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2009

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Ms. Charlene Frizzera
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Re: Medicare Program: Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010

Dear Acting Administrator Frizzera:

The American Society for Hematology (ASH) is pleased to have this opportunity to comment on proposed changes to the physician fee schedule for CY 2010. ASH represents over 16,000 hematologists in the United States who are committed to the treatment of blood and blood-related diseases. ASH members include hematologists who regularly render services to Medicare beneficiaries.

Our comments will focus on the following provisions of the proposed rule that would have an impact on physicians who practice hematology and the Medicare beneficiaries they treat:

- Proposal to update the PE/HR data based on the new American Medical Association (AMA) Physician Practice Information Survey (PPIS).
- Budget neutral proposal to eliminate the use of all consultation codes.
- Various proposals related to the implementation of the Physician Quality Reporting Initiative (PQRI).
- Proposal to establish a panel of experts separate from the AMA RVS Update Committee (RUC) to review RVUs.

Proposal to update the PE/HR data based on the new AMA PPIS survey.

Practice Expense Relative Value Units (RVUs) represent the resources used in furnishing supplies, office rent/lease, equipment and personnel wages (excluding malpractice expense) when providing physician services. Currently PE per hour (PE/HR) data that is the basis for PE RVUs is obtained from the AMA surveys, notably the 1995-1999 Socioeconomic Monitoring Survey (SMS). Updated supplemental survey data has been accepted and is in use by the Agency for certain specialties including cardiology, dermatology, gastroenterology, radiology, cardiothoracic surgery, vascular surgery, physical and occupational therapy, independent laboratories, allergy/immunology, independent diagnostic testing facilities (IDTFs), radiation oncology, medical oncology, and urology.

CMS is proposing to update the PE/HR data, effective January 1, 2010, using the Physician Practice Information Survey (PPIS) recently conducted by the AMA. ASH did not participate in the PPIS therefore, as has been done previously, the medical oncology data will be crosswalked to calculate PE RVUs for hematology. Hematology is expected to experience a -5% impact as the result of changes to PE RVUs. This will result in dramatic payment reductions for all hematologists.

ASH is deeply worried about the grave negative impact that the implementation of the PPIS data will have on practicing hematologists and the Medicare beneficiaries they serve. The most serious and relatively frequent disorders that ASH members diagnose and treat (anemia, bleeding and clotting disorders and blood cancers such as leukemia, lymphoma and multiple myeloma) are particularly prevalent in the elderly and are increasing as the US population ages. The payment reductions resulting from the implementation of these new data would be devastating to hematology practitioners across the country, and could threaten access to specialists for Medicare beneficiaries. ASH trusts that the Agency agrees that an outcome of this nature would be counterproductive and would not be consistent with current initiatives toward increasing access to care.

The Society recognizes and applauds the Agency's desire to manage prudently the resources of the Medicare Trust Fund, which may be depleted as early as 2017. ASH also recognizes that although the medical oncology data is more recent, for the bulk of the specialties the data is over a decade old and there is a need for more current practice expense data. While recognizing the situation facing Medicare, ASH is concerned about the quality of the new survey data (PPIS) in comparison to the data currently used (SMS). Since the resources that will be allocated based on the results of this survey are significant, ASH believes ensuring the validity of the new survey data is critical. From the information that is available ASH believes that the new data is less robust and may actually be less representative of providers than the previous survey. The new medical oncology survey data is based on 50 complete surveys. This is in comparison to the supplemental survey that was based on over 200 complete surveys. ASH is very concerned that such a small sample size cannot adequately capture the practice costs of hematologists. The study could be vulnerable to geographic bias and other methodological problems that would limit its precision in accurately estimating practice expense costs.

ASH's second concern with this proposal is that very few details regarding the new survey data, or the Agency's analysis of the data, have been provided. This lack of transparency seems inconsistent with the Agency's typical handling of proposals regarding new data or other policies. Ordinarily the Agency is very forthcoming and clear when it is proposing to integrate new data or policies into the program, especially when a change of such great magnitude may result. This level of transparency, which physicians have come to expect from CMS and is highly appropriate for a program that is funded by public dollars, seems to be absent this time. ***ASH urges CMS to withdraw its proposal to implement the new PPIS survey data, provide greater information on the validity of the new survey data, and maintain the existing survey data until these issues can be resolved.***

Proposal to budget neutrally eliminate the use of all consultation codes

A consultation service is an evaluation and management (E/M) service furnished by an expert physician or other qualified provider at the request of another provider, usually a different physician. Beginning January 1, 2010 CMS proposes to no longer recognize the CPT codes describing office/outpatient and inpatient consultations. CMS is directing physicians to report office/outpatient consultations using the existing E/M codes for office visits. For an inpatient hospital consult, the consultant will bill an initial hospital care code. This will be conducted in a budget neutral manner by increasing the work RVUs of the visit codes. ***ASH strongly opposes this proposal to eliminate consultation codes. The Society believes it will diminish the value of***

the important consultation services provided by internal medicine subspecialists such as hematologists. ASH urges CMS to withdraw its proposal to eliminate the use of all consultation codes.

