May 20, 2026

Chairman Griffith, Ranking Member DeGette, and members of the Subcommittee,

Thank you for the opportunity to testify on behalf of The American College of Radiology (ACR) - a professional association representing more than 40,000 referral-based physicians practicing diagnostic radiology, interventional radiology, radiation oncology, and nuclear medicine, as well as medical physicists and imaging professionals vital to the health care delivery system. My name is Dr. Dana Smetherman, MD, MPH, MBA, FACR, FSBI and I practiced for many years as a diagnostic radiologist and am currently the Chief Executive Officer of the ACR.

Although patients may not "see" their radiologist, on average, diagnostic radiologists provide care for the highest number of individual Medicare beneficiaries across fifty-six distinct physician specialties and serve more clinically complex Medicare patients than most other physicians nationally.[1] [2] From using low-dose CT lung screening to reduce lung cancer mortality to providing guideline-based breast cancer screening to promote earlier detection, the impact of imaging to improve morbidity and survival is well documented.[3] [4] Imaging also plays a crucial role in the diagnosis and treatment of emergency and hospital patients and accelerates emergency department diagnoses and throughput.[5] [6]

Through early and accurate diagnosis, appropriate utilization management, diagnostic error prevention, and proactive risk mitigation, radiology substantially reduces avoidable downstream complications, unnecessary procedures, and excess utilization, thereby bending the cost curve while improving outcomes. At the same time, radiology functions as

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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

a throughput engine for hospitals and health systems by accelerating diagnostic closure, shortening length of stay, improving emergency department flow, and supporting timely, appropriate treatment decisions.

The ACR is acutely aware of the many challenges our members face as they provide high quality care to Medicare beneficiaries. Workforce shortages persist, driven by rising imaging demand, which we do not control as referral-based physicians, and a limited supply of radiologists. Average "turnaround time," or the number of days from image acquisition to interpretation has increased on average across all modalities 113% since 2014, with 87% of this increase occurring between 2021 and 2023.[7] Financial pressures exacerbated by a long-broken Medicare physician payment system encourage consolidation and impact patient access. Simply put, we are facing an untenable situation.

We believe there are three main components to Fee-For-Service (FFS) Medicare payment reform under the Medicare Physician Fee Schedule (MPFS): payment adequacy and sustainability, budget neutrality updates to the conversion factor, and MACRA reform.

Payment Adequacy and Sustainability

Across the Medicare program, physicians and other clinicians are unique in that there is no statutory annual inflationary update to payment rates under the physician fee schedule. Virtually all other provider types (hospitals, dialysis facilities, post-acute care providers, etc.) have annual payment adjustments built into their Medicare payment systems. These adjustments reflect inflationary cost input pressures (e.g., increases in the cost of labor, supplies, utilities, transportation, etc.) that are largely beyond their control. According to an American Medical Association (AMA) analysis of Medicare Trustees' data, physician reimbursement has declined 33% from 2001 to 2025 when adjusted for inflation.[8] Failure to address this basic underlying reimbursement deficiency threatens the continued ability of physicians to care for their patients. The Centers for Medicare and Medicaid Services (CMS) has described the Medicare Economic Index (MEI) as "the best measure available of the relative weights of the three components in payments under the PFS." Therefore, the ACR recommends that the Congress act with all due haste to add a standing statutory annual inflation adjuster to Medicare's PFS.

Radiologists (as referral-based physicians) are unable to control the volume of their work, which can compound the impact of the lack of an inflationary update. For example, radiologists performed 13% more work (RVUs) per beneficiary in 2021 than in 2025. If RVUs

[7] Christensen E, Drake A, Rula E …National Turnaround Time Trends for Medicare Fee-for-Service Beneficiaries, 2014-2023Journal of the American College of Radiology, 2026; 0 https://www.jacr.org/article/S1546-1440(26)00148-1/abstract

[8] https://www.ama-assn.org/system/files/2025-medicare-updates-inflation-chart.pdf

per beneficiary had remained at 2005 levels, real reimbursement per beneficiary would have declined by 34%. While volume increases have partially mitigated reimbursement declines, real reimbursement still decreased by 25%.[9] Overall, radiologists are increasingly doing more for less.

The ACR acknowledges the fiscal and budgetary challenges associated with Medicare payment reform. To help offset expected costs, ACR suggests amending Section 218 of the Protecting Access to Medicare Act of 2014 (PAMA). The increase in ordering of medical imaging has historically been an issue that has drawn the attention of both the legislative and executive branches of government. This typically results in a reimbursement reduction, which negatively impacts the radiologist, who interprets but does not order medical imaging and has no control over volume.

