American College of Radiology™

June 21, 2024

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

The Honorable Bob Menendez
528 Hart Senate Office Building
Washington, DC 20510

The Honorable John Cornyn
517 Hart Senate Office Building
Washington, DC 20510

The Honorable Bill Cassidy, MD
455 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Michael Bennet
261 Russell Senate Office Building
Washington, DC 20510

The Honorable Thom Tillis
113 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Catherine Cortez Masto
520 Hart Senate Office Building
Washington, DC 20510

The Honorable Marsha Blackburn
357 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Wyden, and Sens. Menendez, Cornyn, Cassidy, Bennet, Tillis, Cortez Masto, and Blackburn:

The American College of Radiology (ACR), representing approximately 41,000 radiologists, radiation oncologists, medical physicists, and imaging professionals, appreciates the opportunity to provide feedback on the bipartisan Medicare Graduate Medical Education (GME) working group draft proposal.

The demand for physicians continues to grow faster than supply, leading to a projected physician shortage of up to 86,000 physicians by 2036.[1] These shortages are driven by the need for more doctors as the population grows and ages, as well as vacancies created by physician retirements. Because of the central role that imaging and minimally invasive image guided therapies play in virtually every significant episode of care, shortages within the field of radiology are especially problematic. Despite the increase in demand for imaging services over the last decade and a half, the number of medical students matching into radiology residency positions through the National Resident Matching Program has remained relatively stagnant (1,084 in 2010 and 1006 in 2023) with 100% of positions filled.[2] Even in the most recent 2024 match, nearly all available resident positions for diagnostic and interventional radiology were filled.[3] If the number of radiologists continues to decrease while the amount and complexity of exams and procedures increase, patients may receive unnecessary surgical interventions— driving up health care costs for both individuals and the Medicare program.

[1] GlobalData Plc. The Complexities of Physician Supply and Demand: Projections From 2021 to 2036. Washington, DC: AAMC; 2024.
[2]National Resident Matching Program, Results and Data: 2023 Main Residency Match®. National Resident Matching Program, Washington, DC. 2023.
[3] National Resident Matching Program, Results and Data: 2024 Main Residency Match®. National Resident Matching Program, Washington, DC. 2024.

Ensuring an adequate supply of physicians is integral to the future of our nation's health care infrastructure. Below, ACR offers feedback to several of the working group's questions outlined in the draft proposal.

Additional and Improved Distribution of Medicare GME Slots to Rural Areas and Key Specialties in Shortage

How could Congress improve the recruitment of physicians to work in rural or underserved communities? For example, would adding criteria to allocate GME slots for hospitals affiliated with centers of excellence, HBCUs, or MSIs and for hospitals affiliated with non-academic hospital settings improve the distribution of physician training and recruitment in rural and underserved areas?

Address Physician Payment
Practicing physicians face many challenges in providing high quality care to their patients. These challenges have been exacerbated by a long-broken Medicare physician payment system, which has failed to keep pace with the true cost of physician practice. According to an American Medical Association analysis of Medicare Trustees data, when adjusted for inflation, physician reimbursement has declined 29 percent from 2001 to 2024. Failure to address this basic underlying reimbursement deficiency not only threatens the continued ability of physicians to care for their patients but it also makes it more difficult to recruit new physicians— let alone those who are willing and able to practice in rural and underserved communities.

Year-over-year reductions to the Medicare Physician Fee Schedule (MPFS) and systematic issues—such as the negative impact of the MPFS's budget neutrality requirements and the lack of a Medicare Economic Index (MEI) based inflationary update— are all factors impacting the longevity of the physician workforce. To ensure there are physicians to provide care in the future, these problems must be addressed in conjunction with increasing Medicare supported GME.

Increase the Number of Medicare Supported GME Positions
In its proposal, the working group highlights the disproportionate shortage of primary care physicians and psychiatrists. While ACR understands the importance of these areas of medicine, there is also a growing need for specialty care. We encourage the working group to look outside of policies dictating a certain percentage of slots to specific specialties and instead consider that there are shortages prevalent in all of medicine. If the committee wishes to improve the distribution of GME slots, other specialties, including radiology, must also be considered.

