

September 9, 2021

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1753-P
P.O. Box 8010
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically: <http://www.regulations.gov>

Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model; Request for Information on Rural Emergency Hospitals

Dear Administrator Brooks-LaSure:

The American Society for Radiation Oncology (ASTRO)¹ appreciates the opportunity to provide written comments on the “Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model; Request for Information on Rural Emergency Hospitals,” published in the Federal Register as a proposed rule on August 4, 2021.

ASTRO members are medical professionals practicing at hospitals and cancer treatment centers in the United States and around the globe. They make up the radiation treatment teams that are critical in the fight against cancer. These teams include radiation oncologists, medical physicists, medical dosimetrists, radiation therapists, oncology nurses, nutritionists, and social workers. They treat more than one million cancer patients each year. We believe this multi-disciplinary membership makes us uniquely qualified to provide input on the inherently complex issues related to Medicare payment policy and coding for radiation oncology services.

In this letter, ASTRO seeks to provide input on the policy change proposals that will impact our membership and the patients they serve, including:

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- Comprehensive Ambulatory Payment Classifications (C-APCs)
- APC Placement of Medical Physics Dose Evaluation (CPT code 76145)
- Health Equity

In a separate comment letter, ASTRO will provide our input on the Radiation Oncology Alternative Payment Model (RO Model).

Comprehensive Ambulatory Payment Classifications (C-APCs)

In the 2022 HOPPS proposed rule, CMS does not seek to further expand the Comprehensive Ambulatory Payment Classification (C-APC) methodology, leaving the number of C-APCs at 69. Although radiation oncology services see a modest increase in the proposal, we remain concerned that these services are still undervalued due to the underlying C-APC methodology. Under the C-APC policy, CMS provides a single payment for all services on the claim regardless of the span of the date(s) of service. Conceptually, the C-APC is designed so there is a single primary service on the claim, identified by the status indicator (SI) of “J1”. All adjunctive services provided to support the delivery of the primary service are included on the claim.

While ASTRO supports policies that promote efficiency and the provision of high-quality care, we have long expressed concern that the C-APC methodology lacks the appropriate charge capture mechanisms to accurately reflect the services associated with the C-APC.

Since the inception of the C-APC methodology, ASTRO has shared our concerns that the policy is poorly suited and wholly inappropriate for the accurate reflection of costs associated with the component coding aspects of the radiation oncology process of care (consultation; preparing for treatment; medical radiation physics, dosimetry, treatment devices and special services; radiation treatment delivery; radiation treatment management; and follow-up care management). In addition, ASTRO has expressed our concerns regarding the claims data and charge capture mechanisms used for rate-setting due to the complexities associated with treating cancer and significant variations in clinical practice and billing patterns across the hospitals that submit these claims. **ASTRO reiterates that the C-APC methodology does not account for this complexity and fails to capture coded claims appropriately, resulting in distorted data. If continued or further expanded, ASTRO is concerned that this will lead to inaccurate payment rates that will jeopardize access to certain radiation therapy services.**

In February 2018, ASTRO met with CMS officials to specifically discuss the impact of the C-APC policy on brachytherapy services. At that time, we supplied the Agency with a detailed analysis specific to the treatment of cervical cancer that verified how the C-APC methodology severely underpays for costs associated with the treatment of cervical cancer. Those concerns were shared again with CMS in response to the 2019 HOPPS final rule, where we supplied our analysis through comments and expressed our disappointment that the Agency did not recognize these concerns.

In the 2020 HOPPS final rule, CMS applied modest increases by reassigning two brachytherapy codes, CPT code 57155 *Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy* and CPT code 58346 *Insertion of Heyman capsules for clinical brachytherapy* from C-APC 5414 *Level 4 Gynecologic Procedures* to C-APC 5415 *Level 5 Gynecologic*

Procedures, increasing their reimbursement rates from \$2,361 to \$4,271. However, these increases still did not adequately account for the actual cost of treatment delivery for these services. This was again the case in the 2021 final rule.

In the 2022 HOPPS proposed rule, this issue remains unresolved, despite the fact that ASTRO has continuously urged the Agency to explore alternatives to its C-APC policy. CMS continues to assign CPT codes 57155 and 58346 to C-APC 5415. In 2022, this C-APC category is expected to be reimbursed at a rate of \$4,525.49. **ASTRO continues to be concerned about how the C-APC methodology impacts radiation oncology, particularly the delivery of brachytherapy for the treatment of cervical cancer, which disproportionately impacts disadvantaged and minority women for whom the health care system has failed to capture their diagnosis through early and frequent intervention. ASTRO again urges CMS to consider allowing brachytherapy to be reported through the traditional APC methodology.**

ASTRO supports CMS policies that promote efficiency and the provision of high-quality care, but the C-APC methodology by design is not equipped to accurately capture the complexities of radiation oncology services, particularly brachytherapy. **If CMS is committed to the C-APC methodology, we recommend that the Agency move brachytherapy for cervical cancer treatment to C-APC 5416 Level 6 Gynecologic Procedures, which is expected to be reimbursed at a rate of \$6,964.98 (our own analysis shows that a more accurate reimbursement for brachytherapy for cervical cancer is \$16,693.48).²**

APC Placement of Medical Physics Dose Evaluation (CPT code 76145)

CMS proposed placing CPT code 76145 in APC 5611 Level 1 - Therapeutic Radiation Treatment Preparation. APC 5611 currently has nine, clinically similar radiation oncology therapeutic radiation treatment codes. CPT code 76145 is not a radiation oncology code, rather a service that is performed in interventional radiology or interventional cardiology.

