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The Honorable Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted via www.regulations.gov
File Code: CMS-1832-P

Administrator Oz:

The Radiology Business Management Association (RBMA) appreciates the opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) regarding the CY 2026 Medicare Physician Fee Schedule (MPFS) Proposed Rule. Established in 1968, RBMA is a professional association that consists of over 2200 radiology practice business leaders who represent over 800 radiology practices in all 50 states. This includes 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.

We recognize the statutory and regulatory constraints under which CMS operates and understand that its authority to make changes to the Medicare program may be limited. Nonetheless, we are grateful for CMS's attention to our feedback and any adjustments that can be made within its purview. RBMA shares CMS's commitment to ensuring that Medicare beneficiaries receive high-quality, cost-effective healthcare, and we look forward to working collaboratively toward that shared goal.

RBMA will provide comments on the following components of the Proposed Rule:

- Proposed Dual Conversion Factors of $33.5875 for qualifying Alternative Payment Model (APM) qualified participants (QPs) and $33.4209 for providers who are not QPs.
- Proposed Efficiency Adjustment
- Proposed Updates to Practice Expense (PE) Methodology - Site of Service Payment Differential

- Proposal for CMS' Permanent Authorization of the Use of Virtual Presence for Diagnostic Tests that Require Direct Supervision
- AMA's PPI Survey and processes for updating cost values
- MIPS and MIPS Value Pathways

Understanding the Current State of Radiology

Before addressing the specific components of the Proposed Rule RBMA believes it is essential to establish a clear understanding of the current challenges facing the radiology industry.

The radiologist workforce is experiencing a critical shortage, with 2,108 open positions currently listed on the American College of Radiology (ACR) job board. This shortage is exacerbated by an aging patient population that requires more imaging services, ongoing reductions in physicians and free-standing facility reimbursement, and increasing demands on radiologists. To meet rising clinical needs, radiologists are working longer hours which is a contributing factor 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.

This crisis is particularly acute in rural areas, where hospital closures are accelerating. Patients in these regions face long travel times for imaging services or lack access to transportation altogether, creating significant barriers to care. As highlighted in the Radiological Society of North America (RSNA) article 'Rural Areas Face Imaging Obstacles on the Road to Health Equity,' Dr. Eberth notes, '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.'

The shortage of radiologists is driven by multiple factors: increasing demand due to demographic shifts and technological advancements, limited training positions, and high rates of burnout and attrition—particularly in the wake of the COVID-19 pandemic. These pressures result in most notably longer patient wait times and increased workloads.

Adding to the demand for imaging services is the growing number of mid-level providers, such as nurse practitioners and physician assistants. These clinicians often rely more heavily on imaging to support diagnosis, potentially ordering studies at a higher rate than physicians with more extensive training. While their involvement can streamline clinical workflows, it also contributes to the rising volume of imaging studies.

Managing radiology practices has become increasingly difficult in this environment. Reimbursement continues to decline while operational costs, including staff salaries, rent, equipment, and supplies—are rising steadily. This creates a paradox unique to healthcare: running a business where revenue decreases year after year despite increasing expenses. In any other industry, such a model would be unsustainable.

Radiology has been disproportionately affected by reimbursement cuts, which have had a direct impact on business operations. Practices are delaying investments in new equipment,

asking staff to work longer hours, and reevaluating contracts with hospitals. In some cases, if the cost of providing services exceeds the associated revenue, practices are forced to request financial support or withdraw from service agreements. In imaging centers where radiology groups control access, some have had to limit services to Medicare patients—a deeply unfortunate but economically unavoidable decisions. As basic business principles dictate, if the cost of delivering a service exceeds the payment received, the service cannot be sustained.

In the fall of 2024, RBMA—through its Radiology Patient Advocacy Network (RPAN)—conducted its fourth annual Medicare beneficiary survey. The results were sobering:
- 56% of respondents reported waiting more than four weeks to schedule an appointment.
- 54% said it took three months or longer to find a physician who was accepting new Medicare patients.

These findings underscore the real-world consequences of the radiology workforce crisis and the broader challenges facing Medicare beneficiaries in accessing timely, quality care.

