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The Honorable Max Baucus
Chairman
Senate Finance Committee
Dirksen Senate Office Building, Room 219
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Washington, D.C. 20150

Dear Chairman Baucus:

On behalf of the American Society of Hematology (ASH), thank you for the opportunity to comment on the Senate Finance Committee's document, *Transforming the Health Care Delivery System: Proposal to Improve Patient Care and Reduce Health Care Costs*. ASH represents over 11,000 hematologists in the United States who are committed to the treatment of blood and blood-related diseases. ASH members include hematologists and hematologist/oncologists who regularly render services to Medicare beneficiaries.

Hematologists treat patients with malignant and non-malignant bleeding disorders. ASH members care for patients – especially elderly patients – with anemia, bleeding and clotting problems and blood cancers – leukemia, lymphoma, multiple myeloma – that affect more and more Americans every day. Other diseases treated by hematologists are relatively rare and all require highly specialized diagnostic and therapeutic services. It is critically important that in making changes to the Medicare system access to hematology services is maintained.

ASH applauds the Committee's commitment to national health reform through the release of this first paper, which has kicked off a substantive dialogue on how to improve the Medicare program not only in Washington but throughout the country. The recently released *2009 Medicare Trustees Report* which highlighted the declining financial health of this major safety net health program underscores both the enormity and gravity of this task.

ASH's physician leadership has articulated the following principles that are essential for effective and sustainable reform for the Medicare program:

- Maintain policies that ensure patients have direct access to hematologists, allowing for the provision of high quality and effective care for blood-related disorders.
- Recognize the value of cognitive services and improve Medicare payment for these services.
- Do not establish policies that increase payment to primary care services by reducing payment for other cognitive services.
- Eliminate the Medicare Sustainable Growth Rate (SGR) formula and provide physicians with an adequate annual update in fees.

Overall, ASH supports the policies and proposals laid out in the Committee's document. ASH believes that all citizens should have access to affordable health care from prevention, to treatment, to end of life care. ASH is eager to work with the Congress and the Administration in developing proposals leading to an improved high quality Medicare system. In that spirit, the Society would like to raise some concerns with specific proposals and address in this letter issues related to bonus payments for primary care services, finding a permanent solution for the Sustainable Growth Rate (SGR) formula, and implementing a physician value based purchasing program that allows all physicians to participate.

Bonus Payments for Primary Care

The Committee proposes that from January 1, 2010 – December 31, 2014 certain providers would be eligible for a bonus of at least 5 percent for providing select evaluation and management services in specified ambulatory settings. This initiative would be budget neutral so it would be funded through either an across-the-board reduction in payments for all other services or through another funding source.

A wide variety of internal medicine subspecialists, including hematologists and many others, such as, nephrologists, rheumatologists, and infectious disease specialists, meet the routine health care needs of medically complex patients with acute and chronic conditions on a regular basis. As they are treating and managing the chronic diseases of their patients, these subspecialists are also typically providing for their primary care needs. Being knowledgeable about the chronic disease allows the subspecialist to provide the highest quality of primary care and it also reduces the duplication of services, thereby reducing overall health care costs.

In a June 2008 Medicare payment Advisory Commission (MedPAC) recommendation to Congress on a primary care bonus, the Commissioners recommended the following definition of primary care: *Primary care-focused practitioners are those whose specialty designation is defined as primary care and/or those whose pattern of claims meets a minimum threshold of furnishing primary care services. The Secretary would use rulemaking to establish criteria for determining a primary-care-focused practitioner.*

ASH believes this would be a much more accurate method of determining primary care practitioners rather than relying on Medicare specialty designations or other similar affiliations or categorizations. ASH urges the Senate Finance Committee to use a definition that is broad enough to include the wide array of internal medicine subspecialists who provide primary care services to chronically ill Medicare beneficiaries.

While ASH strongly supports the concept of a primary care bonus; reduced payments for cognitive services have threatened the viability of primary care practices. However, the Society is very concerned with the proposed budget neutral design requiring any bonus to be financed through reductions in other services, especially other cognitive services. ASH does not support establishing policies that increase payment for primary care services by reducing payment for other cognitive services. Any policy that would finance the bonus through reductions in other parts of the fee schedule will risk reducing access and quality of these other important and needed services. The crisis in access to primary care cannot be addressed without adding funds

for cognitive services. A cost neutral shift that penalizes some primary care providers in order to assist others will not meet the needs of Medicare beneficiaries who have many chronic conditions and comorbidities.

