



Statement for the Record

American Society of Nuclear Cardiology

Hearing before the House Ways and Means Health Subcommittee

On

Developing a Viable Medicare Physician Payment Policy

May 7, 2013

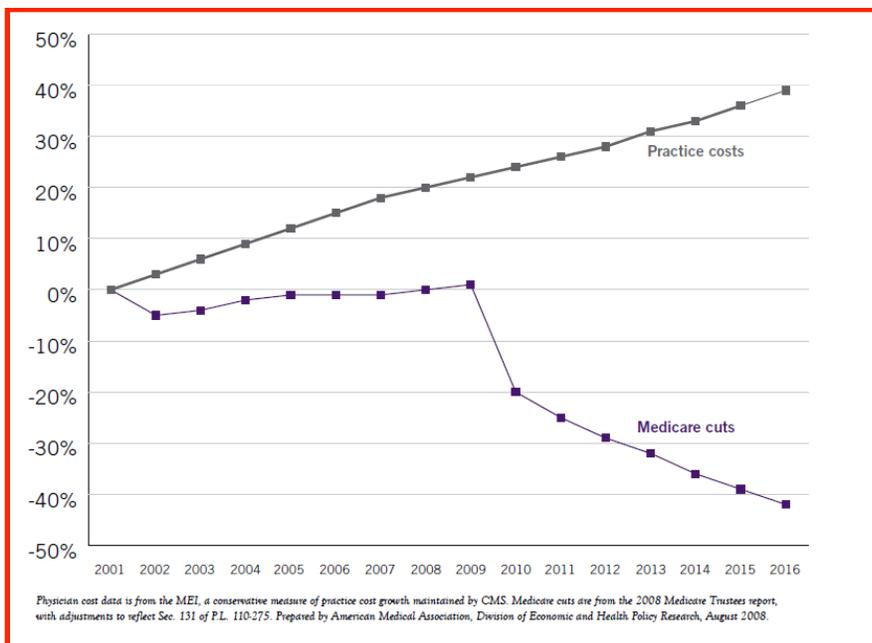
*****TESTIMONY IS EMBARGOED UNTIL THE START OF
THE HEARING TUESDAY, MAY 7, 2013 AT 10:00 AM*****

Chairman Brady, Ranking Member McDermott, and other distinguished members of the Ways and Means Health subcommittee, thank you for the opportunity to testify on behalf of the American Society of Nuclear Cardiology (ASNC). The American Society of Nuclear Cardiology is the leader in education, advocacy, and quality for the field of nuclear cardiology. ASNC is the voice of more than 4,600 physicians, technologists, and scientists worldwide who are dedicated to the science and practice of nuclear cardiology. Since 1993, ASNC has been establishing the standard for excellence in cardiovascular imaging through the development of clinical guidelines, professional education, and research development. While our organization is centered on the practice of diagnostic imaging, it is important to note that a significant percentage of our membership is invested in the practice of general cardiology as well.

My name is Kim Allan Williams, MD, and I currently serve as a member of the ASNC Health Policy Steering Committee. I previously served as a member of the Board of Directors and as president of ASNC. In addition, I am Vice President of the American College of Cardiology for 2013-2014. I joined the faculty of the University of Chicago in 1986 before moving to the Wayne State University School of Medicine in 2010. I chair the Division of Cardiology and I founded the Urban Cardiology Initiative, which is an effort to educate physicians on disparities in healthcare and community health screening in inner city Detroit.

The American Society of Nuclear Cardiology applauds Chairman Brady and Ranking Member McDermott for holding a hearing on such an important topic. We share your view that the instability posed by the Sustainable Growth Rate (SGR) complicates physicians' ability to make desired improvements to their practices, such as the purchase of capital equipment. Data from the American Medical Association (Figure 1) illustrate a divergent trend in practice costs and Medicare payment—declining payment makes it difficult to support a practice and staff. It is encouraging that the Committee is dedicated to finding *workable* alternative reimbursement models rather than merely searching for a quick or easy solution.

