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October 28, 2024

The Honorable Cathy McMorris Rodgers
Chair
Energy and Commerce Committee
United States House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Energy and Commerce Committee
United States House of Representatives
Washington, DC 20514

The Honorable Jason Smith
Chair
Ways and Means Committee
United States House of Representatives
Washington, DC 20514

The Honorable Richard Neal
Ranking Member
Ways and Means Committee
United States House of Representatives
Washington, DC 20515

Re: Medicare Physician Payment Reform Outline

Dear Chair Rodgers, Chair Smith, Ranking Member Pallone, and Ranking Member Neal:

The American Society of Hematology thanks the House Ways and Means and Energy and Commerce Committees ("the Committees") for the opportunity to provide comments on your Medicare physician payment reform policy outline.

ASH represents more than 18,000 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 classical (non-malignant) conditions such as sickle cell disease, thalassemia, bone marrow failure, venous thromboembolism, and hemophilia. In addition, hematologists are pioneers in demonstrating the potential of treating various hematologic diseases and continue to be innovators in the fields of stem cell biology, regenerative medicine, transfusion medicine, and gene therapy. Our mission is to foster high-quality, equitable care, transformative research, and innovative education to improve the lives of patients with blood and bone marrow disorders.

We appreciate the Committees' commitment to ensuring access to high-quality care for Medicare beneficiaries by undertaking the monumental task of reforming the Medicare Physician Fee Schedule (MPFS). As you are aware, Medicare physician payment has stagnated for the last two decades, declining by 29 percent when adjusted for inflation from 2001 – 2024. The Medicare Access and CHIP Reauthorization Act (MACRA) only provided statutory updates to the conversion factor from 2015 – 2019. Therefore, the lack of positive conversion factor updates and the MPFS' budget neutrality requirements have resulted in a series of statutorily required cuts to physician payment over the last four years, which Congress has repeatedly stepped in to mitigate. Despite Congress' interventions, Medicare reimbursement has not kept pace with the continuously increasing cost of delivering care, which includes clinical and office staff salaries and supplies and equipment costs.

The continued erosion in Medicare physician reimbursement is distinctly acute for hematologists. Hematology, particularly classical hematology, is facing a severe workforce shortage, limiting access to much needed expertise in complex hematological disorders, like sickle cell disease,

hemophilia, iron deficiency anemia, and blood clotting disorders such as deep vein thrombosis (DVT). The practice of hematology is rapidly evolving and becoming increasingly complex, requiring physicians to stay current with the latest innovations as they evaluate and recommend the most appropriate therapeutic options to their patients. As a result of this rapid innovation, the costs of practicing medicine, such as providing newly approved innovative cellular and gene therapies, are growing while Medicare reimbursement is shrinking. Additionally, early career physicians are expressing concerns of balancing the eroding Medicare reimbursement rates that cover physician and staff salaries and supplies while being burdened with significant medical school debt. Without adequate reimbursement, there are limited incentives for new physicians to pursue hematology, and especially classical hematology.

The complex care delivered by hematologists is captured primarily by high level evaluation and management (E/M) services. ASH members typically treat patients in the office setting: providing complex disease management, developing treatment plans, and partnering with their patients to implement complicated therapeutic regimens. For these reasons, improved Medicare reimbursement and the proper valuation of physician services, particularly E/M services, is of paramount importance to hematologists. ASH is grateful for the Centers for Medicare & Medicaid Services' (CMS) recent work to redefine and revalue outpatient E/M services and to reimburse for G2211, an add-on code billed with E/M care for patients with whom a physician has a longitudinal relationship. However, these improvements still do not fully capture the complexity of hematologic care, especially given the recent expanding availability of bone marrow transplantation for various hematologic conditions, such as myelodysplastic syndromes (MDS) and SCD, and CAR T-cell therapy to treat leukemia, lymphoma, and multiple myeloma. Meanwhile the increased outpatient E/M valuations have been eroded by the MPFS' budget neutrality requirement and lack of positive increases to the conversion factor.

Payment Updates

ASH members are committed to delivering high-quality care to their patients, but MPFS reimbursement is on an unsustainable path, particularly for hematologists and other physicians who rely on outpatient E/M services to treat Medicare beneficiaries with complex medical conditions. The Committees' outline includes a baseline update to the conversion factor by providing an update of an unspecified percentage of the Medicare Economic Index (MEI) every five years. ASH encourages the Committee to include a more frequent update and supports an annual inflationary update equal to MEI to the MPFS.

An annual inflation-based update will help MPFS reimbursement keep pace with evolving health care needs and ever-increasing healthcare costs while aligning MPFS policy with other Medicare fee schedules. The MPFS is the only Medicare fee schedule that does not have an inflationary update built into its system. For these reasons, we urge the Committees to support an annual inflation-based adjustment to the MPFS conversion factor equal to the MEI, putting the MPFS on par with the other Medicare fee schedules. This will help relieve the downward pressure on the conversion factor and improve MPFS reimbursement to more accurately reflect the costs associated with physician, clinical staff, and office staff salaries and the required equipment and supplies needed to deliver high-quality care.

