology that are not yet addressed in PIMs.

The Society also recommends that CMS be flexible with respect to the types of measures reported, i.e., outcomes measures and process measures. Any system that only bases payment on the outcome of care rendered needs to recognize the wide differences in the nature of the disease processes treated by various specialties which will of course affect patient outcomes including morbidity, mortality and complication rates. Hematologists care for patients with many rare diseases, with many stages and different molecular subtypes. There are few randomized clinical trials or guidelines in hematology, and because the science is ever-changing, a potential quality metric may quickly become out-moded, making year-to-year comparisons difficult. In addition, unlike our proceduralist colleagues, where 30 day outcome parameters can be used, many of the hematologic diseases are chronic in nature, and surrogate end-points may be difficult to abstract and quantify. A "one size fits all" approach to quality measure characteristics would neither be fair nor workable. We strongly urge CMS to continue accepting process measures in its quality reporting programs.

Finally, ASH recommends that CMS ensure a transition period of at least 5 years to allow for stable and predictable reporting. Measures typically take one year to develop, prior to acceptance in the PCPI and NQF queue for testing and approval. A realistic timeframe would allow adequate time for medical specialty societies to develop and put in place a more robust practice improvement and quality measure development program. ASH reminds CMS that the PQRS program was established with very little lead time. Societies like ASH had to scramble and within months develop and have approved new quality measures. The approving organizations were not equipped to handle the number of new measures and a backlog occurred leaving many new and important measures stymied by the process. A period of stability coupled with flexibility will go a long way to ensure strong partnerships focused on meaningful quality improvement.

Again, thank you for the opportunity to comment.

Sincerely,

Janis L. Abkowitz, MD

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President