



September 21, 2009

Nicholas S. Rathod
Associate Director of Intergovernmental Affairs
The White House
1600 Pennsylvania Ave, N.W.
Washington, D.C. 20500

Dear Mr. Rathod,

Thank you for taking time to meet with the American College of Rheumatology on Tuesday, September 15, 2009. We hope you found the meeting valuable, and we appreciate the opportunity to discuss a number of our concerns. During the conversation it was suggested that the ACR send a letter outlining the issues that were discussed to assist you as the White House moves forward with health care reform.

Fix the Flawed Sustainable Growth Rate Formula:

The ACR continues to have grave concerns about the flawed SGR formula, which without a fix will impose over a 20% cut to physician reimbursement in 2010. Congress has repeatedly addressed these increasing cuts with temporary fixes and marginal increases. As we expressed in our meeting, physicians cannot effectively run a practice – in itself a small business – with the fear that their income could be cut so drastically. Additionally, Medicare patients are fearful that they may lose access to their physicians. Therefore, the ACR encourages the White House to advocate for a permanent solution to the SGR. **The ACR requests that the White House urge Congress to replace the flawed SGR formula with a modified version of the Medicare Economic Index which would place physicians on par with hospitals and nursing homes that are currently reimbursed through MEI.**

Stop Insurance Abuse of Denying Pre-existing Conditions:

People with rheumatic diseases are often unable to qualify for insurance based on treatment costs presented by the insurance company as a “pre-existing condition.” Access to coverage for everyone, including those with pre-existing conditions, should be a cornerstone of any health reform bill that is put before the President for signature. If patients with complex diseases are denied insurance based on pre-existing conditions, the President’s goal of “health care access for all Americans” would stop short of providing care for those who need it the most. **The ACR supports the Senate and House legislative language which requires insurance companies to provide coverage to individuals with pre-existing conditions without increasing their premiums or out-of-pocket costs due to those conditions.**

Provide Proper Insurance Coverage for Patients:

Recent media coverage has brought to light a problem that's been in existence for years, especially for people with chronic conditions: being underinsured. Individuals with health insurance coverage may be suddenly hit with high co-pays and insufficient coverage because of a diagnosis that leads to costly treatment. Patients quickly discover the holes in health insurance policies. Arthritis and rheumatic diseases are complex conditions that often require expensive drug treatments. Even patients with comprehensive health care insurance are often faced with co-pays that may cost thousands of dollars for necessary drug therapies, which are classified as "Tier IV" or specialty tiers. Tier IV drugs require patients to pay 20-30 percent of co-pays for drugs that costs tens of thousands of dollars a year. Patients are forced to go untreated because they simply cannot afford these drugs that were developed to treat these complex conditions. **A comprehensive health reform package should include protections for insured patients with complex diseases so that they will have affordable access to the medications, specialists, and treatment they need to lead productive lives.**

Increase Access to DXAs by Providing Adequate Reimbursement:

DXA is a critically important preventative study that, if performed, saves both money and lives. DXAs – bone density scans – are performed for early detection of osteoporosis. Early detection can prevent hip or other bone fractures, which if untreated can lead to chronic immobility and even death, as well as increased health care costs from hip replacements, vertebroplasty and other medical expenditures. Unfortunately, DXA reimbursements have been reduced from approximately \$140 in 2006 to a projected \$53 in 2010. The reimbursement cuts are a result of a CMS practice expense formula that changed the calculation from top down to bottom up. Extreme cuts in DXA reimbursement have forced physicians to cease performing this crucial study because they cannot afford to cover the overhead of equipment utilization and staff operation. A study by The Lewin Group reports that proper DXA reimbursement should be reimbursed at approximately \$135. Unfortunately, these extreme cuts will prevent patient access to this simple, but critical study. **The ACR requests that the White House advocate for inclusion of appropriate reimbursement for DXAs in health care reform so physicians can continue to perform this important diagnostic test.**

Increase Pediatric Rheumatologists by Creating Loan Repayment Program:

There are approximately 300,000 children with juvenile arthritis in the United States. JA is not a preventable disease; however, these children may receive treatments that could delay or prevent serious problems, including permanent joint damage and deformity. One of the greatest obstacles is locating a pediatric rheumatologist to treat this serious condition. There is an extreme shortage of pediatric rheumatologists in the United States, and nine states do not have a single one, forcing children with JA and their families to travel long distances to receive quality, necessary care. The Senate HELP committee health reform legislation currently includes language to create a loan repayment program for pediatric subspecialists like rheumatologists. This would be one small step to address the severe shortage of pediatric rheumatologists and pediatric subspecialists as whole. **The ACR urges the White House Staff to advocate for the inclusion of a pediatric subspecialty loan repayment program provision in the final health reform package.**

