



2013

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June 10, 2013

Representative Fred Upton
Chairman, Energy and Commerce Committee
U.S. House of Representatives
2183 Rayburn House Office Building
Independence and S. Capitol St., S.W.
Washington, DC 20515

Dear Chairman Upton,

The American Society of Hematology (ASH) appreciates the opportunity to offer the Society's comments regarding the proposed legislation to repeal the sustainable growth rate (SGR) formula and reform Medicare's physician fee for service payment system.

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.

Repeal of the SGR and a Period of Stable Payment Rates

ASH strongly supports the repeal of the SGR formula and urges Congress to mandate 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.

Response to Questions on Draft Legislation

ASH is pleased to provide feedback on the questions from the Committee on its draft legislation to reform physician payment. ASH is only responding to those questions most relevant to the Society and its members.

Phase I

1. What is an appropriate period of payment stability in order to develop and vet measures and build the necessary quality infrastructure?

ASH recommends that Congress legislate the level of the conversion factor for a minimum period of 5 years and that the fee updates provided during this period be based on the medical rate of inflation. This is very important for ASH as hematologists care for patients with many rare diseases, at various stages and with different molecular subtypes. Hematologists have only a small number of existing measures (4 measures are currently included in Physician Quality Reporting System (PQRS)) and sufficient time is needed to develop additional measures as well as alternative clinical improvement activities.

Randomized clinical trials and guidelines do not exist for many areas of hematology. Measure development is time consuming and difficult. In addition, many hematologic diseases are chronic in nature and surrogate end-points may be difficult to abstract and quantify. The Society will need to expend significant resources to build the quality infrastructure that the Committee is suggesting and to assure that the many subspecialists in hematology will be able to participate in the program.

2. Considering the different levels of provider readiness, how do we balance the need for a stable period enabling providers to build and test the necessary quality infrastructure, while still incentivizing early innovators to move to Phase II, with opportunities for quality-based payment updates?

As stated in ASH's response to question 1, there are limited quality measures available to hematologists and it will take several years to expand these activities. ASH strongly believes that specialists and subspecialists, who do not participate in a quality performance program because there are no measures related to their clinical practice, should not be penalized. ASH suggests that, in addition to a period of stable payment rates, quality-based payment updates be phased in over several years to provide adequate time for all specialists to participate. 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 without adequate measures.

3. What does a meaningful, timely feedback process look like for providers? What are adequate performance feedback intervals?

There is currently a two-year time delay before Medicare data becomes available to providers. This should be reduced to a year or 6 months, if possible, for feedback to be meaningful.

- 4. How should Peer Provider Cohorts be defined to ensure adequate specificity while preserving adequate comparison group size and ability to develop appropriate measurement sets? For example, is using the American Board of Medical Specialties (ABMS) list adequate?**
- 5. Should the list of Peer Provider Cohorts also include patient, procedural, or disease-specific cohorts in addition to the traditionally-defined specialty groupings? Pros of this approach are that it would offer a more relevant basis for measure development and comparison between physicians, since many physicians perform outside of or in a narrow range of the "stereotype" description of their primary specialty. Cons are that it may create too vast of an array of cohorts. This may dilute the ability to develop meaningful quality measurement sets and comparison groups and impose excessive financial and administrative burden on the physician group as well as upon CMS. In addition to answering, please provide rationale.**

ASH recommends that physicians be allowed to determine the cohort that they can participate in based on the services they provide and the diseases and conditions they treat. Depending on physician availability, primary care doctors in rural settings will treat many patients that would be seen by specialists in cities.

ASH does not think it is appropriate to use The American Board of Medical Specialties (ABMS) to define cohorts for quality measurement purposes as ABMS silos physicians into areas of certification, not necessarily areas of practice. Physicians determine their area of certification based on a variety of variables including the costs associated with initial certification and maintenance of certification. Also, certification is still voluntary and employers (be they hospitals or groups) often provide privileges based on training and experience in addition to certification.

Many physicians trained in hematology/oncology choose to be certified in only one specialty. Specifically, ABIM reports as of February 2013:

- 1,478 Diplomates in Hematology only
- 6,533 Diplomates in Oncology only
- 6,504 Diplomates in Hematology and Oncology

Practicing hematologists/oncologists may be certified in oncology only, but subspecialize in hematologic cancers. ASH would not want such physicians to be excluded from participation in a hematologic quality measurement program.

Phase II

- 1. Understanding that the proposed payment system relies on reporting, how should existing programs such as, but not limited to PQRS, EHR/Meaningful Use, VBM be transitioned into the new system? Are there aspects of the current systems that should be retained, modified or discarded?**

A great deal of work, time and resources have been invested into the development of measures for the 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.

- 2. What Clinical Improvement Activities best promote high quality clinical care and should those activities be required as an integral part of a quality-based payment system?**

While ASH is very supportive of quality measurement based on clinical practice guidelines, the committee should also consider other types of clinical improvement activities that have an impact on quality and patient care. It is important that measures of patient satisfaction, measures about avoiding overuse of services, and measures about conforming to patient safety practices (infection control and appropriate procedural technique) remain available, especially as it will take time for development of a full complement of evidence based measures specific to each specialty.

- 3. What process or processes could be enacted that would ensure quality measures/measurement sets maintain currency and relevance with regard to the latest evidence-based clinical practices and care delivery systems? How would these processes ensure that quality measures evolve with data accumulation and advancement in measure development science, and appropriately account for the relative value of measures as they relate to best possible patient care?**

The current mechanisms of developing and approving measures through a centralized infrastructure are limited. 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.

4. Quality measures are categorized into process, structural, and outcome measures. Should these measures be differentially weighted in a quality scoring system? If so, how?

ASH recommends that process, structural and outcomes measures not be weighted differently. It is very difficult to develop true outcome measures in hematology. This is due to the chronic nature of the diseases treated and the fact that many diseases treated are rare disorders. To differentiate weights would penalize a specialty like hematology.

5. From a variety of backgrounds, providers newly enter (or re-enter) the Medicare system throughout the year. Since these providers have no reference baseline with regard to quality reporting in the Medicare system, how should the system account for their payment during their “observation” year?

ASH recommends that providers initially entering into the Medicare system should be reimbursed using a base payment rate which assumes that they meet a minimum quality standard. If providers initially entering the system exceed expectations within the first year, they should be rewarded with a bonus. To avoid potential abuse of the system, ASH recommends considering a different process for physicians that change practices.

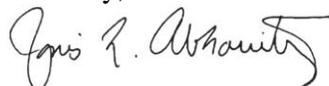
6. Should public and multi-stakeholder input be used during the measure development and selection processes? If so, are there current CMS or non-CMS mechanisms that could be applied?

7. In the interest of transparency, a public comment opportunity is vital to the quality measure development and approval process. Are there current mechanisms that are both substantive and nimble enough to meet the policy framework in the discussion draft of the legislative language?

Seeking input on measures from stakeholders and the public is an important aspect that should be considered as quality performance is incorporated to a greater extent in the physician payment system. The current regulatory process does not seem adequate for these purposes. ASH would suggest that the responsibility for seeking multi-stakeholder input on the development of quality measures be given to the organization taking the lead in developing a measure (this could be a standard/requirement for organizations deemed by CMS to develop measures). A final public review by regulation or other means would be appropriate.

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. 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 Government Relations and Practice Manager Stephanie Kaplan at skaplan@hematology.org or 202-776-0544.

Sincerely,



Janis L. Abkowitz, MD
President