American College of Radiology

American College of Radiology Preliminary Summary of Radiology Provisions in the 2026 MPFS Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2026 Medicare Physician Fee Schedule (MPFS) proposed rule on Monday, July 14, 2025. In this rule, CMS describes proposed changes to payment provisions and to policies for the ninth year of the Quality Payment Program (QPP) and its component participation methods – the Merit-Based Incentives Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

Conversion Factor and CMS Overall Impact Estimates

Beginning CY 2026 there will be 2 separate conversion factors resulting from the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The conversion factor for services provided by a qualifying APM participant is proposed to be $33.5875, inclusive of a .75% annual update. Services provided by non-APM participants have a proposed conversion factor of $33.4209, which includes a .25% annual update. Both conversion factors also include a 2.5% one year increase to the MPFS conversion factor included in the recent budget reconciliation bill as well as a proposed 0.55% budget neutrality adjustment.

If the provisions within the proposed rule are finalized, CMS estimates an overall impact of the MPFS proposed changes to be -2 percent for radiology, -1 percent for nuclear medicine, 2 percent for interventional radiology and -1 percent for radiation oncology.

Physician Practice Information Survey

CMS expressed concerns with the AMA's Physician Practice Information (PPI) and Clinician Practice Information (CPI) survey data and are not proposing to implement the practice expense per hour (PE/HR) data or cost shares from the American Medical Association (AMA) data at this time. For CY 2026, CMS is proposing to maintain the current PE/HR data and cost shares. CMS will continue their contract with the RAND Corporation to analyze and develop alternative methods for measuring PE and related inputs for implementation of updates to payment under the PFS. However, CMS is proposing a "significant refinement" to the PE methodology, as they note that there has been a shift in practice patterns with a decrease in physician-owned practices and a corresponding rise in physicians in hospital-owned practices or physicians employed by hospitals. The PE methodology has allocated the same amount of indirect PE costs per work RVU, regardless of setting. However, with change in practice patterns, CMS is now concerned about overpayments of indirect costs for physicians who practice in the facility setting. Therefore, for each service valued in the facility setting, CMS is proposing to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs.

Medicare Economic Index

For CY 2026, CMS is proposing to continue using the current 2006-based Medicare Economic Index (MEI), due to continued concerns about the redistributive effects that implementing the 2017-based MEI would have on PFS payments.

New and Revised Codes
For CY 2026, CMS is proposing to accept the RUC-recommended values for the 46 new codes for Lower Extremity Revascularization, as well as the codes for CT Cerebral Perfusion, CTA Head & Neck, Prostate Biopsy, Transrectal Ultrasound, Irreversible Electroporation of Tumors, Coronary Atherosclerotic Plaque Assessment, and Percutaneous Decompression of Median Nerve. The ACR will review and provide comments to CMS related to the proposed work RVU refinements to the Endovascular Therapy codes, as well as any practice expense refinements for Radiology-related codes.

Potentially Misvalued Services
Several fine needle aspiration codes were publicly nominated as potentially misvalued services. The ACR will review and provide comments to CMS, as appropriate.

Efficiency Adjustment
In the NPRM, CMS expressed concern about not accounting for efficiencies in the work RVU for non-time-based services. These include efficiencies due to professional gains in experience, new technology, and also as the procedures become more common. Therefore, CMS is proposing to establish an efficiency adjustment to the work RVUs, as well as corresponding updates to the intra-service portion of physician time inputs for non-time-based services such as codes describing procedures, radiology services, and diagnostic tests. There could be corresponding updates to the PE inputs for clinical labor and medical equipment in the future.

To implement this efficiency adjustment, CMS propose to decrease the work RVUs and make corresponding changes to the intra-service physician time for non-time-based services by a factor equal to the MEI productivity adjustment, equivalent to if this factor had been applied every year over the past five years. This would yield a proposed efficiency adjustment of -2.5% for certain codes for CY 2026. The proposal is to apply this efficiency adjustment every three years. CMS is soliciting feedback on the several aspects of the proposal, including the use of the MEI productivity adjustment for calculating the efficiency adjustment, whether efficiencies stop accruing for services after a predefined number of years, whether the introduction of new artificial intelligence will contribute to efficiencies, and how additional efficiencies should be considered for services requiring less time to perform.

Direct Supervision via Use of Two-way Audio/Video Communications Technology
In the March 31, 2020 COVID-19 IFC, CMS changed the definition of "direct supervision" during the PHE for COVID-19 as it pertains to supervision of diagnostic tests, physicians' services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of requiring their physical presence. CMS has previously extended flexibility through rulemaking. The ACR has previously supported CMS's extension of this policy.

CMS is proposing to permanently adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only), for all services described under § 410.26, except for services that have a global surgery indicator of 010 or 090.

CMS is seeking comments on whether to adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only), for all services described under § 410.26, except for services that have a 000, 010, or 090 global surgery indicator.

Drugs and Biological Products Paid Under Medicare Part B

Requiring Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts

By statute, manufacturers are required to pay Medicare a refund for specified discarded amounts of certain single-dose container or single-use package drugs under Part B. In this proposed rule, CMS reviewed two applications for increased applicable percentage for specific products for CY 2026, but CMS is not proposing increased applicable percentages for either drug.

