



October 4, 2011

Glenn M. Hackbarth, JD, MA
Chairman
Medicare Payment Advisory Commission
601 New Jersey Avenue, NW, Suite 9000
Washington, DC 20001

RE: Current Draft Recommendation for Replacing the SGR System

Dear Chairman Hackbarth:

On behalf of the American College of Rheumatology and its more than 8,000 rheumatologists and rheumatology health professionals, I would like to express our sincere appreciation for the focus MedPAC is giving to moving Medicare beyond the Sustainable Growth Rate System. Congress has a historic opportunity to reintroduce sound fiscal policy into the nation's Medicare program, while saving billions of dollars in healthcare spending, as part of a package of reforms developed in association with the Budget Control Act of 2011. While we appreciate the Commission's attempt to identify a plan for moving forward with a repeal of the SGR, we cannot support the draft recommendation presented at the Commission's September 15 meeting.

Based on our understanding of the draft recommendation, the effect would be to freeze payment rates for a narrowly defined set of primary care services for 10 years, and to impose cuts of 5.9 percent to non-"primary care" physicians for each of 3 years followed by a freeze for 7 years. We believe that implementation of this recommendation would be just as threatening to patient access to rheumatology as the 29.5 percent cut that will occur on January 1, 2012, if Congress does nothing.

Incomplete definition of "primary care" services in need of protection

We appreciate the attention that MedPAC has given in the recent past to addressing the real need for Congress to protect access to rheumatology and other cognitive care specialists, who share much more in common with "primary care" providers than with specialties that are more procedurally-focused. Ensuring an adequate supply of these practitioners is important to the nation's health care system and to the millions of people with arthritis, rheumatic and musculoskeletal conditions who need the care that rheumatologists provide. This is especially true given the fact that, like primary care services, the field of rheumatology faces issues of potential physician shortages and lack of new medical students going into the subspecialty, has physicians who are generally lower-paid than more procedural specialists, and faces a growing population that will have needs for these services.

As noted in the June 2011 MedPAC report to Congress, the following goal was to be taken into consideration as recommendations were developed for improving payment systems.

Realign payments for physician and other health professionals to help ensure an adequate supply of practitioners in cognitive (nonprocedural) specialties who focus on managing patients with chronic conditions.

The current recommendation before the Commission does not do this. It seeks only to protect "primary care" services by applying a 10-year freeze to payments for a narrowly defined set of primary care

services. The second part of the definition, that the individual physician have must billed at least 60 percent of their services to Evaluation and Management primary care codes – is problematic in that it appears to provide an assurance that the definition is including only true E/M primary care providers. However, the definition excludes rheumatologists and other cognitive specialists who provide E/M services as a majority of their services, but who do not self-identify as primary care providers. In many cases a rheumatologist or other specialist is a de facto primary care provider for patients.

Rheumatologists are also structurally disadvantaged by the fact that the evaluation and management codes currently do not accurately reflect the work done by physicians. CMS has recognized these problems with the E/M payment structure as it relates to chronic care (CMS-1524-P). The flawed valuation system does not accurately reflect the complexity of a specialty consultation for a patient with chronic diseases, or the extra training completed to be able to treat and diagnose the patient. The current system artificially inflates the reimbursement for physicians who perform procedures while lowering (in the balance neutral system) reimbursement for physicians who perform primarily cognitive services. The result is that physicians who perform surgeries achieve higher reimbursement than physicians that are able to prevent the patient from having a costly surgery.

While rheumatologists serve populations with complex chronic and acute conditions that require medical expertise beyond that of traditional primary care physicians, they often provide the same services as those conventional primary care physicians. They also serve to coordinate care for patients who have chronic conditions. In these cases the rheumatologist serves as the patient's primary care doctor. **If MedPAC is interested in incentivizing cognitive care provided by physicians, it should broaden its definition of "primary care"** to include the subspecialty physicians who also spend a majority of their time providing cognitive and primary care services for patients with complex conditions. MedPAC should consider defining "primary care" in terms of care continuity, care coordination, and integration of services rather than defining it as being provided by only the four physician specialties fortunate to have been listed as eligible.

Inability to model new payment and delivery reforms

In addition to proposing cuts that the Commission has previously said would reduce Medicare beneficiaries' access to medical care, the current proposal would also limit physicians' options for participating in payment and delivery reforms. Many physicians would be unable to continue seeing Medicare patients, much less try various payment reform options. This would be particularly true with accountable care organizations, with which a percentage would be held until the end of the year on top of the 5.9 percent cut per year for three years. **Any plan recommended by the Commission should create an environment that is capable of encouraging payment and delivery reforms.** The ACR recommends the following:

- Specified payment rates for the next 5 years with incremental increases, in order to provide stability as payment options are piloted and evaluated to determine options to best meet the nation's fiscal needs and patient's medical needs;
- Choices of multiple payment and delivery systems for physicians as no one mandated model works for all; and
- Realignment of payments to help ensure an adequate supply of cognitive specialists who focus on managing patients with chronic conditions.

The SGR repeal policy that we support along with other specialties calls for a period of payment stability that would allow observation of which of these new models work best, followed by the adoption of those

that do. Under the current recommendation, neither primary care physicians nor physician specialists will have the operating margins needed to support the care coordination, chronic disease management, and quality improvement models that could improve patient care and lower Medicare costs.

Conclusion

The draft recommendation before the Commission endangers the sustainability of physicians' ability to see Medicare patients and therefore endangers Medicare patients' access to quality care.

The Commission's objective of protecting primary care services is laudable and appropriate. However, the manner in which the Commission is defining "primary care" services is incomplete and harmful. Rheumatology shares much more with primary care services than with other specialties, including primary use of evaluation and management services. We ask that as plans are devised regarding how to replace the SGR, that the Commission reassert its recommendation to include a focus on realigning payment structures to ensure an adequate supply of cognitive specialists. Rheumatologists and other cognitive specialists focus on managing patients with chronic conditions and coordinating their care, often serving as the patient's primary care doctor. Current fee schedules undervalue this specialty care and endanger the future supply of specialists. We also recommend that the SGR be replaced with a transition plan that will allow new payment models to be tested.

Thank you again for your efforts on this important issue. As you finalize any recommendation, please know that the ACR is available as a resource to you. If we can be of any assistance, please contact the ACR's Government Affairs Director, Adam Cooper, at (404) 633-3777 or acooper@rheumatology.org.

Sincerely,



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