



# AMERICAN SOCIETY OF HEMATOLOGY

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Submitted Electronically to: [SGRComments@mail.house.gov](mailto:SGRComments@mail.house.gov)

**Re: American Society of Hematology (ASH) Comments on Repeal of Sustainable Growth Rate (SGR) Formula and Reform of Medicare's Physician Fee for Service Program**

Dear Chairmen Camp, Upton, Brady, and Pitts:

On behalf of the American Society of Hematology (ASH), thank you for the opportunity to offer the Society's input on your proposal 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 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 practice improvement for various hematologic diseases.

Additionally, the Society convenes an annual special symposium on quality that focuses on the successful implementation of quality improvement efforts in the field. Currently, ASH is in the process of developing a list of the top five tests, treatments and procedures to question as part of the American Board of Internal Medicine (ABIM) Foundation's *Choosing Wisely*® Campaign. This initiative aims to help physicians and patients engage in conversations to reduce overuse of tests and procedures and supports physician efforts to help patients make smart and effective care choices. 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 programs. ASH asks the Committees to consider these issues as it looks at reforming physician reimbursement and adding a performance based payment system.

### **Phase 1: Repeal of the SGR and a Period of Stable Payment Rates**

ASH strongly supports Phase 1 of your reform proposal, which would begin with the repeal of the SGR formula and provide a period of predictable payment rates before moving to a system that would recognize the quality of care provided. The continued threat of massive reductions in physician payment due to the SGR, overcome only at the last minute by a legislative rescue, is obviously an ineffective and counterproductive way for the Medicare program to operate. A period of stability will go a long way to rebuild the trust of physicians in the Medicare system. ASH asks that Congress mandate a period of 5 years of stable and predictable payment, which would provide a needed timeframe for medical specialty societies to develop and put in place a performance and quality based payment system. ASH notes its experience with the Physician Quality Reporting System (PQRS) as an example. PQRS 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.

### **Phase 2: Payment System Reforms Reflecting Quality Services**

ASH would support a differential payment system that recognizes the quality of the care provided to patients. In a performance based payment system, it would seem appropriate that the top quality performers should get a bonus and the bottom performers receive some penalty in payment. However, the system needs to be considerably more comprehensive than the PQRS system where bonuses are determined by physicians meeting a couple of reporting standards, which, by themselves, do not actually measure overall quality of care.

ASH greatly appreciates the Committees interest in working directly with specialty medical societies to develop a performance/quality – related payment system as described in phase 2 of your proposal. ASH has developed four quality measures that are included in Medicare's current PQRS system; however, there have been limitations placed on ASH in attempting to create new measures. Measures are expensive to develop and test; and the measure development and approval processes at the AMA's Physician Consortium for Performance Improvement (PCPI) and National Quality Forum (NQF) are slow and limited.

One product that ASH has developed that could translate into the performance/quality related payment system is its Practice Improvement Modules or PIMs. 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 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 a quality-related reimbursement component.

While PIMS may be an option for hematologists to participate in a quality-related reimbursement 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. Hematology PIMs developed by ASH and available through the ABIM focus on the following topic areas: myelodysplastic syndromes (MDS), multiple myeloma, perioperative anticoagulation management and immune thrombocytopenia (ITP). ASH is in the process of developing two additional PIMS focused on non-Hodgkin lymphoma and MDS, but there are many additional diseases and areas covered by hematology that are not yet addressed in PIMs.

The Society would like to raise some additional reasons that implementing the second phase of your proposal will be difficult for hematology and likely for other medical subspecialties. Any system that bases payment on the quality 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. Obviously a “one size fits all” approach to quality would neither be fair nor workable.

Using surgical and procedural specialists (interventional cardiology, GI) as examples for quality metrics are inappropriate when looking at a discipline like hematology. 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.

### **Phase 3: Payment System Reforms Reflecting Efficiency of Care**

With the issues that we have raised related to implementing a payment system that recognizes quality of care, it is difficult for us to see how efficiency measures for hematology could be incorporated into the payment 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.

### **Responses to Additional Questions**

*Local vs. National Standards* - In general, ASH believes quality standards should be national in scope. The Society certainly recognizes the many studies which have pointed out the degree to which medical care varies around the country. However, ASH hopes that if adequate lead time is provided for the development of quality of care measures that the metrics should be national in scope unless of course there are particular racial or ethnic factors that are relevant. There will of course be a need for the national medical societies to work with their State or local affiliates on the development of quality of care measures. In addition, patient education will be a critical activity for which local specialty societies will need to play a key role.

*Reporting Burden* - Ideally, the payment system should be a by-product of the claims and/or electronic medical record system and any additional reporting requirements whether through a registry or other mechanism should be kept to an absolute minimum.

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 Senior Director of Government Relations, Practice, and Scientific Affairs Mila Becker at [mbecker@hematology.org](mailto:mbecker@hematology.org) or 202-776-0544.

Sincerely,



Janis L. Abkowitz, MD  
President