Medicare Shared Savings Program

As of January 1, 2025, the Medicare Shared Savings Program (MSSP) has 477 accountable care organizations (ACOs) with over 650,000 healthcare providers and organizations providing care to over 11.2 million assigned beneficiaries.

CMS is proposing to modify requirements for determining ACO's eligibility for MSSP participation options, for agreement periods beginning on or after January 1, 2027, to limit participation in a one-sided model to an ACO's first agreement period under the BASIC track's glide path (if eligible) and require ACOs inexperienced with performance-based risk Medicare ACO initiatives (defined at § 425.20) to progress more rapidly to higher levels of risk and potential reward under Level E of the BASIC track or the ENHANCED track.

CMS is proposing to modify eligibility requirements to require ACOs to make certain changes to their ACO participant list when an ACO participant experiences a change of ownership (CHOW) where the surviving Taxpayer Identification Number (TIN) is newly enrolled in the Provider Enrollment, Chain, and Ownership System (PECOS) with no prior Medicare billing claims history, during the performance year and outside of the annual change request cycle, and similarly allow for changes during the performance year to the ACO's Skilled Nursing Facility (SNF) affiliate list if a SNF affiliate undergoes a CHOW resulting in change to the Medicare enrolled TIN.

CMS is proposing changes to the MSSP quality performance standard and other quality reporting requirements, including removing the health equity adjustment applied to an ACO's quality score beginning in performance year 2025 and revising terminology used to describe the adjustment and other related terms, in the MSSP regulations, for performance years 2023 and 2024.

CMS is proposing to revise the definition of a beneficiary eligible for Medicare Clinical Quality Measures (Medicare CQMs) for ACOs participating in MSSP, for performance year 2025 and subsequent performance years, so that the population identified for reporting within the Medicare CQM collection type would have greater overlap with the beneficiaries that are assignable to an ACO, and thereby reduce ACOs' burden in the patient matching necessary to report Medicare CQMs.

For alignment with CMS' quality programs, CMS is proposing to update the Alternative Payment Model (APM) Performance Pathway (APP) Plus quality measure set for Shared Savings Program ACOs, including to remove Quality ID: 487 Screening for Social Drivers of Health, and to expand the survey modes for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Merit-based Incentive Payment System (MIPS) Survey from a mail-phone administration protocol to a web-mail-phone administration protocol beginning with performance year 2027.

CMS is proposing to expand the application of the MSSP quality and finance extreme and uncontrollable circumstances (EUC) policies to an ACO that is affected by an EUC due to a cyberattack, including ransomware/malware, as determined by the Quality Payment Program, for performance year 2025 and subsequent performance years.

CMS estimates that these proposals would reduce program spending by $20 million in total through the end of the 10-year period 2026 through 2035.

Quality Payment Program (QPP)

MIPS Value Pathways (MVPs) (p. 900)

In this proposed rule, CMS is requesting feedback on its introduction of six new MVPS that would become available for reporting in 2026. In addition to **the proposed Diagnostic Radiology and Interventional MVPs**, it also includes Neuropsychology, Pathology, Podiatry, and Vascular Surgery MVPs. CMS has organized the Diagnostic Radiology MVP into three clinical groups: 1) General Diagnostic Radiology, 2) Body Imaging (Thoracic/Abdominal), and 3) Advancing Health and Wellness. The proposed Interventional Radiology MVP has been arranged into four clinical groups: 1) Vascular, 2) Dialysis-related, 3) Neurological Intervention, and 4) General Interventional Radiology. Depending on the clinical groups in both MVPs, CMS has assigned measures and activities it considers attributable to these radiologists.

Requests for Information (RFIs) (p. 901)

CMS is soliciting feedback on several RFIs focused on MVPs.

- *The Core Elements in an MVP.* CMS asks how it may encourage MVP reporting that provides patients with more directly comparative clinician performance data.
- *Well-being and Nutrition Measures.* CMS is interested in how it may provide a more comprehensive approach to disease prevention and health promotion.
- *Procedural Codes for MVP Assignment.* Seeking information on an approach that would facilitate specialty reporting of MVPs relevant to their scope of care.
- *Transition Toward Digital Quality Measurement.* As it has in past proposed rules, CMS includes this RFI to continue to gain insights on advancements when making the shift to digital quality measurement.

- *Performance-Based Measures in Public Health and Clinical Data Exchange Objective.* CMS will evaluate measures to assess the degree to which MIPS-eligible clinicians exchange data specified for each measure.
- *Data Quality.* CMS is soliciting information on clinicians' exchange of health information.

MIPS Scoring Overview

The category weights for the 2026 performance year will remain unchanged: **Quality – 30%, Cost – 30%, PI – 25%, and IAs – 15%.** Previously established reweighting formulas for non-patient-facing clinicians and small practices are set to continue with no proposed changes. **CMS proposes maintaining the performance threshold at 75 points through the 2028 performance year.** (p. 906)

CMS finalized the payment adjustment of +/- nine percent for performance years 2020 and beyond. No changes have been proposed to the MIPS adjustment. CMS will maintain the small practice bonus of 6 points for the Quality performance category score, and all previously finalized considerations for small practices.

