American Society of Echocardiography

September 14, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1848-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-1848-P (RIN 0938-AV82); Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Ambulatory Specialty Model; Medicare Shared Savings Program Requirements; and Quality Payment Program Provisions; 91 Fed. Reg. 43842 (July 16, 2026)

Dear Administrator Oz:

On behalf of the American Society of Echocardiography (ASE), I appreciate the opportunity to comment on the Calendar Year (CY) 2027 Medicare Physician Fee Schedule (MPFS) proposed rule, published in the Federal Register on July 16, 2026. ASE is the Society for Cardiovascular Ultrasound Professionals and the largest global organization dedicated to cardiovascular ultrasound imaging. Founded in 1975, ASE represents more than 20,000 physicians, sonographers, nurses, veterinarians, and scientists who perform and interpret echocardiographic examinations across every practice setting, from academic medical centers and integrated delivery systems to independent cardiology practices and critical access hospitals. ASE develops the clinical practice guidelines, appropriate use criteria, imaging protocols, and quality standards that define the practice of echocardiography in the United States and internationally.

Echocardiography is one of the most frequently performed cardiac imaging tests and the diagnostic foundation for the management of heart failure, valvular heart disease, cardiomyopathy, ischemic heart disease, pulmonary hypertension, congenital heart disease, endocarditis, and stroke of cardioembolic origin. It is non-invasive, involves no ionizing radiation, and is the least expensive advanced cardiac imaging modality per study. Payment policy that destabilizes echocardiography does not simply reduce revenue for one specialty; it degrades the diagnostic infrastructure on which nearly every cardiovascular care pathway, quality measure, and alternative payment model in the Medicare program depends.

ASE is deeply concerned that the CY 2027 proposed rule compounds, rather than corrects, the destabilizing policies adopted in CY 2026. Once again, physicians face sizeable reductions in Medicare payment despite continued increases in practice costs and ongoing inflation. This ongoing instability makes it increasingly difficult for practices to recruit and retain cardiac sonographers and other staff, invest in new imaging technology, and maintain beneficiary access to care. ASE recognizes that CMS cannot, acting alone, reform the Medicare physician payment system in a manner that appropriately accounts for inflation. But CMS can, and should, avoid policies that further exacerbate longstanding structural problems.

The rule instead does the opposite in several respects. The conversion factor is reduced again. The 2.5 percent efficiency adjustment is retained without the specialty-specific evidence ASE and others requested and is now extended to newly created and revised codes. The practice expense methodology is being rebuilt on a compressed timeline without published, specialty-level modeling, while the arbitrary halving of indirect practice expense in the facility setting remains in place and CMS now asks whether facility indirect practice expense should be reduced to zero. Payment for separately identifiable evaluation and management (E/M) services furnished on the same day as a procedure would be cut in half. Meanwhile, limited fee schedule resources would be redirected toward new and untested concepts, including shared medical appointments and health coaching. And CMS proposes to sunset traditional MIPS while offering echocardiographers no applicable Merit-based Incentive Payment System (MIPS) Value Pathway (MVP), no echocardiography-specific quality measure, and no viable route to satisfy the new mandatory core measure requirement.

Our detailed comments and recommendations follow. ASE appreciates CMS's stated commitment to accurate, data-driven payment and to supporting independent physician practices, and stands ready to supply the empirical data, registry infrastructure, and clinical expertise needed to achieve both.

Summary of Principal Recommendations

ASE respectfully urges CMS to take the following actions in the CY 2027 final rule.

- **Conversion factor:** Use all available administrative authority to mitigate the proposed reduction in both conversion factors, adopt an annual Medicare Economic Index (MEI)-based update as CMS's stated policy position, and support statutory reform through legislation such as H.R. 6160 and H.R. 8163/S.5181.
- **Redistribution from specialty to primary care:** ASE encourages CMS to seek ways to support new coding and payment policies for primary care, care management, preventive, and lifestyle services without relying on budget-neutrality adjustments that reduce payment for specialty physician services.
- **Advanced APM access:** Work with CMS Innovation Center (CMMI) and specialty physician organizations to develop voluntary, specialty-focused Advanced Alternative Payment Models (APMs), including models that include cardiovascular diagnostic imaging clinicians, so that the two-tiered conversion factor does not penalize specialties for the absence of an available model.
- **Efficiency adjustment:** Withdraw the 2.5% efficiency adjustment, or at minimum exempt codes reviewed by the AMA/Specialty Society Relative Value Scale Update Committee (RUC) within the past ten years and decline to extend the adjustment to new and revised CY 2027 codes.
- **Indirect practice expense:** Withdraw the proposed removal of the indirect practice expense cost index (IPCI) and the associated stabilization adjustment for CY 2027, maintain the current methodology, and identify a genuine source of current specialty-level practice cost data before proceeding.
- **Facility indirect practice expense:** Withdraw the 50% reduction in indirect practice expense allocated from work relative value units (RVUs) in the facility setting and expressly reject any move toward a 0% allocation.
- **Shared medical appointments and health coaching:** Do not establish coding or payment under the MPFS; test these concepts through a limited demonstration or APM first.
- **Duplicate testing RFI:** Pursue interoperability and appropriate use approaches rather than frequency limits, Medicare Administrative Contractor (MAC) nonpayment edits, or retrospective recoupment, and recognize that serial echocardiography is clinically indicated in defined circumstances.
- **Software as a Medical Service:** Require Food and Drug Administration (FDA) clearance or approval as a precondition of payment, adopt the AMA CPT taxonomy of assistive, augmentative, and autonomous artificial intelligence (AI) as the valuation framework, and establish a separate payment pathway, outside the MPFS, for infrastructure-like AI software. Because the MPFS operates under

budget neutrality, a distinct payment mechanism is needed so reimbursement for this software isn't offset by cuts elsewhere in the fee schedule.

- **Ambulatory Specialty Model:** Delay the model's payment consequences, reduce the initial payment adjustment below ±9 percent, add echocardiography-based diagnostic quality measures to the heart failure condition, and extend the permanent specialty redesignation exception to non-invasive cardiovascular imaging.
- **MVP mandate:** Do not set a fixed date to sunset traditional MIPS. Instead, preserve MVPs as a voluntary pathway alongside traditional MIPS until every specialty has measures that reflect its scope of care.
- **Echocardiography quality measures:** A Consider future incorporation of ASE ImageGuideEcho Registry measures, as appropriate and as they become available, into the MIPS inventory and core measure set; consider allowing qualified clinical data registry (QCDR) measures to be eligible for core designation; explore development of a cardiovascular imaging MVP; recognize Intersocietal Accreditation Commission (IAC) accreditation as an improvement activity; and hold echocardiography-focused clinicians harmless until applicable measures and reporting pathways are available.
- **MIPS scoring:** Remove the seven-point topped-out scoring cap from all measures, not just selected ones, and extend the seven- and five-point scoring floors to all measures lacking a benchmark.
- **Primary care RFI:** Recognize that specialists furnish longitudinal, coordinated care, and ensure that new primary care payment approaches do not create incentives to delay or limit clinically appropriate referrals for cardiovascular imaging.
- **CPT and RUC RFI:** Preserve CPT as the coding standard for physician services and preserve specialty society participation in valuation; do not adopt an ICD-10-PCS grouper approach for professional services.

I. Physician Fee Schedule Conversion Factor and the Need for an Inflationary Update

A. Proposed Conversion Factors

CMS proposes a CY 2027 conversion factor of $33.1693 for qualifying APM participants and $32.8409 for other practitioners, reductions of 1.19% and 1.68%, respectively. The reductions reflect the statutory MACRA updates, a positive 0.53% budget neutrality/work RVU adjustment, and expiration of the temporary 2.5% CY 2026 increase.

ASE remains concerned that these reductions occur as practice costs continue to rise, including sonographer compensation, equipment, software, cybersecurity, liability, and accreditation expenses. Continued payment erosion may affect investment, practice stability, and beneficiary access.

B. Support an MEI-Based Annual Update

ASE continues to support an annual MPFS update tied to the Medicare Economic Index (MEI), which CMS has recognized as an appropriate measure of physician practice cost inflation. ASE also supports H.R. 6160 and H.R. 8163/S.5181 as potential approaches to improving payment stability.

