



American Society of Echocardiography

June 5, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016
Submitted via: Regulations.gov

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes for Fiscal Year 2027

Dear Administrator Oz:

On behalf of the American Society of Echocardiography (ASE), thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Fiscal Year (FY) 2027 Inpatient Prospective Payment System (IPPS) proposed rule. ASE is the largest global organization for cardiovascular ultrasound imaging serving more than 20,000 physicians, sonographers, nurses, veterinarians, 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 appreciates CMS' continued efforts to modernize hospital payment policy, improve quality measurement programs, and advance patient access to innovative technologies. The proposed FY 2027 IPPS payment and policy updates will have meaningful implications for hospitals where ASE members practice and where echocardiography services are delivered. As CMS evaluates changes to the IPPS framework and related hospital quality programs, it is important that policies appropriately recognize the clinical value of emerging cardiovascular technologies, minimize unnecessary administrative burden, and support high-quality, evidence-based patient care while supporting hospitals' ability to invest in imaging infrastructure, staffing, and program development.

ASE respectfully offers comments on the following areas of the proposed rule:

1. IPPS Payment Updates and Hospital Implications
2. Changes related to the ICD-10 MS-DRG classification system;
3. The New Technology Add-on Payment pathway and Breakthrough Device Designation considerations; and
4. Proposed modifications to the Hospital Value-Based Purchasing Program, Hospital Inpatient Quality Reporting Program, and interoperability-related policies.
5. Meaningful and Clinically Relevant Quality Measurement
6. Interoperability and Data Exchange

7. Administrative Burden and Reporting Alignment

IPPS Payment Updates and Broader Hospital Implications

ASE notes that CMS proposes a 2.4% increase in IPPS operating payment rates for FY 2027, reflecting a 3.2% market basket update reduced by a 0.8 percentage point productivity adjustment. Hospitals failing to meet Hospital Inpatient Quality Reporting and Medicare Promoting Interoperability Program requirements would receive reduced or no payment updates.

These payment and quality program policies will directly affect hospitals where ASE members practice and may influence institutional decisions regarding cardiovascular imaging services, including echocardiography staffing, equipment investment, information technology infrastructure, and program expansion. In many organizations, ongoing financial pressures and increasing administrative requirements continue to affect hospitals' ability to adopt innovative technologies and maintain sufficient imaging resources necessary to support high-quality cardiovascular care.

ASE recognizes that the proposed 2.4% IPPS operating payment update is a meaningful step at a time when other Medicare payment programs, including the Physician Fee Schedule, have seen little or no positive update. At the same time, ASE encourages CMS to consider the cumulative operational and financial impact of new reporting obligations, interoperability requirements, and payment policy changes, and to monitor whether the overall rate update is sufficient to offset the specific cost pressures hospitals face in maintaining cardiovascular imaging infrastructure, including advanced echocardiography platforms, AI-integrated interpretation tools, and specialized workforce training.

ASE notes CMS' proposal to expand the Comprehensive Care for Joint Replacement (CJR) model into a national mandatory CJR-X model beginning October 1, 2027, covering inpatient and outpatient lower-extremity joint replacement procedures. While outside ASE's primary clinical focus, the Society has direct interest in how this model is structured, as echocardiographic evaluation is a standard component of perioperative cardiac risk evaluation for many joint replacement candidates. ASE requests that CMS ensure the CJR-X bundle calculations account for appropriate preoperative cardiovascular imaging costs, so that mandatory payment models do not inadvertently create financial pressure on hospitals to forgo or delay clinically indicated echocardiography. More broadly, ASE encourages CMS to monitor operational and financial impacts associated with broader mandatory bundled payment models, particularly as hospitals continue balancing quality reporting, interoperability investments, and adoption of new technologies across service lines.

ICD-10 MS-DRG Changes

ASE appreciates CMS' ongoing efforts to refine the ICD-10 MS-DRG system to better reflect contemporary clinical practice, patient acuity, and resource utilization. Accurate classification and payment methodologies are critical to ensuring hospitals can appropriately support the adoption and delivery of advanced cardiovascular diagnostic and therapeutic services.

As new cardiovascular technologies and minimally invasive procedures continue to emerge, it is increasingly important that coding and payment structures adequately recognize differences in procedural complexity, physician work, imaging requirements, peri-procedural management, and downstream resource utilization. Failure to appropriately distinguish these services within the MS-DRG framework may create barriers to patient access and disincentivize adoption of clinically beneficial innovations.

ASE encourages CMS to continue evaluating whether existing DRG assignments appropriately capture the intensity and complexity associated with advanced cardiovascular imaging-guided procedures and novel structural heart interventions. In particular, CMS should consider whether current classifications sufficiently account for:

- Advanced imaging support and interpretation required during complex procedures;
- Increased procedural time and multidisciplinary coordination;
- Additional equipment, software, and imaging platform costs;
- Resource utilization associated with patient selection and peri-procedural management; and
- Clinical distinctions between emerging minimally invasive approaches and legacy procedures.

