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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

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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 2027 Medicare Physician Fee Schedule (MPFS) Proposed Rule.

Established in 1968, RBMA is a professional association that consists of over 2000 radiology practice business leaders who represent over 800 radiology practices in all 50 states. 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 would like to start this letter differently from most comment letters CMS receives. Rather than open with our comments, we will open with a patient's experience.

It's 2:14 a.m. A 68-year-old man arrives by ambulance with a brain aneurysm. The emergency physician does not have time to transfer him. What she does have is a phone number for the on-call interventional radiologist (IR) who is one of two IR physicians covering an entire regional hospital tonight. He answers on the second ring, is in the IR suite in nine minutes, and stops the bleeding before it becomes fatal. The patient goes home to his grandchildren three weeks later.

Picture the same night five years from now, if nothing changes. The hospital's IR program has quietly folded. Not because the physicians were not skilled, but because the economics of hospital-based, middle-of-the-night, unscheduled, life-saving interventional radiology no longer supports keeping the program open. The patient is loaded back into the ambulance for a 90-minute transfer to the nearest facility that still has IR coverage. He does not survive the drive.

This is not hyperbole, and it is not really about money. It is about whether the infrastructure that makes that 2:14 a.m. phone call possible still exists when your rule takes effect. That is what this letter is about, and we want to walk you through it the way it plays out for patients, not just the way it appears in a Federal Register table.

We recognize CMS operates under real statutory constraints and are grateful for the opportunity to comment. We ask that you read what follows, not as a specialty defending its income, but as a description of a supply chain for emergency and diagnostic care that is thinner than most policymakers realize, and that this Proposed Rule will make even thinner.

Part One: The Physician Payment Story Is Not All About Money. It's About Whether the Doors Stay Open

There is a persistent assumption in Washington that radiologists are well-compensated, so a cut here or a flat year there can simply be absorbed by a paycheck. That assumption misses what happens in a radiology practice when reimbursements decrease.

According to the American Medical Association (AMA), Medicare physician payments, adjusted for inflation, have fallen roughly 33 percent since 2001, even as the cost of running a practice, staffing, technology, rent, general liability and malpractice coverage, cybersecurity protections has continued to climb.

Physicians are the only class of Medicare providers without a reliable inflationary update. Every other cost in a radiology practice moves with inflation. Reimbursement does not.

What that funds, or fails to fund, is not a radiologist's take-home pay. It is:

- the overnight technologist and nursing staff who are paid to be there at 2 a.m., whether or not a patient walks through the door;
- the Picture Archiving and Communication System (PACS), Radiology Information System (RIS), and interoperability infrastructure that allows a radiologist to view a patient's prior scans in seconds instead of hours;
- cybersecurity protections that are required to keep private patient imaging data safe from the same threats hospitals face every day;
- and the recruitment and retention budget that determines whether a rural hospital can keep even one interventional radiologist on staff.

When reimbursement falls below what it costs to sustain these things, practices do not absorb it quietly. They consolidate, sell to larger systems, sell to private equity or publicly traded companies, become hospital employees, drop unprofitable service lines, or stop covering nights and weekends. Every one of these responses shows up, eventually, as a patient who could not get imaged, could not get treated, or could not get treated in time.

Ask: We urge CMS to continue communicating to Congress in these concrete, patient-facing terms, that a permanent inflation-based update, and reform of budget-neutrality requirements that trigger automatic cuts, are not abstractions. They determine whether services like the one in our opening story stay open.

Additional information to support RBMA's position is provided in

Part Two: Site of Service — What Happens When the Economics Push Interventional Radiology Out of the Hospital

Interventional radiology is unusual among procedural specialties in that a large share of what makes it valuable to patients happens precisely where the payment system currently pays the least: inside the hospital, at night and weekends, for patients who did not schedule appointments.

Consider three more patients:

- **A 54-year-old woman having a stroke.** Every minute matters. The hospital's stroke response team includes an interventional radiologist who can perform a thrombectomy (blood clot removal) or stop an aneurysm from bleeding. Without in-house IR coverage, she is transferred, and every transferred minute is measurable in brain tissue damage.
- **A 40-year-old man with a massive pulmonary embolism (PE).** The PE response team needs an interventional radiologist available now, not on a referral basis from an outpatient center twenty minutes away.
- **A postpartum hemorrhage patient in active bleeding.** The IR physician performing the embolization that saves her uterus, and her life, is doing so as part of his hospital call coverage, not a scheduled outpatient procedure.

