Congress Looks at Medicare's Rising Imaging Costs

BY JOYCE FRIEDEN
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WASHINGTON — A congressional committee wrestled with whether or how much to regulate or impose standards on imaging procedures at a hearing last month on managing Medicare's imaging costs.

"I'm concerned about putting in a whole group of new structures [to monitor imaging procedures] because the system is structure-heavy already," said Rep. Nancy Johnson (R-Conn.), chair of the health subcommittee of the House Ways and Means Committee. "I'm not sure putting in more oversight is really what we need."

Mark Miller, Ph.D., executive director of the Medicare Payment Advisory Commission (MedPAC), testified that the growth in the volume of imaging services such as PET scans, CT scans, and MRIs performed on Medicare beneficiaries "is growing at twice the rate of all physician services." And what worries MedPAC, he continued, is that increasing the amount of imaging being done doesn't necessarily mean the quality of care is getting any better.

"There is a threefold variation in the use of these services among the Medicare population, and it's not linked to health care quality," Dr. Miller said. "It's more [related to the] availability of services and practice style."

MedPAC also is concerned about the wide variability in imaging quality, he said. "There is variation in the quality of the images produced and in the quality of image interpretation." He said the 17 MedPAC commissioners would like to see the Department of Health and Human Services set quality standards for imaging providers, referring to recommendations submitted to Congress earlier this year (CARDIOLOGY NEWS, March 2005, p. 6).

"Some people characterize this recommendation as directed toward limiting imaging to radiologists only and billing for imaging to radiologists only," Dr. Miller said, alluding to the perceived "turf war" going on between radiologists and other imaging providers. "That is not correct. We believe the standard should apply to all physicians" who do imaging.

Subcommittee member Rep. Jim Ramstad (R-Minn.) said he was happy to hear that imaging would not be restricted to radiologists. "I would hate to see this become nothing more than a turf battle," he said. "It seems to me that overutilization is a complex issue, involving factors like defensive medicine, provider preference, and consumer demand for the best test."

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The subcommittee also heard from representatives for cardiology and radiology groups, each of which took opposing positions on the increase in imaging volume. "We are deeply concerned with the exponential growth in office-based imaging by those who may lack the education, training, equipment, and clinical personnel to safely and effectively use these studies," said James Borgstede, M.D., chair of the American College of Radiology's board of chancellors. "For this reason, the ACR supports many of the MedPAC recommendations that link Medicare reimbursement to quality, safety, and training standards for physicians and facilities which provide medical imaging services."

Kim Williams, M.D., speaking on behalf of the American College of Cardiology, said there was "no credible evidence" to support the idea that office-based imaging was of poor quality. "Patients are really the issue, not the turf wars frequently discussed in the literature of the American College of Radiology," he said. "Office-based medical imaging performed by well-trained specialists is good patient care."

Cardiologists are especially concerned about a MedPAC recommendation involving ownership of imaging equipment. Under the current laws against physician self-referral, physicians cannot refer patients to an imaging center in which they have direct ownership. Dr. Williams urged the subcommittee not to remove a provision in the law that exempts nuclear medicine.

The subcommittee also considered the issue of whether to lower reimbursement for multiple imaging procedures performed in the same visit—specifically, lowering the amount paid for each subsequent image after the first one. Dr. Borgstede noted that the American Medical Association's CPT Editorial Panel has recommended such a reduction, but it will apply to the first image as well. That change will take effect next January, he said.

"We're at a stage where we have to rethink the way we pay physicians," Rep. Johnson said to the two physicians on the panel. "Think about it, and get back to us about what you'd like to see in terms of … steps in the quality ladder." ■

MedPAC Says Physicians Are Ready for Pay for Performance

BY JENNIFER SILVERMAN
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WASHINGTON — Congress should establish a quality incentive payment policy for Medicare physicians, the Medicare Payment Advisory Commission has recommended.

In light of the challenges facing Medicare, "nothing is more important" than distinguishing between providers based on performance, MedPAC Chairman Glenn Hackbarth said at a commission meeting. "Providers are not all created equal—there's abundant evidence that some providers do a better job than others. To continue to pay them as if they're all performing equally well is a tragic situation."

And that was just one of several of the commission's recommendations aimed at establishing a pay-for-performance system across health care channels, using information technology in Medicare initiatives to financially reward providers on the basis of quality.

The recommendations were included in MedPAC's Report to the Congress on Medicare Payment Policy, submitted in March.

"Physicians are ready for a pay-for-performance program," Karen Milgate, a MedPAC research director said at the meeting.

Those participating in such a program could use various facets of information technology to manage patients, such as registries to track patients and identify when they need certain preventive services, or systems for detecting drug interactions, Ms. Milgate said. These types of information have the potential to improve important aspects of care, and increase physician ability to assess and report on their care.

"Without information technology, it would be difficult for physicians to keep up with and apply the latest clinical science and appropriately track and follow up with patients," she said.

"This is true for primary care and especially for patients with chronic conditions. But [it is] also true for surgeons and other specialists, to ensure follow-up after acute events and coordination with other settings of care."

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Considering that it's the only information collected on physicians, Ms. Milgate noted that claims-based measures could be used to determine whether beneficiaries received appropriate follow-up care.

The claims-based process puts no burden on physicians and research shows it's widely available for a broad group of beneficiaries and physicians, she said.

"However, the depth of information on each kind of physician is unclear and we do know that claims-based measures are not available for every single type of physician," she continued.

Because these actions would redistribute resources already in the system, they would not affect spending relative to current law, although they may increase or lower payments for providers, depending on the quality of their care, she said.

Nicholas Wolter, M.D., a MedPAC commissioner from Billings, Mont., cautioned that physicians may be reluctant to embrace yet another change that would limit their revenue, after the sustainable growth rate. Pay for performance might be "another irritation, rather than an incentive," he said.

Are all physicians equally ready for such a system? "I'm not sure that's true," he added.

Smaller practices in particular may not be ready to provide the clinical information necessary for a mature pay-for-performance initiative, Alan Nelson, M.D., a commissioner representing the American College of Physicians, said in an interview. "However, the insistence of payers for incentives to promote quality is something that can't be ignored," he said.

Although a differential payment system that rewards higher quality "is almost certainly in our future," Medicare should proceed with caution on this initiative, taking care to not increase the administrative burden—and always being aware of unintended consequences, Dr. Nelson continued.

Most of these information technology developments "seem to apply more to primary care physicians than other specialties," observed commissioner William Scanlon, Ph.D., a health policy consultant from Oak Hill, Va. "The question is how we would differentiate the rewards for different specialties even on the structural measures?"

He suggested that Congress create a project to test these rewards on an ongoing basis, to accumulate evidence that it was working effectively among the various specialties.

Mandating use of information technology could accelerate use, but "providers could find such a requirement to be overly burdensome," MedPAC analyst Chantal Worzala said. Such requirements could become appropriate as the health care market develops.

The panel also recommended that prescription claims data from Medicare's Part D program be available for assessing the quality of pharmaceutical and physician care.

"Linking prescription data with physician claims could help identify a broader set of patients with certain conditions, and help determine whether they filled or refilled a prescription and received appropriate pharmaceutical care," Ms. Milgate said.

Rewards could also be given to providers who improve outcomes in care for their patients in other settings, such as physicians whose patients do better in hospitals, or home health agencies who manage their patients' care transition to nursing homes, MedPAC analyst Sharon Bee Cheng told commissioners. ■