2026 Proposed Conversion Factors of $33.5875 for qualifying APM participants and $33.4209 for non-qualified APM participants.

Recommendation:
RBMA recommends that CMS provide clear and consistent guidance to providers and Medicare Administrative Contractors (MACs) regarding claims processing and conversion factor determinations, especially given the complexities introduced by radiologists who service multiple systems. RBMA also urges CMS to develop pathways that allow specialty physicians, including radiologists, to meaningfully participate in APMs so they may qualify for the higher conversion factor, recognizing their vital role in patient care. Additionally, RBMA supports the Prompt and Fair Pay Act and recommends that Medicare Advantage plans reimburse providers at the higher conversion factor, aligning their payment structures with those of APMs.

Discussion:
In accordance with statutory requirements under the Medicare Access and CHIP Reauthorization Act (MACRA), CMS has proposed two distinct conversion factors for CY 2026:
- $33.5875 for physicians who meet the participation thresholds used to define Qualifying Participants (QP) in Advanced Alternative Payment Models (APMs)
- $33.4209 for clinicians who are not defined as QPs

These figures represent increases of 3.8% and 3.3%, respectively, based on the CY 2025 conversion factor of $32.3465. These positive adjustments reflect MACRA provisions, including:
- A 0.75% annual update for providers who are QPs in an AAPM
- A 0.25% annual update for providers who are not QPs
- A 0.55% budget neutrality adjustment
- A one-time 2.5% increase in the Conversion Factor as outlined in the recently enacted H.R.1 “One Big Beautiful Bill” Act (OBBBA)

The RBMA respectfully requests that CMS provide clear guidance to providers and Medicare Administrative Contractors regarding the processing of claims and the determination of applicable conversion factors.

Providers participating in APMs are identified on CMS participation lists as either Qualifying Participants (QPs) or Partial Qualifying Participants (Partial QPs). These lists include each APM Entity's Taxpayer Identification Number (TIN) and the National Provider Identifiers (NPIs) of eligible clinicians. To qualify, clinicians must meet specific thresholds based on the percentage of Medicare Part B payments received and the number of Medicare patients treated through the APM during a designated performance period. CMS reviews participation data quarterly ("snapshots") to determine QP status and updates the lists accordingly.

As noted in previous comment letters, our industry continues to face a significant workforce shortage affecting both radiologists and support staff. To meet the increasing demand for imaging services, many radiologists work across multiple entities. For example, a physician may spend one week with a radiology group that participates in an APM, and the next week that same physician may be contracted with a radiology group that is not an APM participant. This fluidity introduces complexity and raises concerns about potential inaccuracies in reimbursement.

In addition, CMS' proposal to make the QP determination at the individual NPI level further disadvantages radiologists. Full-service radiology groups typically consist of multiple subspecialties across a broad spectrum (Mammography, Nuclear Medicine, Interventional Radiology, Musculoskeletal, etc.) and do not calculate Medicare Part B Payments or number of Medicare Beneficiaries at the individual NPI level.

Furthermore, RBMA respectfully wishes to bring to CMS's attention a concerning trend in the implementation of Alternative Payment Models; participation is increasingly being limited to primary care physicians, effectively excluding other specialties- such as radiology- from eligibility for the higher APM conversion factor.

This exclusion places specialty physicians at a disadvantage, despite their critical role in patient care. Several factors contribute to this trend:

- Quality metrics in most APMs are designed around longitudinal, population-based health outcomes, which align more closely with primary care. In contrast, specialists like interventional radiologists often manage acute episodes of care that do not fit within these parameters.
- Specialty physicians frequently treat patients with complex or advanced conditions, making it difficult to apply standard outcome measures or adequately risk-adjust for patient severity.
- Many quality measures, such as those for chronic management, are not applicable to procedural specialties- for example, a surgeon focused on joint replacement or a radiologist interpreting a brain MRI.

RBMA urges CMS to consider solutions that would allow specialty physicians, including radiologists, to participate meaningfully in APMs and/or a different pathway for the higher conversion factor. Without such consideration, the current structure risks undervaluing the contribution of radiologists and other essential specialty providers.