Figure 1. Physician Reimbursement Losing Ground to Inflation, Costs



ASNC, and many other specialty societies, are further encouraged by the Committee's solicitation of physician input on SGR repeal and the development of alternative reimbursement and delivery models. This partnership is likely to lead to legislation that reflects the intricacies of clinical practice and advances best practices. Moreover, ASNC is pleased by the Committee's close consideration of clinical quality measures developed by medical specialties and medical societies. A more direct partnership with medical specialties and the registries they develop and employ will undoubtedly produce actionable quality measures.

Clinical Data Registries

Appropriate Use Criteria (AUC) were developed by ASNC in partnership with several organizations in order to reduce the number of inappropriately ordered tests. Decision support tools such as guidance on the proper use of stress protocols and tracers are important initial steps in quality imaging. ASNC will continue to collaborate in the development of decision support tools to assist referring physicians and nuclear cardiology professionals. To further ensure appropriateness and patient-centered imaging, ASNC is currently establishing the groundwork for the *Cardiovascular Imaging Registry*. This is a natural progression of prior quality initiatives such as clinical application guidelines, imaging procedure guidelines, physician certification, lab accreditation, and AUC.

We envision that the Imaging Registry will be instrumental in developing a robust set of clinical performance metrics of interest to private payers, the Centers for Medicare & Medicaid Services (CMS), and policymakers. These metrics may add further weight to the reality that medical imaging is good medicine, and inform proper reimbursement and performance incentives. Advancements in medical imaging have changed the way cardiologists, oncologists, obstetricians and gynecologists, urologists, family practitioners, neurologists, orthopedic and other surgeons and many other physicians deliver patient care on a daily basis. By integrating medical technology into care plans, patients are receiving more prompt, efficient, effective and cost-effective care. In addition to traditional diagnostics employing medical imaging, we now use imaging to guide minimally invasive treatments and to track ongoing treatment protocols through judicious use of medical imaging. We are enabled as physicians to adjust patient care plans mid-therapy to achieve the best possible outcomes. Several specialist groups intimately integrate medical imaging in the most delicate and intricate aspects of their care. The prudent use of medical imaging to guide a patient's treatment regimen is not only excellent medicine—it also manages short- and long-term costs by reducing wasteful and ineffective invasive testing and treatments.

As stated previously, ASNC is currently establishing the groundwork and defining initial quality metrics. The initial phase of Registry development (end of 2013-Q1 2014) will be focused on data collection of foundational performance metrics that relate to radiation safety and dose protocols, timely reporting of test results, and clinical indication. Registry results will be focused on building the resources related to the implementation of patient centered imaging protocols, improved reporting and appropriate use. While we describe these metrics as foundational, they are of profound importance. A nuclear laboratory may adhere to appropriate use criteria, yet the positive contributions to patient management and care are limited if test results are not communicated in a timely and efficient manner. Many nuclear laboratories have cameras and reporting software that can seamlessly export data directly to the Registry with no additional burden to the physician.

In subsequent phases (2015-2016), ASNC intends to develop the capability to follow the patient through the continuum of care. Partnerships with other registries in the field of cardiology will assist this

initiative. By tracking adherence to Appropriate Use Criteria and resulting treatment decisions, the *Cardiovascular Imaging Registry* may illustrate that nuclear cardiology positively affects downstream costs through more appropriate selection of patients who need invasive testing or revascularization and the management of congestive heart failure. In addition, the Registry may illustrate that nuclear cardiology improves patient outcomes by more appropriate risk stratification to more advanced therapies, should they be required. Thus, the Registry may fully illustrate how diagnostic imaging informs treatment decisions to better serve both the patient population and the Medicare program.

ASNC expects that the metrics developed by the *Cardiovascular Imaging Registry* will enable Congress and CMS to gauge ongoing clinical improvement initiatives. With these data, Congress and CMS may effectively tie reimbursement to these initiatives. Credit should be given for quality improvement initiatives that are already in place and are ongoing, not just for new initiatives each year. For example, a provider should receive ongoing recognition for achieving and maintaining subspecialty board certification, lab accreditation, performing laboratory quality assurance, and participation in the ASNC Registry. These are integral quality activities. Annual "metric updates" must not ignore these ongoing quality measures and simply look for new quality initiatives each year. Financial incentives should be provided to physicians who participate in registries, receive feedback, and address any quality deficiencies that are discovered.

