June 14, 2024

Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Dear Chairman Wyden, Ranking Member Crapo, and Finance Committee Members:

The American College of Radiology (ACR), representing more than 41,000 diagnostic and interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciates the opportunity to comment on the white paper released May 17, 2024, titled "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B".

As a physician medical specialty society, the ACR is acutely aware of the many challenges our members face as they provide high quality care to Medicare beneficiaries. These challenges have been exacerbated by a long-broken Medicare physician payment system. We applaud the Committee's recognition of many of the problems with Medicare's physician payment system, and we hope the Committee finds our comments and observations helpful as it contemplates much needed reforms.

In response to the Committee's white paper, we have organized our comments into those pertinent to Medicare's physician fee schedule (PFS under traditional fee-for-service (FFS) Medicare, followed by comments related to Alternative Payment Models (APMs).

Addressing Payment Adequacy and Sustainability

Among clinicians and providers participating in the Medicare program, physicians and clinicians are unique in that there is no statutory annual update to FFS payment rates under the physician fee schedule. Virtually all other provider types (hospitals, dialysis facilities, post-acute care providers, et cetera) have annual payment adjustments built into their Medicare payment systems to reflect the inflationary cost input pressures those providers face – pressures largely beyond their ability to control (*e.g.*, increases in the cost of labor, supplies, utilities, transportation, *et cetera*). However, since the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015, physicians have singularly been excluded in the Medicare system from any annual inflation adjustment that recognizes the year-over-year increases in the costs of running their practices.[1] According to an American Medical Association (AMA) analysis of Medicare Trustees' data, when adjusted for inflation, physician reimbursement has declined 29 percent from 2001 to 2024.[2] Failure to address this basic underlying reimbursement deficiency threatens the continued ability of physicians to care for their patients. The ACR recommends that the

[1] MACRA established small annual payment updates beginning in 2026 – 0.75 percent annually for physicians participating in alternative payment models, and 0.25 percent annually for other physicians. However, these increases do not come close to tracking the annual cost increases physicians face in operating their practices.

[2] https://www.ama-assn.org/system/files/2024-medicare-updates-inflation-chart.pdf

Congress act with all due haste to add a standing statutory annual inflation adjuster to Medicare's PFS; given that CMS has described the Medicare Economic Index (MEI) as "the best measure available of the relative weights of the three components in payments under the PFS," we would support using full MEI as the best available inflation adjuster.

Conversion Factor Fluctuations and Constraints/Budget Neutrality Updates to the Conversion Factor

Beyond the lack of an inflationary adjuster, ACR asserts that a second substantial structural problem with the PFS stems from the core principle of budget neutrality that governs Medicare's approach to spending for physician services under traditional FFS. In an over-simplified characterization, budget-neutrality requires that except for recognizing certain external factors (such as changes in Medicare enrollment), aggregate Medicare PFS spending in a given year cannot exceed spending in the previous year. While budget neutrality is intended to be a control on Medicare PFS spending, it has created two foundational problems that impede physician's ability to provide care for Medicare beneficiaries.

First, budget neutrality creates a "zero sum game" among physicians, under which increases in payments to some physicians must be offset by decreases in payments for other physicians. Many patients, especially those with chronic conditions, are treated by teams of physicians – specialists and primary care providers - who work in concert to provide their care. The current statutory requirement for budget neutrality in the Medicare Physician Fee Schedule is not conducive to this teamwork model of care. To increase the reimbursement for one service code or set of services (*e.g.*, Evaluation and Management (E&M) services), the Centers for Medicare and Medicaid Services (CMS) is required to reduce reimbursement for other services accordingly. For example, in order for a primary care physician to receive increased reimbursement for a patient's E&M visit, a specialist treating that same patient may receive a reimbursement decrease for a procedure performed (*e.g.*, colonoscopy, radiation therapy). Thus, the current budget-neutrality requirement creates inequities *among* physicians within any given payment year.

Second, the budget-neutrality requirement contributes to year-to-year volatility in the PFS's conversion factor, creating unsustainable volatility within the PFS over time. This volatility can especially affect practice-expense-intensive specialties such as radiology. As a specialty, diagnostic radiology is at the forefront of medical technological innovation and use. Radiology is the major component in the diagnosis of most injuries and diseases. If services are provided in a privately owned, non-hospital-based practice, the cost and maintenance of the equipment used, the cost of owning or renting space to provide these services, employment of staff and dedicated technologists can only survive if there is sufficient reimbursement to cover these expenses. Unfortunately, adequate reimbursement of the practice expense component of the PFS, which is intended to account for both direct and indirect practice expense, falls grievously short of appropriate

and necessary reimbursement to allow community based, privately owned practices to survive.

