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**CMS: Don't turn back the clock on rheumatic disease care**

Good health policy is meant to enhance the health of our citizens. And, above all else, it should improve quality of life for those who need it most. However, well-intentioned alterations in Medicare payments made without consultation with patients and providers often does the opposite for millions of Americans diagnosed with arthritis and other rheumatic diseases.

Consider this: Just twenty years ago, a rheumatoid arthritis (RA) diagnosis meant a life cut short by pain, serious health complications, long-term disability, and early death. Today, however, many patients face a brighter reality; they can look forward to healthy and active lives long after an RA diagnosis. What changed? Pioneering treatments, most notably biologics, were brought to market and made available to patients.

For patients with RA and other rheumatic diseases, biologic therapies have been a lifeline after years of less effective treatments. Biologics, which are derived from living cells, have proven effective at treating some of the most notoriously painful and debilitating conditions, allowing patients to avoid severe deformities and life-changing disabilities. The benefits of these advances can’t be overstated: Arthritis is the nation’s leading cause of disability – more than heart disease, cancer or diabetes – costing $128 billion annually and affecting more than 50 million Americans, according to the Centers for Disease Control and Prevention (CDC).

The introduction of these remarkable new therapies is not the end of the story for patients or their rheumatologists, however. Biologics are life-changing but extremely expensive, and many require administration by infusion, similar to chemotherapy. Access to biologics continues to be a problem for many patients today, especially those who rely on Medicare Part B coverage.

The Centers for Medicare & Medicaid Services (CMS) recently proposed additional Medicare Part B payment cuts that would make it exceedingly more difficult for rheumatologists to obtain and administer biologics. The move would unquestionably exacerbate existing patient access problems, leaving many arthritis patients without treatment options, and pushing others toward more expensive settings like hospitals for their care. Hospital-based infusions often come with higher copays, longer travel times, and the distinct disadvantage of patients having to receive complex therapies absent of the supervision of their trusted rheumatologists, who know the unique personal history of their complicated condition and can monitor for adverse reactions.
For these reasons, arthritis patients and providers are coming together to ask that the proposal to alter Medicare Part B coverage be withdrawn so that patients and providers can have input and so that the potential negative impacts on patients can be understood and avoided.

CMS’ proposed reimbursement changes are part of an experiment the agency says will support the delivery of high-quality care by incentivizing doctors to prescribe the most cost-effective drugs. There’s just one problem: the approach assumes there are less expensive yet equally effective therapy alternatives for all diseases. For patients with rheumatic diseases like RA, this simply is not the case. Biologic treatment options available under Part B are relatively limited, typically with similar pricing.

Biologics must be carefully tailored to each patient. Rheumatic diseases are complex to treat, and therapeutic regimens often include multiple medications and must be frequently adjusted or halted in response to the patient's evolving condition. Once a patient finds a biologic therapy that works, which often may be their only option, he or she should not be forced to switch based on cost.

The flexibility to prescribe the breakthrough treatments that are available allows physicians to make clinical decisions in the best interests of their patients. On the other hand, limiting access to treatments based on cost – as CMS’ policy would do – leaves patients suffering, and providers with their hands tied.

CMS’ proposed Part B reimbursement changes are well intentioned, but the miscalculations could generate vast, unintended consequences. “Cost cutting” is only an improvement when it doesn't come at the expense of patients. By limiting Medicare patients’ access to safe and effective biologic therapies, this proposal threatens the high quality health care the agency was designed to support.

While we understand that the current Medicare system is not sustainable, we don’t believe that demonstration projects should be developed in a vacuum. Prescribers and patients should be involved in identifying and creating demonstration projects that are focused on enhancing quality of care and reducing costs for the system. We know that patient centric solutions deliver better outcomes and true overall value. Eliminating site of service choices is contrary to what we know enhances patient outcomes.

In the end, improved access to biologics is necessary for millions of patients to avoid suffering, complications and long-term disability. Let’s develop these policies in collaboration with patients and providers to overcome unintended consequences for patients. Working together, we can bring about a healthier America, not turn the clock back on rheumatic disease care.

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