RBMA

Advocacy in Action: What's Happening in Radiology

YOUR
RADIOLOGY PRACTICE.
FORWARD.

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RBMA

Radiology Business Management Association

RBMA: Advancing Radiology Business Excellence

Established in 1968, the Radiology Business Management Association represents over 2,000 radiology practice business leaders across 800+ practices in all 50 states. We are the trusted partner advancing the industry and broadening our members' capacity to provide superior patient experiences.

SAN ANTONIO Texas

Our Advocacy Mission

RBMA is a leading voice in Washington D.C., committed to shaping healthcare policy that supports sustainable radiology practices and ensures patient access to high-quality imaging services. We represent the interests of our members, advocating for fair reimbursement models and regulatory environments that foster innovation.

Through active engagement with Congress, CMS, and other key stakeholders, our mission is to safeguard the future of radiology by influencing legislation and regulations that impact diagnostic and interventional imaging.

SAN ANTONIO Texas

Our Advocacy Mission

Federal Affairs Committee

Working "inside the beltway" with legislative and regulatory leaders who influence healthcare policy

Radiology Patient Action Network (RPAN)

Engaging patients directly in advocacy efforts, approaching issues through the patient lens

RBMA's advocacy work operates through two complementary committees that interact on most issues, ensuring comprehensive coverage of policy challenges facing radiology.

Federal Affairs Committee Impact

RBMA leadership and members visit Capitol Hill to meet with key legislative and regulatory individuals who influence healthcare policy. We ensure they understand our industry's critical role.

- Educate policymakers on what radiologists do
- Demonstrate why we're essential to patient care
- Explain our role as the "doctors' doctor"
- Show how Medicare cuts impact patient care

We also facilitate RBMA members meeting with Congressional Representatives in their districts at clinics and offices, demonstrating that radiologists are employers, purchasers, and voters.

Radiology Patient Action Network

Empowering Patients. Influencing Policy. Protecting Access.

Founded by RBMA in 2020, RPAN is a grassroots movement dedicated to amplifying the patient voice in healthcare policy—especially in radiology. RPAN works tirelessly to combat harmful reimbursement cuts, promote equitable coverage, and ensure access to life-saving imaging services.

RPAN's Strategic Approach

Media Visibility

Working with public relations firms to communicate with patients through articles in Axios and CNN, plus op-eds in local newspapers

Congressional Engagement

Championing long-term solutions for physician payments and voicing concerns about imaging patients impacted by cuts

Legislative Tracking

Monitoring state legislation impacting radiology and advocating for beneficial changes across all 50 states

2024-2025 Impact Highlights

30+

Media Outlets

RPAN featured in major publications including Axios, CNN, and Radiology Business Journal

85%

Public Opposition

Americans oppose Medicare imaging reimbursement cuts according to our survey

50

All States

Mobilized calls and letters to Congress from every state in the union

Grassroots Mobilization Success

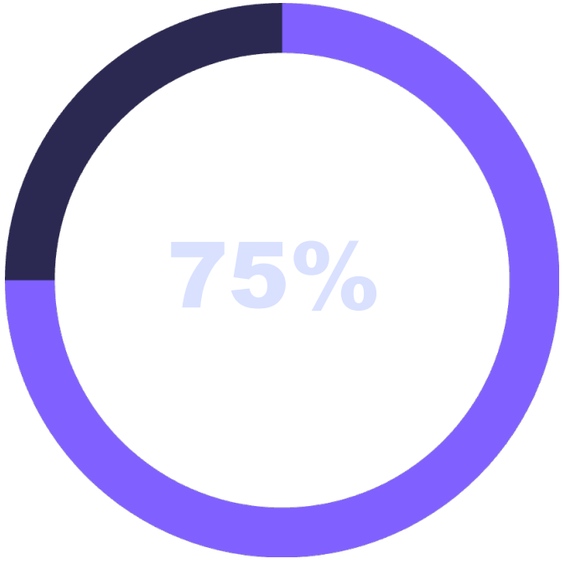
"Don't Cut Docs" Campaign

Mobilized thousands of calls to Congress highlighting the impact of physician payment cuts

"No Tariffs on Health"

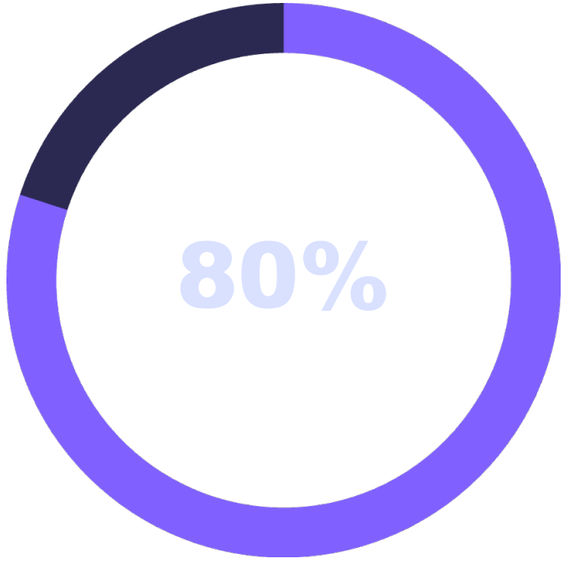
Generated tens of thousands of letters opposing tariffs on medical equipment and supplies

Medicare Beneficiary Survey Power



See Cuts as Medicare Cuts

Overwhelming majority view physician payment reductions as cuts to Medicare itself



Women Oppose Cuts

Female Medicare beneficiaries strongly oppose imaging reimbursement reductions

RBMA and RPAN have conducted their 4th annual Medicare beneficiary survey, providing tremendous advocacy tools. Survey results were used in Senate Finance Committee responses and CMS comment letters.