Clear guidance from CMS will help providers with better planning, auditing payments, and ensuring accurate reimbursement.

RBMA also understands that Medicare Advantage (MA) plans are not subject to the dual conversion factor and will continue to negotiate rates directly with providers. CMS projects a 5.06% average payment increase to MA plans in 2026. RBMA remains concerned about the growing disparity between increased funding to MA plans and the continued decline in physician reimbursement from those same plans. Unlike hospitals and other provider groups, physicians do not receive annual inflationary updates to their reimbursement formulas.

Additionally, in many states, MA plans reimburse physicians at rates that are below traditional Medicare, due to their ability to negotiate contracts and operate within narrow provider networks. This disparity is now being addressed at the congressional level through the introduction of H.R. 4559 – Prompt and Fair Pay Act, sponsored by Representatives Lloyd Doggett and Greg Murphy. This legislation would require MA plans to reimburse providers at traditional Medicare rates. RBMA supports this bill and further recommends that the payment be made at the higher conversion factor as participation in these Medicare Advantage plans have similar rules and processes to an Alternative Payment Model. RBMA reiterates to CMS our willingness to serve as a resource, offering data and insights into the impact of reduced reimbursements on our industry.

Efficiency Adjustment Comments

Recommendation:
RBMA strongly recommends that CMS withdraw the proposed 2.5% efficiency adjustment to work RVUs, citing a lack of empirical support and concerns about its negative impact on physician reimbursement and patient access to care. The adjustment is arbitrary and not resource based, misapplies economic productivity metrics to clinical practice, and fails to account for increased complexity, after hours demands and rising practice expenses – particular in radiology. RBMA urges CMS to reconsider this proposal, as it undermines Congress' intent, adds unnecessary regulatory complexity, and risks worsening the radiologist workforce shortage and access issues for Medicare beneficiaries.

Discussion:
CMS proposes an across the board 2.5% reduction in the work RVU's, which is characterized as an efficiency adjustment. RBMA is concerned about the accuracy of the survey data used by CMS to support this adjustment, coupled with a theory that efficiencies have been gained in work RVU's for non-time-based codes.

RBMA believes that the proposed efficiency adjustment is unsupported by data, is at odds Congress' intent, is inconsistent with President Trump's stated goals of reducing regulatory impact and will ultimately have a negative impact on access to care for Medicare beneficiaries. The net effect of the proposed efficiency adjustment is to devalue physician work, which is yet another setback for physicians following decades of conversion factor reductions in the context of continuing inflation.

The proposed rule posits that non-time-based codes "should become more efficient as they become more common, professionals gain more experience, technology is improved, and other operational improvements (including but not limited to enhancements in procedural workflows) are implemented." In the case of CT, the exponential growth in image volume has surely driven less efficiency not more. A Computed Tomography (CT) study that once consisted of 40 images now frequently contain 400 or more. In addition, AI tools often highlight or flag findings that then require further physician review, confirmation or correlation with other studies. As discussed below, Artificial Intelligence (AI) is currently having a negative impact on radiologist efficiency, which seems likely to become more significant in the near term.

The Proposed Rule states that "studies have demonstrated that CMS continues to overvalue non-time-based services." The single citation in support of this assertion is a 2016 Urban Institute study which was designed to "develop a validation process for the work relative value units (RVUs) used in the fee schedule." The Urban Institute study was clearly not designed to make any assessment of the value of non-time-based services. It seems that while one impetus for the efficiency adjustment is a concern about the quality of survey data, the justification for the efficiency adjustment itself is based on a single survey done nearly a decade ago that was not intended to measure efficiency of all non-time-based procedures in all settings.

The Urban Institute study involved an inadequate sample (94 imaging exams) and interviews with five radiologists who apparently were working exclusively in a multispecialty group practice setting. It appears that the study did not include imaging performed on inpatients or emergency department patients, which differ greatly in terms of clinical complexity and operating environment compared to a multispecialty clinic.

