Address Physician Workforce Crisis: Ensure Patients Have Access to Radiologists

Background

Ensuring an adequate supply of physicians is integral to the future of our nation's health care infrastructure. Unfortunately, the need for physicians continues to grow faster than supply. The United States could see an estimated shortage of between 13,500 and 86,000 physicians by 2036, including in most specialties. These shortages are driven by the need for more doctors as the population grows and ages, as well as vacancies created by retirements.

Issue

Within the field of radiology, physician shortages are especially problematic because of the central role that imaging and minimally invasive image guided therapies play in virtually every significant episode of care. If the number of radiologists continues to decrease while the amount and complexity of exams and procedures increase, the benefit to the patient of reduced surgical intervention and the savings associated with that reduction will be obviated. Congress can help stop the current and impending further crisis in the physician workforce through several short and long-term policy solutions.

Policy Solutions

- Amend the Appropriate Use Criteria (AUC) Section of the Protecting Access to Medicare Act (PAMA) - Implementing PAMA-established AUC programs based on physician-developed guidelines will promote appropriate imaging, reduce the over-ordering of low-value tests, and help manage wait times and backlogs, ensuring that radiologists in shortage areas will only be interpreting necessary imaging tests.

- Increase the Number of Medicare-Supported GME Positions - As medical school enrollment continues to grow (up 30% since 2022), an artificial cap that was placed on Medicare support of graduate medical education (GME) nearly three decades ago has made it difficult for medical resident training to keep pace. While the 1,200 positions recently provided by Congress over the last three years are an important start to training more physicians, additional support is needed.

  To continue addressing the growing physician shortage issue and strengthen the nation's health care system, Congress should enact the Resident Physician Shortage Reduction Act of 2023 (H.R. 2389/ 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 care from providers.

- Reauthorize & Strengthen the Conrad 30 Program - 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. Congress has continued to reauthorize the program and every state has utilized the Conrad 30 program since its inception.

Currently, resident physicians from other countries training in the U.S. on J-1 visas are required to return to their home country for two years after their residency has ended before they can apply for a work visa or green card. The Conrad 30 program allows 30 qualified residents per state to 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.

This Congress, the Conrad State 30 and Physician Access Reauthorization Act was reintroduced in both chambers. H.R. 4942 and S. 665 reauthorize the program and make minor improvements to its functioning. Both bills would reauthorize and expand the Conrad 30 J-1 visa waiver program by allowing the program to expand beyond 30 slots (up to 45) if certain nationwide thresholds are met.

- Support the Healthcare Workforce Resilience Act - Recognizing that barriers to visa authorization can prevent qualified medical professionals from providing care in communities impacted by shortages, legislation has also been introduced in Congress to address the process for employment-based visas. The Healthcare Workforce Resilience Act (H.R. 6205/S. 3211) would initiate a one-time recapture of up to 40,000 unused employment-based visas – 25,000 for foreign-born nurses and 15,000 for foreign-born physicians – so they can strengthen and provide stability to the U.S. health care system. This temporary recapture period concludes three years after the date of enactment.

  Under this legislation, the number of highly trained health care providers could increase by expediting the visa authorization process for qualified individuals, who are urgently needed but stuck overseas due to backlogs and other bureaucratic delays despite many being approved to come to the U.S. as lawful permanent residents. It would also allow for thousands of international physicians who are currently working in this country on temporary visas with approved immigrant petitions to adjust their status.

