



Coalition of State Rheumatology Organizations  
1710 South 17th Street  
Wilmington, North Carolina 28401  
Telephone: (910) 762-1182  
Fax: (910) 332-1111

August 28, 2009

Transmitted electronically  
Please deliver to:

Charlene Frizzera  
Acting Administrator, Centers for Medicare and Medicaid Services  
United States Department of Health and Human Services  
Attn: CMS-1413-P  
Room 314-G, Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

**Re: Medicare Program; CY 2010 Notice of Proposed Rulemaking, Physician Fee Schedule (CMS-1413-P)**

Dear Ms. Frizzera:

On behalf of the members of the Coalition of State Rheumatology Organizations (CSRO), we are providing comments and recommendations in response to the Proposed Rule issued by the Centers for Medicare and Medicaid Services (CMS) regarding the physician fee schedule contained in CMS 1413-P. 74 #132 Fed. Reg. 33520 July 13, 2009

Our organization represents approximately 2,500 private practicing rheumatologists who are enrolled as members in their respective state and regional professional Rheumatology organizations. Rheumatologists are subspecialty physicians who care for and manage some of the most debilitating and sometimes fatal diseases that are responsible for the majority of the disabilities in our country. The primary objective of Rheumatologists is to provide the highest quality care for our patients in order to prevent disfiguring and deforming joint tissue damage that can lead to disability or even death. Our subspecialty, already suffering from manpower shortages, will face serious additional challenges if some of the provisions in the Proposed Rule are retained in the Final Rule.

Our specific comments and recommendations regarding the provisions in the proposed rule follow. We have organized our comments under the topics that directly affect our ability to provide care for patients with autoimmune diseases. We have included some recommendations for each of the topics and would be happy to discuss these further if necessary.

## **I. SGR Based Reimbursement Adjustment and Formula**

The Sustainable Growth Rate (SGR) is a formula that is used to calculate the conversion factor (CF) for professional medical service reimbursements and is dependant upon the growth of the national economy. This method of calculating the CF does not represent the needs of

beneficiaries for health care services, the complexity of diseases or the costs of technological advancements in the treatment of acute and chronic illnesses. Current adjustments are automatically implemented annually and utilize antiquated basis data from over 12 years ago (between April 1, 1996 and March 31, 1997). The proposed CF for 2010 will translate into a reduction of 21.5% over 2009 levels of reimbursement. It is illogical to utilize an SGR formula when the costs are rising for increasingly complex care for an increasing number of beneficiaries while overhead expenses and technological advances are also increasing. This portion of the fee schedule adjustment must be rejected as impossible to administer fairly without harming both patients' and providers' survivability. Continued fee schedule designs that include the SGR in the calculations will only serve to encourage physicians to curtail their services to Medicare beneficiaries or dis-enroll outright. If this formula is not changed, we would not be surprised by either of those two decisions by our members and colleagues since inadequate reimbursements for professional services are an impediment to the delivery of high quality care for beneficiaries and represent a threat to the quality of care for all citizens.

We applaud the Administration's proposal to remove physician administered drug costs from the computation of the Conversion Factor and encourage adoption of this proposal for calendar year 2010 instead of 2012.

## **II. Physician Reimbursement Update**

We are deeply concerned that the proposed rule will reduce payments for treatments for chronic debilitating diseases such as heart disease, cancer and autoimmune diseases due to a reduction in practice expense RVUs as submitted by the AMA RUC committee. For certain services, a staggering additional 20% reduction in reimbursements for specialists in cardiology, rheumatology and oncology are proposed in the current CMS document. CMS has relied on an AMA survey to establish the practice expense RVU. Unfortunately, the survey has serious flaws, and needs to be reviewed for accuracy and for statistical validity.

The survey results are based on a small sampling of physician practices which cannot accurately represent the conditions that are confronted every day by physicians in managing complex diseases in an increasingly complex and costly practice environment. The survey concludes that the cost of providing medical care has actually decreased over the last 5 years. This conclusion alone should have raised a red flag regarding the validity of the survey when costs for everything from electricity, employee wages, insurance and medications all have risen during that time period. Additionally, the survey results never have been fully disclosed, published or opened for review and comment from patient groups or physicians nor have the results ever been subjected to critical statistical analysis.

The provision to reduce the reimbursements for procedures such as infusions of chemotherapy and biologic agents is also disingenuous and contradicts the letter and spirit of the statutes included in the Medicare Modernization Act (MMA) of 2003. At its inception, assurances were given to patients and physicians that the reimbursements for these therapies would continue to accurately reflect the costs and complexity of these professional services in the MMA 2003. The projected reductions threaten the feasibility of providing these services or may even completely eliminate the availability of these services for Medicare beneficiaries in the future.

We strongly disagree with the reduction of practice expense RVUs and the resultant additional decline in payments for life saving complex infusion therapies such as the administration of chemotherapy and biologic agents for autoimmune diseases. At a time when the rates of death

from heart disease and cancer are declining and the rates of disability from diseases such as rheumatoid arthritis are being reduced, CMS-1413-P reduces reimbursements that will dramatically undercut professional capabilities to adequately manage patients with these diseases. We encourage CMS to conduct a survey among physician practices specifically targeting those practices that participate in Medicare beneficiary health care and develop an accurate representation of health care expenses across all specialties and subspecialties. Accuracy of this analysis also needs to be verified by accepted statistical methods and open for discussion and comment.