Budget Neutrality and the Conversion Factor

Without positive updates to the MPFS conversion factor, the budget neutrality requirements exert greater downward pressure on Medicare reimbursement due to the redistributive impacts on MPFS payments. This pressure exacerbates the impression that specialties are pitted against one another when new codes are added to the MPFS, or a family of codes is recommended for an increase in valuation.

Legislation has been introduced in the House, the *Provider Reimbursement Stability Act of 2023* (H.R. 6371), that would address the budget neutrality issue by authorizing the Secretary to compare estimated utilization to actual utilization and adjust the conversion factor based on the difference (either over- or underutilization). The Secretary would be required to report the difference by September 1 of the subsequent year that the estimated utilization was used to calculate budget neutrality. ASH supports this policy and believes it is a good starting point to address estimated utilization that may significantly impact the budget neutrality adjustment. Additionally, ASH supports reform to the budget neutrality requirements which include increasing the outdated budget neutrality threshold of $20 million. This threshold has never been updated since the implementation of the Resource Based Relative Value Scale. H.R. 6371 includes a provision to update this threshold to $53 million and then to increase it every 5 years equal to the cumulative increase in MEI. By raising the threshold and indexing it for inflation in this manner, the redistribution of funds across the MPFS would be more equitable, mitigating the potential for drastic cuts to the conversion factor when new services are added to the MPFS or when high-volume services, like E/M services, are revalued. ASH appreciates the Committees' inclusion of the budget neutrality provisions from H.R. 6371 and recommends that the revisions to budget neutrality policies be included in comprehensive payment reform legislation.

Incentivizing Participation in Alternative Payment Models

The current landscape of Advanced Alternative Payment Models (A-APMs) presents significant barriers to specialty participation, primarily due to the lack of relevant APMs tailored to specific specialties. One barrier that will be difficult to overcome is the number of Medicare beneficiaries with a relevant condition in a specialty to support a model within that specialty. Without a large enough patient population, CMS has said it is impossible to develop and pilot specialty models. Therefore, Congress and CMS should work together to develop another method by which specialties may feasibly and meaningfully participate in APMs.

The downside risk required of A-APMs is a major disincentive to participation. In an environment where the conversion factor and Medicare reimbursement decreases annually, it is not attractive to enroll in models with downside risk, particularly if outcomes are based on factors outside of the physician's control, such as factors associated with social determinants of health. The downward pressure on Medicare physician payment does not make it attractive for physicians, particularly those who treat complicated patients with chronic conditions, to expose themselves to additional financial risk. Therefore, Congress must first address physician payment inadequacy, including updates to the conversion factor and budget neutrality, to create an environment that incentivizes meaningful participation in this space.

ASH recognizes that the Committees are considering reforms to the CMS Innovation Center and the Physician-Focused Payment Model Technical Advisory Committee (PTAC). Any reforms should consider the challenges that hematologists and other cognitive specialists face. We urge the Committees to work with ASH, other specialty societies, and CMS to optimize these processes to move closer to the agency's goal of having all Medicare and most Medicaid beneficiaries enrolled in value-based arrangements by 2030.

Additional Considerations: Ensuring Accuracy of Values within the PFS

While the Committees' outline does not address policy to ensure the accuracy of MPFS services' valuation, as previously mentioned, the complex care provided by hematologists is largely captured by E/M services. ASH respectfully requests that you address this issue in any comprehensive Medicare physician payment reform legislation. ASH supports the development of alternative methodologies that would better reflect and capture the expertise, complex disease management, and development of treatment plans hematologists and other cognitive care specialists provide.

ASH participates in the American Medical Association's (AMA) RVS Update Committee (RUC) and believes it serves an important purpose in the valuation of specific services. However, we do not believe the process is as effective for E/M and non-procedural care as it has been designed for and measures procedures. Despite the best efforts of the AMA Current Procedural Terminology (CPT) Editorial Panel, the RUC, and CMS, the payment challenges associated with E/M codes persist and are a driver of the shortage of hematologists and other cognitive specialists.

As these E/M and non-procedural services continue to be undervalued in the current ecosystem, the underlying challenges related to appropriately capturing complex cognitive care will persist and continue to place pressure on cognitive specialties. Therefore, ASH encourages the Committee to consider a supplemental alternative to more regularly and better support the definition and valuation of E/M and other non-procedural services.

Thank you for the opportunity to provide these comments. We look forward to working with you to reform the MPFS and protect Medicare beneficiary access to physician services. Should you have any questions or wish to discuss these issues further, please contact Carina Smith at casmith@hematology.org.

Sincerely,

Mohandas Narla, DSc
President

Mary-Elizabeth M. Percival, MD, MS
Chair, Committee on Practice