



January 27, 2014

Ms. Marilyn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1600-FC  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850  
*Submitted electronically via [www.regulations.gov](http://www.regulations.gov)*

**Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014 (CMS-1600-FC)**

Dear Administrator Tavenner:

The American Society for Radiation Oncology (ASTRO) appreciates the opportunity to provide written comments on the “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014 (CMS-1600-FC)” published in the Federal Register as a final rule on December 10, 2013.

ASTRO members are medical professionals, who practice at hospitals and cancer treatment centers in the United States and around the globe, and make up the radiation therapy treatment teams that are critical in the fight against cancer. These teams often include radiation oncologists, medical physicists, medical dosimetrists, radiation therapists, oncology nurses, nutritionists and social workers, and 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 we address a number of topics that will impact our membership and the patients they serve including:

- Using Outpatient Prospective Payment System (OPPS) and Ambulatory Surgery Center (ASC) Rates in Developing PE RVUs;
- Adjusting RVUs to Match PE Share of the Medicare Economic Index (MEI);
- Brachytherapy Services (77785-77787) Experiencing Unsustainable Reductions
- Respiratory Management Simulation (+77293);
- Invoice Pricing;
- Ultrasound Guidance Codes Proposed as Potentially Misvalued (76950, 76965);
- Direct PE Inputs for Stereotactic Radiosurgery (SRS) Services (CPT Codes 77372 and 77373);

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- Radiation oncology: Medical Radiation Physics, Dosimetry, Treatment Devices, and Special Services (CPT Code 77301);
- Table 29 CY 2014 Interim Final Codes with Direct PE Input Recommendations Accepted with Refinements;
- Anomalous Supply Inputs;
- Physician Quality Reporting System (PQRS);
- Qualified Clinical Data Registries;
- Electronic Health Records Incentive Program; and
- Physician Compare Website.

### **Using OPPS and ASC Rates in Developing PE RVUs**

CMS believes that hospitals/facilities incur greater costs than those incurred by practitioners furnishing services in offices and other non-facility settings. The agency has found that for some services furnished in the physician office setting, the total Medicare payment exceeds the total Medicare payment for when the service is furnished in a hospital outpatient or ambulatory surgical center. The agency believes this is an inappropriate payment differential and proposed a change in its practice expense methodology beginning in CY 2014, whereby the agency would cap the physician fee schedule (PFS) freestanding practice expense (PE) RVUs so that the total freestanding payment rate would not be greater than the total Medicare payment for the same service provided in an outpatient hospital setting.

CMS is not finalizing this proposed capping policy for CY 2014. ASTRO appreciates the agency's willingness to consider our concerns and those raised by many other stakeholders about the negative impact this proposed policy could have on providers and the patients they serve.

While the proposal is not being finalized for CY 2014, the agency remains concerned that the inappropriate differential is a result of flawed direct practice expense (PE) information used to value the technical portion of payments for services performed in the free standing setting. The agency has indicated that they will develop a revised proposal through future comment and rulemaking.

ASTRO believes CMS made a responsible decision to withdraw the OPPS cap proposal. ASTRO also understands and supports the agency's efforts to responsibly manage Medicare resources. While we continue to have significant concerns about the proposed OPPS cap methodology, we look forward to working with the agency to ensure payment rates accurately reflect the costs of providing these services in both hospital outpatient and freestanding centers. ***If CMS pursues future rulemaking in this area, ASTRO urges the agency to consider the following:***

### **Better Align Units of Comparison**

The physician fee schedule RVUs capture the relative resource costs of each individual service. The OPPS groups *similar* services into Ambulatory Payment Classifications (APCs) and establishes one payment per APC based on mean costs. In other words, while the physician fee schedule is an estimate of the resources used to provide a single service, the APC system is based on the mean costs of a group of services. The actual costs of individual services within an APC

will vary – sometimes significantly. CMS adheres to the “two-times rule,” whereby the highest cost of an individual procedure categorized to any given APC cannot exceed two times the calculated cost of the lowest cost procedure categorized to that same APC. Occasionally there are exceptions to this rule resulting in significantly varying costs within an APC. Therefore, any future ‘capping policy’ must take these drastically different methodologies into account. ***In any future capping policy, ASTRO urges CMS consider the need to fairly compare the physician fee schedule payment rates to the code specific geometric mean costs on the OPSS side - not the APC payment rate.***