> *ASE recommendation:* Use available authority to mitigate the CY 2027 conversion factor reduction and support an annual MEI-based update and broader statutory payment reform.

C. Support Balanced Payment Across Primary and Specialty Care

ASE supports efforts to strengthen primary care, care management, and preventive services, while recognizing that budget-neutral payment increases can create additional pressure on specialty services. Cardiovascular

imaging is foundational to the diagnosis and management of conditions such as heart failure, valvular disease, and cardiomyopathy.

> *ASE recommendation:* Consider the cumulative impact of new payment policies across specialties and avoid disproportionately relying on reductions to cardiovascular imaging and other specialty services to finance new initiatives.

D. Improve Access to Advanced APMs for Specialists

The two-tiered conversion factor creates challenges for specialists who lack access to qualifying Advanced APMs. Cardiovascular imaging clinicians have limited opportunities to participate in such models, making eligibility for the higher update dependent in part on model availability rather than willingness to engage in value-based care.

> *ASE recommendation:* Encourage CMMI to work collaboratively with specialty organizations to explore voluntary, specialty-focused Advanced APM opportunities that appropriately recognize the role of cardiovascular imaging clinicians in diagnosis, treatment planning, longitudinal disease management, and the delivery of high-quality cardiovascular care. As these models are developed, CMS and CMMI should consider existing quality frameworks, including Intersocietal Accreditation Commission (IAC) accreditation, which provides an established structure for laboratory standards, personnel qualifications, imaging protocols, quality improvement, and ongoing assessment of technical and interpretive performance.

II. Efficiency Adjustment

A. What CMS Proposes

CMS proposes to continue the 2.5% efficiency adjustment adopted for CY 2026, which reduces the work RVUs and intra-service physician time of all non-time-based services. CMS further proposes to apply the efficiency adjustment to newly established and revised non-time-based codes for CY 2027 where, in CMS's judgment, the RUC-recommended values did not already account for efficiency gains. CMS grounds the policy in asserted unreliability of RUC survey data, low survey response rates, and the observation that some codes have not been reviewed in twenty-five years or more.

B. Technology Has Increased, Not Decreased, Physician Work

CMS conflates two distinct concepts: the time required to acquire images and the cognitive work required to interpret them. Advances in ultrasound technology have expanded the diagnostic content of an echocardiographic study rather than shortened the physician effort required to interpret it. Contemporary studies routinely include quantitative chamber volumetry, global longitudinal strain, three-dimensional valve morphology, tissue Doppler and diastolic function assessment, right ventricular quantification, pulmonary pressure estimation, and shunt evaluation. Each additional data element must be reviewed for technical adequacy, reconciled against the remainder of the study and prior comparisons, integrated with the clinical question, and documented. Automated measurement software does not eliminate this work; it requires the interpreting physician to verify each machine-generated value, a verification burden that grows with the number of automated outputs.

Nor has the pre-service and post-service work contracted. Protocol selection, contrast decision-making, correlation with prior imaging across modalities, communication of urgent findings, and participation in multidisciplinary valve and heart failure teams have all expanded. In heart failure and structural heart disease, the echocardiographer is frequently the clinician who determines whether a patient proceeds to intervention. That decision-making is the work the fee schedule is meant to measure.

C. CMS Has Not Provided Specialty-Specific Evidence

CMS has not published time-motion studies, physician surveys, claims analyses, or any other empirical evidence demonstrating a 2.5% efficiency gain in echocardiography or in any other identified service family. An across-the-board adjustment applied uniformly to services with radically different technology trajectories cannot be described as data-driven. It is a budgetary instrument. If CMS believes specific services embed uncaptured efficiency, the appropriate response is to identify those services and refer them for review, not to reduce all non-time-based services simultaneously.

The methodology also distorts relativity, which is the fee schedule's foundational purpose. Reducing work RVUs and intra-service time for non-time-based services while leaving time-based services untouched changes the relationship between service families in a way unrelated to the relative resources they consume. Bypassing the RUC to accomplish this undermines the only systematic, transparent, clinician-informed valuation process available to CMS and discourages continued specialty investment in it.

D. Accreditation Already Performs the Function CMS Seeks

Echocardiography laboratories accredited by the Intersocietal Accreditation Commission (IAC) undergo a three-year reaccreditation cycle that requires current and functional equipment, credentialed sonographers and interpreting physicians, evidence-based imaging protocols, and documented comprehensive quality assurance programs with defined quality metrics. That three-year interval mirrors the review interval CMS has itself identified as appropriate. Accreditation is therefore an existing, rigorous, and auditable mechanism through which practice efficiency and quality are already verified. CMS should build on it rather than impose an undifferentiated reduction that ignores it.

> *ASE recommendation:* ASE encourages CMS to rescind the efficiency adjustment. If CMS retains the policy, ASE recommends that CMS consider:
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> 1. Exempting codes reviewed or revalued through the RUC within the past ten years.
> 2. Excluding newly established and revised CY 2027 codes developed using contemporary survey data.
> 3. Publishing specialty-specific evidence supporting any efficiency assumptions.
> 4. Continuing to use the RUC process to evaluate service-specific efficiency.
> 5. Recognize IAC accreditation as an existing mechanism that supports ongoing quality improvement and operational performance, rather than relying on broad reductions to physician work RVUs that are not tied to demonstrated service-specific efficiencies.

III. Determination of Practice Expense RVUs

A. What CMS Proposes

CMS proposes a multi-year transition away from AMA and RUC survey data toward what it describes as objective, routinely updated, and auditable cost data. The proposed rule would phase out the final step of the practice expense (PE) methodology that anchors specialty PE RVUs to 2007 Physician Practice Information Survey (PPIS) PE-per-hour data, replacing it with a PE stabilizer. Specifically, CMS proposes a two-year phase-in that removes methodology steps 12 through 17, the indirect practice expense cost index (IPCI): in year one CMS would apply half of the measured IPCI variation, and in year two the IPCI would be removed entirely.

CMS also proposes a new step 19, a PE stabilization factor that compares the step-18 result to the prior year's value and caps the year-over-year change at plus or minus 5%, with exemptions for new, revised, formerly contractor-priced, and revalued codes; reductions exceeding 20% would be phased over two years. Indirect PE for all services other than 10- and 90-day global services would be allocated using the sum of work and

clinical labor RVUs. In the facility setting, work RVUs would allocate indirect PE at one-half the non-facility amount. CMS also proposes to adjust the indirect PE allocation for visits furnished during a skilled nursing facility Part A stay.

ASE is deeply concerned with these substantial changes to the indirect PE methodology and urges CMS to withdraw the proposals until a more thoughtful and transparent alternative can be developed and proposed for consideration.

B. CMS Has Not Identified a Better Source of Specialty-Level Practice Cost Data

CMS has expressed concerns with the existing data, but it has not identified a superior source of specialty-level practice cost information. ASE has not taken a position on the use of the AMA's updated Physician Practice Information Survey or Consumer Price Index data, but ASE has strongly supported, and continues to support, the continued use of specialty society-derived data to ensure that the indirect costs of specialty physician practices are appropriately recognized. Removing the only specialty-level input currently in the methodology, without replacing it with a better specialty-level input, does not improve accuracy. It removes accuracy.

C. The Stabilization Factor Does Not Substitute for Specialty-Level Cost Data

The proposed stabilization factor is intended to moderate year-to-year changes in PE RVUs; however, several specialties could still experience meaningful payment shifts. ASE is concerned that the stabilizer does not address the underlying need for reliable specialty-level practice cost data currently reflected through the IPCI. Without such data, PE payments may become less closely aligned with differences in indirect costs across specialties.

The magnitude of the projected changes reinforces the need for caution. Analyses of the proposed IPCI removal show substantial increases and decreases across specialties, including increases of approximately 133% for clinical psychology, 85% for vascular surgery, and 73% for independent clinical laboratories, alongside decreases of approximately 20–25% for several other specialties. Changes of this scale warrant further evaluation of the underlying data and allocation methodology. While the ±5% stabilizer may help smooth implementation, it does not by itself resolve questions about whether the resulting values accurately reflect specialty-specific practice costs.