CMS proposes to base the efficiency adjustment on the Medicare Economic Index (MEI) productivity adjustment. As noted in the proposed rule, "the MEI productivity adjustment used for the final MEI update reflects the most recent historical estimate of the 10-year moving average of private nonfarm business total factor productivity." RBMA believes it is unreasonable to extrapolate changes in physician productivity from estimates of nonfarm business productivity across the entire economy. For example, in recent decades productivity increases in the broad economy have largely been driven by technology. We are unaware of any similar impact on physician practice, certainly not within radiology. While robots operate warehouses and assembly lines, the practice of radiology remains reliant on human expertise. Many physicians spending hours clicking in their hospital electronic medical records would argue that technology has in fact made them less efficient.

To the extent that technology has changed radiology practice, it has come with a cost that has not been reflected in the practice expense RVU's, especially in the facility setting. For example, many hospital-based radiology groups have been forced to invest in PACS systems and support staff to facilitate remote reading to mitigate the acute and growing imbalance between the supply of radiologists and the demand for services, especially after hours.

CMS speculates that AI tools may lead to otherwise unaccounted for efficiency gains in specific services. With respect to radiology, RBMA believes much of today's clinical AI is hampering efficiency by generating significant numbers of false positive alerts with more data to be reviewed. To the extent that AI is being adopted by physicians, it adds to practice expense which has not been reflected in the practice expense RVU's.

Another factor that has a major impact on radiology is the shift of care to the emergency department, and outside of normal business hours. Many hospitals now perform much of their imaging outside of normal business hours, and virtually all after hours hospital imaging requires immediate attention. Physician labor costs are much higher after hours and there has been no RVU adjustment to reflect these changes.

RBMA understands that Section 1848(c)(2)(B)(ii)(I) of the Act gives the Secretary the authority to make RVU adjustments to account for changes in medical practice. However, to arbitrarily reduce work RVU's after many years of conversion factor reductions based purely on the time component, without considering offsetting changes in the other components of the work RVU and without adjusting practice expense RVU's to properly account for practice expense is unwarranted. The net effect of the efficiency adjustment is to reduce reimbursement to radiologists, in both the facility and the non-facility settings. Such a reduction in the face of a dire shortage of radiologists and in an environment where MPFS reimbursement does not support recruitment and the retention radiologists is sure to accelerate the radiology access problems that some Medicare beneficiaries are already experiencing.

Our analysis indicates that the impact of the efficiency adjustment in the non-facility setting is understated in Table 92: CY 2026 PFS Estimated Impact on Total Allowed Charges by Specialty. If CMS reduces the work RVU's for all non-time-based codes in both the facility and the non-facility settings by 2.5%, it does not seem possible that the result is a 0% change in work RVU's for interventional radiology, radiology nuclear medicine, and radiation therapy centers in the non-facility setting. In addition, RBMA respectfully requests that it be clearly stated in the Final Rule that this efficiency adjustment applies in both the facility and the non-facility settings.

In the OBBBA, Congress clearly intended to provide some relief to clinicians who are paid under the MPFS from decades of declining reimbursement. With the efficiency adjustment, CMS has instead elected to further reduce reimbursements to radiologists who practice in both the facility and the non-facility settings and to do so arbitrarily.

Finally, the efficiency adjustment undermines the Trump Administration's stated objective to simplify and reduce regulations. The proposed efficiency adjustment adds complexity to the

MPFS with no appreciable benefit to anyone and it fundamentally changes the MPFS in the absence of empirical data. There are many problems with the Medicare Physician Fee Schedule that need to be addressed; however, undervaluing physician work is not one of them. RBMA believes the efficiency adjustment is unreasonable, unsupported, and unnecessary.