None of this work looks like typical "procedure volume." It looks like availability is the physicians on call, in the building or minutes away, ready for cases that cannot be scheduled. This availability has a cost, and it is currently not well reflected in the payment differential between facility and non-facility settings.

If payment policy continues to reward office-based, scheduled IR procedures more favorably than hospital-based, on-call, emergency and inpatient IR coverage, hospitals, especially small and rural ones, many of which have only one or two IR physicians for an entire region will find it progressively harder to justify maintaining that coverage. The predictable result is not fewer

procedures. It's fewer hospitals able to say yes when the ambulance arrives at 2 a.m.

Ask: We ask CMS to evaluate whether widening facility/non-facility payment differentials could erode hospitals' ability to recruit and retain IR physicians capable of sustaining 24/7 trauma, stroke, PE, and inpatient coverage and weighing that risk explicitly, not just the procedural payment comparison, before finalizing this policy.

Additional information to support RBMA's position is provided in Addendum B: Site of Service

Part Three: There Aren't Enough Radiologists — And This Rule Will Make That Worse, Not Better

Here is the part of the story that we think is least understood in Washington: even if the payment issues outlined above were resolved tomorrow, patients would still face a growing problem, because there are not enough radiologists, technologists, and support staff to meet the demand, and that gap is widening.

The United States is currently short an estimated 1,500 radiologists, a number driven by retirements, limited training capacity, post-pandemic attrition, and rising case complexity. At the same time imaging volume is projected to grow 3 to 5 percent annually as the population ages. That combination of fewer radiologists and more demand for imaging is already producing longer turnaround times, growing backlogs, and rising dependence on costly outside teleradiology coverage, particularly in rural and underserved communities that already struggle to recruit physicians.

Picture a patient waiting for a cancer-staging CT to be interpreted by a radiologist. In a well-staffed practice, that interpretation happens on the same day, and treatment planning starts immediately. In a practice that has lost staff because it can no longer compete with market wages or afford the technology that makes radiologists efficient, that same interpretation might take days. For a cancer patient, days matter.

Every dollar this rule removes from radiology reimbursement is a dollar that is unavailable to compete for scarce sonographers, technologists, and radiologists in a labor market where every practice in the country is trying to hire the same limited pool of people. Payment cuts do not just reduce a practice's margin, they reduce its ability to retain the very workforce that produces timely turnaround times which, in turn, impact patient outcomes.

Ask: We urge CMS to treat radiology workforce shortages as a first-order consideration in payment policy, and not as a downstream side effect to be addressed later.

Additional information to support RBMA's position is provided in Addendum C: G2211 and E/M Redistribution and Addendum D: Same Day Payment Reductions

Part Four: The RAND Triplet Study — Why "Just Redistribute the RVUs" Is not as Simple as It Looks

CMS has proposed relying on a RAND analysis which compares "triplet" services (professional/technical/global billed, like imaging) to "non-triplet" services, as a basis for reallocating indirect practice expenses. Let us translate the impact of this proposal, patient by patient.

RAND's own report never demonstrates that the current indirect practice expense (PE) methodology causes physicians to order more imaging. And it cannot, because, by and large, radiologists do not order the imaging studies that they interpret. The ordering decision is made by the treating clinician, based on the presenting patient's history and symptoms, for example a patient with chest pain, a patient with a new headache and vision changes, and a patient whose cancer needs to be staged. The radiologist has no financial stake in whether an order was placed; they simply have a professional obligation to provide an accurate interpretation at the time the image is presented.

RAND's recommended fix of reallocating the indirect PE based on the sum of physician work and clinical labor RVUs sounds more like a technical accounting adjustment. In practice, it rewards services performed by staff who are currently very expensive to hire, e.g. sonographers, who are already in short supply, rather than services that consume a practice's lease expense, information technology systems, compliance efforts, and cybersecurity infrastructure. Two exam rooms running an ultrasound and an MRI draw on largely the same building, the same scheduling system, the same billing office, the same compliance program; however, under RAND's proposed methodology, the one with the pricier, scarcer labor market will be treated as though it also consumes more indirect overhead. That is a measurement of a labor shortage and not a measurement of cost, thus mislabeling it as a cost driver.

The projected impact, a 0.9 to 1.4 percent reduction across radiology, interventional radiology, nuclear medicine, Independent Diagnostic Testing Facilities (IDTFs), and radiation oncology may seem small in a financial spreadsheet. But in a practice that is already operating on thin margins due to a decade of reductions, it is the difference between keeping a rural satellite imaging site open and closing it, which for a patient is the difference between a 20-minute drive for a mammogram and a 90-minute drive.

