American College of Radiology™

January 30, 2025

The Honorable Bill Cassidy, MD
455 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Catherine Cortez Masto
520 Hart Senate Office Building
Washington, DC 20510

The Honorable John Cornyn
517 Hart Senate Office Building
Washington, DC 20510

The Honorable Michael Bennet
261 Russell Senate Office Building
Washington, DC 20510

Dear Senators Cassidy, Cortez Masto, Cornyn, and Bennet:

The American College of Radiology (ACR), representing approximately 41,000 radiologists, radiation oncologists, medical physicists, and imaging professionals, appreciates the opportunity to provide feedback on the bipartisan draft legislation proposed to improve the Medicare Graduate Medical Education (GME) program, released in December 2024 for comment. ACR is pleased that the work started on GME policy solutions last Congress is continuing into the 119th.

The demand for physicians continues to grow faster than supply, leading to a projected physician shortage of up to 86,000 physicians by 2036.[1] These shortages are driven by the need for more doctors as the population grows and ages, as well as vacancies created by physician retirements. Because of the central role that imaging and minimally invasive image guided therapies play in virtually every significant episode of care, shortages within the field of radiology are especially problematic. Despite the increase in demand for imaging services over the last decade and a half, the number of medical students matching into radiology residency positions through the National Resident Matching Program has remained relatively stagnant (1,084 in 2010 and 1006 in 2023) with 100% of positions filled.[2] Even in the most recent 2024 match, nearly all available resident positions for diagnostic and interventional radiology were filled.[3] If the number of radiologists trained does not grow and the amount and complexity of exams and procedures increase, patients may receive delayed diagnoses, and potential unnecessary interventions—driving up health care costs for both individuals and the Medicare program.

Ensuring an adequate supply of physicians is integral to the future of our nation's health care infrastructure. ACR offers general feedback below and input on several of the questions posed for comment.

Improve Distribution of Medicare GME Slots to Key Specialties in Shortage

The draft legislation targets shortages of primary care physicians and psychiatrists. While ACR understands the importance of these areas of medicine, there is also a growing need for specialty care. We

[1] GlobalData Plc. The Complexities of Physician Supply and Demand: Projections From 2021 to 2036. Washington, DC: AAMC; 2024.
[2]National Resident Matching Program, Results and Data: 2023 Main Residency Match®. National Resident Matching Program, Washington, DC. 2023.
[3] National Resident Matching Program, Results and Data: 2024 Main Residency Match®. National Resident Matching Program, Washington, DC. 2024.

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encourage Congress to look outside of policies dictating a certain percentage of slots to specific specialties and instead consider that there are shortages prevalent in all of medicine. If Congress wishes to improve the distribution of GME slots, other specialties, including radiology, must also be considered.

ACR welcomed the recent increase in the number of Medicare supported GME positions by 1200, through both the Consolidated Appropriations Act (CAA) of 2021 and 2023. However, the artificial cap that has been in place since 1997 has made it impossible for resident training to keep up. An additional increase in the number of Medicare supported GME positions is necessary to keep pace with heightened medical school enrollment and to ensure there are enough physicians to work in every type of community.

Number of Slots
ACR appreciates that the draft legislation increases GME residency slots by 5,000 from FY2027-FY2031. While this would provide some relief enabling the additional training of residents, it is still not sufficient to meet the needs of the growing and aging US population. **ACR encourages Congress to consider the Resident Physician Shortage Reduction Act,** legislation introduced last Congress and several prior Congresses, to significantly increase the number of GME slots. 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 health care.

Is the 30-slot cap appropriate for ensuring fair distribution of residency slots across hospitals? What other strategies could Congress consider to ensure hospitals in all regions have an equal opportunity to compete for slots?

ACR believes that a cap of 30 slots per teaching hospital would help provide a wide distribution of resident full-time equivalent (FTE) positions. We also support the provision that, should all positions not be distributed, the Centers for Medicare and Medicaid Services (CMS) would be required to conduct additional distribution rounds until all positions are awarded. We must ensure that all available positions are allocated, as this will help address the projected physician shortage the nation faces.

Residency training generally takes between three to five years (and sometimes longer) and Congress should consider that to fully fund the training of one physician, and continue a full complement increase, a program could need up to three to five FTEs. Therefore, ACR would support the implementation of a five-slot "floor," unless a program has applied for fewer than five slots. The primary goal should be ensuring that programs receive enough slots to build meaningful increases in training programs. There has been tremendous demand for the slots currently being distributed as part of Section 126 of the CAA of 2021 and unfortunately, many teaching hospitals are receiving fractions of slots. ACR believes that setting a "floor" would ensure that qualifying teaching hospitals can meaningfully expand their programs.

Proposed Grants
While ACR appreciates the focus on assisting rural teaching hospitals in expanding their training, we are concerned that the proposed grants to states for assisting with specific distribution programs (like the 5,000 slots made available in this draft legislation) may not be as impactful as codifying or investing in other existing grant programs. This is because there are a relatively small number of rural teaching hospitals that are training at or over their cap and are eligible to take advantage of the slots provided. The creation of grants under 1820(g) could facilitate the uptake of some positions at rural teaching hospitals,

but after the distributions from Section 126 and Section 4122 of the CAA of 2023, there is likely a limited return on this particular investment. Also, under existing law rural hospitals are already able to receive a cap increase for each new residency program started, unlike urban hospitals that have a "fixed" cap.