In 2014, the imaging community had weathered 13 reimbursement reductions since 2006 and was under repeated threat of prior authorization in Medicare Part B. At that time, Congress wisely intervened via Section 218 of PAMA, which requires ordering clinicians to consult physician-developed appropriate use criteria (AUC) via a clinical decision support mechanism (CDSM) prior to ordering advanced diagnostic imaging services under Medicare Part B. Although the statute required CMS to implement the program by January 1, 2017, CMS faced significant challenges operationalizing the real-time claims processing component. As a result, in the CY 2024 PFS Final Rule, CMS indefinitely paused implementation. CMS acknowledged the clinical value of the AUC program and estimated that the federal government could save approximately $700 million annually if it were implemented. [10]

The Radiology Outpatient Ordering Transmissions (ROOT) Act, H.R. 5737/S.1692, introduced by Congresswoman Harshbarger and Congressman Blake Moore, would modernize the AUC program and facilitate implementation of a desperately needed utilization management tool for the ordering of advanced diagnostic imaging services. The Moran Company (an HMA Company) has estimated that, if the AUC program is implemented with the changes included in the ROOT Act, the savings to the federal government would be approximately $2 billion over a ten-year budget window. In addition, the savings to beneficiaries are estimated to be roughly $1.5 billion over the same period.

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[9] Christensen E, Nicola G, Rula E …Budget Neutrality and Medicare Physician Fee Schedule Reimbursement Trends for Radiologists, 2005 to 2021Journal of the American College of Radiology, 2023; 20, 947-953 https://www.jacr.org/article/S1546-1440(23)00521-5/fulltext

[10] https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other

The ROOT Act has been included in the recent Medicare Payment/MACRA Reform discussion draft put forward by Congressmen Joyce, MD, and Murphy, MD, and Congresswoman Schrier, MD. We applaud this inclusion and encourage Congress to act as soon as possible to provide CMS with the statutory changes necessary to modernize and implement the AUC program. These changes would improve patient care, increase ordering accuracy, reduce duplicative scans, avoid unnecessary radiation exposure, and lower costs for both the Medicare program and patients by reducing unnecessary testing and copays and contributing to a more efficient, affordable health care system.

Budget Neutrality Updates to the Conversion Factor

Beyond the lack of an inflationary adjuster, ACR asserts that a second substantial structural problem with the PFS stems from the core principle of budget neutrality that governs Medicare's approach to spending for physician services under traditional FFS. In an over-simplified characterization, budget-neutrality requires that (except for recognition of external factors such as changes in Medicare enrollment) Medicare PFS spending in a given year cannot exceed spending in the previous year. While budget neutrality is intended to control Medicare PFS spending, it has created two foundational problems that impede physicians' ability to provide care for Medicare beneficiaries.

First, budget neutrality creates a "zero sum game" among physicians, under which increases in payments to some physicians must be offset by decreases in payments for other physicians. Many patients, especially those with chronic conditions, are treated by teams of physicians – specialists and primary care providers - who work in concert to provide their care. The current statutory requirement for budget neutrality in the MPFS is not conducive to this teamwork model. To increase the reimbursement for one service code or set of services (e.g., Evaluation and Management (E&M) services), CMS must reduce reimbursement for other services accordingly. For example, for a primary care physician to receive increased reimbursement for a patient's visit, a specialist treating the same patient may receive a reimbursement decrease for a procedure performed (e.g., colonoscopy, radiation therapy). Thus, the current budget-neutrality requirement creates inequities *among* physicians within any given payment year.

Second, the budget-neutrality requirement contributes to year-to-year volatility in the MPFS's conversion factor, stifling innovation and creating unsustainable instability within the MPFS for radiology and other practice-expense-intensive specialties. If services are provided in a privately owned, non-hospital-based practice, there must be sufficient reimbursement to purchase and maintain equipment, own or rent space, and employ the staff and dedicated technologists necessary for these practices to succeed.

Radiology is also at the forefront of medical technological innovation and utilization. While the Hospital Outpatient Prospective Payment System (HOPPS) and the Inpatient Prospective Payment System (IPPS) incentivize the purchase of new technology and artificial intelligence, the MPFS struggles to adequately reimburse all components of practice expense for privately owned, non-hospital-based practices. Unfortunately, the reimbursement of the practice expense component of the MPFS, which is intended to account for both direct and indirect practice expense, falls grievously short of the appropriate and necessary reimbursement to encourage investment in current and future innovation and allow community based, privately owned practices to survive.

