AMERICAN COLLEGE OF RHEUMATOLOGY
EDUCATION • TREATMENT • RESEARCH

Specialists in Arthritis Care & Research
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What Is A Rheumatologist?
A Physician Who Treats Arthritis, Rheumatic and Musculoskeletal Conditions

What is a rheumatologist?
A rheumatologist is a doctor who treats arthritis and other diseases of the joints, muscles, and bones. Some rheumatologists also conduct research to determine the cause of diseases and find better treatment options for these disabling and sometimes fatal diseases.

What training does a rheumatologists have?
Rheumatologists receive four years of medical school, three years of training in either internal medicine or pediatrics and an additional two to three years in specialized rheumatology training.

What diseases do rheumatologists treat?
Rheumatologists treat arthritis, certain autoimmune diseases, musculoskeletal pain disorders and osteoporosis. There are more than 100 types of these diseases, including rheumatoid arthritis, osteoarthritis, gout, lupus, back pain, osteoporosis, fibromyalgia and tendonitis. Some of these are very serious diseases that can be difficult to diagnose and treat.

Rheumatologists are "cognitive specialists." What are "cognitive specialists"?
Cognitive specialists are physicians who have expertise in treating patients with complex medical conditions and who primarily provide evaluation and management services to patients. Patients referred to rheumatologists require expertise which primary care physicians are not trained to diagnose or determine an appropriate treatment plan.

Rheumatologists are specially trained to do the detective work necessary to discover the cause of swelling and pain. It's important to determine a correct diagnosis early so that appropriate treatment can begin. Because some rheumatic diseases are complex, and often change or evolve over time, rheumatologists work closely with patients to identify the problem and design an individualized treatment program.

Rheumatologists are experts in their field.
Rheumatologists typically act as a consultant to advise another physician about a specific diagnosis and treatment plan. In other situations, the rheumatologist manages complex patients relying upon the help of skilled professionals including nurses, physical and occupational therapists, psychologists and social workers. Team work is important, since musculoskeletal disorders are chronic.

Rheumatologists provide high quality care, often at a lower cost.
A rheumatologist is specially trained analyze the medical history and physical examination. Proper tests, a prompt diagnosis and specially tailored treatment results in improved patient outcomes, better quality care and is often less costly.

The ACR encourages Congress to recognize the value of rheumatology care.

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SUPPORT FAIR PHYSICIAN REIMBURSEMENT: PERMANENTLY FIX THE SGR

The American College of Rheumatology strongly urges Congress to pass legislation revising the Medicare payment methodology to ensure appropriate reimbursement for physicians.

Patients Access is Threatened by Steep Medicare Cuts
Since 2002, Congress has repeatedly intervened to prevent severe cuts to the Medicare physician fee schedule. Rheumatologists and other physicians are expected to face a 29.5 percent to Medicare payments as of January 1, 2012. These cuts threaten seniors' access to health care and potentially limit access to care for all Americans.

It is Fiscally Responsible to Fix the SGR Now
From a budgetary perspective, the most responsible action is to repeal the SGR today. In 2005, the scheduled payment cut was 3.3% and the Congressional Budget Office estimated the cost of a 10-year physician payment freeze at $48.6 billion. Today, physicians are facing a 27% cut and the CBO recently estimated the cost of a freeze to be more than $300 billion over 10 years. The cost will be over $500 billion in 2014 if Congress continues to place a "Band-aid" on the problem and does not permanently repeal the SGR this year.

The SGR Contains Factors Over Which Physicians Have Little Control
The sustainable growth rate is part of the formula used to calculate physician reimbursement for Medicare. Unfortunately, the basic premise of the formula is flawed. The SGR is linked to the performance of the overall economy, yet the medical needs of individual patients do not shrink whenever the economy slows. When overall spending on services in the SGR exceeds the per capita gross domestic product, cuts to physician reimbursement are triggered. This skews the calculation of the SGR and triggers overly harsh reductions in physician reimbursement.

ACR urges Congress to be fiscally responsible and permanently repeal the sustainable growth rate before December 31, 2011. Repealing the SGR is essential to ensuring Medicare patients have access to appropriate health care.

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AMERICANS NEED A HEALTHY RESEARCH BUDGET
SUPPORT THE MILLIONS OF AMERICANS WITH RHEUMATIC DISEASE
MAINTAIN CURRENT MEDICAL RESEARCH FUNDING LEVELS

Arthritis, the nation's leading cause of disability, costs the U.S. $128 billion each year.

The American College of Rheumatology strongly urges Congress to **maintain** current funding for federal programs engaged in vital research to combat arthritis and related rheumatic diseases. The number of people with arthritis and released diseases is projected to be 67 million by 2030.