CMS stated in the rule that it believes the rationale for differential payment for a consultation service is no longer supported because documentation requirements are now similar across all E/M services. ASH strongly disagrees with this rationale. Consultation codes were created describing very specific physician work that cannot be accurately described by visit codes. Consultations involve inherently more complex patients. These patients have been referred to the consulting physician because they are presenting with clinical problems that have challenged their primary physician. ASH does not believe that the degree of cognitive work for a hematology consultation can be appropriately described by an E/M visit code. Moreover the documentation requirements for consultation services are typically greater.

ASH fears the proposal will diminish the value of physician work performed by cognitive specialists. Office/outpatient consultation services were reviewed by the AMA RUC during the Third Five Year Review in 2006. At this time the RUC reaffirmed that the value of office/outpatient consultation services should be greater than that of visit codes. CMS accepted these recommended values. ASH is not aware that anything substantive has occurred in the interim that would lead the Agency to no longer accept the values of consultation services which were so recently reviewed by the AMA RUC and accepted by the Agency.

ASH's second concern with this proposal is the precedent it sets in eliminating a whole class of CPT codes. In the past CMS has created G-codes when the Agency has disagreed with the definition of a specific code, but to our knowledge, the refusal to recognize an entire set of codes that are widely used by all physicians is unprecedented. The Society is very troubled by this action.

From a practical perspective this proposal could become very complicated and administratively burdensome to physicians. Consultation codes are widely used by many physicians. If Medicare refuses to recognize codes that are widely accepted by private payors and commonly used by physicians the administrative burden in coding and reporting could increase significantly. ASH is also concerned that the Recovery Audit Contractors (RACs) demonstration project is scheduled to transition into a nationwide permanent program by January 1, 2010. RACs are authorized to review E/M services. If this proposal is implemented, even with the best efforts on education by CMS and individual subspecialty societies, there will be a significant transition period for many physicians with a steep learning curve on appropriate reporting under the new system. ASH is concerned that physicians who are making the effort to comply with the new rules will have difficulties and there will be variations in reporting during the initial transition period. ASH is concerned that this will make physicians unintentionally and unfairly vulnerable to RAC audits.

Moreover ASH believes there is a public health or health services research value in being able to differentiate between consultations and visit codes. Consultation services are also an important element of Medicare demonstration programs such as the Medical Home. In a time when medical professionals are trying to increase the accuracy and granularity of data in medical records, and our capacity to manage greater amounts of data is being enhanced by the

introduction of electronic health records and other resources, ASH does not understand why the Agency would introduce a proposal that would decrease our ability to capture more data.

For all of these reasons ASH urges CMS to withdraw its proposal to eliminate consultation codes.

Various proposals related to the implementation of the Physician Quality Reporting Initiative (PQRI)

Initiated in 2007, the Physician Quality Reporting Initiative (PQRI) is a performance measure reporting program. Participants who successfully report based on criteria established by CMS are eligible for a bonus payment. This proposed rule includes a number of provisions related to the PQRI program. ASH has been supportive of the efforts of CMS to implement PQRI. As a medical specialty society representing practicing hematologists ASH has tried to complement the efforts of CMS with our own initiatives by archiving information on the ASH Web site regarding the PQRI program, conducting a webinar for membership with CMS staff on PQRI, and developing and posting on our Web site educational materials on this important program. ***ASH applauds the Agency's efforts to continue to develop and improve this important program but has significant concerns about the Agency's proposal to establish a minimum patient sample size. The Society is also troubled by comments in the rule that significantly limit the claims-based mechanism of reporting clinical quality measures for PQRI after 2010. ASH urges the Agency to withdraw both of these proposals.***

Minimum Patient Sample Size - CMS proposes establishing a minimum patient sample size for PQRI of at least one measure to enhance the scientific validity of the eligible professionals' performance results (15 patients for the 12 month reporting period and 8 patients for the 6 month reporting period). Separate criteria for measure groups have been proposed.