The Radiology Crisis

Critical Workforce Shortage

CRITICAL CONTEXT

The Radiology Paradox: High Impact, Limited Control

Radiology's Value

Radiologists significantly influence both quality of care and cost containment through accurate imaging, early detection, and precise diagnosis that reduces unnecessary interventions.

Advanced imaging eliminates invasive procedures, reduces hospital stays, and guides minimally invasive therapies—driving better outcomes at lower cost.

The Control Problem

However, radiologists do not control radiology utilization. Except for interventional radiology and follow-up diagnostic mammography, radiologists cannot order imaging studies.

Overutilization is driven by referring physicians' ordering patterns, not radiologists. Yet in most reimbursement models, radiologists are financially penalized for inappropriate studies—decisions outside their control.

1,971

Open Positions

Critical radiologist workforce shortage currently listed on ACR's job board

51.5%

Age 75-84 Growth

Projected population increase by 2055 requiring more imaging services

282%

Age 95+ Growth

Dramatic increase in oldest patients needing advanced diagnostic imaging

Multiple Crisis Factors

1

Aging Population

Growing patient population requires more imaging services than ever before

2

Reimbursement Cuts

Ongoing reductions in physician and facility reimbursement creating financial pressure

3

Increased Demands

Radiologists working longer hours to meet clinical needs, contributing to widespread burnout

4

Unsustainable Pressure

High productivity demands while covering more exams threatens quality of patient care

Mid-Level Provider Impact

The growing number of mid-level providers, such as nurse practitioners and physician assistants, often rely more heavily on imaging to support diagnosis. While their involvement can streamline clinical workflows, it contributes to rising imaging study volumes.

These clinicians potentially order studies at higher rates than physicians with more extensive training, adding to the demand pressure on radiology services.

Business Paradox: Decreasing Revenue – Increasing Operational Impact

Delayed Equipment Investment

Practices postponing purchases of new imaging technology due to financial constraints

Extended Work Hours

Staff working longer hours to maintain service levels with reduced resources

Contract Reevaluation

Practices forced to reconsider hospital service agreements due to unsustainable economics

Difficult Decisions

When service costs exceed revenue, radiology organizations face impossible choices. Some must request financial support from hospitals or withdraw from service agreements entirely.

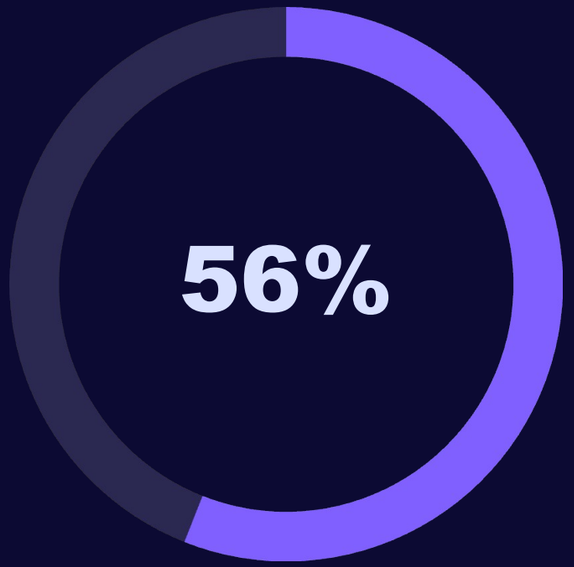
In imaging centers controlled by radiology groups, some have been forced to limit services to Medicare patients—deeply unfortunate but economically unavoidable decisions. Basic business principles dictate that services cannot be sustained when costs exceed payments.

Rural Healthcare Crisis

> **"Rural areas have a disproportionate share of screening-eligible patients, but generally low access to screening. As a result, they are at a higher risk for negative outcomes."**
>
> **— Dr. Eberth, RSNA article 'Rural Areas Face Imaging Obstacles on the Road to Health Equity'**

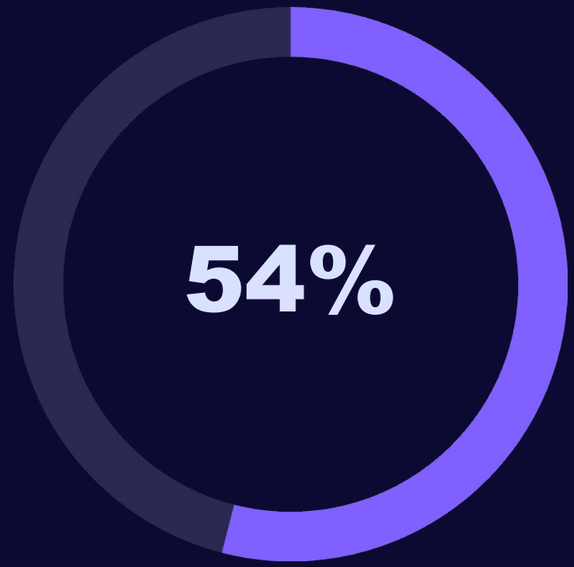
Hospital closures are accelerating in rural areas. Patients face long travel times for imaging services or lack transportation altogether, creating significant barriers to care.