ASE also encourages CMS to maintain transparency regarding the clinical and utilization data used to support proposed DRG modifications and to continue engaging specialty societies and clinical experts during the annual review process. Given the rapid pace of innovation in cardiovascular medicine, timely reassessment of coding and payment policies remains essential.

In addition, ASE recommends that CMS continue exploring mechanisms to better capture the incremental value associated with imaging-intensive procedures that may not be fully reflected through existing coding constructs. Appropriate recognition of imaging-related resource utilization is necessary to support continued investment in technologies that improve diagnostic accuracy, procedural safety, and patient outcomes.

New Technology Add-on Payment and Breakthrough Device Designation

ASE supports CMS' efforts to facilitate patient access to innovative technologies, including through the NTAP pathway, and appreciates the Agency's longstanding recognition of the unique challenges associated with breakthrough and emerging technologies.

ASE is concerned, however, with CMS' proposal to eliminate the alternative pathway for New Technology Add-on Payments (NTAP) under IPPS and transitional pass-through payments under OPSS for technologies receiving FDA Breakthrough Device Designation (BDD). Under this proposal, BDD technologies would be required to meet the same eligibility criteria as non-BDD technologies. ASE believes this change could meaningfully impair patient access to innovative cardiovascular technologies.

The NTAP program serves a critical function: it supports hospital adoption of promising new technologies before sufficient claims data are available for incorporation into standard MS-DRG payment methodologies. FDA Breakthrough Device Designation is itself a substantive regulatory finding as it reflects recognition that a technology may offer more effective treatment or diagnosis for life-threatening or irreversibly debilitating conditions. The existing alternative pathway has helped translate that clinical promise into earlier patient access, and its elimination would remove a meaningful bridge between FDA recognition and adequate hospital reimbursement.

ASE urges CMS to withdraw the proposed elimination of the alternative NTAP pathway for Breakthrough Device Designation technologies and to retain the existing pathway, which has served as a critical bridge between FDA recognition and timely patient access to innovative therapies. If CMS proceeds with elimination, ASE requests that CMS publish a transition plan with a phase-in

period, and engage specialty societies including ASE on alternative mechanisms to preserve early-adoption incentives for imaging-guided cardiovascular devices.

The practical stakes of this proposal are significant for echocardiographers and the patients they serve. Three technologies currently under review for NTAP approval via the Breakthrough Device pathway in this proposed rule, the SAPIEN M3 Transcatheter Mitral Valve Replacement System, the Trilogy Transcatheter Aortic Valve Regurgitation System, and InVision Precision Cardiac Amyloid, each rely substantially on echocardiographic imaging for patient selection, procedural guidance, and post-procedural assessment. ASE requests that CMS consider the downstream impact on cardiovascular imaging programs when evaluating the proposed pathway elimination.

ASE also draws CMS' attention to several structural factors that compound the financial risk hospitals bear in early technology adoption. Emerging cardiovascular technologies frequently rely on advanced imaging guidance and specialized procedural workflows that may not be fully captured in current reimbursement rates. Adoption often requires significant investment in imaging infrastructure, physician training, multidisciplinary care coordination, and specialized staffing, costs that are not adequately reflected in existing payment systems. Furthermore, some breakthrough technologies enter the market under Category III CPT codes or other temporary coding pathways that lack established relative values or historical utilization benchmarks, meaning traditional payment methodologies may not fully reflect the intensity, complexity, or resource demands of these services during the early adoption phase. CMS should remain mindful of these limitations when assessing payment adequacy and access implications.

While ASE fully supports rigorous evidence standards and responsible stewardship of Medicare resources, the Society urges CMS to maintain policies that acknowledge the distinct development, evidence generation, and adoption challenges associated with breakthrough technologies as well as to continue fostering collaboration among CMS, FDA, specialty societies, clinicians, hospitals, and manufacturers to ensure reimbursement policy promotes responsible innovation while preserving appropriate safeguards for patient safety.

Hospital Value-Based Purchasing, Inpatient Quality Reporting, and Interoperability Policies

ASE supports CMS' broader goals of improving healthcare quality, advancing interoperability, reducing unnecessary administrative burden, and promoting meaningful measurement that improves patient outcomes. As CMS considers modifications to the Hospital Value-Based Purchasing (VBP) Program, Hospital Inpatient Quality Reporting (IQR) Program, and interoperability requirements, ASE encourages the agency to prioritize measures that are clinically meaningful, evidence-based, feasible to implement, and aligned across programs.

Within the Hospital IQR Program, CMS proposes adding measures related to Excess Days in Acute Care after hospitalization for diabetes, the Hospital Harm—Postoperative Venous Thromboembolism electronic clinical quality measure (eCQM), and the Advance Care Planning eCQM. CMS also proposes updating several mortality and excess-days measures to include Medicare Advantage patients and shorter performance periods, while removing certain venous thromboembolism and stroke eCQMs beginning with the FY 2030 payment determination.

Within the Medicare Promoting Interoperability Program, CMS proposes updating the Certified Electronic Health Record Technology (CEHRT) definition, removing certain Office of the National

Coordinator for Health Information Technology attestation and referral loop measures, modifying the electronic prior authorization measure, adding a Unique Device Identifier reporting requirement, and aligning eCQM additions and removals with the Hospital IQR Program.

