MACRA Modernization RFI Response
Republican and Democratic Doctors Caucuses
House of Representatives
January 2026

The American College of Radiology (ACR)—a professional association representing more than 40,000 physicians practicing diagnostic radiology, interventional radiology, radiation oncology, and nuclear medicine, as well as medical physicists—appreciates the opportunity to provide input on legislative reforms to modernize MACRA and strengthen physician-led quality programs.

We commend the Republican and Democratic Doctors Caucuses for addressing the need to modernize MACRA and improve physician-led quality programs. CMS's recent proposals to implement MVP-based frameworks and enhance primary and specialty care integration reflect an important step toward reducing complexity and promoting meaningful outcomes. ACR also applauds CMS for its commitment to improving coordination and collaboration between primary and specialty care physicians and their teams, especially at the point of referral, to improve patient care and positive health outcomes. Radiology strongly supports these goals and offers unique capabilities, including guidance for appropriateness of imaging, stewardship of radiation safety, accurate and timely imaging interpretation with evidence-based recommendations for continued care, ensuring completion of such care, and innovative, robust technological solutions that can advance timely, coordinated care and population health.

Radiology is a foundational value-based care asset that drives measurable improvement across the full spectrum of performance domains prioritized by CMS and payers, including clinical outcomes, total cost of care, quality performance, patient experience, access, and workforce sustainability. Diagnostic radiologists, on average, serve the most unique beneficiaries across 56 distinct physician specialties and provide care to more clinically complex Medicare patients than most physicians nationally.[1,2] Imaging's impact on morbidity and survival is well documented, from low-dose CT lung screening reducing lung cancer mortality to guideline-based breast cancer screening promoting earlier detection.[3,4] Imaging plays a crucial role in emergency patients and accelerates emergency department throughput.[5, 6] By ensuring early and accurate diagnosis, appropriate utilization management, diagnostic error prevention, and proactive risk mitigation, radiology reduces avoidable downstream complications, unnecessary procedures, and excess utilization,

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[1] Rosenkrantz, A. B., Hoque, K., Hemingway, J., Hughes, D. R., & Duszak, R., Jr (2018). Unique Medicare Beneficiaries Served: A Radiologist-Focused Specialty-Level Analysis. *Journal of the American College of Radiology : JACR*, *15*(5), 734–739.e2. https://doi.org/10.1016/j.jacr.2018.01.021

[2] Rosenkrantz, A. B., Wang, W., Vijayasarathi, A., & Duszak, R., Jr (2018). Physician Specialty and Radiologist Characteristics Associated with Higher Medicare Patient Complexity. *Academic radiology*, *25*(2), 219–225. https://doi.org/10.1016/j.acra.2017.09.008

[3] Aberle, D. R., Adams, A. M., Berg, C. D., Black, W. C., Clapp, J. D., Fagerstrom, R. M., Gareen, I. F., Gatsonis, C., Marcus, P. M., & Sicks, J. D. (2011). Reduced lung-cancer mortality with low-dose computed tomographic screening. The New England Journal of Medicine, 365(5), 395–409. https://doi.org/10.1056/NEJMoa1102873

[4] U.S. Preventive Services Task Force. (2024). Breast cancer: Screening—Final recommendation statement. JAMA, 331(17), 1506–1514. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening

[5] de Kok, B. M., Eijlers, B., van der Linden, M. C., & Quarles van Ufford, H. M. E. (2021). Lean-driven interventions, including a dedicated radiologist, improve diagnostic imaging turnaround time and radiology report time at the emergency department. Emergency Radiology, 28, 23–29. https://doi.org/10.1007/s10140-020-01803-3

[6] Rachh, P., Pendley, A. M., Duong, P.-A. T., Hanna, T. N., & Heilbrun, M. E. (2021). Decreasing CT acquisition time in the emergency department through Lean management principles. RadioGraphics, 41(E1), E81–E89. https://doi.org/10.1148/rg.2021200107

thereby bending the cost curve while improving outcomes. At the same time, radiology functions as an efficiency driver for hospitals and health systems by accelerating diagnostic closure, shortening length of stay, improving emergency department flow, and supporting timely, appropriate treatment decisions. Radiology programs materially protect institutional financial performance by stabilizing quality metrics, reducing adverse events and malpractice exposure, and strengthening performance in value-based payment programs such as MIPS, ACOs, and hospital VBPs.

