September 10, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

SUBMITTED ELECTRONICALLY VIA http://www.regulations.gov

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program (CMS–1693–P)

Dear Administrator Verma:

The American Society of Hematology (ASH) is pleased to offer comments on the proposed rule outlining revisions to the Medicare Physician Fee Schedule (PFS) for 2019.

ASH represents over 17,000 clinicians and scientists worldwide, who are committed to the study and treatment of blood and blood-related diseases. These disorders encompass malignant hematologic disorders such as leukemia, lymphoma, and multiple myeloma, as well as non-malignant conditions such as sickle cell anemia, thalassemia, bone marrow failure, venous thromboembolism, and hemophilia. In addition, hematologists were pioneers in demonstrating the potential of treating various hematologic diseases; and we continue to be innovators in the field of stem cell biology, regenerative medicine, transfusion medicine, and gene therapy. ASH membership is comprised of basic, translational, and clinical scientists, as well as physicians who are providing care to patients in diverse settings including teaching and community hospitals, as well as private practices.

ASH thanks the Centers for Medicare and Medicaid Services (CMS) for addressing the documentation requirements for evaluation & management (E/M) codes in the proposed rule. However, the Society has strong concerns about the consolidation of E/M services into a single payment level and the establishment of an indirect practice cost index for E/M services. ASH opposes these proposals, which for hematologic services, will impact patient access to care and physician workforce.

ASH offers the following comments on the proposals relating to E/M and other issues and looks forward to working closely with the CMS during the implementation phase. The following are the areas of particular importance of the proposed rule to the Society’s members and the focus of our comments:

1. Evaluation & Management Visits
2. Public Comment Solicitation on Eliminating the Prohibition on Billing Same-Day Visits by Practitioners of the Same Group and Specialty
ASH commends CMS for recognizing the documentation burden associated with the existing evaluation & management (E/M) codes and strongly supports the “Patients Over Paperwork” initiative. E/M documentation and payment changes, if evidence-based, have the potential to improve patient access and satisfaction, as well as reduce physician burden and address the workforce shortages being experienced in hematology and other cognitive specialties. Furthermore, the development of new payment models demands the accurate pricing of all services. We appreciate the agency’s recognition in the proposed rule that the existing outpatient E/M services and their documentation requirements do not accurately reflect current medical practice.

The existing E/M documentation requirements are over 20 years old and pose real challenges for physicians. However, these challenges cannot be completely divorced from the payment inequities that we attribute to the under recognition of the cognitive intensity of the work of hematologists and a range of other cognitive specialties. The current outpatient E/M codes undervalue the purely cognitive physician work relative to that captured in the thousands of procedure codes. The failure of the current codes to capture the most complex E/M activities and the resultant relative undervaluation of these critical services must both addressed to ensure that Medicare beneficiaries have continued access to appropriate care.

Unfortunately, ASH cannot support the proposed payment changes for E/M services that the agency states are “intrinsically linked” to the documentation changes. The agency proposed collapsing 99202-05 and 99212-15 and creating a single rate for these services, developing new G codes for primary and certain specialty care, a new G code for prolonged E/M service, and a multiple procedure payment reduction. These changes will do nothing to address the patient access problems and physician workforce shortages driven by the compensation gap for cognitive care driven by the outdated E/M codes. Instead, collapsing five levels of E/M codes into two will exacerbate the existing compensation disparities facing physicians. The Society urges CMS to work with stakeholders to develop an alternative evidence-based approach to E/M payment and documentation that will reduce burden, be appropriate for inclusion in new models of health care delivery, address the compensation inequity of cognitive physicians, and support the delivery of high quality patient care that can be included in the proposed CY 2020 Physician Fee Schedule.

If CMS is willing to work with stakeholders to develop an alternative payment scheme, we urge the agency to implement the following documentation changes that are not tied to E/M payment changes on January 1, 2019:

- If physicians choose to continue to document under the current guidelines, limit the required documentation of the patient’s history to the interval history since the previous visit (for established patients);
- Eliminate the requirement for physicians to re-document information that has already been included in the medical record by practice staff or by the patient; and
- Remove the need to justify providing a home visit instead of an office visit.