In particular, collecting accurate indirect practice expense data has been challenging due to the need to take into consideration different specialties' practice patterns. The indirect practice expense data needs to be routinely updated to ensure it is accurate and representative to avoid potentially large swings in reimbursement due to redistributive effects in a budget neutral system.[3]

PFS payment reductions are felt hardest by smaller, independent practices, particularly those in rural and underserved areas that continue to face significant health care access challenges. In response, many practices have been acquired by larger entities, including hospitals, health systems, corporate health care networks, and in some instances private equity investment firms, permanently impacting patient access to care. Private practices that have not consolidated are forced to make very difficult decisions when considering investing in technology, potentially hindering innovation and quality of care delivered to patients.

Additional legislative changes necessary to promote stability in the PFS include:

- Update the budget neutrality trigger from $20 million to $100 million.
- Provide a lookback period to reconcile over- and under-estimates of pricing adjustments for individual services to allow for the PFS conversion factor (CF) to be accurately calculated based on actual utilization data.
- Refine which services are subject to budget neutrality. When federal policy changes are expected to result in use of certain services, those services should be exempt from budget-neutrality calculations. These could include newly covered Medicare services that are being incentivized to lower overall Medicare spending (*e.g.* care management codes).
- Timely updates to direct costs used to calculate practice expense relative value units

The ACR acknowledges the fiscal and budgetary challenges associated with Medicare payment reform and appreciates the Committee's interest in targeted polices to offset the costs associated with said reform. One such targeted policy would be to amend Section 218 of the Protecting Access to Medicare Act of 2014 (PAMA) which required ordering clinicians to consult appropriate use criteria (AUC) via a qualified clinical decision support mechanism (qCDSM) prior to the ordering of advanced diagnostic imaging services under Part B. Although statute required CMS to implement the program by January 1, 2017, CMS

[3] The Medicare Payment Advisory Commission (MedPAC), an independent non-partisan congressional advisory agency, recommended such regular data collection as early as 2011, and has consistently recommended that CMS do so (Medicare Payment Advisory Commission, "Moving Forward from the Sustainable Growth Rate (SGR) System, letter to the Congress, October 14, 2011.

https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/10142011_MedPAC_SGR_letter.pdf

has faced significant challenges operationalizing the real time claims processing component of the AUC program, and in the CY 2024 PFS Final Rule indefinitely paused implementation. CMS also acknowledged the clinical value of the program, and estimated that if implemented, the federal government could save approximately $700 million dollars annually. [4]

The ACR has provided the Committee with suggested statutory changes to modernize the AUC program and facilitate implementation. The Moran Company (TMC) has estimated that if the AUC program is implemented with these changes, the savings to the federal government would be approximately $2 billion dollars over a ten-year budget window. The savings to beneficiaries is estimated to be roughly $1.4 billion over the same time period.

Improving Primary Care and Chronic Care

As referenced above, the PAMA AUC program for Medicare Part B is an evidence-based delivery approach that is good for patients, providers and taxpayers. PAMA requires an AUC consultation to be performed via a CMS qCDSM when a health care provider orders advanced diagnostic imaging for Medicare patients. The program ensures that physician-led, physician-developed clinically oriented guidelines are used to guide referring clinicians in their decision-making regarding which imaging exam or procedure, if any, is most appropriate for a patient's condition, illness or injury.

In the 2024 Medicare PFS final rule, CMS paused the PAMA AUC program due to implementation difficulties. However, in the same rule, CMS reiterated its support for the program and estimated that if implemented, the PAMA AUC program could save the Medicare system approximately $700 million dollars annually. Congress will need to pass legislative improvements to the program, removing the real time claims processing requirements for the AUC program to be implemented by CMS.

The ACR and CMS have strongly urged providers that have already implemented CDS programs to continue their use during this pause. This real-time 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. A recent study published in Emergency Radiology found that the rate of inappropriate imaging studies in the emergency department for some modalities can approach 60 percent. Appropriately ordered imaging was three times more likely to yield findings compatible with the initial diagnosis.

