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Dr. Pecora and Mr. Schoen,

Thank you for your consideration of our concerns regarding the original Rheumatology Autoimmune Pathways VBC Program put forth by OMI and BCBS NC. We think that engaging with stakeholder organizations like CSRO and listening to the concerns and proposed changes is the right way of starting such programs.

We agree that subsidizing practices for the administration burden required to participate in the program is appropriate. Such gathering of information based on physicians' good clinical judgement is an added value to both individual and population health.

We have a few questions that we are hoping that you could address to clarify the modified program:

- Can you clarify the terminology of how the administrative bonus is determined? Specifically, we'd like to clarify what is meant by "as a percentage of the physician's contribution or on a transactional basis."
- Additionally, on average how much compensation would accrue using either of those determinants?
- Will the program mandate the signing of the Patient Attestation? Do you have a sample of the wording that you are contemplating?
- We welcome the assurance that the physician's best clinical judgement in the care of the patient is paramount. Does the following statement from your letter mean that if there are no savings using correct clinical judgement, that the administrative bonus will not be given?
  "Only when a physician executes both components of the VBC Program (quality and appropriate treatments) will they be eligible for an administrative payment that results from any savings achieved."
- Can you be more transparent how the data collected will be used?

Finally, we would like to share a suggestion that may make this program more attractive to rheumatologists and increase interest in participating. In an informal survey of rheumatologists, we have found that the administrative reimbursement (payment) to the practice is not nearly as much of an incentive to participate in this program as the relief gained by eliminating the tremendous burden of prior authorizations would be. Would there be an opportunity to include a mechanism to grant providers who participate such relief?

I am sure that BCBS NC and OMI understand that true cost savings are realized when patients achieve low disease activity /remission and the sooner the better. I don't need to enumerate the damage caused by delaying remission in RA and PsA. The short and long term costs alone of increased steroid usage can be dramatic in terms of infections resulting in hospitalizations, osteoporosis with hip and vertebral fractures, increased rates of diabetes, heart disease and the list goes on.

Consequently, allowing the physician and patient to make the best decision will result in long term savings for the patient, the health plan and society. Increased adherence to the correct medicine leads to increased productivity in the workplace, decreased absenteeism and decreased short term disability among many other benefits.

We agree that managing costs is important, and we know the long term cost of the wrong drug at the wrong time for the patient can lead to much higher costs for everyone in the long run.

In other words, the shared savings should focus on these outcomes which are many folds more relevant than simply focusing on drug cost (which is certainly a major problem that is better fixed by addressing the PBM perverse incentive in the drug supply chain).

Again, thank you for your willingness to listen and respond to our concerns regarding this program.

Sincerely,

Madelaine Feldman, MD, FACR, VP of Advocacy & Gov't Affairs,
Member, Payer Issue Response Team (PIRT)

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