AMERICAN COLLEGE OF RHEUMATOLOGY

POSITION STATEMENT

SUBJECT: Access to Care

PRESENTED BY: Committee on Rheumatologic Care

FOR DISTRIBUTION TO: Members of the American College of Rheumatology
Members of Congress
Pharmaceutical Councils/Representatives
Professional Pharmacists' Associations
Medical Review Organizations, e.g. AMCRA
Medicare Carriers/Private Insurers
State Insurance Commissioners

POSITIONS:

1. The American College of Rheumatology (ACR) affirms the ethical responsibility of the healthcare team to place the welfare of the patient above all, as well as the importance of protecting the provider-patient relationship. To preserve patients' access to care by rheumatology providers and the therapies necessary for the treatment of their rheumatologic conditions,

a) The ACR affirms that the discussions and decisions involved in caring for and counseling patients should be free of the threat of legal repercussions.
b) The ACR unequivocally supports the practice of shared medical decision-making between the provider and the patient.
c) The ACR opposes any attempts to interfere with the evidence-based management of patient care and influence providers' clinical autonomy.

2. The ACR recommends that all Americans be covered by continuous health insurance that encourages high-quality health care including care for chronic arthritis and rheumatic diseases.

This coverage should have the following features:

a) No exclusions for preexisting conditions.
b) No lifetime caps on health insurance coverage for any patients, especially for those with rheumatic conditions, considering the high cost of routine therapies for these diseases.
c) Preservation of coverage for young adults up to age 26 as part of family health insurance plans.
d) Access to rheumatology providers should be equitable among diverse populations, races, and genders, especially to those of underserved populations.
e) Access to rheumatology providers and coverage for services that are exceptionally valuable to their patients, including but not limited to medications, appropriately supervised infusions and injections, physical and occupational therapy, psychological care, radiologic imaging, and laboratory testing. See the ACRs position on Therapeutic Substitution and Patient Access to Biologics.

f) Coverage for health education activities for patients with chronic rheumatic diseases in acknowledgment of the importance of education in the management of chronic rheumatic diseases
g) Recognition and mitigation of barriers related to travel for patients with arthritis and other rheumatologic conditions. Laboratory, radiology, and infusion services should be readily available, unfragmented, and conveniently located for patients.
h) Expansion of provider networks to ensure access to expert rheumatology care. Patients who are forced out of network to gain access to reasonably convenient and appropriate care by a rheumatology provider should not be financially penalized for doing so. Provider directories should be complete, readily available, and up-to-date, and adhere to fair health plan contracting practices. Elimination of excessive co-payments that further reduce access to care.
i) Elimination of complicated deductibles and coverage gaps for medications (donut holes) to allow better coverage of medications through Medicare Part D. Patients should not be penalized with extra costs for utilizing patient assistance programs. Medicare beneficiaries should be allowed access to patient assistance programs.
j) Responsibility for Medicare Part B coverage for infusion services should not be shifted onto patients. Exclude Part B and Part D drug costs from the cost component of MIPS score calculations.

3. Prioritization of the following is important to ensure that all patients have timely and uninterrupted access to expert rheumatology care.
a) Early and uninterrupted referral of patients to a provider with expertise in rheumatology, as many conditions are most effectively managed when an accurate diagnosis and initiation of therapy are promptly initiated.
b) Preservation of viable medical practices in a variety of settings and structures including rural and urban environments, small and large practices, single and multispecialty groups, academic centers, solo practices, and practices affiliated with and independent of other health systems. See ACR position on Infusion and Clinic-Administered Injection Therapy in Community Rheumatology Practices.
c) Continued support for telemedicine, including removing licensing impediments and reimbursement of video and phone visits at the same rate as face-to-face visits.
d) Minimizing repeated renewal of referrals for ongoing rheumatologic care as continual and tedious renewal processes are overly burdensome to patients, rheumatology providers, and those initiating the referrals.
e) Expansion of graduate medical education programs to train more adult and pediatric rheumatologists, financial support for trainees (e.g. Pediatric Subspecialty Loan Repayment Program and Public Service Loan Forgiveness Program), expansion of visa waiver programs, and support for physician assistants, nurse practitioners, and nurses to obtain specialized training in rheumatology.