ASTRO believes that CPT Code 76145 is better suited in APC 5724 - Level 4 Diagnostic Tests and Related Services. APC 5724 currently has 17 services, with a range of clinical variability (urology, neurology, internal medicine, radiology, dermatology, allergy, etc.). The resource consumption in APC 5724 more closely aligns with the resources used to perform CPT code 76145. **As such, ASTRO urges CMS to place CPT code 76145 in APC 5724 for 2022.**

Health Equity

Similar to proposals put forth in the 2022 Inpatient Prospective Payment System and Medicare Physician Fee Schedule proposed rules, CMS has asked for input on ways to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable. This includes soliciting comments on potential collection of data and analysis and reporting of quality measure results by a variety of demographic data points including, but not limited to, race, Medicare/Medicaid dual eligibility status, disability status, LGBTQ+, and socioeconomic status.

² https://www.astro.org/ASTRO/media/ASTRO/Daily%20Practice/PDFs/C-APC_Methodolgy_Letter.pdf

ASTRO supports the stratification of quality measure results by race and ethnicity, but also encourages CMS to consider stratification by patient residency in rural versus urban locations. These indicators lend themselves to demonstrating whether a hospital or other healthcare settings may provide healthcare services to an underserved population that is at higher risk for experiencing healthcare disparities.

As for the collection of additional demographic data, the collection of a minimum set of demographic data elements such as race, ethnicity, sex, sexual orientation, gender identity, primary language, tribal membership, and disability status can be valuable to better understanding the patient population served. However, these indicators can be further enhanced through the collection of additional data points such as employment status, education level, insurance status, income level, and distance from provider, which may further inform whether a patient needs additional social and financial supports to ensure they are able to initiate and complete care.

The collection of demographic data and stratification of quality measures can be used to better understand quality measures performance across different patient populations. It will allow for more granular analysis to determine whether interventions that are in place to improve quality are successful for some populations but not for others. Thus, this will inform the need for modifications or changes to quality measures that can be designed to truly drive quality improvement across all patient populations.

Additionally, this data could be used to establish a Hospital Equity Score, but why stop there? Hospital Equity Scores can synthesize reported metrics to better inform decision making for addressing healthcare disparities, but it could be taken one step further and applied to patients seeking care in these facilities by ensuring that they have access to social and financial supports necessary to access and complete medical treatment. **ASTRO supports the concept of developing beneficiary-specific equity scores to identify those patient populations that require wrap around services, such as nutritional counseling, access to healthy food, transportation, housing, etc.** A health equity score can then be further used to tie community need to additional reimbursement that supports the delivery of specific services that are supportive of patients who experience health inequities.

While ASTRO is supportive of efforts to collect better data points for informing improved patient care and outcomes, we continue to urge the Agency to consider the burden—on practices and patients—associated with collecting this data. Not only are time and money needed to upgrade software and implement new programming, but also hospitals and other healthcare settings will require staff to collect data and manage the related programming. CMS cannot meaningfully address the healthcare equity gap without investing in the resources necessary to reach our nation's most vulnerable populations.

Many physicians are frustrated with the existing Certified Electronic Health Records Technology (CEHRT) requirements associated with the Promoting Interoperability programs. Clinicians do not have any control over the electronic health records (EHR) products issued by vendors, yet they are penalized for not achieving CEHRT status. More data submission requirements require

a stronger reporting framework, more commonly applied standards, and changes to workflow, for which there is currently no funding. Additionally, these changes cannot be made overnight, they take time to implement. For example, the Cures Update Edition is set for 2023, yet only Cerner has made adequate upgrades to meet these new requirements. CMS needs to provide adequate time for vendors to prepare and implement upgrade requirements.

Additionally, vendors must be held accountable for the upgrades required to CEHRT systems to ensure improved care coordination and patient access. Hospitals and physicians should not shoulder the burden of meeting these requirements nor should they bear the costs associated with system upgrades. As previously stated, CMS needs to invest in the technological and social resources necessary to improve patient care across all populations. As COVID-19 has demonstrated, a “one-size-fits-all” approach has left many Americans behind. Therefore, the way to achieve health equity will be to target high risk populations with the social support and resources necessary to ensure they are able to achieve better health outcomes.

Thank you for the opportunity to comment on this proposed rule. We look forward to continued dialogue with CMS officials. Should you have any questions on the items addressed in this comment letter, please contact Adam Greathouse, Senior Manager, Health Policy, at (703) 839-7376 or Adam.Greathouse@astro.org.

Respectfully,



Laura I. Thevenot
Chief Executive Officer