American Society of Echocardiography

August 21, 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 thank you for the opportunity to respond to your Request for Information (RFI) on strengthening the Medicare physician payment system. This letter follows the structure of your RFI: Part I responds to your questions on offsets and fiscal responsibility, and Part II offers additional comments on the Patients First Act (H.R. 9693) as introduced. ASE previously submitted comments on the MACRA discussion draft on May 13, 2026, and joined the broader cardiovascular community in a May 8, 2026 letter opposing the Appropriate Use Criteria (AUC) provision in Section 205 of that draft; this letter builds on both.

I. Offsets and Fiscal Responsibility

In response to the RFI's question on potential pay-fors, ASE recommends that Congress fund part of the payment update by mandating Medicare accreditation for echocardiography laboratories, a step consistent with a recommendation the Medicare Payment Advisory Commission (MedPAC) made two decades ago and one Congress has already used successfully for other imaging modalities.

Pay-For: Extend Mandatory Accreditation to Echocardiography

In its March 2005 Report to Congress, MedPAC recommended mandatory accreditation for all imaging services performed on Medicare beneficiaries to address rapid utilization growth and protect patient safety. When Congress acted on that recommendation through the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), it required accreditation only for MRI, CT, PET, and nuclear medicine, leaving echocardiography out. Any Medicare provider can still bill for an echocardiogram today without meeting a federal standard for equipment, personnel, or quality assurance, even though echocardiography is one of the highest-volume cardiac tests Medicare pays for.

A peer-reviewed article published in the Journal of the American Society of Echocardiography shows what closing that gap can achieve. When the Canadian province of Ontario made accreditation mandatory for every echocardiography facility billing its public payer, annual growth in test volume fell from 6.7% to 2.7%, repeat examinations at outpatient facilities dropped from 28.5% to 20.0%, and the province spent roughly $92.3 million less than the pre-policy trend projected over six years, all without a single community losing access to care (Sanfilippo et al., J Am Soc Echocardiogr, 2021). U.S. data point to the same underlying problem MedPAC flagged in 2005: an Intersocietal

Accreditation Commission (IAC) review found 62% of laboratories pursuing accreditation were initially noncompliant with at least one standard (Nagueh et al., J Am Soc Echocardiogr, 2015).

Because an established accreditation infrastructure already exists for Medicare-covered imaging services, Congress could extend a similar accreditation framework to echocardiography without creating a new federal agency or reducing physician payment rates. Accreditation organizations with established expertise in echocardiography could apply existing quality and accreditation processes to establish a national standard for laboratories furnishing echocardiography services to Medicare beneficiaries.

Responsive to the RFI's Overpayment Question

The Ontario experience also speaks directly to the RFI's question of whether Medicare overpays for services that could be delivered more efficiently. Nearly a third of Ontario's registrants had never actually been operating, and solo-physician offices failed critical safety standards at roughly one and a half times the rate of multi-physician practices. Accreditation corrects this without a blunt site-of-service payment cut, and it does so without harming access: no Ontario community lost echocardiography services, and several smaller facilities instead partnered with larger, already-accredited practices to meet the standard.

II. Additional Information

The RFI also invites any additional information relevant to the bill sponsors as they refine this legislation. ASE uses this opportunity to comment directly on H.R. 9693 as introduced. We appreciate that many of the recommendations from our May 13 and May 8 letters were reflected in the bill, and we ask the sponsors' attention to one significant provision that was not.

Supported Provisions

ASE thanks the sponsors for reflecting several of our recommendations in the bill as introduced:

- Budget neutrality: raising the threshold from $20 million to $54.3 million, indexed to the MEI every five years, along with the utilization correction, updated practice expense inputs, and the conversion factor variance cap, matches what we asked for and represents the most meaningful structural fix to the MPFS in decades.
- Conversion factor (Sec. 101): we continue to support a full MEI tie, but recognize the budgetary constraints behind the MEI-1 formula and can support it as a substantial improvement over current law. We ask that the sponsors keep working toward that goal as conditions allow.
- Quality payment reform: we appreciate the Quality Reform Task Force, the notice-and-comment requirement for CMMI model changes (including, we hope, the mandatory ASM for heart failure), the MIPS adjustment cap for 2029–2033, and continued access to claims data for clinical data registries like our ImageGuideEcho Registry. We restate our earlier asks for imaging-focused MVPs and attribution reform, and for a comparable adjustment cap across CMMI models.

