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April 28, 2025

Robert F. Kennedy, Jr.
Secretary, U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201 (*Sent via email to Darcie.johnston@hhs.gov*)

Dear Secretary Kennedy,

As the newly confirmed Secretary of the U.S. Department of Health and Human Services (HHS), the American Society of Hematology (ASH) writes to you today to offer our assistance as you develop and implement programs and policies that will affect our members and their patients with hematologic disorders.

ASH represents more than 18,000 clinicians and scientists worldwide committed to studying and treating blood and blood-related diseases. These chronic disorders encompass malignant hematologic disorders such as leukemia, lymphoma, and multiple myeloma, as well as classical (or non-malignant) conditions such as sickle cell disease (SCD), thalassemia, bone marrow failure, venous thromboembolism (VTE), and hemophilia. Hematologists have been pioneers in advancing, understanding, and treatment of various hematologic diseases. Hematologists continue to be innovators in the fields 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 providing care to patients. Our mission is to foster high-quality care, transformative research, and innovative education to improve the lives of patients with blood and bone marrow disorders.

ASH appreciates your commitment to reduce the significant burden associated with chronic diseases through the Make America Healthy Again (MAHA) Commission and other programs within HHS. Chronic hematologic diseases encompass a wide range of conditions that not only place a lifelong strain on patients, significantly impacting their quality of life through ongoing management, hospitalizations, and treatments, but they also drive considerable health care costs. This underscores the urgent need for coordinated federal efforts.

As the MAHA Commission works to reduce the burden of chronic diseases, I urge you to prioritize hematological conditions. ASH welcomes the opportunity to collaborate with you and the MAHA Commission to advance health policies that improve the lives of individuals living with chronic hematological diseases, many of which are rare and impose significant burdens on those living with them. This letter focuses on areas where ASH believes improvements can be made related to access to care and biomedical research. It is imperative that individuals with SCD and blood cancers can access comprehensive care including innovative therapies that biomedical research has advanced. ASH looks forward to collaborating on the following key health priorities:

- Sickle Cell Disease
- Advancing Biomedical Research
- Access to High-Quality Care for Patients
- Physician Payment Reform
- Access to Innovative Therapies
- Prior Authorization
- Telehealth

Sickle Cell Disease

Dating back to President Donald Trump's first term, HHS has prioritized SCD and the burden it places on patients and their families and the healthcare system. ASH urges you to consider the following issues related to SCD; we believe that your increased focus on reducing the burden of chronic disease in the United States will only further progress related to SCD. Affecting approximately 100,000 Americans, SCD is an inherited, lifelong disorder, which results in patients' red blood cells becoming rigid and sickle shaped. Sickle cells can get stuck in blood vessels and block blood flow, causing pain and organ infarctions. The worst complications include stroke, acute chest syndrome (a condition that lowers the level of oxygen in the blood), organ damage, other disabilities, and premature death. Additionally, patients with SCD are also at increased risk of infection from certain types of bacteria. Therefore, it is important for people with SCD to have access to high-quality, comprehensive and coordinated care, including the range of treatment options currently available.

ASH encourages you to build on the efforts of President Trump's first Administration, including commissioning the National Academies of Sciences, Engineering, and Medicine (NASEM) report on *Addressing Sickle Cell Disease: A Strategic Plan and Blueprint for Action*, and hosting the First Lady's 2020 Roundtable on Improving the Lives of Americans Living with SCD. These efforts created a foundation for additional federal investment and programs to meaningfully improve health outcomes.

Comprehensive and Coordinated Care

Today, many people with SCD face barriers accessing experienced care teams and therapies and receive uncoordinated care outside of a medical home leading to poor clinical outcomes, avoidable complications, low quality of life, and increased costs to the healthcare system. Individuals with SCD are living longer, and it is imperative that policies be enacted to improve the care they receive and their quality of life.