Reward Clinical Improvement Activities and Pay for Performance

ASNC embraces a payment methodology which rewards a specialty's advancements in care quality and clinical improvement activities. Nuclear cardiologists strive to provide high quality care and have developed a wide array of decision support tools to improve patient care. These include strategies to reduce radiation exposure, means of increasing image quality, promoting the accurate interpretation of test results through peer review, and an array of Appropriate Use Criteria for diagnostic imaging. The current fee-for-service structure does not provide adequate reimbursement for these activities. It is ASNC's contention that a reimbursement system which incentivizes the use of clinical improvement activities may more effectively encourage these initiatives in nuclear cardiology.

Differences in specialties should be based on the specific quality and improvement targets. The overall approach should strive to reward and recognize improvements rather than the development of absolute, punitive thresholds. The overall approach and framework should be similar across specialties. The concept of ***continuous*** quality improvement should be first and foremost—new payment models should improve the aggregate quality of care rather than seek to eliminate all outliers. To this end, ASNC recommends each specialty work with both CMS and private payers to determine a three-year course for necessary improvement based on known gaps and opportunities for improvements.

For example, in terms of implementing performance into the fee-for-service system, ASNC proposes awarding physicians with high levels of improvement 110% of the fee schedule, physicians demonstrating modest improvement 100% of the fee schedule, and those demonstrating no movement 90% of the fee schedule. An important element of this concept is legal indemnification. If nuclear laboratories are to be paid for AUC adherence and thus asked to perform a gatekeeper function, it is integral that nuclear laboratories receive legal protection for the decision not to perform inappropriate tests.

While we endorse this concept, a number of pertinent questions remain. What entities, in addition to the National Quality Forum (NQF), will approve physician-developed quality metrics? Will medical

societies be able to utilize metrics that are awaiting approval? Which government agency will provide independent physicians and group practices with their quality scores? Will the appeal process be formal or informal?

Alternative Payment Models

Flexibility and the provision of clear, concise information will be key variables as we transition to alternative payment models. ASNC is pleased the Committee's framework allows for flexibility and does not envision a "one-size fits all" approach to payment and delivery reform. For certain specialties and certain providers, fee-for-service may ultimately be the most appropriate payment and delivery system.

ASNC supports an approach that permits participation in multiple Alternative Payments Models (APMs). If the Committee seeks to enhance provider flexibility, it follows that this provision would be part of the legislative framework. It is feasible that a provider group may participate in multiple shared savings arrangements simultaneously. Participation in multiple models may enable providers, CMS, private payers, and policymakers to obtain additional data regarding APMs—level of patient satisfaction, utilization, the need for additional reforms, etc. Conversely, limiting participation may inhibit the flow of key data.

Data must be in real time, focused on meaningful and actionable information, and in a standard format that can be used to identify where improvement is needed. These foundational principles are applicable to meaningful provider participation in new payment and delivery models. Moreover, provider participation in the development of new models and means of educating providers will further support participation. New models may be ineffective if implemented in a top-down manner or interpreted as the government dictating the practice of medicine. National specialty societies and regional collaborative organizations may perform this education function.

ASNC asserts a clear definition of "participation in models" would support provider participation. Threshold levels of participation and the particulars of new models require clear and concise definitions. For instance, would participation in innovative programs led by private payers such as CareFirst or United Healthcare suffice? What criteria must accountable care organizations (ACOs) meet?

Stable Updates in Physician Reimbursement

In comments to the SGR framework and in discussions with multiple members of Congress, ASNC stressed the importance of stable and predictable updates as we transition to alternatives. The prospect of substantial annual reductions due to the SGR and the wait for Congressional action to temporarily avert the reductions destabilize the practice of medicine and impede investments in alternative models. We therefore endorse the Committee's proposed stable, predictable fee schedule updates during the transition period.

ASNC encourages the Committee to provide stable and predictable updates for a period of five years. This timeframe grants physicians the ability to make investments and practice modifications that may improve quality and efficiency, and to assess alternative payment models both within Medicare and the private sector. This five-year period of stability also may provide ample time and resources for CMS to prepare for and to be equipped to effectively administer alternative models.