Ask: Before implementing RAND's recommended methodology, we ask CMS to obtain evidence of a causal link between indirect PE allocation and ordering behavior. We also ask CMS, to recognize that clinical labor RVUs are shaped heavily by workforce shortages and are not an accurate stand-in for the real indirect costs (rent, IT, cybersecurity, compliance, accreditation) that radiology practices bear regardless of staffing mix.

Additional information to support RBMA's position is provided in Addendum E: Rand Study: Triplet vs. Non-Triplet Codes

Part Five: The Broader Practice Expense Overhaul — Why the Building Does not Get Cheaper When the Radiologist Works Fewer Hours

CMS's broader proposal of phasing out the Indirect Practice Cost Index, reducing reliance on specialty survey data, and reallocating indirect PE based on physician work and clinical labor, relies on an assumption that is worth stating plainly: physician time and clinical staffing are the primary drivers of a practice's overhead.

In radiology, that assumption does not match reality. A radiology practice's largest indirect costs, its Picture Archiving and Communication System (PACS) and its Radiology Information System (RIS), the cybersecurity program that secures a Protected Health Information (PHI), the accreditation and quality-reporting infrastructure, the liability coverage, the revenue cycle management staff, do not shrink when physician work hours or clinical labor inputs change. The cost to manage digital imaging is the same regardless of if the radiologist reading its output spends five minutes or 30 on the case. There is not a direct correlation between a cybersecurity budget and physician RVUs.

If indirect PE allocation shifts to rely primarily on physician work and clinical labor as proxies, technology-dependent specialties like radiology, where infrastructure, and compliance costs are large relative to physician time, risk having their real costs systematically underrepresented. The patient-facing consequences are the same as described throughout this letter: underfunded infrastructure eventually means degraded operations, delayed technology upgrades, or practice consolidation, each of which can yield reduced access or less efficient and lower-quality imaging care.

Ask: Given the scale of redistribution this proposal would cause across specialties, we ask CMS to convene a multi-specialty technical advisory panel to include not only physician representatives but practice administrators and healthcare economists, before finalizing this methodology, and to require evidence that the new allocation approach accurately reflects the cost structure of technology-intensive specialties like radiology.

Additional information to support RBMA's position is provided in Addendum F: CMS Proposed Practice Expense RVU Reforms

Part Six: Duplicate Imaging — Please Do Not Penalize the Physician Who Does Not Make the Decision

CMS has asked for input on reducing duplicate imaging and improving interoperability. We are in complete support of this goal. Patients do not benefit from duplicative scans that are unnecessary, and every radiologist would rather have full access to a patient's prior imaging than to reconstruct a clinical picture from scratch.

Any policy that is adopted must consider that by the time a radiologist is involved, the patient has already had the scan.

A patient arrives in the emergency department after being transferred from another facility, and the emergency department physician orders a CT because any prior images are not available in time to influence the patient's treatment plan. The radiologist who interpreted that CT was not the ordering physician; yet he has a professional obligation to provide a professional interpretation that, in retrospect, is deemed to have been unnecessary.

Financially penalizing the interpreting radiologist for the ordering physician's decision, does not reduce duplicate imaging. It simply makes the radiologist bear the financial consequences of a systemic problem.

A better fix and one that would help the patient in the emergency department is interoperability at the point of ordering to ensure the ED physician has access to any prior scans before deciding if a new one is needed.

Ask: We urge CMS to direct any accountability measures, incentives, or decision-support requirements toward the ordering process, where the decision to order additional studies is made, rather than toward the interpreting radiologist who has no control over that decision.

Additional information to support RBMA's position is provided in Addendum G: Request for Information: Duplicate Laboratory Testing, Imaging and Sharing/Interoperability.

Closing

We opened with a patient arriving in the emergency department at 2:14 a.m. We would like to close by asking CMS to protect the fragile, understaffed, expensive-to-maintain infrastructure that makes it possible for a physician to answer that call, to be in the room in nine minutes, and to save a life that would otherwise be lost during a 90-minute transfer.

Every proposal in this rule from the conversion factor, the site-of-service differential, the RAND-based PE reallocation, the broader practice expense overhaul, and the duplicate imaging framework, is a percentage in a CMS table. However, from the patient's perspective these proposals influence questions such as is the imaging center down the street still open, does the stroke team have an interventional radiologist on call tonight, and will the scan to detect cancer be read in hours or in days.

Our "ask" is not for CMS to disregard budget neutrality or statutory constraints. It is, however, for CMS to weigh these decisions with full knowledge of how they impact a patient who is anxiously waiting for a diagnosis.