D. The Number, Pace, And Opacity of the Proposed Changes Prevent Meaningful Comment

More broadly, ASE is concerned with the number and pace of the changes CMS is proposing to the PE methodology and with the lack of transparency regarding their true impacts. Making multiple PE changes simultaneously makes it difficult for stakeholders to understand the impact of each proposal in isolation, how the policies interact, and what is ultimately driving significant shifts in payment across services and specialties. In a recent briefing, CMS declined requests for additional data that would allow stakeholders to better understand these effects, leaving significant unanswered questions and limiting the ability of the medical community to evaluate the proposals and comment meaningfully.

This is particularly concerning given CMS's stated priority of supporting independent physician practices, which could be further disadvantaged by significant changes to the allocation of indirect PE adopted without adequate data and analysis. Independent cardiology and cardiovascular imaging practices are precisely the practices least able to absorb an unexplained payment shift and least able to model one in advance.

E. Echocardiography's Practice Expense Profile is Capital- and Labor-Intensive

Echocardiography's indirect and direct cost structure is materially different from other office-based specialties whose data most heavily influence aggregate PE modeling. An echocardiography service line requires:

- credentialed cardiac sonographers, whose compensation has risen sharply amid a documented national workforce shortage;
- advanced ultrasound systems with three-dimensional, strain, and contrast capability, on replacement cycles of roughly five to seven years, plus annual service contracts;
- transesophageal probes requiring high-level disinfection equipment, tracking, and periodic replacement;
- PACS, cardiovascular information system, and structured reporting infrastructure, with associated interface, storage, and cybersecurity costs;
- ongoing sonographer and physician education to maintain credentialing; and

Any methodology that reallocates indirect PE without accounting for this profile will systematically misprice cardiovascular ultrasound. ASE is particularly concerned about the effect on rural hospitals, critical access hospitals, and safety-net facilities, where echocardiography volume is insufficient to absorb fixed equipment and staffing costs and where the loss of a service line means patients travel for basic cardiac diagnosis.

> *ASE recommendation*: ASE encourages CMS to delay implementation of the proposed CY 2027 indirect PE methodology changes while it identifies additional sources of specialty-level practice cost data and further evaluates the individual and cumulative impacts of the proposals. Any future methodology would benefit from transparent service- and specialty-level analyses, with underlying data presented in separate tables for each proposed change to allow stakeholders to assess the independent effects of each policy. ASE also encourages CMS to provide adequate time for stakeholder review, evaluate the methodology specifically for diagnostic imaging services, and continue incorporating specialty society-derived data where appropriate.

F. Specialty Assignment for Low-Volume Services

CMS proposes expected specialty assignments for low-volume services in Table A-B1 of the proposed rule and maintains a February 10 annual deadline for specialty society input. ASE appreciates the transparency of publishing proposed assignments and asks CMS to confirm that low-volume echocardiographic services, including congenital and fetal echocardiography codes, are assigned to cardiology or pediatric cardiology rather than to a specialty with a materially different cost structure. ASE requests that CMS provide the underlying utilization crosswalk for these assignments so societies can verify them within the February 10 window.

IV. Site-of-Service Payment Differential and the Request for Information on Hospital-Employed Physicians

A. What CMS Proposes and Asks

CMS continues the site-of-service payment differential adopted for CY 2026, under which indirect PE RVUs allocated per work RVU in the facility setting are half the non-facility amount, and issues a request for information (RFI) on how indirect PE varies by practice setting and employment arrangement. CMS asks (1) how PE costs vary for physicians practicing in facilities and by employment status, and what portion of indirect PE such as coding, billing, and scheduling attaches to the MPFS service rather than being reflected in the Outpatient Prospective Payment System (OPPS) payment; (2) what amount of indirect PE hospital-employed physicians incur in the facility, and whether the 50% indirect PE allocation is accurate or could be lower, "such as 0 percent"; and (3) whether a new HCPCS modifier identifying employed physicians would be a reasonable mechanism to identify and reduce facility PE.

CMS acknowledges in the proposed rule that stakeholders, including ASE, raised concerns that the differential fails to account for independent groups that provide hospital-based services while continuing to bear their

own overhead, and that the policy risks accelerating consolidation. CMS declined to modify the policy. ASE urges CMS to revisit that conclusion.

B. CMS's Assumption Does Not Describe How Cardiovascular Imaging Is Delivered

As ASE emphasized during the CY 2026 rulemaking, CMS's assumption that many facility-based physicians no longer maintain separate offices does not reflect the circumstances of many specialists, who continue to incur significant indirect practice expenses. This is the norm rather than the exception in cardiovascular care. Cardiologists routinely furnish services in hospitals and ambulatory surgical centers (ASCs) while also owning and maintaining independent practices where they evaluate patients for other conditions, conduct follow-up and post-operative visits, and perform office-based imaging. The same physician may read a transesophageal echocardiogram in a hospital in the morning and see patients in an independently owned office in the afternoon. To date CMS has not demonstrated that these specialists have lower indirect practice costs.

Interpreting an echocardiogram performed in a hospital outpatient department requires the interpreting practice to maintain:

- professional coding and billing operations, including denial management and audit response;
- reading workstations, viewing software licenses, and structured reporting systems, frequently distinct from the hospital's;
- remote and secure access infrastructure, including cybersecurity and business associate compliance;
- professional liability coverage for interpretation;
- credentialing, licensure, continuing medical education, and maintenance of certification;
- internal peer review, quality assurance, and appropriate use criteria compliance; and
- administrative staff for scheduling coordination, prior authorization, and results communication.

None of these costs are paid through the OPPS technical payment, which compensates the hospital for the facility resources used to perform the study. Setting facility indirect PE to zero would pay the professional component as though it were costless to produce, and ASE regards a 0% allocation as indefensible on the present record.

C. The Policy Accelerates the Consolidation CMS Says it Wants to Prevent

At a time when independent specialty practices already face significant pressure to consolidate or to be acquired by hospitals, health systems, or private equity, this policy serves only to accelerate those changes. That outcome runs directly counter to CMS's stated objective of supporting independent physician practices. In cardiovascular imaging, consolidation has predictable consequences: services migrate to the hospital outpatient department, total program cost per study rises, and beneficiary cost-sharing increases.

D. Refinements Should Distinguish Practice Arrangements, Not Merely Employment Status

ASE supports CMS's solicitation of additional information and encourages CMS to consider refinements that better account for differences in practice and employment arrangements without disadvantaging independent physician practices. ASE does not object in principle to a HCPCS modifier that identifies hospital-employed physicians, provided the modifier is used to identify practice arrangements accurately so that independent practices bearing their own overhead are protected, rather than solely as a mechanism to reduce payment.

ASE cautions, however, that employment status alone is an imperfect proxy for who bears indirect practice cost. Cardiovascular imaging is delivered under a wide range of arrangements: hospital employment; independent groups under professional services agreements; academic faculty practice plans; multispecialty groups with hospital-based imaging contracts; remote interpretation arrangements; and hybrid models in which the same physician reads studies in an office one day and a hospital outpatient department the next. Any modifier must therefore come with clear, publicly available reporting instructions, must not create audit

or denial exposure for practices operating in good faith under hybrid arrangements, and must not be implemented before CMS has data establishing what allocation the modifier is meant to support.

> *ASE recommendation*: Do not adopt any further reduction of facility indirect PE, and expressly reject a 0% allocation. If CMS pursues a HCPCS modifier for hospital-employed physicians, it should be adopted for the purpose of accurately identifying practice and employment arrangements and protecting independent practices that furnish professional services in facility settings while bearing their own overhead, not as a payment-reduction device, and CMS should defer any payment consequence until it has commissioned and analyzed a stratified specialty-level cost survey. ASE is prepared to work with CMS and other cardiovascular organizations to design and field such a survey, including for interpretation-only arrangements that current data sources capture poorly.

V. Request for Information: Reduction of Duplicate Laboratory Testing and Imaging, and Result Sharing

A. What CMS Asks

CMS seeks comment on reducing duplicative laboratory testing and imaging, citing siloed results, delayed care, avoidable program cost, and unnecessary radiation exposure. Options under consideration include clarified billing instructions to laboratories and imaging centers regarding duplicate-test parameters; local MAC edits producing nonpayment or reduced payment for duplicates; payment integrity levers to recoup payments from providers who performed duplicative tests; and frequency limitations on certain tests. CMS also asks about clinical exceptions, whether duplication should be defined by timeframe or limited to certain services, incentives for imaging and laboratory interoperability standards, conformance testing and certification, accountability for providers who fail to share results, and possible minimum data-sharing requirements using Fast Healthcare Interoperability Resources (FHIR) and PDF/A as a condition of Medicare payment. CMS notes fragmented imaging exchange, limited application programming interfaces, patient-matching difficulty, and continued reliance on CDs and DVDs.