While the population living with this chronic disorder is small, coordinating the care they receive has the potential to reduce the cost of their care significantly. At the University of Virginia, "a small cohort of individuals with sickle cell disease were identified as a high utilizer population who accounted for 7% of all readmissions to the general medicine services and nearly $1 million in annual costs."[1] In response, a multidisciplinary team developed individualized care plans for this small group of patients. These care plans were made available in the electronic medical record to inpatient, outpatient, and emergency department providers. In the four quarters after the intervention, "total costs were reduced by 24% from $949,935 to $717,226."

ASH proudly supports the bipartisan *Sickle Cell Disease Comprehensive Care Act of 2025* (S.721), a bill that authorizes state Medicaid programs to provide comprehensive, coordinated care through a Medicaid health home model for individuals based on their SCD status alone. Health homes for SCD will help to alleviate the many challenges and disparities in care that individuals with SCD have faced for far too long. This bill provides a multi-faceted approach to care, ensuring SCD patients have access to coordinated clinical, mental health, and ancillary services to address their needs. In addition to improving care, the bill would save money in the Medicaid program by reducing costs associated with lower healthcare utilization. **ASH urges you to support this legislation and other policies to improve care coordination for SCD patients.**

Half of individuals living with SCD rely on Medicaid for their care. While we support improving efficiency in the Medicaid program and reducing fraud, waste, and abuse, cuts to Medicaid funding or the covered benefits would jeopardize access to essential services and treatment. **We encourage you to work with Congress to protect and strengthen Medicaid coverage to ensure individuals with SCD receive the comprehensive care they need.**

Federal Data Collection

The Centers for Disease Control and Prevention's (CDC) Sickle Cell Data Collection Program has been critical in collecting and analyzing longitudinal data about people living in the U.S. with SCD. Through the program, which was implemented during President Trump's first term, the CDC awards SCD data collection grants to states, academic institutions, and non-profit organizations to gather information on the prevalence of SCD and health outcomes,

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[1] https://shmabstracts.org/abstract/precision-medicine-an-individualized-approach-to-the-highest-utilizers-of-hospital-based-care/

complications, and treatment that people with SCD experience. Currently, sixteen states participate in the data collection program, with data being collected from multiple sources to create individual health care utilizations profiles. **ASH is deeply concerned that the CDC's entire Division of Blood Disorders and Public Health Genomics (DBDPHG), including staff that implement the data collection program, was placed on administrative leave.** Support for this program is essential to help strengthen and expand the program's current efforts, which will help enable individuals living with this disease to receive adequate care and treatment.

Our Society has made tremendous investments to address the burden of SCD, which includes supporting efforts to advance data and research. The ASH Research Collaborative (ASH RC), founded by ASH in 2018, was established to improve the lives of individuals with blood diseases by fostering collaborative partnerships to accelerate progress in hematology. Specifically, the ASH RC SCD Data Hub collects real world data that is used for research and to support clinical practice and patient outcomes. Participating health systems and hospitals submit electronic health record (EHR) data for patients with SCD and the data is used to support primary investigators' research topics and site benchmark reporting.

Additionally, the Assistant Secretary for Technology Policy / Office of the National Coordinator for Health Information Technology is creating a SCD minimum core dataset under the United States Core Data for Interoperability Plus (USCDI+) program. The USCDI+ SCD project intends to establish minimum core data elements and definitions that can be implemented within certified EHR systems. The project will also identify additional data elements beyond the existing USCDI core to address the unique needs of SCD research and quality improvement efforts. **ASH urges you to continue to strengthen and expand these data programs through additional federal support.**

Advancing Biomedical Research

Medical research funded through the National Institutes of Health (NIH), the largest source of public funding for medical research in the world, has been a driving force behind many decades of advances that have improved the health of people in every state and community, providing cures and hope for patients and caregivers. Hematology research has also helped pave the way for many discoveries both within and outside of hematology. Discoveries made by hematologists have led to extraordinary advances in other fields of medicine, including new and better treatments for some of the world's deadliest and costliest diseases such as heart disease and stroke.

