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May 15, 2009

Senator Max Baucus
Chair, Senate Finance Committee
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Senator Charles Grassley
Ranking Member, Senate Finance Committee
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Re: Senate Finance Committee's Health Reform Policy Options: *Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs*

Dear Chairman Baucus and Ranking Member Grassley:

The American Society of Nuclear Cardiology (ASNC) is pleased to provide comments on the Senate Finance Committee's policy document *Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs*, released on April 28, 2009.

ASNC is a greater than 5,000 member professional medical society, which provides a variety of continuing medical education programs related to nuclear cardiology and cardiovascular computed tomography, develops standards and guidelines for training and practice, promotes accreditation and certification within the nuclear cardiology field, and is a major advocate for furthering research and excellence in nuclear cardiology and cardiovascular computed tomography.

Transparency and Evidence-Based Decision-Making for Imaging Services

Transparency in Self-Referrals

ASNC agrees with transparency of medical billing and believes that greater transparency may help in eliminating inappropriate utilization of services. We also strongly believe that the "in-office ancillary services" exception contained in the Stark law is an ESSENTIAL provision in ensuring that patients receive convenient care by physicians they know and trust and who know their clinical histories best. In that regard, ANSC understands the proposal to require that physicians inform patients in writing at the time of referral that the patients could obtain services from another physician. By their very own prior patterns of service consumption, patients appear knowledgeable about this option.

However, ASNC DOES NOT support the proposal that would require physicians to provide patients with a list of suppliers in the area in which the patient resides. Requiring physicians to keep an up-to-date list of providers in the area where each patient resides is an impossible, unreasonable and unbelievably burdensome request. Many physicians see patients from all areas of their cities, counties and even states, and physicians do not have the time or resources to find out which physicians offer which services in each of their patients' areas of residence, much less keep these lists current in an economy constantly in flux. The patients would also not benefit from having such



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a list, as there would be no guarantee that the same insurance carriers cover all the various providers on the list. ASNC recommends that, if Congress chooses to move forward with this proposal, Congress mandate that CMS and third party payers be required keep an up-to-date list of which physicians provide which services for each covered individual's area of residence. The administrative burden of this concept would clearly disrupt medical care and create bias that has no basis in improving quality care.

Promotion of Adherence to Appropriateness Criteria for Imaging Services

ASNC was extremely pleased to see that the Senate Finance Committee is looking at alternatives other than radiology benefit managers (RBMs) as it looks to ensure appropriate imaging. As a physician organization, our experience with RBMs has been abysmal, and we are strongly opposed to an RBM mandate. RBM guidelines favor one imaging modality over another regardless of physician judgment, clinical factors and appropriate patient care. RBM guidelines are incongruent with current literature and imaging guidelines published by medical journals and medical specialties. The practice parameters created by RBMs do not involve direct input from actively practicing local physicians or relevant physician organizations prior to endorsement, and the RBM guidelines do not include rationales used to set their practice parameters. Their guidelines are usually based on initial cost containment only (indeed their own revenue stream is based on percent cost saved only) and do not reflect what is best for the patient or what downstream utilization and quality outcomes may be obtained.

As the policy document points out, the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 mandates lab accreditation as the tool to be used to assure the quality of diagnostic imaging services. ASNC believes that having physician offices achieve accreditation through private accrediting bodies with recognized national standards (such as ICANL) will undoubtedly ensure higher quality imaging. The MIPPA also focuses on quality through a two-year voluntary appropriateness criteria demonstration project, and we believe the use of appropriateness criteria is a very constructive way of addressing quality and assuring greater patient care.

Over the past few years, Medicare has seen a decrease in the growth of advanced diagnostic imaging. Spending for imaging services fell sharply in 2007, down an estimated \$1.8 billion from 2006, a 14% decline. Further, an early version of the 2008 Medicare carrier claims summary file from CMS clearly shows that the volume/intensity of imaging continues to moderate and, more specifically, that the growth for advanced imaging was just 3% (compared to 5% in 2007). The use of myocardial perfusion testing, the most common test performed by nuclear cardiologists, has decreased in the Medicare population. Specifically, between 2006 and 2007 the use of this technique decreased 3.1%.

