



American Society of Hematology

Helping hematologists conquer blood diseases worldwide

April 10, 2026

The Honorable Gregory F. Murphy
407 Cannon House Office Building
Washington, DC 20515

The Honorable John Joyce
2102 Rayburn House Office Building
Washington, DC 20515

The Honorable Kim Schrier
1110 Longworth House Office Building
Washington, DC 20515

Sent electronically to catherine.hayes@mail.house.gov; matt.tucker@mail.house.gov; and amy.zhou@mail.house.gov

Dear Co-Chairs of the GOP Doctors Caucus and Chair of the Democratic Doctors Caucus,

On behalf of the American Society of Hematology (ASH), thank you for the opportunity to provide comments on the Joint Doctors Caucus Draft Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Update Framework (the Framework) you recently released. ASH recognizes this legislation aims to modernize and update several elements of the Medicare Physician Fee Schedule (MPFS), and the Society appreciates and supports the bipartisan commitment to ensuring access to high-quality care for patients by reforming MACRA and updating payments made under the MPFS.

ASH represents more than 18,000 clinicians and scientists worldwide committed to studying and treating blood and blood-related diseases. These 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 the understanding and treatment of various hematologic diseases. Hematologists are 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.

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 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 several years.

The continued erosion in Medicare physician reimbursement is distinctly acute for hematologists. ASH members deliver complex care, including disease management, developing treatment plans, and partnering with patients and care teams to implement complicated therapeutic regimens. While improvements to redefine and revalue outpatient evaluation and management (E/M) services and the addition of the complex-care add on code (G2211) have made progress to mitigate the reimbursement gap for complex cognitive care, the current payment structure still does not fully capture the clinical complexity and longitudinal management needed to appropriately care for patients with hematologic conditions. Additionally, the hematology specialty is facing a severe workforce shortage. The workforce shortage limits access to much needed expertise in complex hematological disorders, such as sickle cell disease. This shortage is exacerbated by new physicians' concerns of balancing the eroding Medicare reimbursement rates coupled with significant medical school debt, which leads to new physicians not entering the field of hematology.

Given the importance of physician payment reform for the sustainability and accessibility of hematology services and the reforms included in the Framework, ASH's comments focus on the following elements:

- Conversion Factor
- MIPS Reform
- Budget Neutrality

Title I - Conversion Factor Update

MEI Policy

The *Framework* outlines conversion factor update policy that would regularly update the conversion factor equal to Medicare Economic Index (MEI) minus 1%, with limits on the year-to-year variances by ensuring there are no increases or decreases to the conversion factor that are greater than 2.5% in either direction.

An annual inflation-based update will help MPFS reimbursement 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, ASH supports an annual inflation-based adjustment to the MPFS conversion factor equal to the MEI minus 1%. 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. The additional limits on the conversion factor variances will also provide greater predictability for physician reimbursement and therefore create financial stability for physicians.

Primary Care Add on Payment

The *Framework* also includes a primary care add-on payment for the same five-year duration as the proposed MIPS transition period. The suggested funding for the primary care add-on payment is \$500 million per year and would be exempt from budget neutrality requirements. Understanding that the *Framework* does not provide details as to how primary care would be defined in this instance, we encourage you to consider using evaluation and management (E/M) service codes to define primary care. These codes are used not only by primary care physicians but are also used by hematologists and other non-procedural specialties to bill for services that include routine office visits, chronic care visits (including management of blood disorders and diseases), follow-up visits, medication management, care coordination and treatment planning. Essentially, providing E/M services and getting reimbursed for those services are the livelihood of hematology practice.

As previously mentioned, the Society appreciates the work that has been done to improve Medicare payment for E/M services, including the total overhaul of the E/M CPT code set in 2021. The E/M code family was revised to better capture the time, intensity, medical-decision making, and cognitive effort of providing E/M services. In conjunction with that overhaul, the E/M code family work relative value units (RVU) and practice expense RVUs were updated through the AMA Relative Value Update Committee (the RUC) survey process, and ASH members participated in this survey given how important E/M codes are for hematology services.

The RUC survey process for the revised E/M codes found that the work RVUs should be increased to account for the additional complexity, time and intensity of caring for people with ongoing chronic diseases and severe illnesses. However, members of the ASH Reimbursement Subcommittee and other Society leaders shared that the increased work RVUs (as determined by the RUC survey process, and subsequently approved under the MPFS regulation process), have not “made their way” to the physicians providing the care. Many members report that while the work RVUs for the E/M services increased, neither their salaries nor their payment for E/M services rendered showed any improvement. In fact, members reported that their institutions simply raised RVU targets, based on the updated work RVUs for E/M services, instead of providing compensation increases that better reflect the revised E/M codes. It is likely that the institutions were beneficiaries of the increased work RVUs rather than the physicians who deliver the care.

We mention this because while ASH supported the revisions of the E/M code set and participated in the subsequent RUC survey, hematologists ultimately experienced minimal benefit. If the primary care add-on payment under consideration by the Joint Caucuses were to be defined by E/M codes, we urge you to ensure that the add-on payment would go directly to the physician, and not the institution or some other entity.

Title II - MIPS Reforms

The *Framework* includes provisions to improve CMS’ merit-based incentive payment system (MIPS) quality reporting by establishing a Quality Care Reform Task Force to develop and implement new quality reporting metrics. While the Task Force is developing new reporting metrics, the MIPS

penalties and bonuses would be revised from -9% to 9% to -2% to 2%. However, given that not all specialties have qualified clinical data registries to report through and not all physicians have clinically meaningful participation options for MIPS, implementation of these reforms pose several implementation challenges.

ASH remains concerned about the limited ability for certain specialties, including hematology, to participate meaningfully in MIPS. 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 (a specialty with some population overlap with hematology, including patients with blood cancers such as leukemia), but a hematology-focused provider who specializes in sickle cell disease or other blood disorders may not have clinically relevant measures.

Moreover, immense administrative burden is 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, ASH encourages the consideration of 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.

Title IV - Budget Neutrality Reform

The *Framework* addresses current limitations of budget neutrality and would, if passed increase the budget neutrality threshold from \$20 million to \$54.3 million and will provide subsequent updates by indexing the threshold to the cumulative percentage increase in the MEI every five years. ASH appreciates the inclusion of the budget neutrality provisions given that the budget neutrality threshold has never been updated since the implementation of the Resource Based Relative Value Scale in 1992. 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.

Additionally, the *Framework* outlines the reconciliation of any differences in utilization estimates and actual utilization of codes. The current budget neutrality requirements exert downward pressure on Medicare reimbursement and exacerbate the redistributive impacts for other payments under the MPFS. This redistributive effect pits specialties against one another when new codes are added to the MPFS, or a family of codes is recommended for an increase in valuation. ASH appreciates the effort to more accurately use utilization estimates and actual utilization of codes to address estimated utilization that may significantly impact the budget neutrality adjustment.

ASH would like to thank the Co-Chairs of the GOP Doctors Caucus and Chair of the Democratic Doctors Caucus for the opportunity to provide comments on the Joint Doctors Caucus Draft

MACRA Update Framework. The Society appreciates the bipartisan efforts to reform MACRA, and update payments made under the MPFS, given the importance of physician payment reform for the sustainability and accessibility of hematology services. Should you have any questions or require further information, please contact ASH Manager for Health Care Access Policy, Carina Smith, at casmith@hematology.org.

Sincerely,

A handwritten signature in black ink, appearing to read "ME Percival". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

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