

May 8, 2026

The Honorable John Joyce, MD
2102 Rayburn House Office Building
U.S. House of Representatives
Washington, D.C. 20515

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

The Honorable Kim Schrier, MD
1110 Longworth House Office Building
U.S. House of Representatives
Washington, D.C. 20515

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

On behalf of the undersigned cardiovascular societies, we write to provide feedback on your draft legislative proposal to reform the Medicare Access and CHIP Reauthorization Act (MACRA), strengthen the Medicare Physician Fee Schedule, and improve the Merit-based Incentive Payment System (MIPS). We appreciate your continued leadership on physician payment reform, your commitment to reducing administrative burdens and your support of a sustainable physician workforce.

We offer comments regarding Sec. 205 “Modification of Appropriate Use Criteria Data Collection for Applicable Imaging Services.”

The cardiovascular community has long supported the development and consultation of appropriate use criteria (AUC) as an important tool 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 and supported with resources for education of ordering clinicians. In this context, we have concerns with establishing 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 Sec. 205 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) limits clinician flexibility with how AUC is consulted. Cardiologists also experienced, during the voluntary testing phase of the PAMA AUC mandate, the inability to consult AUC developed by our societies because of which AUC were available in

the CDSMs acquired by their hospitals or health systems. This is significant because 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

Given the outstanding questions and the diversity of perspectives among physician organizations on this issue, **we request that Sec. 205 be removed from the current draft.** Rather than a separate AUC compliance framework, restructuring MIPS offers an important opportunity to encourage appropriate resource use and the delivery of high-value care not just within imaging, but across services, by leveraging AUC and appropriate resource use measures.

We appreciate the opportunity to provide input and stand ready to work with you to advance policies that support high-value cardiovascular care.

Sincerely,

American College of Cardiology

American Society of Echocardiography

American Society of Nuclear Cardiology

Society for Cardiovascular Magnetic Resonance

Society of Cardiovascular Computed Tomography

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.