B. ASE Shares the Objective and Supports the Interoperability Agenda

ASE strongly supports eliminating genuinely unnecessary repeat imaging. Echocardiography involves no ionizing radiation, but avoidable repeat studies still consume sonographer capacity, delay diagnosis, increase beneficiary cost-sharing, and burden the program. The root cause is almost always the inability to obtain a prior study and its report at the point of care, not physician preference.

ASE therefore supports the interoperability options in the RFI and urges CMS to prioritize them. ASE has invested substantially in structured echocardiographic reporting and in the ImageGuideEcho Registry, and can advise CMS on the data elements that make a prior echocardiogram clinically usable rather than merely retrievable. Priority interoperability actions ASE supports include:

- standards-based imaging exchange as a condition of participation for facilities furnishing advanced imaging, so that DICOM image objects and structured reports are accessible without physical media;
- FHIR-based access to imaging reports and to discrete measurement data, not merely to a static document;
- conformance testing and certification for imaging exchange, so that nominal compliance is verified in practice; and
- defined transition timelines to retire dependence on CDs and DVDs.

C. Payment Denial, Recoupment, and Frequency Limits are the Wrong Tools
ASE strongly opposes the enforcement-oriented options. Each would penalize clinicians for information failures they cannot control and would harm beneficiaries.

First, retrospective recoupment from the provider who performed a study is fundamentally unfair. A sonographer and interpreting physician who perform a medically appropriate study at the request of a treating clinician have no reliable way to know that a comparable study was performed elsewhere and never shared. Recoupment would transfer the cost of a national interoperability failure onto the imaging practice.

Second, local MAC edits producing nonpayment or reduced payment would create inconsistent national policy, exactly the fragmentation CMS has worked to reduce elsewhere. Contractor-level duplicate edits would differ in lookback period, code sets, and exception handling, so identical clinical circumstances would be paid differently in different jurisdictions.

Third, and most consequentially, frequency limitations are clinically unsound for echocardiography. Serial echocardiography is not duplication; it is the standard of care in numerous defined circumstances, including:

- titration and reassessment of guideline-directed medical therapy in heart failure, where change in left ventricular ejection fraction determines candidacy for device therapy;
- surveillance of valvular heart disease, where interval change in severity determines timing of intervention;
- cardio-oncology surveillance during and after potentially cardiotoxic therapy;
- suspected or confirmed infective endocarditis, where repeat studies detect vegetation progression, abscess, and valve destruction;
- post-procedural assessment following valve repair or replacement, transcatheter intervention, or device implantation;
- acute clinical deterioration, hemodynamic instability, new murmur, arrhythmia, stroke, or suspected pulmonary embolism; and
- pre-operative and peri-procedural assessment when clinical status has changed.

A frequency limit expressed as a fixed interval, however generous, will deny medically necessary studies in these situations and will do so disproportionately for the sickest beneficiaries. If CMS nonetheless pursues frequency parameters, they must be built from clinical society guidelines and appropriate use criteria, must include the exceptions above, must apply prospectively with clear documentation pathways rather than through retrospective denial, and must be tested against real-world claims and clinical data before implementation.

D. Accreditation is a Constructive Alternative
The cardiovascular community, including ASE, has long supported accreditation as a meaningful framework for promoting appropriate, high-quality echocardiographic imaging. Accreditation programs establish standards for laboratory operations, personnel qualifications, imaging protocols, quality assurance, and ongoing performance improvement. Rather than relying on additional appropriate use criteria requirements or denial-based mechanisms, CMS should build on these existing accreditation structures and improve access to prior imaging results through interoperable data exchange.

> *ASE recommendation*: Prioritize interoperability requirements, including standards-based imaging exchange, FHIR-based access to imaging reports and discrete measurements, and conformance testing. CMS should avoid retrospective recoupment, local MAC duplicate-payment edits, or fixed frequency limitations for echocardiography, and instead recognize accreditation and specialty-developed quality standards as important safeguards against unnecessary or duplicative imaging. Any

future duplication policy should be prospective, clinically grounded, developed with specialty societies, and include appropriate exceptions for medically necessary serial imaging.

VI. Software as a Medical Service (SaMS) and Artificial Intelligence

A. What CMS Proposes

CMS proposes to retire the term "Software as a Service" in favor of "Software as a Medical Service" (SaMS), defined as software-based technologies that support clinical decision-making through algorithmic analysis, distinguished from prescription digital therapeutics and remote monitoring technologies, and distinct from FDA's "Software as a Medical Device" (SaMD) construct.

Under the MPFS, CMS proposes to remove ten HCPCS codes for algorithmic analyses of laboratory tests from the Clinical Laboratory Fee Schedule (CLFS) and to price them by contractor under the MPFS, with all future SaMS-on-laboratory codes contractor priced, and seeks comment on additional codes for similar treatment. In the companion CY 2027 OPPS proposed rule, CMS establishes an interim SaMS payment policy that designates 36 HCPCS codes as SaMS in Table 61, reassigns 21 of them from clinical ambulatory payment classifications (APCs) to New Technology APCs with rate continuity, moves the ten laboratory-based SaMS codes to New Technology APCs, and creates a new status indicator "O1" with the same specifications as status indicator "S," while asking whether status indicator "T," which applies multiple procedure discounting, would be preferable.

CMS also asks whether AI companies could furnish Annual Wellness Visits, whether to create new technology-enabled care management codes, and proposes a new incentive rewarding clinicians' responsible use of AI, which would require maintaining organizational policies governing how AI-enabled tools are evaluated, deployed, and monitored, or helping to create or pilot such tools.

B. Terminology and Taxonomy

ASE supports a clearer term than "Software as a Service," which described a commercial delivery model rather than a clinical function. However, "Software as a Medical Service" is close enough to FDA's "Software as a Medical Device" to invite confusion in a field where the distinction between a regulated device and a payable service matters greatly. ASE asks CMS to state expressly in the final rule that the SaMS designation is a payment classification and carries no implication regarding FDA regulatory status, and to publish and maintain the SaMS code list in a single, publicly accessible location updated with each rulemaking cycle.

More important than the label is the analytic framework. ASE has consistently urged CMS to adopt the AMA CPT taxonomy that classifies AI-enabled services as assistive, augmentative, or autonomous, and to establish distinct valuation and payment pathways for each category. That taxonomy maps directly onto the resource question the fee schedule must answer, because the three categories differ precisely in how much physician work remains. In echocardiography, nearly all current AI functions, including automated border detection, chamber quantification, strain calculation, view classification, and image quality feedback, are assistive or augmentative. The interpreting physician remains fully responsible for verifying every automated measurement, reconciling discrepancies, and rendering the diagnosis. These tools do not reduce physician work; they add a verification and oversight obligation on top of it. This is the same point ASE makes about the efficiency adjustment in Section II, and CMS should not adopt one position on AI for valuation purposes and the opposite position for efficiency purposes.

C. FDA Clearance Should be a Precondition of Payment

ASE reiterates its position that CMS should not pay for a SaMS product that has not been cleared or approved by FDA for the clinical use being billed, and should not pay for use outside the cleared indication. Medicare

payment confers de facto legitimacy on a technology. Paying for uncleared algorithmic analysis would place beneficiaries at risk and would encourage market entry ahead of validation. ASE further urges CMS to require, as a condition of payment, that the algorithm's intended population and validation population be disclosed, so that clinicians can identify performance gaps in populations underrepresented in validation data.

D. Contractor Pricing is Not a Payment Policy

Moving the ten laboratory-based algorithmic analysis codes to contractor pricing under the MPFS has three consequences CMS should address directly. First, it produces geographic payment variation for an identical software output, since a cloud-based algorithm does not vary by jurisdiction. Second, it attaches beneficiary cost-sharing where none previously applied under the CLFS. Third, it draws these services into MPFS budget neutrality, so that adoption of software services reduces payment for physician work across the entire fee schedule.