Radiology's role in care coordination is well documented through initiatives such as the CMS Innovation Center's (CMMI) Transforming Clinical Practice Initiative (TCPI), where radiologists partnered with referring physicians to champion imaging appropriateness and high-value referral management. Breast and lung cancer screening programs, along with management and tracking of actionable incidental findings, demonstrate radiology's active engagement in population health, preventive care and improved patient outcomes. A modernized program should build on these strengths by leveraging radiology registries and evidence-based practices to reduce burden and enhance quality.

Beyond clinical outcomes, value accrues through greater diagnostic confidence, tailored investigations, and better patient experiences, as shown in outcomes research.[7,8] By reducing diagnostic uncertainty and improving communication, radiology enhances patient experience and engagement, while simultaneously serving as a cognitive and operational stabilizer for clinicians, mitigating burnout and strengthening interdisciplinary care delivery. Collectively, these contributions position radiology not as a cost center, but as a high-leverage strategic investment essential to the success of modern value-based healthcare systems.

Below are our responses to questions posed in your Request for Information (RFI).

1. 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?

[7] Thompson, M. J., Zigman Suchsland, M., Hardy, V., Lavallee, D. C., Lord, S., Devine, E. B., Jarvik, J. G., Findlay, S., Trikalinos, T. A., Walter, F. M., Chou, R., Green, B. B., Wernli, K. J., Fitzpatrick, A. L., & Bossuyt, P. M. (2023). Patient-centred outcomes of imaging tests: Recommendations for patients, clinicians and researchers. BMJ Quality & Safety, 32(9), 536–548. https://doi.org/10.1136/bmjqs-2022-015203

[8] Jarvik, J. G., Lavallee, D. C., Belafi, A., Bresnahan, B. W., Comstock, B. A., James, K., Ma, C. C., Sherman, K. J., & Tosteson, A. N. A. (2018). Patient-centered outcomes related to imaging testing in US primary care. Journal of the American College of Radiology, 15(10), 1416–1426. https://doi.org/10.1016/j.jacr.2018.07.005

Stable and Predictable Payment Updates

Radiology groups face annual fee schedule cuts that discourage investment in value-based care. **Congress should provide inflation-adjusted updates to the Physician Fee Schedule to ensure financial stability for practices participating in CMMI models.**

Permanent and Accessible Incentives for Advanced APMs
Current Advanced APM bonuses are temporary and difficult for radiology to access. **Making these incentives permanent and broadening eligibility will encourage radiology practices to adopt innovative care models.**

Lower Participation Thresholds for Specialty Practices
Radiologists frequently practice in facility-based settings, bill under the hospital or imaging center's TIN, have limited direct patient encounters, and use minimal E/M codes—factors that impede patient attribution and aggregate payment thresholds required for APM qualification. Because current thresholds are designed around longitudinal primary-care relationships, they are misaligned with radiology's episodic, consultative contributions. Although in the CMS Quality Payment Program, radiology is considered a "non-patient-facing" specialty due to fewer face-to-face patient visits, radiology's impact on patient care is significant. Diagnostic radiologists, on average, serve the most unique beneficiaries across the previously mentioned 56 diverse physician specialties and serve more clinically complex Medicare patients than most physicians.[1,2] Thus, it is essential to consider the critical impact of radiology in care coordination and to recognize how strategically placed radiology is to the success of value-based payment programs. **Any legislative changes must include radiology-specific entry points and performance benchmarking in CMS-prioritized performance domains**. With the aging population and ongoing advancements and innovations in medical imaging, the volume and frequency of imaging continue to increase, making it more important that payment models account for radiology's growing role in timely diagnosis, care coordination, and population health—rather than penalizing the specialty for structural differences in patient attribution and encounter patterns.

