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Doctors Caucus Members

The Radiology Business Management Association (RBMA) appreciates the opportunity to provide input on (1) legislative reforms to ensure future Centers for Medicare & Medicaid Innovation (CMMI) models deliver real improvements in cost and quality and can be scaled successfully, and (2) how a reformed, physician-led quality program can reduce administrative burdens, apply across clinician types and settings, and focus on meaningful outcomes. These comments reflect both system level structures and radiology specific realities.

Established in 1968, RBMA is a professional association that consists of over 2000 radiology practice business leaders who represent over 800 radiology practices in all 50 states. Included are diagnostic radiology, interventional radiology, nuclear medicine, Independent Diagnostic Testing Facilities (IDTFs) and radiation oncology.

RBMA is the trusted partner of radiology professionals, advancing the industry and broadening our members' capacity to provide superior patient experiences.

RBMA applauds the Doctors Caucus' initiative to make improvements to these CMS programs, specifically related to imaging utilization.

To provide context for our recommendations, radiologists are often called the **"doctor's doctor"** because they provide critical diagnostic insights that guide nearly every specialty's treatment decision. The radiologist's interpretation forms the foundation for treatment care plans, surgical decisions, and medical management. They interact with every physician specialty and actively participate in tumor boards, multidisciplinary conferences, and patient-focused committees. It is their job to ensure imaging findings are integrated into holistic, evidence-based care.

Radiology significantly influences both quality of care and cost containment as follows:

- Improved Quality:
  - Accurate imaging results enable early detection and precise diagnosis, reducing misdiagnoses and unnecessary interventions.
  - Imaging findings help to tailor treatment plans which result in improved outcomes and patient safety.
- Cost Containment:
  - Imaging often eliminates the need for invasive surgical procedures by providing non-invasive diagnostic clarity.
  - Advanced imaging reduces hospital stays and prevents complications by guiding minimally invasive therapies.

Radiology is a keystone of modern medicine as it:

- Enables precision medicine
- Reduces unnecessary surgeries
- Supports multidisciplinary care
- Drives better outcomes at a lower cost

However, it is important to recognize that radiologists do not control radiology utilization. Except for interventional radiology, who has their own clinical practice, and follow up diagnostic mammography, radiologists cannot order imaging studies and, once the patient is scanned it is the radiologist's clinical responsibility to interpret the studies that have been ordered by the referring clinician. Overutilization is driven by the referring physician's ordering patterns, not by the radiologist. Yet, in most reimbursement models, radiologists are financially penalized for inappropriate or non-authorized studies, even though these decisions are outside of the radiologist's control. Any payment or quality model must recognize that radiologists are consultants, not drivers of utilization, and it should reward this added value rather than impose penalties for factors beyond the radiologist's control.

Attached, please find an article published in the Journal of American College of Radiology. This article uses claims data to project future imaging utilization through 2055 incorporating population growth, aging, insurance and utilization trends. As expected, the demand for imaging will increase significantly, particularly for those who are Medicare eligible. Highlighting page 135, "By age, the population of those < 35 year of age is projected to decline 8.4% by 2055, and those > 35 years of age is projected to grow 21.6%. More specifically, growth is concentrated in the 75 to 84, 85 to 94, and > 95 age groups, which are projected to increase by 51.5%, 149.6% and 282.11% respectively." This article further details how the increase in this age group (as well as all age groups) will continue to increase over time.

The radiologist workforce is experiencing a critical shortage, with 1,971 open positions currently listed on the American College of Radiology's (ACR) job board. This shortage is exacerbated by an aging patient population that requires more imaging services, ongoing reductions in physician and free-standing facility reimbursement, and increasing demands on radiologists. To meet rising clinical needs, radiologists are working longer hours which is contributing to widespread burnout. The pressure to maintain high productivity while covering a greater number of exams is unsustainable and threatens the quality of patient care.

Substantive changes in the healthcare delivery structure and reimbursement are essential to meeting future demands. Reiterating, RBMA applauds the Doctors Caucus initiative to tackle these pressing issues.

RBMA comments are as follows:
What legislative reforms are most needed to ensure future CMMI models deliver real improvements in cost and quality, while also ensuring successful scaling of innovations?

By design, radiology's ability to participate in CMMI's models have been underwhelming. This is unfortunate due to the important role of radiologists in patient care.

As of the date of this letter, there has not been a CMMI model in production that has a significant impact on Radiology. The Radiology Oncology Model, originally slated for implementation in 2022, continues to be delayed by congressional legislation and CMS, therefore no data is available on the benefits of this model to radiology oncology.