MPFS payment reductions are felt hardest by smaller, independent practices, particularly those in rural and underserved communities that continue to face significant health care access challenges. In response, many practices have chosen to be acquired by larger entities, including hospitals, health systems, corporate health care networks, and in some instances private equity investment firms, which can permanently impact patient access to care. Independent private practices that have not consolidated are forced to make exceedingly difficult decisions when considering investing in technology or providing care in different geographic areas. These choices can hinder innovation, decrease access to services, and jeopardize the quality of care delivered to patients.

Additional legislative changes necessary to promote stability in the MPFS are outlined in H.R. 8163, the Provider Reimbursement Stability Act of 2026. These changes include updating the budget neutrality threshold, providing a lookback period to reconcile over- and underutilization estimates, and making more timely updates to the direct costs used to calculate practice expense relative value units. These statutory changes are long-overdue, and we applaud Congressmen Murphy, MD, Schneider, Joyce, MD, Suozzi, Onder, MD, and Panetta as well as Congresswomen Miller-Meeks, MD, Schrier, MD, and Kelly for their leadership on this issue.

MACRA Reform

Radiology's role in care coordination is well documented through initiatives such as the CMS Innovation Center's (CMMI) Transforming Clinical Practice Initiative (TCPI) Radiology Support, Communication and Alignment Network (RSCAN),[11] [12] where radiologists partnered with referring physicians to champion imaging appropriateness and high-value referral management. Additionally, breast and lung cancer screening programs, along with

[11] J Am Coll Radiol. 2020 May;17(5):597-605. doi: 10.1016/j.jacr.2020.02.011.
[12] J Am Coll Radiol. 2019 DOI: 10.1016/j.jacr.2018.12.044

management and tracking of actionable incidental findings, demonstrate radiology's active engagement in population health, preventive care, and improved patient outcomes.

Beyond clinical outcomes, value accrues through greater diagnostic confidence, tailored investigations, and better patient experiences, as shown in outcomes research.[13] [14] By reducing diagnostic uncertainty and improving communication, radiology enhances patient experience and engagement. At the same time, radiology serves 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.

Reforms to the existing MACRA program should include:

Permanent and Accessible Incentives for (Advanced) Alternative Payment Models (APMs)

APM thresholds are built around longitudinal primary-care relationships. Radiologists frequently practice in facility-based settings, bill under the hospital or imaging center's Tax Identification Number (TIN), have limited direct patient encounters, and use minimal E/M codes; these factors impede the patient attribution and aggregate payment thresholds required for APM qualification. With an aging population and ongoing advancements in imaging technology, the frequency of imaging continues to rise. Therefore, it is even more important to design payment models that recognize radiology's consultative, episodic role in care coordination and measurable impact on diagnostic accuracy, appropriateness of care, and timely intervention. Missed follow-ups impact more than 10% of patients and can delay necessary care for serious conditions like cancer.[15] This example underscores the need for robust tracking systems, patient engagement strategies, and technology-enabled

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[13] 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-centered 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

[14] Zigman Suchsland M, Witwer E, Truitt A. ..Patient-Centered Outcomes Related to Imaging Testing in US Primary Care https://www.jacr.org/article/S1546-1440(18)31044-5/fulltext
Journal of the American College of Radiology, 2018; 16, 156-163

[15] 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/

workflows to close gaps in the imaging pathway and fully realize the value of radiology in population health.[16] [17]

Eliminating Merit-based Incentive Payment System (MIPS) Tournament Style Penalties

Rather than relying on tournament-style penalties, where lower-performing clinicians effectively fund the updates for higher performers, we suggest 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., 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.

Applicability of EHR Requirements in MIPS

Certain participation requirements under the MIPS, including the entire "Promoting Interoperability" performance category, depend on access to and use of certified electronic health record technology (CEHRT). CEHRT refers to a traditional EHR system, or a combination of EHR modules, whose functionalities have been certified by the Health and Human Services Office of the National Coordinator for Health Information Technology (ONC) and that meet CMS' regulatory requirements at 42 CFR 495.4.

However, many diagnostic specialties, such as radiology and pathology, do not routinely use conventional EHR systems designed for primary care settings. Instead, they rely on specialized software platforms tailored to their unique clinical workflows and data needs. While CMS appropriately allows these clinicians to qualify for reweighting under the Promoting Interoperability category as “non-patient-facing eligible clinicians,” this policy has limitations. Specifically, reweighting reduces flexibility in meeting MIPS requirements and fails to adequately recognize the contributions these specialties make to the patient’s medical care record and meaningful use of technology.