Alternatives such as prior authorization impose tremendous administrative burdens on physician practices, and shift costs onto physicians. In addition, prior authorization takes medical decisions out of doctors' hands and may delay or deny lifesaving care to those who need it. The ACR has long supported congressional and regulatory efforts to reduce

[4] https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other

physician administrative burden across all payment systems. Prior authorization is a major contributor to this burden.

A recent national survey of hospitals, health systems and post-acute care providers by Premier found nearly 53% of Medicare Advantage (MA) claim denials were eventually overturned and paid. But administrative costs to fight the denials averaged nearly $48 per MA claim, survey participants reported.[5]

Additionally, far too often prior authorization decisions are made by non-physician health plan employees based on a "black box" set of criteria on a delayed timeline that prioritizes health plan profits over patients. The imaging AUC program is a minimally burdensome alternative to prior authorization that could be effectively used in FFS Medicare.

To move forward with AUC implementation, the ACR has proposed significant administrative simplification amending language to the Senate Finance Committee. We urge the swift adoption of the revised, updated legislative text to provide CMS with the statutory changes needed to implement the AUC program. These changes will first and foremost improve patient care by decreasing unnecessary utilization and associated copayment costs while providing a utilization management tool far superior and less burdensome than any prior authorization process. But more importantly, the implementation of the program will ensure the patients receive the most appropriate imaging study at the right time.

Hybrid Per Beneficiary Per Month Payment Model Under FFS

In 2019, CMS finalized for 2021 implementation a major revaluation of the outpatient E&M codes. Additionally, in an effort to boost primary care reimbursement, CMS finalized G2211, a CMS-generated add-on code intended to be billed in conjunction with E&M services to account for complex, longitudinal care. The combination of these two policies led to an overall proposed budget neutrality reduction to the CF of -10.2%. In 2021, specialties who frequently bill for E&M services, such as endocrinology, primary care, and rheumatology, were projected to receive payment increases of up to 16%. Specialties like radiology, which rarely if ever bill for E&M services, were facing corresponding reimbursement reductions of roughly 10% due to the statutorily required application of budget neutrality, a 26% swing in the PFS. [6]

To mitigate this conversion factor decrease, Congress passed a series of conversion factor increases that not only help the "losing" specialties, but also add additional reimbursement for primary care. Those who bill E&M services benefit from increased relative value units as well as increases to the conversion factor.

The ACR appreciates the Congressional effort to bolster the PFS CF annually. However, the CF continues to decline, and as referenced above, specialties with high practice expense

[5] https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims

[6] https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf

costs that rarely bill E&M continue to bear the brunt of the reductions associated with increases intended to bolster primary care, especially without an MEI based inflationary update.

The ACR has no official policy on a possible hybrid per beneficiary per month (PBPM) model for primary care. However, we are concerned that a hybrid model constrained by the PFS statutory budget neutrality requirement will further stress a broken reimbursement system that is already unable to adequately reimburse practice-expense-intensive specialties for the services they provide. Radiology and other providers billing through the PFS who are not patient-facing or do not frequently bill E&M services are unable to absorb constant decreases to pay for primary care increases.

Supporting Chronic Care Benefits in FFS

Imaging is often at the diagnostic forefront of many chronic conditions, including cancer. The ACR firmly believes that early detection saves lives, and we are committed to ensuring patients have access to screening tests to increase their likelihood of positive outcomes.

The U.S. Preventive Services Task Force (USPSTF) is an independent, volunteer panel of national experts in disease prevention and evidence-based medicine. The Patient Protection and Affordable Care Act (PPACA) includes provisions that eliminate patient cost sharing requirements as a barrier to accessing lifesaving cancer screens. PPACA requires individual and group (employer) insurance plans to provide certain preventive screening tests, as determined by a variety of agencies and advisory bodies, including the USPSTF, the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration (HRSA), to beneficiaries free of out-of-pocket costs.

Lung Cancer Screening

The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. A study found that between January 1, 2015, and June 30, 2020, there were 118 total LCS-detected cancers in 113 individuals (3.4%). Most LCS-detected cancers were adenocarcinomas (62 of 118 [52%]), 55.9% (65 of 118) were stage I, and 16.1% (19 of 118) were stage IV.[7] Despite the effectiveness of LDCT, a recent study showed that only 1.8% of eligible Americans with commercial insurance received lung cancer screening.[8] ACR is committed to work with patients and referring providers to increase the uptake of LDCT to improve beneficiary health and reduce associated treatment costs through early diagnosis. We encourage federally funded public health initiatives to help achieve that goal.