ASH has significant concerns with this proposal and its potential to create a barrier to participation for providers treating patients with rare conditions. For example, hematologists treat patients with bleeding disorders and other relatively rare diseases, all of which require highly specialized diagnostic and therapeutic services. The Society is concerned that the proposed minimum threshold would be difficult for most providers to meet and would thus create a barrier for participation. ASH believes that the minimum threshold requirement would be unfairly biased against providers who treat patients with rare diseases.

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. Because appropriate measures do not yet exist for all ASH members, some members have felt the frustration of not being able to participate in PQRI. Adding the additional barrier of a minimum patient threshold will create more frustration and only discourage participation at a time when CMS should be actively recruiting providers to participate.

In other parts of the rule, CMS has proposed linking PQRI with other Medicare programs such as the Medicare Confidential Feedback Program and the Physician Value Based Purchasing

Program. If PQRI is going to increase its presence in the Medicare program the Agency needs to ensure that the program is accessible to as large a proportion of providers as possible. PQRI and the concept of physician quality programs are still in their infancy. Medicare should focus on encouraging participation, not on creating barriers. While design changes to improve the scientific validity of the program may be desirable, ASH does not believe the creation of a minimum patient threshold is an appropriate approach.

Limiting the Claims-Based Mechanism of Reporting after 2010 – In 2009 providers could submit measures either through claims or via a qualified registry. For 2010 CMS is proposing to add a third reporting mechanism, the electronic health record (EHR), for a limited subset of measures. This proposal is contingent upon the successful completion of the 2009 EHR data submission testing process. ASH is pleased that CMS is moving forward with increasing the participation options for PQRI. The Society believes that greater flexibility in the program that recognizes and allows for participation of physicians from a wide variety of practice settings is the best way to expand and develop the program. Yet at the same time CMS states it is considering significantly limiting the claims-based mechanism of reporting clinical quality measures for PQRI after 2010. Similar to our concerns on the proposal to create a minimum patient sample size, ASH believes dropping the claims-based reporting option too quickly could create a barrier to participation in PQRI.

ASH understands that CMS sees the claims-based reporting option as less efficient and accurate than registry or EHR reporting. But claims-based reporting is the only option for many physicians at this time. Until the other options become more widely available in practical terms, CMS must protect the claims-based reporting option. ASH is pleased that CMS is focusing on improving this program, but urges the Agency not to move too quickly on this proposal.

Alternative Reporting Period Option – ASH was pleased to see that CMS is proposing an alternative reporting option (July 1-December 31, 2010) for providers reporting individual measures by registries and those reporting measure groups either through the claims process or via registry. The Society sees this as another example of the Agency trying to increase the flexibility of the program. ASH urges CMS to expand the alternative reporting period option to physicians reporting individual measures through claims. For many physicians, including hematologists, reporting measure groups is not an option. ASH believes that allowing for an alternative reporting period for these providers will encourage participation in the program. The initial implementation of the PQRI program can be daunting. The final measure specifications are not posted until November or December creating a very compressed timetable for a January 1 program implementation. ***ASH believes the alternative reporting period would be very helpful to many providers and the Society urges CMS to expand this option to providers reporting individual measures via the claims-based process.***

Proposal to establish a panel of experts separate from the AMA RVS Update Committee (RUC) to review RVUs

In the proposed rule CMS has requested input on the creation of a group of experts separate from the AMA RUC to help the Agency improve the review of relative value units. Although hematology does not have a permanent seat on the RUC, the specialty is an active participant in the process and has been a recent occupant of the rotating internal medicine seat on the RUC.

The RUC has been criticized by outside observers, such as the Medicare Payment Advisory Commission (MedPAC), and even by internal participants of the process. While ASH acknowledges the RUC process is flawed, the Society believes its strength and the value that it provides Medicare is in the input it receives from physicians who serve Medicare beneficiaries in practices across the country in a wide variety of practice settings.

ASH is intrigued by the concept of an additional Panel of experts that could potentially supplement the efforts of the RUC and look forward to further discussion in future rulemaking. While the Society is open to considering the creation of such an entity, ASH would emphasize that the participation of practicing physicians reflecting the span of specialties providing services to Medicare beneficiaries is essential for this panel to be an effective addition to the process. In addition, it is imperative that any Panel have processes that are transparent.

Thank you for the opportunity to submit these comments. If ASH can provide additional information, please contact Carol Schwartz, Senior Manager, Policy & Practice at ASH 202-292-0258/cschwartz@hematology.org.

Sincerely,

A handwritten signature in black ink that reads "Nancy Berliner". The signature is written in a cursive, flowing style.

Nancy Berliner, MD
President