Patient Access Reality



Long Wait Times

Respondents waited more than four weeks to schedule appointments



Provider Shortage

Took three months or longer to find physicians accepting new Medicare patients

RBMA's fall 2025 Medicare beneficiary survey revealed sobering findings that underscore real-world consequences of the radiology workforce crisis.

Radiology is HARD!

Managing radiology organizations has become increasingly difficult. Reimbursement continues to decline while operational costs—staff salaries, rent, equipment, supplies—rise steadily. This creates a paradox unique to healthcare: running a business where revenue decreases year after year despite increasing expenses.
In any other industry, such a model would be unsustainable. Yet this is the reality facing radiology c today.

Back to the Basics: How does radiology get paid?

Let's talk about RVUs?

Think of an RVU as a basic unit of measure that allows medical services to be valued compared to other medical services. Services with higher costs, complexity, time requirements, or skill demands have higher RVUs compared to those that do not.

Work RVU

Value of physician service including technical skill, physical and mental effort, and physician time

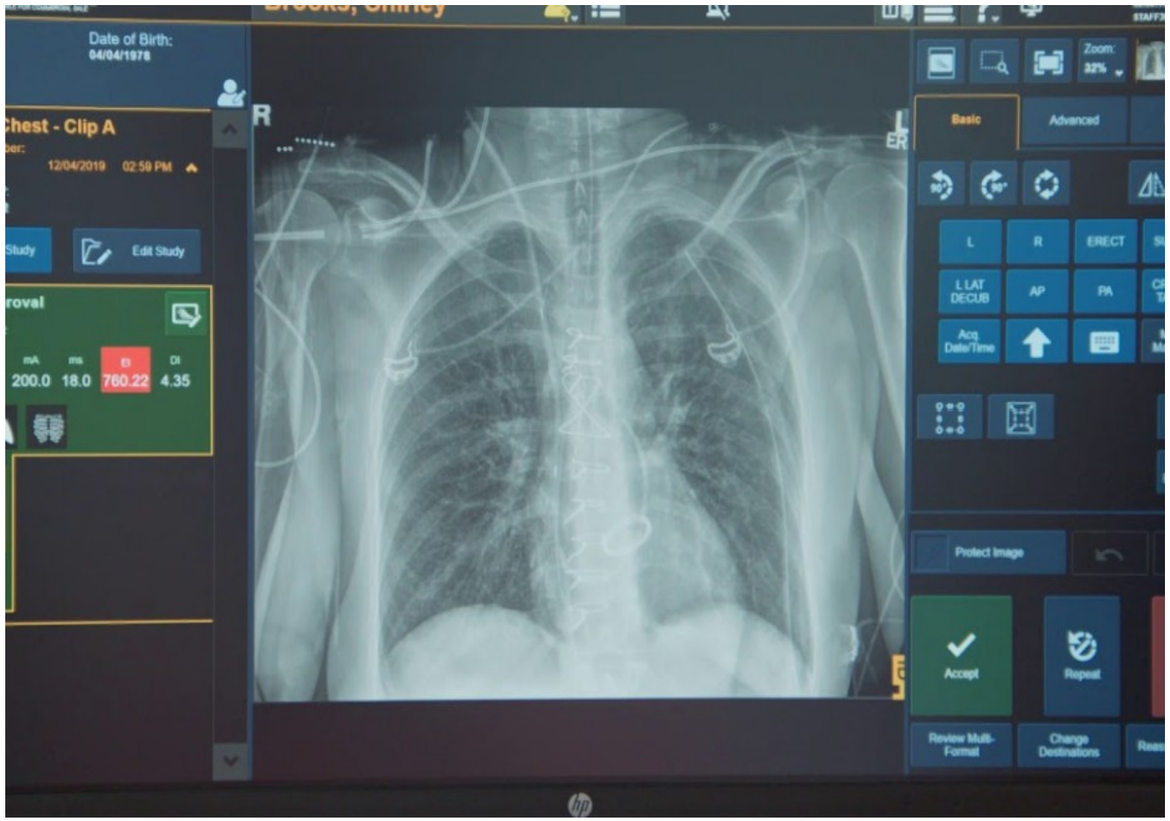
Practice Expense RVU

Overhead costs including rent, equipment, supplies, and non-physician staff costs

Malpractice RVU

Value reflecting relative cost of medical malpractice insurance for providers

Known Issues with the current MPFS Formula impacting Radiology



RVU Values associated with Indirect Costs not represented.

