RBMA | Radiology Business Management Association

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June 14, 2024

Hon. Ron Wyden, Chairman
Hon. Mike Crapo, Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Bldg.
Washington, D.C. 20510

Re: Comments on Committee Whitepaper on Medicare Physician Payment Reform

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the Radiology Business Management Association (RBMA), we appreciate the opportunity to share our feedback on the Committee's May 17th whitepaper, "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B".

Established in 1968, RBMA is a professional association that consists of over 2,200 radiology practice business leaders who represent over 800 radiology practices in all 50 states. This includes diagnostic radiology, interventional radiology, nuclear medicine, IDTFs and radiation oncology.

RBMA is encouraged by the Senate Finance Committee's important step towards meaningful Medicare physician payment reform. It is crucial to implement an annual payment update that keeps pace with inflation and to modernize the outdated Medicare budget neutrality policies. These issues have resulted in significant cuts to radiology services, increased provider consolidation, and jeopardized the quality of care and access for Medicare patients, as detailed below.

Key Concerns

1. **Impact of Budget Neutrality on Radiology Services:** The current budget neutrality requirements necessitate that any increases in payment rates for specific services must be offset by corresponding reductions to other services or service providers. This approach disproportionately affects radiology, where technological advancements and enhanced imaging techniques are crucial but often more costly. The mandatory across-the-board cuts have reduced radiology reimbursement rates, threatening the sustainability of radiology practices and limiting patients' access to essential diagnostic services.

2. **Lack of Inflationary Updates:** Unlike other sectors within Medicare, the MPFS lacks an annual update tied to inflation, resulting in a 26% decline in inflation-adjusted payments from 2001 to 2023. Radiology practices face rising costs for equipment, supplies, and staff salaries, which are not adequately reflected in the declining MPFS rates. This discrepancy hinders the ability of radiologists to invest in technologies that are becoming the standard of care and maintaining patient access.

3. **Poor Alignment between MIPS and Radiology.** When Congress reformed the MPFS structure in MACRA, the changes were premised on creating physician opportunities to earn bonus payments through the Medicare Incentive Payment System (MIPS). Unfortunately, this promise has largely not been realized for radiology due to a shockingly small number of radiology-specific MIPS measures. It has been documented that this inhibits the ability of radiology practices to meaningfully participate in MIPS and gain an opportunity for bonus payments.[1] Currently, available MIPS quality measures developed by CMS for the field of diagnostic radiology are as follows:

    1. Measure 145: Exposure dose indices reported for procedures using fluoroscopy
    2. Measure 360: Optimizing patient exposure to ionizing radiation: Count of potential high dose radiation imaging studies: CT and cardiac nuclear medicine studies
    3. Measure 364: Optimizing patient exposure to ionizing radiation: Follow-up CT imaging for incidentally detected pulmonary nodules according to recommended guidelines
    4. Measure 405: Appropriate follow-up imaging for incidental abdominal lesions
    5. Measure 406: Appropriate follow-up imaging for incidental thyroid nodules in patients
    6. Measure 436: Radiation consideration for adult CT: utilization of dose lowering techniques

    Four of the above measures are topped out – meaning a maximum of 7 points available, rather than 10. Thus, using the current point system calculation, if a large radiology practice were to score perfectly on the above measures, their final MIPS score would be 83 points (out of 100). This assumes that the practice provides fluoroscopic procedures (measure 145). If the practice does not, it would not meet the threshold for six quality measures and would potentially be subject to the maximum penalty.

    Over the past few years, CMS has begun developing "Merit-based Incentive Payment System Value Pathways" (MVPs), which are subsets of measures and activities that can be used to meet MIPS reporting requirements. Such pathways were developed in response to feedback that traditional MIPS reporting was overly complicated and burdensome and that various specialties did not have enough relevant measures. CMS has a stated goal of sunsetting MIPS and fully transitioning to MVPs. Despite this and the fact that many medical specialties have MVPs available to them, radiology remains one of the few specialties without a developed MVP. If the full transition to MVPs is to take place, participation must reflect all specialists.