Programs like the Health Resources and Services Administration's (HRSA's) Rural Residency Planning and Development (RRPD) grants provide up to $750,000 for new rural residency training programs. One of the biggest obstacles to developing new training programs is the startup costs, because hospitals do not receive any Medicare support for GME programs until residents arrive to train at the facility. This means that hospitals are left to fund the substantial startup costs without any assurance that the program will receive future Medicare support. RRPD grants provide startup capital for new programs to hire faculty, achieve accreditation, and upgrade the hospital infrastructure to accommodate resident trainees. Key to the success of RRPD grants is the ability for grantees to receive technical assistance from rural GME experts who guide hospitals through the difficult first steps of developing new rural residency programs. Since 2019, RRPD grants have led to the development of 46 new rural residency programs training 460 resident physicians. **Last Congress, ACR joined the Association of American Medical Colleges (AAMC) and others in the medical community in supporting the Rural Residency Planning and Development Act of 2024 (H.R. 7855), which would authorize a dedicated funding stream for the RRPD.** ACR continues to recommend that Congress codify the RRPD program.

Other Opportunities Congress Should Consider

Ensure Radiologists in Shortage Areas Only Interpret Necessary Imaging Tests
Often, when there is a lack of specialists in rural areas, other providers are utilized to supplement care, which frequently results in the increased ordering of tests and in turn, an increased demand for imaging services.

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 specialty**, which indicates radiology's prominent role in patient care.[4] As a result, the demand for imaging services continues to rise. One way to reduce the increasing demand for imaging services is to modernize and **implement Section 218 (b) of the 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, CMS has faced significant logistical difficulty during the regulatory process. In the 2024 MPFS final rule, the agency indefinitely paused implementation pending statutory changes but did reiterate their support for the program. ACR proposes eliminating the provisions creating challenges for CMS by amending Section 218 (b) of PAMA. The ACR has provided draft technical corrections language to the staffs of the Senate Finance Committee, as well as the House Ways and Means and House Energy and Commerce Committees. The Congressional

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

Budget Office (CBO) has performed an initial analysis to confirm savings from a study conducted by The Moran Company (TMC).

Expand 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. About one-third of resident physicians in the U.S. are international medical graduates and approximately half of those residents are noncitizens practicing under a specific non-immigrant visa (J-1), which requires them to return to their country following residency for two years before they can apply for a work visa or greed card. Under the Conrad 30 program, these physicians can 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. Although the Conrad 30 program is within the Senate Judiciary Committee's jurisdiction, solutions to the physician workforce crisis will require a multitude of policy considerations. ACR encourages the Senate Finance Committee to collaborate with other committees on strategies to address physician shortages.

While the Conrad 30 program helps physicians who are educated and trained in the U.S. continue to care for patients here, it only allows 30 waivers per state. Congress has continued to reauthorize this program and every state has utilized it since its inception. To build upon its success and strengthen care in rural areas, Conrad 30 should be expanded. **ACR encourages Congress to reauthorize and strengthen the Conrad 30 program by passing the Conrad State 30 and Physician Access Reauthorization Act.** Legislation was introduced last Congress (S.665), to reauthorize the program and make minor improvements to its functioning by increasing the number of waivers per state beyond 30 and up to 45, if certain nationwide thresholds are met.

Are the proposed data categories in Section 7 sufficient for understanding the GME landscape without overburdening small hospitals? Are there other useful data points or reporting methods that should be included?

The proposed data categories in Section 7 are sufficient for understanding the GME landscape and are all currently reported by teaching hospitals to the federal government or accrediting bodies. Teaching health systems and hospitals spend hundreds of hours and thousands of dollars reporting on their GME programs, and Medicare cost reports contain a wealth of information on how teaching hospitals deploy their Medicare GME funds. ACR is encouraged by Section 7's emphasis on using existing sources of data to complete this report and supports transparency, however we would oppose any duplicative and unnecessary reporting.

Is creating a GME Policy Council the right approach to guiding future GME slot allocations? Is the scope and responsibility of the Council adequate to make it effective?

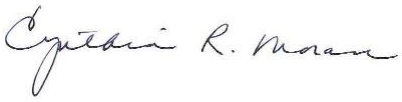
ACR does not believe that the creation of a council is necessary and has strong concerns with Congress ceding any GME slot distribution authority to a federal advisory committee. We recommend removing this provision of the draft legislation. The legislation awards 5,000 FTEs from 2027 through 2031, but input from the GME Policy Council applies to positions awarded after 2032. With the high demand for Medicare-supported GME slots, it is unlikely that many, if any FTEs will be left over for distribution through the recommendations of the GME Policy Council.

We urge you to also consider that many teaching hospitals have been excluded from distributions under the CAA of 2021 and 2023 because of CMS' prioritization based on Health Professional Shortage Area (HPSA) score. The number of hospitals that have been eligible for distributions under Section 126 and Section 4122 is a subset of teaching hospitals nationally. Because we expect that CMS will not be able to use the same distribution prioritization policy for slots created under this draft legislation, the number of institutions eligible to receive awards will likely be far greater.

Alternatively, CMS could leverage the Council on Graduate Medical Education (COGME) and other physician training stakeholders to provide input to policymakers. COGME has expertise that has been key in developing programs with high impacts on rural and underserved communities and has been instrumental for the HRSA-administered Teaching Health Center Graduate Medical Education (THCGME) Program and rural residency programs. COGME has also fostered stakeholder communities in rural and underserved areas. These are critical areas of workforce development and COGME and other stakeholders could provide input on the distribution of unawarded positions to both Congress and the Secretary of Health and Human Services (HHS).

ACR thanks you for consideration of our comments and welcomes the opportunity to collaborate with Congress as this legislation evolves to address the physician workforce crisis.

Sincerely,



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