Proposed Updates to Practice Expense Methodology - Site of Service Payment Differential

Recommendation:
RBMA stands with the house of medicine in expressing concern that the proposed site of service payment differential is not evidence-based or supported by data. RBMA recommends CMS reconsider this policy and work with physicians to develop data-driven, evidence-based solutions before implementing this policy. Should CMS decide to move forward with the Site of Service Payment differential, RBMA recommends that CMS explicitly clarify in the final rule that the proposed reduction in the indirect portion of the facility practice expense (PE) RVUs allocated based on wRVUs does not apply to diagnostic radiology services billed with the 26 modifier (Professional Component Only), as these services incur similar indirect costs across both the facility and the non-facility settings. Additionally, RBMA urges CMS to reconsider the proposed 50% reduction in PE RVUs for interventional radiology services exempt these services from the reduction, noting that such reductions could harm independent practices.

Discussion:
In the proposed rule, CMS introduces significant refinements aimed at addressing shifts in physician practice settings. Specifically, for services delivered in facility settings, CMS proposes to reduce the indirect portion of the facility practice expense (PE) relative value units (RVUs) allocated based on work RVUs to half the amount allocated to non-facility PE RVUs. CMS explains that applying equal indirect PE RVUs across settings may overstate the costs for facility-based physicians and distort relativity. CMS states "*Resources to furnish services may not be adequately reflected in facility and non-facility settings and could potentially contribute to undesirable financial incentives to higher-priced settings of care (hospitals) & away from more efficient settings (physician offices).*"

RBMA is concerned that the proposed 50% reduction of the facility indirect practice expense RVUs is arbitrary and lacks supporting evidence or data. Physician groups continue to face significant increasing direct and indirect costs that have not been reflected in the Medicare Physician Fee Schedule reimbursement formula through RVU adjustments and/or an inflation factor. Ongoing reimbursement reductions risk diminishing competition and innovation, limiting patient choice particularly in rural or underserved areas and undermining the sustainability of independent private practices. RBMA believes that CMS should work with physicians to develop data-driven, evidence-based solutions before implementing this policy.

In the event CMS moves forward with the proposed updates to the practice expense Site of Service Payment differential, RBMA has confirmed with CMS staff that diagnostic radiology services billed with a 26 modifier are exempt from this adjustment, regardless of the site of service. In a follow-up email with CMS staff, it is stated "For the site of service adjustment, I can

confirm that it is an intended policy choice that the PE RVUs remain the same for codes with the 26 modifiers in the Facility and Non-facility setting. Codes with 26 modifiers have historically always had the same PE RVUs in both sites of service and it was intended to maintain this relationship for CY 2026 rulemaking."

RBMA appreciates CMS's recognition that radiology groups incur similar indirect costs regardless of where care is delivered. If this proposed change is implemented, RBMA encourages CMS to provide clarity and clearly state that the indirect practice expense differential does not apply to the professional component (modifier 26) of diagnostic radiology services in either setting –when the PC is billed separately (as in the facility setting and the non-facility setting when there is split-billing) and in the non-facility setting when the professional component is part of a global TC/PC payment.

Furthermore, RBMA emphasizes that the current RVU values for radiology's indirect expenses remain undervalued. CMS has acknowledged that the last Physician Practice Information Survey (PPIS), conducted in 2006–2007, significantly underrepresented several specialties, including radiology. Since then, radiology practices have evolved considerably and are becoming more complex, are facing increased regulatory burdens, and are experiencing substantial growth in overhead costs. Including diagnostic radiology services in this adjustment would further disadvantage radiology groups.

Additionally, RBMA's analysis of several interventional radiology services reveals that the surgical codes used by this specialty are impacted by the proposed practice expense site of service payment differential. While it is reasonable to acknowledge that interventional radiologists benefit from not having to cover facility overhead (e.g., surgical suite rent), these physicians still bear substantial indirect costs—such as billing, coding, IT infrastructure, administration, scheduling, and marketing.

RBMA believes that a 50% reduction in the indirect PE RVU component for interventional radiology services is excessive. RBMA is particularly concerned that such a reduction could accelerate consolidation and threaten the viability of independent interventional radiology practices, especially given that many procedures must be performed in facility settings.

RBMA respectfully urges CMS to exempt interventional radiology services from this site of service adjustment and to conduct further analysis on actual indirect costs incurred by this specialty before implementing any adjustment to reimbursement.

