2025 ACR Health Policy Statements

The ACR will advocate for and encourage implementing policies to improve healthcare outcomes. The ACR's advocacy will support legislative and regulatory policy initiatives to:

- Expand patient access to the care of rheumatologists and rheumatology interprofessional team members and alleviate the burden of utilization management policies on rheumatology professionals.
- Improve patient access to the most effective treatments and therapies.
- Support appropriate and sustainable reimbursement for rheumatologists and rheumatology interprofessional team members.
- Increase federal funding for rheumatology research.
- Broaden opportunities in and support the rheumatology workforce.

I. Overview and Section Summaries

i. Principles of Policymaking

Rheumatologists and rheumatology professionals deliver evidence-based care to patients. **When data and science are available, physicians and other scientists are in the best position to evaluate and interpret health data. Policymakers should work in collaboration with physicians and scientists to create health policy that is evidenced-based.**

Science and data are critical for developing effective and targeted interventions to address public health challenges and improve population and individual patient health outcomes. Scientific evidence plays a crucial role in health policymaking as it allows evidence-based insights to inform decisions about public health interventions and resource allocation. The analysis of scientific data can identify high-risk populations, as well as help to evaluate the effectiveness of past policies and approved treatments. This can ultimately help to improve health outcomes.

The ACR supports health policymaking based on scientific evidence where available.

ii. Summary of Sections

Expand Patient Access to Care by:

- Supporting adequate, affordable, and continuous health insurance for all Americans.
- Reducing the administrative burdens on healthcare providers that detract from patient care.
- Promoting efficiency and interoperability of Electronic Health Records (EHRs).
- Modifying antitrust restrictions that bar practices from collectively negotiating with insurance carriers to support the viability of small medical practices.
- Reform of Recovery Audit Contractor practices and guidelines to effectively identify fraud.
- Revisit aspects of medical liability law to reduce costs to the system of “defensive medicine” while protecting patients who have been harmed.
- Prioritizing patient care through network and formulary adequacy and effectively regulating managed care systems.
- Protecting patients from surprise billing without deterring reimbursement for care or incentivizing further narrowing of insurance provider networks.
- Expanding access to care through appropriately utilized and reimbursed telemedicine.
- Supporting initiatives that diminish racial and ethnic disparities in care delivery and clinical trials.

Remove Barriers to Patient Access to Treatment by:

- Limiting the use of specialty tiers and other methods of excessive patient cost sharing.
- Ensuring patient assistance programs work to the benefit of patients.
- Adequately reimburse providing treatments covered by Medicare Part B.

- Managing treatments under Medicare Part D without unduly burdening providers or limiting access to medications integral to the treatment of rheumatic diseases.
- Protecting vulnerable patients, like those with rheumatic disease, by supporting appropriate immunization schedules and vaccine research.
- Prioritizing patient safety with appropriate sites for treatment.
- Reducing the cost of treatments by examining the practices of stakeholders for areas that may add substantial costs to accessing prescription drugs with no benefit to patients.
- Taking steps to reduce drug shortages.
- Increasing access to biosimilar options.
- Recognizing the cost of administrating complex treatments under Medicare Part B, including the necessary time and skill needed to safely administer such treatments.
- Support the federal Comparative Effectiveness Research program.

Support Rheumatological Care in Medicare by:

- Promoting appropriate management of the Medicare Access and CHIP Reauthorization Act (MACRA) to facilitate effective care of patients by appropriately reimbursed providers.
- Reforming the Medicare Physician Fees Schedule (MPFS) to recognize the value of providing cognitive specialty care.
- Recognizing the actual cost to providers of administering osteoporosis testing (DXA).
- Reform and stabilize Medicare payments so providers can afford to treat vulnerable patients.
- Require clarity for seniors considering Medicare Advantage plans.

Funding Rheumatology Research through:

- Increased funding for research in the National Institutes of Health (NIH) including appropriate support for the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS).
- Sustained funding for National Institute of Allergy and Infectious Diseases (NIAID).
- Adequate funding for the Agency for Healthcare Research and Quality, Department of Defense, and Veterans Affairs medical research.
- Increased arthritis research funding in the Congressionally Directed Medical Research Program at the Department of Defense.
- Increased funding for the National Arthritis Action Plan and other rheumatologic-related activities of the CDC.

Preserving and Growing the Rheumatology Workforce by:

- Restricting the use of noncompete clauses to restrict the medical workforce.
- Preserving physician autonomy in treatment decisions.
- Expanding education and training opportunities for future rheumatologists and reducing their financial burden.
- Developing measures for the quality of care that are linked to meaningful clinical outcomes.
- Reducing barriers to entry to the healthcare workforce for physicians requiring visas.
- Applying adequate guardrails to expanding Private Equity investments in healthcare.

II. Expand Patient Access to Care

i. Healthcare Reform

The executive and legislative branches of the federal government continue to reform policies regarding insurance coverage. The ACR is concerned that reducing subsidies for health insurance, withholding cost-sharing reductions, and the repeal of the mandate that individuals maintain health insurance, could raise the costs of care, and reduce patients' ability to afford/access health insurance and therefore medical care.

The ACR Supports:

- Ensuring the availability of sufficient, affordable, and continuous insurance coverage that makes high-quality healthcare accessible for all Americans.
- Maintaining affordable health insurance premiums, deductibles, and cost-sharing, including ongoing support for cost-sharing subsidies.
- Prohibiting health insurance companies from excluding participants based on preexisting conditions.
- Allowing children to remain on their parent's insurance plan until age 26.
- Capping annual out-of-pocket patient costs.
- Banning lifetime limits on healthcare costs for payers.
- Refining the definition of essential health benefits and continuation of these, to guarantee patient access to robust healthcare services.

II. Expand Patient Access to Care

ii. Administrative Burdens

Administrative burdens on healthcare practitioners have dramatically increased in the past decade. The ACR is concerned about these administrative burdens coupled with rising costs to provide healthcare and the resulting uncertainty for physician practices.

While intending to improve access to and quality of care for patients, legislative mandates for electronic health records, MACRA, and prior authorization/utilization management reforms have created mounting levels of administrative burden for medical practices that reduce their bandwidth for patient care.

Physicians now spend up to twice as much time documenting and managing administrative requirements as directly caring for patients. It is counterintuitive to ask practices to become more efficient through participation in administrative activities that are time-consuming, confusing, and burdensome.

The ACR urges the reduction of administrative burdens associated with MACRA and prior authorization.

The ACR supports:

- A 90-day reporting window for all MIPS categories, especially Promoting Interoperability (formerly Advancing Care Information).
- Initiatives intended to reduce the administrative and regulatory burden imposed upon healthcare providers participating in the Medicare program.
- Allowing administrative set-up costs for advanced alternative payment models to count as the necessary financial risk, at least on an interim basis.
- Placing guardrails around Step Therapy policies including mandatory exceptions to “fail first” protocols to prioritize patient health and honor the rheumatologist/patient relationship.
- Streamlining prior authorization by:
    - Creating a universally accepted prior authorization form with the option to electronically submit.
    - “Gold card” legislation, which creates a continuous prior authorization exemption for physicians who earn an 80% approval rate on prior authorization requests for a given service over a period of six months.
    - Carrying over prior authorizations for stabilizing medications to new insurance plans.
    - Eliminating additional prior authorizations for chronic patients who are stable on a specific medication or therapy by making prior authorization approvals extend for the duration of the treatment without the need for additional or annual renewal.
    - Eliminating prior authorization for medications that do not have an equally effective alternative.

- Codifying exceptions to prior authorization requirements where these policies threaten patient health.
- Requiring timely appeals of prior authorization denials with standardized and published processes and determination timelines.
- Increasing transparency by insurance companies through the publication of formularies, specifying which medications require prior authorization and the specific related requirements.
- Requiring insurers to report the prior year's prior authorization approvals and denials along with the accompanying timelines to respond to prior authorization requests including the time from initial receipt of a prescription or prior authorization request for a medication until the treatment is received by the patient.
- Requiring peer-to-peer reviews for prior authorization to be assigned to a physician licensed in the same or similar medical specialty.

II. Expand Patient Access to Care

iii. Electronic Health Records

The transition from paper-based to electronic health records (EHR) in recent years has enhanced the ability of healthcare providers to document patient visits and services provided during the visit. When properly applied, EHR may effectuate significant improvements in access to care, patient safety, quality and efficiency of care, patient-provider communication, and care coordination among providers.

The increasingly complex EHR systems have proportionately increased the administrative burden for physicians and members of rheumatology care teams which take time away from patient care. Additionally, the implementation of these complex EHR systems is directly correlated with provider burnout, struggles with maintaining the workforce, and challenges in maintaining optimal patient care.

Many factors contribute to the inadequacies of the current EHR structure. EHR should improve efficacy and reduce redundancies in our healthcare system, but we are far from achieving those goals. The ACR supports measures designed to strengthen the impact of the EHR product provided by vendors to rheumatology providers, encourages dialogue between EHR administrators and the practices, and apply standard practices and accountability measures to ensure that the EHR provides value to patient care.

While data collection is an important task these programs can perform, the most important goal behind them should remain to improve patient care, increase efficiency, decrease errors, and improve quality of care by increasing coordination among providers and communications between patients and their healthcare teams. In this pursuit, EHR systems have inadvertently increased the administrative burdens on provider teams which has reduced the time for direct patient care with no clinically significant outcomes to show for it.

Additionally, the burden of implementing and upgrading the EHRs should not be shouldered solely by physicians. Vendors should be expected to actively participate in the implementation and troubleshooting process and should be held accountable for failures in implementing their systems.

The ACR supports:

- Minimizing administrative burdens associated with EHRs including electronic prescribing.
- The interoperability of EHRs, together with other measures to streamline information sharing for clinicians; the use of qualified registries; and the prevention of information blocking by EHR vendors.

- Developing efficient, secure, affordable, and interoperable standard-based EHR systems, with federal financial support for medical practices to defray the cost of implementation.
- Timely implementation of bidirectional EHR data exchange capabilities among different health systems and medical practices. This will improve the continuity of care and decrease medical errors.
- Requiring that EHR compliance goals be shared with vendors and that vendors share in penalties when compliance goals are not met due to technology implementation problems.
- Preventing information/data blocking regarding medical registries and the interoperability of EHR, and the provision of more credit for providers who participate in specialty clinical data registries under MIPS (such as ACR RISE registry which uses EHR to improve patient care, outcomes, and practice efficiency).
- Requiring that vendors provide a robust interface to allow communication and data sharing from one EHR to another, including EHR compatibility for a uniform electronic prior authorization process.
- Decreasing the administrative burden on clinicians and improving redundancies in these programs through collaboration between the developers and practicing clinicians.

