June 22, 2015

The Honorable Orrin Hatch
Chairman
Committee on Finance
U.S. Senate
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
U.S. Senate
Washington, D.C. 20510

The Honorable Johnny Isakson
U.S. Senate
Washington, D.C. 20510

The Honorable Mark Warner
U.S. Senate
Washington, D.C. 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner:

The American Society of Nuclear Cardiology (ASNC) thanks you for initiating a bipartisan process to address the challenges in caring for Medicare patients with chronic conditions, and we appreciate your solicitation of ideas from public and private stakeholders on ways to improve outcomes for this patient population.

Nuclear Cardiology plays a pivotal role in establishing the diagnosis and prognosis of heart disease. Nuclear cardiology involves the use of noninvasive techniques to assess myocardial blood flow, evaluate the pumping function of the heart, as well as to visualize the size and location of blockage or a heart attack. Among the techniques of nuclear cardiology, myocardial perfusion imaging (MPI) using Single Photon Emission Computed Tomography (SPECT) and Positron Emission Tomography (PET) are the most widely used.

We are part of the cardiovascular care team and the non-invasive imaging tests we perform and interpret provides information that allows us to effectively risk stratify patients with coronary artery disease. Noninvasive assessment of cardiac risk is widely used to determine medical treatment, including which patients should undergo cardiac catheterization for consideration of revascularization.

Two keys to effective treatment of patients with chronic coronary artery disease are:

- appropriate diagnostic testing, including through the adherence of appropriate use criteria (AUC); and
- practice acquisition of new/improved software and equipment that yield higher quality results.

Appropriate Diagnostic Testing

ASNC develops and promotes the use of guidelines and AUC so nuclear cardiac imaging is used only when it is clinically indicated. ASNC has also launched ImageGuide Registry, the first registry ever developed for non-invasive cardiac imaging, which has begun to collect data that will lead to improvements in patient quality and safety, as well as test appropriateness.

The primary limitation in adherence to AUC is education and awareness of the ordering professional, although adherence to AUC for cardiovascular disease is also challenged by the complexity of the patient. According to behavioral and performance needs assessment of interprofessional referrals and collaboration in nuclear imaging conducted by ASNC in 2014, physicians are challenged in applying AUC when selecting patients for nuclear imaging.

The Centers for Medicare and Medicaid Services (CMS) is required by Congress to implement by Jan. 1, 2017 an AUC program for advanced imaging services. ASNC strongly supports the use of AUC and has offered itself as a resource to CMS as it works to fulfill its mandate.

Because diagnostic tests determine the course of treatment, choosing the right test for the patient impacts patient outcomes and overall cost of care. ASNC supports and is a leader in providing appropriate use educational initiatives for advanced diagnostic referrers and specialists. We firmly believe that tremendous education and assistance of ordering professionals, led by CMS, prior to implementation of the AUC program on Jan. 1, 2017 will be vitally important, as will implementing the program in a manner, such as a phased approach, that does not impose significant burden on ordering professionals.

While CMS is in the very early stages of implementation of the AUC Program, we encourage the Committee to consider adherence to AUC as a clinical practice improvement activities category under the Merit-Based Incentive Payment System (MIPS) as established by the Medicare Access and CHIP Reauthorization Act. We believe this would reduce administrative burden to providers and streamline quality improvement efforts. Furthermore, adherence to AUC will be inherent to the success of many of alternative payment models, thereby negating the need for a separate AUC program. We believe that incorporating AUC as either a voluntary or mandatory clinical practice improvement activity within MIPS would

circumvent a number of the complexities that confront CMS in implementing the AUC Program, including reconciliation of conflicting AUC and bridging AUC and clinical decision support.

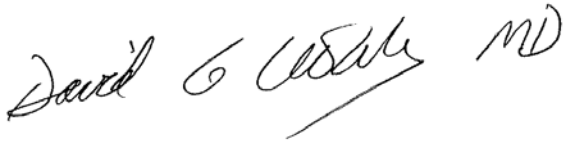
Technology Investments

Treatment decisions are only as reliable as the diagnostic tests used to make those decisions. Unfortunately, reductions in reimbursement for nuclear cardiovascular services limit opportunities to upgrade equipment and software or replace aging equipment, which means lower quality imaging that results in more repeat testing and treatment decisions that may not be well-informed. Over the past five years, payments for nuclear cardiology services have declined on average of 10 percent, leading to reimbursement rates that are unsustainable for many practices and, consequently, shifts in sites of service for nuclear cardiac imaging. Payment adequacy is essential, in all sites of service, and must remain a central tenant of the Committee's efforts.

Finally, we believe as a statement of principle that all alternative payment models must recognize and allow for the right test at the right time. Choice of test should be made by the physician in consultation with the patient, and based upon the test's predictive value, while accounting for individual patient variables. We ask you to adopt this principle as you strive to meet your stated goals, in part, of incentivizing the appropriate level of care for patients living with chronic diseases, improving patient outcomes and reducing growth in Medicare spending.

ASNC appreciates your consideration of its input and looks forward to future opportunities of engagement as continue your process of addressing the needs of patients with chronic conditions. Should you require additional information and for future communications on this topic, please contact Georgia Hearn at 301-215-7575ext207 or at ghearn@asnc.org.

Sincerely,



David Wolinsky, MD
President
American Society of Nuclear Cardiology