

The American Registry of Radiologic Technologists (ARRT), American College of Radiology (ACR), the American Society of Radiologic Technologists (ASRT), and the Society of Radiology Physician Extenders (SRPE) submit to the House Ways and Means Subcommittee on Health this statement for the record related to the June 19, 2012 hearing on the Medicare Payment Advisory Commission's (MedPAC's) June 2012 Report to Congress.

As recognized by the MedPAC report, the Medicare fee-for-service (FFS) benefit package has not been substantially altered since the program was created in 1965. Nonetheless, since that time medical technology and the practice of medicine has changed considerably. As MedPAC notes, "the rigid statutory parameters give Medicare's program managers little flexibility to change its benefit design in response, even as other insurers change their benefit packages."

We commend MedPAC for exploring efforts to reform the design of the Medicare FFS benefit package to protect beneficiaries and improve the efficiency of the program. As MedPAC recognizes, the quality of care as well as its cost-effectiveness may be improved materially if the care is coordinated among providers and the providers have access to the best, most efficient tools to care for their patients.

Consistent with these efforts, we believe that Congress should recognize additional categories of non-physician practitioners that provide, high quality, cost effective care. There are many instances where the only way to satisfy the increasing demand for health care services is to rely on highly skilled non-physician practitioners. Mid-level practitioners, as part of a health care team, often can make a marked improvement in the quality of care provided to patient. This is particularly true in the field of radiology, where the entire community reached a consensus on the need to create a mid-level professional – the radiologist assistant (RA). An RA is an advanced-level radiographer who assists, but does not replace, the radiologist in the diagnostic imaging environment. The RA profession was created in response to an increased demand and need for complex medical imaging services and a shortage of radiologists. All stakeholders in the radiology community – radiologists, technologists, and certifying bodies – collaborated to develop a comprehensive, advanced education and training program for radiographers so that they could expertly and safely perform radiologic assessments and procedures (excluding interpretations) that traditionally were performed by radiologist.

An RA has completed a vigorous academic program that includes a nationally-recognized curriculum, as well as a clinical preceptorship with a radiologist. The RA educational program is required to award a baccalaureate degree, at a minimum, and must educate students to perform diagnostic imaging and interventional radiology procedures within the RA's scope of practice. Today, 12 universities offer education and supervised clinical training for the RA. Twenty-nine (29) states license or certify RAs. In addition, an RA must pass a nationally-recognized certification examination. An RA may be certified by ARRT as a registered radiologist assistant (RRA) or by the Certification Board for Radiology Practitioner Assistants as a radiology practitioner assistant (RPA).¹ RAs always practice under the on-site supervision of a radiologist.

¹ The term "RA" should be interpreted to include RRAs and RPAs. The primary difference between RRAs and RPAs is the certification body. Both certification organizations require the individual to be a certified radiographer, complete an advanced educational program

Private insurers have shaped their benefit packages to include services performed by RAs, thereby recognizing the important role of RAs in providing high quality, efficient medical imaging services beyond what a general radiographer can provide. While the private sector swiftly recognized the value of RAs, the Medicare program has not kept pace. Currently, Medicare erroneously applies the same level of physician supervision to procedures performed by an RA that it applies to procedures performed by a general radiographer. This ignores the RA's advanced education and training, and is inconsistent with the scope of practice established for RAs by many states' laws. The Centers for Medicare & Medicaid Services (CMS) requires "personal" supervision (a physician must be physically present in the room during the procedure) for services that many states (as well as ACR, ASRT, SRPE and ARRT) have determined can be safely and effectively performed by an RA under "direct" supervision (a physician must be present and immediately available to furnish assistance and direction throughout the procedure but does not need to be present in the room when the procedure is performed). As a result, there are unnecessary delays in scheduling and performing diagnostic and interventional procedures for Medicare beneficiaries, reduced access to quality care for beneficiaries (particularly in rural and underserved areas), inefficient radiology practices and departments, and higher costs to the Medicare program. We believe that it is past time for Medicare beneficiaries to have the same opportunity to benefit fully from the services that RAs provide.

Thus, the entire medical imaging community, including ACR, ASRT, SRPE and ARRT, support the Medicare Access to Radiology Care Act of 2011 (H.R. 3032), which was introduced by Representatives Dave Reichert (R-WA), Bill Pascrell (D-NJ), Pete Olson (R-TX), and Jim Matheson (D-UT). The bill is currently cosponsored by a bipartisan group of 31 Representatives. It would update the Medicare benefit package to include services furnished by RAs in those states where RAs are recognized by the state scope of practice laws. Thus, where a state law provides that RAs are subject to the "direct" supervision of a radiologist for certain procedures, the Medicare program would apply that supervision standard as well for RA services provided in that state. Radiologists would continue to bill the Medicare program for RA services, but the services performed by RAs would be reimbursed at a lower rate than that of radiologists. This would enable Medicare to realize savings and would ensure that there is no adverse impact on the federal budget.

If H.R. 3032 is enacted into law, radiologists would be available for more complex procedures, urgent cases, consultations with referring physicians, and imaging study interpretations. Medicare beneficiaries would benefit from improved quality of care, efficient services and timely access to imaging procedures. This, we believe, would be a good policy that is totally consistent with MedPAC's recommendations for the future of the Medicare program.

specific to the radiologist assistant's knowledge and skill level (including a clinical preceptorship with radiologists), and pass a comprehensive examination.