Reduce Administrative Complexity Through Data Integration
Radiology already collects rich clinical data through registries such as ACR's National Radiology Data Registry (NRDR**). Congress should mandate alignment of reporting requirements with existing specialty registries to reduce burden and accelerate scaling.** NRDR encompasses multiple modules that track imaging appropriateness, outcomes, and efficiency, including the Dose Index Registry, Lung Cancer Screening Registry, and General Radiology Improvement Database. Leveraging these registries for automated reporting will eliminate redundant administrative tasks, improve data accuracy and timeliness, and enable outcome-focused metrics such as diagnostic accuracy and turnaround times. **Congress should preserve and strengthen the role of clinician-led clinical data registries as foundational infrastructure for quality measurement and**

improvement. Registries provide clinically meaningful, real-world data that cannot be captured through claims alone and are essential for accurate benchmarking and outcome measurement.

Transparency and Stability in Model Development

Congress should require CMMI to provide public comment periods for all new models and prohibit termination of existing models without notice and stakeholder input. These steps will ensure models fulfill the original vision of fostering innovation rather than serving as a vehicle for unrelated policy priorities.

2. 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 across settings, while meaningfully focusing on real outcomes?

A modernized physician-led quality program should reflect the realities of healthcare delivery and the critical central role of radiology practice, both community and academic/hospital-based, while promoting meaningful quality improvement and reducing administrative burden. The ACR has advanced strategies to achieve these goals, including ongoing advocacy for modernization through letters and policy recommendations. Modernization must also account for radiology's unique value stream in patient care, which transforms clinical questions into actionable insights, enabling early and accurate diagnosis, guiding treatment decisions, and improving outcomes such as reduced morbidity and mortality.[3,4] Yet, current value-based care models often overlook these contributions because Alternative Payment Model (APM) thresholds are built around ongoing primary-care relationships. As previously described, this structure disadvantages radiologists, whose facility-based practice patterns, billing arrangements, limited direct patient encounters, and minimal E/M code usage impede patient attribution and the aggregate payment thresholds required for APM qualification. With an aging population and ongoing advancements in imaging technology, the volume and frequency of imaging continue to rise, making it even more important to design payment models that recognize radiology's consultative, episodic role in care coordination and its measurable impact on diagnostic accuracy, appropriateness, and timely interventions. Missed follow-ups—impacting more than 10% of patients—can delay critical care for serious conditions like cancer[9], underscoring the need for robust tracking systems, patient engagement strategies, and

[9] The Joint Commission. (2019, December). Quick Safety, Issue 52: Advancing safety with closed-loop communication of test results. https://digitalassets.jointcommission.org/api/public/content/77c6421712dc463eae4b2398f9bf01a5?v=e9bc1e0f

technology-enabled workflows to close gaps in the imaging pathway and fully realize its value in population health.[10,11]

Congress should ensure that future quality programs incorporate the following principles:

Specialty-Specific Frameworks Built on MVPs

Radiology needs curated measure sets that reflect its integral role across the diagnostic imaging value stream, as previously described, ensuring clinically relevant activities are meaningfully assessed throughout the patient journey. Radiology serves a wide breadth of clinical areas—neurologic, cardiothoracic, musculoskeletal, genitourinary, pediatric and more—that should be considered in any encapsulation of a measure set within the new Diagnostic Radiology MVP. Currently, this MVP is primarily focused on a narrow range of body imaging and does not adequately address other subspecialties or clinical areas. **Congress should ensure that the MVP is expanded to include additional subspecialty clinical groupings.** By accepting and incorporating more measures across these subspecialties, CMS can build out the MVP to better reflect the full scope of radiology practice and enable all radiologists to participate meaningfully in quality reporting. Broader inclusion will ensure that measures address imaging appropriateness, timely communication of critical findings, and other subspecialty-specific activities that directly advance patient safety and outcomes. **If less than inclusive, Congress should require that future programs allow voluntary participation in MVPs or, for radiology, allow both subspecialty and condition-based grouping.**

In addition to ensuring that MVPs accurately reflect the diversity and complexity of radiology practice, it is also critical that the associated payment update mechanisms promote fairness and continuous improvement. **Rather than relying on tournament-style penalties, where lower-performing clinicians effectively fund the updates for higher performers, future payment models should adopt a more equitable, fractional approach to inflationary updates.** Under this system, all clinicians would receive an update based on their performance, with top performers earning a higher percentage increase (e.g., full inflationary update), and others receiving a proportionally smaller update rather than a penalty or no update. This approach incentivizes improvement across the board, supports stability, and recognizes incremental progress in quality.