That third consequence is the one ASE has raised most persistently, and it is the same redistribution problem described in Section I.C. Clinical software is infrastructure. It is capital, licensing, and computing cost, not physician work. Funding these services from the same budget-neutral pool that supports physician work means that each increment of software adoption can reduce payment for the clinicians who must supervise its use, interpret and validate its outputs, integrate those outputs into clinical decision-making, and ultimately assume the associated medical, legal, professional liability, and ethical responsibility for patient care.

If CMS retains contractor pricing on an interim basis, it should at minimum publish the pricing methodology and resulting rates, require MACs to post rates on a common schedule, commit to a defined transition to national pricing, and report utilization annually so stakeholders can evaluate the budget neutrality effect. Additionally, we encourage CMS to recognize in regulation that responsibility for software-enabled care should be appropriately shared between physicians and software manufacturers, with clinicians accountable for clinical decision-making and manufacturers accountable for the safety, performance, and reliability of their products.

E. OPPS status indicator and New Technology APC treatment

ASE supports the use of New Technology APCs with rate continuity as an interim measure and supports the new status indicator "O1" modeled on status indicator "S." ASE opposes assigning SaMS codes to status indicator "T." Multiple procedure discounting reflects efficiencies achieved when procedures share pre-service and post-service work and operative resources. No such efficiency exists for software analyses, where the marginal cost of a second distinct algorithmic analysis is essentially independent of the first. Applying "T" would systematically underpay multi-algorithm workflows, which are increasingly common in cardiovascular imaging.

F. AI Should Not Furnish Annual Wellness Visits

ASE opposes any policy permitting an AI company to furnish an Annual Wellness Visit. The visit's value lies in clinical judgment, longitudinal relationship, physical assessment, and individualized counseling. Substituting an algorithmic interaction would not deliver the statutory benefit. To the extent CMS is interested in technology-enabled care management, ASE would engage constructively on codes that describe clinician-supervised use of technology, provided the physician work of oversight, verification, and clinical response is recognized and valued. ASE is willing to comment further on the proposed responsible-AI-use incentive and asks that any such incentive be achievable by small and independent practices that adopt vendor-supplied tools rather than developing their own.

> *ASE recommendation*: ASE recommends that CMS clarify SaMS as a payment classification, require FDA clearance or approval for the billed indication, and use the AMA CPT AI taxonomy to inform valuation and physician oversight. CMS should avoid creating additional MPFS budget-neutrality

pressure by pursuing a more consistent national payment pathway for clinical software and, if contractor pricing continues, publish methodologies and rates. Under OPPS, ASE supports New Technology APC placement and status indicator O1 rather than T and opposes AI companies furnishing Annual Wellness Visits.

VII. Ambulatory Specialty Model

A. What CMS Proposes

The Ambulatory Specialty Model (ASM) is a mandatory model under section 1115A of the Social Security Act with five performance years running from January 1, 2027 through December 31, 2031, targeting heart failure and low back pain. Payment adjustments apply two years after the performance year to all Part B covered professional services furnished by the participant, beginning at plus or minus 9% for the 2029 payment year based on 2027 performance and growing to plus or minus 12% by 2033. General cardiology is included; cardiac electrophysiology is excluded.

For CY 2027 CMS proposes to define "ASM beneficiary," "dual eligible proportion," and a new "rural area" definition aligned to the MIPS definition at 42 C.F.R. § 414.1305; eliminate any right of voluntary withdrawal while adding CMS termination authority for program integrity, patient safety, and compliance failures; expand taxpayer identification number (TIN) change exceptions; provide that the payment multiplier follows the national provider identifier (NPI) to a new TIN; establish a permanent specialty redesignation exception for heart failure participants who move to cardiac electrophysiology, cardiac surgery, interventional cardiology, advanced heart failure and transplant cardiology, or adult congenital heart disease; limit the safe harbor and MIPS waiver to active performance periods; allow small practices of 15 or fewer clinicians to submit quality at the group level; add a claims-based lumbar magnetic resonance imaging overuse measure for low back pain; score administrative claims-based measures at the TIN/NPI level; remove un-benchmarkable measures from the numerator and denominator rather than scoring them zero; award five bonus quality points for voluntary patient-reported outcome measure submission and five final score points for rural participants; make electronic prior authorization optional in 2027 and mandatory in 2028; and substantially revise collaborative care arrangement requirements.

B. The Model Measures Heart Failure Care While Ignoring the Imaging That Defines it

ASE's central concern with the ASM is clinical rather than administrative. Heart failure cannot be diagnosed, phenotyped, or managed without echocardiography. Left ventricular ejection fraction determines whether a patient has heart failure with reduced, mildly reduced, or preserved ejection fraction, and therefore which guideline-directed therapies apply. Echocardiography identifies the valvular, infiltrative, hypertrophic, and pericardial etiologies that require entirely different management. Serial echocardiography determines whether ejection fraction has recovered on therapy or whether the patient now meets criteria for device therapy or advanced therapies. Every process and outcome measure in a heart failure model depends on an accurate echocardiogram having been performed, interpreted, and reported.

Yet the ASM contains no measure of the quality, completeness, or timeliness of the diagnostic imaging on which it rests. A participant can score well on pharmacotherapy measures while relying on incomplete or unquantified echocardiographic assessment. Conversely, a participant who invests in comprehensive, guideline-concordant, quantitatively complete echocardiography receives no credit for it. This is a significant gap, and it is readily fixable: ASE has already developed and validated echocardiography measures suited to exactly this purpose, described in Section VIII.

ASE recommendation: Consider incorporating echocardiography-based diagnostic quality measures into the heart failure condition in the ASM, including measures addressing quantified ejection fraction, wall

motion, and assessment of left ventricular structure and systolic function. As appropriate, future ASE ImageGuideEcho Registry measures could help inform this work. ASE would welcome the opportunity to collaborate with CMS and CMMI on measure development, specification, and testing

C. The Payment Adjustment is Too Large, Too Soon, and Applied Too Broadly

A plus or minus 9% adjustment applied to all Part B professional services, escalating to plus or minus 12%, is among the largest performance-based adjustments in Medicare, and it is mandatory. Because the adjustment applies to all of a participant's Part B professional services and not only to services furnished to the model's beneficiary population, a cardiologist's entire Medicare professional revenue is placed at risk based on performance in one condition. Combined with the CY 2027 conversion factor reduction, the retained efficiency adjustment, an unvalidated practice expense methodology, and the proposed same-day E/M reduction addressed in Section IX.C, the aggregate exposure for a cardiology practice in the model's first performance year is substantial.

ASE also notes that performance year 2027 begins on January 1, 2027, roughly six weeks after the final rule is expected to publish. That is not enough time for practices to build the data infrastructure, workflow changes, and collaborative care arrangements the model contemplates.

ASE recommendation: Delay the first performance year, or designate performance year 2027 as a reporting-only year with no payment consequence. Reduce the initial payment adjustment below plus or minus 9% and slow the escalation schedule. Limit the adjustment to services furnished to the model's attributed beneficiary population rather than all Part B professional services.

D. Specific Technical Comments

- **Elimination of voluntary withdrawal:** ASE opposes removing any withdrawal right from a mandatory model with a payment adjustment of this magnitude. At minimum CMS should permit withdrawal on demonstrated hardship, including practice closure, workforce loss, natural disaster, or material change in practice composition.
- **Payment multiplier following the NPI**: Attaching the multiplier to the NPI on movement to a new TIN creates significant consequences for physician recruitment, acquisitions, and employment transitions, and may make clinicians with an unfavorable multiplier less employable through no fault of the acquiring practice. CMS should provide that the multiplier does not transfer where the clinician moves to a TIN that was not a model participant or should apply it only prospectively from the date of transfer.
- **Specialty redesignation exception:** ASE supports the permanent redesignation exception for heart failure participants who move to the listed cardiovascular subspecialties, but the list omits non-invasive cardiovascular imaging. A general cardiologist who transitions to a dedicated echocardiography or advanced cardiac imaging practice no longer manages heart failure longitudinally and should be eligible for redesignation on the same terms.
- **Safe harbor and MIPS waiver availability:** Limiting the fraud and abuse safe harbor and the MIPS waiver to active performance periods creates gaps at model transitions. CMS should extend both through any wind-down and reconciliation period.
- **Rural bonus and rural definition:** ASE supports the five-point rural bonus and alignment of the rural definition to 42 C.F.R. § 414.1305 and asks CMS to confirm that practices serving rural beneficiaries from a non-rural site are considered for comparable adjustment, since echocardiography is frequently interpreted remotely for rural facilities.

