The American College of Radiology (ACR), representing approximately 41,000 radiologists, radiation oncologists, medical physicists, and imaging professionals, appreciates the opportunity to submit a statement for the record in response to the Senate Finance Committee hearing titled "Bolstering Chronic Care Through Medicare Physician Payment" held April 11th, 2024.

As a physician medical specialty society, we are 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, which has failed to keep pace with the true cost of physician practices. According to an American Medical Association analysis of Medicare Trustees data, when adjusted for inflation, physician reimbursement has declined 26 percent from 2001 to 2023. Failure to address this basic underlying reimbursement deficiency threatens the continued ability of physicians to care for their patients.

For many patients, especially those with chronic conditions, teams of physician specialists work in concert with the primary care provider to provide treatments for their patients. This coordinated, teamwork model of care is disincentivized in the Medicare Physician Fee Schedule (MPFS) due to statutorily required budget neutrality.

Additionally, physicians have singularly been excluded in the Medicare system from any kind of annual inflation adjustment that directly impacts the costs of running their practices. Congress must act to add a Medicare Economic Index (MEI) based inflationary update to the MPFS.

With the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress intended to encourage and incentivize a transition from traditional fee-for-service to a value-based care model, via either an alternative payment model (APM) or the merit-based incentive payment system (MIPS). Much of diagnostic radiology is non-patient facing, however numerous significant exceptions are found in the provision of breast imaging, and in interventional radiology procedures. As largely non-patient facing physicians, as with a number of other medical specialties, diagnostic radiologists have found it extremely difficult to meaningfully participate in the MACRA statutory programs. Recent studies show that one third to nearly one half of radiologist interactions with Medicare beneficiaries are single, isolated interactions.[1] In addition, outdated and contested CMS regulations prohibit diagnostic radiologists from billing evaluation and management codes [2], the codes most frequently billed for patient encounters. These two factors severely limit the ability of radiologists to participate in any value-based payment model. As Congress considers MACRA reform, the nature of practice

[1] Eric W. Christensen, et al; Prevalence of "One-Off Events" in Radiology: Implications for Radiology in Episode-Based Alternative Payment Models,

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

for all physicians, including radiologists and other non-patient facing physicians, must be considered for true reform to take place.

As a specialty, diagnostic radiology is at the forefront of medical technological innovation and use. The science of 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 like all businesses if there is sufficient reimbursement to cover these expenses. Unfortunately, adequate reimbursement of the practice expense component of the MPFS, which is intended to account for both direct practice expense (clinical labor, supplies, and equipment) and indirect practice expense (rent, administration, and other overhead), 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 complex nature of data sets while having to take into consideration of 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.

These reimbursement reductions are felt hardest by smaller, independent practices, like those in rural and underserved areas that continue to face significant health care access challenges. In response, many practices have been acquired by larger healthcare entities, including hospitals, health systems, and corporate healthcare networks, 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.

The continued downward spiral of the MPFS and resulting changes in the practice of medicine have contributed to a workforce shortage that is being experienced by the entire physician community, radiology included. Recent data from the American Association of Medical Colleges (AAMC), projects a shortfall of up to 86,000 physicians by 2036. This is extremely concerning, especially considering an ageing population that has benefited from diagnostic imaging technological advances that have enabled patients to live longer with chronic conditions.

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, which indicates radiology's prominent role in patient care.[3]. As a result, the demand for imaging services continues to rise and the supply of radiologists is increasingly unable to meet that demand. One way to reduce the increasing demand for imaging services is to implement Section 218 (b) of the

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

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 Centers for Medicare and Medicaid Services (CMS) has faced significant logistical difficulty during the regulatory process 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.

In order to move forward with AUC implementation, the ACR has proposed significant administrative simplification 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 and provide a utilization management tool far superior to any prior authorization process. Winnowing down the number of unnecessary advanced imaging studies will also have a direct, dramatic impact on unnecessary imaging studies which will advantage the current status of workforce shortages in diagnostic radiology.

The ACR encourages swift Congressional action to increase both the current and future supply of radiologists. To address current supply, the expansion of the Conrad 30 program (S. 665) would allow more physicians who have trained in the United States on a J-1 visa to continue to practice medicine in the US without having to return to their home country post residency. The Healthcare Workforce Resilience Act (S.3211) would recapture unused immigrant visas for physicians and nurses, which will ultimately lead to an increase in currently practicing physicians to meet the needs of our population. To address future supply, the ACR encourages passage of the Resident Physician Shortage Reduction Act (S 1302), and add Medicare funded graduate medical education (GME) slots and help close the projected physician shortfall.

We are encouraged that Congress is recognizing the need for substantive Medicare physician payment reform and look forward to future discussions. If you have any questions, please contact Cindy Moran, Executive Vice President, Government Relations, Economics and Health Policy, at cmoran@acr.org.

Thank you,

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