Critical hematology research is supported by leading NIH institutes and centers, including the National Heart, Lung, and Blood Institute (NHLBI), National Cancer Institute, National Institute of Diabetes and Digestive and Kidney Diseases, and National Institute on Aging, among others. This work is essential to advancing our understanding and treatment of blood disorders and improving patient outcomes. The practice of hematology has benefited from NIH investments which have led to the development of cutting-edge therapies in the field of hematology, including gene therapies for SCD, thalassemia, and hemophilia, and chimeric antigen receptor (CAR) T-cell therapies for certain blood cancers.

Few treatments are available to help individuals with SCD manage the pain crises associated with this genetic disease. Prior to the 2023 approval of two gene therapies, blood and bone marrow transplants were the only curative options. Research conducted by NHLBI and the National Human Genome Research Institute played a critical role in developing these two groundbreaking gene therapies offering patients a new curative option. Additionally, CAR-T therapy, first approved for children with acute lymphoblastic leukemia (ALL) and certain adults with large B-cell lymphoma, has provided a vital treatment option for individuals with relapsed or treatment-resistant cancers. The first child with ALL was treated with CAR-T at the NIH Clinical Center in 2012, with NIH support helping to advance the clinical trials that made this therapy a reality. These innovations are changing the practice of classical and malignant hematology, and the *ASH Agenda for Hematology Research* highlights key emerging and transformative areas of research that will launch the field into the next generation of therapies for hematologic conditions.[2]

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[2] https://www.hematology.org/research/ash-agenda-for-hematology-research

NIH-supported research occurs in every state and nearly every congressional district[3] and NIH funding directly and indirectly supports hundreds of thousands of jobs nationwide, including nearly 408,000 jobs supported in FY 2024.[4] Should there be cuts to the NIH, including caps on facilities and administrative costs, many institutions would no longer be able to afford the costs necessary to perform research or would scale back significantly. Across institutions jobs would be lost, laboratories would close, and the research workforce capacity would be cut. Cuts to NIH will result in fewer clinical trials, less fundamental discovery research, slower progress delivering new innovations and life-saving advances, and erosion of U.S. global leadership in biomedical research.

ASH encourages you to continue to recognize the value of biomedical research and innovation by supporting robust funding for NIH and ensuring that the agency has the resources to support the timely review of grant applications and the work of existing grantees. The Society recognizes that NIH's current programs and structure could be optimized to make the best use of federal investment and welcomes the opportunity to work with you and Congress to ensure any changes to the agency continue to support this pipeline for innovative therapies for patients and the next generation of researchers.

Access to High-Quality Care for Patients

Drug Shortages

In 2023 and 2024, this country experienced one of the worst chemotherapy drug shortages in its history, with fifteen indispensable chemotherapy drugs in short supply simultaneously. Sterile injectable drugs, including chemotherapies, are particularly vulnerable to shortages affecting the care of patients with classical hematologic conditions and hematologic malignancies. These shortages are continuing; and as an example, several hematologic drugs that are currently experiencing shortages include Rho(D) Immune Globulin (Human) RhoGAM, doxorubicin, methotrexate sodium, and others. Generally, these drugs are established low-cost treatments, and their shortages have significantly impacted ASH members' practices and patients. The incidence and duration of drug shortages are growing, and the shortages of critical hematology therapies can lead to delays in and rationing of care, negatively affecting treatment decisions, creating emotional distress for patients and families, and resulting in worse health outcomes.

When drugs are in shortage, hematologists and other physicians are forced to make difficult treatment decisions, including administering alternative and notably more intense treatment regimens. These alternatives may result in significant toxicities, creating a host of challenges and complications for some patients. For others, alternative treatments can lead to relapse and even death. The strain on patients and providers caused by drug shortages can be avoided. While the causes of these drug shortages are multiple and complex, there is an urgent need to mitigate current shortages and prevent future shortages.

ASH urges you to classify these drugs as essential medicines and to explore policies that can be implemented by HHS to ensure that chemotherapies and other sterile injectable drugs are less vulnerable to shortages. Additionally, we recommend working with Congress to improve transparency around shortages and support the manufacturing and purchasing of high-quality generic drugs produced through resilient supply chains. This includes manufacturing more sterile injectable drugs in the United States rather than overseas. As different policies are considered, ASH would like to offer itself as a partner and a resource.

