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Written Testimony of the American College of Rheumatology

On Reforming Medicare Physician Payments

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The American College of Rheumatology is pleased to have the opportunity to provide the House Ways & Means Committee written testimony on our recommendations for reforming the Medicare physician payment system. I commend Chairman Herger and Ranking Member Stark for your interest in reforming the current payment system and look forward to working with you to develop a sustainable solution to Medicare.

The ACR represents over 5,500 rheumatologists - physicians who treat arthritis, rheumatic and musculoskeletal conditions, many of which are complex, chronic, painful, disabling and sometimes fatal diseases. These rheumatic conditions include rheumatoid arthritis, psoriatic arthritis, lupus, and ankylosing spondylitis. Rheumatologists are uniquely trained to perform intense evaluation and management services to ensure proper diagnosis, determine the best treatment option and provide expert care. Rheumatology services require lengthy discussions and review of a patient's history. It is necessary to recognize that unlike many internal medicine subspecialists, rheumatologists do not perform invasive procedures regularly and rarely visit the hospital. 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 model which should be acknowledged in physician payment reform.

Permanently Repeal the Flawed SGR Formula

It is generally recognized that the sustainable growth rate is flawed and must be repealed. For the past ten years, physicians have been subjected to ongoing concerns regarding their Medicare reimbursement. In

2010 alone, Medicare physicians dealt with five short term patches and four retroactive “fixes”. Although eventually patched, the repeated retroactive “fixes” forced rheumatologists to endure revenue interruption, 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. The ACR supports the premise that the SGR should be discarded for other payment mechanisms.

Create 5-Years of Payment Stability

As Congress determines next steps in reforming the physician payment system, it must develop a period of stability for both physicians and Medicare beneficiaries. While considering alternative payment methods, Congress should establish a five year stability period that includes incremental increases in physician payments. This will provide physicians and beneficiaries necessary confidence in the Medicare system and allow sufficient time to test, adjust and implement new payment models.

Balance the Payment System

A successful health care system must include a balance of physicians - both primary care physicians and specialists. Currently, the physician payment system is imbalanced, weighing reimbursements for physicians who perform procedures higher than cognitive specialists, such as rheumatologists, neurologists, endocrinologists, hematologists and infectious disease specialists, who perform primarily evaluation and management services. The current system devalues spending time with patients. This creates considerable pay inequity among physicians resulting in workforce issues and in turn, impedes patient access to appropriate, specialized care. By ensuring appropriate balanced reimbursement for cognitive specialists, medical students can chose careers based on talent and interest rather than income potential. Without a balanced and adequate workforce, the delay in proper diagnosis and treatment results in needless patient suffering and increased health care costs.

Evaluation and Management Services

Congress recognized the physician payment imbalance - and the undervaluing of evaluation and management services – and took a positive step by including the 10% primary care bonus in the *Affordable Care Act*. However, the bonus only helps a single group of physicians who perform significant E/M services. Cognitive specialists who predominately perform E/M services should also be included and receive a bonus payment.

With the additional training rheumatologists and other cognitive specialists receive, they have been lumped together with surgical and procedural specialties even though their patient care aligns more with primary care. Recognizing the differences in these specialties is important when reforming the physician payment system.

Physician pay inequities exacerbate the imbalance of the physician workforce. Rheumatologists have completed 2-3 years of additional training after their internal medicine residency. This additional training prepares specialists to handle complex diseases and determine best treatment options. Workforce and training surveys forecast shortages in various specialties, such as rheumatology, endocrinology and neurology over the next 20 years. This is particularly concerning with the aging baby boomer generation.

Prior to 2010, physician specialists were reimbursed for a consultation service. A consultation occurs when one physician requests the expertise of another physician to appropriately diagnosis a patient. The elimination of consultation codes in 2010, combined with inadequate payment for high level E&M consultative services, demonstrates CMS' failure to recognize the advanced training and expertise in cognitive specialty care. Adequately reimbursing cognitive specialists for their advanced training,

expertise and ability is essential to ensure high valued care is accessible to patients with complex, chronic conditions.

Multiple Models

Numerous payment models have been proposed to improve the system. However, there is not one payment model that works for all physicians.

ACOs

Regulations were released in March of this year to provide guidance in developing accountable care organizations. The ACO strives to reduce costs while providing quality health care. With a focus on reducing costs, rheumatologists are concerned that ACOs may avoid including rheumatologists and rheumatology patients due to the high cost associated with treating chronic, debilitating conditions that often require expensive biologic medication treatments. Alternatively, requesting or requiring rheumatologists to join ACOs could reduce the availability throughout the US, forcing patients to travel long distance to receive high quality health care from a qualified rheumatologist. Rheumatologists are committed to reducing health costs while providing high quality care, yet we remain concerned about the ability of rural and underserved community providers continuing care for their patients.

The Patient Centered Medical Home

The patient centered medical home concept has been thoroughly discussed. Rheumatologists agree that patients should be the center of care and that physicians should be responsible for coordinating patient care. However, rheumatologists are specially trained to diagnose and treat patients with arthritis, rheumatic and musculoskeletal conditions. Rheumatologists would rather not be responsible for a patient's routine preventive examinations or immunizations. There has been discussion of a 'neighbor' concept to the medical home, but reimbursement models have not been released. The PCMH is limited in

utility beyond the primary care physician. The model will likely fail unless an appropriate reimbursement model is provided for specialists' consultative services.

Payment Bundling

Bundled payments for specific diseases or conditions have also been widely discussed. The ACR remains concerned about implementation of this system. Patients with multiple chronic conditions, like RA or lupus, are treated by a variety of specialists. For example, upon diagnosis of RA or during a flare the patient may frequently see a rheumatologist. However when the disease is well-controlled that patient may go months without seeing their rheumatologist. This complicates how the diagnostic bundled code must be split among the physicians in a fair and equitable manner. In addition, the bundled payment model is not conducive to itinerant Americans who often change physicians. Conceptually a bundled payment system seems viable, but realistically, a bundled payment system may only work for a small number of beneficiaries.

Multi-Target System

The multi-target system, establishing separate targets for various services, is a concept worth reconsidering. This could potentially create a more level field if designed with appropriate safeguards in place. However, as with any new model, it is untested, but should not be abandoned without further discussion.

Immediate Steps

- Immediately eliminate the flawed SGR.
- Establish a five year stability period to allow the Center for Medicare and Medicaid Innovation to assess alternative payment models.

- Consider payment options that account for the diverse set of physician specialties and practice-types.
- Recognize that cognitive specialists play an essential role in diagnosing and managing chronic conditions.
- Balance the currently skewed reimbursement system to ensure a stable physician workforce across all physician groups.

Payment reform is a complicated mission and it is challenging to satisfy all physician sectors. We commend the Ways & Means Subcommittee on Health's interest in developing a more stable, fair and appropriate system that will ensure patients have access to necessary care.

The American College of Rheumatology appreciates the opportunity to provide written testimony and looks forward to working with the subcommittee to repeal the SGR and transition to a system that incorporates new payment models designed to improve care coordination, quality, and control cost.