BACKGROUND:

The mission of the American College of Rheumatology (ACR) includes advocacy for excellence in the care of both adults and children with autoimmune and musculoskeletal diseases. The ACR is deeply concerned about any barriers which may limit the ability of patients with arthritis or other rheumatic diseases to obtain affordable, high quality, high value healthcare. The ACR objects to any attempt to influence or interfere with clinical autonomy in the care of patients, shared decision-making, and evidence-based care. The ACR, therefore, advocates for patient access to adequate and affordable health insurance, including access to a rheumatology professional for both initial consultative services as well as ongoing care, access to medications and other

medically necessary treatments for rheumatic conditions, and preservation of all appropriate therapeutic options without undue influence or interference.

Lack of insurance affects many patients with rheumatic disease, including children[3]. Not only does this lack of coverage have a detrimental effect on the health of the uninsured individuals[4], but it can also impact the medical and economic well-being of the insured population in the same community[5]. The need to improve and expand access to high-value healthcare is especially important for patients with rheumatologic conditions for three reasons:

1. Patients suffering from rheumatic conditions reap tremendous benefits in terms of reduced morbidity and prevention of disability when their disease is controlled quickly by virtue of a prompt and accurate diagnosis and the rapid initiation of appropriate therapy[6].
2. New therapeutic options, especially a class of medicines called biologics, have revolutionized the treatment of rheumatic conditions but the high cost of these treatments precludes their appropriate use in many patients[7].
3. Timely access to expert rheumatologic care is hindered by a national workforce shortage of rheumatologists[8].

REFERENCES:

1. Infusion and Clinic-Administered Injection Therapy in Community Rheumatology Practices. Available at https://assets.contentstack.io/v3/assets/bltee37abb6b278ab2c/blt0d48cecb6daeb1c7/acr-position-statement-infusion-clinic-administered-injection-therapy-community-rheumatology-practices.pdf (accessed 12 June 2023).
2. Therapeutic Substitution. Available at https://assets.contentstack.io/v3/assets/bltee37abb6b278ab2c/blt1272c33d2efefcc5/acr-position-statement-therapeutic-substitution.pdf (accessed 12 June 2023).
3. Patient Access to Biologics. Available at https://assets.contentstack.io/v3/assets/bltee37abb6b278ab2c/bltc08fad62b94c7439/acr-position-statement-patient-access-to-biologics.pdf (accessed 12 June 2023).
4. American Medical Association Code of Medical Ethics. Available at https://www.ama-assn.org/delivering-care/ethics/patient-physician-relationships (accessed 13 September 2019).
5. American College of Rheumatology Code of Ethics. Available at https://www.rheumatology.org/Portals/0/Files/Code%20of%20Ethics.pdf (accessed 13 September 2019).
6. Key Facts about the Uninsured Population, Sept 2016, Kaiser Family Foundation. Available at http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/ (accessed 23 Jan 2017).
7. American College of Physicians. Achieving a High Performance Health Care System with Universal Access: What the United States Can Learn from Other Countries. Philadelphia: American College of Physicians; 2007: Position Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.)
8. America's Uninsured Crisis: Consequences for Health and Health Care, Institute of Medicine Report available from the National Academies Press, 500 Fifth Street, N.W., Lockbox 285, Washington, DC 20055; (800) 624-6242 or www.nap.edu.
9. Demoruelle MK and Deane KD, Treatment Strategies in Early Rheumatoid Arthritis and Prevention of Rheumatoid Arthritis, 2012, Curr Rheumatol Rep. 14(5): 472–480.
10. Harrold LR et al, Cost-Related Medication Nonadherence in Older Rheumatoid Arthritis Patients, 2013, J Rheumatol. 40(2): 10.3899/jrheum.120441.

11. 2015 Workforce Study of Rheumatology Specialists in the United States. Available at www.rheumatology.org/portals/0/files/ACR-Workforce-Study-2015.pdf (accessed 13 September 2019).

Approved by Board of Directors:
05/2000, 05/2005, 08/2009, 08/2013, 02/2017, 09/2019, 08/2023