- **Small practice group submission:** ASE supports permitting practices of 15 or fewer clinicians to submit quality data at the group level and to report improvement activities at either the TIN or TIN/NPI level.
- **Un-benchmarkable measures:** ASE strongly supports removing un-benchmarkable measures from the numerator and denominator rather than assigning zero points. This corrects a longstanding inequity for specialties with limited measure availability and should be applied consistently across the Quality Payment Program, as discussed in Section VIII.
- **Patient-reported outcome bonus:** ASE supports the five-point bonus for voluntary patient-reported outcome measure submission and encourages CMS to include heart-failure-specific instruments that capture functional status change, which correlates with echocardiographic findings.
- **Electronic prior authorization:** ASE does not object to optional electronic prior authorization in 2027 but urges CMS to confirm before making it mandatory in 2028 that certified capability is widely available and that failure attributable to vendor readiness will not be penalized.
- **Collaborative care arrangements:** ASE supports broadening permissible counterparties and asks CMS to confirm that arrangements with hospital-based and independent echocardiography laboratories qualify, so that participants can align on diagnostic quality and turnaround.

VIII. Quality Payment Program

A. What CMS Proposes

CMS proposes that beginning with the CY 2029 performance period, all MIPS eligible clinicians other than those reporting through the APM Performance Pathway (APP) must report through an MVP, sunsetting traditional MIPS after the CY 2028 performance period and 2030 payment year. CMS proposes three new MVPs for CY 2027, addressing diabetic disease, hospitalist care, and hypertension, and modifies all 27 existing MVPs to incorporate core measures. Virtual groups could report MVPs beginning in CY 2029.

Beginning with the CY 2027 performance period, CMS proposes to remove the current requirement to report one outcome measure, or one high-priority measure where an outcome measure is unavailable, and to replace it with a requirement to report at least one designated "MIPS core measure" as one of the four required measures in an MVP or one of the six required measures in traditional MIPS. CMS proposes to designate 78 measures in the inventory as core, including a minimum of three core measures per MVP. Selection would be based on whether the measure is outcome-based; collection type availability and the clinician's ability to meet reporting requirements, with CMS proposing not to designate any QCDR measures as core so that core measures are broadly available; measure adoption and current and historic performance rates; and whether the measure is most reflective of the care central to the MVP's clinical focus. Clinicians without an available and applicable core measure could attest during the submission period and report another measure; small practices would be exempt from the requirement and from the attestation; and topped-out core measures would be exempt from the seven-point scoring cap and eligible for up to ten achievement points under the defined topped-out measure benchmark.

The quality inventory would comprise 180 measures, with 20 removals and 10 additions for CY 2027, one addition for CY 2028, and 43 substantive changes. Of specific relevance to cardiovascular care, CMS proposes to add an LDL-C monitoring and management measure stewarded by the American Heart Association and to remove three cardiology measures, addressing antiplatelet therapy in coronary artery disease, beta-blocker therapy in coronary artery disease, and chronic anticoagulation in atrial fibrillation, beginning in CY 2027 because the measures have been retired by their steward.

B. ASE Opposes a Fixed Date for Mandatory MVP Reporting

ASE strongly opposes setting a fixed date to transition to mandatory MVP reporting because of unresolved challenges with the MVP framework and with MIPS generally. As CMS works with stakeholders to resolve these issues, ASE urges CMS to maintain MVPs as a voluntary pathway alongside traditional MIPS, so that clinicians retain a choice of reporting pathway that best reflects their patient populations and practice needs.

ASE appreciates and supports the goals of the MVP pathway, which are to provide a set of clinically relevant measures and activities that better reflect clinicians' scope of care while simplifying the program, minimizing reporting burden, and improving comparability of performance data. But full implementation of MVPs requires that all specialties be able to participate meaningfully, and ASE does not believe MVPs are a significant enough departure from traditional MIPS to achieve that level of participation.

C. The MVP Framework Inherits the Measure Gaps and Scoring Problems of Traditional MIPS

The MVP pathway is hampered by its reliance on the existing MIPS measure inventory, which still suffers from major gaps in specialty-specific measures. Specialty-specific measures remain inaccessible for several reasons:

- the resource-intensive process of developing measures, obtaining CMS approval, and stewarding measures over time;
- the historic removal or rejection of specialty-specific measures from the program;
- scoring policies that cap achievement points regardless of performance because a measure is topped out or lacks a benchmark; and
- unnecessarily rigid QCDR requirements, which have caused many specialties with robust registries to leave the program.

This issue remains relevant to ASE because specialty-specific quality measurement often depends on clinical registries and other data infrastructure that require substantial investment to develop and maintain. Although the ImageGuideEcho Registry is not currently participating as a QCDR, ASE has in the past and could again elect to pursue QCDR status in the future. ASE's experience nonetheless underscores the challenges specialty organizations face when program requirements increase in cost and administrative complexity without providing clear, sustainable pathways for specialty-developed measures to satisfy MIPS requirements.

As a result, specialists may have little option but to report measures of limited relevance to their practice rather than measures that meaningfully reflect the care they provide. While ASE appreciates that MVPs require reporting on fewer quality measures than traditional MIPS, the more limited measure set does not resolve underlying specialty measure gaps and may further restrict meaningful reporting options.

MVPs also retain the siloed structure of the four MIPS performance categories and provide limited recognition for broader investments in quality infrastructure. Echocardiography practices engage in accreditation, structured quality improvement, quantitative imaging, peer review, and performance assessment, yet receive little or no credit for these activities across MIPS categories. CMS should consider ways to recognize these comprehensive quality investments, including IAC accreditation and other specialty-led quality improvement activities.

The MVP framework also retains scoring policies that can disadvantage specialists regardless of performance. ASE appreciates recent efforts to mitigate the effects of scoring caps and limited benchmarks, but these protections remain narrow. CMS should continue to address scoring policies that limit specialists' ability to succeed when clinically relevant measures are unavailable, topped out, or lack reliable benchmarks.

D. CMS Must Invest in Specialty Measure Development Before Sunsetting MIPS

Before CMS can move forward with sunsetting MIPS and transitioning to MVPs, there is an urgent need for additional policies, funding, and technical support to incentivize the development and use of additional, more meaningful specialty-specific measures. Investing in these resources would produce more meaningful quality information for patient and clinician decision-making, ensure the availability of enough quality measures to align with the growing number of episode-based cost measures, and give clinicians a genuine opportunity to succeed in CMS quality programs beyond MIPS, including APMs.

There is a misconception that the large measure inventory is what makes MIPS complex and burdensome. In fact, most specialists feel hampered by the lack of measures that meaningfully represent their patient population and would welcome additional measures to choose from. CMS has allocated extensive resources to the development and refinement of episode-based cost measures and should devote a comparable level of resources to developing and refining quality measures so that every MIPS eligible clinician has appropriate measures to report.

> *ASE recommendation*: Do not set a fixed date to sunset traditional MIPS. Preserve MVPs as a voluntary pathway alongside traditional MIPS while CMS works with clinical stakeholders and Congress to fundamentally improve the program. Before finalizing any sunset date, publish an analysis identifying specialties and subspecialties without an applicable MVP, together with a funded plan for closing each gap, and dedicate resources to specialty quality measure development comparable to those dedicated to episode-based cost measures.

E. Echocardiography Has No Quality Measures, No Core Measure, and No MVP

ASE's most urgent comment on this rule is the following. The Quality Payment Program contains no echocardiography-specific quality measure. It never has. As CMS now proposes to make MVP reporting the only pathway and core measure reporting mandatory, that absence stops being an inconvenience and becomes a structural exclusion.