RBMA found that in April 2025, the Healthcare Leadership Council asked Avalere Health to analyze CMMI's programs and effectiveness. Avalere reviewed 18 CMMI models, focusing on federal spending, care quality, and transparency in model design and implementation.
In their analysis, Avalere reported:

- One-third delivered significant net savings
- One-third had substantial losses
- One-third had minimal financial impact

Quality outcomes varied: four models saw clear improvements, three had marginal positive effects, seven were mixed, and four showed no significant change.

The successful models were those that demonstrated cost reductions without quality decline (and vice versa). Avalere's examples of successful programs are:

- Pioneer ACO advanced ACO policy development
- BPCI-Advanced informed broader episodic payment design
- Maryland's program influenced multi-payer cost-control strategies
- APMs (including MSSP enhancements) that contributed meaningful savings with improved accountability

Future CMMI models should ensure that ALL clinical specialties have the opportunity for input and participation. Currently CMMI does not have any internal ongoing multidisciplinary clinical committee for guiding its model portfolio. MACRA established the Physician Focused Payment Model Technical Advisory Committee (PTAC) which advises the Secretary of HHS, but CMMI is not required to adopt PTAC recommendations. Additionally, there are currently no radiologists who serve on the PTAC. Physician members include internal medicine, osteopathic medicine, and experts in value-based payments, but none are radiologists. RBMA recommends that CMMI create a true multidisciplinary clinician committee to propose, review, and analyze future CMMI models.

Additionally, the provider community should understand how funding for these models is allocated. As you know, the Medicare fund that pays physicians operates under a principle of "budget neutrality." This means that changes in utilization, RVU values, or the introduction of new CPT® codes affect overall reimbursement for all physicians. Funding for CMMI models should not be drawn from this fund, as not all physician subspecialties can participate equally.

If MIPs were to be reformed or replaced entirely, what would a new physician-led quality program look like? How can we ensure a new program reduces administrative burdens and is applicable to all types of clinicians in all settings, while focusing meaningfully on real outcomes?

To be brutally honest, the MACRA MIPs program is a "pay for reporting" program vs. a "pay for quality" program. The burden AND cost to comply with are on the backs of physician organizations and are significant. Physician groups must purchase software for monitoring and reporting, outsource reporting functions, hire staff, etc. all to ensure that the medical record contains the appropriate documentation to meet a MIPS quality measure.

- A comprehensive 2023 academic literature review by Yale University concluded that MIPS "has not led to improvements in quality, decreases in spending, or increases in value."
- **This same study revealed substantial administrative burden.** Participating practices spent an average of **$10,000–$15,000 per physician in 2019**, with similar associated time costs.
- Alternative Payment Models (APMs) under MACRA (e.g., MSSP ACOs) showed modest net savings, usually between 0.5% and 1.5% annually, but MIPS itself lacks comparable financial outcomes.

While **APMs may have delivered some cost reductions, MIPS has not**. It has instead added administrative expense without offsetting savings in Medicare spending.

In addition, there are significant parity issues in MIPS that involve how performance scoring and payment adjustments affect different types of providers, often creating unintended disparities. For example, there is a disproportionate burden on small and rural practices. Smaller practices and rural providers often lack the staff and technology needed for complex reporting, thus making compliance harder and more expensive. These groups tend to score lower, not because of poor clinical care, but due to structural disadvantages.

Safety net providers and specialty providers are also disadvantaged. Studies show safety-net providers (serving vulnerable populations) are more likely to receive positive payment adjustments, but the actual dollar amounts are very small, on average only a few hundred dollars over several years. Why? Because adjustments are tied to Medicare volume, and these providers typically have a higher Medicaid patient base vs. a Medicare patient base.

Specialty practices often perform negatively in the current MIPs environment. This is not a result of either their quality or cost efforts, but the acuity of the patient base they serve. An example: A neurosurgeon who specializes in non-curable brain cancer will likely have both negative outcomes and high costs. This is not an indication of his/her skill but the characteristics of the patient base they serve. Because of this, Specialty providers are many times excluded from participation in system wide APMs. Specialty providers inherently care for patients with complex medical conditions and their inclusion in an APM tends to increase costs

associated with care provided and overall system performance.

Like issues affecting specialty practices, socioeconomic and patient mix factors also play an important role. Providers serving patients with complex social needs may score lower on outcome measures, even when delivering high-quality care, because risk adjustment is limited.

One last point, the opportunity exists to manipulate APMs or Medicare Shared Savings programs. Patients with higher acuity or chronic illnesses are classified in a different risk adjustment category where quality and cost measures are more liberal than the general population. We have all read articles where Medicare beneficiaries are given a diagnosis, such as diabetic retinopathy or arterial sclerosis, that are exaggerated from their clinical conditions thus giving advantage to their clinician for better performing quality scores.

Bottom Line - MIPS was designed to reward quality and efficiency, but its structure often amplifies disparities, has high compliance costs with minimal financial benefit, is complex and burdensome, and is subject to bias and manipulation. MIPS fatigue is real and can contribute to clinician burnout.

