June 18, 2024

The Honorable Ron Wyden
Chairman
Senate Committee on Finance
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Senate Committee on Finance
239 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

The American Society of Nuclear Cardiology (ASNC) appreciates the opportunity to submit comments in response to the bipartisan Senate Finance Committee white paper," Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B."

ASNC is a 4,900 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.

ASNC commends you and members of the Committee for your leadership to address the pervasive challenges within Medicare's Physician Fee Schedule (PFS) and Medicare fee-for-service (FFS), not the least of which is inadequacy of annual Medicare physician payment updates and current requirements of budget neutrality. **We acknowledge that comprehensive reform to Medicare payment policy may take time, but providing physicians with an annual update beginning in 2025 that is tied to the Medicare Economic Index (MEI) is a step we urge Congress to take action on this year.**

There is also an urgency to reforming budget neutrality requirements to avoid cuts to the conversion factor and significant fee schedule redistribution in the future, including more frequent updates to prices and rates for direct cost inputs for practice expense relative value units which includes clinical wage rates, prices of medical supplies, and prices of equipment.

The length between updates has made price changes more significant rather than if prices were updated more frequently. As highlighted in the white paper, beginning in CY 2022, the Centers for Medicare and Medicaid Services (CMS) initiated a four-year phase-in of a clinical labor pricing update. The clinical labor pricing update changed the rate per minute for a nuclear medicine technologist from the current rate of 0.62 to 0.88, a 43 percent increase. Because nuclear cardiology has a lower share of direct costs associated with clinical labor and has high-cost supplies, the result was a significant *decrease* in payment for nuclear cardiology services, including a 12 percent cut to myocardial perfusion imaging. These cuts, arising from budget

neutrality requirements, were fundamentally unfair. While wages paid to technologists rose, as well as the costs of machines and equipment, CMS finalized a cut to these services to preserve budget neutrality.

ASNC is on record in support of the *Strengthening Medicare for Patients and Providers Act,* (H.R. 2474), which provides a permanent annual update equal to the increase in the MEI, and the *Provider Reimbursement Stability Act* (H.R. 6371), which would make much-needed reforms to budget neutrality. ASNC requests that passage of both bills be considered a priority.

POLICIES THAT ENCOURAGE IMPROVEMENT IN QUALITY OF CARE AND PROMOTE CLINICAL QUALITY OF CARE

A long-standing issue of importance to ASNC is the development, promotion and use of appropriate use criteria (AUC) for advanced diagnostic imaging tests. AUC are based on scientific evidence and practice experience and are intended to define "when to do" and "how often to do" a given test in the context of an individual patient, the health care environment, and a physician's judgment. While the criteria can inform individual patient care decisions, they are best used to evaluate patterns of care by physicians over time and serve as a framework for reducing "Rarely Appropriate" cases. The goal of AUC is to enable cost-effective, high-quality patient care.

ASNC appreciates the recognition among an increasing number of lawmakers that reform of the *Medicare Access and CHIP Reauthorization Act (MACRA)* is needed, including easing the burden of participation in the Merit-based Incentive Payment System (MIPS). **Legislative changes to MACRA offer an opportunity for Congress to incentivize the appropriate use of advanced diagnostic imaging services and to repeal the Medicare AUC Program.**

Medicare AUC Program Background

In 2014, Congress passed the *Protecting Access to Medicare Act (PAMA)* [Public Law 113-93], establishing the Medicare AUC Program for advanced diagnostic imaging [§ 218b]. The program requires consultation and documentation of AUC when an advanced imaging service is ordered for and provided to Medicare beneficiaries. The law pre-dates enactment of *MACRA*.

Advanced imaging services include:

Computed tomography (CT);
Positron emission tomography (PET);
Nuclear medicine; and
Magnetic resonance imaging (MRI).

As written, the AUC Program applies to *every* clinician who orders or furnishes an advanced diagnostic imaging test, except for emergency and inpatient services.

The law is very prescriptive, requiring consultation of AUC using a CMS-qualified clinical decision support mechanism (CDSM) at the time a practitioner (or clinical staff acting under a practitioner's direction) orders an advanced diagnostic imaging service for a Medicare beneficiary. The CDSM provides a determination of whether the order adheres to AUC or if the AUC consulted was not applicable.

Upon consulting AUC, the ordering professional must provide the following information to furnishing professionals and facilities, who must, in turn, report this AUC consultation information on their Medicare claims to be paid for the test:

- Ordering professional's National Provider Identifier;
- CDSM consulted; and
- Whether the service ordered would or would not adhere to consulted AUC or whether consulted AUC was not applicable to the service ordered.

Ultimately, practitioners whose ordering patterns are considered outliers will be subject to prior authorization.

Following years of CMS rulemaking toward implementation of the AUC Program, in November 2023, CMS finalized its proposal to pause the AUC Program and to rescind AUC Program regulations, effectively ending the program's "educational and operational testing period." CMS paused the program and rescinded all regulations stating in the proposed rule "inherent risks in terms of data integrity and accuracy, beneficiary access, and potential beneficiary liability for advanced diagnostic imaging services render the AUC program impracticable."