The only echocardiography-adjacent measures in the MIPS inventory are the cardiac stress imaging appropriate use measures, numbers 322, 323, and 324, which address preoperative evaluation in low-risk surgery, routine testing after percutaneous coronary intervention, and testing in asymptomatic low-risk patients.[1] All three are overuse or "do not do" measures whose denominators span single-photon emission computed tomography myocardial perfusion imaging, stress echocardiography including CPT codes 93350 and 93351, coronary computed tomography angiography, and cardiac magnetic resonance. None of them measures the quality, completeness, or diagnostic accuracy of an echocardiographic examination. A clinician can achieve a perfect score on all three without any assessment of whether the echocardiograms performed were technically adequate, quantitatively complete, or guideline-concordant.

The MVP landscape is no better. The Advancing Care for Heart Disease MVP, MVP identifier G0055, whose most applicable specialties are cardiology, internal medicine, and family medicine, contains no echocardiography measure and no cardiac imaging measure of any kind. Its measure set consists of pharmacotherapy, process, and outcome measures.[2] There is no cardiovascular imaging MVP and no echocardiography subgroup pathway.

The consequences for an echocardiography-focused clinician under the proposed framework are as follows:

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[1] CMS, MIPS Quality Measure #322 specification (Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk Surgery Patients), https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2022_Measure_322_MIPSCQM.pdf

[2] CMS Quality Payment Program, "Explore MVPs", https://qpp.cms.gov/reporting-requirements/measures-activities/explore-mvps

- **No applicable MVP exists:** When traditional MIPS sunsets after CY 2028, clinicians whose practice is predominantly echocardiographic interpretation will be required to report through an MVP that does not measure what they do.
- **No applicable core measure exists:** Beginning in CY 2027 these clinicians will be forced to attest that no applicable core measure exists, an accurate attestation that nonetheless documents their exclusion from meaningful quality measurement, and the small practice exemption will not reach the many echocardiographers in larger groups and health systems.
- **The exclusion of QCDR measures from core designation forecloses the obvious remedy:** CMS proposes not to designate any QCDR measure as core. Because the only validated echocardiography measures in existence are QCDR measures, this proposal guarantees that no echocardiography measure can ever be a core measure unless CMS also brings those measures into the MIPS inventory.
- **Scoring is driven by measures unrelated to their work:** Clinicians will be scored on pharmacotherapy and chronic disease management measures for patients whose care they do not longitudinally manage or will report overuse measures that cannot demonstrate quality performance.
- **Payment adjustments will not reflect quality:** The result is a payment adjustment, in a program whose statutory purpose is to reward quality, that is unrelated to the quality of the care actually furnished.

F. The MIPS Core Measure Proposal

ASE supports CMS's proposal to remove the current requirement to report one outcome or high-priority measure. That requirement is especially problematic in the context of mandatory MVPs, where clinicians face a more limited selection of measures and may be unable to identify a relevant outcome or high-priority measure. In that situation the requirement simply increases administrative burden by forcing clinicians to report measures of limited applicability rather than measures that truly matter to their patients.

ASE has concerns about the core measure proposal, however, because it would likewise box clinicians into reporting specific measures and would add another layer of complexity at a time when CMS is trying to streamline the program. Ideally clinicians should have the flexibility to choose measures most relevant to their practice. ASE appreciates that CMS is trying to increase reporting on measures that are most important to clinicians and patients and that reflect care central to a specialty, condition, or episode. But CMS can accomplish that through other strategies: incentivizing the development and adoption of new measures; extending the seven- and five-point scoring floors to all measures that lack a benchmark rather than only measures new to the program; and removing the topped-out scoring cap from all MIPS measures rather than only selected ones.

The topped-out scoring cap disadvantages clinicians who sustain high-quality care over time and limits scoring potential for reasons unrelated to performance. ASE appreciates CMS's recent updates to the topped-out measure policy but exempting some measures from the cap and not others is arbitrary and confusing. Applying these favorable scoring policies more universally would incentivize more frequent use of topped-out and non-benchmarked measures, expand the population of reporters, help build more accurate and representative benchmarks, and potentially demonstrate that performance on some measures is not truly as high as perceived.

If CMS moves forward with the core measure proposal, it is critical that CMS also adopt the following policies:

- permit clinicians to attest to not having an available, relevant core measure, as proposed;
- exempt small practices from the core measure requirement, as proposed;
- exempt all core measures from the seven-point topped-out scoring cap and make them eligible for up to ten points under the defined topped-out measure benchmark, as proposed;

- confirm that an accurate attestation carries no scoring penalty, so that a clinician who correctly attests that no applicable core measure exists is not assigned zero achievement points for a CMS inventory gap; and
- before finalizing, consult with affected specialties to determine which measures should be classified as core, and confirm that registry and electronic health record vendors are ready to support them. ASE is concerned that CMS made decisions about which measures should be classified as core without consulting the specialty societies affected by each MVP. These decisions should be made transparently and with the input of specialty-specific experts.
- reconsider the proposal to exclude QCDR measures from core designation, or in the alternative adopt validated specialty registry measures into the MIPS inventory so that they become eligible.

G. Recommendations on Echocardiography Quality Measurement

ASE recommendation: Establish a cardiovascular imaging MVP, or a defined echocardiography subgroup reporting pathway, so that clinicians whose practice is predominantly cardiovascular diagnostic imaging have a pathway that measures their actual work.

ASE recommendation: Recognize IAC echocardiography laboratory accreditation as a qualifying MIPS improvement activity and as an important component of future imaging quality assessment, while also considering opportunities to provide broader credit for participation in physician-led clinical registries, including ImageGuideEcho, as those capabilities evolve.

ASE recommendation: Hold clinicians harmless where no applicable core measure or applicable MVP exists, by excluding the affected measure or category from the denominator rather than assigning zero points, consistent with the approach CMS proposes for un-benchmarkable measures in the Ambulatory Specialty Model.

H. Additional Quality Payment Program Comments

- **Cardiology measure removals:** ASE does not object to removing measures retired by their steward, but the net effect is fewer cardiovascular measures at the moment MVP reporting becomes mandatory. CMS should pair each removal with a replacement addressing the same clinical domain and should treat the cardiovascular measure inventory as a priority gap.
- **Topped-out measure scoring:** ASE supports exempting measures topped out for two or more consecutive years from the seven-point cap and scoring them on a one-to-ten topped-out benchmark and urges CMS to extend that treatment to all MIPS measures rather than a selected subset.
- **Security Risk Analysis removal:** ASE supports removing the Security Risk Analysis measure from the Promoting Interoperability category as duplicative of existing HIPAA Security Rule obligations.
- **Electronic prior authorization measures:** ASE urges caution in making electronic prior authorization required for CY 2028 with failure resulting in a zero score for the entire Promoting Interoperability category. That is a severe consequence for a capability dependent on vendor and payer readiness outside the clinician's control. CMS should provide a hardship exception and confirm vendor availability before finalizing.
- **CEHRT alignment to HTI-5:** ASE asks CMS to confirm that removal of 34 certification criteria will not eliminate imaging-relevant interoperability capabilities, particularly given the imaging exchange concerns raised in the duplicate testing RFI discussed in Section V.
- **FHIR-based digital quality measurement RFI:** ASE supports the long-term move to digital quality measurement and supports FHIR as the standard but urges a longer runway than a two-year transition beginning in CY 2028 with mandatory adoption in CY 2030. Imaging measures depend on

discrete data elements that are not yet consistently captured in FHIR resources. ASE offers its structured reporting and registry experience to help define the imaging data elements required.

- **Third-party intermediary requirements:** The proposal to require QCDRs and qualified registries to support at least six quality measures, including at least one MIPS core measure, may create challenges for specialty-focused registries serving areas where no applicable core measure exists. This is particularly relevant to echocardiography, where CMS has not identified an echocardiography-specific core measure and proposes that QCDR measures not be eligible for core designation. Although ImageGuideEcho is not currently participating as a QCDR, ASE could elect to pursue QCDR status in the future, and the proposed requirements could limit the viability of such specialty-focused participation. CMS should therefore consider developing applicable echocardiography core measures or providing an exception for registries serving clinician populations without a relevant core measure. ASE also encourages CMS to reconsider requiring intermediaries with fewer than ten participants to audit all participants, as this may impose disproportionate administrative and financial burden on smaller specialty registries.
- **MVP scoring normalization RFI:** ASE supports exploring score normalization within each MVP. Without normalization, clinicians reporting MVPs with few or difficult measures are disadvantaged relative to those with large, favorable measure sets. Normalization should occur at the performance category level so that the source of any disadvantage is transparent.
- **QP determination at the TIN/NPI level:** ASE supports applying qualifying and partial qualifying APM participant status at the TIN/NPI level rather than the NPI level, which better reflects the practice context in which clinicians actually participate.