RBMA recommends that CMS focus on specific programs that are manageable, will increase quality while reducing costs, and allows all providers to participate equally, and remain unchanged long enough to afford providers the time needed to drive quality improvements. RBMA outlines 3 programs below:

Program 1: Appropriate Use Criteria.

In the 2014 PAMA legislation Congress required CMS to implement a program to ensure that radiology studies that are ordered and performed are appropriate for the patient's condition. Over the past 10 years, CMS has attempted to comply with this legislation but has found it to be difficult to implement and operationally burdensome. In the 2024 Medicare Physician Fee Schedule Final Rule CMS stated that they were postponing its implementation indefinitely and would need Congressional action to move forward.

In 2025 the American College of Radiology (ACR) joined Senator Marsha Blackburn and Senator Catherine Cortez Masto in introducing the Radiology Outpatient Ordering Transmission Act (ROOT Act) S. 1692. A companion bill HR 5737 has been introduced in the House. The ROOT Act's purpose was to remove the barriers hindering the implementation of the AUC program as noted by CMS. Given that Congress is currently managing numerous competing priorities, the ability to advance the ROOT Act is limited.

The Radiology Business Management Association has a practical approach for CMS to consider:

- <u>Post Transaction of High-Tech Imaging Studies</u>
  CMS should implement a retrospective review of advanced imaging claims against AUC using existing, already approved Provider Led Entities or PLEs.
- Operational Framework

    - CMS assigns a PLE to work with each Medicare Administrative Contractor (MAC)
    - MACs transmit claims data to the PLE, which will then be processed through the PLE's AUC database
    - The PLE generates reports by ordering physicians showing the percentage of studies that have passed/failed AUC criteria
- Integration with MIPS
  CMS would then incorporate the ordering physicians' AUC compliance scores into MIPS, creating a feedback loop that would promote evidence-based ordering of studies. Clinicians who have a positive pass percentage over a certain threshold will receive a positive adjustment to their MIPS score and clinicians who perform below the threshold will receive a negative adjustment to their MIPS score
- Over time, inappropriate imaging should decline, reducing overutilization and possibly resulting in an overall increase in the conversion factor for all physicians. (PLE's would charge CMS a fee for processing the files and generating the reports.)
- A positive byproduct of this model is that the "indication for a radiology exam" should improve, thus increasing quality of care and resulting in better diagnoses
- To promote adoption of this program, legislation could exempt providers from medical malpractice liability if they follow AUC guidelines
- Any Medicare savings from reduced overutilization could be partially shared with those who positively participate in the program including radiology with the details to be developed collaboratively

Program 2: Following up on Incidental Findings.

On the surface this appears to be a "radiology centric" program, however it is the responsibility of the entire "house of medicine" to ensure that providers are appropriately following up on actionable incidental findings on radiology exams.

This program would reduce missed or delayed diagnoses by ensuring timely, guideline-concordant follow-up for *actionable* incidental findings (AIFs) detected on imaging, while avoiding unnecessary follow-up for clearly benign lesions. Evidence shows large proportions of test results are not acted upon and implementing this program would lead to early detection, improved patient care, and a reduction in healthcare costs.

CMS already measures appropriate "*no follow-up recommended*" for simple renal cysts and small benign adrenal lesions (MIPS **#405**), pulmonary nodules found on CT Scans (MIPS **#364**) and follow up of incidental thyroid nodules (MIPS **#406**) along with other registry measures. With these existing measures CMS is signaling alignment with the value of incidental findings. This concept could further be expanded by using the ACR Incidental Findings algorithms (liver, renal, adrenal, pancreas, adnexa, thoracic) coupled with the ACR's "Closing the Recommendation Follow-up Loop" guidelines. Patient care is ultimately improved by ensuring actionable incidental findings are identified and clearly communicated, tracked and followed.

Eligible clinicians include but are not limited to radiology groups, ER physicians/hospitalists,

primary care, and specialty practices that assume longitudinal responsibility. This program would follow the incidental finding through the full patient cycle of identification, communication, accountability, and completion. It would also designate a specific clinician to be the "custodian of follow up," who would be identified at report sign off.

Like MQSA breast requirements, this measure would require systems be in place to identify incidental findings, recommend any further imaging studies, confirm notification to the "custodian of follow up" and "close the loop" confirming the information was received and that the clinician is responsible for the patient's follow up care.