RBMA stands ready to work with CMS as a resource for the operational and economic realities of radiology practice, and we welcome the opportunity for further dialogue as this Proposed Rule is finalized.

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Addendum A: Conversion Factor

RBMA appreciates CMS's transparency regarding the proposed 2027 Medicare Physician Fee Schedule (MPFS) conversion factors of \$33.17 for qualifying Alternative Payment Model (APM) participants and \$32.84 for non-qualifying APM participants. We recognize these adjustments are largely the result of statutory budget neutrality requirements and other factors that have been established by Congress, and that CMS has limited authority to alter the underlying methodology.

Nevertheless, RBMA would be remiss if we did not express our profound concern regarding the continued erosion of physician reimbursement under the Medicare program.

For years, physician practices have been asked to do more with less. While CMS and policymakers have increasingly looked to physicians to improve quality, advance value-based care, invest in technology, expand access, address workforce shortages, and reduce administrative burdens, Medicare payments have moved in the opposite direction. The result is a growing disconnect between the cost of delivering care and the reimbursement provided to support it.

According to the American Medical Association (AMA), when adjusted for inflation, Medicare physician payments have declined by approximately 33 percent between 2001 and 2025, while physician practice expenses have continued to rise. Unlike virtually every other class of Medicare providers, physicians do not receive an annual inflationary update that adequately reflects increases in staffing, technology, rent, supplies, liability insurance, cybersecurity requirements, and other operating costs.

No other business sector could reasonably be expected to remain viable under a payment system in which real revenues decline year after year while costs consistently increase. Yet that is precisely the environment in which physician practices all across the country operate today.

The impact on radiology has been particularly severe. Radiology practices face escalating labor costs, increasing technology investments, growing cybersecurity obligations, higher equipment expenses, and rising compliance requirements. At the same time, imaging demand continues to grow as the population ages and more conditions are diagnosed and managed through advanced imaging. Imaging utilization is projected to rise significantly over the coming decades, with many sources estimating annual growth rates of approximately 3 to 5 percent.

Unfortunately, the radiology workforce is not keeping pace with the demand. Numerous studies and workforce analyses have documented a growing national shortage of radiologists that is driven by retirements, training capacity limitations, post-pandemic attrition, and increasing workload complexity. Current estimates suggest the United States is already short approximately 1,500 radiologists, with shortages expected to worsen absent meaningful intervention.

The consequences are already being felt throughout the healthcare system. Hospitals and imaging facilities are experiencing longer interpretation turnaround times, increasing backlogs, recruitment challenges, and growing dependence on costly fee-for-time and teleradiology services. Rural and underserved communities are especially vulnerable, as they often face the greatest difficulty recruiting and retaining radiologists, most notably interventional radiologists.

At the same time, continued reimbursement reductions are contributing to the acceleration of consolidation throughout healthcare. Independent physician practices and community-based radiology groups face mounting financial pressures that make it increasingly difficult to remain viable. As smaller practices are absorbed into larger systems and market competition diminishes, healthcare costs will ultimately increase rather than decrease. A payment environment that undermines independent practice viability does not serve Medicare beneficiaries, physicians, or taxpayers.

While RBMA understands that CMS is constrained by statutory budget neutrality requirements, the agency should continue to communicate clearly

to Congress the real-world consequences of the current physician payment system. The annual cycle of payment reductions, temporary legislative patches, and mounting financial instability is neither predictable nor sustainable.

RBMA urges CMS to continue supporting broader reforms that:

- Provide a permanent inflation-based update mechanism for physician services;
- Address the harmful effects of budget neutrality requirements that routinely trigger payment reductions;
- Recognize the significant workforce challenges facing radiology and other physician specialties;
- Preserve the viability of independent physician practices and community-based care; and
- Ensure Medicare beneficiaries have timely access to high-quality imaging services.

Without meaningful reform, continued reductions in Medicare physician reimbursement will only exacerbate workforce shortages, accelerate consolidation, reduce patient access, and place additional strain on a healthcare system already struggling to meet a growing demand. Radiology is a critical component of nearly every patient care pathway. Policymakers should take care not to further weaken the specialty's ability to serve Medicare beneficiaries at a time when demand for imaging services has never been greater.