Requests

- Amend the Appropriate Use Criteria (AUC) Section of the Protecting Access to Medicare Act (PAMA)
- Cosponsor the Resident Physician Shortage Reduction Act (H.R. 2389/S. 1302)
- Cosponsor the Conrad State 30 and Physician Access Reauthorization Act (H.R. 4942/ S. 665)
- Cosponsor the Support the Healthcare Workforce Resilience Act (H.R. 6205/ S. 3211)

The Budgetary Effects of the Modification to Appropriate Use Criteria (AUC) Advanced Diagnostic Imaging Program

The Moran Company, an HMA Company, was engaged by the American College of Radiology (ACR) to "score" the effects of legislative modifications to the appropriate use criteria (AUC) advanced diagnostic imaging program in section 1834(q) of the Social Security Act, as added by section 218(b) of the Protecting Access to Medicare Act of 2014 (PAMA) (P.L. 113-93). Since PAMA's passage, CMS has faced challenges implementing the AUC program, and the agency recently decided to indefinitely pause implementation, citing the real-time claims-based reporting requirement in section 1834(q)(4) as "an insurmountable barrier" to full implementation.[i]

The proposed legislative modifications would eliminate this reporting requirement and allow CMS to fully operationalize the program. This means that under proposed law, additional imaging services would be subject to AUC consultation via clinical decision support mechanism (CDSM), some of which will be flagged as inappropriate and either entirely averted or redirected to a more appropriate service.

On net, we estimate that the legislative modifications would decrease direct spending by about $2.0 billion over the FY 2024-FY 2033 budget window. While additional detail is available in an extended report, the below outlines our findings at a high level.

Key details:

- In addition to the decrease in federal direct spending referenced above, we estimate that Medicare beneficiaries would also save about $1.4 billion over the current budget window via reduced cost-sharing.
- To model the impacts of the fully operationalized program, we used annualized 2023 data from CareSelect Imaging software, a CMS-qualified CDSM product of Change Healthcare that provides AUC consultation.
- The data suggests that in 2023, over $178 million in inappropriate allowed charges would have been furnished and billed to Medicare had the charges not first undergone CareSelect's AUC consultation.
- After applying a multiplier to capture allowed charges that would be flagged as inappropriate via alternative CDSM products participating in the full program, we discounted the number to account for inappropriate imaging sessions that are not averted but redirected to a different imaging service and ultimately furnished to the Medicare beneficiary.

Estimated Budgetary Effects of Legislation Modifications to AUC Advanced Diagnostic Imaging Program

	By Fiscal Year, Millions of Dollars											
	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2024-2028	2024-2033
	Increases or Decreases (-) in Direct Spending											
Total Changes in Direct Spending												
Budget Authority	204	205	199	198	207	185	195	196	197	211	1,013	1,996
Estimated Outlays	204	205	199	198	207	185	195	196	197	211	1,013	1,996

Estimates are relative to the Congressional Budget Office's May 2023 baseline.

[i] See pages 79259 of the Medicare Physician Fee Schedule CY 2024 Final Rule (88 FR 78818)

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Administrative Simplification of the Imaging Appropriate Use Criteria Program

Background

Through Section 218(b) of the Protecting Access to Medicare Act of 2014 (PAMA), Congress established the consultation of appropriate use criteria (AUC) by providers ordering advanced diagnostic imaging exams (AUC program). The AUC program is an effective and evidence-based program, founded on physician-developed guidelines that is intended to optimize patient care by guiding providers as to whether an advanced imaging study is appropriate and if so, which kind of study is most appropriate. The AUC program is housed within an Electronic Medical Record via clinical decision support technology and has demonstrated improvement in the ordering of the correct imaging study in hundreds of institutions over several years. Entities using this AUC program have shown reductions in unnecessary utilization of imaging studies resulting in savings to both the institutions and copayment costs to patients.

The PAMA Imaging AUC program was mandated by the Congress to be implemented on January 1, 2017. Regrettably, statutory requirements in the 2014 legislation have resulted in numerous implementation problems and delays. It is now apparent that the Congress must revisit the PAMA AUC program and make significant changes to the existing statute to make the program implementable.