Additionally, ASH is concerned about the role of direct-to-consumer (DTC) advertising in potentially exacerbating shortages and affecting patient care. Pharmaceutical companies continue to advertise for drugs in shortage causing patients to ask their physicians about their prescription. The choice to pursue a certain therapeutic regime should be the result of consultation between a physician and patient. DTC advertising undermines these relationships and decisions about an individual's care. **ASH urges you to examine the broader implications of DTC advertising on the healthcare system and availability of medicines.**

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[3] Federation of American Societies for Experimental Biology. Federal Research Funding Data. https://www.faseb.org/science-policy-and-advocacy/federal-funding-data

[4] United for Medical Research. NIH's Role in Sustaining the U.S. Economy. https://www.unitedformedicalresearch.org/annual-economic-report/

Maternal Health

There is a close connection between hematology and maternal health, given the risks of hematologic complications of pregnancy for all women. Hemorrhage and venous thromboembolism are two of the top five causes of death in pregnant women.[5] Postpartum hemorrhage is a leading cause of morbidity and mortality in the United States,[6] and women on anticoagulants or with anemia are at high risk of postpartum hemorrhage.[7]

Iron deficiency is the most common cause of anemia during pregnancy and is linked to poorer outcomes for both mother and baby, including a higher risk of premature delivery, low birth weight, postpartum depression, and even maternal death. However, current estimates likely undercount cases of iron deficiency due to inconsistent diagnostic criteria—particularly regarding appropriate ferritin cutoff levels—and variable screening practices, leading to underdiagnosis and undertreatment. Significant evidence gaps remain regarding the current standards of care for screening and treatment. Improving iron deficiency screening, prevention, and treatment is critical to reducing complications and enhancing maternal and infant health outcomes.

Furthermore, women with inherited bleeding disorders have a risk of having a child with a bleeding disorder, which impacts both their own care during delivery (mode of delivery) and may carry long-term implications for their child if affected.[8] Additionally, women with anemia, women on blood thinners to control blood clots, women with blood cancer, and women with SCD are especially at high risk of pregnancy related complications including death. **ASH welcomes the opportunity to collaborate with you to build on the progress made by President Trump during his first term in reducing maternal mortality and improving maternal health outcomes, particularly for women affected by hematologic diseases and disorders.**

Fertility preservation is a critical, yet often overlooked, component of comprehensive care for women with hematologic conditions. Several malignant and classical hematologic conditions and related treatments can potentially cause infertility or impair fertility.[9] For example, treatments for SCD, like hydroxyurea, may affect sperm production and egg quality, and chronic transfusions may lead to iron overload and impaired gonadal function. **For these reasons, ASH urges you to support affordable, comprehensive health insurance coverage for fertility preservation procedures for patients with hematologic conditions. Additionally, we believe the NIH should prioritize research on fertility management and the connection between hematologic conditions and infertility.** Advances in medical technology and treatment protocols are continually improving the prospects for fertility preservation among cancer survivors and individuals with hematologic conditions like SCD.

Physician Payment Reform

On January 1, Medicare physician payment was cut by 2.83% when Congress failed to intervene. This represents the fourth year in a row Congress has allowed the Medicare Physician Fee Schedule's (MPFS) conversion factor to be cut by varying rates, all but guaranteeing that Medicare reimbursement will not cover the cost of delivering care to beneficiaries. ASH urges you to work with Congress to reform physician payment, including reimbursement for cognitive care services. ASH firmly believes Medicare physician payment reform is essential to safeguard access to care for beneficiaries and support the sustainability of the health care and hematology workforce.