### **III. Changes to Consultation Codes**

We urge CMS to retain the consultation codes in the fee schedule. Consultations with sub-specialists are an integral part of assisting the medical management provided by primary care physicians. If consultations are unsupported, primary care physicians may find it much more difficult to obtain requested sub-specialist evaluations and receive assistance from sub-specialists in the management of complex problems. This may become especially critical for hospitalized patients should some sub-specialists decide to reduce their participation on hospital staffs. Removing consultation codes could potentially create a second class medical care system for Medicare beneficiaries and even for all other non-Medicare beneficiaries whose insurers adopt this same deletion. It will not be cost effective for subspecialists to provide their expertise and give professional recommendations in the care of hospitalized patients and perhaps even in some outpatient settings.

### **IV. Modifications to the Competitive Acquisition Program (CAP)**

The CAP program has not been viable for the majority of private practicing physicians. The excessive costs and complexity of inventory management and demographic transmissions associated with participation in this program are not acceptable. The program will need to be simplified, restructured for partial participation and some restrictions removed in order for a CAP program to be a viable alternative to other mechanisms of drug acquisition.

### **V. Imaging Payments - Bone Mineral Density Testing**

The reimbursements for Dual X-ray Absorptiometry (DXA) testing for bone mineral density measurement have declined significantly in each of the last 3 years from approximately \$160 per scan to approximately \$65 in 2009 with projected reductions to \$48 in 2010. This reduction in the CMS-1413-P is the proposed value before any modifying effects based upon the SGR reductions. These reimbursements are already at a point where medical specialists are abandoning the technology with potentially devastating consequences. Many subspecialists' practices are dismantling and removing testing equipment from their offices. The lack of adequate reimbursement is decreasing the availability of this testing and is beginning to have a negative effect on the diagnosis and management of osteoporosis in the population at risk (predominantly women). Data analyses presented at recent scientific meetings have clearly demonstrated an increase in the number of fractures when plotted against the declining utilization of DXA testing (Singh, et al ACR Poster session 2008; Singh, et al EULAR Poster Session 2009).

At a time when quality measures and primary prevention strategies are at the forefront of discussions regarding health care reform, CMS has initiated a cost containment strategy regarding DEXA testing over the last 3 years that is short sighted and promotes poor quality care by

decreasing access to patients for diagnosing and management of patients at risk of osteoporotic fractures. Evidence that CMS reimbursement policies are having a negative effect on outcomes in osteoporosis diagnosis, evaluation and management with a commensurate increase in the numbers of fractures already exists. The increase in fragility fractures will result in an increased cost of medical care in the long run as a result of increased hospitalizations, increased long term nursing care and higher numbers of surgeries for serious fractures. Each fracture occurrence also carries a significantly higher mortality as well as morbidity when compared with early diagnosis and aggressive treatment modalities. **We would advise CMS to expect that this single decision affecting DXA scan utilization will lead to an increased mortality in the Medicare population.** We recommend a reversal of the downward reimbursement spiral for DXA and a return to reimbursement rates that were in effect in 2006. It is far less expensive to support scan availability and quality medical care for osteoporosis than it is to care for patients who have fragility fractures.

## **VI. 106% ASP Calculations for Part B drugs**

On behalf of arthritis patients who receive in-office medications from rheumatologists for the treatment of severe and debilitating autoimmune diseases, the ASP + 6% calculation continues to increase the overall aggregate cost of administration of these agents by shifting these services to higher cost centers. The formula erroneously includes prompt pay discounts and insurance company rebates in the calculations which negatively impacts physicians from obtaining adequate reimbursement for drug acquisition including the physical aspects of purchase, storage and inventory of these drugs. Our own survey data (submitted to MedPAC) concluded that the weighted average reimbursements for Part B biologics administered in private practice Rheumatologists' offices are insufficient to cover these costs. When drug cost reimbursement is inadequate, many patients are shifted to hospital outpatient care centers which increases costs, is more time consuming, and is less efficient for patients. We strongly recommend that CMS work together within the Administration and with Congress to remove the prompt pay discounts and insurance company rebates from the formula calculations in ASP methodology.

Conclusions: The CSRO appreciates the opportunity to submit comments and recommendations to CMS. We look forward to working with you and your staff to ensure that Medicare beneficiaries have meaningful and ready access to professional services for complex autoimmune and degenerative diseases in a way that does not threaten the continued viability of private practice Rheumatology as well as other subspecialists. If you have any questions related to these comments, please contact Gregory F. Schimizzi, M.D. (910-762-1182) or Michael C. Schweitz, M.D.(561-659-4244).

Sincerely,

Gregory F. Schimizzi, M.D.  
President, Coalition of State Rheumatology Associations

Michael C. Schweitz, M.D.  
Vice President, Coalition of State Rheumatology Associations