Addendum B: Site of Service

RBMA understands CMS's methodology for distinguishing between facility and non-facility practice expenses and how these different settings should be adequately reflected in any reimbursement formulas. However, we urge the agency to evaluate if widening payment differentials could have unintended consequences, specifically for hospital-based Interventional Radiology services. RBMA is concerned that a continued payment differential in this specialty may lead to higher physician employment by hospitals and health systems and could negatively impact beneficiaries' access to critical inpatient and emergency interventions. Payment policies that consistently favor outpatient office-based services at a time when hospitals are seeking to preserve access to essential interventional radiology coverage are not in the best interests of Medicare beneficiaries. RBMA questions if CMS has evaluated if increasing payment differentials between facility and non-facility settings will adversely affect the sustainability of a hospital's IR program with respect to supporting both 24/7 emergency and inpatient care?

In addition to providing clinical interventional services, hospital-based IR physicians are expected to:

- Participate in trauma programs
- Serve on stroke and PE response teams
- Provide inpatient consultative care
- Overnights and weekends

Those activities are typically not required in an outpatient setting and they create costs and workloads that cannot be sustained by procedural payments alone.

And rural and smaller community hospitals are even more vulnerable. Most have only one or two IR physicians supporting an entire region. If economic incentives favor office-based services, maintaining hospital coverage may become even more difficult.

RBMA urges CMS to consider the cost of Interventional Radiology in a hospital setting and if the proposed changes will undermine the hospital-based infrastructure that Medicare beneficiaries depend on for acute interventional care.

Addendum C: G2211 and E/M Redistribution

RBMA supports CMS's proposal to replace G2211 with a percentage-based modifier (MOD1) rather than a flat add-on payment, and we agree this approach better avoids the distortion created when a straight-dollar add-on represents a much larger proportional increase for a low-level E/M visit than for a high-level visit. That said, RBMA urges CMS to take a more measured, conservative approach to how MOD1 is valued and monitored going forward, so that this correction does not inappropriately take money away from specialties that do not utilize G2211 or its successor modifier.

Since the MPFS operates under a statutory budget neutrality requirement, every dollar CMS allocates to MOD1 is a dollar redistributed away from other services and specialties, including diagnostic radiology, interventional radiology, nuclear medicine, and radiation oncology. Diagnostic radiology rarely, if ever, bills the office/outpatient E/M code set to which MOD1 would attach, and even interventional radiologists who maintain clinic-based relationships with patients represent a small fraction of overall E/M billing nationally. As a result, radiology has already absorbed a disproportionate share of the budget neutrality impact associated with G2211 since 2021 without deriving any offsetting benefit from the code, and this pattern will simply continue under MOD1 if CMS's valuation methodology is not calibrated conservatively and revisited as real-world data becomes available.

RBMA specifically requests that CMS:

1. Adopt a conservative initial value for MOD1 and phase in any increase. CMS proposes valuing MOD1 at 16 percent of the base E/M code, derived from a weighted average of prior G2211 utilization. Given that CMS's utilization assumptions for this policy have been overstated in every rulemaking cycle since 2021, RBMA recommends CMS apply a discount to its weighted-average calculation, or phase in the 16 percent value over two years, to avoid repeating the overcorrection that produced the outsized 2024 conversion factor cut.
2. Establish a prospective reconciliation mechanism that compares projected MOD1 utilization to actual claims experience annually and adjusts the following year's budget neutrality calculation accordingly,

rather than allowing a one-time miscalculation to compound indefinitely in the conversion factor, as has occurred with G2211 since 2024.

3. Publish specialty-level utilization and redistribution data for MOD1 in the same manner CMS currently reports specialty impact tables, so that specialties bearing the cost of this policy, but not using it, can meaningfully evaluate and respond to its ongoing impact in future rulemaking.
4. Retain and clarify the existing eligibility criteria for MOD1 (i.e., the same "continuing focal point" and "single, serious or complex condition" standards that apply to G2211 today). Converting the code to a modifier does not resolve the ambiguity in these undefined terms, and CMS should use this transition as an opportunity to provide concrete, auditable criteria before further expanding the policy's reach.

RBMA does not object to CMS appropriately compensating complex relationship-based care. We object to a valuation and estimation methodology that has, in practice, imposed outsized and uncorrected costs on specialties that structurally cannot benefit from the policy. A modifier-based approach is a reasonable structural improvement, but structural improvement alone does not address the underlying estimation problem that has driven this redistributive harm to date. RBMA urges CMS to pair this transition with the more conservative valuation, reconciliation, and transparency measures outlined above.

Addendum D: Same Day Payment Reductions

RBMA urges CMS not to finalize its proposal to reduce payment by 50 percent when a separately identifiable office/outpatient Evaluation and Management (E/M) service reported with modifier -25 is furnished on the same day as a procedure with a 0-, 10- or 90-day global period. This proposal is directly relevant to interventional radiology practices, which may furnish a distinct, medically necessary E/M service, for example, an initial consultation to evaluate a patient for an image-guided procedure, on the same day as a globally billed procedure.