II. **Expand Patient Access to Care**

iv. Antitrust Reform

Current antitrust regulations strengthen the position of health insurance companies while threatening the viability of physician-owned private practices. These laws restrict private practices from negotiating as a special interest group with large insurance companies, creating a barrier to collaboration and integration of clinical services which would improve quality of care, benefiting patients, providers, and payers.

Previous investigations have shown a “revolving door” between state insurance commissioners and the health insurance industry, where some commissioners were previously employed by health insurance companies or sought employment after their term. This raises the question of the ability of these government officials to effectively regulate the insurance industry.

Current policies have provided immunity from enforcement of anti-trust and anti-kickback laws when health insurance companies own and/or manage pharmacy benefit managers (PBMs), and pharmacies (including specialty pharmacies). These policies have undermined access to and survival of independent pharmacies and have led to financial arrangements that are anti-competitive and not in the best interest of patients and the public.

The ACR supports:

- Amendments to the National Labor Relations Act and other appropriate federal legislation to ease antitrust restrictions, and permit physicians’ representatives to engage in collective negotiation with private payers, to promote a more level playing field.
- Legislation for regulation of state insurance commissioners and appropriate auditing.
- Legislation and rulemaking aimed at placing guardrails around insurance company ownership of PBMs and pharmacies.
- Legislation and rulemaking to remove the “safe harbor” from the Anti-Kickback Statute (AKS) for payments from drug companies to health insurance companies and pharmacy benefit managers (PBM).

II. **Expand Patient Access to Care**

v. Reform of Recovery Audit Contractor Practices

The ACR acknowledges that we must address the billions of dollars lost each year by the Centers for Medicare and Medicaid Services due to fraud and abuse. To help recoup those losses, Congress established a recovery audit system utilizing Recovery Audit Contractors (RACs) administered by CMS. RACs are private contractors that use CMS guidelines to review claims. RACs are currently paid in direct proportion to the amount of money recovered from providers. This payment scheme is essentially bounty hunting. It is prone to abuse by overzealous contractors. The practitioner is often presumed guilty and often faces an arduous and expensive appeals process.

The ACR believes that RACs should be held accountable for reviewing claims based on CMS requirements and ensuring they identify fraudulent activities, not merely errors. They should be paid based on their performance in following these requirements, rather than being paid based on the monetary incentives they might receive.

The ACR supports reforming audit practices and guidelines to:

- Eliminate fraud and abuse and promote the appropriate use of diagnostic and therapeutic modalities for the care of rheumatology patients.
- Oppose the contingency fee system for RAC compensation. The contingency fee system encourages aggressive and potentially inappropriate tactics based on payment of a percentage of the recovered dollars.
- Incentivize RAC identification of fraud, not errors.
- Replace financial penalties with a corrective action plan.
- Shift all costs incurred by individual practitioners due to RAC audits or other billing audits unless a willful disregard for CMS billing rules is subsequently established to be borne by the auditors. This should include the costs associated with compliance with the auditors, such as printing and clerical time.

II. **Expand Patient Access to Care**

vi. Medical Liability Reform

Meaningful medical liability reform is a major step toward lowering the costs of healthcare, reducing the federal deficit, and improving patient access to quality physician care, while still providing fair compensation to patients who are truly harmed by cases of medical negligence. Research has shown that patients have greater access to physicians in areas that have instituted tort reform compared to those without such reforms. Additionally, lower malpractice risk has been shown to result in less "defensive medicine," with physicians ordering fewer invasive and expensive procedures, driving total healthcare costs down. The current system is failing injured patients, with only a small portion of funds going to the injured patient. Additionally, patient safety is negatively impacted, as fear of reporting errors leads to underreporting and limiting quality process improvement.

The ACR advocates for medical liability reform to reduce healthcare costs and preserve patients' access to care.

The ACR supports:

- Fair, timely, and equitable patient compensation for injuries caused by negligent care.
- Voluntary reporting of errors to promote quality improvement with confidentiality laws.
- Safe harbor for practicing in accordance with standard guidelines of care.
- A cap on non-economic damages.
- Standards for expert witnesses.
- A rigid statute of limitations from the day of discovery.
- The elimination of joint and several liability.
- Limits on contingency fees.
- Alternatives to traditional litigation such as arbitration and, in some cases, specialized medical liability courts.
- Establishment of state patient compensation funds.
- Establishment of state medical malpractice review panels consisting of physicians from the defendant's specialty that review malpractice claims before they may proceed to court, thus helping to discourage frivolous litigation.

II. Expand Patient Access to Care

vii. Network and Formulary Adequacy

Health insurance provider networks, including Medicare Advantage and formularies, are often overly restrictive, and unsafe, and can inappropriately limit patients' access to necessary care. Both public and private health insurance provider networks often contain incorrect or missing information, which makes it difficult for consumers to choose plans based on network adequacy.

Truthfulness in advertising health insurance plans is essential for both patients and healthcare providers. Patients expect to have access to the healthcare providers associated with the insurance plan when they initially selected which plan best met their needs. Patients should not be forced to lose or transfer care to a new provider when plans abruptly change networks and will no longer reimburse for care from the patient's previously chosen in-network provider. These changes can limit access to the already limited provider options in the geographic area accessible to the patient.

Changes in formulary components are also sometimes made outside of enrollment periods. An unexpected change could force a patient to change their treatment plan when their disease was previously well controlled on a different treatment. This disruption threatens patient health as well as trust in their care team. Payers should be restricted from changing drug formularies outside of open enrollment periods so patients and physicians can predict what treatments will be covered. An informed consumer should be able to rely on a payer's formulary for the entire year until the next open enrollment. Patients should have ready access to a payer's formulary to better inform their decision when choosing a health plan. Additionally, these formularies should be easily accessible to providers to avoid delays in provision of care when treatment plan changes are needed.

To ensure the quality of patient care, managed care systems should be regulated in a manner that ensures essential patient protection. The ACR advocates for issues affecting the quality of patient care, including managed care reform and access to care.

The ACR supports:

- Requiring insurers to set their provider networks in advance of open enrollment.
- Ensuring providers remain on a network unless the insurance company documents the cause for their removal.
- Requiring insurance provider networks to contain sufficient options and reasonable access to specialty physicians, including rheumatologists.
- Requiring insurance providers to publish their drug formularies for reference by both patients and providers
- Prohibiting overly restrictive drug formularies and creation of drug formularies solely based on financial expediency rather than a scientific basis.
- Prohibiting changes in drug formularies outside of open enrollment periods.
- Prohibiting indication-based formulary design and exclusion of protected drug classes.
- Prohibiting health insurers from incentivizing switching patients' treatments for any non-medical reason, but specifically to a payer's preferred alternative.

Further, it is the ACR's Position that:

- Patients covered by managed care plans should be provided with access via a point-of-service option, which would allow the beneficiary to seek appropriate out-of-network treatment.
- Physicians, health professionals, and patients, rather than health plans, should make determinations regarding patient treatment options.
- Patients covered by managed care plans should be provided with information on all treatment options and coverage available.
- Patients should have access to the payer's review and appeals process, including decision timelines, requirements, and peer-to-peer review processes.
- If participation between a health plan and health professional is terminated because of a change in the terms of provider participation, the covered enrollee should be notified and should be able to retain the services of the provider, paid for by the health plan.
- Rheumatologists and other sub-specialists should be allowed to act as the principal care provider to patients with the chronic conditions they are specifically trained to treat.
- To coordinate care effectively, care management service codes should be simplified and available to physicians and specialists on the care team who are primarily responsible for disease management. Management of multiple chronic diseases requires team communication and should not be limited to only one physician per individual patient.

II. **Expand Patient Access to Care**

viii. Surprise Billing

Narrow provider networks utilized by insurance companies often necessitate or lead to patients receiving some care and services from providers who are out-of-network. The ACR supported the "No Surprises Act" which went into effect in 2022 to protect patients from responsibility for costs incurred above their in-network cost for any reason including emergencies, network coverage gaps, or lack of clarity regarding their network providers.

The ACR supports protecting patients from unexpected financial liabilities and resolving any payment disputes between insurance companies and out-of-network providers instead. However, the ACR is concerned that this policy change does not address and may exacerbate the lack of adequate in-network provider options in some payers' networks by disincentivizing insurance companies to maintain adequate provider networks.

The ACR supports the following principles regarding surprise billing:

- Protect patients from additional costs and payment disputes between their insurance company and an out-of-network provider when billing at out-of-network rates was not anticipated by the patient.
- Require insurers to provide timely, upfront, commercially reasonable payment for out-of-network services and efficient implementation of the new independent dispute resolution process.
- Require insurers to provide initial payment of a commercially reasonable rate that is fair to all stakeholders in the private market, including actual local charges as determined through an independent claims database.
- Require insurers to have transparent reporting requirements of their in-network
- Ensure new imbalances are not created in the private healthcare marketplace through marketplace leverages to health insurers at the expense of providers.
- Establish strong, measurable, and enforceable network adequacy requirements. This is essential to ensure that insurers maintain adequate provider networks and do not force patients to go out-of-network to access the care that they need.
- Create balance in the system of arbitrating payments/dispute resolution of out-of-network care by ensuring that the cost of petitioning insurance companies for payment is not so high as to deter providers from pursuing reimbursement and therefore incentivizing insurers to further narrow their network of providers.

II. **Expand Patient Access to Care**

ix. Expanding Telemedicine

Telemedicine is the provision of healthcare services and education over a distance using telecommunications technology. The ACR recognizes that telemedicine is a tool that can increase access and improve outcomes for patients with rheumatic diseases when used as an adjunct to face-to-face assessments. Specifically, telemedicine can decrease financial, geographic, disability-related, and time barriers to care. Telemedicine can also reduce pollution that negatively impacts patients with rheumatic disease. The COVID-19 pandemic presented both challenges and opportunities to rheumatologists and rheumatology health professionals who have rapidly adopted telemedicine in routine practice.

Telemedicine's potential benefits in improving patients' access to care both during and after the COVID-19 pandemic necessitate careful evaluation and investment for the continuity of telemedicine in the healthcare system and its successful implementation. Also, extreme weather events can displace patients from their homes, disrupt access to roadways and other transportation, and otherwise interrupt medical care. Telemedicine can help mitigate that disruption and allow for continuity of care. Efforts by rheumatology professionals to expand telemedicine use have been hampered by many factors, including federal and interstate licensing, state regulations, and reimbursement issues.