Deficit Reduction Act of 2005

Physician Practice Information Survey (PPIS)

CMS periodically re-evaluates cost structures supporting RVU values to ensure accuracy. The PPIS survey, conducted in 2007, asked physicians to provide direct and indirect costs plus practice characteristics like hours worked, vacation time, number of physicians, and practice locations.

The survey's intent: ensure practice expense RVUs—specifically indirect RVUs—accurately represent costs to provide medical services.

1
2007-2008

PPIS survey conducted via AMA physician master file

2
March 2009

Results compiled and submitted to CMS

3
2010

Data incorporated into Medicare Physician Fee Schedule

The PPIS Problem

Asking physicians to complete surveys is not high on their priority lists. Requesting this level of financial detail from physicians alone is somewhat comical—and the results proved it.

Of 7,400 total respondents, only 105 combined responses came from radiologists, interventional radiologists, or nuclear medicine physicians. Worse: only 21 acknowledged ANY direct practice expenses. The remainder were academic radiologists who reported zero costs.

The survey instrument was extremely difficult to complete and did not capture accurate data.

The Current Data Gap

The Pressing Issue

No current data exists to accurately represent radiology's indirect costs

- 2007/2008 PPIS had insufficient radiology responses
- Survey instrument was extremely difficult to complete
- Not conducive to capturing accurate information
- Radiology practice has changed dramatically since then
- Radiology entities/structures are much more complex today

In 2025, AMA with Mathematica resurveyed physicians. But in the 2026 Final Rule, CMS rejected those results and continues asking stakeholders how best to update this information.

2005 LEGISLATION

Deficit Reduction Act Impact

The Deficit Reduction Act of 2005 was federal law aimed at reducing spending by cutting Medicare and Medicaid expenditures. One of the most impactful areas was Medicare reimbursement for imaging services in physician offices.

The DRA capped reimbursement for the technical component of imaging to the lesser of the Hospital Outpatient Prospective Payment System (HOPPS) rate or the Medicare Physician Fee Schedule. The goal: save Medicare $2.8 billion over five years.

DRA's Impact on Radiology

Significant Cuts

Reductions of 20-50% for outpatient and office-based imaging

- **MRI technical component: ↓ ~35%**
- **MR angiography: ↓ ~25%**
- **CT: ↓ ~9-20%**
- **Nuclear medicine: ↓ ~16%**

Disproportionate Impact

Radiologists hit harder than non-radiologist physicians

- **2007: Medicare Part B imaging payments dropped 12.7%**
- **MRI and CT office volumes declined or grew slowly**
- **Clear flattening of advanced imaging growth**

Business Model Strain

Practices faced severe financial challenges

- **Reduced profit margins**
- **Delayed/canceled equipment purchases**
- **Need for operational restructuring**
- **Workflow optimization requirements**

2026 Medicare Physician Fee Schedule

Each year, the Federal Affairs Committee reviews the Proposed Medicare Physician Fee Schedule released in July and writes a comprehensive letter outlining impacts on radiology. We coordinate with the ACR to ensure alignment—our comment letter focuses on business and operational elements while ACR tackles clinical aspects.

RBMA's comments are highlighted in the final rule and have influenced CMS decisions. We then summarize salient points and distribute to members for reference.

1

Dual Conversion Factors

$33.5875 for APM participants; $33.4209 for non-participants

2

Efficiency Adjustment

2.5% reduction to work RVUs across the board

3

Practice Expense Updates

Site of service payment differential changes

4

Virtual Supervision

Permanent authorization for diagnostic tests requiring direct supervision

5

MIPS & MVPs

Quality reporting program updates and transitions

Dual Conversion Factors Explained

$33.59

APM Participants

Qualifying participants in Advanced Alternative Payment Models

$33.42

Non-Participants

Clinicians not defined as qualifying participants

These represent increases of 3.8% and 3.3% respectively from the 2025 conversion factor of $32.35. Increases reflect MACRA provisions including annual updates and a one-time 2.5% increase from the "One Big Beautiful Bill" Act.

CMS estimates overall radiology impact: -2% diagnostic radiology, -1% nuclear medicine, +2% interventional radiology, -1% radiation oncology.

The APM Challenge for Radiologists

Our industry faces a significant workforce shortage affecting radiologists and support staff. To meet increasing imaging demand, many radiologists work across multiple entities.

For example: a physician may spend one week with a radiology group participating in an APM, and the next week with a group that is not an APM participant. This fluidity introduces complexity and raises concerns about reimbursement accuracy.

APM Participation Barriers

Primary Care Focus

APM participation increasingly limited to primary care physicians, effectively excluding radiology and other specialties from the higher conversion factor

Quality Metrics Mismatch

Quality metrics designed around longitudinal, population-based outcomes align with primary care but not acute episodes managed by specialists

Complex Patient Populations

Specialty physicians treat complex conditions making it difficult to apply standard outcome measures or adequately risk-adjust for severity

Inapplicable Measures

Many quality measures for chronic management don't apply to procedural specialties like radiology

RBMA urges CMS to create pathways allowing specialty physicians to participate meaningfully in APMs and qualify for the higher conversion factor.

