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**2013**

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Representative Fred Upton  
Chairman, Energy and Commerce Committee  
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Dear Chairman Upton,

The American Society of Hematology (ASH) appreciates the opportunity to offer the Society's comments regarding the Energy and Commerce Committee's latest draft of the proposed legislation to repeal the sustainable growth rate (SGR) formula and reform Medicare's physician fee for service payment system. Committee staff have provided a list of questions, many of which the Society has responded to in previous letters to the Committee (for your reference, ASH's previous letters are available via the following hyperlinks: [June 10, 2013 letter](#), [April 15, 2013 letter](#), and [February 25, 2013 letter](#)). ASH's responses to the major elements of the proposed legislation are summarized below.

ASH is concerned that this latest legislative draft leaves many key provisions of the proposed physician payment system unaddressed. There are few details on the update incentive program's implementation, operation, oversight, and impact on payment. For that reason, we are unable to provide specific responses to many of the questions raised by the Committee staff. ASH suggests that Committee staff meet with the physician community to provide more information on the proposal. ASH has provided a list of questions pertaining to the latest version of the draft legislation at the end of this letter. These may serve as the basis for future discussion and enable our Society and others to more precisely respond to the Committee.

### **ASH Comments on Major Elements of Energy and Commerce Legislative Proposal**

#### **Repeal of the SGR and a Period of Stable Payment Rates**

ASH strongly supports the repeal of the SGR formula and strongly supports legislation that mandates a period of a minimum of 5 years of predictable payment rates in its place. The continued threat of massive reductions in physician payment due to the SGR, overcome at the last minute by temporary legislative rescues, is an ineffective and counterproductive way for the Medicare program to operate. Given the multiple changes in Medicare and new requirements for physicians, physician practices need a period of stable payment rates to avoid interrupting patient access and further tumult in the system.

#### **Provider Competency Update Incentive Program**

ASH also seeks a phase-in of the Update Incentive Program (UIP) as there are limited quality measures available to hematologists and it will take several years to expand these activities so that all subspecialists in hematology can participate. ASH strongly believes that the UIP should not penalize specialists and subspecialists who do not participate in a quality performance program because there are no measures related to their clinical

practice. ASH would support bonus payments for early innovators; however, the funding for these incentives should not be financed through the fee schedule, which could potentially penalize specialists whose specialty does not yet have adequate measures. ASH would assume that physicians who do not participate in Medicare, as well as those in Medicare Advantage, would not participate in the UIP.

A great deal of work, time and resources have been invested into the development of measures for the existing Medicare quality improvement programs. ASH recommends that the existing measures be evaluated by interested specialty societies to determine their relevance to current practice and efforts to coordinate measures between the existing programs be enhanced. Combining the existing programs into a single quality performance program with greater incentives than the current system offers would likely increase participation by physicians.

ASH continues to be concerned that efficiency measures will be difficult to incorporate into an incentive system. This may have to be done in a more general way, such as looking at efficiencies in evaluation and management services or other services or tasks that are shared by all types of practitioners. ASH asks that efficiency measures only be implemented after the quality-related payment system has been incorporated into practice for several years. By that time, more experience in this area will have been gained from the alternative payment options such as ACOs and medical homes.

Committee staff has specifically requested comments on the two alternative payment models offered for UIP. Based on the description given (more detail on this would be helpful), ASH would prefer the “threshold or benchmark” model. As described in the Committee’s handout, the standards for this quality incentive payment would be known in advance and the benchmarks could be limited to a few levels – such as highest, intermediate and lowest. ASH would favor a model whereby all providers can earn the maximum update rather than the “percentile” model whereby each individual provider is ranked at the end of the year based on their composite score relative to that of his/her peers. ASH believes that the “percentile” model is problematic in that it assumes a level of precision in the quality ranking system which is unrealistic and unfair to base an incentive payment system for all physicians. The “percentile” model also guarantees that some physicians will be ranked low even if great improvement in quality is achieved. It also rewards specialties as a group which will have the unintentional effect of penalizing the low achievers in a specialty that has embraced quality performance and/or rewarding a specialty that underperforms in terms of quality measures.

### **Recommendation to Develop “Deeming” Process**

ASH has greatly appreciated the work of the American Medical Association (AMA) Physician Consortium for Performance Improvement (PCPI) and the National Quality Forum (NQF), but the Society has been frustrated with the slowness of the processes and the limited number of measures that can be developed at one time. Many specialty societies and other organizations are equipped to independently develop quality programs. While this too will take time and resources, ASH would like the Committee to consider a process by which specialty society programs could be deemed to meet CMS’ standards for quality programs. CMS could set standards for quality measure development and measures developed by societies (or other organizations) that follow these standards would be included in the Medicare program. It would be the responsibility of the “deemed” organizations to review and collect data on the measures they develop and to update or eliminate measures as appropriate. This would be a process somewhat analogous to that used by the Accreditation Council for Continuing Medical Education (ACCME) to set and enforce standards in physician continuing education within the United States. ACCME acts as the deeming or overseeing body for institutions and organizations providing continuing medical education activities.

**Questions for Further Discussion of Proposed Legislation**

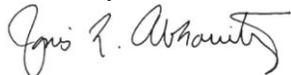
As stated above, ASH would like to provide the Committee with more specific input, but would need additional information to better understand the fundamental framework of the proposed payment system. The Society would greatly appreciate the Committee's views related to the key questions below:

- What is the timing for implementation for the competency update incentive program so we can assess whether it is realistic?
- How will the conversion factor be updated? Will there be a single conversion factor updated on a cumulative basis or an annual adjustment, returning to a baseline standard each year?
- How will the conversion factor update and the update incentive program score or composite rate be combined?
- Why does the Committee use the term quality offset ("offset" sounds like a penalty rather than an incentive payment)? Will the UIP score determine if the provider gets a full or partial update?
- Does the legislation anticipate that there will be peer cohort standards for most services performed by all providers or will it more closely resemble the PQRS incentive system whereby a limited number of quality measures are reported? We reiterate that there are limited and in some cases no evidence-based standards for many services.
- The legislation seems to anticipate that registries may be the prime reporting mechanism for competency measures, yet there are no registries for the majority of specialties. How does the Committee envision that specialties without registries will meet the requirement?
- While there is a group reporting option, will scoring and feedback only occur at the individual provider level? Has the Committee considered allowing group practices to deal with individual provider performance issues within the group?
- Will there be a minimum proportion of a provider's services that needs to be covered under a peer cohort for the UIP update to apply?
- Have there been discussions with CMS and the MACs on the feasibility of implementing the update incentive program? Is quarterly feedback to individual providers realistic?

The Society thanks you again for the opportunity to submit these comments. 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 outcomes for patients with hematologic disease.

ASH would welcome the opportunity to meet with you to further discuss the Society's questions and concerns. If you have any questions or would like additional information, please have your staff contact ASH Government Relations and Practice Manager Stephanie Kaplan at [skaplan@hematology.org](mailto:skaplan@hematology.org) or 202-776-0544.

Sincerely,



Janis L. Abkowitz, MD  
President