



August 1, 2023

RE: Improving Care Delivery and Integrating Specialty Care in Population-Based Models Request for Input

Dear: Physician-Focused Payment Model Technical Advisory Committee (PTAC):

The American College of Radiology (ACR), representing over 40,000 diagnostic, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciates the opportunity to submit comments on the Physician-Focused Payment Model Technical Advisory Committee request for information on “Improving Care Delivery and Integrating Specialty Care in Population-Based Models.”

The ACR appreciates the PTAC’s efforts to include stakeholder feedback on Population-Based Total Cost of Care (PB-TCOC) models and the integration of specialty care in advanced primary care models and Accountable Care Organizations (ACOs), particularly in light of the ACR’s ongoing concerns over radiologists’ ability to engage fully in the Quality Payment Program (QPP). Radiologists struggle to participate in Alternative Payment Models (APMs) and the Merit-based Incentive Payment System (MIPS). Hindrances to successful participation in MIPS include radiologists’ ineligibility to earn the maximum incentive adjustment despite perfect performance due to the limited number of MIPS clinical quality measures equating to 10 points and lack of attribution to episode-based cost and Promoting Interoperability measures. However, the ACR is committed to ensuring that patients have appropriate and readily available access to medically necessary diagnostic and non-diagnostic services radiologists provide.

The ACR recognizes the importance of ensuring that radiologists participate in APMs, due to the major role imaging plays in achieving better quality and cost savings through the rendering of an early diagnosis. However, such opportunity is clearly lacking in the current state based on an insufficient number of disease-based or episode-based APMs. Participation in many APMs, such as ACOs and patient-centered medical homes, is only available to primary care providers. Relevant Advanced APMs are particularly limited for radiologists.

Physician-Focused Payment Models (PFPs) offer a powerful opportunity for enhancing Advanced APM participation by specialists, specialty-driven PFPs, along with the PTAC’s role in guiding their development and approval, provides a compelling opportunity for radiologists to demonstrate and earn rewards for their unique contributions toward patient care. Since holding radiologists accountable for APM measures that do not apply to them would be unfair and fail to incentivize higher-value care, effective PFPs will require creativity, innovation, and collaborative development. Inserting radiologists into transformative care delivery afforded by APMs and PFPs positions this specialty to contribute to higher-quality care, cost savings, and improved patient health and may be done so through a broadly applicable model for radiology. PFPs for breast, lung, and colorectal cancer screening and cancer staging

and follow-up could be developed standalone or integral to a multi-specialty population-based model.

Q1. How do primary and specialty care providers' roles in managing patients' care vary in different contexts? What are some reasons for these differences? To what extent are these differences likely to affect best practices for improving specialty integration? Which approaches would be most appropriate in certain contexts, and why?

Diagnostic radiologists play an essential role in patient care and serve more Medicare beneficiaries annually than any other medical specialty.ⁱ Primary care physicians or other referring clinicians direct patients to diagnostic radiologists for myriad reasons. Imaging studies may be ordered due to the emergence of new symptoms, monitoring the status of current illness, or indication-based screening among others. Studies show that radiologists, on average, provide care for the largest number of unique beneficiaries across 56 unique physician specialties. Even though radiologists less frequently interact directly with patients, the sheer volume of patient care provided highlights the current and potential impact of radiologists in coordinating patient care.ⁱ

Q2. How should the roles of primary and specialty care providers be defined when managing chronic conditions?

Historically, diagnostic radiologists have lacked continuity with the patients whose images they read, and therefore episodes of care have remained undefined. However, with their increasing role in population-based care coordination, radiologists are visibly establishing their long-term significance to individual patients and particular populations. Examples of radiologists' involvement in care coordination include informing appropriate use of imaging (e.g., clinical decision support), partnering with referring physicians on the best use of imaging in accordance with evidence-based criteria, intelligent scheduling considering patients' specific needs, helping patients prepare for imaging tests, communicating the actionable results found on imaging, and assuring that evidence-based recommended follow-up tests occur, particularly for incidental findings with potential risk for cancer or cardiovascular disease.

