October 31, 2022

The Honorable Ami Bera, MD
U.S. House of Representatives
172 Cannon House Office Building
Washington, DC 20515

The Honorable Kim Schrier, M.D.
United States House of Representatives
1123 Longworth House Office Building
Washington, DC 20515

The Honorable Earl Blumenauer
United States House of Representatives
1111 Longworth House Office Building
Washington, DC 20515

The Honorable Bradley Schneider
United States House of Representatives
300 Cannon House Office Building
Washington, DC 20515

The Honorable Larry Bucshon, MD
U.S. House of Representatives
2313 Rayburn House Office Building
Washington, DC 20515

The Honorable Michael C. Burgess, M.D.
United States House of Representatives
2161 Rayburn House Office Building
Washington, DC 20515

The Honorable Brad R. Wenstrup, D.P.M.
United States House of Representatives
2419 Rayburn House Office Building
Washington, DC 20515

The Honorable Mariannette Miller-Meeks
United States House of Representatives
1716 Longworth House Office Building
Washington, DC 20515

Delivered by email to macra.rfi@mail.house.gov

Dear Representatives Bera, Bucshon, Schrier, Burgess, Blumenauer, Wenstrup, Schneider, and Miller-Meeks:

The American Society of Nuclear Cardiology (ASNC) appreciates your leadership and commitment to working toward a more affordable, sustainable, and patient-centered health care system, and offers the following thoughts about how the Medicare program can support the appropriate delivery of high-quality advanced diagnostic imaging.

The Protecting Access to Medicare Act (PAMA) of 2014 prevented a cut in Medicare physician payments due to the Medicare sustainable growth rate (SGR) formula. It also established, under Section 218, the Medicare Appropriate Use Criteria (AUC) Program for advanced diagnostic imaging. Approximately one year after PAMA's passage, the Medicare Access and CHIP Reauthorization Act (MACRA) was enacted, replacing the SGR and creating the Quality Payment Program (QPP).

Within the QPP, Congress consolidated CMS' legacy quality reporting programs into the Merit-based Incentive Payment System (MIPS). In doing so, Congress intended to reduce the burden associated with physician participation in separate quality programs. Unfortunately, the AUC Program has remained as an administratively burdensome stand-alone program, delinked from MIPS and alternative payment models (APMs) and any measurement of patient outcomes.

In 2018, Ways and Means Chairman Kevin Brady and Rep. Peter Roskam, then Chairman of the Subcommittee on Health, sent a letter to CMS Administrator Seema Verma on the subject of provider regulatory relief which stated:

> "Finally, in an effort to reduce burdens and barriers to provider participation in various programs, including MIPS, we ask you to further address an issue of reporting consolidation. Over the next few years, physicians are expected to report under several different methods varying by specialty. Specialties participating in qualified clinical data registries (QCDR) or appropriate use criteria (AUC) should be given an opportunity to report in a singular fashion under MIPS. We urge CMS to take steps to create a uniform system in order for this to occur."

CMS has been unable to fully implement the AUC Program due to its extraordinary scope and complexity and the Agency has made clear it lacks the statutory authority to make significant changes to the Program, including incentivizing the consultation of AUC through MIPS, or recognizing that encouraging appropriate use of advanced diagnostic imaging is inherent in APMs.

ASNC encourages Congress to consider improvements to MIPS and APM programs, and, in the process, repeal the Medicare AUC Program. Instead of the AUC Program, Congress should work with medical societies to identify ways in which the QPP can be maximized for encouraging the consultation of AUC and in a manner that promotes flexibility for the consultation by ordering professionals of provider-developed, evidence-based AUC.

AUC Program Background

The AUC Program requires consultation and documentation by physicians and other health care professionals of AUC when an advanced imaging service is ordered for and provided to Medicare fee-for-service beneficiaries. Advanced imaging services include:

- Computed tomography (CT);
- Positron emission tomography (PET);
- Nuclear medicine; and
- Magnetic resonance imaging (MRI).

If ever fully implemented, the AUC Program would apply to every clinician who orders or furnishes an advanced diagnostic imaging test, except for emergency and inpatient services. CMS has acknowledged the number of clinicians affected by the program is "massive," crossing almost every medical specialty and having a particular impact on primary care physicians since their scope of practice can be vast.

The law is very prescriptive, requiring consultation of AUC using a qualified Clinical Decision Support Mechanism (CDSM) at the time a practitioner (or clinical staff acting under a practitioner's direction) orders an advanced diagnostic imaging service for a Medicare beneficiary. The CDSM provides a determination of whether the order adheres to AUC or if the AUC consulted was not applicable.

Upon consulting AUC, the ordering professional must provide the following information to furnishing professionals and facilities, who must, in turn, report this AUC consultation information on their Medicare claims to be paid for the test:

- Ordering professional's National Provider Identifier (NPI);
- CDSM consulted; and
- Whether the service ordered would or would not adhere to consulted AUC or whether consulted AUC was not applicable to the service ordered.

Ultimately, practitioners whose ordering patterns are considered outliers (yet to be defined by CMS) will be subject to prior authorization.

Legislative Solutions

Through their medical societies and institutions, physicians have led the way with the development of AUC for diagnostic imaging, and they continue to advocate for its use. Independent, evidence-based guidelines are also widely used throughout the health care system, including for advanced imaging.

Although Congress may have believed the AUC Program was a straight-forward approach to encourage the use of AUC by clinicians who order advanced imaging tests, the law has always faced implementation challenges and opposition from physicians who are weary of the imposition of new administrative burdens of questionable value. In some cases, the law would actually preclude utilization of well-established physician guidelines.

ASNC asks Congress to repeal the AUC Program and work with medical societies to find new ways to integrate AUC into practice with a focus on low-value imaging. For example, a system that examines the frequency of testing for rarely appropriate indications by the ordering provider.

With any approach to AUC consultation, ordering clinicians must not be confined strictly to the use of a CMS qualified, and proprietary, CDSM. Other decision support tools and clinical guidelines embedded into electronic health record systems must also be recognized. Confining consultation to a qualified CDSM increases cost and takes away the ability of physicians to consult AUC developed by their specialty society. For example, cardiologists have experienced situations in which a qualified CDSM eliminates their ability to continue consultation of AUC developed by cardiovascular societies (including ASNC and the American College of Cardiology (ACC)) and forces them to consult AUC developed by the American College of Radiology which vary from the ACC/ASNC AUC in their structure, approach, and appropriateness ratings.

ASNC supported language included in the FY2022 report that accompanied the House-passed Labor-Health and Human Services-Education spending bill that requests a report from CMS to Congress on

implementation of this program, including "challenges and successes." ASNC looks forward to CMS' report and consideration of existing quality improvement programs and innovative payment models to facilitate appropriate use of advanced diagnostic imaging, as well as other services provided to Medicare beneficiaries.

Conclusion

Maintaining the AUC Program and imposing consultation requirements on physicians outside of the QPP contributes to physician regulatory burden and cost and does not facilitate meaningful quality improvement that drives better patient outcomes. ASNC stands ready to work with you to repeal the program and work toward a more meaningful and targeted approach to encouraging the appropriate use of diagnostic imaging. For more information please contact Camille Bonta, ASNC policy consultant, at (202) 320-3658 or cbonta@summithealthconsulting.com.

Sincerely,

Dennis Calnon, MD
President
American Society of Nuclear Cardiology