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

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[5] Main, E. K., McCain, C. L., Morton, C. H., Holtby, S., & Lawton, E. S. (2015). Pregnancy-related mortality in California: causes, characteristics, and improvement opportunities. Obstetrics and gynecology, 125(4), 938–947. https://doi.org/10.1097/AOG.0000000000000746

[6] Reale, S. C., Easter, S. R., Xu, X., Bateman, B. T., & Farber, M. K. (2020). Trends in Postpartum Hemorrhage in the United States From 2010 to 2014. Anesthesia and analgesia, 130(5), e119–e122. https://doi.org/10.1213/ANE.0000000000004424

[7] Nyfløt, L. T., Sandven, I., Stray-Pedersen, B., Pettersen, S., Al-Zirqi, I., Rosenberg, M., Jacobsen, A. F., & Vangen, S. (2017). Risk factors for severe postpartum hemorrhage: a case-control study. BMC pregnancy and childbirth, 17(1), 17. https://doi.org/10.1186/s12884-016-1217-0

[8] James AH, Jamison MG. Bleeding events and other complications during pregnancy and childbirth in women with von Willebrand disease. J Thromb Haemost. 2007;5(6):1165-1169. doi:10.1111/j.1538-7836.2007.02563.x

[9] https://www.hematology.org/advocacy/policy-statements/ash-policy-statement-on-coverage-of-fertility-treatment-in-hematologic-care

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, but not fully eliminate, until this year where no action was taken. Additionally, no other Medicare fee schedule has been subject to decreasing reimbursement, as they all include a mechanism for positive inflationary updates.

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. 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 about 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.

For these reasons, we urge you to work with Congress to:

- **Include a baseline update to the Medicare Physician Fee Schedule conversion factor by providing an update equal to the Medicare Economic Index (MEI) every five years. An annual inflation-based update will help Medicare reimbursement keep pace with evolving health care needs and ever-increasing health care costs while aligning MPFS policy with other Medicare fee schedules.**

- **Give HHS the authority to compare estimated utilization to actual utilization and adjust the conversion factor based on the difference (either over- or underutilization). 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.**

- **Increase the outdated budget neutrality threshold of $20 million to $53 million and update it every five years equal to the cumulative increase in MEI.**

Lastly, ASH believes that the current processes for valuing physician services should be assessed. The complex care provided by hematologists is largely captured by evaluation and management (E/M) and other cognitive services. In 2019, the Trump Administration redefined and revalued E/M codes for the first time in decades, a first step towards the appropriate valuation of cognitive care. We encourage you to work with CMS and Congress to consider additional Medicare physician payment reform 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 is for procedures. Despite the best efforts of the AMA Current Procedural Terminology Editorial Panel, the RUC, and the Centers for Medicare & Medicaid Services (CMS), the payment challenges associated with E/M codes persist and are one of the drivers of the shortage of hematologists and other cognitive specialists. As E/M and non-procedural services continue to be undervalued in the current payment system, the underlying challenges related to appropriately capturing complex cognitive care will persist and continue to place pressure on hematology and other cognitive specialties.

ASH encourages you to consider alternatives to more regularly and better support the definition and valuation of E/M and other non-procedural services. We welcome the opportunity to work with you to improve reimbursement for hematological care and mitigate the persistent workforce shortages that result from inadequate reimbursement.

Access to Innovative Therapies

Advances in science have led to a recent surge of approvals for treatments for hematologic diseases and disorders. Many of these diseases are rare, requiring typically high-cost, highly specialized diagnostic, and therapeutic services. ASH members have been at the forefront of pioneering transformative therapies, yet the high costs of these innovations remain a significant barrier for care delivery. ASH developed a set of principles to ensure that all individuals have access to high-quality, clinically appropriate, and specialized care, including innovative therapies.[10]

CAR-T therapy, first approved in 2017 for certain patients with lymphoma and leukemia, is a potentially life-saving cellular therapy for patients who have failed prior therapies. Several new CAR-T products and additional indications are expected in the next few years. In addition, gene therapies for beta thalassemia and SCD have been developed, offering potential cures for diseases with previously limited treatment options. These innovative treatments come at a high cost, creating potential barriers to access.

Many of these innovative therapies are designed to be a one-time treatment, reducing the need for other, ineffective treatments, or a lifetime of maintenance therapies, but as noted, they come at a high cost. Innovative payment solutions, which have been slow to develop, are needed to address current barriers and prevent future barriers to access. As seen with CAR-T therapy, payment policies and solutions have not kept pace with the innovations in science and approvals. The lack of a sustainable payment solution has limited patient access to care for this potentially life-saving therapy.