Support for CMS' Permanent Authorization of the Use of Virtual Presence for Diagnostic Tests that Require Direct Supervision

Recommendation:
RBMA strongly supports CMS's proposal to permanently allow virtual direct supervision for Level 2 diagnostic tests, citing improved patient access, safety and no negative impact on program integrity or utilization.

Discussion:
RBMA writes in strong support of CMS' proposal to make permanent the use of a virtual presence via audio/video communications technology for diagnostic tests that require direct supervision (i.e., Level 2 diagnostic tests).

Since first implemented during the public health emergency, outpatient hospital departments, physician offices and free-standing independent diagnostic testing facilities have safely and effectively implemented virtual direct supervision models and have shown that deploying virtual direct supervision is an excellent innovation that drives patient access while at the same time improving patient safety without a threat to program integrity or overutilization. In RBMA's view, the availability of virtual supervision and the policies and procedures that have been put into practice by outpatient imaging providers and suppliers have made administration of contrast under direct supervision safer. As we have seen and CMS has recognized, outpatient imaging centers virtually supervising Level 2 diagnostic tests with contrast using real time audio and video communications technology have promoted and improved patient safety by assuring that appropriate protocols have been implemented and training the qualified personnel (including radiologic technologists) on site as well as the physician or non-physician practitioner providing the virtual direct supervision to recognize and respond to contrast reactions.

Safe and effective virtual supervision is accomplished both through the supervision requirements and through the ability to immediately respond appropriately to contrast reactions in patients. RBMA supports the current requirement by CMS regulation to allow direct supervision by physicians or by non-physician practitioners, if permitted by state law, in all settings.

For several years, CMS has requested in its rulemaking any quality data that supported making permanent the COVID flexibility to allow virtual direct supervision for radiology test that use contrast agents. The past year, RBMA conducted an informal survey of members who indicated that they are making use of virtual "direct supervision." When asked "How would you describe your preparedness for adverse reactions to contrast compared to your preparedness when direct supervision was performed on site?" 30 percent of the respondents felt their ability to respond to a contrast reaction had improved. No respondents reported any negative impact to patient care or a reduction in their ability to respond to contrast reactions. When asked, "How would you describe the timeliness of response compared to when direct supervision was performed onsite?" Once again, 30 percent of members reported faster response times. No respondents reported any negative impact on timeliness of responses or other patient care considerations.

Additionally, data accepted for presentation at the American College of Radiology Quality and Safety Conference on September 9, 2025, by the Chief Quality Officer of RBMA member Lumexa Imaging shows that virtual supervision of contrast administration is as safe as onsite supervision with over 600,000 contrast studies considered.

RBMA would like to again note that program integrity and utilization will not be negatively impacted by making virtual direct supervision for imaging services permanent. That risk is guarded by the requirements at 42 CFR 410.32(a) that limit the test ordering authority only to the patient's treating physician or practitioner (and not the supervising physician or other staff of the imaging services provider).

AMA's PPI Survey and processes for updating cost values

Recommendation:
RBMA believes that CMS should work with the AMA to consider how the 2024 PPI data could be used in the future to reflect changes in physician practice costs and physician hours worked. RBMA recommends that CMS continue to explore alternative methods – such as those developed by the RAND Corporation for updating indirect practice expense (PE) data, due to concerns about the accuracy and representativeness of the AMA/Mathematica PPI Survey, despite strong radiology participation. We also urge CMS to avoid relying on hospital cost reports for setting technical component (TC) reimbursement rates, citing their inconsistency and lack of actionable detail. RBMA calls on CMS to review and modify the Deficit Reduction Act (DRA) TC cap policy, which currently limits reimbursement for imaging services to the lower of OPPS or MPFS. We argue this cap distorts true costs, disproportionately affects access to high-cost imaging modalities like CT and MRI and discourages innovation.

Discussion:
In the proposed rule, CMS expressed concerns about AMA/Mathematica's PPI Survey results and have chosen not to incorporate their PE/HR recommendations as it relates to updating the indirect cost component of physician fee schedule formula. CMS expressed concerns regarding low response rates and small sample size in the AMA survey. CMS continues to contract with RAND corporation to develop alternative methods for updating. CMS continues to ask for stakeholder input on how to update this information.