[10]Schwartz, F. R., Roth, C. J., Boardwine, B., Hardister, L., Thomas-Campbell, S., Lander, K., Montoya, C., & Jaffe, T. A. (2021). Electronic health record closed-loop communication program for unexpected nonemergent findings. Radiology, 301(1), 123–130. https://doi.org/10.1148/radiol.2021210057

[11] Kadom, N., Venkatesh, A. K., Shugarman, S. A., Burleson, J. H., Moore, C. L., & Seidenwurm, D. (2022). Novel quality measure set: Closing the completion loop on radiology follow-up recommendations for noncritical actionable incidental findings. Journal of the American College of Radiology, 19(8), 881–890. https://doi.org/10.1016/j.jacr.2022.03.017

Outcome-Oriented Measures

Congress should ensure that future programs move beyond generic process metrics to measures that either directly capture outcomes (e.g., diagnostic accuracy or demonstrably link high-value radiology processes to better outcomes) and patient safety (e.g., timely communication of critical results, radiation dose optimization, and follow-up of actionable incidental findings). Because radiology is largely consultative and non-patient-facing, a broader definition of "outcome" should explicitly include intermediate outcomes and patient-safety measures that reflect radiology's role in accurate diagnosis and treatment planning. For example, lung cancer screening programs reduce mortality by detecting cancer early. Appropriateness Criteria provide guidance to prevent unnecessary imaging and downstream harm; however, their effectiveness depends on consistent adoption. Rapid turnaround times with closed-loop communication shorten time to diagnosis and strengthen clinical decision-making. **Congress should prioritize specialty society developed measures that use validated quality registries (e.g., NRDR) to document these links and maintain clinically meaningful, feasible reporting.**

Integration with Existing Registries to Reduce Burden

Radiology already has robust registries (e.g., NRDR) that track key quality indicators, including radiation dose optimization, screening adherence, timeliness of follow-up, and cancer detection rates. **In future programs, Congress should encourage the use of these registries to leverage automated and digital reporting, minimizing manual and less advanced automated data collection, and supporting interoperability goals.** Registry-developed, specialty society-driven measures should be prioritized because they reflect real-world clinical practice and patient outcomes, ensuring that quality programs remain clinically meaningful and relevant.

Inclusive Design for Facility-Based Clinicians

Because of their facility-based billing and limited direct patient contact, radiologists are often excluded from meaningful participation under current attribution models. **Congress should ensure that future programs accommodate these realities so that radiologists can participate meaningfully without an undue burden and avoid a one-size-fits-all approach.**

Flexibility for Innovation and Cost Alignment

Rigid cost measures, such as the Total Per Capita Cost (TPCC), are designed for longitudinal, primary-care relationships and are misaligned with radiology's episodic, consultative role if applied broadly. **While radiology is currently excluded from the TPCC measure, Congress should ensure that future cost methodologies adopt episode-based or imaging-specific metrics that encourage evidence-based imaging and care coordination without penalizing specialties for factors beyond their control.**

ACR appreciates your leadership in advancing policies that support physician-led innovation and meaningful quality improvement. As Congress considers reforms to modernize the Quality Payment Program, it is vital that the unique contributions and needs of radiology are fully addressed.

Radiology stands ready to collaborate on solutions that enhance patient care, promote equitable participation across specialties, and reduce unnecessary administrative complexity. We look forward to serving as a resource and working together to achieve these shared goals. Radiology stands ready to collaborate on solutions that enhance patient care while reducing unnecessary administrative complexity.