American College of Radiology™

Hill Day Issue Overview:
Potential Questions

Proposed Amendments to the Protecting Access to Medicare Act of 2014

- Why has CMS paused the implementation of the AUC program?
    - CMS has had difficulty operationalizing the "real-time" claims processing requirements in the existing statute as well as trying to prevent inappropriate non-payment of services. However, in the proposed and final rule announcing the pause, CMS strongly reinforced the benefits of the program and indicated implementation would provide significant Medicare savings. The proposed changes to the PAMA AUC program would resolve the current administrative issues without undermining the purpose of the program.
- Who may be opposed to these changes?
    - Since its inception, a handful of organizations have argued that the original bill/law was too cumbersome and would add to the physician workload. We believe implementation of the PAMA AUC program, with the requisite updates, is the best approach for ensuring patients receive the right imaging study at the right time. It is also a critical utilization control and a viable alternative to comprehensive prior authorization requirements.
- Why haven't these proposed legislative changes been introduced as a bill?
    - Jurisdictional committee staff on both sides of the Capitol have advised that the changes we are seeking can be made as an amendment during the Committee mark-up process of a future Medicare-related legislative package and therefore do not warrant the separate introduction of a bill.
- Does ACR have a financial interest in AUC?
    - The ACR has invested heavily in staff and volunteer time over 30 years to develop and maintain its Appropriateness Criteria. The College receives a fee for licensing its Appropriateness Criteria content to one of the multiple CMS-designated clinical decision support mechanism (CDSM) providers.

Physician Workforce Crisis

- How are the new GME slots distributed under the Resident Physician Shortage Reduction Act?
    - CMS is required to consider the likelihood of a teaching hospital filling positions and must distribute at least 10% of the positions to each of the following categories of hospitals:
        1. hospitals in rural or non-contiguous areas;
        2. hospitals training over their GME cap;
        3. hospitals in states with new medical schools or new branch campuses, as of January 1, 2000; and
        4. hospitals that serve areas designated as health professional shortage areas (HPSAs), with priority given to hospitals that are affiliated with a historically Black medical school.

- Have there been any hearings on the Resident Physician Shortage Reduction Act and/or is it gaining traction this Congress?
    - This specific bill has not been taken up at the Committee level yet but the concept of increasing GME and addressing health care workforce shortages has been discussed. In the House, the bill has

a great deal of support— currently 172 cosponsors. The Senate bill only has 6 cosponsors. While this bill has frequently been introduced in past Congresses, it has yet to be enacted into law. However, several provisions of the bill have been incorporated into other legislation that has been enacted, such as the 1200 new GME positions, over the last three years. Hopefully, Congress can incorporate additional GME positions into a larger health care package this Congress.

- Can only health care institutions in medically underserved areas, or those in health professional shortage areas, benefit from the Conrad 30 program?
    - One unique component of the bill reauthorizing the Conrad 30 program is that there is a provision stipulating that three new Conrad 30 slots per state may be used by academic medical centers, regardless of whether in a health professional shortage area.

- Do legislative proposals such as the Conrad 30 program and the Healthcare Workforce Resilience Act take jobs away from American citizens?
    - No, both the Conrad State 30 and Physician Access Reauthorization Act and the Healthcare Workforce Resilience Act have provisions requiring those receiving the Conrad 30 waiver or benefiting from an expedited visa, meet certain requirements preventing prioritizing non-citizens or citizens for employment.

Medicare Payment Reform

- Why are physicians seeking payment "relief" beyond 2024?
    - 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). These year-over-year cuts clearly demonstrate that the current Medicare physician payment system is broken. Inclusion of a Medicare Economic Index (MEI)-based inflationary update in the MPFS would allow Medicare reimbursement to keep pace with the true cost of practice and maintain beneficiaries' timely access to health care services.
- After Congress fixed the SGR, shouldn't we have been done with annual patches?
    - Short term patches are frustrating for all involved. Physicians would much rather be using their time to see patients instead of talking to Congress about Medicare reimbursement. The need for short-term payment relief is due to the statutorily required application of budget neutrality to the MPFS, the impact of which Congress can blunt by passing long-term reform legislation such as H.R. 2474.
- How much will it cost to enact H.R. 2474, the Strengthening Medicare for Patients and Providers Act?
    - The ACR anticipates the cost to be in the billions of dollars, although it is not aware of any official Congressional Budget Office (CBO) estimates at this time. The College, as well as its specialty society colleagues, are committed to working with Congress to identify appropriate offsets to lower the cost of the legislation.