Medicare Advantage Concerns

The Disparity

Growing gap between MA plan funding and physician reimbursement

Medicare Advantage plans are not subject to the dual conversion factor and negotiate rates directly with providers. Unlike hospitals, physicians receive no annual inflationary updates.

In many states, MA plans reimburse physicians below traditional Medicare rates due to narrow provider networks. HR 4559—the Prompt and Fair Pay Act—would require MA plans to reimburse at traditional Medicare rates.

RBMA supports this bill and recommends payment at the higher conversion factor, as MA plan structures mirror Alternative Payment Models.

Action Steps: Dual Conversion Factor

01

Verify APM Status

Use CMS Quality Payment Program Participation Status Lookup Tool with physician NPI numbers. Check periodically as status updates throughout the year.

02

Maintain Communication

For APM participants, maintain ongoing communication with APM organizations. Reinforce radiology's value to prevent loss of status.

03

Audit Payments

Regularly audit Medicare payments to verify MACs apply the correct conversion factor.

04

Negotiate MA Contracts

Link reimbursement to the higher conversion factor. Emphasize that MA benefit designs mimic APMs, requiring greater radiology involvement.

CRITICAL ISSUE

The Efficiency Adjustment

CMS finalized an across-the-board 2.5% reduction in work RVUs, characterized as an "efficiency adjustment." RBMA strongly opposes this adjustment, citing lack of empirical support and concerns about negative impacts on physician reimbursement and patient access.

The adjustment is arbitrary and not resource-based, misapplies economic productivity metrics to clinical practice, and fails to account for increased complexity, after-hours demands, and rising practice expenses—particularly in radiology.

Why the Efficiency Adjustment Fails

Unsupported by Data

Based on a single 2016 Urban Institute study with inadequate sample (94 imaging exams, 5 radiologists) not designed to measure efficiency

Increased Complexity

CT studies that once had 40 images now frequently contain 400+. AI tools flag findings requiring further physician review

Technology Costs

PACS systems and support staff for remote reading add practice expenses not reflected in RVUs

After-Hours Shift

Much hospital imaging now occurs outside normal hours, requiring immediate attention at higher labor costs

The Reality: Less Efficiency, More Complexity

CMS posits that non-time-based codes "should become more efficient as they become more common." In radiology, the opposite is true. Exponential growth in image volume has driven less efficiency, not more.

AI tools currently have a negative impact on radiologist efficiency, generating significant false positive alerts with more data to review. To arbitrarily reduce work RVUs after years of conversion factor reductions—without considering offsetting changes or adjusting practice expense RVUs—is unwarranted.

Action Steps: Efficiency Adjustment

Although this results in an overall reduction of approximately 1% to reimbursement, members should plan accordingly in their 2026 budget process.

In coming months, RBMA will gather data to illustrate that radiology has not gained efficiency over time but has become more complex. We will need your help gathering this data.

Budget Impact

Adjust 2026 budgets for ~1% reduction

Data Collection

Document increased image volumes and AI review time

Advocacy Support

Participate in RBMA data gathering efforts

Site of Service Payment Differential

CMS finalized refinements addressing shifts in physician practice settings. For services in facility settings, CMS reduced the indirect portion of facility practice expense RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs.

RBMA expressed concern that this 50% reduction is arbitrary and lacks supporting evidence or data. Physician groups face significant increasing costs not reflected in Medicare reimbursement through RVU adjustments or inflation factors.

Interventional Radiology Impact

RBMA's analysis reveals that interventional radiology surgical codes are impacted by the site of service payment differential. While IRs benefit from not covering facility overhead, they still bear substantial indirect costs: billing, coding, IT infrastructure, administration, scheduling, and marketing.

A 50% reduction in indirect PE RVU for interventional radiology is excessive and could accelerate consolidation, threatening independent IR practice viability.

RBMA urges CMS to exempt interventional radiology services and conduct further analysis on actual indirect costs before implementing any adjustment.

Action Steps: Site of Service Differential

Code-Level Analysis

Review facility vs. non-facility impacts by specific code

Budget Adjustments

Appropriately budget 2026 reimbursement changes

Monitor Redistribution

Track how RVU cuts to some codes increase others

Although diagnostic radiology is exempt, interventional radiology is not. Practice expense has its own budget neutrality—cuts to one set of codes can result in increases to others not affected.

POLICY WIN

Virtual Direct Supervision Made Permanent

RBMA strongly supports CMS's decision to permanently allow virtual direct supervision for Level 2 diagnostic tests. Since first implemented during the public health emergency, this has proven safe and effective.

Outpatient facilities have safely implemented virtual direct supervision models, driving patient access while improving patient safety without threatening program integrity or causing overutilization. Virtual supervision has made contrast administration safer through improved protocols and training.