Finalizing these changes would be a significant first step towards CMS’ stated goal of reducing administrative burden. They can also easily be adopted by commercial payers that tend to adopt Medicare payment policies. This will also eliminate the possibility that physicians will be forced to document E/M visits under two sets of requirements, one for Medicare and the other for private payers, representing an increase in physician burden, if only for the short term.
ASH’s concerns with the proposals in the rule related to E/M visits are as follows:

**Proposed Documentation Changes**
ASH provided comment on the proposed documentation changes in response to the CY 2018 Physician Fee Schedule proposed rule. The Society stressed the importance of medical decision making in documenting office visits but cautioned CMS that the complexity of care delivered to patients with hematologic conditions like acute leukemia or sickle cell disease, is not fully captured by the requirements for documenting medical decision making.

To help reduce burden, the agency has proposed in the CY 2019 proposal, to allow physicians to document medical necessity, and either medical decision making, time, or the current 1995/1997 guidelines for a level 2 visit. The agency claims this change will reduce the time physicians spend documenting office visits by approximately 51 hours. However, ASH conducted an informal survey of its members to assess the impact of this proposal on their time and workflow and found that there is unlikely to be significant time during the workday that is liberated to see new patients or to spend additional time with existing patients. Some of our members noted that EHRs have enabled them to document their notes quickly and many other members reported that they spend time on nights and weekends completing the documentation for their office visits. Additionally, members noted that extra time spent on patients is not all related to documentation; for example, providers spend a significant amount of time on coordination of care.

Additionally, while our members do document to fulfill CMS’ billing guidelines, there are also legal and patient care reasons driving this documentation that will not change even if CMS’ requirements do. There are medical reasons for documenting a higher visit level, particularly for the medical decision-making component. For example, if a patient presents with a bleeding disorder, the hematologist must document everything related to bleeding since the patient’s childhood, all of the patient’s medical issues, family history, and any medications taken by the patient. In a follow up, the hematologist will spend extensive time counseling the patient and family and outlining a treatment plan. The hematologist will document all of this in addition to how the disease and/or medication impacts the patient in their daily life and any plans for surgery. This level of documentation goes well beyond that required for a level 2 visit. These notes are a key component of providing high quality care for complex patients. For these reasons, it is unlikely our members will be able to just document a level 2 visit for many of the patients they treat.

**Single Payment Level Proposal**
CMS proposed a single payment amount for codes 99202-25 and 99212-15 of $135 and $93 respectively. These values were determined by a weighted average of the work RVUs based on specialty utilization for levels 2-5 E/M visits. To address the reimbursement shortfalls that some specialties would have experienced as a result of the code collapse, the agency proposed creating complexity add-ons for primary care of $5 and for certain specialty care of $13.70. These add-on codes were funded by a multiple procedure payment reduction (MPPR) for any E/M service billed with modifier 25 on the same day as a procedure to remain budget neutral.

ASH members typically rely on level 4 and 5 visits and will be disproportionately impacted by this proposal. The agency provided their estimated impact in Tables 21 and 22 of the rule, but this differs significantly from a recent analysis conducted by the American Medical Association (AMA) included in Appendix A. CMS estimated that hematology/oncology (combined) would have less than a 3% decrease in payment, while the AMA estimated that hematology/oncology (combined) would see a 1% increase in payment. Of greater concern is the AMA analysis of hematology, as a separate category, which showed a 16% decrease in payment. This accounts for services provided by hematologists who treat complex, non-malignant hematologic diseases such as sickle cell disease, hemophilia and other bleeding and clotting disorders. A 16% decrease in payment would significantly impact these physicians’ practices. ASH is concerned as to why these analyses yielded different results and would like more analyses to be completed prior to implementation.
We are also deeply concerned about unintended consequences for patients that may result from these payment proposals. Our members treat patients with multiple complex and chronic conditions. A survey of ASH members showed that they typically spend more than the scheduled amount of time with their patients. Additional time is spent on educating the patient and on coordination of care, especially for patients with sickle cell disease or with complex coagulation disorders. However, the reduced payment for level 4 and 5 visits will likely force providers to spend less time during each clinical encounter or limit each visit to 1 or 2 problems at the direction of the financial leadership at their institutions. It is not clear from the rule that the agency has fully considered these implications on cognitive specialties like hematology.

The reduced reimbursement is not financially viable for community-based practices; academic medical centers and other large referral centers may end up being the only institutions that will treat the sickest and most complex Medicare beneficiaries. Besides the financial strain it may place on these institutions, it will likely create an additional burden on patients who may be forced to travel longer distances to find a physician who will treat them. Furthermore, the more demanding workload coupled with lower payments for this high intensity work will be another reason that medical students with growing student debt choose not to enter hematology and other cognitive specialties. We simply cannot support a proposal that has not been fully analyzed and vetted and that may exacerbate the workforce shortages currently facing our members. We are also concerned about a proposal which may also create barriers to access to care for patients.