Studies have proved that medical imaging alters medical care and ultimately saves lives and improves quality of life. A recent CDC report stated that the average life expectancy for males and females increased by four years since 1980 (73.7 years in 1980 to 77.8 years in 2005), and the death rate for ischemic heart disease has fallen 60% since 1980. The value and use of diagnostic imaging has undeniably played a role in Americans ability to live longer and healthier lives. For these reasons, ASNC strongly urges Congress to fully evaluate the effects the MIPPA accreditation provision and appropriateness criteria demonstration project have on the delivery and reimbursement of imaging services prior to mandating further imaging provisions.



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ASNC is concerned that the policy options outlined in the Finance Committee document contain unrealistic timelines and penalties too severe. While ASNC fully supports the use of appropriate use criteria in monitoring physician ordering patterns, the process of vetting the criteria through a national standards organization and establishing transparent standards for reporting patterns of adherence to appropriate use criteria will take a significant amount of time and certainly not be in place by 2010. Further, in order to collect physician data, physicians will need to have technology in place to capture their ordering patterns, which will undoubtedly be costly and require additional staff. The policy document does not address what type of technology will be needed or how physicians are expected to cover the additional expenses. Unfunded mandates create great burdens on clinical patient care. Answers to these burdens must be sought in a phase in period to the use of appropriate use criteria.

Sustainable Growth Rate (SGR)

ASNC was extremely disappointed to see no long-term solution to the severely flawed sustainable growth rate (SGR) formula included in the policy document. A realistic budget baseline for future Medicare payment updates, which accurately reflects the anticipated costs of providing physicians with positive updates under a new update system in lieu of SGR-related cuts, should be incorporated into the federal budget this year.

While ASNC is grateful that Congress has continued to provide short-term payment fixes over the past years, the SGR update system is broken and needs to be replaced with an updated payment system that better reflects increases in physicians' practice costs. From the conversion factor, phase-in of new practice expense values and continuing effects of the recent Five Year Review of work values, nuclear cardiologists are experiencing profound payment reductions beyond most of the House of Medicine. These payment cuts, along with the marginal 1% payment updates for 2010 and 2011 and 0% update for 2012 proposed in the document, will surely impact physicians' ability to adopt information technology and quality initiatives, as well as to continue accepting new Medicare patients as they prepare for the influx of baby boomers. Further, ASNC is extremely concerned about the significant payment cuts physicians would face after 2012 in the policy options proposed. As always, ASNC remains committed to working with Congress and the Senate Finance Committee to implement a permanent fix to the severely flawed SGR update methodology.

Comparative Effectiveness Research

ASNC understands the interest in comparative effectiveness (based on outcomes) research. Indeed, a strength of our field has been the development of outcomes research by our research community and our use of it to do continuous performance improvement. This experience allows us to understand how vital good process is to such outcomes research and how difficult it is to achieve. It has also allowed us to understand that such published trial results simply become a start for more focused clinical discussions and consensus building and do not represent a result unto themselves. ASNC is concerned that too much government control over such a process would lead to government pressured clinical decision making for patients. Independent balanced stakeholder committees hold more promise in process, but construction and operations in the abstract are much easier than in the pragmatic. In the end, it is clinicians who must respect and believe in the process if quality care is to



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be delivered to the populace (and therefore need the most say). ASNC wishes to voice great caution on this topic. Potential gains are great, but great monetary waste and erosion of the individual physician-individual patient relationship could occur if thoughtful construction is not accomplished.

Again, ASNC appreciates the opportunity to provide comments regarding these important issues. We are pleased that the Senate Finance Committee is gathering feedback from the medical community prior to creating hard policy, and we look forward to continuing our discussions with you as you continue to work towards health care reform. Should you have any questions, please feel free to contact Emily Gardner, ASNC Director of Health Policy, at 301-215-7575 or via email at egardner@asnc.org. Thank you.

Sincerely,

A handwritten signature in cursive script, reading "William A. Van Decker", is positioned below the word "Sincerely,".

William Van Decker, MD, FASNC, FACC
Chair, ASNC Government Relations Committee