Medical Research Improves the Health of Millions of Americans
Cuts to the national medical research budget deny hope to millions of patients and families struggling with rheumatic diseases. The U.S. leads the world in development of medical therapies, but budget cuts will dramatically slow down or halt progress.

Examples of federally funded projects directly benefiting patients and families suffering from rheumatic diseases:
- NIH funding supports investigators at the University of Colorado who identified that lung inflammation is one of the earliest causes of rheumatoid arthritis. These findings are leading toward prevention of RA, a disease which leads to significant morbidity and increased mortality.
- Thanks to NIH support, large multicenter projects including research teams in New York, Texas, California, and Massachusetts are able to study the relation to the genes of thousands of rheumatoid arthritis and lupus patients, leading to the identification of 20 genes each for each condition that will help explain the causes and lead to new treatments of these diseases.
- NIH funding at the University of California is supporting research that has identified new ways of suppressing the immune system that will be less toxic than current methods used to treat autoimmune diseases affecting tens of thousands of people in the U.S.
- With federal funding, researchers identified a new genetic link to systemic sclerosis (also known as systemic scleroderma) and confirmed three previously discovered links to the disease, which can cause thickening of the skin, narrowing of blood vessels, and scarring of internal organs.

Support Biomedical Research and Our Nation's Economy
Federal funding not only supports important biomedical research in rheumatic diseases, but also provides an economic stimulus to communities nationwide in the form of jobs and customers for local businesses. NIH awards and grants alone support over 350,000 jobs across the country. With continued advancements, the economy can look forward to long term stimulation through patents, devices, and new therapies and treatments. In FY07, the NIH supported:
- **$22.846 billion** in grants and contracts to U.S. universities and research institutions
- **$50.537 billion** in increased output of goods and services to the country
- **350,894** new jobs nationwide with **$18.286 billion** in taxable wages

NIH Support is Critical for Maintaining Our Nation's Medical and Scientific Workforce
NIH career development research and training grants support young trainees in the early stages of their research careers as gain experience to become independent researchers and medical school faculty throughout the country. Workforce studies by the ACR project a large faculty shortage for training the next generation of physicians in arthritis and rheumatic disease. NIH budget cuts would impact the U.S. academic research and training environment and would be detrimental to the entire medical profession and the patient communities they serve.

The ACR urges Congress to maintain current medical research funding to provide improve the health of millions of Americans.

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Stop "Bounty Hunter" Incentives to Recovery Audit Contractors

The American College of Rheumatology urges Congress to repeal the "bounty hunter" incentive for Recovery Audit Contractors to ensure physicians are protected from aggressive auditors.

What is the Recovery Audit Contractors Program?
In 2006, Congress created the Recovery Audit Contractor program to help the Centers for Medicare and Medicaid Services identify improper payments made by Medicare. These contractors are private entities retained by the Federal government to identify and recoup overpayments and underpayments made to physicians and health care providers.

"Bounty Hunter" Incentives Increase Overall Health Care Cost
RACs are compensated by a percentage of the identified and recovered payments, not by a flat fee. The incentive to identify overpayments creates Medicare "bounty hunters", targeting many physicians and providers who bill in good faith and according to their best judgment.

Fraud and Abuse Should Not Be Tolerated
Medicare fraud is the intentional deception or misrepresentation that an individual makes knowing it to be false, which results in unauthorized benefits to oneself or another person. Medicare fraud and abuse is a critical issue, costing Americans upward of $60 billion annually. Additionally, it threatens the solvency of the program established to provide care to seniors and disabled Americans. Physicians and providers who intentionally commit Medicare fraud and abuse should be penalized.

However, physicians who bill in good faith and to their best judgment should not be subjected to aggressive auditors motivated by "bounty hunter" incentives.

What Can Congress Do?
RAC is an enormous burden on affected physicians and has failed to eradicate billing mistakes. Congress must ensure physicians and health providers are protected from administrative burden and aggressive auditors.

ACR requests that Congress repeal the "bounty hunter" incentive for recouped payments and establish a flat fee-for-service payment for services rendered.

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**Ensure Access to Drug Therapies Through Drug Competition:
Place Safeguards on FDA Approval Process**

The American College of Rheumatology urges Congress to place safeguards on the Food and Drug Administration drug approval process to ensure patient access to affordable care.

Affordable Access to Drug Therapies
Congress has demonstrated that reducing the cost of health care and improving patient access to care – through affordable insurance coverage, eliminating exclusions for pre-existing conditions, the Medicare "donut hole" – are its highest health policy priorities. Unfortunately, access to drug therapies has been adversely affected due to FDA regulation of an unapproved drug. The most recent example is the FDA's regulation of colchicine, the existence of which pre-dated the Agency.