Stop the Elimination of Physician Consultation Codes

The Centers for Medicare & Medicaid Services released their proposed physician fee schedule rule in early July. Physicians were shocked to see the elimination of consultation evaluation and management codes. Specialty physicians, like rheumatologists, use these codes to reflect the considerable time spent analyzing complex patient symptoms, physical findings, and laboratory and imaging results in order to arrive at a diagnosis and treatment plan and coordinate with their primary

care physician and other specialists. Because specialty physicians have trained an additional three years to develop the comprehensive knowledge necessary to effectively diagnosis and treat complex conditions, they should be appropriately compensated. The ACR understands that physicians who primarily perform new and established evaluation and management services are not adequately reimbursed. However, eliminating consultation codes to increase reimbursement for primary care physicians in an attempt to solve one problem will create another one. Specialists that primarily see patients using consultation codes should not be penalized at the expense of primary care physicians. **The ACR requests the White House ask CMS to prevent the elimination of consultation codes.**

The Practice of Defensive Medicine Reform Medical Liability:

Medical liability reform is an important issue for the physician community. Increases in medical liability insurance premiums on top of decreases in physician reimbursement make it difficult for physicians to maintain sustainable practices. Additionally, many physicians feel compelled to practice defensive medicine to prevent potential medical liability suits that could arise if certain procedures are not performed. Allowing physicians to practice “good faith” medicine without fear of frivolous lawsuits will help reduce unnecessary procedures. **The ACR appreciates President Obama’s suggestion to have demonstration projects regarding medical liability reform, but urges comprehensive medical liability reform to improve effective, efficient and high-quality health care delivery.**

Interoperability of EMRs Will Save Money by Reducing Duplication of Studies:

Interoperability of electronic medical records would allow physicians to share patient information preventing repeated studies and lowering costs of the health care system. Physicians perform studies on patients, which are often sent to other physicians. Frequently, the records are not transferred, delayed or lost. This requires repeated studies. If physicians could transfer information electronically, repeated studies could be prevented thus, lowering cost. The infrastructure is currently unavailable for patient information sharing due to the various types of EMR systems. Review of HIPAA regulations will also be necessary to facilitate the flow of important medical information. **Thus, the ACR encourages improvements in system interoperability to improve care delivery and lower unnecessary costs to health care system.**

Comparative Effectiveness Research is Positive if it Protects Personalized Medicine:

The ACR supports comparative effectiveness research to determine the best treatment options for the majority of patients. The key is *majority* of patients. Medicine is both an art and a science and patients react differently to various therapies. **The ACR requests that physicians maintain the autonomy to provide individual treatment to patients and not have dictated formularies for patient care. Additionally, actively practicing physicians should be included on the CER panel to assist in reviewing medical treatment options.**

Review Recovery Audit Contract (RAC) procedures to look for true fraud:

RACs are considered “bounty hunters” in the physician community. Individuals are sent to physician offices to review charts and receive a percentage of what their findings. Unfortunately, coding rules are very complex especially as they relate to evaluation and management codes, which rheumatologists generally perform. The ACR supports fraud and abuse prevention, but encourages a review of the RAC process. RAC auditors should not be financially compensated by the total percentage of bill errors, which may reflect mistakes due to complex coding and billing rules – but is not intentional fraud. **The ACR requests that contracts be re-written as a flat rate rather than a percentage of overall coding errors.**

As the Finance Committee plan was released this week, the ACR is still in the process of reviewing the Chairman's mark. However, we have initial concerns with cutting reimbursements for specialists to increase payments to primary care physicians and general surgeons. The ACR supports the need for adequate pay for primary care, but strongly opposes the reallocation of funds. Medical specialties, especially those who perform highly complex E/M services, should not be negatively impacted for their services. Therefore, the ACR encourages the White House to ask Congress to create new funding to increase services for primary care.

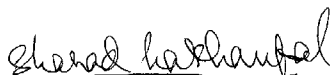
We appreciate you taking the time to meet with us to discuss these important issues. We all look forward to continued dialogue on these important issues and working with you on necessary reforms in health care delivery.

If you have any immediate questions, please feel free to contact ACR Director of Government Affairs Aiken Hackett at (404) 633-3777.

Sincerely,



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