#### Benchmarking to Most Currently Available Data

The original CMS proposal used the 2013 OPSS/ASC rates to establish the 2014 MFS cap rates, which therefore fails to utilize the most current data available to CMS. In addition, it is important to note that APC rates are based on claims data from two years prior. Therefore, CY 2014 rates would be based on CY 2012 cost data. Benchmarking the PFS rates to CY 2013 OPSS rates, which are actually based on CY 2011 cost data, is an unacceptable and inappropriate time lag. ***ASTRO strongly recommends that any future Medicare ‘capping policy’ should use contemporaneous comparison years. For example, the 2015 payment rates should use underlying data from the MFS and the OPSS for 2015.***

#### Low Volume

In the original proposal, CMS exempted codes with low volume in the OPSS or ASC. However, CMS did not apply the low volume cap specifically to the ASC setting. ***If CMS pursues an OPSS cap proposal in the future, the agency must exclude any service for which 5% percent or less of the total numbers of services are furnished in the ASC.***

#### Adjusting RVUs to Match PE Share of the Medicare Economic Index (MEI)

The Medicare Economic Index (MEI) is a measure of practice cost inflation that was developed in 1975 as a way to estimate annual changes in physicians’ operating costs and earning levels. The MEI is a fixed-weight input price index, with an adjustment for the change in economy-wide, private nonfarm business multifactor productivity. This index is comprised of two broad categories: (1) physicians’ own time; and (2) physicians’ practice expense (PE). MEI impacts the annual SGR update as well as the calculation of PE RVUs.

#### Implementation Methodology Disproportionately Impacts Office-Based Services

Based on recommendations from the Technical Advisory Panel, CMS is finalizing a proposal to adjust the relationship among the work, PE, and malpractice (MP) RVUs. This budget neutral policy is being implemented by adjusting the conversion factor, PE RVUs and malpractice (MP). The change in the relationship among work, PE, and malpractice RVUs could be accomplished by applying adjustments directly to the work, PE, and malpractice RVUs or by holding the RVUs constant for one component, scaling the other two components and applying a budget neutrality adjustment to the conversion factor. CMS proposed to make the adjustment by holding work RVUs constant. They argued that PE RVUs are developed annually, irrespective of changes in the direct PE inputs for particular services, so that scaling of PE RVUs is less disruptive to the public review of values that determine PFS payment rates.

These proposed changes lead to revised RVUs based on new weights for work (increased to 50.866%), PE (decreased to 44.839%), and malpractice (unchanged at 4.295%). Specialties that perform procedures in an office and by default have higher PE RVUs are hit hardest by these changes, as they have to absorb the neutrality adjusters.

CMS’ decision to offset the adjustments based on the philosophy that it is “less disruptive to the public review of values that determine physician fee schedule payment rates” unfairly burdens physicians in the office setting, including freestanding radiation oncology centers that have experienced significant payment reductions in recent years. ***ASTRO strongly urges the agency to consider alternatives methodologies for offsetting these MEI adjustments and reexamine the issue in 2015.***

**Brachytherapy Services (77785-77787) Experiencing Unsustainable Reductions**

Brachytherapy is a form of radiation therapy where a radiation source is placed inside or next to the area requiring treatment. It offers convenient and cost-effective treatment for many Medicare patients.<sup>1</sup> Brachytherapy is also associated with a low risk of serious adverse side effects.<sup>2</sup> As the chart below illustrates, several brachytherapy services are slated for drastic reductions in for CY 2014.

CPT	Mod	Descriptor	Freestanding		
			2014 RVUs	2013 RVUs	% Change
77785		Hdr brachytx 1 channel	6.63	7.37	-10.0%
77785	TC	Hdr brachytx 1 channel	4.57	5.30	-13.8%
77785	26	Hdr brachytx 1 channel	2.06	2.07	-0.5%
77786		Hdr brachytx 2-12 channel	13.53	16.37	-17.3%
77786	TC	Hdr brachytx 2-12 channel	8.82	11.64	-24.2%
77786	26	Hdr brachytx 2-12 channel	4.71	4.73	-0.4%
77787		Hdr brachytx over 12 chan	21.55	28.09	-23.3%
77787	TC	Hdr brachytx over 12 chan	14.45	20.95	-31.0%
77787	26	Hdr brachytx over 12 chan	7.10	7.14	-0.6%