Background
Colchicine is used to treat gout and Familial Mediterranean Fever. It was first isolated in 1820 and identified for its pain-relieving and anti-inflammatory effects. Until June 2009, FDA considered colchicine an unapproved drug that was widely used as a safe and effective treatment for these conditions. In 2006, FDA updated its policy to regulate all unapproved drugs that existed prior to FDA by requiring an approval process to ensure patient safety.

Based on clinical trials and a literature review, FDA approved a branded colchicine, and granted its manufacturer three years market exclusivity for acute gout and seven years exclusivity for Familial Mediterranean Fever. **The pharmaceutical company subsequently increased the cost of the drug from $6/month to approximately $300 per month – <u>a 5,000% cost increase</u> – placing essentially the same drug out of reach for many patients.**

While a new drug approval generally provides market exclusivity to its manufacturer, given that colchicine has been produced for centuries, the manufacturer of the newly branded version of colchicine should not receive market exclusivity.

But because of this exclusivity, unapproved colchicine has been forced off the market. Thus, Medicare and private payors no longer cover unapproved colchicine, increasing the overall cost of health care for patients, the Federal government and private insurers.

Other drugs, such as quinine, have suffered the same consequence, increasing the cost of treatment and preventing patient access to care.

What Can Congress Do?
Congress provides government oversight of FDA to ensure patient safety for drug therapies. Drug safety is critically important in providing safe and effective patient care. However, permitting a pharmaceutical company to control the market for a drug that has been used for almost 200 years is an unintended consequence of FDA's policy and adversely effects access to care.

ACR requests that Congress review the approval process for unapproved drugs and place safeguards to prevent price gouging by pharmaceutical companies and to ensure patients maintain access to safe, inexpensive and essential treatments.

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PROTECT SICK PATIENTS FROM EXTREME COPAY BURDEN

The American College of Rheumatology (ACR) strongly urges Congress to stop insurance companies from charging significantly higher copays for certain expensive medications.

Health insurance companies are rapidly adopting a new pricing system for expensive drugs, asking patients to pay hundreds and even thousands of dollars for needed prescriptions.

Traditionally, individuals and families paid reasonable co-pays for medications as part of their health insurance coverage. These co-pays often fell under a three tier system under which, for example, a beneficiary would pay one lowest amount for a generic medication, a higher amount for a name brand medication, and the highest amount for a medication off formulary (e.g., $15/$20/$30).

- Recently, insurance companies have instituted a new copay referred to as Tier IV requiring patients to pay 20 – 30% copays for specialty drugs or medications.
- Tier IV often applies to the most expensive medications. This pricing scheme can cost patients thousands of dollars a month.
- The medications, although expensive, allow individuals to lead productive lives. These medications benefit individuals with debilitating conditions such as multiple sclerosis, rheumatoid arthritis, hemophilia, hepatitis C and some cancers.
- Often, there are no inexpensive equivalents for the drugs in Tier IV. Accordingly, seriously ill individuals are forced to pay for needed medications at a high cost.
- Tier IV undermines the very concept of insurance—group risk sharing to protect individuals from high health care costs. If insurance companies are allowed to continue with Tier IV pricing, patients will be forced to go without necessary medication.

ACR urges Congress to pass legislation restricting insurance companies from Tier IV pricing.

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SUPPORT PREVENTIVE HEALTH CARE:
ENSURE MEDICARE FRACTURE PREVENTION AND OSTEOPOROSIS TESTING

Chronic reductions in Medicare reimbursement for osteoporosis screenings have resulted in reduced access to this important service. Section 3111 of the Patient Protection & Affordable Care Act provided relief to physicians who perform preventative osteoporosis testing for 2010-2011. To ensure continued access to this necessary preventative screening, Congress must provide sustained relief for, at a minimum, two additional years (2012-2013).

Senators Olympia Snowe (R-Maine) and Debbie Stabenow (D-Mich.) and Representatives Shelley Berkley (D-Nev.) and Michael Burgess, MD (R-Texas) introduced the *Preservation of Access to Osteoporosis Testing for Medicare Beneficiaries Act of 2011* (H.R. 2020/S. 1096). This legislation extends payment for DXA scans at the current reimbursement rate of 70 percent of the 2006 reimbursement level through 2013.