ACR welcomed the recent increase in the number of Medicare supported GME positions by 1200, through both the Consolidated Appropriations Act (CAA) of 2021 and 2023. However, the artificial cap that has been in place since 1997 has made it difficult for resident training to keep up. An additional increase in the number of Medicare supported GME positions is necessary to keep pace with heightened medical school enrollment and to ensure there are enough physicians to work in every community.

ACR encourages the working group to consider the Resident Physician Shortage Reduction Act of 2023, **S. 1302**. This bipartisan legislation would increase the number of federally supported medical residency positions by 2,000 annually for seven years. The Resident Physician Shortage Reduction Act is

crucial to expanding the physician workforce and to ensuring that patients across the country are able to access quality health care.

Methodology for Distribution
ACR has long supported the Resident Physician Shortage Reduction Act, which served as the basis for the CAA in 2021 and 2023. The distribution methodology set forth in the CAA of 2023, while targeting mental health physicians, if implemented properly, would allow for a fair distribution of slots for a diverse representation of hospitals across the country. Specifically, it stipulates that no fewer than 10% be distributed to each of four categories of qualifying hospital:

- hospitals in rural areas, or treated as rural,
- hospitals that are over their Medicare FTE cap,
- hospitals in states with new medical schools or branch campuses, and
- hospitals that serve geographic Health Professional Shortage Areas (HPSAs).

ACR has concerns with the way the Centers for Medicare and Medicaid Services (CMS) has chosen to interpret the distribution methodology by over-prioritizing Health Professional Shortage Areas (HPSAs) in the distributions that have been made thus far. For the CAA of 2021 distribution, CMS has relied on a flawed distribution methodology, resulting in hospitals that would qualify under the four categories but may have a low, or no HPSA score, being denied slots. While CMS initially stated that they would refine the process with stakeholder feedback, they doubled down on this over-prioritization in their FY 2025 Medicare Inpatient Prospective Payment System (IPPS) proposed rule, where they outlined the distribution process for the CAA of 2023 slots.

ACR strongly recommends that any future legislation increasing Medicare supported GME positions include stringent statutory language directing CMS to adhere to the distribution methodology set forth to ensure "qualifying hospitals" receive the slots and there is no room for interpretation with rulemaking.

Ensure Radiologists in Shortage Areas Only Interpret Necessary Imaging Tests
Often, when there is a lack of specialists in rural areas, other providers are utilized to supplement care, which frequently results in the increased ordering of tests and in turn, an increased demand for imaging services.

Although many patients do not have a face-to-face encounter with their radiologist, radiologists care for more Medicare beneficiaries per year than any other physician specialty, which indicates radiology's prominent role in patient care.[4] As a result, the demand for imaging services continues to rise. One way to reduce the increasing demand for imaging services is to modernize and **implement Section 218 (b) of the Protecting Access to Medicare Act of 2014 (PAMA)** which requires all ordering providers to consult appropriate use criteria (AUC) via a clinical decision support mechanism prior to the ordering of advanced diagnostic imaging services for Medicare beneficiaries. This educational tool is critical, particularly in areas where non-physician providers order advanced imaging to both educate the provider and ensure patients receive the right test at the right time. The program can also help eliminate "low value" imaging which can inconvenience the patient, cost both the patient and the Medicare system money and often be of little to no clinical relevance. Although Congress required the PAMA program be implemented by 2017, the CMS has faced significant logistical difficulty during the regulatory process

[4] Andrew B. Rosenkrantz et al; Unique Medicare Beneficiaries Served: A Radiologist-Focused Specialty-Level Analysis, Journal of the American College of Radiology.