The implementation of three new high dose rate (HDR) brachytherapy procedures codes in 2009 (i.e., 77785, 77786, 77787), corrections to HDR brachytherapy direct practice expense inputs for 2010, and utilization of the AMA Physician Practice Information Survey data has resulted in significant reductions to HDR brachytherapy reimbursement for freestanding cancer

<sup>1</sup> Rabinovitch R, Winter K, Kuske R, Bolton J, Arthur D, Scroggins T, Vicini F, McCormick B, White J . RTOG 95-17, a Phase II trial to evaluate brachytherapy as the sole method of radiation therapy for Stage I and II breast carcinoma-year-5 toxicity and cosmesis. *Brachytherapy*. 2014 Jan-Feb;13(1):17-22. doi: 10.1016/j.brachy.2013.08.002. Epub 2013 Sep 14.

<sup>2</sup> Garsa AA, Ferraro DJ, DeWees TA, Deshields TL, Margenthaler JA, Cyr AE, Naughton M, Aft R, Gillanders WE, Eberlein T, Matesa MA, Ochoa LL, Zoberi I. (2013). “A prospective longitudinal clinical trial evaluating quality of life after breast-conserving surgery and high-dose-rate interstitial brachytherapy for early-stage breast cancer.” *Int J Radiat Oncol Biol Phys*. Dec 1;87(5):1043-50. Accessed on 1/21/14: <http://www.ncbi.nlm.nih.gov/pubmed/24161428>.

centers beginning in 2009. ASTRO is very concerned that these cuts fail to reflect the costs of providing these services in the community setting and will jeopardize patient access to these services. ASTRO has heard from many brachytherapy sub-specialists and other members that they will no longer be able to provide these services or will be forced to severely limit these services going forward under these lower payment rates. Brachytherapy offers cost-effective care to Medicare beneficiaries. Continued cuts to its reimbursement, however, jeopardize this important subspecialty and the patients they serve. ***ASTRO urges CMS to reconsider these significant cuts.***

#### Reconsider RUC Recommendations

Practice expense inputs for the HDR codes 77785-77787 were recently reviewed at the RUC. The agency's decisions on these recommendations were announced in the 2014 final MPFS; listed in Table 29 of the regulations. ASTRO was disappointed that the agency rejected many of the recommendations made by the RUC. These recommendations were based on surveyed data and vigorously vetted.

In particular, we object to the agency's rejection of the "emergency service container-safety kit" on the list of equipment and categorization of the kit as an indirect practice expense. We strongly urge CMS to reconsider this decision, as by the standards used by CMS; this item is clearly a *direct* practice expense input.

The emergency container is a safety device used when a source must be retrieved manually. It is mobile and must be in the treatment room during source exchange. The service cannot be performed unless it is in the room. Direct practice expense inputs are those costs directly assumed by a physician in the course of providing the service. These include the costs of medical supplies, staff time, and equipment. Indirect practice expense inputs measure the costs a practice incurs, such as the cost of labor, rent, office supplies, insurance etc. The description of the emergency container clearly puts it into the category of a direct practice expense input. ***ASTRO requests CMS to reconsider its decision and reclassify this item as a direct practice expense input.***

CMS also reduced time from the RUC recommendations for several direct inputs for the HDR codes 77785-77787. The refinements resulted in reductions from the RUC recommended times and can be found on pages 74370-74372 in the display copy of the final regulations. ASTRO was very disappointed that the agency did not accept the RUC recommendations. These inputs were carefully vetted at the RUC; the process of care was reviewed, steps were taken to ensure that there were no overlaps in time and to confirm that allotted time followed RUC methodology. ***ASTRO requests CMS to accept the RUC direct input recommendations for HDR codes 77785-77787.***

#### Significant Cuts Require Greater Scrutiny

When PE RVUs change so drastically from year to year, the instability wreaks havoc on physicians who provide these services and for the patients they serve. Cuts of this magnitude demand that the agency apply special review and attention to the methodology and the data that result in such significant swings in payment. When the service cuts are clustered around a

specific procedure, it may also create inappropriate incentives or disincentives. While there may be some situations where the costs of these services vary significantly from year-to-year, it is more likely that the physician's costs are fixed for a period of time, meaning that such significant payment reductions can jeopardize the ongoing provision of these services and, in severe situations, the ability to remain able to provide patient care.

