# Medicare Appropriate Use Criteria Program: Statement of Repeal


**Summary:**

In 2014, Congress passed the *Protecting Access to Medicare Act* (PAMA) [Public Law 113-93], establishing the Medicare Appropriate Use Criteria (AUC) Program for advanced diagnostic imaging, mandating, among other things, the prescribed use of AUC decision support tools. Nearly eight years later, AUC program implementation and rulemaking are incomplete, prompting concerns about the law's complexity and the cost and regulatory burden incurred by physicians and other health care providers to meet program requirements if the program were ever to take effect — in whole or in part.

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 straightforward 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.

**Since PAMA's enactment, new Medicare payment and delivery models that hold clinicians accountable for health care resource use have evolved. When coupled with repeated implementation delays, the AUC Program is now outdated. It should be repealed, and Medicare should leverage existing quality improvement programs to encourage the consultation of AUC for advanced diagnostic imaging.**


**Program Overview:**

PAMA established the AUC Program, an untested payment and prior authorization model that 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 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 will be subject to prior authorization.

The law established 2017 as the program's start date. However, technical challenges have impeded implementation. The program's penalty phase will now occur on the later of January 1, 2023, or the January 1 that follows the declared end of the public health emergency for COVID-19. However, there is no indication CMS can even implement the AUC Program in a manner that fully complies with the law due to challenges with operationalizing documentation requirements on Medicare claims.

**Request for Program Repeal**:

The AUC Program has been fraught with implementation challenges since its enactment and, in the intervening time, has grown outdated — particularly with subsequent enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the rise of new health care payment and delivery models that hold clinicians responsible for health care resource use, such as alternative payment models, the Merit-based Incentive Payment System and Primary Cares Initiative.

For example, on November 20, 2020, the Center for Medicaid and Medicaid Innovation announced details of the first cohort of Primary Care First participants, which includes 916 primary care practices. Primary Care First, which began on January 1, 2021, will focus on advanced primary care practices ready to assume financial risk by moving away from fee for service to a prospective population-based payment. Under such a payment arrangement, primary care physicians will be incentivized to improve quality and patient experience of care and reduce expenditures through appropriate utilization of health care resources.

Furthermore, by finalizing new exceptions to the physician self-referral law for value-based arrangements,[1] CMS recognized value-based health care delivery and payment systems, by design, provide safeguards against overutilization.

[1] Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations; CMS-1720-F. https://www.federalregister.gov/documents/2020/12/02/2020-26140/medicare-program-modernizing-and-clarifying-the-physician-self-referral-regulations

**While there may be differing ideas about how to foster the use of AUC by clinicians, there is widespread agreement the program should not and cannot be implemented as originally envisioned. The AUC Program should be repealed on the basis that the program:**

- **Diverts provider resources away from quality improvement activities.** The AUC Program implementation is occurring at the same time providers are struggling to assign adequate resources for information technology infrastructure and Quality Payment Program participation. The AUC Program has no metrics of quality or patient outcomes.

- **Takes away provider flexibility for consulting AUC.** Clinicians are required to only use CDSMs qualified by CMS and only AUC developed by certain qualified entities. The prescriptive nature of the law and accompanying rules will, in many cases, force clinicians to abandon long-standing methods of AUC consultation, as well as the consultation of specialty-specific AUC and guidelines.

- **Adds administrative burden.** The AUC Program sets up a complex exchange of information between clinicians that is not yet supported by interoperable electronic health record systems and relies on claims-based reporting. At the same time, CMS is migrating away from claims reporting for quality data.

- **Is a costly and disproportionate response to imaging utilization.** According to the Medicare Payment Advisory Commission, beneficiary encounters overall grew modestly from 2017-2018, with imaging encounters growing the slowest at 0.7 percent.[2] According to one estimate, it will cost $75,000 or more for a practice to implement a clinical decision support mechanism to comply with the AUC Program rules.[3]

Broad agreement exists across the health care stakeholder community that the AUC Program cannot work. Congress should heed this message and **repeal the program now!**

[2] Report to the Congress: Medicare Payment Policy. Medicare Payment Advisory Commission. March 2020. http://www.medpac.gov/docs/default-source/reports/mar20_medpac_ch4_sec.pdf?sfvrsn=0

[3] Association for Medical Imaging Management; 2017 https://ahralink.files.wordpress.com/2017/03/cds-survey-2017.pdf