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Chairman Dave Camp
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

Sent via email to *physician.feedbackwm112@mail.house.gov*

Dear Chairman Camp:

On behalf of the American Society of Hematology (ASH), thank you for the opportunity to offer the Society's insights on needed changes to Medicare's physician payment system and on how to integrate quality and value-based measures into different practice arrangements to improve health outcomes and efficiency in the Medicare program.

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.

ASH joins the chorus of organizations and physicians urging Congress to repeal the SGR formula and provide a predictable and stable system for updating fees over time to fully and realistically account for the costs of operating a medical practice. The threats of massive reductions to the conversion factor due to the flawed sustainable growth rate (SGR) formula need to be eliminated. A system where each year physicians are faced with payment reductions of 20 to 30 percent only to be bailed out by last minute temporary fixes cannot be sustained. Physicians will increasingly look to minimize their exposure to Medicare by not taking new patients or by opting out of the program entirely.

In addition, ASH asks the Committee to address the imbalance in payments for cognitive services compared to those for procedural services. This issue goes well beyond the need to attract and retain primary care physicians, which receives the most public and congressional attention. Primary care is critical to the nation's health care system, but so too is access to medical specialists as well as adequate compensation of medical specialists who do not perform lucrative procedural services. Despite some efforts to modestly increase the relative values for evaluation and management services by CMS and the AMA Relative Value Update Committee (RUC), the payment scale is still substantially skewed in favor of physicians who perform surgical and other procedural services. Consequently, the Society urges the Committee to advance the Medicare Physician Payment Innovation Act (H.R. 5707) introduced by Representatives Heck and Schwartz. ASH believes that this bill is a good first step in addressing the chaos physicians currently face because it would eliminate the SGR and provide for stable updates in fees for five years. In addition, the bill provides for differential updates of 2.5 percent for primary care, preventive and care coordination services provided by any

clinician for whom 60% of their Medicare allowable charges are for those same services. Both primary care and cognitive specialists who meet this definition would receive the higher rate increase.

Before providing responses to the questions raised in your letter, we would like to raise a few issues related to Medicare reimbursement in general and caution that transforming physician payment must be done carefully. ASH agrees with the goal of transforming the Medicare physician payment system to one that preserves and promotes the patient-physician relationship while encouraging physicians to provide high quality of care delivered in a cost effective manner. However, it is critical to recognize the significant changes that have already taken place in the health care system and to keep them in mind as changes are made. In this connection, we would note the following:

- The rate of growth of Medicare spending has substantially moderated the last few years. In fact, in 2010 and 2011 per enrollee spending increased only at about the rate of overall inflation. Per enrollee spending for physician services subject to the Sustainable Growth Rate (SGR) increased by only 2.1 percent in 2011.

- The SGR was, of course, established to serve as a mechanism to constrain the growth of spending due to increases in the volume and intensity of physician services. However, recent trends indicate that the growth in volume and intensity has moderated substantially, increasing by less than 1 percent in 2011. For example, per enrollee utilization for most imaging procedures and surgical procedures actually showed negative growth in 2011. The growth in imaging and procedural services was one of the main contributors as to why SGR spending targets were not met in prior years. The data strongly suggests that practice guidelines, increased focus on quality of care, and other systemic changes in physician practice patterns have led to this slow down in spending. ASH therefore believes suggestions that the reduction in utilization is primarily due to the state of the overall economy are misplaced.

- While the growth of spending for physician services has been greatly reduced, ASH recognizes that this does not solve the budgetary problem of replacing the SGR formula. However, radical changes in physician payment should be considered very carefully because they might not be needed to constrain future growth in physician services and might in fact cause irrevocable damage to the health care system.

- Moreover, as Congress considers changes to transform the physician payment system, the impact on the overall medical care system must be taken into consideration -- not just spending for physician services. For example, despite the overall reduction in the growth of spending for most categories of physician services per Medicare enrollee, the use of hospital emergency room (ER) visits increased by about 5 percent in 2011. ASH believes this is attributable to the shortage of primary care physicians and inadequate payments for consultation services leading some primary care and medical specialists to limit their Medicare practice. Increased ER visits result in substantially higher payments to hospitals in addition to the physician's ER payments.

With respect to your specific questions, the following are some comments and recommendations for your consideration:

Rewarding Quality and Efficiency

1. *How do you think quality, efficiency, and patient outcomes should be incorporated into the Medicare physician payment system? (Please include details on experiences with non-Medicare payers that could be instructive.)*

Meaningful quality and outcomes should be incorporated into the Medicare physician payment system. Programs to improve quality, efficiency and outcomes should be developed with the prospective and adequate input from physicians to ensure their relevance and feasibility. However, the economic reality of added costs of reporting, analysis and compliance with such programs need to be recognized by CMS and Congress. Due to the wide array of physician practice models and settings, "generic" efficiency parameters and metrics may not be relevant, feasible or meaningful if implemented broadly. More pragmatic and realistic measures of efficiency can be created appropriate to different practice settings with input from the specific segments of the physician community. Efficiency measures should be incorporated only after adequate evaluation by prospective operational models of care.