The ACR supports:

- The use of telemedicine along with in-office evaluations, emphasizing that it should not replace essential face-to-face assessments conducted at medically appropriate intervals.
- The use of telemedicine to improve patient access and mitigate healthcare disparities through lessening geographic restrictions on telemedicine practice.
- Continued parity of reimbursement for in-office visits, audio-visual visits, and sufficient reimbursement for audio-only visits, by CMS, Medicaid, and commercial payers, after the declared COVID-19 public health emergency (PHE) has ended, if telemedicine services abide by the following principles:
    - The provider-patient relationship should include both in-person and telemedicine services in accordance with the American Medical Association (AMA) Code of Medical Ethics, specifically Ethical Practice in Telemedicine.
    - Patients should have a choice of provider for telemedicine services, as is required for all medical services.
    - The standards and scope of care provided remotely via telemedicine services should be consistent with related in-person services. The limitations of the relevant technologies should be recognized, and appropriate steps are taken to mitigate these limitations.
    - The provision of telemedicine services must be properly documented.
- Telemedicine platforms providing an efficient mechanism to obtain informed consent for the delivery of telemedicine services, including information for patients or their surrogates about the distinctive features of telemedicine, the credentials of the healthcare professionals involved, and the limitations of the technologies.
- Appropriate protocols to protect the security and integrity of patient information, while balancing the need for access to telehealth services.

- Proposals that would reduce barriers to the interstate practice of telemedicine where appropriate.
- Fee structures for hospital telemedicine support based on a transparent and fair formula.
- The promotion of outcomes-based research regarding telemedicine use in the practice of rheumatology.
- The coverage for interprofessional care via telemedicine, including occupational therapy, physical therapy, behavioral health, and pharmacy
- The allowance of prescribing medically indicated controlled substances to select patients via telehealth

The ACR opposes:

- Geographical restrictions on telemedicine practice and supports the ongoing ability of patients to access telemedicine services from their home after the PHE had ended.
- Policies that mandate the use of specified telemedicine platforms or use telemedicine as a means of constructing restrictive networks or diverting patients to their “preferred” providers.

II. Expand Patient Access to Care

x. Recognition and Research for Health Disparities

The ACR recognizes that inequality and inequity are invisible undercurrents impacting the lives of many of our members and patients. The ACR condemns all acts that cause marginalization, discrimination, or harm to any person based on race, ethnicity, age, gender identity and expression, socioeconomic status, sexual orientation, religion, or disability. Understanding the root causes and impacts these inequities have on patients and their health and finding effective solutions to lessen inequities is needed to improve access to care.

From lupus morbidity and mortality to arthritis disability, and most recently to COVID-19 burden, severity, and deaths, people of color have suffered disproportionately. Physicians and healthcare professionals are bound to protect the health of all of humanity. The ACR pledges to be a leader for inclusion and change for our members, trainees, staff, and our patients.

The ACR supports:

- Initiatives that diminish racial and ethnic disparities for patients with rheumatic diseases including care delivery and clinical trials.
- Research and government funding to identify, recognize, and reduce racial, ethnic, geographic, and socioeconomic disparities in rheumatic disease diagnosis, care delivery, and outcomes.
- Targeting funding for research and the evaluation of providers' implicit bias and develop strategies and policies to address this.
- Recognizing the central role of social determinants on health disparities and health outcomes and the mobilization of resources and research funding to better understand and address these disparities.
- Increasing funding for rheumatology research workforce diversity.

III. Remove Barriers to Patient Access to Treatment

i. Specialty Tiers and Excessive Patient Cost Sharing

Patients often face cost-based barriers to care due to policies created and implemented by insurers to shift as much of the cost as possible onto the patient. This frequently comes in the form of “specialty tiers” for prescription drugs.

Many commercial health insurance policies put vital medications (such as biologic treatments) into “specialty tiers” that require a higher patient cost-sharing. These specialty tiers (Tier IV and higher) require patients to pay “co-insurance,” a percentage of the cost of these drugs (often 25 to 33 percent or more), as opposed to a co-pay, a difference that can cost patients hundreds or even thousands of dollars per month for a single medication.

Commercial health insurance plans also use co-insurance to force patients to pay a large percentage of the cost of non-generic drugs when their total out-of-pocket spending exceeds an annual threshold.

These coinsurance practices often put medically necessary treatments financially out of the reach of the majority of American patients. Proposed changes to Medicare Part B medications threaten to create similar issues.

The ACR strongly opposes excessive patient cost-sharing in specialty cost-tiering practices by insurers.

The ACR supports:

- Restricting specialty drug tiering by insurance carriers.
- Reducing out-of-pocket treatment costs by capping total annual out-of-pocket expenditures for patients under both public and private insurers.
- Eliminating co-insurance policies that make biologic drugs unaffordable. eliminating co-insurance policies.

III. Remove Barriers to Patient Access to Treatment

ii. Patient Assistance Programs

Biologics, cancer immunotherapies, and curative antivirals, have been recognized as revolutionary treatments for patients with a compendium of rheumatic diseases such as rheumatoid arthritis, systemic lupus erythematosus, juvenile arthritis, vasculitis, and inflammatory muscle diseases, among others.

For patients on Medicare, the expense of utilizing these treatments can quickly escalate, rapidly exceeding the cost that Medicare Part D will cover, but not reaching the range of catastrophic coverage in place for Part D. Similar issues regarding high out-of-pocket costs also occur for patients with commercial insurance policies. As a result, many patients must forego life-altering treatments solely because of the expense to the patient. Ideally, the ACR would like for the cost of drugs to be reduced and for Medicare and other insurance policies to simply cover the cost of these essential treatments for chronic, non-curable diseases. However, in the absence of this type of solution, the ACR supports an alternative approach.

Patient Assistance Programs sponsored by pharmaceutical manufacturers provide access to critical treatments for patients who otherwise would not be able to afford such treatments. This is merely a band-aid approach and is a suboptimal way to address the high costs of therapies. While helpful in the short term, the ACR acknowledges concerns about these programs. When insulating patients from medication costs, these programs distort demand for lower-cost therapies and lead to increases in drug list prices. This problem is likely to become more pronounced in the coming years. Until more holistic measures can be implemented to reduce the cost of these treatments, patient assistance programs are needed and helpful but should be paired with measures that will spur a reduction in drug list prices to facilitate necessary change in the long term.

Both commercial payers and Medicare Part D restrict Patient Assistance Programs. Some commercial insurance carriers, for example, do not apply patient assistance program contributions towards patients' deductibles or out-of-pocket maximums (so-called "copay accumulator programs"). This essentially requires that a patient pay twice for drug costs: once with an assistance program and again with their own money. This creates an additional financial barrier to treatment.

The result is that many patients are faced with unexpected and unaffordable costs of thousands of dollars to get the medicines they need. 95% of medicines that are subject to programs like these do not have a less expensive alternative and 69% of those who depend on such assistance make less than $40,000 a year, leaving them at risk of losing access to necessary healthcare. Therefore, ACR takes the position that all payments, whether they come directly out of a patient's pocket or from the help of copay assistance, should count towards the out-of-pocket cost calculations and deductibles of the patient, thereby removing a hurdle to access to prescribed treatments.

Among those with Medicare Part D coverage, access to any assistance programs is highly restricted. Drug companies currently may not offer direct support to Medicare Part D patients because of certain anti-kickback laws. While some companies have responded by supporting charitable foundations that provide financial assistance, patients have difficulty receiving help if they do not qualify or if the foundations' resources have been expended. The unintended

consequence is that patients are forced off effective disease-modifying therapy when they become a Medicare Part D beneficiary because they can no longer afford their medications

The ACR supports:

- Increasing access to patient assistance programs for Medicare Part D beneficiaries if Medicare does not fully cover the cost of essential treatments - Patients should not be denied newly developed therapies such as biologics solely because of their cost and insurance provider.
- Allowing beneficiaries to accept financial co-pay assistance for specialty cost-tier drugs from pharmaceutical companies for Part B and Part D drugs.
- Legislation to reduce barriers to treatment for patients by requiring health plans to count the value of copay assistance toward a patient plan's cost-sharing requirements and deductibles. This would ensure that all payments for prescription medications, whether they come directly out of a patient's pocket or from the help of copay assistance, count towards their out-of-pocket cost calculations.

The ACR opposes:

- Restrictions preventing the application of funds from assistance programs toward patients' deductibles and out-of-pocket maximum payments.

III. Remove Barriers to Patient Access to Treatment

iii. Access to Treatment under Medicare Part B

The ACR supports adequate reimbursement for providers of Part B drugs to maintain patient access to these treatments by covering the cost of providing them incurred by a specialty care team. These costs include drug acquisition, inventory maintenance, scheduling treatments, information technology, patient privacy protection, acquiring prior authorization (PA), appropriate storage of the medication, billing, and safe administration of these complex drugs. Multiple current and proposed policy changes threaten Medicare beneficiaries' access to Part B drug treatments by reducing reimbursement for treatment without reducing the cost of acquiring and providing the treatment. For example, CMS's decision to include the costs of Part B drugs when calculating the cost component of MIPS scores is likely to reduce patient access in this manner. It is not clear how those costs will be attributed to specific physicians or groups, and whether or how Medicare will track Part D drug costs. If Part B drug costs are included in cost calculations, but Part D drug costs are not included, physicians may be penalized for providing medically necessary Part B drug treatments to their patients, especially when the Part B drug does not have a Part D corollary.

Unfortunately, due to a lack of appropriate reimbursement for the specialized care that rheumatologists provide, practices rely on income from Part B treatments. As such, the ACR is concerned that the variety of threats to reimbursement for physicians who provide Part B drugs to patients threatens the viability of rheumatology practices in the U.S., especially when Medicare reimbursement for outpatient services has decreased annually, placing provider solvency and patient access to care at significant risk. As a result, many rheumatologists may be forced to cease providing these treatments because the payment rate does not cover actual cumulative costs.

With limited access to in-office treatments, patients will be forced to seek treatment in hospitals where their physicians will not have direct supervision, as they would in the office setting, to monitor for adverse events including allergic reactions, they face higher copayments, facility fees, and often longer travel times. This unnecessarily increases healthcare costs and burdens on patients and the healthcare system. When the patient is forced to make a separate trip after seeing their provider to receive a medication infusion it puts an increased physical, financial, and logistical burden on the patient who is likely struggling with pain and inflammation as this set-up requires additional travel, time away from work and family, and any parking fees or tolls.

The ACR supports adherence to the ASP + 6% reimbursement rate for in-office treatments as well as these policies to maintain patient access to treatments:

- Repealing sequester cuts to Medicare including the cuts to Part B drug reimbursements.
- Removing prompt pay discounts between drug manufacturers and distributors, which artificially reduces drug reimbursement rates to physician practices, from the reimbursement formula for administering in-office drugs under Medicare Part B.
- If Medicare changes reimbursement to a flat fee system, then that fee must cover all the services required to maintain access to treatments as noted above. Also, this flat fee must increase annually with inflation in accordance with the Medicare Economic Index (MEI).