Reimbursement challenges associated with high-cost therapies remain a challenge for patients accessing innovative therapies. Therefore, ASH commends the Centers for Medicare & Medicaid Innovation Center's (CMMI) for developing the Cell & Gene Therapy (CGT) Access Model for SCD, which aims to address the high cost and improve access to gene therapies for people with Medicaid living with SCD. While supporting the model, ASH continues to stress the importance of comprehensive care to fully optimize health outcomes for the SCD community and encourages the exploration of similar value-based payment models for other high-cost treatments.

ASH encourages you to ensure access to innovative therapies, like CAR-T therapy and gene therapies, and welcomes the opportunity to continue to work together to eliminate barriers to appropriate patient access.

Prior Authorization

Treatment decisions should be made between a physician and the patient; yet many times, policies, put in place by the Federal government or insurance companies, can impact these decisions. A 2022 physician survey by the AMA found that 86% of respondents reported that prior authorizations resulted in increased use of health care resources, leading to waste rather than the cost savings claimed by insurers.[11] Approximately two-thirds of respondents reported that prior authorization (PA) requirements led to either diversion to ineffective initial treatments or additional office visits (64% and 62%, respectively).

Step therapy and PA, widely used amongst insurers to reduce costs, both have the potential to delay patient access to necessary, high-quality medication and to increase administrative burden for physicians. Unfortunately, these utilization management techniques are even used for commonly prescribed, evidence-based treatments, considered to be the standard of care, and many times limit the physician's ability to prescribe the best/evidence-based standard of care for their patients. Many individuals with SCD, for which recurrent severe acute painful crises and chronic daily pain are the most common complications, are forced to switch from long-acting pain medications they have been taking for years because of failed PA requests or a new PA must be filed every month for the same medication, placing an undue and unnecessary administrative burden on the physician to deliver medically appropriate care. Additionally, PA often delays care for bone marrow transplants and cellular therapy, potentially resulting in additional toxic therapy to be administered despite clear indications for these other treatments.

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[10] https://www.hematology.org/advocacy/policy-news-statements-testimony-and-correspondence/policy-statements/2019/access-to-hematology-care-in-an-age-of-innovation

[11] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

Not only are physicians and their staff affected by PA, but patients also suffer the undue burden of delayed care and worse outcomes. **ASH encourages you to work with CMS to address the challenges associated with the prior authorization of medical services and prescription drugs in the Medicare Advantage program.**

Telehealth

The telehealth flexibilities implemented by CMS in 2020 have transformed ASH members' practice, improving patient access to care, particularly for patients with chronic, complex and acute conditions and rural populations. Telehealth is also very helpful for elderly patients, and as a way to allow patients to avoid missing work to travel to appointments. Patients with hematologic conditions may not have access to a local hematologist because of the persistent workforce shortage, and telehealth can help them receive necessary specialized care, including follow-up care and review of medication options and lab results, regardless of their geographic location.

ASH supports the permanent removal of originating site requirements and geographic restrictions for telehealth services. These barriers limit telehealth access and impede access to care. By permanently eliminating these restrictions, patients, regardless of where they live, can better access high-quality services via telehealth. This policy change would be particularly beneficial for patients in underserved or rural and remote areas who face challenges traveling to in-person appointments. Additionally, we support having CMS permanently remove the frequency limitations for telehealth services. Allowing physicians the capability to virtually care for patients when it is medically appropriate and flexible for both the physician and the patient increases access to care. Our Society recognizes that CMS does not have the statutory authority to extend telehealth flexibilities permanently. **ASH encourages you to work with Congress to grant CMS the authority to ensure that patients have access to these services on a permanent basis.**

Thank you for the opportunity to share our health care priorities. ASH looks forward to working with you to advance the health of all Americans including those who suffer from chronic illnesses. Should you have any questions, please contact Stephanie Kaplan, ASH Director of Government Relations and Public Health at *skaplan@hematology.org* or 202-776-0544.

Sincerely,

Belinda R. avalos, MD

Belinda Avalos, MD
ASH President