American Society of Echocardiography

May 13, 2026

The Honorable John Joyce, MD
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Greg Murphy, MD
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Kim Schrier, MD
U.S. House of Representatives
Washington, D.C. 20515

Dear Dr. Joyce, Dr. Murphy, and Dr. Schrier:

On behalf of the American Society of Echocardiography (ASE), the Society for Cardiovascular Ultrasound Professionals™, we write to offer comments on your discussion draft to reform the Medicare Access and CHIP Reauthorization Act (MACRA) and strengthen the Medicare Physician Fee Schedule (MPFS). ASE is the largest global organization for cardiovascular ultrasound imaging serving more than 20,000 physicians, sonographers, nurses, and scientists and as such is the leader and advocate, setting practice standards and guidelines for the field. Since 1975, the Society has been committed to advancing cardiovascular ultrasound to improve lives. ASE holds seats in the American Medical Association House of Delegates and represents medical practitioners in the U.S. who use imaging to detect and manage heart and circulation diseases.

We commend your leadership on physician payment reform and appreciate the attention this draft gives to the structural flaws that have driven years of payment instability. Below we offer our perspective on provisions that are most consequential for echocardiography practice and patient access to cardiac imaging.

Conversion Factor and Payment Updates (Sec. 101)

ASE strongly supports tying the Medicare physician payment update to the Medicare Economic Index (MEI). The MPFS is the only Medicare payment system without an annual inflationary adjustment, and the consequences have been severe. As we noted in our comments on the CY 2026 Physician Fee Schedule Proposed Rule, physicians have lost more than 33% in real Medicare payment since 2001 while practice costs rose 59% over the same period. This gap is not sustainable and directly threatens patient access to echocardiography and other life-saving cardiovascular services.

The CY 2026 final rule illustrated the problem clearly. Despite a modest base conversion factor increase, a newly finalized -2.5% efficiency adjustment reduced work RVUs for all non-time-based codes, including the full diagnostic echo code family. In addition, facility-based echo services faced estimated cuts of up to 11%. This pattern of statutory updates offset by neutrality adjustments, efficiency reductions, and stale practice expense inputs has created chronic instability for echo labs, particularly in rural and underserved communities. Echo labs have increasing wait times due to shortages of staff, greatly influenced by these economic pressures.

We urge an amendment to Section 101 to set the conversion factor update equal to the full MEI, rather than MEI minus one percentage point. A formula structurally set below inflation will reproduce the same downward spiral over time. The floor and ceiling mechanism is a welcome addition, but the underlying formula must reflect the true cost of delivering care. Echo labs depend on rapidly evolving ultrasound technology, AI-enabled imaging platforms, and highly trained sonographers whose wages have risen sharply. Sub-inflationary updates will compromise access to care.

Budget Neutrality Reforms (Secs. 401-404)

ASE strongly supports the budget neutrality reform package in Title IV, which we endorsed in our April 2026 letter of support for the Provider Reimbursement Stability Act. Raising the threshold from $20 million to $54.3 million and indexing it to the MEI every five years corrects a 1992-era figure that now triggers systemwide cuts from routine code revaluations. The utilization estimate correction mechanism in Section 402 addresses a related chronic problem: the Centers for Medicare & Medicaid Services (CMS) overestimates utilization when new codes are introduced, generating inflated neutrality cuts that are never reversed when actual volumes prove lower. This correction will be especially important as echocardiography continues to expand with point-of-care ultrasound, three-dimensional imaging, and AI-assisted interpretation.

Section 403's requirement to update clinical staff wages, medical supply prices, and equipment costs simultaneously at least every five years directly addresses echocardiography's cost structure. CMS has allowed these inputs to grow stale, systematically undervaluing echo overhead at a time when sonographer wages and imaging equipment costs have risen significantly. The 2.5% year-to-year conversion factor variance cap in Section 404 provides the payment predictability that echo labs need for planning and workforce decisions. Together, these provisions represent the most meaningful structural improvement to the MPFS in decades, and ASE urges their enactment.

Quality Payment Program, Alternative Payment Models, and Value-Based Care (Secs. 201-204, 301-303)

ASE supports the legislation's approach to Merit-based Incentive Payment System (MIPS) reform and improved specialty access to value-based care. We offer comments on two central concerns.

First, specialty physicians lack viable pathways to alternative payment models, and MIPS provides no meaningful destination for most of them. Existing Merit-based Incentive Payment System Value Pathways have been built primarily around primary care frameworks that do not reflect how imaging-focused specialists practice or deliver value. Without viable pathways, specialty physicians bear the administrative cost of MIPS compliance with no route to the higher-value frameworks MACRA was designed to promote. ASE recommends that Congress direct CMS to develop a specialty-inclusive MIPS and MVP framework that accommodates imaging-focused clinicians and team-based care. This should include MVPs for cardiovascular imaging developed with specialty society input, performance assessment for imaging consultants based on their specific clinical contribution rather than the broader episode, and recognition of imaging's diagnostic and risk-stratification role in outcomes attribution rather than defaulting to the managing or referring clinician. Additionally, ASE supports the Quality Reform Task Force in Section 202(E), which would require specialty-specific quality and cost containment measures to carry Task Force endorsement before they can be applied. Generic MIPS measures have not reflected echocardiography's clinical realities, and this Task Force creates the right structure to fix that.