Rewarding Quality over Time In Addition to Peer Group Comparisons

ASNC asserts it is essential to reward quality over time in addition to quality compared to peers. We urge the Committee to establish an incentive program which rewards providers for sustained high performance as well as substantial quality improvement. Limiting incentives strictly to improvement may create a ceiling for providers who start at or achieve a high level of performance. Restricting incentives to high-threshold levels of achievement may inhibit the participation of providers who start at low levels. Since the objective is to “raise all ships,” ASNC encourages the Committee to implement incentives with the aforementioned nuances.

ASNC also contends successful pay-for-performance programs encourage collaboration among providers and provider groups. It is our understanding that peer groups would consist of providers focusing on the same set of three-to-five quality measures. This suggests the possibility of collaboration among providers and provider groups, yet we assert the peer group concept requires greater detail. The Committee may enhance the statistical validity of quality measures by banding together small practice groups. Establishing transparent means of evaluating providers, particularly the public disclosure of measurement specifications used to develop performance tiers, may further enhance validity. However, ASNC remains concerned that peer groups may create a set of winners and losers unless the providers in a specific group are obtaining substantial incentives from the system, either by demonstrating a high level of quality or demonstrating significant quality improvement. This concern is accentuated by a budget neutral approach to payments for quality and efficiency. Providers in a pay-for-performance program should receive a positive base payment and additional payments for meeting quality and efficiency objectives. A budget neutrality requirement threatens this concept.

Improving Geographic and Risk Adjustment Procedures

ASNC asserts current geographic and risk adjustment procedures in method are insufficient. This is shown by the recent reduction in payment for thirty-day readmissions, which disproportionately targeted inner city safety net hospitals. The stratification system should include measures of the socioeconomic status of the community which the provider serves. Non-claims based information such as functional status, socioeconomics, culture, linguistics, and geography affect how patients interact with the healthcare system. Functional status affects how a patient seeks care and follows treatment instructions. Moreover, current geographic and risk adjustment procedures do not fully account for comorbidities. This may significantly affect reimbursement under alternative payment models as two-thirds of noninstitutionalized Medicare beneficiaries over the age of 65 have two or more chronic conditions¹. Provider groups that serve a disproportionate number of sick individuals, such as patients with coronary artery disease, will likely be underpaid, and those with healthy populations will be overpaid.

Solid and transparent risk adjustment and attribution methods will be critical in identifying and understanding variances in quality and cost across specialties, settings, and locations. ASNC encourages the Committee to develop, test and improve such methods.

¹ Am J Manag Care. 2008;14(10):679-690

Properly Addressing Outliers

Outliers are a concern for specialty societies as well as policymakers. The Committee on Ways and Means may effectively address outliers in a variety of ways. Their conception of registries and associated clinical quality measures is encouraging. For instance, the intent of the ASNC Registry is to produce a Laboratory Report Card—an in-depth lab assessment and data collection initiative that will provide a roadmap to continuous performance improvement. The Report Card may effectively identify knowledge gaps and concrete measures labs may take for Quality Improvement. We encourage Congress to create an incentive structure which rewards labs for addressing these gaps.

ASNC contends that timely access to performance data is integral to quality improvement. Physicians respond to clinical data and will alter practice patterns accordingly. If a physician is given a feedback report with clinically relevant data, he/she may alter practice patterns to improve quality. ASNC hopes that a system heavily reliant on measures developed by medical specialties and medical societies would effectively provide timely feedback. In multiple comment letters, ASNC has urged CMS to improve the timeliness of the feedback reports delivered as part of the PQRS and Value-Based Payment Modifier programs, while understanding the practical difficulties therein. CMS intends to distribute reports containing 2012 data to physicians in the fall of 2013. This lag time makes it difficult for physicians to improve their understanding of program criteria or rules of participation and respond in a timely manner.

In alternative reimbursement models based on quality, it is our hope and expectation that all physicians will receive timely feedback reports. Actionable information is critical to improvements in the quality of care delivered by physicians, irrespective of their potential status as outliers.

The American Society of Nuclear Cardiology appreciates this opportunity to offer testimony and looks forward to further discussion with Committee members and staff. The current Medicare physician payment formula produces unrealistic savings on paper, requires Congress' consistent short-term intervention, and creates needless delays and hassles for patients. We hope this collaborative effort between Congress and the house of medicine will lead to the repeal of the Sustainable Growth Rate and meaningful reform of Medicare payment.