In the final rule, CMS affirmed a position long-advocated by ASNC that encouraging AUC consultation is inherent in existing Medicare quality programs and that a siloed, standalone AUC program is unnecessary. The final rule stated:

> *"While a standalone program specifically requiring AUC consultation when ordering advanced diagnostic imaging services would directly target goals of improving advanced diagnostic imaging ordering patterns, our experience in recent years has demonstrated that the goals of appropriate, evidence based, coordinated care can be achieved more effectively, efficiently and comprehensively through other CMS quality initiatives."*

CMS has stated it intends to reevaluate the program but has not indicated when implementation efforts may recommence.

Future Considerations for Promoting AUC Consultation to Improve Quality of Care

Although Congress may have believed the AUC Program was a straight-forward approach to encourage the consultation of AUC by clinicians, CMS' decision to indefinitely pause the program and rescind its regulations only underscores the complexity of the law. ASNC strongly supports the consultation of AUC, but has held the position, even prior to the enactment of

PAMA, that the law is overly prescriptive, complex, and siloed from, rather than integrated with, the Quality Payment Program (QPP).

Any attempt at maintaining the AUC Program and imposing consultation requirements on physicians outside of the QPP contributes to physician regulatory burden and cost and does not facilitate meaningful quality improvement that drives better patient outcomes. Instead, **we respectfully ask the Finance Committee to work with ASNC and other medical societies to find ways to align consultation of AUC with the next generation of the QPP in a manner that does not add to clinician administrative burden and practice expense and creates provider flexibility for the consultation of physician-developed, evidence-based and transparent AUC or of advanced diagnostic imaging guidelines using a mechanism best suited for their practice, specialty and workflow.**

Beyond the technical challenges CMS faced with implementation of the AUC Program, a flaw of the statute was the vastness of the program requiring AUC consultation and claims documentation for *every* advanced diagnostic imaging test. **ASNC recommends that efforts designed to encourage consultation of AUC should be focused on areas of low-value care.**

Furthermore, **ordering clinicians must not be confined strictly to the use of a CMS qualified, and proprietary CDSM for consulting AUC as stipulated in *PAMA*.** Other decision support tools and clinical guidelines embedded into electronic health record systems must also be recognized. Confining consultation to a qualified CDSM increases cost and takes away the ability of physicians to consult AUC developed by their specialty society. For example, cardiologists have experienced situations in which a qualified CDSM eliminates their ability to continue consultation of AUC developed by cardiovascular societies (including ASNC and the American College of Cardiology (ACC)) and forces them to consult AUC developed by the American College of Radiology which vary from the ACC/ASNC AUC in their structure, approach, and appropriateness ratings.

A recently-published study in the *Annals of Internal Medicine* concluded that substantial discrepancies in the scope, methods, and formatting of provider-led entity-developed AUC for imaging in suspected coronary artery disease exist.

This study underscores the problems with the AUC Program are not just limited to the real-time claims reporting requirement, but with the basic underpinnings of the program. **As Congress reevaluates *MACRA* and the QPP, the most-straightforward solution is the incorporation of AUC into value-based purchasing programs, including allowing institutions working under alternative payment models to adopt locally run AUC programs as part of their movement toward quality.** ASNC is eager to work with the Committee to move beyond current law's one-size-fits-all approach to AUC consultation and instead identify ways to encourage the consultation of AUC in a manner that is meaningful and has the potential to improve patient outcomes.

Summary: ASNC Suggestions for Repealing and Replacing the AUC Program

- The Medicare AUC Program for advanced diagnostic imaging should be repealed and new ways to integrate AUC into practice should be explored with a focus on low-value imaging, such as those imaging services identified by the Medicare Payment Advisory Commission. For example, a system that examines the frequency of testing for rarely appropriate indications by the ordering provider. Registries that collect data on appropriateness quality measures should be leveraged.

- AUC consultation must not be confined strictly to the use of a CMS qualified CDSM. Other decision support tools and clinical guidelines embedded into EHR systems must also be recognized. Confining consultation to a qualified CDSM increases cost and takes away the ability of physicians to consult AUC developed by their specialty society.

- Requirements of consultation of AUC should be met by simple attestation (i.e., was AUC consulted?). The ordering clinician must attest for a specified percentage of orders rather than 100 percent of all cases. The AUC Program, as currently constructed, imposes enormous administrative burden (and cost burden) on ordering physicians and on laboratories that perform the imaging procedures.

- Attestation by the ordering clinician should be confined to services identified as low-value (e.g., rarely appropriate indications) and could be incorporated as a MIPS Improvement Activity for specialties most apt to provide these low-value services. Like MIPS measures, AUC consultation requirements should be lifted when the volume of targeted low-value services drop below a specified threshold. Thoughtful discussion is needed on how low-value is defined, as "low-value" tests are not always such.

- Improvement Activities that promote innovative, locally-tailored approaches to appropriate imaging utilization should be encouraged and supported.

ASNC appreciates your leadership on Medicare physician payment policy and improving the health of our Medicare beneficiary population. Thank you for consideration of ASNC's feedback. We welcome an opportunity for a virtual meeting to further discuss options for incentivizing the consultation of AUC. To arrange a meeting or for questions, please contact Camille Bonta, ASNC policy advisor, at cbonta@summithealthconsulting.com or (202) 320-3658.

Sincerely,

Lawrence Phillips, MD
President,
American Society of Nuclear Cardiology