If, after further review, such reductions are deemed appropriate, the agency should strongly consider mitigating the impact of such cuts by phasing them in over time. The lack of stability these swings in payment cause are harmful not just to the individual provider but also to beneficiaries and the Medicare program itself. It is in the agency's interest to mitigate significant payment disruptions. *ASTRO urges CMS to explore ways to mitigate significant payment cuts from year-to-year on an individual service or groups of related services.*

### **Respiratory Management Simulation (+77293)**

In 2014, the simulation code family was updated to better reflect changes in the process of care and technology. In addition, CPT code +77293 was created to describe respiratory management. This new code describes the work involved in simulating a patient treatment using motion (respiratory) tracking of a mobile target volume. ASTRO submitted work and practice expense recommendations to the AMA RVS Update Committee (RUC), and we are pleased that CMS accepted all of the RUC's work recommendations and many of the PE recommendations for these codes.

ASTRO has identified an error in the direct labor file related to CPT code +77293. Row 6768 of the public use file for Labor assigns 23 minutes of an audiologist (L052A) to this code. The correct staff type is Medical Physicist (L152A). *ASTRO requests CMS to correct this error for CY 2014.*

### **Invoice Pricing**

For more than a decade, ASTRO has worked diligently with CMS and the RUC to supply documentation/copies of paid invoices to price radiation oncology supplies and equipment. These invoices are distributed to all RUC meeting participants and included as public information on the CMS site. We have expressed concern in the past with CMS and the RUC regarding the current collection process. Often providers are reluctant to provide invoices because they fear that their individual practice can be identified. This is especially the case with smaller specialties, such as radiation oncology.

CMS stated in the Final Rule *"We believe it is likely that the pricing information would be less market sensitive if the information served to confirm the assumptions we already display in the direct PE input database."* From this statement we are concerned that CMS believes specialty societies are not submitting pricing information because pricing is lower than the CMS prices included in the direct PE database. That is *not* the case. Stakeholders in the marketplace are often able to identify the practice through this process, which has major implications to price negotiations and service lines in local markets. This makes it challenging for us to collect invoices.

We support the agency's efforts to make sure that the PE database is based on the most current and accurate prices. We are committed to working with CMS and the RUC to provide this data. ***Because of the limitations with the current process, ASTRO strongly encourages CMS to work with specialty societies and the RUC to establish an acceptable process for data collection that would better protect the sources of this sensitive information.***

#### **Ultrasound Guidance Codes Proposed as Potentially Misvalued (76950, 76965)**

Contract Medical Directors (CMDs) identified several codes as potentially misvalued and appropriate for review by CMS. CMS stated it will consider codes identified by CMDs as potentially misvalued. There were two radiation oncology services on this list.

- 76950, Echo guidance radiotherapy, and
- 76965, Echo guidance radiotherapy.

ASTRO requests that both of these codes be removed from the list of potentially misvalued ultrasound guidance codes. CPT code 76950 is scheduled to be deleted in CY 2015. CPT code 76965 was reviewed by the RUC Relativity Assessment Workgroup (RAW) in October 2013. CPT code 76965 is most commonly billed with CPT codes 77787 and 55875. The physician time for CPT code 76965 is 62 minutes. The physician time for CPT code 77787 is 90 minutes and CPT code 55875 is 90 minutes. There is no discrepancy in procedure times and therefore, no issue of 'potentially inaccurate payments' and the RUC Relativity Assessment Workgroup concurred with this. ASTRO believes this RUC review has addressed any concerns that it is a potentially misvalued code. For these reasons, ***ASTRO requests CMS remove both CPT code 76950 and 76965 from the list of potentially misvalued codes.***

#### **Direct PE Inputs for Stereotactic Radiosurgery (SRS) Services (CPT Codes 77372 and 77373)**

Since 2001, Medicare has used HCPCS G-codes, in addition to the CPT codes, for stereotactic radiosurgery (SRS) to distinguish robotic and non-robotic methods of delivery. CMS believes that it is no longer necessary to continue to distinguish robotic versus non-robotic linac-based SRS through the HCPCS G-codes.