ASE Strongly Opposes Section 207 and Urges Its Removal

Set against that support, one provision remains a serious and continuing concern: Section 207, "Modification of Appropriate Use Criteria Data Collection for Applicable Imaging Services." The discussion draft's standalone AUC mandate, which the cardiovascular community asked Congress to strike in our May 8 coalition letter, was not removed. It was retained and restructured: Section 207 amends Section 1834(q) of the Social Security Act to shift AUC reporting from claims-based

documentation to direct reporting by the clinical decision support mechanism (CDSM) to the Secretary, beginning January 1, 2027. This is a change in mechanics, not a change in substance. The underlying structure our coalition opposed is still there: a standalone, mandatory AUC consultation requirement tied to CMS-qualified CDSMs, imposed outside of any broader quality framework.

The House of Cardiology is united in opposition to this approach, and our objections are not new. ASE and the cardiovascular societies raised the same concerns during the original PAMA AUC rollout, and history has borne them out:

- CDSM access does not equal AUC access. During the PAMA voluntary testing period, cardiologists repeatedly found they could not consult their own specialty societies' AUC, because hospitals and health systems selected CDSMs based on cost and contractual convenience, not clinical rigor. A standalone mandate hands that same gatekeeping power to CDSM vendors again, with no guarantee that the AUC available at the point of care reflect current, specialty-endorsed evidence for cardiac imaging.
- The prior program failed on its own terms. The PAMA AUC program was delayed for years, generated significant administrative burden and cost for practices, and was never fully implemented. 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 way to promote appropriate imaging use. Section 207 revives the same model CMS itself abandoned.
- A reporting change does not fix a structural problem. Moving from claims-based documentation to CDSM-to-Secretary reporting addresses an operational inconvenience, not the substantive flaw. Ordering clinicians remain confined to whatever CDSMs their health system has contracted with, and the compliance and cost burden of a parallel, standalone mandate falls on practices regardless of how the data ultimately reaches CMS.
- There is a better vehicle already in this bill. The Quality Reform Task Force gives imaging and cardiovascular societies a direct role in developing AUC-based measures inside a reformed MIPS/POINTS quality and resource-use framework. That structure lets appropriateness be assessed by clinicians who understand cardiac imaging, rather than through a one-size-fits-all mandate layered on top of the quality program Congress is otherwise trying to simplify.

For these reasons, ASE strongly urges that Section 207 be removed from the Patients First Act. We restate our position from May 8: appropriate use of advanced diagnostic imaging should be addressed through the Quality Reform Task Force, not a parallel standalone mandate. If Section 207 is nonetheless retained as the bill advances, we ask at minimum that AUC consultation not be limited to CMS-qualified CDSMs, that any compliance thresholds be established through notice-and-comment rulemaking with full cardiovascular imaging specialty society participation, and that no payment consequences be imposed prior to further study. ASE stands ready to work directly with your offices on this issue.

Conclusion

ASE's response to this RFI reflects two related contributions. In Part I, we have identified a fiscally responsible, evidence-based offset, extending mandatory accreditation to echocardiography facilities, that Congress can use to help fund a permanent, inflation-based payment update without cutting the fee schedule. In Part II, we have commended the sponsors for incorporating the budget neutrality, conversion factor, and quality payment reforms ASE requested, and we have raised our strongest concern with the bill as introduced: Section 207's standalone AUC mandate.

To be direct: ASE is supportive of the majority of the Patients First Act as written and welcomes the structural reforms it would deliver for physician payment. However, ASE is unable to support the legislation as long as it includes the AUC mandate in Section 207. We ask that the sponsors remove Section 207 so that ASE and the broader cardiovascular community can support this bill's enactment without reservation. ASE stands ready to work with your offices on both fronts, identifying additional offsets and resolving the AUC provision, 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 additional information, please contact Katherine Stark, ASE Director of Advocacy, at kstark@asecho.org.

Sincerely,

Cynthia Taub, MD, FASE
President, American Society of Echocardiography