    The white paper states that the Finance Committee is "considering repealing or scaling back the MIPS program to relieve physicians' administrative burden and alleviate churn from Advanced APMs (A-APMs) back to MIPS." It is known that CMS has encouraged Quality Payment Program (QPP) participants to participate in the A-APM track rather than the MIPS track. Unfortunately, many providers who previously participated in the A-APM are now choosing to revert to MIPS. The 2022 QPP experience report notes that the maximum MIPS payment adjustment was higher than the APM bonus, which has dropped from a 5% bonus in 2022 to a 3.5% bonus in 2023 to a 0.75% qualifying APM conversion factor in 2024 and beyond. There are also more stringent volume thresholds for A-APM participation (35% in 2023 to 50% in 2024 and beyond). These

[1] https://www.neimanhpi.org/press-releases/radiologists-at-major-disadvantage-in-mips-when-working-in-radiology-focused-practices-according-to-new-study/

factors thwart congressional intent to drive more physicians toward A-APMs. Accordingly, it is critical that Congress again extends clinicians' bonuses for participating in an A-APM, as without congressional action, there won't be a separate bonus in the future – only a slightly higher conversion factor update under the Medicare PFS.

4. **Barrier to Entry into Advanced Alternative Payment Models (AAPMs).** MACRA was intended to accelerate the widespread adoption of Advanced APMs, including through the creation of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), which was intended to facilitate the review of potential future APMs for adoption by clinicians. However, despite PTAC's recommendations, CMS has yet to test any model through CMMI. Additionally, CMMI initiatives offer few opportunities for specialists and show little synergy with radiology beyond the Radiation Oncology model.

5. **Forced Consolidation and Its Impacts:** The financial pressures from reduced reimbursements drive radiology practices toward consolidation with larger hospital systems or corporate entities. This trend reduces competition and leads to higher healthcare costs overall, as larger systems tend to have higher administrative costs and charge more for services. Furthermore, consolidation often reduces patient access to specialized radiology services, particularly in rural and underserved areas.

6. **Critical Radiologist Shortage:** The radiologist workforce faces a significant shortage, with (currently at 1,869 jobs listed) open positions on the American College of Radiology job board. This shortage is compounded by an aging population that requires more imaging services and continued precipitous cuts to reimbursement. Radiologists are being forced to work longer hours and increase their reading speed to meet the demand, leading to concerns about diminished interpretive accuracy and widespread burnout among radiologists. The increased workload and pressure to maintain high productivity levels are unsustainable and jeopardize the quality of patient care. This workforce crisis is specifically acute in rural areas. Rural hospitals across the U.S. are closing at a rapid pace. As a result, patients must drive longer distances for necessary services or lack access to transportation, which tends to be a barrier to care; this could lead to severe consequences. In an RSNA article titled "Rural Areas Face Imaging Obstacles on the Road to Heath Equity", Dr. Eberth states, "Rural areas have a disproportionate share of screening eligible patients, but generally low access to screening. As a result, they are at a higher risk for negative outcomes."

7. Annual Threshold Increases: Moving the current $20M yearly threshold to $50M, as discussed in HR 6371, is still woefully inadequate. For example, when Congress passed the Consolidated Appropriations Act of 2024 to only partially mitigate the Medicare Physician Fee Schedule cuts for the present year, they provided an additional $500 million for the Medicare conversion factor. While this assistance was appreciated, radiology practices reported being cut by 3% or more, and the conversion factor dropped for all provider types. However, we were pleased to see the inclusion of H.R. 2474, the Strengthening Medicare for Patients and Providers Act, which would permanently tie annual Medicare reimbursement updates with the Medicare Economic Index (MEI) in the white paper. The passage of this legislation would ensure that physician reimbursement keeps up with rapid inflation.

<u>Impact on Patients</u>

As a consequence of the foregoing factors, most of which are driven by the MPFS, radiology is facing challenges that have a direct negative impact on patients, particularly those with chronic conditions who require regular imaging for disease management. Delayed or less frequent imaging can lead to late

diagnosis and suboptimal treatment outcomes, exacerbating patients' health issues and increasing long-term healthcare costs.

Last fall, the RBMA's Patient Action Network (RPAN) Commissioned a poll of 1,200 Medicare beneficiaries seeking to learn more about the impacts continued cuts have had on their access to care. We found that nearly half of those polled had experienced new barriers or diminished access over the past year:

In the past two years, have you experienced any of the following barriers to access for imaging care?

