AMERICAN SOCIETY OF HEMATOLOGY
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May 31, 2013

Senator Max Baucus
Chairman
Senate Committee on Finance
511 Hart Senate Office Building
Washington, DC 20510

Senator Orrin Hatch
Ranking Member
Senate Committee on Finance
104 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Baucus and Ranking Member Hatch,

The American Society of Hematology (ASH) appreciates the opportunity to offer the Society's comments regarding repealing the sustainable growth rate (SGR) formula and reforming 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 predictable payment rates in its place. The continued threat of massive reductions in physician payment due to the SGR, overcome only at the last minute by a temporary legislative rescue, is an ineffective and counterproductive way for the Medicare program to operate. Given the multiple changes in Medicare and new requirements on physicians, physician practices need a period of stable payment rates to avoid interrupting patient access and further tumult in the system. 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.

ASH's Response to Committee's Questions

ASH appreciates the fact that the Senate Finance Committee is seeking input from the health care provider community on how to improve Medicare's physician payment system. ASH has provided responses to the questions included in your letter below.

1. What specific reforms should be made to the physician fee schedule to ensure that physician services are valued appropriately?

Improve Value of Cognitive Services

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 and adequate compensation of medical specialists who diagnose and manage critically ill patients. Despite some efforts to modestly increase the relative values for evaluation and management (E/M) 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.

Congress has recognized the need to improve payments for primary care physicians. However, hematologists who manage the care of patients with chronic diseases such as hemophilia or sickle cell anemia or for acute conditions such as leukemia or lymphoma face many of the same problems as primary care physicians. That is, hematologists are largely limited to the use of inadequately reimbursed E/M codes to describe their services. As Congress considers improvements in payment for primary care, ASH urges you not ignore the needs of hematologists and other internal medicine specialists who face very similar problems.

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 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 physicians 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 conferences and 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. As an initial step, the established E/M non-face-to-face codes such as telephone consultations and 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.

The current documentation requirements for determining level of service for E/M codes should be substantially revised, as much of the documentations has been rendered obsolete by EHRs and does not apply to sub-specialized care. The current system for classifying services bases the level of E/M code largely on the number of body systems reviewed and not on the complexity of the evaluation. This lends itself to undervaluation of the most complex cognitive services. With the electronic health record and enhanced diagnostic coding through ICD 10, there may be the ability to improve the coding and payment system for E/M services and at the same time, lessen unnecessary documentation. Since this cannot be done overnight, ASH asks the Committee to direct CMS with the assistance of the medical community and outside experts to undertake a fundamental reassessment of E/M coding and payment.

Reinstate Medicare Reimbursement for Consultations

Several years ago and despite the opposition of virtually all of organized medicine, CMS decided to discontinue recognition of consultations as a billable service under Medicare. Physicians were directed to use office and clinic visit codes to describe their highly specialized services. We firmly believe that there is a need for the consultation codes when the treating physician or the family wants an independent

assessment of a complex medical problem. These services are not appropriately valued by the other E/M codes. We would ask the Committee to direct CMS to reinstate the consultation codes which continue to be recognized by private insurers.

2. What specific policies should be implemented that could co-exist with the current FFS physician payment system and would identify and reduce unnecessary utilization to improve health and reduce Medicare spending growth?

Utilize Initiatives such as ABIM Foundation's *Choosing Wisely*® Campaign

The American Board of Internal Medicine (ABIM) Foundation launched a multi-phase national campaign in partnership with specialty societies and *Consumer Reports* to promote appropriate medical decision making and the stewardship of health care. This campaign is designed to help consumers and physicians engage in a conversation about resources, the overuse of particular tests and procedures and to support physician efforts to help patients make smart and effective care choices. Similar to the National Correct Coding Initiative, the *Choosing Wisely*® lists can be use to help identify tests, treatments, and/or procedures that are not effective.

Recognizing that patients often request tests and treatments that may not be in their best interest, and that physicians often struggle with decisions about ordering tests and procedures as a way of covering all possible bases, the ABIM Foundation launched the campaign, having specialty societies create and disseminate evidence-based lists of five tests and/or procedures in their specialty whose necessity should be questioned by both physicians and patients. While there may be some cases where the particular test is needed, in many cases more care does not equal higher-quality care.

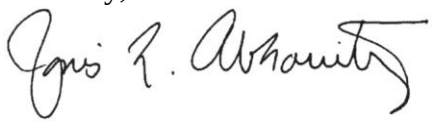
ASH used a methodologically rigorous approach to develop its list of the top five tests, treatments and procedures to question as part of the ABIM Foundation's *Choosing Wisely*® Campaign, which will be released in the fall of 2013. ASH believes that initiatives such as this will do much to reduce the over utilization of services that are not effective, avoiding unnecessary and even harmful interventions, and reduce the rapidly-expanding costs of the health care system.

3. Within the context of the current FFS system, how specifically can Medicare most effectively incentivize physician practices to undertake the structural, behavioral and other changes needed to participate in alternative payment models?

ASH believes that physicians can be incentivized to participate in alternative payment models in several key ways. First, physicians must concur that the alternative payment model is worthwhile –that it will both effectively and efficiently enhance patient care. The model also must allow for all specialists to participate in a meaningful way. The PQRS program fell short in this regard as many subspecialists in hematology were not able to report quality measures that applied to their practice. Second, incentives should be of sufficient value of offsetting the cost to implement the model. For many physicians, the 1-2 percent bonus payments available to participants in the eRx and PQRS programs were not a sufficient incentive to undertake the administrative changes needed. Many physicians are only beginning to comply with these programs now in order to avoid penalties. Third, the administrative burden to implement new models should be minimized as much as possible. Finally, it is critical that stability be provided to the Medicare Physician Fee Schedule so that physicians have some confidence that it is worthwhile to incur the costs of reconfiguring their practice or entering into new arrangements with other providers under whatever alternative payment model is being proposed before it is substantially replaced or revamped by another alternative. In this connection, the accountable care organization concept needs to be given time to mature and be evaluated as a payment model.

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
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