- Protecting Medicare patients' ability to receive administered biologic agents in a monitored healthcare setting with onsite supervision by a provider with appropriate training in biologic infusions, preferably in the same location as the prescriber.
- Excluding Part B drug costs from the cost component of MIPS score calculations. If drug costs are to be included, the ACR cannot support including Part B drug costs without also including Part D drug costs.

III. Remove Barriers to Patient Access to Treatment

iv. Access to Treatment under Medicare Part D

The inception of the Medicare Part D program has greatly increased Medicare beneficiaries' access to medication by providing drug coverage. However, some aspects of the program are burdensome to providers, while others limit access to medications integral to the treatment of rheumatic diseases.

The ACR supports:

- Medicare negotiating with pharmaceutical companies to achieve more affordable pricing of drugs covered under Part D.
- Treating physicians deciding with a patient on the most appropriate, efficacious, and cost-effective therapy without Part D benefits influencing the choice of therapy.
- The $2000 annual cap on out-of-pocket costs introduced in the 2025 Medicare Pharmacy Payment Plan and additional options for capped monthly payments to allow beneficiaries to spread those out-of-pocket costs across the calendar year.
- Patient assistance programs for Medicare beneficiaries for Part D drugs.
- Where MIPS formulas impact providers, the most equitable formula would not include drug costs. Omitting or including both Part B and Part D drugs in the MIPS formula to ensure that providers who prescribe Part B drugs are not penalized or do not look "costlier" than those who mostly prescribe Part D drugs.

III. Remove Barriers to Patient Access to Treatment

v. Immunizations and Vaccinations

People with rheumatic diseases are more susceptible to debilitating illness or death from infections. This occurs as their underlying disease and the immunosuppressive medications used to treat them make infection more dangerous and vaccination potentially less effective. Adults and children with rheumatic disease represent a vulnerable population who receive protection against infection not only from their own response to vaccination, but from the immunity of the surrounding population.

The ACR supports the rigorous scientific process of the CDC's Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the U.S. population as a means of protecting vulnerable patients with rheumatic diseases.

The ACR also supports a rigorous scientific approach to vaccine research that enables the timely development and approval of vaccines directed towards existing or emerging infections.

III. Remove Barriers to Patient Access to Treatment

vi. Prioritizing Patient Safety

All classes of biologics used in autoimmune diseases have the potential to cause serious adverse medical events. Serious infections affect 2-5% of patients per year of exposure and adverse drug reactions associated with biologics occur in up to 30% of patients in clinical trials.

It is ACR's position that experienced providers, available on-site, are most capable of deciding whether it is safe to continue therapy in the setting of mild reactions and providing prompt treatment for moderate or severe reactions. Any financial considerations related to potential cost savings of home infusions should not override patient safety and standards of care.

This includes limiting payer-mandated "white bagging" drug acquisition systems where patients are required to purchase medications through specialty pharmacies that are owned by the PBM or insurer, thus allowing PBMs to make a large profit on the rebates they demand from drug manufacturers. This drives drug prices higher and has the potential to cause disruptions in care by adding a layer of red tape and financial burden to the patient. Additionally, hospitals and infusions centers are unable to perform their own quality control measures on the medications which could present risk to patients.

Some PBMs require or incentivize the use of specific pharmacies, often mail-order pharmacies owned by the PBMs. When receiving medications from these mail-order pharmacies, deliveries may be left on unsecured doorsteps at unregulated temperatures for medications that require cold-chain continuity. Additionally, major weather events can cause lengthy delays for medication shipments, significantly increasing the risk of a flare that worsens a patient's condition. Allowing patients to choose their own pharmacy is necessary for streamlining care and helping to prevent delays in treatment.

The ACR Supports:

- Proper administration of biologic infusions taking place under close supervision in a provider's office, infusion center, or hospital rather than in a patient's home, unless the patient and provider decide that home infusion is in the patient's best interest.
- Policies or pilot programs that reduce the price and cost of drugs while maintaining safe patient access to medically necessary treatment and ensuring the provider's ability to administer and dispense treatments.
- Patient access to safe and cost-effective intravenous infusion therapy.
- Measures to preserve the long-term viability of and accessibility of patient access to infusion therapy in a variety of settings including infusion centers overseen by their private rheumatology provider.
- The traditional "buy and bill" model which over time reduces the cost of drugs, offers many benefits to patients and practices, allows for immediate availability of drugs, less waste to the system, safer handling and storage of drugs, and substantially reduced administrative burden.
- Equality in payment for identical intravenous therapy.
- Policies or pilot programs that reduce the cost of drugs to patients and the system while maintaining access to medically necessary treatment and ensuring providers' ability to

administer and dispense treatments including limiting payer-mandated “white bagging” drug acquisition systems.

- Allowing patients to choose the pharmacy from which they receive all of their medications, particularly specialty medications.

The ACR opposes:

- “Brown bagging”, “white bagging” and or other similar attempts to limit access to infusion drugs.
- Policies that mandate home infusion over allowing patients and providers to choose the safest site of care

III. Remove Barriers to Patient Access to Treatment

vii. Drug Pricing

The ACR believes that safe and effective treatments should be accessible to all patients at the lowest possible cost. Recent federal proposals to curb spending have included multifaceted approaches such as Medicare using its authority to negotiate lower drug prices and regulating additional utilization management (e.g., step therapy) by insurance plans. Also, payment models have moved towards holding physicians accountable for the cost of the care they provide, though physicians have little control over rising drug costs. The ACR supports shared decision-making between patients and providers and that decreases barriers to patients accessing treatment.

Pharmacy benefits managers (PBMs) are companies that manage prescription drug programs and formularies on behalf of health insurers, Medicare Part D drug plans, large employers, and other payers. These companies are projected to make $740 billion by 2029 in the medical treatments business with no treatment to patients by:

- acting intermediaries between insurers, drugmakers and pharmacies.
- Setting patient copayment amounts and determining which drugs are covered by which insurers; and
- Negotiating discounts and rebated from drugmakers in exchange for preferred placement of drugs on insurers' formularies.

PBMs profit from:

- Rebates, or money that a drugmaker agrees to pay them each time a prescription for a drug is filled, which is calculated as a percentage of a drug's list price; and
- Spread pricing, or the difference between what the PBM charges the insurer for medication and the amount it reimburses the pharmacy for same treatment when it dispenses it to the patient.

Due to this, they are incentivized to favor coverage of medicines whose distribution provides PBMs with higher rebates, fees, spread pricing, and other profits. ACR stands by a practitioner's need for drug formularies to reflect evidence-based guidelines and clinical data, rather than profits derived from the drug distribution system. Federal Trade Commission has brought actions against some of the large PBMs and their affiliated group purchasing organizations (GPOs) for engaging in anticompetitive practices that have artificially inflated the list price of insulin drugs. Similar concerns pertain to access to biologics and related drugs needed by our patients.

The ACR supports policies that:

- Require pharmacy benefit managers to disclose rebates, fees, and other discounts received, including what percentage was passed on to the patient, pharmacy, and insurance company.
- Delink PBM profits from negotiated drug prices.
- Require any rebates negotiated by PBMs to pass through to patients or payers to offset patient costs.

- Establish uniform definitions for terms used in disclosures by specifying what constitutes a rebate, discount, fee, and amount received from a manufacturer.
- Enforcement of fair pricing practices by the FTC for PBMs for biologics and related disease modifying medications.
- Provide patients with reliable access to high-quality treatments to control disease activity as well as prevent premature death, disability, and permanent damage to joints and organ systems.
- Reduce and streamline utilization management tools in the drug distribution process, including Medicare Part D, which delay and/or prevent patients from accessing medicines.
- Provide transparent processes for justifiable overrides and a reasonable timeframe for the processes by a physician or rheumatology interprofessional team member for step therapy policies.
- Ensure patients' safe access to Medicare Part B treatments in monitored settings. Intravenous biologic agents should be administered in a monitored healthcare setting with onsite supervision by a provider with appropriate training in biologic infusions. The ACR opposes forced relocation of infusion to patient homes or other sites not directly supervised by a licensed provider.
- Promote the use of evidence-based treatment guidelines, when available, adapted for individualized treatment decisions made by doctors and patients.
- Improve FDA capacity and manufacturer ability to bring safe, effective biosimilars to market to maximize access to treatment by lowering costs.
- Ensure all stakeholders, including pharmaceutical manufacturers, insurers, health IT vendors, and device manufacturers, share the burden of controlling healthcare costs.
- Limit or cap out-of-pocket prescription drug costs for patients,
- Promote transparency in drug pricing, including reporting of:
    - Formulas that pharmaceutical companies, pharmacy benefit managers, and health insurance companies apply to determine the cost of prescription medication.
    - Incentives given by drug companies to pharmacy benefit managers or health insurance companies related to the dispensing or promotion of their manufactured drugs.
- Oppose restrictive insurance company rules that prevent the application of copay assistance funds toward patient deductibles and out-of-pocket maximum limits (so-called copay accumulator programs).
- Reduce the cost of prescription drug treatments to patients and the healthcare system without threatening access to care by targeting provider payments without also reducing the cost of providing the treatment to providers.

III. Remove Barriers to Patient Access to Treatment

vii. Drug Shortages

The ACR supports policies to address the causes of drug shortages and reduce their negative impact on patients and physicians.

Several drugs prescribed by rheumatologists have experienced shortages in recent years resulting in treatment disruptions for patients. These shortages can cause rheumatology patients to experience disease progression including additional pain and immobility, relapses of life-threatening diseases, and add to suffering and disability.

The ACR is concerned that there is a lack of timely communication to physicians and the public of impending drug shortages.

The ACR Supports:

- Addressing the causes of drug shortages and reducing their impact on patients and physicians.
- Efforts of the FDA to minimize drug shortages.
- The creation of redundancy in the drug supply chain for critical drugs, including generics and intravenous fluids, by providing incentives to manufacturers to produce these drugs.
- FDA policies to further broaden reporting rules to ensure that manufacturers provide early warning of disruptions in the supply of a drug.

III. Remove Barriers to Patient Access to Treatment

ix. Biosimilars

Biosimilars are medicines that could be cost-saving alternatives for the specialty drugs called biologics, which are large, complex therapeutic agents given by injection or infusion. The relationship between biosimilars and biologics (at the regulatory but not biochemical level) is akin to the relationship between generic and brand-name medicines; however, biosimilars are not generic copies of the reference drug. Due to the complexity of biologics used in rheumatoid arthritis and other autoimmune diseases, separate regulatory approval and dispensing pathways were created to ensure effectiveness and protect patient safety.