2. To what extent has our organization developed and/or facilitated the use of:

a. *Quality and outcome measures*

ASH created four hematology process measures that have been endorsed on a time-limited basis by the National Quality Foundation (NQF) and currently are under review by NQF's Cancer Committee to receive full endorsement this year. The measures are included in the Physician Quality Reporting System (PQRS). The measures are:

- **Myelodysplastic Syndrome (MDS) and Acute Leukemias**
  CMS Measure #67 (Hematology Measure #1) - Baseline cytogenetic testing performed on bone marrow
  Description: Percentage of patients aged 18 years and older with a diagnosis of MDS or an acute leukemia who had a baseline cytogenetic testing performed on bone marrow.

- **Myelodysplastic Syndrome (MDS)**
  CMS Measure #68 (Hematology Measure #2) - Documentation of baseline iron stores in patients receiving erythropoietin therapy
  Description: Percentage of patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy with documentation of iron stores prior to initiating erythropoietin therapy.

- **Multiple Myeloma**
  CMS Measure #69 (Hematology Measure #3) - Treatment with bisphosphonates
  Description: Percentage of patients 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous biophosphonates within the 12 month reporting period.

- **Chronic Lymphocytic Leukemia (CLL)**
  CMS Measure #70 (Hematology Measure #4) - Baseline flow cytometry
  Description: Percentage of patients aged 18 years and older with a diagnosis of CLL who had baseline flow cytometry studies performed.

b. *Evidence based guidelines*

ASH has developed, published, and maintains these evidence-based guidelines:

- American Society of Hematology 2011 Clinical Practice Guideline on the Evaluation and Management of Immune Thrombocytopenia (ITP)

- American Society of Hematology/American Society of Clinical Oncology 2010 clinical practice guideline update on the use of epoetin and darbepoetin

- ASH is currently working with the College of American Pathologists (CAP) to develop and publish an evidence-based guideline on the Initial Work Up of Acute Leukemia

ASH is providing or has provided expertise, review and comments to other societies in developing guidelines on hematologic problems. Examples are as follows:

- The International Collaboration for Guideline Development, Implementation and Evaluation for Transfusion Therapies – Transfusion Medicine Guideline

- AABB Guideline on Use of Red Blood Cells

- American Academy of Orthopaedic Surgeons –Guideline on Preventing Venous Thromboembolistic Disease in Patients Undergoing Elective Hip and Knee Arthroplasty

- American College of Chest Physicians - Evidence-based Clinical Practice Guideline on Antithrombotic Therapy and Prevention of Thrombosis (9th Edition)

- Infectious Diseases Society of America on its Clinical Practice Guidelines for the Immunization of the Immunocompromised Host

c. *Patient Registries*

ASH does not operate any patient registries.

d. *Continuous quality improvement programs or strategies*

ASH offers Practice Improvement Modules (PIMs) to its members to allow participants in the American Board of Internal Medicine (ABIM) Maintenance of Certification (MOC) programs to conduct self-evaluation of practice performance and earn 20 practice improvement points in addition to 20 *AMA PRA Category 1 CME Credits*™. ASH currently has modules in the area of myelodysplastic syndromes, multiple myeloma, immune thrombocytopenia and perioperative anticoagulation management.

e. *Electronic Health Records*

Some, but not all of ASH's members have adopted electronic health records. A significant number of ASH members are based in hospitals and academic health centers where the hospital or physician practice plan has invested in and implemented EHRs. A smaller portion of ASH members in private practice have adopted EHRs. While many of the larger hematology/oncology group practices have adopted EHRs the physicians have expressed concerns that the technology currently available is difficult to use and often complicates patient care.

3. What clinical improvement activities have been developed and are supported by your organization or have otherwise been used effectively by your members?

The ASH Annual Meeting is the premier hematology meeting that advances the practice of hematology and provides continuing medical education credits (CME) to participants. As part of the Annual Meeting education program, ASH offers a Special Session on Quality. Last year's topic was on quality indicators

and their relevance to hematology in the areas of Acute Myeloid Leukemia, Venous Thromboembolism prevention and Sickle cell disease. The session examined how measures are derived, how they can be measured, and the potential consequences for failing to adhere to the indicators. The 2012 session will focus the basic concept of quality improvement for practices and institutions. Two clinical areas relevant to hematology will be featured: retrieval of temporary vena caval filters, and appropriate use of Venous Thromboembolism prophylaxis in hospitalized patients.