[7] Lung Cancer Screening in Clinical Practice: A 5-Year Review of Frequency and Predictors of Lung Cancer in the Screened Population. https://www.jacr.org/article/S1546-1440(23)00861-X/abstract

[8] Comparison of Lung Cancer Screening Eligibility and Use between Commercial, Medicare, and Medicare Advantage Enrollees. https://www.jacr.org/article/S1546-1440(23)00139-4/fulltext

Breast Cancer Screening

In 2009, and as part of a scheduled re-review in 2016, the USPSTF released breast cancer screening guidelines assigning a "C" grade to screening mammography for women age 40-49 years and a "B" recommendation for biennial screening mammography beginning at age 50. In 2024, USPSTF revised its recommendation and assigned a "B" grade for biennial screening mammography beginning at age 40 through age 74.[9] This represents significant departure from breast cancer screening guidelines of leading clinical organizations for women's health - including the American College of Radiology/Society for Breast Imaging, National Comprehensive Cancer Network and the American Medical Association, whom all recommend breast cancer screening begin annually at age 40 for women of average risk.

Breast cancer patient groups joined the ACR and other clinical organizations in expressing opposition and urged Congress to support the Protecting Access to Lifesaving Screenings (PALS) Act by placing a moratorium on the USPSTF breast cancer screening guideline change, ensuring women continue to have access to annual screening mammography beginning at age 40 with no co-pay. The initial moratorium was included in the Consolidated Appropriations Act of 2016, has been renewed several times, and is set to expire January 1, 2025.

The ACR also supports enactment of the Find It Early Act (H.R. 3086), which would require all health insurance plans to cover supplemental screening and diagnostic breast imaging with no out-of-pocket costs for women considered to be at high risk for breast cancer.

Colon Cancer Screening

The USPSTF recommends screening for colorectal cancer in all adults aged 45 to 75 years. Colon cancer is one of the top five cancers in the U.S., and at least one in 25 people will develop colorectal cancer in their lifetime. Fortunately, colon cancer can be cured 90% of the time if caught early.[10] Recent studies have shown that colon cancer mortality rates are 47% higher in Black men and 34% higher in Black women compared to White men and women[11] with roughly one-fifth of this racial disparity attributable to lower screening rates. The USPSTF recommends a myriad of colon cancer screening tests including CT colonography (CTC), a less invasive and less expensive colon cancer screening test that utilizes computed tomography to identify any potentially pre-cancerous colonic polyps without the patient having to undergo sedation. CTC is not covered by Medicare but is an American Cancer Society recommended colon cancer screening test with broad private payer coverage in all fifty states. Medicare beneficiaries who reside in communities with

---

[9] https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening#:~:text=The%20Task%20Force%20recommends%20that,of%20dying%20from%20this%20disease.

[10] https://fascrs.org/patients/diseases-and-conditions/a-z/screening-and-surveillance-for-colorectal-cancer-e

[11] https://aacrjournals.org/cebp/article/21/5/728/69412/Contribution-of-Screening-and-Survival-Differences

annual per capita income of $100,000 or more are 5.7 times more likely to receive CTC than those residing in communities with per capita income of less than $25,000.[12] Medicare coverage of CTC would increase early detection and save lives of Medicare beneficiaries. The ACR continues to work to obtain CMS coverage of CTC by providing clinical evidence supporting the use of CTC, including the value of CTC in increasing colon cancer screening in vulnerable populations.

Additional Considerations: Ensuring Accuracy of Relative Values within the PFS

The current PFS structure is adequate for setting relative value units (RVUs). It remains imperative that a diverse set of stakeholders discuss relativity and that such decisions are not made without a deep understanding of physician services by those who perform them. The AMA is the best entity to address and audit all these issues.

The AMA demonstrates consistent transparency in RVU recommendations by providing clear guidelines, criteria, and methodologies used for determining values. This transparency should extend to how stakeholder input is solicited, evaluated, and incorporated into final decisions. There needs to be continued meaningful engagement of diverse stakeholders, including health care providers, professional organizations like the AMA, specialty societies, patient advocacy groups, and industry representatives. We need to ensure continued accuracy and reliability of data used in RVU calculations through rigorous data collection, validation, and analysis procedures. This includes regularly updating data sources to reflect current medical practice patterns, patient demographics, and technological advancements.