Quality Performance Category

CMS proposes to maintain the measure scoring policy established in 2025 which identifies certain measure sets affected by limited measure choice and adjusts the benchmarks of point-capped measures to allow for a maximum score of 10 points. CMS proposes extending this policy to MVPs, noting that many MVPs are affected by the same issue as the specialty sets. (p. 1063)

The diagnostic radiology measures previously identified for this scoring adjustment will continue to receive an adjusted benchmark in 2026. These measures include:

- #143: Oncology: Medical and Radiation – Pain Intensity Quantified
- #360: Count of Potential High Dose Radiation Imaging Studies: CT and Cardiac Nuclear Medicine Studies
- #364: Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules
- #405: Appropriate Follow-up Imaging for Incidental Abdominal Lesions
- #406: Appropriate Follow-up Imaging for Incidental Thyroid Nodules (p. 1064)

CMS has proposed a new benchmarking methodology for scoring administrative claims-based quality measures beginning with the 2025 MIPS performance period. CMS notes that performance scores for claims-based measures have historically been lower than their registry-

based counterparts, likely due to their use of performance period benchmarks rather than established historical benchmarks. This new scoring methodology, which is based on standard deviation, median, and a point value derived from the performance threshold, is proposed with the intention of improving scores of physicians reporting claims-based measures. (p. 1072)

Improvement Activities Performance Category

CMS has proposed the removal of the Achieving Health Equity subcategory. Many of the activities previously included in this category were removed from the program in early 2025. CMS also proposed the addition of a new subcategory titled Advancing Health and Wellness, as well as the addition of three new IAs into the subcategories of Population Management and Patient Safety and Practice Assessment. (p. 984)

The three IAs proposed for addition to the program are:

- IA_PM_XX: Improving Detection of Cognitive Impairment in Primary Care
- IA_PM_XX: Integrating Oral Health Care in Primary Care
- IA_PSPA_XX: Patient Safety Use of Artificial Intelligence

The last activity, "Patient Safety Use of Artificial Intelligence," was proposed with the intent of addressing adverse patient events attributed to the use of AI in healthcare. (p. 990)

Cost Performance Category

CMS proposes to modify the Total Per Capita Cost (TPCC) measure candidate event and attribution criteria. **Modifications may exclude candidate events initiated by an advanced care practitioner Taxpayer Identification Number -National Provider Identifier (TIN-NPI) if all other non-advanced care practitioner TIN-NPIs in their group are excluded based on the specialty exclusion criteria**. CMS also proposes adopting a two-year informational feedback period for newly implemented MIPS cost measures (page 904).

Promoting Interoperability Performance Category

CMS proposes to continue to automatically reweight the MIPS Promoting Interoperability category for non-patient-facing clinicians who do not report performance data. For clinicians participating in the category, CMS proposes a new "measure suppression" policy that would allow the agency to decide against counting a measure against the participant's PI score if that measure is infeasible or inappropriate. For example, CMS is proposing to temporarily suppress the Electronic Case Reporting measure of the Public Health & Clinical Data Exchange objective for the CY 2025 performance period due to current disruptions within the Centers for Disease

Control and Prevention (CDC). CMS is also requesting information on transitioning certain attestation-based measures to performance-based and improving data quality.

APM Performance Pathway

CMS is proposing to update some quality measures in the APM Performance Pathway (APP), original quality measure set and the APP Plus quality measure set to reflect the proposed changes to measures specified for the quality performance category. CMS is proposing to incorporate the updated versions of MIPS quality measures used in the APP quality measure set.

Advanced APMs

CMS is proposing to add an individual level calculation to Qualifying APM Participant (QP) determinations, as set forth in proposed regulation text at §§ 414.1425(b)(3 and (c)(3), for all eligible clinicians participating in an Advanced APM, such that each eligible clinician would receive both APM Entity level calculation and an individual level calculation.

CMS is also proposing to expand the scope of the services in the sixth criterion of the definition of "attribution-eligible beneficiary" at § 414.1305 to use covered professional services (section 1848(k)(3)(A) of the Act). CMS believes these proposals would modernize and improve the QP determination approach across Advanced APMs.

CMS is proposing to sunset the Advanced APM criterion at § 414.1415(c)(7), which currently limits Medical Home Model participants to 50 clinicians. Lastly, CMS is proposing to modify §§ 414.1455(a)(b)(3)(ii) and (b)(3)(vi) pertaining to the QP Targeted Review process to align with MIPS Targeted Review process set forth at § 414.1385 to ensure that the QP and MIPS Targeted Reviews occur concurrently.

CMS published Fact Sheets on the overall MPFS proposed rule, the Quality Payment Program, the Shared Savings Program, and a Press Release.

ACR staff will review the entire MPFS proposed rule in the coming weeks and will provide a comprehensive summary of the rule. The ACR will also submit comments to CMS by the comment period deadline.