Reduce Administrative Complexity Through Data Integration

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[16] 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://pubmed.ncbi.nlm.nih.gov/34374592/

[17] 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

Radiology already collects rich clinical data through registries such as ACR's National Radiology Data Registry (NRDR). NRDR encompasses multiple modules including the Dose Index Registry, Early Lung Cancer Detection Registry, National Mammography Database, General Radiology Improvement Database, and Assess-AI. These registries provide radiology groups with outcome-focused comparative performance metrics such as diagnostic accuracy, radiation safety optimization, cancer detection rates, population health management data, and post deployment monitoring of AI in real-world clinical practice. Registries also offer clinically useful, real-world data and insights 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 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.

Outcome-Oriented Measures

Currently, radiology only has a single outcome measure, due in large part to the CMS' strict interpretation of its published outcome measure definition.[18] We support future programs that move beyond generic process metrics to emphasize measures that either directly capture or demonstrably link high value radiology processes to better outcomes. ACR believes a broader, more inclusive approach to outcome/intermediate outcome measure classification would better reflect radiology's role in accurate and timely diagnosis through the provision of safe, high quality imaging services.

Future quality programs should incorporate the following principles:

Specialty-Specific Frameworks Built on MIPS Value Pathways (MVP)

Radiology needs curated measure sets that emphasize the role and value of diagnostic imaging in clinically relevant activities throughout the patient's journey. From exam selection and request to image acquisition, interpretation, reporting of findings and recommendations, and referral coordination and monitoring, radiology serves a wide breadth of clinical areas and activities. Radiology is involved across care settings and encompasses an extensive range of clinical conditions (including patients with oncologic, neurologic, cardiothoracic, musculoskeletal, genitourinary, and many other diseases); this range of clinical foci is an important consideration in developing measure sets within a

[18] https://mmshub.cms.gov/about-quality/types/overview

diagnostic radiology MVP. Otherwise, only a fraction of radiology will be addressed, and there will be gaps in addressing quality across patient populations. If future programs do not include the vast array of radiologic care, Congress should allow voluntary participation in MVPs or subspecialty grouping and condition-based grouping for radiology.

Broader inclusion will ensure that measures address imaging appropriateness, follow-up imaging recommendations and management, timely communication of critical findings, coordination of care, and other subspecialty-specific activities that directly advance patient safety and outcomes.

A goal of transitioning traditional MIPS to MVPs is to use the MVP model as an on-ramp for value-based attribution models like APMs. As facility-based clinicians, radiologists often bill under facility TINs, do not submit patient evaluation and management (E/M) codes, and, in most cases, do not have direct patient encounters. As a result, most radiologists are excluded from significant participation in current attribution models, i.e., APMs. Congress should ensure that future programs accommodate these realities so radiologists can participate meaningfully without undue burden, rather than being forced into a one-size-fits-all approach.

Outcome-Oriented Measures

Congress should also make certain that future programs use the broader definition of "outcome measure" to explicitly include intermediate outcomes and patient safety measures. For example, early detection of lung or breast cancer through screening reduces mortality and improves longevity. These outcomes are achieved through accurate interpretation, reporting, and guideline-based follow-up recommendations. Timely imaging reports with closed-loop communication shorten time to diagnosis and strengthen clinical decision-making. Congress should prioritize specialty developed measures that use validated quality outcome measures and better reflect radiology's role in accurate diagnosis and treatment planning.

Integration with Existing Registries to Reduce Burden

Congress should preserve and strengthen the role of clinician-led clinical data registries as foundational infrastructure for quality measurement and improvement. Congress could accomplish this goal by mandating alignment of reporting requirements with existing specialty registries to reduce burden on practices and individual physicians and accelerate scaling.

Radiology currently uses robust registries (e.g., NRDR) to track key quality indicators, including radiation dose optimization, screening adherence, timeliness of follow-up, and cancer detection rates. In the future, Congress should encourage the use of these registries

to leverage automated and digital reporting mechanisms, minimize manual, less advanced automated data collection, and support interoperability goals. Registry-developed, specialty-driven measures should be prioritized because they reflect real-world clinical practice and patient outcomes. This will help ensure that quality programs remain clinically meaningful and relevant.

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. While radiology is currently excluded from TPCC, Congress should ensure future cost methodologies adopt episode-based or imaging-specific metrics to encourage evidence-based imaging and care coordination without penalizing specialties for factors beyond their control.

Thank you again for the opportunity to testify today. ACR looks forward to continued collaboration to ensure Medicare beneficiaries retain access to high-quality care for generations to come.

If you have any questions, please do not hesitate to contact Josh Cooper, Executive Vice President of Government Affairs at jcooper@acr.org.

Sincerely,

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