Add-on Proposals
CMS proposed the primary care and complexity add-on codes (GPC1X and GCG0X) to offset some of the cuts in reimbursement for certain services that would have resulted from collapsing the level 2 through 5 office visits. ASH cannot support the add-on services as proposed because they do not capture the added work inherent in cognitive services, as previously described. We also believe the application of both these codes as defined by the agency is arbitrary.

CMS’ proposed specialty add-on code CGC0X has a value of 0.25 RVUs and can be billed with both new and established patient visits. The agency defines the proposed code’s descriptor to be: Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, or interventional pain management centered-care. In follow up discussions, the agency has stated GCG0X is not specialty specific, instead it applies to care related to these specialties.

CMS valued this add-on at $13.70. When billed in conjunction with the single payment established patient visit worth $93, this still falls short of the current level 4 reimbursement of $109 and level 5 reimbursement of $148. This reduction, while small, will have a significant impact on a practice that typically bills levels 4 and 5 visits over the course of a year. The value of this code also assumes that all specialty visits have the same level of complexity. A patient with sickle cell disease could have a range of complications, including severe pain, stroke, acute chest syndrome, or organ damage. A visit with this patient, for example, would be much more complex than a visit with a patient being seen to determine if medication levels are adequate.

ASH encourages CMS to consider creating a complexity adjuster that could be applied to E/M services provided by a broader group of specialists and tied to the complexity of the patient’s condition rather than the specialty. A better measure of complexity must be developed and must be captured by any new E/M coding and payment scheme. If CMS were to devise an alternative method of complexity based on this concept, ASH would welcome the opportunity to work with the agency to appropriately value it.

The agency also proposed the creation of a new 30-minute prolonged service G code (GPRO1) that can be used for any office visit lasting more than 30 minutes beyond the office visit. ASH appreciates the agency’s intent to recognize that there are circumstances where longer visits are necessary, as this add-on could be
particularly relevant for our members. Evaluating how often a practice or specialty will utilize GPRO1, however, is dependent upon knowing how to account for the time of the base E/M code. It is unclear whether the base is the proposed times of 38 and 31 minutes for the new and established consolidated level 2-5 services, respectively, or the existing times for the individual codes (i.e. 10 minutes for a level 2 visit). For some patients, such as a returning bone marrow transplant patient, our members may spend as long as an hour face-to-face with the patient. ASH believes that the add-on code was intended to compensate the physicians for longer visits required to treat medically complex patients but in order to better evaluate the impact, we request that the agency clearly articulate the time requirements for any new E/M and add-on codes that may be considered in future rulemaking.

*Multiple Procedure Payment Reduction*

As previously stated, CMS funded the flawed add-on codes through a multiple procedure payment reduction to be applied when a procedure and an E/M code is billed with modifier 25 on the same day. The agency provided no resource-based justification for this reduction. Many of our members provide an office visit on the same day as chemotherapy administration and would be adversely impacted by this proposal.

The AMA Resource Based Relative Value Update Committee (RUC) has already eliminated the overlap in physician work, clinical staff time, supplies, and equipment. The chemotherapy administration codes were just valued at the January 2017 RUC, and the current values of these and most other procedures account for any overlap with an office visit. This proposed reduction will only be an unjust decrease in value.

*Practice Expense Methodology*

The CMS proposal to collapse payment for office visits included creating a new Indirect Practice Costs Index (IPCI) solely for office visits, overriding the current methodology for these services which accounts for indirect practice costs by specialty. If the agency had not taken this approach, they recognized that “establishing a single PFS rate for new and established patient E/M levels 2 through 5 would have a large and unintended effect on many specialties.” The proposal, however, does have a significant impact on the IPCI for hematology and several other specialties even though the agency was attempting to minimize any unintended consequences. According the AMA’s calculations, hematology will see a 20 percent decrease in its IPCI, resulting in significant reductions in the practice expense values for multiple hematology services.