The burden for providers is significantly reduced as much of this is already in place through either Clinical data registries or the Joint Commission's safety standards. This program would create a national standard for all providers to comply. An example: patient presents in the emergency department and ER physician orders a CT. The CT reveals a 2.2 cm lesion, likely a benign adrenal adenoma. Radiology report/impression includes ACR reference, no immediate ER action, outpatient endocrine/PCP surveillance timing, and named custodian which would either be the patient's PCP or an assigned hospital clinician. A system would record patient information, incidental findings, how they were communicated and to whom (the custodian of follow up, followed by acknowledgement from clinician of notification). If unresolved at/after X number of days, facility will send automated reminders at 4 and 8 weeks, then a direct notification to the patient via letter or phone call.

This program leverages existing CMS/QCDR/ACR measures and matches Joint Commission expectations for timely diagnosis and reduction of diagnostic error risk. This program is built on already developed guidelines, so clinicians have confidence in its application and promotes consistency across systems.

To support implementation, CMS could establish a dedicated fund for participating providers, helping to build or enhance the infrastructure necessary to manage incidental findings effectively. This would ensure equitable participation and accelerate adoption across diverse practice settings.

Program 3: Participation in national HIEs.

The radiology industry can attest to the transient nature of its patient population which is a mobile population who seeks care in many different settings across wide geographic areas. Having a complete longitudinal medical record is vitally important, but there are significant gaps in medical record sharing and interoperability.

The goal of this program would be to accelerate nationwide secure exchange of electronic health information (EHI) by incentivizing providers to:

1. Participate in HIEs (state, regional and nationally) and
2. Exchange information under TEFCA/QHIN at the national layer. This plan leverages and extends CMS's Interoperability & Patient Access Final Rule

CMS already requires event notifications and FHIR-based APIs, with TEFCA-aligned PI/MIPS options available. Adding specific incentives will boost adoption, enabling bi-directional exchange and TEFCA use, which will help to reduce fragmented medical information and support consistent care across providers.

Other Considerations: RBMA also highlights the AMA's proposed replacement for MIPS, known as the Data-Driven Performance Payment System (DPPS). There are elements of this proposal that are worthy of consideration:

- Provides annual updates to the conversion factor that are tied to Medicare Economic Index
- Caps maximum penalties at ½ of a physician's annual payment update
- Funds quality improvement and readiness for Alternative Payment Models through the penalties which eases the burden on small, rural and safety net physicians
- Freezes the performance threshold at 60 points for at least 3 years
- Eases health IT requirements, allowing for a "yes/no" attestation for certified EHR use or registry participation
- Fulfills the improvement activity requirement automatically through participation in a Qualified Clinical Data Registry
- Replaces broad cost metrics with episode-based cost measures that directly reflect physician-influenced care
- Freezes the application of adjustments in years in which the update to the conversion factor is negative

The benefits of this program to Radiology and other physician specialties that struggle with meeting MIPS & MIPS Value Pathways are as follows:

1. <u>Reduced Administrative Burden</u>
   Radiology often struggles with MIPS reporting because many measures are not specialty relevant. DPPS simplifies reporting and allows registry participation (e.g., ACR's NRDR) to count towards improvement activities, which aligns well with radiology workflows.
2. <u>Stable Payment Updates</u>
   DPPS eliminates the competitive "tournament" structure of MIPS, replacing it with predictable annual updates. This is important for radiology practices that have limited ability to influence cost and outcome measures under MIPS.
3. <u>Better Specialty-Relevant Measures</u>
   DPPS emphasizes episode-based cost measures and clinically meaningful quality metrics. Radiology could advocate for imaging-specific episodes or diagnostic accuracy measures, improving fairness compared with broad population-based metrics in MIPS.
4. <u>Support for Smaller Practices</u> DPPS would reinvest penalty dollars into technical assistance and readiness for Alternative Payment Models, which could help smaller and independent radiology practices transition toward value-based care without punitive risk.

Radiology plays a foundational role in modern medicine, yet current CMS models and MIPS structures have failed to recognize our unique position as consultants rather than drivers of utilization. Future reforms must prioritize programs that are practical, equitable, and outcome-focused while reducing administrative burden and improving patient care. By implementing evidenced based initiatives such as retrospective AUC reviews, standardized follow up for incidental findings, and incentives for participation in national HIE frameworks, CMS can achieve meaningful cost savings, enhance quality, and foster true interoperability. We urge policymakers to adopt these recommendations and ensure that all specialties, including radiology, have a voice in shaping models that deliver real value for patients and providers alike.

RBMA appreciates the opportunity to provide input on potential reforms and improvements to the Medicare Quality Payment Models. We recognize the complexity of these programs and value the Doctors Caucus' thoughtful consideration of provider perspectives and any refinements within its jurisdiction. RBMA remains committed to working collaboratively with Congress and CMS to advance policies that promote high-quality, cost-effective care for Medicare beneficiaries. We welcome ongoing dialogue and stand ready to serve as a resource in shaping a sustainable future for radiology and the broader healthcare system.

Sincerely,
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