ASE appreciates CMS' efforts to align measures and reporting requirements across programs and supports thoughtful modernization of hospital quality infrastructure. However, these changes may create additional operational and reporting demands for hospitals and health systems, particularly those already managing significant interoperability and data exchange challenges associated with cardiovascular imaging.

Meaningful and Clinically Relevant Quality Measurement

ASE encourages CMS to continue refining quality measurement programs to focus on measures that are strongly associated with improved patient outcomes and that minimize duplicative reporting requirements. Hospitals and clinicians continue to face substantial reporting burden associated with overlapping federal quality programs, particularly when measures are inconsistently specified or require extensive manual abstraction.

The Society supports efforts to:

- Reduce measure redundancy across federal programs;
- Retire measures that have reached performance “topped out” status or demonstrate limited clinical utility;
- Increase reliance on electronic clinical quality measures (eCQMs) and digitally specified measures where feasible; and
- Incorporate specialty expertise during measure development and maintenance.

ASE encourages CMS to address a persistent gap in the Hospital IQR Program: despite the central role echocardiography plays in the diagnosis and management of a wide range of inpatient conditions, cardiovascular imaging remains largely absent from the program's quality measurement framework. Rather than proposing additional reporting requirements on clinicians, ASE requests that CMS engage ASE and relevant cardiovascular specialty societies in a structured review of whether existing inpatient quality measures adequately capture the diagnostic and clinical contributions of echocardiography to patient outcomes. Where gaps are identified, ASE is prepared to collaborate with CMS and the measure development community to explore approaches that reflect imaging quality without imposing duplicative or burdensome reporting obligations on hospitals and sonographers.

ASE further encourages CMS to ensure that cardiovascular-related measures appropriately account for patient complexity, evolving standards of care, and differences in available institutional resources. As CMS expands inclusion of Medicare Advantage patients within several quality measures and shortens performance periods for select programs, the Society encourages careful monitoring of methodological impacts, data completeness, and unintended consequences for hospitals serving clinically complex populations.

Interoperability and Data Exchange

ASE supports CMS' continued emphasis on interoperability and improved exchange of health information across care settings. Effective interoperability can improve care coordination, reduce

duplicative testing, enhance clinical decision-making, and support more efficient longitudinal management of patients with cardiovascular disease.

At the same time, interoperability requirements should be implemented in a manner that recognizes operational realities and minimizes unnecessary administrative and financial burden on hospitals and clinicians. Cardiovascular imaging data present unique technical and workflow challenges due to large file sizes, complex imaging formats, integration with cardiovascular information systems and electronic health records, and variation across vendor platforms.

ASE encourages CMS to support practical, scalable interoperability policies that facilitate efficient exchange of cardiovascular imaging information while recognizing the substantial investments required for imaging infrastructure modernization, system upgrades, cybersecurity protections, and workflow integration. In particular, ASE encourages CMS to:

- Promote adoption of standardized imaging data formats, terminology, and exchange frameworks;
- Align interoperability requirements across federal programs to reduce duplication and implementation complexity;
- Recognize the operational and financial burden associated with upgrading imaging and information technology systems; and
- Provide reasonable implementation timelines and flexibility for hospitals and health systems.

ASE encourages CMS to continue collaborating with specialty societies, clinicians, and technical experts to ensure interoperability standards and quality measures appropriately reflect the needs of imaging-intensive specialties and support clinically meaningful exchange of cardiovascular imaging data.

Administrative Burden and Reporting Alignment

ASE appreciates CMS' ongoing efforts to streamline reporting requirements and reduce unnecessary administrative complexity. Hospitals and physicians continue to dedicate substantial resources to quality reporting activities that may not always translate into meaningful improvements in patient care.

The Society encourages CMS to continue identifying opportunities to harmonize measure specifications, reporting periods, submission requirements, and performance methodologies across programs. Greater alignment between the Hospital VBP Program, Hospital IQR Program, Promoting Interoperability Program, and other federal initiatives could significantly reduce operational burden while improving data consistency and usability.

ASE also encourages CMS to carefully evaluate the cumulative impact of new reporting requirements, particularly on smaller hospitals, rural facilities, and resource-constrained health systems that may face disproportionate implementation challenges.

Conclusion

ASE appreciates the opportunity to provide comments on the FY 2027 Hospital Inpatient Prospective Payment Systems proposed rule. The Society supports policies that promote patient access to innovative cardiovascular technologies, ensure appropriate recognition of procedural

complexity and imaging-related resource utilization, and advance meaningful quality improvement without imposing unnecessary administrative burden.

We look forward to continued collaboration with CMS as the agency refines payment, quality, and interoperability policies affecting cardiovascular imaging and patient care. If you have questions or would like additional information, please contact Katherine Stark, Director of Advocacy, kstark@asecho.org.

Sincerely,

A handwritten signature in black ink that reads "D Wiener MD". The signature is written in a cursive, slightly slanted style.

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