If the proposed rule is finalized, there are 1,100 CPT codes that will experience a non-facility practice expense payment reduction, which cannot be explained by any other factor other than the change in their service level IPCI predominantly due to the E/M payment collapse. An analysis of these changes to the specialty-level IPCI are estimated to result in a redistribution of almost $1 billion between Medicare specialties. This large redistribution in Medicare payment would occur even though there was little or no change in the underlying resource costs involved in performing most services. For example, chemotherapy services, which have a slight increase in proposed direct practice costs for CY2019 due to an unrelated proposal to reprice Medicare supplies and equipment, would still experience a total Medicare payment cut of over 10 percent (i.e., CPT codes 96401, 96409, 96411, 96413, 96415, 96416, 96417, 96422, 96423, and 96425, which accounted for almost $400 million in total Medicare allowed charges for 2017, are each individually proposed to decrease in total Medicare payment of at least 10 percent).

*Public Comment Solicitation on Eliminating the Prohibition on Billing Same-Day Visits by Practitioners of the Same Group and Specialty*

Medicare will not pay for two E/M visits billed by a physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day unless the physician documents that the visits are for unrelated problems. ASH is pleased to see that the agency now believes that there may be certain instances where this does not make sense and inconveniences patients.
Physicians are increasingly providing team-based care. CMS and private payer policies are encouraging this type of practice, and most importantly, it improves the quality of care patients receive. Prohibiting billing of the two E/M visits on the same day by practitioners in the same group and specialty undermines the type of collaboration required to deliver team-based care effectively. In hematology practices, it is common for multiple providers to see a patient with a bone marrow transplant and leukemia on the same day. Physicians are either forced to forego reimbursement for a visit or inconvenience patients by forcing them to make a return visit to see a second member of the practice.

**Teaching Physician Documentation Requirements for Evaluation and Management Services**

In the rule, CMS responded to feedback that the E/M documentation requirements for visits provided by teaching physicians are burdensome and duplicative of notes already made by residents and other members of the health care team. ASH supports the proposed change to allow a physician, resident, or nurse to document the visit and specifically note that the physician was present at the time the service was provided. This proposed change will eliminate duplicative work for physicians, residents, and other members of the health care team.

**Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services**

ASH applauds CMS for its proposals to expand medical care using telecommunications technology, specifically for the creation of the Brief Communication Technology-based Service, e.g. Virtual Check-in (GVCI1) and Remote Professional Evaluation of Recorded Video and/or Images (GRAS1). We believe that these codes will increase patient access and provide new options for our members to treat patients. Our members frequently consult in this manner with patients outside of office visits and do not receive separate compensation for those services; this proposal is a step towards improving compensation for the care our members already provide.

We request that CMS provide clarification about whether these services can be billed during the same time period that a physician may be providing Chronic Care Management (CCM) services. As we understand the proposal, GVCI1 and GRAS1 would be considered separate from the care provided as part of the CCM service and could be billed and would appreciate further guidance from the agency on this point.

**Home Monitoring for Anticoagulation Management**

Many thousands of patients who have artificial heart valves, certain abnormal heart rhythms or a history of blood clots take the blood thinning drug warfarin to reduce the risk of stroke or new clots. To manage patients on warfarin, physicians monitor a specific blood test—the prothrombin time (PT/INR) test. While this testing is typically provided in the hospital or physician’s office, approximately 20 percent of patients receiving warfarin are candidates for monitoring in their homes. Medicare pays for home PT/INR monitoring as a diagnostic service under the physician fee schedule.

Since 2006, these services have faced a steady decrease in reimbursement, with a reduction of 56 percent and 25 percent for demonstration/training and on-going monitoring, respectively. In the final CY2018 Medicare Physician Fee Schedule rule, CMS implemented a reduction in payment without fully considering all of the inputs that comprise the service and did not survey suppliers of home PT/INR monitoring services to develop current indirect practice expense values. As a result, CMS systematically reduced the practice expense RVUs for these services by using proxies rather than specifically identifying a direct-to-indirect cost relationship for this service. While CMS did not propose or discuss specific changes to PT/INR to address these issues in the proposed CY2019 Medicare Physician Fee Schedule, a third-party market research study utilized by CMS did result in changes for direct practice expense inputs for all supplies and equipment across the fee schedule. As a result, PT/INR payments have again been adjusted based on incomplete data. The inaccuracies and wide fluctuations in payments for home PT/INR monitoring threaten the financial viability for these important services and significantly diminish access to this service for Medicare beneficiaries. We urge CMS to undertake a more comprehensive review of indirect and direct practice expense inputs and relationships. Among other ideas, CMS could consider a crosswalk to another specialty as an interim step to prevent a significant reduction...
in access to PT/INR services. At a minimum CMS should consider holding payments harmless while additional analysis is completed.