Highlights of ASH® is held a few weeks after the annual meeting, and is a smaller meeting that provides an opportunity for physicians to hear leading experts discuss the most practice-changing findings and the latest treatment options that were presented during the annual meeting.

ASH offers a Consultative Hematology Course designed to provide updates in non-malignant hematology to community practitioners who were trained as hematologists-oncologists, but who now see patients with non-malignant hematologic disorders on a less frequent basis. The goal of the course is to improve the quality of care of clinical problems that arise in everyday practice and require the expertise of a hematologist. The course uses case-based presentations and interactive discussions on topics such as thrombosis, thrombocytopenia, bleeding, and white blood cell abnormalities.

ASH also offers an evidence-based webinar program throughout the year. The sessions feature presentations by experts in the field, cover the most current information on how to best diagnose and care for patients and provides time for questions and answers. Topics for the 2011-2012 program include sickle cell disease, Antiphospholipid Antibody Syndrome, Stroke, Renal Disease, and Treatment with Hydroxyurea in Adults with Sickle Cell Disease, Pain in Sickle Cell Disease, Thrombotic Complications in Pregnancy, Thrombosis and Cancer, Plasma Cell Malignancies, Oral Anticoagulants, and Evaluation and Management of Immune Thrombocytopenia.

ASH has also developed Quick Reference Guides for its clinician members, which are based on evidence based guidelines. The quick reference guides are summaries of clinical practice guidelines; guides are being converted into mobile downloads for smart phones and tablets. Current Quick Reference Guides include:

- Heparin Induced Thrombocytopenia
- Evaluation and Management of Immune Thrombocytopenia
- Anticoagulant Dosing and Management of Anticoagulant-Associated Bleeding Complications in Adults
- von Willebrand Disease

ASH has partnered with Medscape to provide hematologists with an opportunity to earn CME credits by testing their comprehension of clinical articles published in *Blood*. *Blood* is a weekly peer-reviewed journal published by ASH.

The ASH Self-Assessment Program (ASH-SAP) is an educational product offering up-to-date information in the field of hematology for internists, hematologists, pediatricians, and hematology-oncology fellows. It includes a textbook available in print and online and an accompanying exam which contains more than 220 questions in adult and pediatric hematology. ASH designates the ASH-SAP for a maximum of 50 A*MA PRA Category 1 Credits*™. In addition, physicians participating in the ABIM Maintenance of Certification (MOC) program who complete the ASH-SAP/MOC module can earn 70 medical knowledge points.

5. Is there anything else your organization would like to share with the Committee on how to reward physicians for high quality, efficiency, and patient outcomes?

- Programs should be developed to incentivize and reward physicians for quality, efficiency, and improved patient outcomes. Participation in these programs should be voluntary. Opportunities exist to reduce overall costs burdens by engaging physicians to voluntarily reduce hospital admissions, duration of hospital stay, ER visits, and overutilization of services. As an example, groups of physicians can collectively agree to provide staggered or extended evening and weekend office hours to reduce unnecessary ER visits. Physicians can receive extra incentive payments for these initiatives, care co-ordination and other innovative cost saving measures which would also improve quality of care and customer satisfaction of patients. Any added costs for compensating physicians for these initiatives would be more than offset by reduction in payments for hospital costs associated with ER visits.

- Reasonable regulatory latitude is essential to foster innovation and efficiency though the dynamics of market forces, in order to drive cost efficiencies. Medicare can adopt successful examples from the private sector, geared for incentivizing quality and costs.

- Taking into account the payment for the physician and payment to the hospital, there are huge disparities in Medicare payments for the same services provided to Medicare beneficiaries in the hospital outpatient setting versus the physicians' office setting. More incentives given to physicians to enhance and expand services delivered in their offices will result in significant savings to the total Medicare system.

Alternate Payment Models

1. *Are there quality-enhancing alternatives to fee for service, such as bundled payments and shared savings models that our members have experience with or are developing with private payers?*

ASH believes the Accountable Care Organization model is very promising, offering opportunities to improve quality of care and result in substantial cost savings to the Medicare program. However, as discussed below, there are a number of changes needed for ACOs to realize their potential.

There are multiple and significant barriers for physician participation and adoption of ACOs, bundled payment initiatives and gain sharing programs. Under current regulations, physician groups cannot participate readily in Medicare ACOs due to very high start-up costs (average approx. $1.2 million) and initial annual operating costs (nearly $ 1 million per year). The unintended consequence of this is that predominantly large hospital systems or Physician/Hospital organizations (PHOs) with strong financial resources will be the only entities able to create Medicare ACOs. Most physician groups find it difficult or impossible to come together and create the capital base necessary to transcend these financial and legal barriers to allow deployment of these novel delivery models.

