



November 29, 2010

Donald Berwick, MD  
Administrator,  
Center for Medicare and Medicaid Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Dr. Berwick,

The American College of Rheumatology appreciated meeting with you on November 15 to discuss issues related to quality, specialty care and health care delivery systems. As the only professional society for rheumatology providers representing over 8,000 rheumatologists, researchers and health professionals, the ACR is committed to promoting policies and practices that help our members provide the best care for patients. We would like to highlight the following issues:

**The ACR appreciates your leadership in the quality movement and looks forward to collaborating with CMS in developing appropriate quality measures and implementing effective electronic medical record systems.** The ACR is actively involved in developing and testing clinically meaningful quality measures, and growing the Rheumatology Clinical Registry. Furthermore, the ACR is actively providing our members information and resources regarding the EHR Incentive Program. We believe that meaningful use of electronic health records can improve the safety and quality of care; however, the definition of 'meaningful use' will have significant implications for the future of health informatics. It is important to learn from Stage 1 before instituting significant expansions in Stages 2 and 3. Of particular concern to the ACR is the lack of clinical quality measures appropriate for rheumatology providers. Measure reporting should be performed to generate meaningful data and inform practice improvement – not just to check a box. This sentiment is consistent with the EHR Meaningful Use Program's foundational goals. The ACR is working to specify e-measures for submission to CMS for inclusion in the Stage 2 program. The measures we will propose already have the support of the profession and will be closely aligned with our PQRI reporting. We ask that CMS take a proactive role in ensuring that the CMS EHR Incentive Program is as meaningful to rheumatologists and other subspecialists as it is to primary care practitioners.

We are happy to serve as a resource to CMS if we can be of help as you embark on the challenging process of implementing Stage 1 of meaningful use and finalizing Stages 2 and 3. More broadly, the ACR is able to uniquely offer clinical and methodological expertise, as well as education and information dissemination to our membership. We invite CMS to partner with the ACR in identifying the best strategies to ensure the highest quality care for beneficiaries with rheumatologic conditions.

**The ACR requests that CMS consider the role of cognitive specialists, such as rheumatologists, who provide care for chronic disease patients when developing inventive health care delivery systems such as accountable care organizations and the patient centered medical home to improve care coordination.** The ACR is concerned that payment reform options such as ACOs do not include a role for rheumatologists. Most of the current models involve working with hospitals. There are many specialists that rarely admit and/or work with hospitals. Additionally, the ACR is also concerned that some physicians may cherry pick healthier patients. Patients with chronic conditions could be left without appropriate care. Reform options must ensure that all patients, especially patients with chronic diseases, will have access to quality care. We appreciate the opportunity to formally comment via the Federal Register.

**Finally, the ACR requests that CMS recognize the importance of subspecialty care and appropriately reimburse subspecialists, like rheumatologists, for their expertise.** CMS's policy change in the 2010 Physician Fee Schedule to eliminate consultation service codes asserts that the value of subspecialty care is no longer appreciated in medicine. As you know, subspecialists have completed additional training and acquired medical expertise that primary care physicians do not receive. Primary care physicians frequently request consultations from subspecialists for patients with complex conditions which the PCP cannot appropriately diagnosis or treat. Evaluation and management of these more complicated patients requires the review of additional pertinent medical information that is not accounted for in the current code for new patients. With the elimination of consultation codes, subspecialists are now required to provide similar specialty care, but are no longer reimbursed appropriately for their expertise.

In our meeting, ACR President David Borenstein, MD, highlighted a case where a 96 year old female patient had developed acute back pain. Her internist prescribed pain medicine over the phone. With no improvement, she went to the emergency room. She was evaluated with multiple tests and received a urinary infection diagnosis and placed on an antibiotic. The internist called Dr. Borenstein the following day stating her pain had increased and the internist requested Dr. Borenstein see her on an emergent basis. After examination, the area of pain was located. Two spine x-rays were performed and the patient was appropriately diagnosed with an L3 vertebrae osteoporotic fracture. The x-ray cost Medicare approximately \$100. The patient was placed on pain therapy and treatment for osteoporosis. She returned three months later - no longer on pain medicine, taking her bisphosphonate therapy for osteoporosis and required little family assistance to be functional. This case supports the value of rheumatology in the health care system and their ability to provide low cost, high-quality health care.

Rheumatologists across the country can provide daily examples, such as this, where a PCP performs expensive screenings without successfully determining a diagnosis. Upon referral, the rheumatologist provides an appropriate diagnosis and treatment based on a conversation and an inexpensive test. As a result, the patient's health improves. Rheumatologists provide better outcomes at lower cost when complex patients with arthritis, rheumatic and musculoskeletal conditions are referred early. **The ACR asks that CMS acknowledge improved patient outcomes and cost-savings associated with effective collaboration between specialists and primary care physicians by reinstating consultation codes.**

We appreciate you taking the time to meet with us to discuss these important issues. The ACR welcomes your request for a future meeting and look forward to a continued dialogue on these important issues.

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

Sincerely,

David Borenstein, MD



President,  
American College of Rheumatology

Audrey Uknis, MD,



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