Action Steps: Virtual Supervision

1

Real-Time Requirements

Ensure virtual supervision is real-time audio and visual throughout exam performance

2

Qualified Personnel

Have qualified individuals on-site who can respond to contrast reactions

3

Policies & Procedures

Document policies addressing CMS requirements and contrast reaction protocols

4

State Law Compliance

Consider state laws and scope of practice requirements for on-site supervision

MIPS and MVP Updates

RBMA supports CMS's proposed changes to MIPS and MVPs, especially excluding NPs and PAs from TPCC measure attribution in specialty practices. We support developing a Diagnostic Radiology MVP and urge CMS to expand the Interventional Radiology MVP.

1

2026 Performance Year

Performance threshold maintained at 75 points for predictability

2

MVP Development

Diagnostic Radiology MVP offers targeted, relevant quality reporting

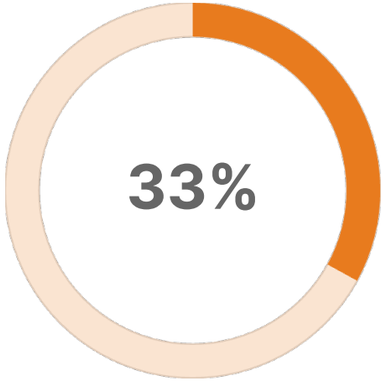
3

2029 Potential Transition

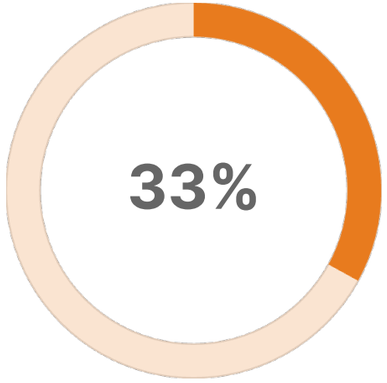
Possible full transition from traditional MIPS to MVPs

CMMI Models: Mixed Results and Missed Opportunities

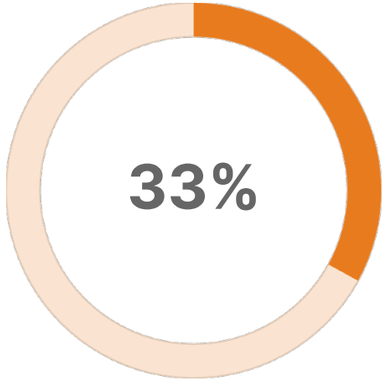
By design, radiology's ability to participate in CMMI models has been underwhelming. As of this letter's date, there has not been a CMMI model in production with significant impact on radiology. The Radiation Oncology Model, originally slated for 2022, continues to be delayed.



Of CMMI models delivered significant net savings



Had substantial losses with no benefit



Had minimal financial impact either way

Key Recommendations for CMMI Reform

Multidisciplinary Input

CMMI should create a true multidisciplinary clinician committee to propose, review, and analyze future models. Currently, no radiologists serve on the Physician Focused Payment Model Technical Advisory Committee (PTAC).

Transparent Funding

The provider community should understand how funding for CMMI models is allocated. Funding should not be drawn from the Medicare physician fund, as not all subspecialties can participate equally.

Equal Participation

Future CMMI models must ensure ALL clinical specialties have opportunity for meaningful input and participation in program design and implementation.

SOLUTIONS

Three Practical Programs to Replace MIPS

The current MIPS program is a "pay for reporting" program versus a "pay for quality" program. A 2023 Yale University review concluded that MIPS "has not led to improvements in quality, decreases in spending, or increases in value." Participating practices spent an average of $10,000–$15,000 per physician in 2019. RBMA recommends three manageable programs that increase quality while reducing costs:

> **"Radiology plays a foundational role in modern medicine, yet current CMS models have failed to recognize our unique position as consultants rather than drivers of utilization. Future reforms must prioritize programs that are practical, equitable, and outcome-focused while reducing administrative burden and improving patient care."**

Program 1: Appropriate Use Criteria

Implement retrospective review of advanced imaging claims against AUC using Provider Led Entities (PLEs). MACs transmit claims to PLEs, which process through AUC databases and generate compliance reports by ordering physician. Integrate scores into MIPS to promote evidence-based ordering and reduce overutilization.

Program 2: Incidental Findings Follow-Up

Ensure timely, guideline-concordant follow-up for actionable incidental findings detected on imaging. Leverage ACR algorithms and "Closing the Recommendation Follow-up Loop" guidelines. Designate a "custodian of follow-up" at report sign-off to track findings through identification, communication, and completion.

Program 3: National HIE Participation

Accelerate nationwide secure exchange of electronic health information by incentivizing providers to participate in Health Information Exchanges and exchange information under TEFCA/QHIN at the national layer. This reduces fragmented medical information and supports consistent care across providers.