Regulatory latitude from anti-trust, Stark and anti-kickback statutes is needed for physician organizations to form ACOs. Without creating specific and clear cut safe-harbors for physicians to work together in forming alliances to adopt novel care delivery methods, physician groups will remain constrained and unable to move forward with novel projects to improve care delivery, quality, outcomes and costs.

Patient Involvement and Regulatory Relief

1. *How do you think physicians can encourage beneficiaries to seek appropriate, high-value health care services?*

- There should be continued effort by CMS to engage beneficiaries in preventive care, health maintenance and wellness. While some improvements have been made over the years such as waiving copays for some preventive services and covering a "Welcome to Medicare" physical exam, traditional Medicare funding continues to be predominantly for acute care for illness and payment for preventive care has been largely neglected.

- Coverage of home-based services is limited under Medicare, which results in patients needing more frequent hospital services or services at extended care facilities, thereby driving Medicare costs even higher. Innovations in elder care and non-traditional, home-based living, as opposed to nursing home care, should be explored. Medicare should pilot programs for funding evidence-based preventive, health maintenance and wellness programs.

2. Are there administrative and regulatory burdens that see barriers to fundamental delivery system reform? If so please describe

The Society notes that we have heard from some members, particularly those in smaller private practices who report that they are not participating in some new Medicare programs (i.e., PQRS) because the financial burden to set up and implement the program is greater than the incentive provided. ASH recommends the Committee take note of the impact of implementing new programs on the physician practice as it continues to develop future reforms.

3. Are there unnecessary administrative and regulatory burdens that you see as taking valuable time away from seeing patients and/or increasing costs to the Medicare program? If so, please describe.

The following are some of the examples which increase the overall costs to Medicare by arbitrarily constraining physician efficiency and productivity and impede innovation and adoption of new care delivery models.

- The current physician E&M codes require "face to face" time with the patient as the essential basis for payment with some minimal "pre and post time" assigned. However, medical care is provided in a more complex continuum of interactions with the members of the care team, including deliberations and review of relevant clinical material and data sources; many of these interactions occur outside the physician's exam room and without the patient's presence. This is particularly true for specialists such as hematologists who manage complex hematologic and oncologic problems; the time and effort required for which this is only minimally captured in the E&M visit codes. Basing physician payments on "time-slots" in the exam room is counter-intuitive to improved efficiency, innovations in care delivery and leveraging EHR for physician to provide relevant and appropriate care to bring about desired health outcomes. There are established codes for some of these non- face-to-face activities such as team conference, telephone consultations, but CMS has chosen not to recognize these interactions. Providing compensation to physicians to manage complex medical problems will, in the long run, result in improved quality of care and program savings.

- Especially for cognitive medical services and specialties which manage complex medical problems, there should be reduced reliance on only face to face time in determining payment for evaluation and management services. As an initial step, the established E/M non face to face codes such as team

management services should be recognized by CMS. Ultimately it might be desirable to have a periodic bundled payment for managing a patient with a complex medical problem.

- There is a constantly increasing plethora of regulatory documentation with increasing complexity, required by the CMS, thereby over-burdening the physicians and taking precious time away from patient care and clinical decision making. The vast majority of these forms relates to attestations for durable medical equipment and miscellaneous ancillary therapies and could be completed by the designated staff instead of the physicians. Every year, new requirements for documentary attestations are imposed by the CMS without evidence-based data on performance, outcome or overall cost reduction to Medicare. Conceivably, the deployment, management and oversight of compliance with every new documentation and attestation requirement will increase the overall costs to Medicare. Furthermore, the loss of physician productivity and economic loss due to reduced efficiency of care delivery will add incremental costs to the Medicare program over time.

- Finally, the Society would like to note the problem of the lack of synchronization of the incentive and penalty phases of Medicare's E-prescribing, Electronic Health Record (HER), and PQRS programs. Physicians are required to meet separate requirements and are facing present and future financial penalties if they do not successfully participate in multiple Medicare programs, including the e-prescribing program, the HER meaningful use program, and PQRS.

  In addition, CMS has decided to back-date the reporting requirements under the penalty programs so that a physician will face a penalty based on activity in a year prior to the year that the penalty specified in the law. CMS has essentially pushed up deadlines for participation by a full year or more, and this back-dating policy will subject a significant number of physicians to financial penalties and slow down the adoption and implementation rates of EHRs. These programs should be better synchronized so that physicians who successfully participate in one program are protected from penalties associated with the other programs.

The Society thanks you again for the opportunity to submit these comments and looks forward to working with you to find a permanent solution to the physician payment issue and prevent future disruption by short-term measures to correct the SGR formula. ASH would welcome the opportunity to meet with you to further discuss the Society's concerns. If you have any questions or would like additional information, please have your staff contact ASH Senior Director of Government Relations, Practice, and Scientific Affairs Mila Becker at *mbecker@hematology.org* or 202-776-0544.

Sincerely,

Armand Keating
President