IX. Requests for Information

A. Request for Information on Redesigning Primary Care

CMS seeks input on reconsidering the relative payment for primary care services under the MPFS, the role of technology-enabled primary care, and the establishment of prospective primary care payment within the Medicare Shared Savings Program and potentially more broadly across Original Medicare.

ASE recognizes the importance of strengthening primary care and improving prevention, early diagnosis, care coordination, and chronic disease management. ASE disagrees, however, with any approach that would strengthen primary care by shifting limited fee schedule resources away from specialty medicine, or that presumes primary care clinicians are the exclusive source of longitudinal, coordinated care.

Many Medicare beneficiaries with serious, chronic, or complex conditions rely on specialists to diagnose and manage their conditions over many years. Specialists develop and modify treatment plans, manage high-risk medications, monitor disease progression, coordinate care, and prevent complications and costly downstream care. In cardiovascular care this is the norm: a patient with severe aortic stenosis under echocardiographic surveillance, a patient with hypertrophic or infiltrative cardiomyopathy, a patient receiving cardio-oncology surveillance during cancer therapy, and a patient with heart failure undergoing serial assessment of ejection fraction are all in longitudinal, imaging-guided specialty care. Increasing payment for one category of clinicians through reductions to others does not address the underlying inadequacy of Medicare physician payment and could undermine access to the specialty care necessary to achieve CMS's broader goals for prevention and improved outcomes.

ASE is also concerned that prospective primary care payment, if not carefully designed, could create financial incentives to delay or limit clinically appropriate referrals for diagnostic testing. Echocardiography is uniquely exposed to that risk because it is nearly always ordered by another clinician. Delayed echocardiography in

heart failure, valvular disease, or suspected endocarditis leads to later diagnosis, more advanced disease at presentation, and higher downstream cost.

> *ASE recommendation:* As CMS considers future payment reforms, including prospective and technology-enabled approaches, recognize the complementary roles of primary and specialty care and ensure that new payment models do not create incentives to delay or limit clinically appropriate referrals, including referrals for cardiovascular diagnostic imaging. CMS should engage specialty societies in the development of any future proposals and pursue policies that strengthen collaboration and appropriately value both primary and specialty care rather than prioritizing one at the expense of the other.

B. Request for Information on CPT and the RUC

CMS seeks comment on asserted harms or challenges associated with the AMA's licensing of CPT, on conflicts of interest, on alternatives to the RUC, on private competition to supplement CPT, and on paying for procedural services based on ICD-10-PCS codes grouped in a manner analogous to Medicare severity diagnosis related groups or ambulatory payment classifications.

ASE, like most specialty societies, is engaged in efforts to develop codes and relative value recommendations through the AMA CPT Editorial Panel and the RUC. ASE is deeply concerned that replacing CPT or introducing a competing coding system would create significant disruption and administrative burden for physician practices. The existing Medicare physician payment system, including the assignment of relative values and payment rates, is built around CPT. Transitioning to a new coding system would require substantial changes to billing systems, payer policies, clearinghouse and electronic health record configurations, and practice workflows, and would simultaneously disrupt quality measurement, clinical registries, and clinical research, all of which are coded in CPT.

ASE also supports the continued role of the RUC. That process allows specialty societies to bring clinical expertise and direct knowledge of the resources required to furnish services to the development of relative value recommendations, while CMS retains ultimate authority for establishing values under the MPFS. The remedy for imperfect valuation is a better-resourced, more transparent valuation process, not the elimination of clinician input.

ICD-10-PCS is a procedure classification designed for inpatient facility settings. It does not describe diagnostic imaging interpretation, cognitive work, or the professional component of a service, and it has no mechanism for capturing the distinctions that matter in echocardiography, such as the difference between a limited and a complete study, the presence or absence of spectral and color flow Doppler, or the addition of strain or three-dimensional acquisition. A grouper built on ICD-10-PCS would collapse clinically distinct services into undifferentiated payment categories and eliminate the data granularity CMS itself relies on for utilization analysis, quality measurement, and program integrity.

> *ASE recommendation:* Rather than pursuing an ICD-10-PCS grouper for professional services, CMS should consider opportunities to strengthen the current framework through improved survey methodologies, additional objective data sources, and greater transparency regarding the use of RUC recommendations. CMS should carefully consider the implementation costs and administrative burden associated with significant changes to CPT or the existing valuation process relative to the potential benefits. ASE supports maintaining CPT as the coding standard for physician services and preserving meaningful specialty society participation in valuation.

X. Request for Recognition of Echocardiography as Advanced Cardiovascular Imaging

ASE renews its request that CMS appropriately recognize contemporary echocardiography as an advanced cardiovascular imaging modality in future payment, quality, and imaging policy. Echocardiography has evolved well beyond traditional two-dimensional ultrasound and now routinely incorporates three-dimensional volumetric acquisition and reconstruction, myocardial deformation and strain imaging, ultrasound enhancing agents, quantitative Doppler and hemodynamic assessment, and sophisticated post-processing and multimodality correlation. These services require specialized equipment, highly trained sonographers, physician expertise, and established quality-assurance infrastructure.

ASE recognizes that the current statutory definition of "advanced diagnostic imaging" under section 1834(e) of the Social Security Act identifies MRI, CT, and nuclear medicine, including PET, while excluding ultrasound. That statutory distinction, however, no longer reflects the clinical sophistication, technological capabilities, or resource intensity of contemporary cardiovascular ultrasound. Modern echocardiography incorporates advanced acquisition, quantitative analysis, three-dimensional imaging, strain assessment, contrast enhancement, and complex hemodynamic evaluation that are integral to cardiovascular diagnosis and treatment planning. The legacy statutory classification should therefore not limit CMS's ability to recognize echocardiography appropriately in broader payment, quality, and imaging policy.

Echocardiography provides diagnostic information that is comparable and complementary to other advanced cardiovascular imaging modalities and frequently determines whether additional CT, CMR, PET, invasive testing, or therapeutic intervention is necessary. CMS itself recognizes the extensive structural and functional information provided by echocardiography. Treating echocardiography differently solely because of its underlying ultrasound technology risks overlooking its contemporary resource requirements and central role in cardiovascular diagnosis.

> *ASE recommendation:* CMS should recognize echocardiography as an advanced cardiovascular imaging modality for purposes of future payment and quality policy development, while acknowledging the existing statutory definition of advanced diagnostic imaging. Where CMS considers additional imaging quality safeguards, ASE encourages reliance on established accreditation, specialty-developed clinical standards, and quality-assurance programs, rather than imposing new administrative requirements that do not reflect the existing oversight of accredited echocardiography laboratories.

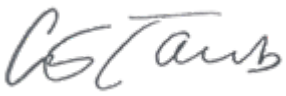
XI. Conclusion

The CY 2027 proposed rule asks echocardiography to absorb a fourth consecutive year of downward payment pressure through a reduced conversion factor, a retained and now expanded efficiency adjustment, an unvalidated practice expense methodology, a halving of payment for separately identifiable same-day services, and continued redistribution of limited fee schedule dollars toward new and untested concepts, while simultaneously proposing to move all quality reporting into a framework that contains no measure of echocardiographic quality. ASE does not believe CMS intends this outcome. But it is the outcome the rule produces.

ASE's requests are concrete and, in the case of quality measurement, immediately actionable. The measures CMS needs already exist. They are specified, tested, and reported today through the ASE ImageGuideEcho Registry. Adopting them would strengthen the heart failure condition of the Ambulatory Specialty Model, improve the validity of the Advancing Care for Heart Disease MVP, give echocardiography-focused clinicians a legitimate pathway under any future MVP framework, and give CMS its first genuine measurement of the diagnostic foundation on which cardiovascular care rests.

ASE appreciates CMS's consideration of these comments and welcomes the opportunity to meet with agency staff to discuss any of the issues raised, to provide data on echocardiographic practice costs and workflow, and to work with CMS and its measure development contractors on echocardiography quality measures. Please direct any questions or requests for additional information to Katherine Stark, ASE Director of Advocacy, at kstark@asecho.org.

Sincerely,



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