Congress authorized the FDA to provide two pathways for biosimilar approval: 1) biosimilar agents that have equivalent safety, purity, and potency as original biologics; and 2) a higher level of interchangeable biosimilars in which alternating or switching between an original biologic and biosimilar would not be predicted to cause any changes in efficacy or safety. The ACR strongly supports the rigorous pathway for interchangeability approved by the FDA in 2019. The FDA must ensure that biosimilars and interchangeable biosimilars are safe and effective.

The ACR recognizes increasing cost pressures may cause payers to push patients toward biosimilars. This is most appropriate when there is data available. In the absence of data, payers should provide transparent guardrails around “non-medical switching” which allow the patient and provider to choose the best treatment for that patient with tenuous disease control. For patients with stable disease, transition to a biosimilar product may be reasonable if cost savings are available, although we remain concerned that pharmacy benefit managers’ (PBM) lack of pricing and rebate transparency leaves formulary decisions opaque. The decision to change therapy from a reference product to a biosimilar should be made jointly between the patient and the physician and non-medical switching should not be forced on stable patients.

Federal and state/local regulations must ensure appropriate dispensing and monitoring, including regulation that prevents the rebate-based pharmacy benefits management system from excluding lower-cost biosimilars. Payers and pharmacy benefit managers must ensure that biosimilars improve patients’ access to biologic treatments and that the financial savings are passed along to patients.

The ACR strongly believes that safe and effective treatments should be available to patients at the lowest possible cost. Decisions regarding the approval and use of biosimilars must be driven by sound science and consider several guiding principles, including:

- Appropriately reimburse all biologics approved for rheumatic conditions with recognition of the complexity of administration, monitoring, coding, and reimbursement...
- When starting new biologic therapy, clinicians consider a variety of patient-specific factors which include the severity of the illness, the most appropriate route of administration, and mechanism of action. Should the appropriate medication have a biosimilar option, the ACR supports initial biosimilar use. However, if the most

appropriate biologic does not have a biosimilar option, it should be approved by the patient's insurer and not be switched to a different biologic class.

- In patients on established therapy, the final decision to switch from a reference product to a biosimilar should rest with the prescriber and the patient. The ACR opposes insurer-mandated forced switching to biosimilars and is concerned over frequent non-medical switching with biosimilars. In jurisdictions where substitution by someone other than the prescribing provider is lawful, the prescribing provider and the patient should be notified immediately when a substitution is made.
- If a patient does not have adequate efficacy or has adverse effects to a biosimilar, the reference product (originator drug) should be authorized by the health plan even if it is not on the health plan formulary.

III. Remove Barriers to Patient Access to Treatment

x. Administration of Complex Treatments under Medicare Part B

Biologic medications are vital in preventing disability and death in inflammatory arthritis and systemic autoimmune diseases. Early aggressive therapy with a range of drugs, including biologics, has been shown to reduce joint damage, deformities and improve function which can reduce work absenteeism, disability, death, costly procedures/surgeries and hospitalizations. In recent years, a growing number of contractors have stopped reimbursing for these treatments at the appropriate higher “complex” rates without regard for the necessary time and skill needed to safely administer such treatments.

Biologics are far more complicated at the molecular level than traditional chemically synthesized pharmaceuticals. They are much larger molecules than other classes of pharmaceuticals with an average molecular mass 1000 times greater than aspirin. Their size and biologic properties preclude oral administration, a fact which complicates storage and delivery to patients. The stability, efficacy and tolerability of the drugs necessitates great care in the proper delivery and administration of the drug with respect to temperature, mechanical agitation and proper reconstitution. Biologics also carry the risk of serious adverse events with drug reactions being common at the time of infusion which required the appropriate training and oversight of staff giving the medication. Similar to chemotherapy agents administered in oncology, biologics carry high potential toxicity, and supervising practitioners must assure the purity of the biologic materials they administer and be sure that the medication has not been compromised.

The ACR strongly supports the use of biologics in the treatment of rheumatic disease when indicated. Administering biologics for rheumatic diseases requires advanced training and necessitates special handling of medications as well as increased monitoring for patient safety. Patient access to biologic treatment should not be threatened based on the region in which they live or the contractor that covers their treatments. The ACR urges a national policy requiring that payments for the administration of Part B drugs that fall within the ‘biologic’ class of drugs be appropriately reimbursed as complex which is reimbursed at a rate commensurate with the experience needed to provide these drugs safely, rather than simple code, which is used in the administration of normal saline.

The ACR supports:

- Reimbursement of biologic infusions in accordance with CPT coding, as biologics for rheumatic diseases require advanced training by healthcare professionals to administer and necessitate special handling, storage, and increased monitoring for patient safety.
- Enforcement of transparency requirements for Medicare contractors in regards to reimbursement for complex treatments
- Efforts by Congress to ensure seniors have access to medically necessary biologics by supporting appropriate reimbursement

III. Remove Barriers to Patient Access to Treatment

xi. Comparative Effectiveness Research

Comparative Effectiveness Research (CER) efforts were established by the Affordable Care Act to evaluate the safety, efficacy, and cost of a given medical treatment, care delivery intervention, or service relative to other treatments for the same condition. High-quality CER and cost-effectiveness analyses (CEA) can and should inform the individual provider and patient decisions about the relative value of diagnostic and therapeutic options.

Indeed, CER has the potential to enhance understanding of the pros and cons of different treatments, as well as highlight the need for multiple treatment options to address heterogeneous groups of patients. However, CER and CEA results must not be misconstrued or inappropriately applied to individual patients via inflexible insurer policies designed to control costs, thereby overriding medically appropriate, individualized decision-making by providers and patients.

The ACR supports:

- CER should be applied to common problems that impact rheumatology patients and providers. The ACR advocates that federal funding of CER research (such as the Patient-Centered Outcomes Research Institute (PCORI), the Agency for Healthcare Research and Quality (AHRQ), and the National Institutes of Health, etc.) should target rheumatic and musculoskeletal diseases with requests for applications from rheumatology researchers.
- The collection of anonymized patient data in registries such as RISE (Rheumatology Informatics System for Effectiveness), which can serve as powerful databases for CER if they are robustly populated with sufficient patient data.
- Ongoing funding of CER initiatives to follow up the initial $1.1 billion investment made in 2009 through the American Recovery and Reinvestment Act (ARRA), understanding that groups such as PCORI and AHRQ are subject to ongoing funding allocation and perennially at risk of underfunding.
- Ongoing transparency regarding oversight of the distribution of CER funds and communication of results.
- Collaboration between the FDA and drug manufacturers to increase the collection of CER data for inclusion in drug labeling.

IV. Supporting Rheumatological Care in Medicare

i. Medicare Payment Reform Under MACRA

In April 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) eliminated the Medicare payment system based on the Sustainable Growth Rate formula and implemented a transition period intended to incentivize payments based on value. 2025 is the ninth year of the Merit-Based Incentive Payment System (MIPS), which scores providers based on (i) Quality (based on PQRS), (ii) Promoting Interoperability (formerly Advancing Care Information, and based on Meaningful Use), (iii) Clinical Practice Improvement, and (iv) Cost. Providers' performance on MIPS measures will provoke payment adjustments, in the form of bonuses or penalties two years after the reporting year unless providers join an Alternative Payment Model (APM).

In 2018, CMS implemented the resource use, or cost, category as a component of MIPS scoring. This is concerning as Part B drug costs are included in the cost component and count toward a practitioner's score, though Part D drug costs are not included. Under this system, rheumatologists may be penalized for providing medically necessary Part B drug treatments to their patients. The ACR supports new cost measures that are developed and integrated in a way that accurately reflects the complexities of cost measurement and does not inadvertently discourage clinicians from caring for high-risk and medically complex patients. This will safeguard practitioners, especially specialists like Rheumatologists, where there is a higher use of necessary and effective yet expensive medications, like biologics.

Overall, the MACRA framework forces providers to choose between the uncertainty and financial risk of joining an APM and the possibility of overwhelming financial burdens from the MIPS system. A third option, the MIPS Value Pathway (MVP) has been instituted to help ease providers, especially the smaller groups and solo practitioners, from MIPS to APMs and began implementation in 2023. The initial reporting period is through 2025 and in 2026 multispecialty groups will be required to form subgroups. These three programs must allow for meaningful and streamlined quality measurement without placing an unnecessary burden on the provider. Practices may see fewer Medicare patients or opt out of Medicare altogether if they are not able to succeed under these programs. Patients could be left with longer wait times and travel distances or increased out-of-pocket costs.

Flexibility in the design of the MIPS and future MVPs and simplicity in implementation should drive the refinement of these programs. Participation in APMs would be improved by lowering payment amount and patient count thresholds required to achieve qualifying participant status in an advanced APM and by minimizing initial risks to which providers are exposed. Appropriate data and measurements should be used to develop these programs to ensure there are no biases against certain patients and their physicians.

The ACR Supports:

- Appropriate management of MACRA and protecting access to rheumatologists and rheumatology interprofessional team members in these ways:
    - Use of metrics that are clinically relevant, efficient, and promote quality of rheumatologic care in the components of the Merit-Based Incentive Payment System (MIPS) and implementation of MIPS Values Pathways (MVPs).
    - Creating and giving proper accreditation to a variety of Alternative Payment Models and demonstration projects that recognize the value of care provided by rheumatologists and rheumatology interprofessional team members.
    - Counting participation in a Qualified Clinical Data Registry such as RISE toward MIPS participation under MACRA.
    - Transparency in MIPS, MVPs, and APMs, allowing practicing physicians to easily understand and implement these programs.
    - Improving transparency and accountability of the processes by which Medicare Administrative Contractors implement Local Coverage Determinations and ensure provider input on all new or revised policies.
- Maintaining the revised relative value unit (RVUs) for evaluation and management codes that reflect the work and medical decision-making required by cognitive subspecialists.
- Maintaining appropriate reimbursement conversion factor for the work RVU's so that the change in the wRVU yields appropriate reimbursement to physicians as intended.
- Excluding Part B drug costs from the cost component of MIPS score calculations. If drug costs are to be included, the ACR cannot support including Part B drug costs without also including Part D drug costs.
- Congressional action to control excessive drug price increases.
- Simplifying the MIPS and MVPs program through reduced reporting requirements and flexibility to account for practice variation.
- Continuing a minimum 90-day reporting period for MIPS domains of Promoting Interoperability and Improvement Activities.
- Ensuring that providers who participate in a Qualified Clinical Data Registry (QCDR), such as RISE, can maximize credit in MIPS for doing so.
- Ensuring providers will be informed of performance outcomes in real time to enable them to make changes before the next performance period.
- Minimizing barriers to forming virtual groups to report performance.

Development of APMs that place adequate value on rheumatology care and are feasible for small practices such as the ACR rheumatoid arthritis APM.