Participation in the AMA/Mathematica PPI Survey

Through the American College of Radiology, RBMA actively supported the AMA and Mathematica's Practice Expense (PE) Indirect Cost Survey (PPI Survey) by informing members, issuing alerts, and encouraging participation. As a result, radiology achieved the third highest response rate, following Primary Care and Office-Based Medicine. RBMA appreciates the efforts of AMA and Mathematica to modernize cost data collection. However, despite this engagement, the RBMA remains concerned about the accuracy and representativeness of the results, particularly regarding the diversity of radiology practice structures.

Historical Context and Data Limitations

As CMS is aware, the 2006/2007 PPI Survey had limited radiology participation, with only 105 responses from radiologists, interventional radiologists, or nuclear medicine physicians out of 7,400 total respondents. Of these, only 21 reported any direct or indirect practice expenses. The survey instrument was difficult to complete and failed to capture accurate data. Since then, radiology practices have evolved significantly, with increased complexity, regulatory burden, and overhead costs.

RAND Corporation Engagement

RBMA is encouraged by CMS's continued engagement with the RAND Corporation. We reviewed the 2021 RAND reports and tested the proposed long and short survey instruments. We support CMS's efforts to explore alternative methodologies for updating practice expense data and offer RBMA resources and engagement in this effort.

Concerns with Hospital Cost Reports

CMS proposes using routinely updated hospital data to set relative or absolute rates, particularly for technical services under the MPFS. RBMA expresses concern about the reliability of hospital cost reports. A recent Health Affairs Scholar article dated May 22, 2025, highlights the variability and lack of actionable detail in these reports, stating: "Hospitals report widely variable administrative expenses (7.0 percentage points between the 25th and 75th percentile), with few detailed, and often mislabeled, data to guide the identification of savings opportunities. As structured today, the Medicare Cost Reports are not a consistent, reliable, or actionable dataset to aid hospitals or policymakers in quantifying and addressing excess administrative spending." (1)

Request to Modify the Deficit Reduction Act Technical Component Cap

Regardless of whether CMS proceeds with using hospital cost reports translated to OPPS reimbursement data, RBMA respectfully requests CMS modify, within their jurisdiction, the Deficit Reduction Act (DRA) of 2005 provision that caps the technical component (TC) reimbursement for imaging services at the lesser of the OPPS or MPFS rate. This policy has had unintended consequences that warrant reconsideration:

1. Inaccurate Hospital Cost Reports: These reports are often inconsistent or incomplete, distorting the true cost of imaging services, especially in outpatient settings.
2. Disproportionate Impact on Access and Innovation: The TC cap has reduced reimbursement for high-cost modalities like CT and MRI, limiting access and discouraging innovation.
3. Inconsistent Policy Application: Some services, such as screening mammography, are exempt from the TC cap. Similar exemptions should be considered for other critical services like CT colonography.

RBMA urges CMS to initiate a formal review of the DRA TC cap policy, considering the evolving landscape of imaging technology, the need for accurate cost data, and the importance of equitable access to imaging services. We appreciate CMS's continued engagement with stakeholders and welcome the opportunity to provide further input.

1. https://pmc.ncbi.nlm.nih.gov/articles/PMC12096959/#:~:text=In%20summary%2C%20hospitals%20report%20widely,and%20addressing%20excess%20administrative%20spending.

MIPS and MIPS Value Pathways

Recommendation:

RBMA supports CMS's proposed changes to MIPS and MVPs, especially the exclusion of NPs and PAs from the TPCC measure attribution in specialty practices. RBMA also supports the development of a Diagnostic Radiology MVP, as proposed. We urge CMS to expand the Interventional Radiology MVP, to proceed cautiously with procedural code-based MVP

assignment, and to ensure the implementation of digital quality measures does not disadvantage hospital based and smaller practices.