There are currently no specific situations or conditions that would formally assign diagnostic radiologists the responsibility of managing patients' chronic conditions. However, their increasing leadership in care coordination and improving care continuity is on the rise for patients whose imaging studies yield anticipated findings, detect actionable findings (AFs), and actionable incidental findings (AIFs) (findings unrelated to the clinical indication for the imaging test for which follow-up is recommended).ⁱⁱ The tracking and follow-up of pulmonary nodules incidentally discovered on imaging is an ideal use case for diagnostic radiologists to demonstrate their influence on population-based health outcomes.

Incidental pulmonary nodules are an increasingly common result of routine radiology care, occurring more often than initially thought. According to the evidence it is estimated that more than 1.5 million adult Americans will have a pulmonary nodule identified each year.ⁱⁱⁱ Given the increased discovery of pulmonary nodule AIFs, and to increase the rate of early cancer diagnosis, it is important to assure that lung nodules with the potential to represent undiagnosed lung cancer receive actionable follow-up recommendations and that these recommendations consistently align with evidence or consensus-based guidelines. Depending on the classifications of AIF,

radiologists may use internationally recognized evidence-based recommendations such as those cited in the ACR Incidental Findings Committee's White Paper on *Managing Incidental Findings on Thoracic CT: Lung Findings*^{iv} and the Fleischner Society's *Guidelines for Management of Incidental Pulmonary Nodules Detected on CT Images*.^v

Q 3. What approaches are most commonly being used to facilitate coordination between primary and specialty care providers in advanced primary care models? Why are these approaches being used?

Even though established cancer screening programs such as breast, colorectal, prostate, and lung cancer screening are effective, detecting cancer through incidental findings has increasingly resulted in improved patient outcomes.^{vi} By communicating actionable results discovered on imaging to patients and their primary care physician or other referring clinician, and ensuring that follow-up occurs, whether found incidentally to or for the indication of an imaging exam, radiologists are supporting their patients' receipt of evidence-based care earlier in the disease pathway.

ACR dedicates resources to quality and safety initiatives (through quality measurement and a clinical data registry) focused on improving care coordination by supporting radiology practices' quality improvement of annual screenings and other recommended imaging exams and following up with patients who receive recommendations in the final radiology report regarding their actionable findings (including AIFs). From their participation in ACR's initiatives and other methods of stakeholder feedback, it is apparent that radiology practices are committed to their patients achieving positive health outcomes in a timely fashion. They also identify tracking recommendation follow-up and screening adherence as key contributors to this goal. Unfortunately, practices face barriers to implementing tracking and follow-up workflows, limiting care coordination, including accessing the resources needed and perceptions regarding responsibilities associated with patient communication.

Since the detection and subsequent treatment of pre-malignant lesions and early cancer can improve patients' quality of life-related outcomes and survival rates, thereby reducing the national cancer death rate and the detection of cancers and other treatable conditions at an early stage is also associated with reduced overall treatment costs, it seems logical for radiology practices to execute follow-up and tracking procedures. However, adopting and implementing follow-up and tracking workflows requires practices to invest substantial resources, comprising additional staff time and integration of health information technology platforms. Yet, diagnostic radiology practices are not reimbursed for the tracking and follow-up of evidence-based radiologist recommendations. As such, practices lacking the resources to adopt an adequate tracking and follow-up workflow cannot assume this vital process, while those implementing a workflow are burdened by their current approach. In addition, concerning radiologists' uncertainty about the responsibility of follow-up communication with patients, ACR disseminated a survey in 2019 that collected information on the state of radiology-recommendation follow-up in practice and tracking adherence to radiology recommendations. In 2021 the *JACR* published the survey's analyzed results with an article describing and comparing AIF management by emergency physicians and radiologists. According to the article, there was strong agreement that ordering clinicians were responsible for arranging and ensuring follow-up recommendations of AIFs. Interestingly, it was determined that even though many radiology

practices are not easily able to execute a tracking and follow-up process adequately, most radiologists reported departmental or practice policies or guidelines for AIFs requiring closed-loop communication.^{vii}