- Lower the payment amount and patient count thresholds required to achieve qualifying participant status in an advanced APM and minimize initial risks to which providers are exposed to encourage smaller practices, many of which are in under-served areas, to participate in APMs.
- Policy encouraging smaller practices to participate in APMs by lowering the payment amount and patient count thresholds required to achieve qualifying participant status in an advanced APM, and by minimizing initial risks to which providers are exposed.
- Policy ensuring new payment models include only those quality measures that are meaningful to patients and simple for providers to implement.
- Implementing efficient evidence-based performance measures that improve the quality of care and promote fair reimbursement for work done by rheumatologists and rheumatology interpersonal team members in collecting and reporting administrative data.

IV. Supporting Rheumatological Care in Medicare

ii. Cognitive Specialty Reimbursement

Rheumatic diseases require specialized management by a rheumatologist who has completed substantial additional training to diagnose and treat these complex diseases with the necessary expertise. Through early identification and treatment of these conditions, rheumatologists and their interprofessional team members can effectively care for patients, while limiting the need for unnecessary or costly testing and procedures. This protects patients from disability, increasing quality of life and decreasing the cost to the healthcare system.

Cognitive care like rheumatology involves face-to-face, non-procedural medical care in which physician specialists examine and counsel patients as they evaluate and manage the patient's conditions. Primary care physicians, rheumatologists, and other cognitive specialists provide ongoing care to patients and primarily bill evaluation and management (E/M) codes. Annual reductions to reimbursement for these services despite record rates of inflation is driving rheumatology practices to sell to larger entities or shutter completely as the cost to render care is higher than the reimbursement from Medicare.

The Physician Fee Schedule changes finalized by CMS in 2020, which took effect in 2021 increased reimbursement for E/M codes, reflecting the specialized knowledge, physical exam skills, and expert medical decision-making that are required to provide rheumatologic care. This increase also takes into consideration the extra time required to assess and treat these complex diseases.

ACR advocated for the implementation of the G2211 code, an additional code which more appropriately captures the costs providers pay to deliver ongoing care to patients living with single, serious, or complex chronic diseases like rheumatic and musculoskeletal conditions. After a three-year delay as part of coronavirus-related legislation to ensure all specialties do not suffer negative E/M reimbursements in 2021, the G2211 code was implemented on January 1, 2024.

The ACR supports:

- Increasing reimbursement for cognitive care services commensurate with specialized care.
- Repealing the balanced budget requirement for the physician fee schedule.
- Appropriately valuing evaluation and management codes and other measures in the Medicare physician fee schedule (MPFS).
- Fighting cuts to the Medicare program and returning to previous funding/payment percentages.
- Repeal the sequester cuts to the MPFS.
- Maintaining the E/M improvements for care provided by cognitive subspecialists that took effect in 2021 and 2024.
- Avoiding or mitigating cuts to reimbursements for services provided by any member of the rheumatology care team under Medicare, including but not limited to rheumatologists, physical therapists, physician assistants, nurse practitioners, and occupational therapists.

- Continuing the work between the ACR and the AMA CPT Editorial Panel to create new codes that accurately reflect the time and expertise of cognitive specialists who primarily provide E/M services.
- CMS research to achieve a comprehensive understanding of cognitive physician roles to inform changes in payment models for E/M services.
- Advocating the importance of the updated E/M codes for cognitive specialties, the changes to their Medicare reimbursements as a result, and the benefit to appropriately valuing cognitive specialty teams in their employ.
- Passing legislation that would update all reimbursements under the Medicare Physician Fee Schedule annually in accordance with the Medicare Economic Index (MEI).

IV. Supporting Rheumatological Care in Medicare

iii. Osteoporosis Testing (DXA)

Appropriate reimbursement is essential to preserving patients' access to critical tests such as dual x-ray absorptiometry (DXA) testing of bone density which is considered the "gold standard" for diagnosing osteoporosis. Osteoporosis is a silent disease that often is not discovered until a fracture occurs. One out of two women and up to one in four men will suffer an osteoporotic fracture in their lifetimes. Further, the cost of osteoporosis and related fractures was projected in 2023 to increase to more than $25 billion by 2025.

Bone density assessment via DXA can identify those at high fracture risk who may benefit from treatment. However, the reduction in reimbursement below the cost necessary to provide the test limits patient access to DXA. The reduction in DXA reimbursement has impacted office-based more than hospital-based DXA which prevents many offices from providing this service to their patients. Consequently, fewer office-based practices offer this screening service, leading to a decrease in treatment and a rise in fractures and costs to the healthcare system overall.

Preserving patient access to DXA testing will help to restrain unnecessary costs to Medicare, Medicaid, and the private sector by permitting access to fracture prevention services and reducing hospitalization and other costly fracture-related expenditures such as long-term nursing care. The mortality rate after a hip fracture in a person over 65 years old reaches 25%. Improving access results in early treatment and decreases mortality.

The ACR supports appropriate reimbursement for preventive osteoporosis screenings (DXA).

- The ACR supports legislation that would increase DXA reimbursement rates to reflect the actual cost of providing this test for patients who are at risk for osteoporosis.
- To close the care gap for osteoporosis patients, the ACR supports hospital funding for fracture liaison services to identify those at the highest risk of subsequent fracture for intervention.

IV. Supporting Rheumatological Care in Medicare

iv. Additional Medicare Reforms

ACR opposes the following Medicare reforms:

- Use of step therapy in Part B drug distribution to protect patient access to appropriate treatment and minimize overhead inefficiencies on the part of providers.
- "User fee" tax on healthcare providers for participation in the Medicare and Medicaid program.

Additionally, the ACR supports the following Medicare reforms:

- Modernizing the Stark laws against physician self-referral to align new healthcare delivery models with value-based and shared risk reimbursement models.
- Allowing the Congressional Budget Office to use dynamic scoring/longer time frames for scoring healthcare legislation so that CBO scores accurately reflect cost savings over time.
- Improving the transparency and accountability of the processes by which Medicare Administrative Contractors implement Local Coverage Determinations and ensure provider input on all new or revised policies.
- Increased transparency of Medicare formularies and evidence-based decisions made with input from specialty-trained providers.
- Easing access to medical directors and more timely resolution of patient care issues including prior authorizations.
- Measures to prevent financial distress and ensure provider solvency during public health crises to ensure patient access to care.
- Recognizing the actual cost to providers of administering safe and effective patient care.
- Updating the Medicare Physician Fee Schedule for inflation in accordance with the Medical Economic Index (MEI) annually.

IV. Supporting Rheumatological Care in Medicare

v. Clarity Around Medicare Advantage

Medicare Advantage (MA) plans are private health plans offering Medicare-covered benefits for a premium and often additional copayments and coinsurance in exchange for restricted provider networks, referral requirements for specialty care, prior authorization requirements, and limited access to office-administered medications covered under Medicare Part D. Unfortunately, most patients are unclear about these restrictions or the value of the MA plan due to the lack of transparency in marketing around these products. Multi-million-dollar marketing campaigns target seniors promising comprehensive coverage without identifying the trade-offs. Insurance agents, often incentivized with commissions, aggressively push new enrollments and persuade Medicare beneficiaries to switch to MA plans. While switching to an MA plan is easy, the process to return to Traditional Medicare is much more difficult, further complicating seniors' access to the care they need.

One of the most misleading aspects of MA plan marketing is the framing of coverage. Patients are told they will receive Medicare Part A, Part B, and Part C, without clear explanation that Part C is another name for Medicare Advantage. This framing obscures the trade-offs involved, leaving many seniors unaware of the restrictions and additional hurdles they will face when accessing their care under an MA plan. A growing concern is the impact of MA plans on seniors' access to medications. Many patients who previously had coverage for office-administered medications, like those frequently used to treat rheumatic disease, under Traditional Medicare, find themselves losing this critical benefit after switching to MA plans. These patients are often forced to rely on charitable foundations or free medication programs, creating unnecessary stress and barriers to essential treatments.

The lack of transparency around these limitations is not only confusing but detrimental to the health of many seniors. It is imperative that patients understand the potential consequences of switching to MA plans, particularly the loss of flexibility, access to care, and consistent coverage for necessary treatments. Transparency and patient education must be prioritized to ensure individuals can make informed decisions about their healthcare.

ACR encourages policymakers to ensure that Medicare Advantage Organizations use reasonable processes to approve or define care options for our patients. These decisions cannot be made solely on the basis of cost as our patients are complex, often have multiple chronic conditions, and deserve the best and most effective possible care.

ACR supports:

- Increased patient education about plan differences between MA plans and Traditional Medicare so that they can fully understand what benefits they may gain as well as what coverages they may lose such as provider network and medication therapies
- Medicare Advantage plan transparency regarding provider networks and drug formulary coverages for patients to reference

- Delinking insurance broker and agent commissions or profits from the sale of MA plans.
- CMS streamlining the use of prior authorization by MA plans by:
    - Requiring MA plans report how often they approve or deny relevant medications and services to CMS.
    - Establishing a process to make 'real-time decisions' for routinely approved services.
    - Requiring MA plans to use electronic prior authorization.
    - Ensuring prior authorization requests are reviewed by qualified medical personnel in the appropriate field.
    - Protecting seniors from disruptions in care if they transition between MA plans.

V. Funding Rheumatology Research

i. Medical Research Funding

Funding for the National Institutes of Health (NIH) supports our nation's status as a leader in medical innovation and accelerates lifesaving research, while also providing employment opportunities in communities across the country. NIH awards and grants support over 400,000 jobs. More than 83 percent of NIH funding is spent in American communities creating employment opportunities at more than 3,000 universities, medical schools, teaching hospitals, and other research institutions in every state.

NIH funding peaked in 2003, then severe budget cuts to the NIH in FYs 2003 to 2015 resulted in the lowest grant funding rates in history. These cuts slowed the progress of developing improved diagnostics, prevention strategies, and new treatments for arthritis, rheumatic diseases, and their comorbidities (cardiovascular diseases, cancer, and infections), at a time when the population is aging and the number of people with arthritis and related diseases is steadily rising. Such cuts in health research funding limit the potential for discoveries and damage our economy through losses in skilled, high-paying jobs, new products and industries, and improved technologies.

Recognition of this grave problem prompted budget increases in FYs 2016 through 2022 and in 2023 NIH funding was 1.3% higher than its 2003 peak when adjusted for inflation. Then in 2024 funding again decreased, signaling another backslide. Continued advocacy for NIH funding, both broadly focused on basic science as well as advancing clinical research relevant to patients with rheumatic and autoimmune diseases, is paramount to ensure progress in rheumatology-related biomedical research.

The ACR advocates for the funding of basic, translational, clinical, and outcomes research in rheumatologic diseases through the Rheumatology Research Foundation, NIH, Department of Defense, and Centers for Disease Control alongside other research-focused lay and professional organizations toward this aim.

