September 14, 2026

The Honorable Morgan Griffith
Chairman
Energy and Commerce Committee
Subcommittee on Health
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Diana DeGette
Ranking Member
Energy and Commerce Committee
Subcommittee on Health
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Griffith and Ranking Member DeGette:

The undersigned cardiovascular organizations write to express our uniform opposition to the *Radiology Outpatient Ordering Transmission (ROOT) Act* (H.R. 5737).

We appreciate your continued leadership to advance much needed reforms to the Medicare physician fee schedule. We believe reforms to the Merit-based Incentive Payment System (MIPS) contained in the *Patients First Act* will contribute to a reduction in administrative burden and more meaningful quality performance measurement. The *ROOT Act*, however, adds administrative burden, cost and new reporting requirements that are siloed from other quality improvement activities.

Our organizations support the development and consultation of appropriate use criteria (AUC), and corresponding measures, as important tools to promote evidence-based, patient-centered care. We believe AUC can be most effective when incorporated into broader quality improvement and value-based care frameworks. In this context, we oppose a stand-alone AUC consultation requirement.

Experience with the AUC program established under the *Protecting Access to Medicare Act (PAMA)* demonstrated significant operational and policy challenges. CMS ultimately determined that a separate AUC consultation mandate was not the most effective or efficient mechanism to advance appropriate imaging use and instead emphasized more integrated approaches through existing quality programs.

While the *ROOT Act* addresses certain technical challenges of the AUC Program under PAMA, significant concerns remain. In particular, the continued reliance on CMS-qualified clinical decision support mechanisms (CDSMs) limit clinician flexibility with how AUC is consulted. During the voluntary testing phase of the PAMA AUC mandate, physician specialists experienced the inability to consult AUC developed by their own societies because of which AUC were available in the CDSMs acquired by their hospitals or health systems. This is contrary to the *Patients First Act* which is committed to ensuring that physicians and other health care professionals are only asked to report on measures that are relevant and meaningful to their specialties and the care they provide.

There are real differences among AUC in structure, approach, and appropriateness ratings. The Provider-led Entities (PLEs) that develop AUC use several different methods for reviewing relevant literature, constructing clinical scenarios, and grading appropriateness. For example, an analysis of seven PLEs that had published AUC related to coronary artery disease had significant variability in the number of clinical scenarios for the evaluation of cardiac symptoms, ranging from 6 to 210.[1]

Further, a new AUC mandate is burdensome from the perspective that it is a repetitive task that does not account for specialty experience and expertise. Physicians who have completed specialty or surgical training should not have to perform a formal AUC consultation for every imaging order, particularly for routine imaging that falls squarely within their specialty.

For example, a cardiologist evaluating a patient with new or worsening chest pain has specialized knowledge of cardiovascular disease, understands the patient's risk factors and clinical presentation, and may order coronary CT angiography or stress imaging to evaluate for ischemic heart disease. In this situation, requiring the cardiologist to click through an AUC decision-support tool every time an image is needed will add administrative burden without necessarily improving the clinical decision.

Even with AUC consultation, the ordering clinician must be able to navigate a clinical decision support tool and provide appropriate inputs, because the usefulness and accuracy of the AUC tools depend on the quality and accuracy of the information entered. Effective use of AUC requires resources dedicated to clinician education and outreach. Neither the R*OOT Act*, nor the corresponding provision in the *Patients First Act* (Section 207) provide for this.

We urge further dialogue with our societies around AUC and its application rather than a new administrative mandate that would be imposed by the *ROOT Act*. While the *ROOT Act* may have been presented as a practical revision to the underlying mandate, the short-comings and anticipated practice burden of the mandate have not yet be adequately addressed.

Thank you in advance for your consideration of our concerns.

Sincerely,

American College of Cardiology
American Society of Echocardiography
American Society of Nuclear Cardiology
Society for Cardiovascular Angiography and Interventions
Society for Cardiovascular Computed Tomography

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[1] Winchester DE, Keating FK, Patel KK, Shah NR. The Medicare Appropriate Use Criteria Program: A Review of Recommendations for Testing in Coronary Artery Disease. Ann Intern Med. 2023 Sep;176(9):1235-1239. doi: 10.7326/M23-1011. Epub 2023 Aug 22. PMID: 37603865.