Discussion:
RBMA commends CMS for its responsiveness to stakeholder feedback, particularly in revising the attribution methodology for the Total Per Capita Cost (TPCC) measure. We strongly support the proposal to exclude nurse practitioners (NPs) and physician assistants (PAs) from TPCC attribution when all other clinicians in the group are excluded based on specialty. This change appropriately reflects the clinical roles of NPs and PAs and prevents undue cost attribution to specialty practices such as radiology.

RBMA appreciates CMS's commitment to maintain consistency in the MIPS program year-over-year. The decision to retain the performance threshold at 75 points for the 2026 performance year provides predictability and allows practices to plan effectively. We also support the continued weighting of performance categories and the preservation of small practice bonuses.

RBMA acknowledges CMS's ongoing efforts to transition from traditional MIPS to MVPs and appreciates the transparency in outlining a potential full transition by the 2029 performance period. While we support the MVP framework's intent to streamline reporting and enhance relevance, RBMA urges CMS to ensure that radiologists—particularly those in diagnostic and interventional subspecialties—can meaningfully participate before sunsetting traditional MIPS. An example of meaningful participation is ensuring the mix of quality measures contained within the MVP allows most radiology practices to report 4+ measures that are applicable to their practice.

RBMA supports the development of the Diagnostic Radiology MVP, which offers a more targeted and relevant approach to quality reporting. By aligning measures with clinical practice, this MVP has the potential to reduce administrative burden and improve the accuracy of performance assessment.

We share the concerns expressed by the Society of Interventional Radiology (SIR) regarding the proposed Interventional Radiology MVP. The current measure set includes only three broadly applicable quality measures, with the remainder focused on subspecialized areas such as stroke, dialysis access, and women's health. This narrow scope risks excluding many IRs from meaningful participation and may impose undue burden. We urge CMS to expand the measure set to better reflect the diversity of IR practice and to reconsider the cost measures included, which may not fairly represent IR contributions.

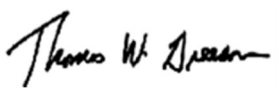
CMS is also seeking input on several RFIs that could inform the future direction of MVP development. One specific request is the use of procedural codes for MVP Assignment. RBMA urges caution regarding the use of procedural codes (e.g., CPT, HCPCS) to automatically assign clinicians to MVPs. While this approach may streamline reporting, it risks misalignment for providers whose procedures span multiple specialties. For example, interventional pain

management codes are used by radiologists, anesthesiologists, and physiatrists. We respectfully request that CMS consult with relevant specialty societies before advancing this proposal.

Another area where CMS is looking for stakeholder input is the transition toward digital quality measurement (dQM) tools. The agency is requesting feedback on the use of FHIR-based APIs and successor technologies, EHR integration, and automated data capture to support real-time, interoperable reporting. RBMA recognizes the potential benefits of transitioning to digital quality measures (dQMs), including improved interoperability and real-time data analysis. However, we remain concerned about the disparate nature of health information systems across providers, such as those who achieve "certified HealthIT" criteria vs those that do not, or those systems that encourage utilization of third-party solutions vs. those that do not. For many independent radiology groups with limited IT resources, and the inherent barriers to switching practice systems of record, implementing and maintaining numerous FHIR-based APIs and EHR integrations is prohibitively costly and unsustainable for most practices. We respectfully request that CMS engage with business associations of medicine to ensure that dQM implementation meets the 21st Century CURES act interoperability objectives and does not inadvertently accelerate industry consolidation or disadvantage smaller practices.

RBMA appreciates the opportunity to provide feedback on the CY 2026 Medicare Physician Fee Schedule Proposed Rule. We recognize the complexity of the rulemaking process and the limitations of CMS's authority under current statue. Nevertheless, we are grateful for CMS's thoughtful consideration of stakeholder input and any refinements that can be made within jurisdiction. Our association remains committed to working collaboratively with CMS to advance policies that support high-quality, cost-effective care for Medicare beneficiaries. We welcome continued dialogue and stand ready to serve as a resource in shaping a sustainable future for radiology and the broader healthcare system.

Respectfully submitted,



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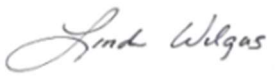

Linda Wilgus
Co-Executive Director RBMA