

ACR Policy Statements
Recommendations from ACR Government Affairs Committee

- 1. Increase advocacy for improved patient care, improve reimbursement for rheumatologists and health professionals and collaborate with other organizations that support this strategy (such as the AMA, ACP, etc.)**
- 2. Advocate for issues affecting ACR/ARHP member reimbursement and effective/efficient practice.**

Medicare Reform

- a) ACR supports Congressional legislation that replaces the sustainable growth rate (SGR) component of the Medicare payment formula with the adoption of a reasonable Medicare Economic Index which will ensure that physicians will be fairly compensated and patients will have appropriate access to care.
- b) ACR opposes the institution of a “user fee” tax on health care providers for participation in the Medicare and Medicaid program.
- c) ACR supports the reevaluation and simplification of documentation requirements for the billing of evaluation and management services.
- d) ACR believes that graduate medical education (GME) is a necessary public good that must be protected, and as such supports efforts to ensure that the federal government continues to provide adequate and stable funding sources for GME.
- e) ACR supports reevaluation of the Stark I and II laws against physician self-referral in light of changes in the realities of health care delivery since their original adoption.
- f) ACR supports initiatives intended to reduce the administrative and regulatory burden imposed upon health care providers participating in the Medicare program, in order to facilitate the delivery of care to their patients.
- g) ACR will work with the Centers for Medicare and Medicaid Services (CMS) to expand its current list of quality of care demonstration projects to include non-oncology medical specialists who, like oncologists administer drugs to our patients, expend similar practice expense resources and by whom equally important data collection can be performed

Prescription Drug Benefit

- a) Medicare Part D should be evaluated and simplified to assist patients and physicians and other healthcare providers in order to achieve the following:
 - i. Implementation of this benefit should not increase regulatory or administrative burdens for physicians and other healthcare providers.
 - ii. CMS should improve the surveillance of Part D benefits that apply to drugs for certain non-rheumatological conditions covered under Part B, in order to reduce administrative burdens to rheumatologists justifying Part D coverage.
 - iii. Part D benefits should not limit, incentivize, or otherwise steer doctors or patients away from what the treating rheumatologist judges to be the most efficacious medical therapy for patients with rheumatic diseases.
 - iv. Reimbursement for off-label use of drugs when evidence supports their efficacy
- b) ACR supports measures to maintain access to and affordability of rheumatic disease medications, through oversight and reform of insurance and formulary practices that may

- not allow appropriate use of medications due to formulary restrictions or co-payment/coinsurance structures.
- c) ACR supports legislation that will allow Medicare to negotiate with pharmaceutical companies and achieve improved prices of drugs covered under Part D.

Access to Care and Therapies

- a) ACR believes that all Americans should have access to health care coverage.

3. Increasingly advocate for the funding of basic and clinical arthritis research. Actively collaborate with the AF, NIH, and others to increase funding and grants.

- a) ACR supports substantial increase and sustained funding for the NIH budget.
- b) ACR supports annual increases in the NIAMS and NIAD budget, particularly in areas of research in rheumatic diseases.
- c) ACR supports pursuit of optimal funding levels for AHRQ and VA medical research.
- d) ACR supports funding levels that allow for a continued emphasis on patient based research, such as translating advances in basic science to clinical innovations in patient care.
- e) ACR supports ending the use of budgetary mechanisms, which arbitrarily limit research funding.
- f) ACR supports funding for the National Arthritis Action Plan and other rheumatologic related activities of the CDC.
- g) ACR supports the principles regarding pediatric research and the HRSA manpower study set forth in the Children's Health Act of 2000.
- h) The ACR supports the enactment of the Arthritis Prevention, Control and Cure Act.

4. Advocate for issues affecting quality of patient care.

Managed Care Reform (Patient Protection)

- a) ACR believes that patients covered by managed health care delivery systems should be provided with access via a point-of-service option, which would allow the beneficiary to seek appropriate out-of-network treatment.
- b) ACR believes that the physicians and patients rather than the health plans should make determinations regarding patient care issues.
- c) ACR believes that patients covered by managed health care delivery systems should be provided information on full disclosure of treatment options and coverage.
- d) ACR believes that all patients should have timely access to a review process with an opportunity for independent review by individuals with appropriate expertise when service is denied.
- e) ACR believes that all health plans should be held accountable in a court of law for medical decisions that are counter to the treating physician's recommendations and result in death or harm to a patient, once an appropriate appeals process has been completed.

Access to Care

- a) ACR believes that if participation between a health plan and health professional is terminated because of change in the terms of provider participation, the covered enrollee should be notified and should be able to retain the services of the provider, paid for by the health plan, if no other specialist is reasonably accessible.
- b) ACR believes that specialists such as rheumatologists who choose to should be allowed to act as the principal care provider for those patients with the chronic conditions the physician is specifically trained to treat.

Quality of Care

- a) ACR supports physician performance measures that foster improvement of clinical care by striving to link performance measures to outcomes.
- b) ACR performance measures should be developed by rheumatologists and related health professionals and should assess and focus on those elements of clinical care over which rheumatologists have direct control.
- c) Any data collection required to support performance measurement should be reliable and practical and should not violate patient privacy or add to the administrative burden experienced by rheumatologists.
- d) Providers should be appropriately reimbursed for work involved in collection and reporting this data.
- e) ACR supports the notion that performance measures should not be used in a punitive way by payors.

5. ACR supports all efforts to assure the availability of appropriately trained adult and pediatric rheumatologists.

6. Recruit and train ACR/ARHP members and patients to participate in ongoing advocacy activities.

7. Increase collaboration efforts with organizations that share similar public policy positions. Promote leadership of ACR/ARHP members within these organization.

8. Tort Reform

- a) ACR supports a cap on non-economic damages.
- b) ACR supports standards for expert witnesses.
- c) ACR supports a rigid statute of limitations from day of discovery.
- d) ACR supports the elimination of joint and several liability.
- e) ACR supports the limitation on contingency fees.
- f) ACR supports the alternative means of dispute.

9. Electronic Health Records

- a) ACR supports the continued development of safe, secure, and interoperable standard based electronic health record (EHR) systems and for the continued governmental provision of financial resources to implement such systems.
- b) ACR supports the development of guidelines regarding the handling of shared information.