Although CMS proposed in its Medicare Physician Fee Schedule Proposed Rule of July 2023, and later finalized in its November 2023 rule, to "pause" the implementation of the PAMA AUC program due to administrative hurdles, in doing so the agency reinforced the benefits of the program as well as indicated significant estimated savings ($700,000,000 per year) associated with its eventual implementation. Proposed language to address the current law's administrative hurdles has been drafted and **a study by The Moran Company modeling the Congressional Budget Office's (CBO) scoring process estimates the draft amendments would provide a savings to Medicare in the range of $2 billion over ten years. The Moran Company also estimated that Medicare beneficiaries would also save about $1.4 billion over the current budget window via reduced cost-sharing.**

Issue

Specifically, CMS has identified certain claims processing challenges in its most recent proposed rule that cannot be resolved without corrections to the underlying statutory language. Enacting proposed amendments to the underlying statutory language will address the CMS-identified challenges as well as address administratively burdensome requirements identified by stakeholders during the implementation process.

Administrative Simplification

The American College of Radiology supports retaining the basic structure and intent of the PAMA Imaging AUC program. However, proposed amending language would remove the unimplementable point- of- care "real time" claims processing obligation and replace it with an ordering provider's attestation of "conferring/reviewing" qualified AUC for the ordering of advanced imaging studies. This ordering data would be collected and subject to an annual, retrospective review and audit by CMS. Compliance or non-compliance data would be collected and could be reviewed by hospitals or health systems to help manage utilization within their facility and act as an important educational tool for ordering providers.

Furthermore, in consultation with medical specialty societies, the amending language would provide additional exclusions within the PAMA statute. The AUC consultation process would not be required for those ordering providers

who participate in clinical trials. In addition, small and rural practices (as defined by CMS) would not be required to consult AUC.

Finally, the amending language would ensure the appropriate oversight and compliance mechanisms are in place by adding a compliance review study (based on two years of collected data) that will aid both Congress and the Administration in determining further measures that may need to be taken to improve the program.

These technical changes to PAMA will ensure that CMS implements the AUC program without further delay and in a manner that is least burdensome to providers. Absent these legislative changes, the benefits of the AUC program, including reducing unnecessary advanced imaging exams, will go unrealized.

Request

Congress should amend PAMA this year by including technical and administrative simplification language in its next Medicare-related legislative package.

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Medicare Payment Reform

Background: Since December of 2020, Congress has acted annually to mitigate statutorily required reductions to the Medicare Physician Fee Schedule (MPFS) by applying a positive adjustment to the MPFS conversion factor (CF) - the basic starting point for calculating Medicare reimbursement. Most recently, the Consolidated Appropriations Act of 2024 increased the congressional bump to the Medicare Physician Fee Schedule (MPFS) conversion factor (CF) by 1.68% beginning March 9 for the remainder of 2024. When combined with the already existing 1.25% CF bump that Congress passed at the end of 2022, the result is a 2.93% increase over what the CF would have been without congressional action.

This bipartisan Congressional effort, a result of intense advocacy from an ACR-led coalition of physician and non-physician organizations, mitigated impending payment reductions by roughly 50% for 2024 granting short-term stability for providers to ensure beneficiaries continue to have access to high quality care.

Issue: These year-over-year reductions clearly demonstrate that the current Medicare physician payment system is broken. Systemic issues such as the negative impact of the MPFS's budget neutrality requirements are amplified by the lack of a Medicare Economic Index (MEI)-based inflationary update, which would allow Medicare reimbursement to keep pace with the true cost of practice. As one of the only fee schedules without an inflationary update, physicians are particularly vulnerable to compounding financial factors that generate significant instability for health care professionals and threaten beneficiaries' timely access to essential health care services.

House Recommendations:

- Cosponsor H.R. 2474, the Strengthening Medicare for Patients and Providers Act, which adds a permanent, MEI-based inflationary update to the MPFS
- Consider long-term reforms to mitigate major shifts within the MPFS, including exploration of adjustments to budget neutrality requirements

Senate Recommendations:

- Introduce companion legislation to H.R. 2474 to add a permanent, MEI-based inflationary update to the MPFS
- Consider long-term reforms to mitigate major shifts within the MPFS, including exploration of adjustments to budget neutrality requirements

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Additional Issue Background and ACR Position

(Issues/Legislation you may be asked about during your meeting)

Artificial Intelligence (AI)

Last year, the White House issued an Executive Order the Safe, Secure, and Trustworthy Development and Use of Artificial Intelligence, which is the latest of many U.S. government efforts spanning multiple Administrations to address assorted AI policy challenges. In February, the U.S. House of Representatives announced formation of a Bipartisan Task Force on AI to report on AI legislative oversight needs. While these recent efforts clearly show that the government is working to identify its role in this quickly developing landscape, this topic might be raised during hill meetings.