CMS bases this policy on an assumption of "likely" duplication rather than demonstrated evidence and does not explain why it is now revisiting a substantially similar policy it declined to finalize in 2019. RBMA is particularly concerned that CMS's own valuation process already removes duplicative work and practice expense for procedures typically furnished alongside an E/M visit since the RUC's work-survey instructions exclude time associated with a distinct modifier -25 service, and the misvalued code initiative has separately revalued codes commonly billed together. A further 50 percent, across-the-board reduction, applied to the entire value of the service rather than the specific component where overlap might exist, would effectively double count that adjustment.

This is especially significant for independent interventional radiology practices, which bear the full cost of clinical staff, supplies, and equipment reflected in the non-facility payment for both the E/M visit and the procedure and cannot offset a below-cost payment with facility revenue. RBMA agrees with CMS's stated goal of sustaining independent practice, but a policy that pays below the cost of furnishing care works against that goal and risks accelerating the very consolidation CMS seeks to avoid.

RBMA urges CMS to withdraw this proposal and to address any genuine instances of duplicative payment through the established, code-specific misvalued code and RUC valuation processes rather than a uniform, payment-level reduction.

Addendum E: RAND Study: Triplet vs. Non-Triplet Codes

RBMA appreciates CMS's efforts to evaluate potential refinements to the allocation of indirect practice expense (PE) under the Medicare Physician Fee Schedule (MPFS). We also appreciate the analytic work performed by RAND. However, we have significant concerns regarding both the policy rationale underlying the report and the conclusions drawn from its analysis.

RAND distinguishes between "Triplet Codes" (services reported through professional component (PC), technical component (TC), and global billing codes) and "Non-Triplet Codes." According to RAND, the current MPFS methodology allocates indirect PE RVUs differently for these two categories of services. Specifically, global triplet services receive indirect PE allocations based on the combined value of physician work RVUs and clinical labor PE RVUs, while non-triplet services generally receive allocations based on the greater of physician work RVUs or clinical labor PE RVUs.

RAND suggests that this methodology may result in higher indirect PE allocations for certain imaging and diagnostic services relative to other physician services. The report further references literature discussing potential overuse of imaging and diagnostic testing and posits that payment differentials may create incentives to furnish triplet services. However, the report does not establish a direct causal relationship between the current indirect PE allocation methodology and imaging utilization patterns.

RAND evaluated two potential approaches:

1. Convert all services to triplet services; or
2. Modify the indirect PE allocator so that all services receive indirect PE allocations based on the combined value of physician work and clinical labor.

RAND ultimately recommends the second option, concluding that it is operationally less burdensome because it avoids creating millions of new PC and TC code combinations and minimizes associated administrative complexities.

Under the recommended approach, RAND estimates the following impacts:

- Radiology: **-0.9%**
- Interventional Radiology: **-0.8%**
- Nuclear Medicine: **-1.0%**
- Independent Diagnostic Testing Facilities: **-1.4%**

- Portable X-Ray Suppliers: **-1.4%**
- Radiation Oncology/Radiation Therapy Centers: **-1.2%**

Before implementing reforms that redistribute indirect PE RVUs across specialties, RBMA urges CMS to carefully evaluate the underlying assumptions and potential unintended consequences.

Concern #1: RAND Does Not Demonstrate That Indirect PE Allocation Drives Imaging Utilization

A central premise of the RAND analysis is that the current indirect PE methodology may contribute to overutilization of imaging services. However, the report does not provide evidence demonstrating that the methodology itself influences physician ordering behavior.

This distinction is particularly important in radiology because imaging utilization is generally driven by referring clinicians, not interpreting radiologists. In most cases:

- Diagnostic imaging services are ordered by treating physicians.
- The ordering physician often has no financial relationship with the imaging provider.
- Imaging utilization is influenced by numerous factors beyond reimbursement methodology, including clinical guidelines, an aging population, advances in technology, increased disease burden, patient complexity, and concerns regarding medical liability.

Absent evidence demonstrating that indirect PE allocation directly affects ordering behavior, RBMA believes CMS should proceed cautiously before implementing significant redistributions of RVUs based on assumptions regarding imaging utilization.

Concern #2: Clinical Labor RVUs Are Not a Reliable Proxy for Indirect Practice Costs

RBMA is equally concerned that RAND's recommended approach may rely too heavily on clinical labor inputs as a proxy for indirect practice expense.