The ACR urges repeal of federal budget sequestration to end ongoing automatic across-the-board budget/spending cuts that have severely damaged America's research enterprise.

The ACR supports:

- Sustained funding for the NIH budget at current levels or above.
- Within the NIH budget, the ACR supports:
    - Evaluation of funding allocation relative to the quantitation burden of specific autoimmune, inflammatory, and degenerative diseases.
    - Promotion of collaborative research across institutes to address the burden of multi-organ diseases requiring multidisciplinary research efforts.
    - Appropriate support for the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS).
    - Sustained funding for National Institute of Allergy and Infectious Diseases (NIAID) to ensure continued progress in understanding of diagnosis and treatment of immune-mediated diseases.
- Adequate funding levels for the Agency for Healthcare Research and Quality, Department of Defense, and Veterans Affairs medical research.

- Increase dedicated arthritis research funding in the Congressionally Directed Medical Research Program at the Department of Defense to $20 million. The funding for a continued emphasis on patient-based research and clinical innovations in patient care.
- Increased funding for the National Arthritis Action Plan and other rheumatologic-related activities of the CDC.
- Continuous funding of the Patient-Centered Outcomes Research Institute (PCORI) to support the implementation of science research and to help implement improved care principles in rheumatology clinics.
- Research by the Health Resources and Services Administration (HRSA) that includes trends in disease incidence and treatment, and workforce demographics to predict future physician workforce needs.
- Funding of the current Loan Repayment Program and development of other research career development programs that support physicians and other health professionals in research careers to ensure an adequate research workforce.
- Increasing global collaborative research in rheumatic and autoimmune diseases that positively impact population health.
- Enhance funding for basic, translational, clinical, and outcomes research by the NIH, CDC, and DOD in the areas of arthritis and rheumatic disease along with related comorbidities (such as infections, malignancies, and cardiovascular disease).

VI. Preserving and Growing the Rheumatology Workforce

i. Support the Current Medical Workforce

The U.S. faces a shortage of rheumatologists. According to recent projections, the U.S. will face a physician shortage of between 54,100 and 139,000 physicians by 2033, more than two of five currently active physicians will be 65 or older within that time. Therefore, efforts focused on expanding healthcare coverage for Americans without also growing the medical workforce may not actually expand access to care for patients. While we started talking about it during the pandemic, 40% of practicing physicians were feeling burned out at least once a week even before the COVID-19 crisis. The COVID-19 pandemic exacerbated this issue as we have seen more burnout, retirements, and career transitions of the medical field. Decreasing reimbursement has necessitated increasing daily patient volume exacerbating burnout and furthering career changes that negatively impact the workforce.

This is also when concerns about noncompete clauses in physician employment contracts peaked as physicians advocating for the safety of healthcare workers and patients faced threats of termination. Due to noncompete clauses, this could result in months or years of unemployment or forced relocation. One-sided noncompete clauses are prevalent in healthcare, affecting between 37% and 45% of physicians. These clauses can be particularly problematic for residents, fellows, and young physicians by limiting their career advancement opportunities and restricting their ability to provide care in economically or socially marginalized communities. Additionally, noncompete clauses can perpetuate anticompetitive practices in areas dominated by large healthcare systems; diminishing career opportunities and ultimately resulting in reduced patient access to care.

The rheumatology workforce also relies on medical professionals who need durable visas to treat patients in the U.S. The system of care in our country and the patient population benefit from easier access for these professionals who mitigate the deficit in the rheumatology workforce.

The ACR supports:

- Providing incentives to maintain and attract an adequate workforce of adult and pediatric rheumatology specialists to care for people with arthritis and rheumatologic diseases.
- Banning noncompete contracts for physicians in clinical practice who are employed by for-profit or nonprofit hospitals, hospital systems or staffing company employers. Removing noncompete clauses for the additional benefits of improved patient access, enhanced availability of specialist coverage and reduced health inequities by allowing physicians to work for multiple hospitals.
- Systemic reform to reduce administrative burden, increase reimbursement rates, and implementation of other initiatives that help combat physician burnout and moral injury.
- Support flexible employment models, including telemedicine, to reduce barriers for physicians to remain in the workforce and increase patient access.

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ii. Preservation of Physician Autonomy in Treatment Decisions

The ACR recognizes the integrity of the patient-physician relationship and its role in patient-centered decision-making during the course of clinical care. Physician autonomy in the context of this relationship ensures that treatment decisions are guided by a combination of the best available evidence, clinical expertise, and patient preferences. However, non-endorsed guidelines adopted by insurance carriers can preclude rheumatologists from prescribing what they deem the most appropriate treatment for a given patient. This reduces access to treatment not just by prohibitive cost, but the additional barrier of formulary restrictions that are created by intermediaries in the drug distribution system.

Additionally, Artificial Intelligence (AI) is a powerful computational tool with growing applications in the medical field. By capturing and analyzing data beyond the traditional patient-provider encounter, it has the potential to lead to more rapid diagnosis and personalized treatment plans, hopefully resulting in improved patient outcomes. AI has immense potential to facilitate care and may become an integral part of the evaluation and management of those with rheumatic disease, with reimbursement for data review likely better covered under a value-based model as opposed to a fee-for-service model. However, AI does have limitations that raise concerns for the rheumatology community.

AI should complement but cannot replace the expertise and clinical judgment of the rheumatologist or rheumatology professional. The role of the rheumatologist is to interpret and integrate the information provided by AI algorithms into the clinical context of each individual patient, considering their unique medical history, symptoms, and preferences. Moreover, AI should be used as a tool to support and enhance, not replace, the human interaction and communication between the physician and patient that is critical for shared decision-making. Importantly, all decisions made are the responsibility of the care provider and not that of an algorithmic tool.

Additionally, the ACR is deeply concerned about the impact of the U.S. Supreme Court's *Dobbs v. Jackson* ruling as it interferes with patient-physician shared-decision making. Rheumatology patients often face complex health challenges where it is medically necessary to delay, and in some cases advisable to terminate, a pregnancy to avoid life-threatening complications of severe chronic inflammatory diseases. Planning for a medically safe pregnancy often requires contraception or the use of assisted reproductive technology. Restrictions that limit these options may endanger patient safety and hinder the physician's ability to provide evidence-based care.

The ACR supports:

- Reimbursement provisions for off-label use of drugs when supported by available evidence.
- Drug formularies based on the standard of care and evidence-based practice recommendations.

- Reforming insurance practices that preclude appropriate medications due to formulary restrictions or excessive co-payment/coinsurance requirements in order to allow access to affordable rheumatic disease medications.
- Universal prior authorizations compatible with electronic health records.
- Strategies for lowering the cost of expensive medical therapies, except for cost savings proposals that compromise the standards of high quality, safe clinical practice.
- Including rheumatologists in pharmacy review committees when formulary benefits programs are being revised or developed.
- Transparency around the derivation of algorithms regarding reliability, variability, and the freedom from bias that impacts patient care.
- Efforts to create rheumatology-specific tools to assist patients and providers at each step of rheumatologic care and assess their impact on the rheumatology workforce.
- Efforts to assess how the interpretation of AI-generated data from patients impacts reimbursement.
- Greater regulatory oversight of the use of AI in evaluating patient claims and prior authorization requests
- Clear policies regarding how patients in some states can access critical treatments such as methotrexate, a necessary medication that is commonly used to treat many rheumatic diseases, due to its alternate use as a medication to terminate pregnancy – though in much higher doses.

The ACR opposes:

- Policies that force patients stable on a biologic therapy to switch to a payer-preferred biologic or biosimilar.
- Mandatory drug switching of stable medical therapy guided by insurance as such switching is inappropriate and potentially harmful to patients.
- Overly restrictive step therapies, fail-first policies and tiering of biologics into specialty-tier pricing which render them unaffordable for patients.
- Legislation or regulation that would permit therapeutic substitution by pharmacists, such as substitution of one biologic or biosimilar for another, unless the pharmacist is acting in accordance with a collaborative practice agreement with the prescribing physician, nurse practitioner, or physician assistant, or unless the substitution is of an interchangeable biosimilar, in which case the prescriber should be immediately notified of the substitution.
- Indication-based formulary design.
- Attempts to limit access to care through the use of computer algorithms.
- Policies that limit access to comprehensive reproductive healthcare.
- State restrictions that intrude on the practice of medicine and interfere with the patient-physician relationship, leaving millions with limited access to reproductive healthcare services.

VI. Preserving and Growing the Rheumatology Workforce

iii. Educating and Training future Rheumatologists

There are currently many geographical areas of the United States with limited or no access to a rheumatologist or rheumatology care provider, a trend expected to significantly worsen in the coming decades according to the latest Rheumatology Workforce Study. There is a predicted shortage of 4,133 rheumatologists in the U.S. by 2030, with the expected number of providers to be less than that at 4,051. Recent figures suggest that arthritis, only one of the many diseases rheumatologists care for, maybe even more common than previously estimated, with an estimated 91.2 million Americans affected in 2015, and the cases are rising.

Additionally, the availability of pediatric rheumatologists is at a crisis level, with fewer than 400 pediatric rheumatologists in the United States providing care at present. Eight states do not have a single board-certified and practicing pediatric rheumatologist and three states only have one. As a result, many children and adolescents with pediatric rheumatic diseases have limited access to high-quality care for their conditions. Rheumatologists trained to care for adult patients do not have sufficient training to provide the highest quality care for pediatric patients while general pediatricians have not received adequate training to treat the intricacies of pediatric rheumatology conditions.

Medicare supports physician training by funding Graduate Medical Education (GME) training positions for specialty care including Rheumatology. Eight US states currently do not have any adult rheumatology fellowship positions, and twenty-five US states do not have any pediatric rheumatology fellowship positions. Pipelines suggest medical students are growing in number; however, filling of training positions varies by availability. In adult rheumatology, there are more applications than positions, and in pediatrics, many positions do not fill. In recognition of the need to address these workforce shortages, the 116th Congress lifted the cap on Medicare support for GME costs which had been effectively frozen since 1997, increasing the number of all GME spots by 1,000 over the course of 5 years. However, this is not enough to meet the shortage of rheumatology providers, let alone all physician specialties

The ACR believes that graduate medical education is a necessary public good that must be protected. Any cuts in GME funding would further exacerbate the growing shortage of physicians across several specialties, including rheumatology, and increased funding is necessary to support a healthcare workforce capable of meeting the needs of America’s patient population.

Funding for loan repayment programs that support physicians entering the workforce in rural or underserved areas and specialties promotes workforce expansion. In particular, pediatric subspecialty loan repayment programs can encourage more pediatricians-in-training to pursue additional specialty training in rheumatology.