and in the 2024 MPFS final rule indefinitely paused implementation pending statutory changes. CMS also reiterated their support for the program and estimated that if implemented, the PAMA AUC program could save the Medicare system approximately $700 million dollars annually. ACR proposes eliminating the provisions creating challenges for CMS by amending Section 218 (b) of PAMA The ACR has provided draft technical corrections language to the staffs of the Senate Finance Committee, as well as the House Ways and Means and House Energy and Commerce Committees. **Modeling a CBO-like scoring process, The Moran Company estimates the AUC draft technical corrections would save the Medicare system more than $2 billion over ten years.**

Would increasing the cap for hospitals in states with the lowest number of GME slots, rather than for all hospitals, improve distribution of GME slots to areas with workforce shortages?

While some states may appear to have more Medicare-supported GME slots, there are teaching hospitals in regions of most states that are in dire need of slots. ACR urges the committee to ensure that the distribution of slots is based on the specific needs of communities. Fewer slots at the state level may not necessarily mean a more dire workforce shortage, depending on population and demand.

Encouraging Hospitals to Train Physicians in Rural Areas

How can existing rural track programs be strengthened and expanded through Medicare GME?

Created in 1994, the Conrad 30 program has brought more than 15,000 physicians who completed their residency in the U.S. to underserved communities. About one-third of resident physicians in the U.S. are international medical graduates and approximately half of those residents are noncitizens practicing under a specific non-immigrant visa (J-1), which requires them to return to their country following residency for two years before they can apply for a work visa or greed card. Under the Conrad 30 program, these physicians can remain in the U.S. without having to return home for two years if they agree to practice in a medically underserved area for three years. Although the Conrad 30 program is within the Senate Judiciary Committee's jurisdiction, solutions to the physician workforce crisis will require a multitude of policy considerations. ACR encourages the working group to collaborate with other Senate committees on strategies to address physician shortages.

While the Conrad 30 program helps physicians who are educated and trained in the U.S. continue to care for patients here, it only allows 30 waivers per state. Congress has continued to reauthorize this program and every state has utilized it since its inception. To build upon its success and strengthen care in rural areas, Conrad 30 should be expanded.

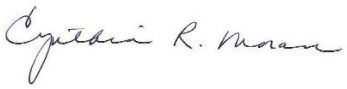
ACR encourages Congress to reauthorize and strengthen the Conrad 30 program by passing the Conrad State 30 and Physician Access Reauthorization Act, S. 665. This legislation reauthorizes the program and makes minor improvements to its functioning by increasing the number of waivers per state beyond 30 and up to 45, if certain nationwide thresholds are met.

ACR join the American Association of Medical Colleges (AAMC) and others in the medical community in supporting the Rural Residency Planning and Development pilot program (RRPD) which since 2019, has helped support the creation and sustainability of rural residency programs. Funding from RRPD helps to cover start-up costs, accreditation, faculty development, and recruitment, and expand the number of trained physicians in rural settings. There is legislation introduced in the House, the Rural Residency

Planning and Development Act of 2024 (H.R. 7855), which would authorize a dedicated funding stream for the RRPD. **ACR encourages similar legislation to be introduced in the Senate** which would make a significant contribution to the long-term sustainability of rural healthcare access and help alleviate shortages in rural areas.

ACR appreciates the opportunity to provide feedback on the working group's GME proposal and we look forward to working with the Senate Finance Committee on policies to address the physician workforce crisis.

Sincerely,



Cynthia R. Moran
Executive Vice President
American College of Radiology

HEADQUARTERS
1892 Preston White Drive
Reston, VA 20191
703-648-8900

GOVERNMENT RELATIONS
505 Ninth St. N.W.
Suite 910
Washington, DC 20004
202-223-1670

CENTER FOR RESEARCH AND INNOVATION
50 South 16th St., Suite 2800
Philadelphia, PA 19102
215-574-3150

ACR INSTITUTE FOR RADIOLOGIC PATHOLOGY
1100 Wayne Ave., Suite 1020
Silver Spring, MD 20910
703-648-8900