**Quality Payment Program/Merit-based Payment System**

In regard to the Quality Payment Program, ASH thanks CMS for its continued efforts to reduce the administrative burden associated with the Medicare payment system through its “Patients Over Paperwork” initiative. ASH remains concerned, however, that the complexity of the program still poses challenges for small practices and rural providers. Below the Society outlines our specific concerns on the following issues:

1. **Low-Volume Threshold**
2. **Increased Performance Threshold**
3. **Increased Weight of the Cost Category**
4. **Promoting Interoperability Performance Category**
5. **Quality Category – Topped Out Measures**
6. **Facility-based Scoring**
7. **Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration**

**Low-Volume Threshold**

ASH supports the CMS proposal to add a third category to the low-volume threshold to qualify a physician for exemption from the Merit-based Incentive Payment System (MIPS). The third category, which includes clinicians that provide 200 or fewer covered professional services under the PFS, will help ensure that small practices and rural providers can be excluded from MIPS.

The agency also proposes an opt-in policy for MIPS eligible clinicians who are excluded based on the low-volume threshold determination. If a clinician meets or exceeds one or two of the exclusion criteria, he or she can opt into the program. ASH supports the agency’s proposal to provide this opt-in option for providers and practices that believe they can succeed in MIPS, providing an important opportunity for them to potentially earn a payment bonus.

**Increased Performance Threshold**

ASH opposes the proposed increase of the performance threshold from 15/100 to 30/100 and instead recommends that CMS either maintain the current threshold of 15/100 or phase in the increase gradually over time. We believe that providers are still adjusting to and understanding how this program applies to their practice. For ASH members, the program still lacks meaningful ways for hematologists to participate with a limited number of hematology-specific quality or episode-based cost measures. Also, we are still only in the second year of the program, and providers do not yet have a complete picture of how successful their participation has been to date. ASH is extremely appreciative of the steps CMS has taken to gradually implement this program thus far but is concerned that the only complete performance data available to review is from year 1 of the program. Before making additional changes, more data is needed for a better assessment of the program.

**Increased Weight of the Cost Category**

ASH opposes CMS’ proposal to increase the weight of the Cost Performance Category to 15 percent. While this is a modest 5 percent increase over last year, ASH continues to have significant reservations about the application of this category to hematologists and does not believe providers and CMS are ready for the increased weight of this category. Using claims to measure cost performance does not fully capture all aspects of providing high quality care at low cost. The majority of hematologic diseases and disorders are considered complex and rare, which, unfortunately, can make treating them costly.

Patients with malignant and non-malignant blood disorders represent diverse patient populations, whose cost of care assessment requires a carefully-nuanced analysis that extends far beyond what is feasible with coded
billing data. For patients with acute leukemia, for example, the cost per patient may vary by orders of magnitude based upon disease status (therapy-responsive vs. refractory to standard treatment modalities), genetic/molecular/genomic risk assessments, age, performance status, and the intent of treatment (curative vs. palliative). For patients with adverse-risk genetic and genomic features (such as the presence of duplications of the \( \text{FLT3} \) gene), blood/bone marrow stem cell transplant represents best practice. Those undergoing bone marrow transplant represent a very high-cost population of patients, whose high-cost care results in better survival outcomes and represents high-value care. Unfortunately, the clinical risk data used in this clinical assessment cannot be gathered through CMS’ standard data abstraction methods. This deficiency creates a significant problem since tertiary care centers and providers who offer this expensive, high quality, personalized medical care is likely to be unfairly penalized when compared to those caring for patients with less complicated diagnoses who require less expensive care.

Similarly, patients with chronic lymphocytic leukemia with unmutated heavy chain genes or with deletions of chromosome 17 have much worse survival outcomes and higher care costs than those chronic lymphocytic leukemia patients without these abnormalities. These high-risk patients may benefit from hematopoietic cell transplantation, which therefore represents best practice and inures greater care costs. CMS’s current data abstraction and cost assessment methods again fail to capture this level of differentiation.

These specific examples explain why hematologists are at an unfair disadvantage under the cost performance category. Before this category counts towards a clinician’s final score, CMS must finalize the required risk adjustment, attribution methodologies, and ensure that there are adequate episode measures for all specialties, including hematology.