CMS must develop a long-term strategic plan for RVU updating and rate-setting that anticipates future health care trends, technological advancements, and changes in patient demographics which ensures accuracy over time and that considers economic factors such as inflation, cost of living adjustments, and reimbursement rates for medical equipment and supplies when setting conversion factors and payment rates. This should remain physician focused to ensure sustainable payment models.

By implementing these structural improvements, CMS can enhance the integrity, reliability, and accuracy of its RVU and rate-setting processes, ultimately leading to more equitable and effective reimbursement for healthcare services.

---

[12] Sociodemographic Factors and Screening CT Colonography Use Among Medicare Beneficiaries https://www.ajronline.org/doi/10.2214/AJR.23.29703

The ACR supports the reinstatement of the Refinement Panel in the relative value appeals process. The Refinement Panel served as a means for specialties to appeal code values that were refined by CMS that they did not agree with by bringing it forward for additional review by an objective body or group of physicians. This was a transparent process and, much like the Relative Value Scale Update Committee (RUC) process, allowed clinical experts and physicians to speak to the procedure(s) and address any questions posed by the Panel. The Panel members would then submit their votes, and the outcome would later be shared with the specialties.

When the Refinement Panel was first implemented, it was a highly respected process by the specialty societies, the RUC, and CMS. The Panel's final recommendations were uniformly accepted and implemented by CMS prior to 2011. After 2011, changes were made to the Refinement Panel that reduced its impact before it was eventually dissolved in 2016 by CMS.

To ensure the Refinement Panel's objectivity, CMS should not determine which codes should be reviewed by the Panel. The specialties or stakeholders should be able to bring forward any code(s) that they feel requires review by an objective party. Additionally, CMS should agree to implement the Panel's recommended value without further refinement.

The ACR supports the AMA's RUC as the most credible and reliable input to the rate-setting process. These inputs could be supplemented by Health Policy Research Institutions with appropriate expertise and resources to conduct comprehensive analyses of CMS's RVU determination and rate-setting processes to provide valuable insights into the implications of CMS policies on various stakeholders.

Incentivizing Participation in Alternative Payment Models

In 2015, Congress replaced the flawed sustainable growth rate formula and enacted the Medicare Access and CHIP Reauthorization Act (MACRA), which was intended to assist clinicians in shifting from a volume-based payment system to a value-based payment system. The Quality Payment Program (QPP) included two pathways, the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (A-APMs).

Historically, radiologists have had an easier time participating in MIPS than in A-APMs. Many A-APMs have been focused on primary care providers and have proven difficult for radiologists and other non-patient facing physicians to participate. The ACR has continuously advised CMS to provide more A-APM opportunities for radiologists, however we continue to struggle to attain the required amount of patient attribution to become qualifying APM participants.

A study that analyzed a large commercial payer database found that 33.2%-45.8% of imaging studies were stand-alone patient encounters[13]. This high number of single patient encounters makes it incredibly difficult for radiologists to participate within the framework

[13] https://www.sciencedirect.com/science/article/abs/pii/S0363018823001238

of episodic measurement and value-based payment models. Outdated regulations prohibit diagnostic radiologists from billing E&M codes, the codes most frequently billed for patient encounters.[14] There are limited efficiencies to be gained when radiologists participate in APMs. For complex patients with significant continuing care, radiologists can add value by collaborating with referring clinicians to improve quality, safety, and value of imaging. Radiologists' expertise can help guide ordering clinicians in reducing the variation in their ordering pattern. APMs can be devised to incentivize this role for ongoing care, but for the one-third to one-half of radiologist workload that is not part of an ongoing episode of care, such payment models would not be effective.

The ACR has been supportive of the American Society for Radiation Oncology's (ASTRO) Radiation Oncology Case Rate Program (ROCR) that would transform radiation oncology reimbursement by changing payment from per fraction to per patient. ROCR is a simplified approach compared to the indefinitely delayed CMS RO Model.

The ACR appreciates the opportunity to comment on the Committee white paper and looks forward to working together to ensure Medicare beneficiaries continue to have access to high quality care. If you have any questions, please contact Cynthia Moran, Executive Vice President, Economics and Advocacy with the American College of Radiology at cmoran@acr.org.

Thank you,

Cynthia R. Moran
Executive Vice President, Economics and Advocacy
American College of Radiology

[14] Medicare Benefit Policy Manual, Ch. 15, § 80.6.1