Osteoporosis Screening Can Reduce Risk of Fractures
Osteoporosis involves a gradual loss of bone, which causes bones to become thinner, more fragile and more likely to break. Due to the complications of fracture, the disease is associated with significant mortality and morbidity. Osteoporosis and low bone mass affect an estimated 44 million Americans.

In order to reduce the impact of osteoporosis, it is important to diagnose it prior to fracture and initiate treatment for those at high risk. Dual-energy x-ray absorptiometry (DXA) is recognized as the "gold standard" for diagnosing osteoporosis and monitoring the response to therapy. Knowledge of bone density and other risks for fracture allows patients and their health care providers to choose preventative or treatment options to reduce risk of future fracture.

Severe Medicare Reductions Hurt Patient Access
Until relief in the ACA, DXA reimbursements drastically decreased between 2006 and 2010, dropping from approximately $148 to $54. The temporary reimbursement increase to 70% of the 2006 Medicare reimbursement level has provided some relief to physicians providing access to this crucial preventative screening. However, physicians and patient groups indicated that these cuts will make it cost-prohibitive to continue to provide these services in physician offices, where two-thirds of patients are currently tested.

Congress Should Support Continued Access to Preventive Osteoporosis Screenings
Reimbursement relief will curb the reduced access to DXA screenings, improve patient care, and prevent unnecessary costs to the Medicare program through reduced fracture expenditures.

The ACR strongly encourages Congress to pass the *Preservation of Access to Osteoporosis Testing for Medicare Beneficiaries Act of 2011* (H.R. 2020/S. 1096) to continue access to preventative osteoporosis screenings by extending the reimbursement increase for an additional two years.

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SPECIALISTS ARE KEY TO SUCCESSFUL HEALTH CARE
HELP PATIENTS GET THE RIGHT DIAGNOSIS AND TREATMENT

A Successful Reformed Health Care System Requires A Balance of Physicians

Primary care physicians are an essential component to any health care system. Equally important are specialists. However, the current state of health care reform devalues the importance of certain types of specialists – cognitive specialists. Cognitive specialists primarily perform evaluation and management services to diagnose and treat complex, chronic and debilitating diseases, such as rheumatoid arthritis and lupus. These physicians are lumped in with surgical/procedural specialists and therefore, ignored by the system. A successful health care system must have primary care physicians to handle coordination of care and routine issues as well as refer complex, chronic diseases to appropriate specialists who have the expertise and additional training to manage those diseases.

Devaluing Specialty Care Could Lead To The Loss of Cognitive Specialists

Rheumatologists, endocrinologists, infectious disease physicians, and neurologists are all cognitive specialists. These physician specialists have expertise in a single area of medicine. They obtain the specialty designation by continuing their medical education for an additional two to three years, and this additional training prepares them to handle complex diseases and determine best treatment options.

Recent Policy Changes Devalue Specialty Care

While cognitive specialists are valued by patients, they are clearly undervalued by the Centers for Medicare and Medicaid Services, which was made clear in 2010 when CMS eliminated consultation service codes used to recognize the services of a specialist. This policy change fails to acknowledge specialty expertise and the detailed work that is performed in a consultation – thereby deterring medical students from pursuing training in rheumatology and other cognitive specialties. This kind of devaluation could result in a drastic reduction of the nation's ability to meet future health care needs – especially in the diagnosis and treatment of complex, chronic conditions.

Rheumatology workforce and training surveys forecast extreme shortages over the next 20 years, which is of particular concern considering nearly 50 million Americans suffer from arthritis and rheumatic diseases, and many more will be added to this number as baby boomers continue to age.

Unfair Incentives Send a Strong Message and Threaten Patient Care

While Congress took a step in the right direction with the *Affordable Care Act*, it sent a strong message: primary care physicians and physicians who perform procedures are valued; cognitive specialists are not. The *Affordable Care Act* provides a 10 percent payment bonus to designated primary care physicians to improve their workforce. And, when this bonus is combined with Medicare's current consultations policy, cognitive specialists are now reimbursed less than primary care physicians — even when performing the same E&M services — despite the fact that their patients' conditions are often chronic, severe, and difficult to diagnose and treat.

This skewed reimbursement model provides no incentives to pursue rheumatology and other cognitive specialties. Without an adequate and fair payment system and a balanced physician workforce, patients will be unable to access necessary and appropriate, high-quality, cost-effective health care.

The Solution: Equality in Reimbursement

The ACR requests Congress to adequately reimburse cognitive specialists who care for patients with complex medical conditions that require a level of expertise, which is beyond the training of the primary care physician.

The ACR also requests Congress require CMS to accept a payment add-on code that recognizes the value of specialty care for patients with complex medical conditions in care coordination, better outcomes and cost savings in the health care system.