The mandatory Ambulatory Specialty Model (ASM) for chronic heart failure, finalized by CMS in the CY 2026 Physician Fee Schedule rule to begin in 2027, exemplifies this problem. Echocardiography is central to heart failure diagnosis, risk stratification, treatment monitoring, and outcomes assessment. Yet specialty imaging providers had little engagement in the model's design, and fundamental questions about how imaging utilization will be measured, attributed, and scored under episode-based cost frameworks remain unanswered. ASE is deeply concerned that echo services will face increased financial scrutiny without the clinical evidence or operational frameworks to contextualize appropriate imaging use.

For this reason, ASE strongly supports Section 302's requirement that Centers of Medicare and Medicaid Innovation (CMMI) model modifications and mandatory expansions be subject to notice-and-comment rulemaking. The ASM was developed with limited specialty input and limited transparency. We urge that this rulemaking requirement apply to the ASM before implementation and that CMS be required to publish clear information on how echo and imaging services will be attributed and incorporated into episode cost calculations.

Second, ASE has long raised concerns that MIPS budget neutrality creates a tournament-style system where physicians can invest in quality and still face negative adjustments based on relative peer performance. The same dynamic applies to established and forthcoming payment models: the ASM for heart failure carries a payment adjustment of up to 9%, the same range currently applied under MIPS, creating meaningful financial risk for specialty practices with little ability to influence model design or outcomes attribution. We appreciate that Section 204 reduces the maximum MIPS adjustment to plus or minus 2% for payment years 2029 through 2033. We urge Congress to extend this principle broadly, applying a comparable cap on maximum payment adjustments not only within MIPS but across established and future CMMI models, including the ASM. A consistent limit on downside and upside exposure would reduce financial volatility for specialty practices and allow quality improvement efforts to drive performance rather than relative rank within a tournament structure.

Appropriate Use Criteria for Imaging Services (Sec. 205)

ASE joins the broader House of Cardiology in urging removal of Section 205 from this legislation. We ask that appropriate use of advanced diagnostic imaging instead be addressed through the Quality Reform Task Force established in Section 202(E), where imaging societies can develop AUC-based measures integrated within a reformed MIPS quality and resource use framework rather than a standalone mandate.

The history of the PAMA AUC program supports this approach. In the past these AUC-based systems increased practice costs and delayed care. CMS rescinded all AUC program regulations in November 2023, and in the CY 2024 Physician Fee Schedule Final Rule affirmed that a siloed, standalone AUC program is not the most effective or efficient approach to achieving appropriate imaging use. Section 205, like the ROOT Act on which it is modeled, does not resolve the core structural problem: ordering clinicians would remain confined to CMS-qualified clinical decision support mechanisms that may not include the most rigorous or specialty society-endorsed AUC. When health systems select CDSMs based on cost and convenience, clinicians lose access to the specialty-developed AUC that best reflect clinical evidence, with downstream consequences for care quality and costs.

If Section 205 is retained, we urge at minimum that AUC consultation not be limited to CMS-qualified CDSMs, that compliance thresholds be established through notice-and-comment rulemaking with full cardiovascular imaging specialty society participation, and that payment consequences not be imposed prior to the GAO study. We stand ready to work with your office on an approach that promotes appropriate imaging use through the Quality Reform Task Force rather than a parallel mandate.

Expanded Access to Claims Data for Clinical Data Registries (Sec. 203)

ASE supports Section 203's provision allowing qualified clinical data registries and clinician-led registries to access Medicare and Medicaid claims data for quality research and outcomes analysis. ASE operates the ImageGuideEcho Registry, a registry with structured echocardiography performance data collected across participating practices. Linking registry clinical data with Medicare claims data would allow ASE to conduct risk-adjusted outcomes research, validate echo performance measures, and strengthen the evidence base for the Quality Reform Task Force. We encourage Congress to ensure that data access fees are set at a level that does not burden non-commercial specialty society registries.

Conclusion

ASE appreciates your leadership on this legislation and the commitment to addressing structural problems in Medicare physician payment. We strongly support the budget neutrality reforms in Title IV, the Quality Reform Task Force, notice-and-comment rulemaking for CMMI models, and registry claims data access. We urge amendment of the conversion factor formula to the full MEI, and we ask for continued engagement with echocardiography providers on cost containment measure implementation and the AUC provision. ASE stands ready to work with your office to advance sustainable, equitable physician payment reform that protects patient access to cardiac imaging. If you have any questions on the Society's comments or if we may provide any additional information, please contact Katherine Stark, ASE Director of Advocacy, at kstark@asecho.org.

Sincerely,

David Wiener, MD, FASE
President, American Society of Echocardiography