



April 29, 2011

The Honorable Fred Upton,
Chairman
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Henry Waxman
Ranking Member
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Upton and Ranking Member Waxman:

The American College of Rheumatology representing over 5500 rheumatologists appreciates the Energy & Commerce Committee's bipartisan effort to repeal the current Medicare sustainable growth rate formula and determine a new physician payment system.

Rheumatologists are specialists who provide expert care to over 7 million adults and children in the US who have chronic, complex rheumatic and musculoskeletal conditions such as rheumatoid arthritis, psoriatic arthritis, lupus, and ankylosing spondylitis. Rheumatologists are a unique specialty of physicians that perform "detective work" by conversing at length with patients seen previously (and treated unsuccessfully) by a number of other physicians, and reviewing voluminous charts to make a correct diagnosis. It is significant to note that unlike other internal medicine subspecialists, rheumatologists do not perform invasive procedures regularly and visit the hospital rarely.

Given the types of diseases we treat, and the adults and children who rely on our specialized care, rheumatologists do not fit into common payment molds. The ACR appreciates the opportunity to provide suggestions on physician payment reform.

Discard the Flawed SGR Formula

Everyone agrees the flawed SGR formula must be repealed. The flawed formula forces physicians to worry year after year how they will be reimbursed. The retroactive "fixes" in 2010, although appreciated, forced rheumatologists to endure interruption in revenue, causing financial instability in the office and disruption in patient care. The SGR causes economic turmoil in the health care system and is tremendously detrimental to Medicare patients' access to care given its instability. Rather than belabor the point, the ACR is in agreement that the formula should be discarded for other payment mechanisms.

Create 5-year Transition Stability Plan

Stability, both for physicians and for beneficiaries, is essential as Congress determines the next steps in the physician payment system. Since modifications to the physician payment system will not happen immediately, Congress should consider establishing a set term of five years with incremental increases each year as new payment options are piloted, adjusted, and implemented. This will give physicians and beneficiaries much-needed confidence that physicians will be available for care, and will be reimbursed for their care.

Balance the Payment System

During the five year transition, Congress should appropriately balance the currently skewed reimbursement model between proceduralists (physicians that perform procedures) and cognitive

specialists (physicians that primarily perform evaluation and management services). Not only does the current system devalue spending time with a patient – a crucial ‘cognitive procedure’ in a field like rheumatology – it establishes considerable pay inequities among physicians. The repercussions of these policies result in fewer numbers of young physicians going into such specialties, and patients unable to access proper, effective care. Inevitably the delay in proper diagnosis and treatment results in needless suffering among patients and increased health care costs.

Evaluation and Management Services

Face-to-face time spent with a patient to make a diagnosis is referred to as evaluation and management. Prior to 2010, physician specialists were reimbursed for a consultation service. A consultation is when one physician has requested the education and experience of another physician to see the patient and review the chart to determine a diagnosis. The elimination of consultation codes in 2010, combined with inadequate payment for high level E&M consultative services, sent a strong message that CMS fails to recognize the advanced training and expertise in “cognitive specialty” care. Congress should require CMS to reinstate consultation codes to ensure specialists are appropriately recognized for advanced training and expertise, and that patients with complex chronic conditions have access to specialty physicians.

The *Affordable Care Act* made a step in the right direction when it provided primary care physicians with a 10% bonus in recognition of the current unbalanced system. Unfortunately, the “fix” only helped a single group of physicians who perform significant evaluation and management services. Rheumatologists, neurologists, infectious disease physicians, endocrinologists, and other physicians also spend significant time performing evaluation and management services. Congress should provide an increase to all physicians that spend a majority of their time performing crucial evaluation and management services.

A concept discussed a few years ago is deserving of reconsideration today. The target system, which would establish five separate targets for various procedures, could potentially create a more level field if designed with appropriate safeguards in place. With any new model, one concern is that it’s new and untested. Additionally, smaller specialties are concerned larger specialties with more lobbying power could increase their reimbursement target at the expense of other specialties. However, this concept should not be abandoned without further discussion.

Multiple Models

Numerous payment models have been suggested throughout the years. A constant refrain, though, is that some of the models work for some physicians, but no model works for all physicians. Accountable care organization regulations were recently released, and require a base of 5000 beneficiaries with primary care physicians being central in the ACO. Rheumatologists are both curious and concerned about ACOs. ACOs are set-up to encourage physicians to find ways to reduce costs while providing quality care. Rheumatologists treat patients with chronic debilitating diseases and use expensive biologic medication treatments to stop disease progression. We are concerned that ACOs may shun rheumatologists and rheumatology patients because of the expensive treatment options. At the same time, requesting or requiring rheumatologists join ACOs could reduce the availability throughout the US, requiring patients to drive longer distances to see a qualified rheumatologist. While rheumatologists are as interested as other physicians in reducing costs while providing quality care, rural and underserved community providers cannot abandon their patients.

Patient centered medical homes have been discussed in great detail both through the ACA and through the press. Rheumatologists agree that patients should be the center of all care, and that physicians be

responsible for coordinating care. However, rheumatologists went to school to diagnose and treat patients for rheumatic diseases. Rheumatologists do not want to be responsible for monitoring if patients have done routine preventative examinations and immunizations. Primary care specialties have been working on a neighbor concept to the home but reimbursement models have not been released. The PCMH is limited in utility beyond the primary care physicians and until an appropriate reimbursement model is provided for specialists that need to fill out additional paperwork without the benefit of consultation reimbursement, the model seems prone to failure.

Another concept is bundled payments for specific diseases or conditions. We understand the concept, but are concerned how it could be implemented. Patients with multiple diseases see a variety of specialists, and the diagnostic bundled code would need to be split among the physicians in a fair and equitable manner. If patients live in one place and see the same physician, perhaps one fee could be paid on an established length of time, but it's not clear how a bundled payment system would work for Americans who regularly move or switch physicians. For rheumatologists, it's also difficult to understand how they would be reimbursed for patients with complex chronic diseases such as rheumatoid arthritis. For example, at the beginning of diagnosis or during a flare the patient may be seen frequently, but may go a few months without seeing a physician when the disease is well-controlled. Conceptually a bundled payment system seems worth pursuing, but realistically, it is hard to envision how a bundled payment would work except for a small number of beneficiaries.

Moving Forward

The flawed SGR formula should be eliminated and new payment reform options implemented. These options need to take into account the diverse set of physician specialties and practices, and one model will not fit all. Payment reform must acknowledge the work performed by cognitive specialists to ensure the patients receive optimum care by trained specialists. This can only happen by ensuring appropriate balanced reimbursement to cognitive specialists so that medical students will feel comfortable choosing careers based on talent and interest rather than income potential.

The ACR is intrigued by the Centers for Medicare and Medicaid Innovation dedicated to support innovative payment and delivery models. We are currently working on developing options for cognitive specialists such as rheumatologists. Therefore, the five-year transition period would be appreciated.

Payment reform is a complicated mission and it's challenging to satisfy all physician sectors. We commend the Energy & Commerce Committee's dedication to develop a more stable, fair and appropriate system that will ensure patients have access to necessary care.

The ACR welcomes the opportunity to be a resource on the complexity of our specialty and our patients' conditions. Please feel free to contact Aiken Hackett, ACR director of government affairs at ahackett@rheumatology.org or (404) 929 4811 for additional information.

Sincerely,



David Borenstein, MD
President
American College of Rheumatology