Finding a Permanent Solution for the SGR Formula

ASH was pleased to see a temporary fix for the Sustainable Growth Rate (SGR) formula in the Committee's proposal, but the update in physician fees must be addressed in a more permanent fashion through the elimination of the SGR formula and the implementation of a methodology that would provide an adequate annual update in Medicare physician reimbursement rates.

The SGR needs to be replaced this year with an updated system that reflects increases in physicians' and other health professionals' practice costs. A budget baseline for future Medicare payment updates, which accurately reflects the anticipated costs of providing physicians with positive updates under a new update system in lieu of SGR-related cuts, should be incorporated into the federal budget. One alternative to the current system is to link the updates to the Medicare Economic Index (MEI). ASH recommends that the MEI be adjusted to include all costs of a current medical practice and use realistic productivity assumptions. This methodology would provide needed stability and predictability to the system.

Implementing a Physician Value Based Purchasing Program that Allows All Physicians to Participate

In its document the Committee proposes to move the current physician quality program from a voluntary program that provides bonuses for successful participation to one that has penalties for non-participation.

ASH supports the implementation of innovative payment system reforms that support physicians in the provision of high quality care in a cost-effective manner. At the same time, the Society recommends that any legislation on physician quality measures recognize the inherent complexity of implementing quality initiatives in the physician community. CMS staff has acknowledged in public meetings that as challenging as it has been to implement reforms on the hospital side, physician payment reforms are inherently more complex.

ASH is concerned that the current Medicare quality programs for physicians expanded in the Committee's proposal do not allow all physicians to participate, yet if made compulsory, these physicians would be penalized for lack of compliance. A good example where this is playing out within our own specialty is with the Physician Quality Reporting Initiative (PQRI) program. While ASH has been very active in developing measures for hematologists, the current list of approved measures does not apply to all hematologists. For instance, specialists that primarily care for patients with lymphoma, hemophilia, or sickle cell disease currently do not have measures applying to these areas. Similarly, in every specialty there is a subset of physicians providing care for patients with rare diseases who do not have measures that would apply to them. The system to develop measures for a wide range of physicians will take time and it would be unfair to penalize physicians for lack of compliance when the program design does not allow for them to participate.

An additional concern for hematologists and other specialties caring for very complex patients is the capacity of the various quality initiatives to account for the severity of their patient population and the intensity of their work. Physicians who care for very sick individuals with terminal diseases will have higher morbidity and mortality rates even when the provider does everything according to accepted standards and guidelines. Any program must adjust for the severity of the patients being treated.

Because of their inherent complexity, quality programs should be pilot tested and evaluated in a variety of practice settings, geographic locales among different specialties and patient populations. ASH recommends a rigorous evaluation with input from physicians and stakeholders on which innovations are ready for wider implementation, which require more evaluation and which need further refinement and testing.

In order for any of these innovations to be widely instituted a sophisticated health information technology (HIT) system will be required. While ASH was pleased to see funding for HIT in the Stimulus Bill, the Society's members have expressed a great deal of concern about whether current technology will allow for the effective deployment of these systems within the existing timetable. Many ASH members have also indicated that even when systems are in place or are quickly being put into place, these systems exist in isolation and are not able to communicate with other systems resulting in many providers delaying in the investment of HIT until there are further advances in technology.

ASH is very concerned that the HIT infrastructure is not sufficiently developed yet. The Society realizes that reforms to the current Medicare payment system are necessary for the program to survive, yet it believes greater investments will be needed in health information technology in order for these innovations to succeed. ASH also recommends that the Committee give serious consideration to expansion of the system used by the VA, which has proven effectiveness and can serve as a foundation to a national electronic medical records system while billing and other services can be added to it.

ASH looks forward to working with the Congress and Administration on health care reform and would be pleased to provide your Committee with any additional information on the issues raised in this letter. Your staff can contact Carol Schwartz, ASH Senior Manager of Policy and Practice at 202-292-0258 or cschwartz@hematology.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Nancy Berliner". The signature is fluid and cursive, written in a professional style.

Nancy Berliner, MD
President