When conferring with radiologists and other subject matter experts (i.e., radiology practice administrators, health information technology vendors, and patients) during the planning, development, and execution of ACR's quality and safety initiatives, it was evident to the associated ACR staff and member-leadership that radiologists recognize the value derived from tracking follow-up and adherence presents to patients, payers, and other stakeholders—given diagnostic radiologists' disconnection from care episodes, ensuring patients complete radiologist-recommended follow-up and other imaging adherence is a way for radiologists to establish their effect on patient health outcomes since detection and subsequent treatment of pre-malignant lesions and early cancer can improve these patients' quality of life-related outcomes and survival rates, thereby reducing the national cancer death rate. Detection of cancers and other treatable conditions at an early stage is also associated with reduced overall treatment costs.^{viii}

Screening Follow-up Care and Incidental Findings

Radiologists serve a vital role in population health services, including mammography, low-dose lung cancer screenings, abdominal aortic aneurysm screening, and screening CT colonography. Radiology is an integral part of population health services and ensures access to screening services. During many of these screening services, follow-up care is necessary.

Radiologists are critically involved in identifying incidental findings. In addition to those discovered on lung cancer screening (LCS), pulmonary nodules are among the most frequent IFs found during hospital visits.^{ix} Using Low-dose CT (LDCT), LCS has been shown to reduce the mortality rate in patients with lung cancer and other treatable conditions. LCS is a valuable technology that in addition to identifying early cases of lung cancer and improving patient outcomes, advances the early detection of incidental pulmonary nodules and other AIFs (e.g., coronary artery calcification (CAC) and solid organ masses, etc.). "IFs are commonly encountered on LDCT examinations performed for LCS and have been reported to occur in 8% to 94% of patients, depending on the definition used."^x

As mentioned previously, radiologists are familiar with the evidence-based recommendations associated with the follow-up of AIF pulmonary nodules. Given the rates at which these nodules are discovered and indicate follow-up, compared with the approximated cost savings attributed to LCS/early cancer detection follow-up of AIF pulmonary nodules would provide cost savings for those lung cancers detected apart from LCS. Similarly, screening mammography can detect cancer early when it is most treatable. This improves the odds of survival and can help avoid more extensive treatment. Furthermore, radiologists understand the importance of distinguishing insignificant/unimportant findings that require no additional studies for those that are potentially significant and may require further evaluation and possible intervention.

Conclusion

Diagnostic radiologists are critical to the patient care path. The value they provide is evident to patients whose screening exams or AIF follow-up recommendations result in early disease detection, their treating clinicians who use the imaging results and radiologists'

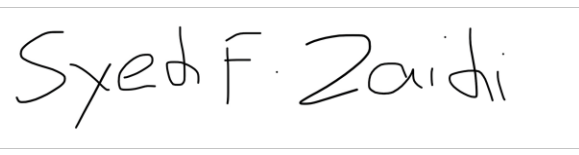
recommendations to inform on treatment next steps, and healthcare payers responsible for the costs associated with the downstream effects of cancer treatments. Additionally, diagnostic radiologists' identification of non-pertinent imaging findings is crucial for establishing cost savings as these results inform on unnecessary therapies frequently associated with the presenting health problem.

The ACR appreciates the opportunity to provide these comments on PB-TCOC. The ACR values the work of the PTAC and appreciates the opportunity to provide comments and perspective on the QPP. The ACR looks forward to the continued work of the PTAC. If you have any questions or comments, please contact, Christina Berry via email at cberry@acr.org.

Respectfully Submitted,



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^v MacMahon, H; Naidich, DP; Goo, JM; Lee, KS; Leung, ANC; Mayo, JR; Mehta, AC; Ohno, Y; Powell, CA; Prokop, M; Rubin, GD; Schaefer-Prokop, CM; Travis, WD; Van Schil, PE; Bankier, AA. *Guidelines for*

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