The ACR, with its Data Science Institute (DSI), has long advocated the radiology perspective on AI safety and performance, model transparency, bias mitigation/nondiscrimination, responsible medical use, radiologist access to useful innovation, and appropriate payment policy.

ACR Position: Many radiologists are using AI in their practices and as Congress works to develop policies and guidelines around use of AI, the ACR is a valuable resource.

Screening for Communities to Receive Early and Equitable Needed Services for Cancer Act of 2023 (SCREENS for Cancer Act) (H.R. 3916/S. 1840)

Introduced by Reps. Joseph Morelle (D-NY) and Brian Fitzpatrick (R-PA) in the House, the SCREENS for Cancer Act would strengthen resources for early cancer detection. Specifically, the bill would reauthorize the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) through 2028, making it easier for vulnerable populations to get the preemptive care they need. The NBCCEDP provides lifesaving breast and cervical cancer screening and diagnostic services to women who are low-income, uninsured or underinsured who do not qualify for Medicaid. This bill was advanced by the House Energy and Commerce Committee on March 21 and as a next step, would need to be voted on by the House. There is a Senate counterpart to this legislation, S. 1840, introduced by Sens. Tammy Baldwin (D-WI), Susan Collins (R-ME), and others, and it has been placed on the Senate calendar for future consideration.

ACR Position: *Support*

Facilitating Innovative Nuclear Diagnostics (FIND) Act of 2023 (H.R. 1199/S. 1544)

Medicare's current reimbursement structure limits patient access to innovative imaging tools that improve diagnosis of many devastating conditions, including Alzheimer's and Parkinson's disease, advanced cardiac disease, and cancers of the prostate, breast, and brain. Currently, CMS considers diagnostic radiopharmaceuticals as "supplies" through a packaged payment system, which creates a significant barrier to patient access to the newer, more precise generation of diagnostic nuclear imaging drugs. H.R. 1199 directs

HHS to pay separately for all diagnostic radiopharmaceuticals which would expand access to the most advanced and effective PET radiopharmaceuticals and enhance physicians' ability to diagnose advanced illnesses earlier and with greater accuracy.

ACR Position: *Support*

Find it Early Act (H.R. 3086)

Championed by Congresswoman Rosa DeLauro (D-CT), the Find it Early Act requires coverage with no cost sharing for additional screening and diagnostic breast imaging exams for the detection of breast cancer for certain individuals assessed to be at greater risk for breast cancer.

The coverage requirement would apply to private insurance, Medicare, Medicare Advantage, Medicaid, TRICARE, and the Department of Veterans Affairs.

ACR Position: *Support*

Nuclear Medicine Clarification Act of 2023 (H.R. 6815)

H.R. 6815 would drastically change Nuclear Regulatory Commission (NRC) rules to require controversial injection site measurements and "extravasation" dosimetry of unclear accuracy or significance during up to 20 million nuclear medicine (NM) procedures annually. The bill—which would impact all healthcare facilities that provide NM imaging or therapy (including PET, SPECT, RPTs, etc.)—is championed by a device vendor that sells nuclear uptake probes and dose estimation software. H.R. 6815 would have unintended negative consequences for cancer patients and NM providers via substantial compliance costs, reduced patient access to NM procedures, local NM scheduling limitations based on compliance tool availability, and a nationwide device supply dependency. It would ignore standards of care and medical physics, financially benefiting a single device vendor at the direct expense of cancer patients and NM providers.

ACR Position: *Oppose*