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April 15, 2013

The Honorable Dave Camp, Chairman
House Ways and Means Committee
The Honorable Fred Upton, Chairman
House Energy and Commerce Committee
United States House of Representatives
Washington, DC 20515

Dear Chairman Camp and Chairman Upton:

The American College of Rheumatology, representing over 9,000 rheumatologists and health professionals, appreciates the opportunity to provide additional feedback to the Ways & Means and Energy & Commerce Committees on your joint proposal to repeal and replace the sustainable growth rate system.

The ACR continues to emphasize the need to eliminate the SGR component of the Medicare payment formula and replace it with an equitable and sustainable reimbursement system. We appreciate your ongoing leadership and efforts toward this goal. The SGR must be replaced by a system with multiple options recognizing the spectrum of practice and provider types. The system should also value the non-procedural, specialized care rheumatologists provide for Medicare patients who have chronic and complex conditions. Under the modified fee-for-service system the framework envisions, it is essential that the system provide for flexibility and for specialty-specific, physician-driven and transparent quality measures.

In order to ensure patient access, it is important that SGR repeal is not paid for by cuts in healthcare. In fact, **positive physician payment updates should be an integral part of the replacement framework.** At a bare minimum we recommend a payment update should be implemented immediately that would counterbalance the two percent sequestration cuts to Medicare provider reimbursements and reduce the harmful impacts on patient access.

It is important to continue to note that physician reimbursements have remained virtually frozen for over a decade despite increases in the cost of providing patient care. While physicians and specialty societies can help CMS with quality measures that are truly relevant and that drive improvement of patient care and outcomes, CMS should help providers with reimbursement updates that will allow them to implement these new frameworks and be able to continue to care for patients. We recommend providing positive updates each year during the Phase I period during which stable payment rates will be statutorily applied, first in order to counteract the sequester cuts and second to match inflation of practice costs, which has not abated in the last decade.

Adequate reimbursement is essential to providing for a physician workforce that will ensure all Medicare beneficiaries can access the care they need. As noted by the National Commission on Physician Payment Reform, in the current fee-for-service system time spent on services performed under evaluation and management codes is reimbursed at lower rates than time spent providing services under procedure codes. This contributes to growing shortages of primary and cognitive specialty care providers as more medical students choose procedural specialties over

cognitive specialties. The commission recommends that annual updates should be increased for evaluation and management codes, which are currently undervalued.

It is important to recognize that issues of insufficient reimbursement for care coordination and complexity of care are not exclusive to primary care providers. The additional training required to become an expert in a cognitive care specialty and the specialized care provided to patients should be recognized by appropriate reimbursements. If these services are not appropriately valued, the numbers of these specialists will continue to dwindle and beneficiaries' access to care will be further restricted.

Questions for Phase II

We understand the joint proposal would repeal the SGR and replace it with a multi-year period of stable payment updates, which would be set by statute. During this "Phase I", quality measures and qualified clinical data registries would be created or improved by providers and approved by CMS. After this first period, during "Phase II", fee-for-service payments to providers would consist of a "base" rate and a "variable" rate based on performance on quality measures or participation in clinical improvement activities. Providers would be given flexibility and multiple options for how their performance is assessed. Quality measures on which providers are measured against themselves or others will be risk-adjusted based on severity of patient conditions.

How should the Secretary address specialties that have not established sufficient quality measures?

We recommend that CMS work with specialty societies to address those specialties that have not established sufficient quality measures. Provider input and endorsement is essential for the acceptance and use of quality measures, and providers have an important perspective with regard to what constitutes quality of care in a specialty. **Therefore it is very important that providers play a role in the development of quality measures.** Specialty societies are well-positioned to facilitate the development of quality measures as well as facilitate consensus within the membership about validity and feasibility of those measures. Specialties that do not have many quality measures should be allowed to use measures that are not NQF-endorsed as long as they are developed with a rigorous methodology and stem from clinical practice guidelines that are also developed under a rigorous methodology. **Because the process for submission to NQF is on a three-year cycle and entails a very onerous process, requiring NQF endorsement for all quality measures would delay the implementation of meaningful quality measures.**

The ACR has developed and continues to develop meaningful quality measures that evaluate true metrics of quality of care in the specialty, and we welcome the opportunity to create measures that matter for rheumatologists. The ACR's approach to guidelines and quality indicator development are evidence-based and state-of-the-art.

Is it appropriate to reward improvement in quality over time in addition to quality compared to peers?

Yes. **A workable payment system based on quality should be flexible**, rewarding those providers that demonstrate high quality of care using meaningful and clinically important measures, as well as well rewarding those providers who engage in quality improvement activities and demonstrate an improvement in quality over time.

Are there sufficient clinical practice improvement activities relevant to your specialty? If not, does your organization have the capability to identify such activities and how long would it take?