2026 OPPS Final Rule Impact

Payment Rate Update

2.6% increase raising conversion factor to $91.415 for CY 2026, applying to all outpatient hospital imaging services

3D Printing Services

CPT 0559T reassigned to APC 5734 with payment $135.93, up from $60.27

CEUS Enhancement

CPT 76978 & 76979 received higher APC placement with new payment rate $243.77

AI/SaaS Stability

APC placements remain stable for 2026; CMS thanked stakeholders for AI reimbursement feedback

Quality Reporting

OP-40 CT Radiation Safety added as voluntary measure in OPPS Quality Reporting Program

MAJOR LEGISLATION

One Big Beautiful Bill Act (OBBBA)

Enacted July 4, 2026, the OBBBA introduces sweeping healthcare reforms. While many provisions take effect in 2026 or 2027, radiology groups must begin preparing now to mitigate risks and seize opportunities.

2.5%

Medicare CF Increase

One-time increase to Medicare Conversion Factor for CY 2026

11.8M

Projected Uninsured

Estimated increase in uninsured individuals by 2034 due to Medicaid changes

$50B

Rural Health Fund

Five-year fund for rural healthcare transformation

Action Steps: Preparing for Change

01

Review Coverage Processes

Ensure processes accurately determine active Medicaid coverage within the new 30-day retroactive period (vs. 90 days)

02

Financial Impact Analysis

Run scenarios where 10-20% of Medicaid patients become uninsured to determine financial impact and plan organizational changes

03

Engage with Hospitals

Start discussions with hospital leadership and ER colleagues. Be part of the solution for more effective care deployment

04

Contract Review

Review managed care contracts, identify revenue opportunities, and streamline prior authorization and denial management

05

Rural Health Opportunities

Communicate with state departments applying for the $50B Rural Health Transformation Fund about radiology's critical role

Accelerating AI Adoption in Healthcare

The Radiology Business Management Association's responds to HHS on removing barriers and incentivizing artificial intelligence in clinical care

⚠ CRITICAL BARRIERS

Three Major Obstacles to AI Innovation

Financial Uncertainty

Organizations struggle to determine how to pay for AI, how reimbursement will evolve, and how to build viable financial models while AI use cases remain fluid.

Operational Complexity

Integrating AI into established workflows is complex. Workforce readiness and willingness to adopt AI tools remain uncertain, requiring significant change management.

Contractual Ambiguity

Key liability questions remain unresolved: Who is responsible when AI makes an error? How will malpractice insurers treat AI-assisted care? Data ownership concerns persist.

HHS Policy Recommendations

HHS should not assume AI will immediately create efficiencies. Early implementation often requires increased workflow steps, staff time, and capital investment. To incentivize adoption without reducing base reimbursement, HHS should pursue these strategic approaches:

Financial Support Mechanisms

02

Provide funding for AI procurement, implementation, and ongoing operationalization rather than reducing reimbursement

Regulatory Clarity

03

Create regulations clarifying data ownership, liability standards, and malpractice coverage expectations

Federal Certification Framework

Establish vendor compliance verification exceeding HIPAA and cybersecurity standards

Tariff Exemptions

Ensure AI tools and technologies are exempt from tariffs to reduce financial burden

The Core Challenge

Clinicians remain unsure how to model the long-term costs and reimbursement of AI. HHS policies that reduce cost barriers will significantly improve adoption rates across healthcare organizations.

The AI Reimbursement Paradox

Artificial intelligence holds substantial promise to improve the quality, consistency, and safety of radiologists' interpretations. AI tools can flag subtle findings, reduce perceptual errors, prioritize urgent cases, and support clinical decision-making.

> **A central challenge is that current Medicare and commercial payer reimbursement systems reward physician time and malpractice risk rather than measurable improvements in quality or outcomes. If AI improves efficiency, it may paradoxically threaten reimbursement, discouraging adoption even when patient care improves.**

Under existing payment structures, radiologist work RVUs are based on assumptions about time and cognitive effort. AI-assisted workflows that shorten reading times could be interpreted as lowering physician work, even though the radiologist retains legal responsibility and malpractice risk.

Payment Reform Strategies

SOLUTIONS **FORWARD**

Without payment reform, AI risks becoming a victim of its own success. Policymakers can address this dilemma through complementary strategies that align reimbursement with quality, accountability, and long-term value:

Recognize AI as Work Augmentation

Create add-on payments or new RVU components tied to validated AI use that demonstrably improves diagnostic accuracy and patient outcomes. Such payments should be permanent, not time-limited.

Adopt Value-Based Models

Broader adoption of bundled payments would allow providers to capture the financial benefits of higher-quality, more efficient care enabled by AI technologies.

Account for Persistent Liability

Payment policies should reflect that AI does not eliminate professional liability. Radiologists remain legally accountable even when AI assists interpretation.

RBMA remains committed to working collaboratively with HHS to advance policies that promote high-quality, cost-effective care and shape a sustainable future for radiology and the broader healthcare system.

The Critical Role of State Healthcare Advocacy in Radiology

Federal Gridlock

Congressional deadlock has stalled vital healthcare legislation, leaving key radiology issues—scope of practice, reimbursement reforms, and technology integration—unresolved at the national level.