Indirect practice costs include a broad range of expenses necessary to support patient care, including:

- Facility rent and occupancy expenses;
- Information technology infrastructure;
- Scheduling and patient access operations;
- Billing and revenue cycle management;
- Regulatory compliance programs;

- Administrative support functions;
- Utilities and facility operations;
- Cybersecurity and data protection requirements; and
- Accreditation and quality reporting activities.

These costs support the operation of the entire practice and are often largely independent of the clinical labor required for any individual service.

By contrast, clinical labor RVUs are influenced by staffing models, labor market conditions, workforce shortages, and wage pressures rather than actual consumption of indirect practice resources.

For example, ongoing shortages of qualified sonographers have significantly increased labor costs associated with ultrasound services. Under RAND's proposed methodology, ultrasound services could receive proportionately greater indirect PE allocations because of higher clinical labor inputs, even though the underlying indirect costs supporting those services, such as facilities, information technology systems, billing operations, compliance activities, and administrative infrastructure, may be comparable to those supporting CT or MRI services.

As a result, RBMA is concerned that the proposal may unintentionally distort indirect PE allocations rather than improve their accuracy.

For these reasons, RBMA urges CMS to exercise caution before implementing any methodology that materially redistributes indirect PE RVUs based primarily on physician work and clinical labor inputs without clear evidence that the resulting allocations more accurately reflect actual indirect resource consumption.

Addendum F: CMS Proposed Practice Expense RVU Reform

RBMA recognizes that CMS is proposing a fundamental restructuring of the methodology used to allocate practice expense RVUs under the MPFS. These changes would significantly reduce reliance on specialty-specific survey data, including information derived from the AMA's Physician Practice Information Survey (PPIS), and replace portions of the current methodology with approaches based on more objective and auditable data sources.

CMS has expressed concerns that existing survey-based cost information is expensive to collect, difficult to validate, updated infrequently, and may no longer accurately reflect contemporary physician practice costs. In response, CMS proposes several significant changes to the PE methodology.

Proposed Reforms

1. Revised Indirect Cost Allocation

CMS proposes allocating indirect practice expenses using a combination of physician work RVUs and clinical labor RVUs. Under this approach, services requiring greater physician effort and more substantial clinical staff support would generally receive a larger share of indirect overhead.

2. Elimination of the Indirect Practice Cost Index (IPCI)

CMS proposes gradually phasing out the IPCI, which currently relies on specialty-specific survey data originating in 2007. CMS believes these data no longer accurately reflect current practice costs and proposes transitioning to alternative data sources that it views as more objective and transparent.

3. Reduced Reliance on Specialty Survey Data

CMS proposes removing several survey-dependent components of the PE methodology and replacing them with approaches based on auditable cost data.

4. PE RVU Stabilization Policy

CMS proposes a stabilization mechanism that would limit annual PE RVU increases or decreases to five percent during implementation to mitigate disruptive payment fluctuations.

RBMA Concerns Regarding the Proposed Methodology

RBMA appreciates CMS's interest in modernizing practice expense valuation. Nevertheless, these proposals represent some of the most consequential

changes to PE methodology in many years and have the potential to substantially redistribute reimbursement across physician specialties and subspecialties.

Because of the far-reaching implications of these reforms, RBMA urges CMS to proceed deliberately and ensure that any revised methodology is supported by robust empirical evidence demonstrating that the resulting allocations more accurately reflect actual practice costs.

Importantly, physician work and clinical labor, while significant contributors to practice expense, do not fully capture the broad range of costs required to operate modern physician practices.

For radiology practices, these expenses include:

- Commercial and medical office rent;
- Information technology infrastructure;
- Cybersecurity and data protection programs;
- PACS, RIS, AI, and interoperability investments;
- Software licensing and maintenance;
- Regulatory compliance activities;
- Accreditation and quality reporting requirements;
- Professional liability coverage;
- Revenue cycle management and administrative support services; and
- Ongoing capital investments necessary to sustain high-quality patient care.

Many of these costs continue to rise regardless of physician work hours or clinical staffing levels. In some cases, these expenses have increased at rates that significantly exceed general inflation.

RBMA is concerned that a methodology that is overly dependent on physician work and clinical labor may systematically underrepresent the true cost structure of technology-intensive specialties such as radiology, where substantial investments in infrastructure, cybersecurity, software, compliance, and operational support are essential to patient care.