There are some clinical practice improvement activities in rheumatology such as registry participation and maintenance of certification performance improvement activities. However, the ACR would work to expand such activities. Development and implementation of these types of activities require significant resources and time.

Should small practices have the ability to aggregate measurement data to ensure that there are adequate numbers of patient events to reliably measure performance? If so, how?

The ACR is supportive of methods for practices of all sizes to participate in quality improvement activities.

Questions for Phase III

We understand that during "Phase III" of the proposed framework there would be an option for providers who meet a minimum quality threshold to earn incentive payments for efficient use of resources.

How much time is needed to refine the methodology for determining and attributing efficient use of health care resources?

These are complex matters and we recommend that the methodology be carefully developed and vetted by the range of stakeholders. A timeframe of multiple years may be essential.

It will be important to take the time to get components of any cost of care framework right. Our understanding is that CMS currently uses the Hierarchical Condition Categories method for risk adjustment. However, this model currently only explains around 12 percent of individual variation in cost. Most of the variation in cost is random and not predictable. This may be acceptable for large ACO's, but the model's appropriateness is very limited with regard to providing valid risk adjustment for individual physicians or small groups. Individual physicians have little control over per capita costs of care. As your attention to risk adjustment in performance measures acknowledges, physicians may feel incentivized to avoid sicker patients with multiple comorbidities who are more likely to need expensive hospitalizations and procedures. Some may feel they cannot afford to take care of patients with greater overall health care needs due to the risk of financial penalty.

Questions of attribution, determining responsibility when multiple physicians see a patient, are very important to consider. **Attributing per capita costs to individual doctors will likely have negative unintended consequences for patient care in some specialties.** Attributing episode based costs to individual physicians may work for acute problems and certain procedures, but its application for chronic disease is very difficult. Adjusting payment based on costs may be a valid approach for large organizations but it is difficult to imagine anything but a negative impact on health care if done on the individual or small group level.

Is it preferable to only have a payment implication based on efficiency for providers that meet a minimum quality threshold?

The ACR believes that providing high quality care should be the first priority of providers. There are many complicated factors to consider with regard to the definition of efficiency and the ACR welcomes further conversations as this aspect of the proposal is further developed. In the

meantime we strongly recommend that assessing and paying for cost efficiency should only be implemented as a next step after quality of care standards have been met by a provider.

Questions for APM Adoption

Under the joint proposal, we understand that providers who are participating in an Alternate Payment Model could opt out of the modified fee-for-service program envisioned by the framework.

What do you believe will be necessary to support provider participation in new Alternate Payment Models?

Particularly for specialties that traditionally have been based on small-to-mid-size and solo practices, details about payment structures and reporting requirements will need to be concise and easy for practitioners to understand. More guidance is needed for providers to assess which models might be most appropriate for them and how they might need to modify their approaches and structures in order to make move into new models.

What is a reasonable time frame for CMS to approve and adopt APMs?

We recommend that CMS adopt a flexible approach to approval and adoption of APMs, one that may be varied for different types of models and developers of models. Physicians will need sufficient time to examine different payment reform options and make the changes to their practice.

Should providers be able to participate in more than one payment model?

Yes. In certain geographic areas and circumstances some providers will need to be able to participate in multiple payment models, in particular because of shortages of certain specialists like is the case for rheumatologists in many areas. It will be important that this participation in more than one payment model not be deterred by differences in administrative requirements among the models. Basic, universal administrative requirements for participation should be developed.

Questions for Current Law Improvement

What improvements upon current law do you believe will be required to support alternate payment model adoption?

More providers will be willing to consider participation in alternate payment models when adequate incentives for adopting the models and assurance of safeguards against the risk of the models are clearly present. We also recommend more consistent Stark and anti-trust relief.

What improvements upon current law do you believe will help ease the administrative burden upon medical providers and allow more time caring for Medicare beneficiaries?

The ACR strongly supports the committees' attention to and concern with reducing the administrative burdens, including efforts to reduce reporting and regulatory burdens experienced by physicians. Compliance with reporting requirements is already taking too much of physicians' time. In particular for specialties whose providers tend to practice in small group and solo practices, there is general concern about the decreasing time for the genuine face-to-face

interaction with patients that is central to quality patient care. The committees' reform vehicle should take into account the costs of complying with new frameworks in the midst of growing burdens on physicians, and seek to streamline and reduce reporting requirements.

The ACR commends your leadership and the committees' commitment to repealing the SGR and replacing it with a viable system rewarding quality of care rather than volume. We stand ready to assist you further as you develop further details of your framework and legislative language. Please contact Adam Cooper, director of government affairs, at (404) 633-3777 or acooper@rheumatology.org. Thank you for moving forward with this important initiative.

Sincerely,

Audrey B. Uknis, MD

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President, American College of Rheumatology