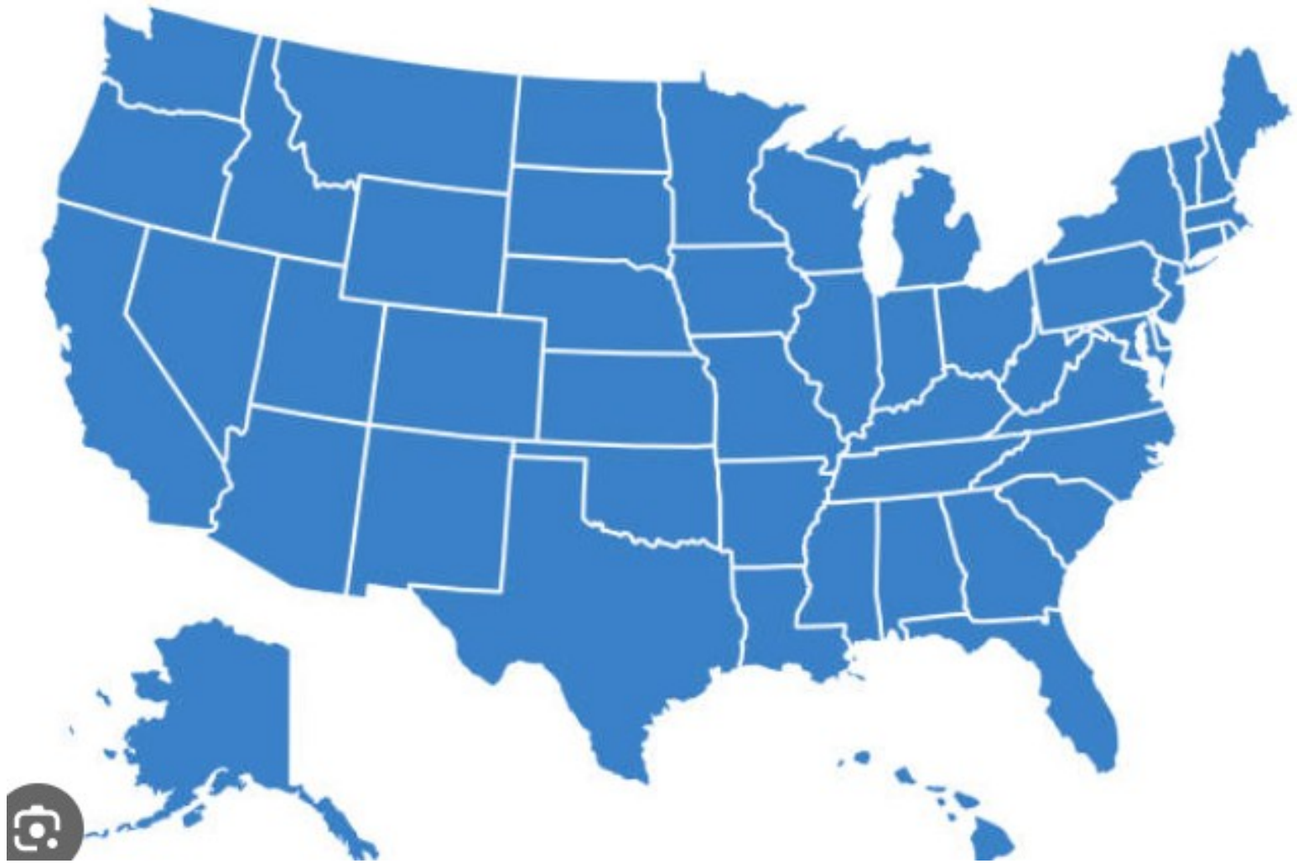
States Leading Change

State legislatures have emerged as the primary battleground for healthcare policy innovation, directly shaping radiology practice standards, payment models, and patient access to imaging services.

Local Solutions Matter

State-level advocacy enables radiologists to respond swiftly to regional healthcare challenges, ensuring policies reflect local patient populations and rapidly evolving imaging technologies.

Why States Are Leading Radiology Legislative Efforts



In 2026 alone, state legislatures are considering hundreds of bills that directly impact the radiology industry. This surge in state level legislation reflects the reality meaningful health reform happens at the state level, instead of the federal level.

Active State Initiatives:

Moving Forward: Empowering State-Level Advocacy

Engage Lawmakers

Build year-round relationships with state legislators and regulatory officials to ensure radiology perspectives inform policy development before bills are drafted.

Build Coalitions

Partner with patient advocacy groups, healthcare systems, and allied medical specialties to amplify radiology's voice and demonstrate broad support for evidence-based policies.

Educate Policymakers

Provide lawmakers with clear, compelling information about radiology's essential role in diagnosis, treatment planning, and population health management.

The RBMA provides comprehensive resources—including policy talking points, legislative tracking, grassroots coordination, and expert testimony support—to amplify radiology's voice in all 50 state capitals. Through sustained state-level engagement, RBMA helps shape healthcare policy, protect patient access to quality imaging, and secure the future of our specialty.

Invest in Your People

> **"CFO Says: What if we invest in our people and they leave?"**
>
> **"CEO Says: What if we don't and they stay?"**

Radiology is HARD! We know how difficult our industry is and how impossible it is to stay on top of all issues alone.

Associations educate and develop leaders. Thank you for investing in your pe

Questions?

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