The Public Student Loan Forgiveness Act (PSLF) addresses the rheumatology workforce shortage in two ways. First, the program encourages young physicians to choose rheumatology despite the relatively lower compensation than other areas of medicine. Second, it encourages

new fellowship graduates to remain at academic medical centers and train the next generation of rheumatologists rather than accepting a potentially higher-paid position in private practice. Unfortunately, in 2018 and 2019, in the first group of applications for forgiveness under this program, more than 99% were denied. However, recently, more applicants are receiving their loan forgiveness through the PSLF program, and policy makers must protect these programs.

Similarly, the Pediatric Subspecialty Loan Repayment Program (PSLRP) specifically addresses the pediatric rheumatology workforce by encouraging pediatricians to pursue additional subspecialty training, despite the lower compensation compared to general pediatric practice, through loan forgiveness opportunities. By providing loan forgiveness, this helps offset the decreased salary and helps incentivize the additional years of training and subsequent delay in earnings. This program was funded in FY2022 by the 117th Congress for the first time since its authorization by Congress in 2010. With the approved $15 million, it is estimated that approximately 100 two-year awards will be funded. While this is an important first step, the ACR supports full funding at $30 million per year.

Lastly, rheumatologists and other cognitive specialties are excluded from most federal and state public loan forgiveness programs. The ACR supports establishing new state-based loan forgiveness programs that would encourage cognitive specialists to practice in underserved areas. More broadly, structural changes in the reimbursement system addressing the balanced budget requirement for the Medicare Physician Fee Schedule, undervaluation of E/M services, and cognitive care services are additional critical steps that can mitigate this impending medical workforce crisis.

Training and teaching the future generation of rheumatologists is imperative. Program directors, associate program directors, and other faculty play an important role in this. While GME designates certain full-time equivalent (FTE) requirements for formal roles such as program director and associate program director, the academic hospitals that employ these physicians often view these FTEs through the lens of a non-revenue generating FTE. When this FTE time is unprotected or pressured to be replaced by revenue-generating clinical duties, this can detract from the valuable and important time needed to teach the fellows. Ultimately, this lowers the quality of education the fellows receive during this critical period.

The ACR supports:

- Expanding the medical workforce by increasing funding for Graduate Medical Education (GME) training position expansion.
- Repeal caps on residency positions.
- Increasing funding for the Pediatric Subspecialty Loan Repayment Program (PSLRP).
- Legislation to defer student loan interest while physicians are in residency to reduce the financial barriers to entering subspecialty training.
- Maintaining the Public Service Loan Forgiveness Act with full funding.
- Establishing loan forgiveness programs for cognitive specialties in underserved areas at the state level.

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iv. Quality of Care

In recent years, many quality measures and programs have been developed to improve patient outcomes. These efforts encompass a broad array of best practices ranging from the use of diagnostic tests, medications, and procedures to physician practice protocols and hospital operations. These measures impact how physicians treat patients and how physicians are reimbursed for their services. Rheumatologists are taking the lead to ensure that the emerging systems provide evidence-based, patient-centered, physician-directed rheumatologic care, and that incentive programs do not conflict with the quality medical practices of rheumatologists and rheumatology interprofessional team members.

The ACR supports:

- Development of provider performance measures that are linked to meaningful clinical outcomes
- Development of performance measures by rheumatologists and health professionals through the ACR, and assessment of and focus on those elements of clinical care over which rheumatologists have direct control.
- Policies requiring that any data collection to support performance measurement be reliable and practical, driven by specialists rather than payers, and that it should not violate patient privacy or add to the administrative burden experienced by rheumatologists and rheumatology interprofessional team members.
- Appropriate reimbursement of providers for work involved in the collection and reporting of quality measure data.
- Periodic review of performance measures to ensure that these measures are fulfilling their intended purpose and limiting inefficient resource allocation

The ACR opposes:

- Performance measures being used to penalize providers.

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v. Visa Access for Physicians

In 2018, more than 2.6 million immigrants, including 314,000 refugees, were employed as healthcare workers, with 1.5 million of them working as doctors, registered nurses, and pharmacists. Where immigrants represent 17 percent of the overall U.S. civilian workforce, they are 28 percent of physicians.

International Medical Graduates who seek entry into U.S. programs of Graduate Medical Education (GME) must obtain a visa that permits clinical training to provide medical services. Nearly one-fourth of the active U.S. physician workforce are foreign graduates and international medical graduates (IMG). Nonimmigrant or immigrant visas are needed for IMG physicians and healthcare professionals to legally practice in the U.S. when they are not U.S. citizens. The proportion of residency programs sponsoring H-1B visas for training has gradually decreased in the last few years as the immigration requirements are multistep, costly (for the employer), and often complicated with bureaucratic immigration nuances. To support the healthcare workforce, future legislation should facilitate easier access to more visas for those seeking roles in the US medical workforce.

The H-1B visa allows a foreign national to enter the U.S. for professional-level employment for up to six years. The H-1B visa is available to graduates of foreign medical schools who have passed the necessary examinations, have a license or other authorization required by the state of practice, and have an unrestricted license to practice medicine or have graduated from a foreign or U.S. medical school. Currently, J-1 visa-holding resident physicians from other countries training in the US are required to return to their home country for two years after their residency has ended before they can apply for a work visa or green card to work in the US. The Conrad 30 program allows these physicians to remain in the US without having to return home for two years if they agree to practice in a medically underserved area for three years. The Conrad 30 program helps physicians who are educated and trained in the US continue to serve in our medical workforce.

Critically, programs like Conrad 30 are retaining US-trained physicians who want to continue to practice in the U.S. International medical graduates who complete their residency and fellowship training programs are typically on a J-1 visa. Without a Conrad 30, or similar waiver, these visas require IMGs to return to their country of origin for at least two years before applying for another visa or green card. The Conrad 30 program provides an exemption to these visa holders and allows U.S.-educated and trained physicians with a J-1 visa to enter the American medical workforce directly upon the completion of their residency if the IMG practices in a medically underserved community. This helps reduce the current physician shortage in under-resourced areas. A key part to this program’s success is the management by the individual states. However, the number of waivers has been limited despite the increasing healthcare workforce shortage.

ACR Supports:

- Continuing and expanding the Conrad 30 program, which allows U.S.-educated and trained physicians with a J-1 visa to enter the American medical workforce upon the completion of their residency.
- Reallocating unused visas for IMGs to ensure durable immigration status for these medical professionals.
- Additional programs that would expand access to durable visas for qualified healthcare professionals.

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vi. Private Equity in Healthcare

The investment in healthcare by healthcare has grown significantly in recent years, with a more than six-fold increase in physician practice acquisition and an estimated $750 billion total in deal values between 2009 and 2019. While complex and multifactorial, this has been partly accelerated by the multiple regulatory and financial challenges faced by medical practices, including decreasing annual reimbursement rates and rising costs to operate a practice.

While purchase by private equity may immediately alleviate financial pressure on a medical practice, the core business model of private equity is antithetical to our healthcare priorities. Private equity's focus on short-term revenue generation, consolidation, and use of leverage can lead to perverse incentives that are antithetical to a healthcare market that prioritizes access, quality of care, and the patient-physician relationship over profit. Studies and market analyses have raised concerns about the effects of private equity in accelerating concentration, anti-competitive practices, market stability, costs to patients and payers, quality of care, and health outcomes, amongst other impacts. These concerns were noted by the Senate Budget Committee in their January 2025 report on private equity in healthcare, which highlighted a pattern of underinvestment, service reductions, financial and operational mismanagement, hospital closures, and a focus on profit over patient care which led to significant declines in healthcare quality and access.

Recent physician surveys have also demonstrated a predominantly negative view of private equity involvement in healthcare, with the most unfavorable views on physician well-being, healthcare prices or spending, and health equity. While research on the impact of private equity on health outcomes and quality of care remains scant, there appears to be evidence of its leading to degradation in care rather than improvement. Further, many private equity acquisitions are structured with limited to no antitrust scrutiny, allowing little oversight or evaluation of their impact on healthcare.

For these reasons, the ACR supports:

- Policies that support access to high quality care, preservation of the patient-physician relationship and duty of care over profit-driven care.
- Increased research into the impact on the market and healthcare outcomes of for-profit enterprises and private equity in healthcare.
- Revision of federal and state antitrust reporting requirements to ensure proper assessment of the impact of private equity acquisitions on competition
- Increased transparency around private equity deals in healthcare.
- Medicare payment reform to improve financial solvency of physician practices and decrease incentives for acquisition and consolidation.
- Banning noncompete clauses as a way of lowering barriers of entry to concentrated markets.

VII. Abbreviations

ACR	American College of Rheumatology
AHRQ	Agency for Healthcare Research and Quality
AI	Artificial Intelligence
AMA	American Medical Association
APM	Alternative Payment Model
ARP	Association of Rheumatology Professionals
ASP	Average Sales Price
BPCA	The Best Pharmaceuticals for Children Act
CBO	Congressional Budget Office
CDC	Centers for Disease Control and Prevention
CDMRP	Congressionally Directed Medical Research Program
CER	Comparative Effectiveness Research
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CPT	American Medical Association Current Procedural Terminology
DOD	United States Department of Defense
DXA	Dual-energy X-ray absorptiometry
E/M	Evaluation and Management Codes
EHRs	Electronic Health Records
FDA	Food and Drug Administration
FTE	Full-time Equivalent
FY	Fiscal Year
GME	Graduate Medical Education
HIT	Health Information Technology
HRSA	Health Resources and Services Administration
IT	Information Technology
MA	Medicare Advantage
MACRA	Medicare Access and CHIP Reauthorization Act
MEI	Medicare Economic Index
MIPS	Merit-based Incentive Payment System
MFN	Most Favored Nation
MMA	Medicare Modernization Act
MPFS	Medicare Physician Fee Schedule
MVPs	MIPS Value Pathways
NIAID	National Institute of Allergy and Infectious Diseases
NIAMS	National Institute of Arthritis and Musculoskeletal and Skin Diseases
NIH	National Institutes of Health
PA	Prior Authorization(s)
PBM	Pharmacy Benefit Manager(s)
PCORI	Patient-Centered Outcomes Research Institute
PHE	Public Health Emergency
PQRS	Physician Quality Reporting System

PSLF	Public Student Loan Forgiveness
PSLRP	Pediatric Subspecialty Loan Repayment Program
QCDR	Qualified Clinical Data Registry
RACs	Recovery Audit Contractors
RBRVS	Resource-based Relative Value Scale
RISE	Rheumatology Informatics System for Effectiveness
RVU	Medicare Relative Value Unit(s)
US	United States of America
VA	United States Department of Veterans Affairs