Accordingly, CMS should not assume that physician work and clinical labor are adequate proxies for all indirect practice expenses without demonstrating that such an approach accurately reflects real-world costs across diverse specialties and practice settings.

Recommendation: Convene a Multi-Specialty Technical Advisory Process

Given the scope and complexity of these proposed reforms, RBMA strongly recommends that CMS convene a multi-specialty technical advisory panel or stakeholder workgroup before implementation.

Such a group should include:

- Physician specialty societies;
- Practice administrators;
- Health economists;
- Healthcare finance experts; and
- CMS technical staff.

This collaborative process would allow stakeholders to evaluate the proposed methodology, assess specialty-specific impacts, identify unintended consequences, and develop recommendations that better reflect the realities of operating physician practices across the healthcare system.

Radiology practices are currently facing increasing imaging demand, persistent workforce shortages, escalating technology and cybersecurity costs, and continued reimbursement pressures. Additional reductions resulting from major changes to indirect PE allocation could further strain practice sustainability and ultimately affect patient access to medically necessary imaging services.

RBMA therefore urges CMS to proceed cautiously, engage stakeholders broadly, and ensure that any modifications to PE methodology are supported by transparent, representative, and empirically validated data. Reforms of this magnitude should improve the accuracy of practice expense valuation without creating unintended redistributions that undermine access to care or fail to reflect the true costs of operating modern physician practices.

Addendum G: Request for Information: Duplicate Laboratory Testing, Imaging and Result Sharing/Interoperability.

CMS is concerned that fragmented information sharing contributes to repeated imaging, delayed care, and higher Medicare spending. CMS is asking for stakeholder input on how to:

- Reduce unnecessary duplicate imaging and laboratory testing
- Improve interoperability and results sharing
- Ensure prior imaging and test results are available when needed
- Better align payment policy with efficient information exchange

RBMA appreciates CMS's efforts to reduce unnecessary duplicate imaging and laboratory testing, improve interoperability, enhance the availability of prior studies and results, and align payment policy with efficient information exchange. We strongly support these objectives and believe that sharing of clinical information across disparate health information systems has the potential to improve patient care, reduce delays in diagnosis and treatment, eliminate avoidable testing, and lower overall healthcare expenditures.

Radiology is particularly well-positioned to appreciate the value of timely access to prior imaging studies and reports. Comparison with prior examinations is often essential to accurate diagnosis and appropriate treatment management. Greater interoperability and more reliable exchange of imaging records would unquestionably benefit patients, referring clinicians, and the Medicare program.

At the same time, RBMA respectfully urges CMS to recognize the distinct roles of ordering and interpreting physicians when considering policy approaches related to duplicative imaging. Radiologists generally do not order imaging examinations. The request for an imaging study is typically made by the ordering/treating clinician based on the patient's history and clinical presentation. In many settings, particularly hospitals and emergency departments, radiologists have no control over when an examination is ordered, when it is performed, or what information was available to the ordering provider at the time the order was placed.

By the time a radiologist becomes involved, the examination has already been completed and is awaiting interpretation. The radiologist is professionally and clinically obligated to provide a timely and accurate interpretation regardless of whether the study is ultimately determined to be duplicative or avoidable. The radiologist expends the same expertise, time, professional judgment, and resources to interpret the examination and communicate findings to the care team in all scenarios.

For this reason, RBMA strongly cautions against payment policies that would financially penalize interpreting radiologists for duplicate imaging studies. Such policies would assign responsibility to physicians who neither initiate nor control the underlying decision to perform the examination. Financial penalties directed toward the interpreting provider would fail to address the root causes of duplicate testing and could create unintended consequences for patient care.

Instead, CMS should focus its efforts on improving the availability and accessibility of prior imaging and clinical information at the point of ordering. Educational initiatives, decision-support tools, interoperability standards, and accountability measures should be directed to the ordering process, where decisions regarding the necessity of repeat imaging are made. Policies that facilitate access to prior studies and reports, that encourage participation in interoperable data-sharing networks, and that support clinical decision-making at the time of ordering are more likely to reduce unnecessary utilization while preserving access to medically appropriate imaging services.

Radiologists should not be held financially responsible for circumstances beyond their control, particularly when they are obligated to interpret studies that have already been performed. Meaningful reductions in duplicative imaging will be achieved through improved information exchange, interoperability, and ordering-provider decision support, rather than through payment reductions targeting interpreting physicians.

RBMA looks forward to working with CMS and other stakeholders to advance practical solutions that improve interoperability, reduce unnecessary

duplicate testing, enhance patient care, and ensure that accountability is appropriately assigned within the healthcare delivery system.