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June 14, 2024

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

The American Society of Hematology thanks the Senate Finance Committee ("the Committee") for the opportunity to provide comments on the white paper titled, "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B," outlining policy concepts related to Medicare physician payment reform and meeting the needs of patients with chronic disease.

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 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 Committee's commitment to ensuring access to high-quality care for patients and reforming the Medicare Physician Fee Schedule (MPFS). As you are aware, Medicare physician payment has stagnated for the last two decades, declining by 30 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 updates and the MPFS' budget neutrality requirements have resulted in a series of statutorily required cuts to the conversion factor over the last four years.

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. This shortage is driven by new physicians' concerns of balancing the eroding Medicare reimbursement rates that cover physician and staff salaries and supplies, and significant medical debt. At the same time, 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 new therapies to their patients, such as the recently approved cellular and gene therapies and the expanding availability of bone marrow transplantation. The proliferation of these new and complex therapies comes at a time when the costs of practicing medicine are growing, while Medicare reimbursement, accounting for inflation, is shrinking.

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 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 and 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, meanwhile the increased outpatient E/M valuations have been eroded by the MPFS' budget neutrality requirement.

Addressing Payment Update Adequacy and Sustainability

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. An important first step to addressing payment adequacy and protecting patient access to care is to provide an annual inflationary update to the MPFS conversion factor equal to the Medicare Economic Index (MEI).

ASH appreciates that the Committee has recognized and described MEI as the "best measure available" of the relative weights of the three components of PFS payments – work, practice expense, and malpractice. We also agree with the Committee that the current policy threatens the viability of independent practices and does not reflect practice cost inflation. An annual inflation-based update will allow MPFS reimbursement to keep pace with evolving health care needs and ever-increasing healthcare costs and align MPFS policy with that of 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 Committee to support an annual inflation-based adjustment to the MPFS conversion factor equal to the MEI. This will undoubtedly relieve the downward pressure on the conversion factor and ensure that MPFS reimbursement accurately reflects 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 even greater downward pressure on Medicare reimbursement and exacerbate 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, due to the redistributive impacts for other payments under the MPFS.

Legislation has been introduced in the House, the *Provider Reimbursement Stability Act of 2023* (H.R. 6371), that would address this 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 including increasing the outdated budget neutrality threshold of $20 million. As the Committee has recognized, this threshold has never been updated, and has

remained the same for more than 30 years. Different threshold updates have been proposed in Congress, and ASH encourages the Committee to consult with health economists to determine the most appropriate update. Additionally, Congress should provide for an increase every 5 years equal to the cumulative increase in MEI. By raising the threshold in this manner, redistribution of funds across the MPFS will be more equitable, preventing 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.

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. To address this gap, Congress could legislate and require that CMS develop and pilot a certain number of specialty models annually, working in partnership with relevant specialty societies. 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 can feasibly and meaningfully participate in APMs.

Additionally, 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 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 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.

Reducing Physician Reporting Burden Related to MIPS

As structured, not all physicians have clinically meaningful participation options in CMS' merit-based incentive payment system (MIPS). ASH appreciates the efforts taken by CMS to transition to further develop and improve MIPS, including the creation of MIPS Value Pathways (MVPs); however, we remain concerned about the limited ability for certain specialties, including hematology, to participate, and the lack of meaningful measures. Even for specialties that have a robust set of measures, measures that are meaningful to all segments of their membership may not be available. For example, in hematology, there may be relevant measures related to oncology but a provider who specializes in sickle cell disease or other rare blood disorders may not have clinically relevant measures.

Moreover, as the Committee has thoughtfully recognized, there is immense administrative burden placed upon physicians subjected to MIPS reporting requirements, taking precious time away from patient care. Recognizing the financial and administrative investment that is required to develop and maintain measures, Congress and CMS should look for additional methods to measure quality performance and improvement through the information that is reported through electronic medical records and registries. Quality reporting should not be an additional administrative burden on physicians and their staff. Instead, it should be seamlessly incorporated into existing workflows, utilizing advanced technology, to allow physicians to focus more time on patient care.

Supporting Chronic Care in the Primary Care Setting

ASH recognizes that the Committee is exploring a hybrid payment model in Medicare FFS that would allow for a per-beneficiary, per-month (PBPM) payment, provided in advance to the clinician. Hematology and other specialists often serve as the medical home for patients with chronic conditions. For example, hematologists direct the care of

patients with blood cancers and classical hematological conditions like sickle cell disease. Like primary care physicians, hematologists face many of the same challenges, such as workforce shortages driven by concerns about medical debt and reimbursement rates. To support chronic care and high-quality care for patients with complicated conditions, like SCD, Congress must look for solutions to apply beyond primary care.

Supporting Chronic Care Benefits in FFS

ASH is appreciative of the policies included in the CHRONIC Care Act that allow Medicare Advantage plans to cover certain non-medical, health related services, such as transportation to medical appointments, meals, and minor home modifications to prevent falls; however, Medicare FFS generally does not cover these types of services. In order to reduce downstream health care costs and improve outcomes for patients with chronic disease or those that require ongoing, longitudinal care, this Committee should support coverage for non-emergency medical transportation (NEMT) in Medicare FFS. Not all patients have access to public transportation or their own vehicle, and a robust NEMT benefit would help ensure that patients are able to keep their appointments with their physicians needed to manage their conditions.

Additionally, continuing the telehealth flexibilities is important to supporting longitudinal care for patients with chronic conditions or require ongoing follow up in Medicare FFS. For patients who lack regular transportation, telehealth provides them with a reliable method to receive care. By keeping both the audio-visual and audio-only options, beneficiaries can access care in the instance that they cannot get to a doctor's office. Maintaining these flexibilities particularly helps bridge the gap for patients in rural or underserved areas, ensuring they receive consistent and equitable healthcare services.

Additional Considerations: Ensuring Accuracy of Values within the PFS

We are pleased to see that the Committee is examining structural improvements to help bolster program integrity, reliability, and accuracy in CMS' RVU rate-setting process. Senators Sheldon Whitehouse (D-RI) and Bill Cassidy (R-LA) introduced the *Pay PCPs Act*, which establishes a Technical Advisory Committee (TAC) to provide the Secretary with technical input regarding the accurate determination of RVUs. We support the concept of establishing a committee of experts to provide this input on E/M and non-procedural services.

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 is for procedures. Despite the best efforts of the AMA CPT Editorial Panel and RUC and CMS, the challenges with E/M codes persist and are a driver of the shortage of hematologists and other cognitive specialists, including primary care physicians.

Therefore, ASH supports the establishment of a TAC to define and value E/M and other non-procedural services more regularly as a supplement to the AMA's RUC. The TAC's charge should be to implement an evidence-based, data-driven approach to assess the E/M and non-procedural service code definitions and ensure that their valuations are accurate, reliable, and reflect the value of the specialty expertise and longitudinal care our members deliver to Medicare beneficiaries. Following an analysis of data, research, methodologies, and knowledge gaps, a TAC would be well-suited to develop a set of recommendations to address inadequacies of E/M service code definitions and valuations and ensure payment is adequate for these services. ASH believes that the composition of a TAC should be modified from what Senators Whitehouse and Cassidy have advanced. It should include individuals with expertise in healthcare policy, such as physicians, patients, health economists, coders, health informaticists, and other stakeholders with expertise in payment policy; with this expertise, the TAC will be well-positioned to address the challenges faced across cognitive specialties.

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
Chair, Committee on Practice