- *Closure of doctor's office or imaging center: 14%*
- *Having to travel farther for imaging care: 13%*
- *Longer times to schedule imaging care: 16%*
- *Longer office wait times in to receive imaging care: 6%*
- *Longer times awaiting results of imaging exams: 3%*
- *Last-minute cancellation or rescheduling of imaging exams: 3%*
- *Other/none [CAPTURE VERBATIM]: 45%*

Further, we asked, "***Do you agree or disagree with the government's proposal to pay healthcare providers less for your Medicare services?***

- *Agree: 9%*
- *Disagree: 76%*
- *Not sure: 15%*

RPAN will again be performing a statistically valid poll of over 1,000 Medicare beneficiaries this fall, and if there are specific questions the Working Group would like to see asked or information we can provide, please let us know. Radiology plays a crucial role in Health Equity. Most Medicare beneficiaries will have a radiology exam at some point in their lives. RBMA has joined the American College of Radiology to positively impact health equity for women, people of color, and rural populations through its work with the Radiology Health Equity Coalition (RHEC). This coalition advocates for these marginalized populations through critical imaging services such as mammography, lung and colon cancer screenings, and mobile imaging services for underserved rural populations. Continued cuts to radiology reimbursement and the lack of inflationary adjustments put these services at risk.

<u>Recommendations for Policy Reforms</u>

1. **Adjust Budget Neutrality Requirements:** We recommend revisiting the budget neutrality requirements to ensure they do not disproportionately impact essential services like radiology. Introducing higher thresholds for budget neutrality adjustments or excluding certain high-impact diagnostic services from these calculations could provide the sustainability and certainty necessary for these essential services.

2. **Implement Inflationary Updates:** We respect CMS' position of postponing the incorporation of MEI rebasing to allow AMA and Mathematica time to conduct an updated PPI Survey, however, it will take time to calculate the impact of this survey and gauge its accuracy and representation. We recommend the committee consider a provisional MEI update for the Medicare Physician Fee Schedule while this work is being done. Aligning PFS updates, even provisional, with inflation rates, similar to other Medicare payment systems, would help ensure that

reimbursement rates keep pace with the rising costs of delivering high-quality radiology care. This adjustment would support the financial viability of radiology practices and ensure continued patient access to critical imaging services.

3. **Conversion Factor Adjustments:** Over several physician fee schedule cycles, new CPT codes and or revalued or misvalued codes have resulted in certain specialties receiving significant increases in reimbursement for services while others experience significant decrease, especially in high volume procedures such as radiology. Our underlying costs to provide the service have not changed and in fact have increased over time. We understand the importance of ensuring adequate reimbursement for primary/preventive care services, but doing so at the expense of specialty services, including especially radiology, is unwise given the role that diagnostic imaging and interventional radiology play in early diagnosis and lower-cost treatment options. Introducing higher thresholds or excluding certain high-impact diagnostic services from these calculations could provide much-needed relief. .

4. **Promote Value-Based Care Models:** Encouraging the adoption of value-based care models tailored for radiology can help shift the focus from volume to value, promoting efficiency and better patient outcomes. These models should include appropriate metrics that reflect the unique contributions of radiologists in patient care There needs to be more and better pathways to implementing AAPMs, including by Congress being more assertive in legislating such options or directing their creation by CMMI. The RBMA has been working on a model AAPM that would measure radiology group practice Medicare spending against a blend of historic and regional reference group spend under a shared loss/shared savings framework. New quality metrics would include health equity measures and the use of clinical decision support tools to educate ordering clinicians. We have attached a draft of our proposal for your reference.

5. **Reduced or eliminate patient financial barriers to necessary breast imaging services:** Women aged 40 to 74 can receive screening mammograms without out-of-pocket costs. But mammography facilities may need to perform follow-up covered diagnostic breast imaging studies -- including diagnostic mammograms, breast ultrasound scans, and breast MRI -- if they are ordered by the patient's treating physician as clinically indicated based on the radiologist's mammographic findings that are equivocal, or if they are suspicious or suggestive of malignancy. In that circumstance, these additional tests are covered but carry out-of-pocket costs to the patient, which too often serves as financial barrier to these vital diagnostic services. Legislation introduced last year in the U.S. Congress, The Find it Early Act, would require all private payers - along with traditional Medicare and Medicare Advantage plans, Medicaid and TRICARE - to cover any supplemental breast imaging services, beyond screening mammograms ordered by the patient's physician. This legislation follows the lead of over 20 states that have already codified similar provisions into statute. RBMA supports this legislation designed to bring supplemental imaging exams to women without patient out-of-pocket costs for co-payment and deductible payments.

Conclusion

The RBMA strongly urges the Senate Finance Committee to consider these recommendations, which are crucial in mitigating the adverse effects of current policies on radiology services. By addressing the challenges posed by budget neutrality and the lack of inflationary updates, we can ensure that

radiologists continue to provide high-quality, accessible, and affordable care to Medicare beneficiaries. We look forward to working with the Committee to achieve these goals and improve the healthcare landscape for all patients.

Sincerely,

Robert T. Still,
Executive Director