Promoting Interoperability Performance Category
ASH asks that CMS consider delaying the implementation of its proposal to require use of 2015 certified electronic health record technology (CEHRT) by all eligible providers until January 2020. The agency had previously granted providers with the flexibility to either use the 2014 or 2015 CEHRT. While more providers may now be using 2015 CEHRT, the vast majority of providers are likely still using 2014 technology. Requiring all eligible providers to switch to 2015 CEHRT before January 1, 2019 is unrealistic and will place a significant financial burden on providers who may not have budgeted for such an expense. The Society supports CMS’ intention behind this proposal, to reduce burden by better streamlining workflows and utilizing more comprehensive functions to meet patient safety goals and improve care coordination, but we believe that providers must be given at least a full year’s notice before requiring use of 2015 CEHRT.

CMS is also proposing a new simplified scoring methodology for this category as clinicians have expressed frustration with the overly-complicated methodology currently used for this category’s scoring. ASH supports efforts to reduce the complexity of the scoring methodology, and we favor a system that provides the flexibility for eligible providers to select the measures that are most relevant to their practice and patient population and are the least burdensome to implement.

Quality Category – Topped Out Measures
The agency proposes to maintain its definition of topped out measures for year 3 of the program: a measure whose performance is so high and unvarying that meaningful distinctions and improvement in performance can no longer be made. ASH continues to appreciate the agency’s concerns about the impact topped out measures may have on a clinician’s performance and desire to include meaningful measures in the program. However, ASH members, particularly those in solo and small group practices, cannot easily substitute new measures if the 4 hematology specific measures and others appropriate for the management of patients with hematologic diseases are deemed to be topped out. We remain concerned that the lack of meaningful measures may undermine our members’ ability to succeed in the Merit-Based Incentive Payment System (MIPS). ASH would welcome the opportunity to work with CMS to expand the number of meaningful hematology measures included in the program.
Facility-based Scoring

CMS is proposing to implement facility-based scoring for 2019, where facility-based clinicians can use their facility’s Hospital Value-Based Purchasing score as a proxy for their Quality and Cost performance categories. The agency stipulated that an individual clinician must furnish 75 percent or more of their covered professional services in inpatient hospital, on-campus outpatient hospital, or an emergency room with at least one service billed with POS code used for the inpatient hospital or the emergency room setting. CMS will automatically apply facility-based measurement to those eligible clinicians and groups that would benefit by having a higher combined Quality and Cost scores.

ASH appreciates CMS’ implementation of this policy first referenced in last year’s rulemaking. We believe providing this flexibility will be extremely beneficial to our members who have few meaningful measures available to report. The Society continues to urge CMS to recognize that specialists, particularly those treating highly complex, orphan disease, are facing obstacles to meaningful participation in this program.

Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration

ASH is supportive of the proposed Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration. The Society believes this demonstration has the potential to make quality reporting more consistent across payers and less burdensome for providers. ASH looks forward to receiving more detailed information about this demonstration and is supportive as long as it does not increase the reporting burden facing providers.

Thank you for the opportunity to provide comments on proposed rule outlining revisions to the Medicare Physician Fee Schedule (PFS) for 2019. We welcome the opportunity to discuss these proposals, and others being considered, with you and your team. If you have any questions or require further clarification, please contact Leslie Brady, ASH Policy and Practice Manager at lbrady@hematology.org or 202-292-0264.

Sincerely,

Alexis Thompson, MD, MPH
President
### Appendix A

**Estimated Impact of CY2019 Evaluation and Management Proposed Policy by Medicare Specialty**

*Includes CPT Codes 99201-99215, GC10X, GC11X, GP60X and GPO1X, but does not include GPR01 - prolonged service

Analysis uses Estimated CY2017 Medicare Utilization and CY2019 Medicare CF for both "Current Method" and "Proposed Method"; E/M MPPR Estimate based on 2016 Medicare Carrier 5% Standard Analytic File

Excludes specialties with less than $1 million in CY2017 allowed charges for 99201-99215 or claims with unknown specialty designation

#### Medicare Designated Specialty

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<th>Medicare Designated Specialty</th>
<th>Total Medicare Payment for Office Visits w/o Policy Changes (Using CY2018 Total RVUs)</th>
<th>Change in Payment Due To Proposed E/M Collapse Policy (includes G codes)*</th>
<th>Additional Change in Payment Due to E/M MPPR Policy</th>
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