Two of the four current SRS G-codes are paid in the nonfacility setting through the PFS. These two codes, G0339 and G0340, describe robotic SRS treatment delivery and are contractor priced. CPT codes 77372 and 77373, which describe SRS treatment delivery without regard to the method of delivery, are currently paid in the nonfacility setting based on resource-based RVUs developed through the standard PE methodology.

CMS did not propose to replace the contractor-priced G-codes for physician fee schedule payment but did seek comment from the public and stakeholders, including the RUC, regarding whether or not the direct PE inputs for CPT codes 77372 and 77373 would continue to accurately estimate the resources used in furnishing typical SRS delivery were there no coding distinction between robotic and non-robotic methods of delivery.

ASTRO responded to the CMS' request for information regarding whether the direct PE inputs for CPT codes 77372 and 77373 were accurate. All SRS and SBRT treatments, including

robotic treatments, are appropriately captured with CPT codes 77372 and 77373. These codes have been recently reviewed by the RUC. CPT code 77372 was reviewed in April 2013 and CPT code 77373 was reviewed in January 2013. As part of this review of direct PE inputs, all technologies, including those with robotic functionality, were incorporated. In addition, equipment invoices for all these technologies were included with the RUC's submission to CMS. The price for the SRS system, CMS equipment code ER083, is the result of weighting six different treatment systems. ***ASTRO recommends that CMS replace the contractor-priced G-codes for stereotactic radiation therapy with the existing CPT codes.***

**Radiation oncology: Medical Radiation Physics, Dosimetry, Treatment Devices, and Special Services (CPT Code 77301)**

CPT code 77301 describes intensity modulated radiation therapy (IMRT) planning. It was reviewed by the RUC in April 2012. CMS removed the equipment item "computer system, record and verify" from CPT Code 77301 and adjusted equipment time for "treatment planning system, IMRT (Corvus w-Peregrine 3D Monte Carlo)" from 376 to 330 minutes. The agency's rationale for these changes was that the computer system was not previously an input for this service and there was not sufficient information or evidence for them to conclude that there should be a change.

ASTRO believes there is evidence that these inputs are necessary and appropriate. ASTRO made a detailed presentation at the RUC on both these topics: the record and verify system and the treatment planning system.

The record and verify system is computer software that checks the position of the couch, collimator, gantry and any beam modifiers before a treatment is given. The work on the record and verify system is an essential part of the IMRT planning process and needed for patient safety.

The treatment planning system is used for 376 minutes, which includes time for the physician, physicist and dosimetrist to do the following tasks on the system: image correlation and manipulation, contouring, planning and verification. In the final rule, CMS argued that the time the physician spends on the treatment planning system 'is not appropriately placed on the technical component.' The physician spends significant independent time, not with clinical staff, at the treatment planning computer console performing work described by 77301. The independent physician time on the machine must be considered as time the treatment planning system is in use and included under equipment time for CPT Code 77301.

CMS is finalizing the CY 2013 interim final direct PE inputs for CPT code 77301 as established, which is not appropriate. ***ASTRO urges CMS to add the record and verify back in to the direct practice expense inputs for 77301 and re-adjust the times for the treatment planning system back to 376 minutes. The update should be retroactive to January 1, 2014.***

**Table 29 CY 2014 Interim Final Codes with Direct PE Input Recommendations Accepted with Refinements**

Table 29 in the CY 2014 Final Medicare Physician Fee Schedule lists refinements made by CMS

to RUC recommendations on direct PE inputs. These refinements are open to public comment. Earlier in this letter ASTRO identified several concerns with refinements found in this table related to HDR codes 77785-77787. In addition to these concerns, ASTRO would also like to address two additional codes.

CPT Code 77373 (SBRT delivery)

CMS has reduced the RUC recommended times for two pieces of equipment from 104 to 86 minutes.

- EQ211, pulse oximeter w-printer
- ER056, SRS system, SBRT, six systems, average

***The equipment times should remain at the RUC recommended time of 104 minutes. These recommendations were closely reviewed at the RUC and standard times were allocated.***

CPT Code 77600 (Hyperthermia treatment)

CMS has reduced the RUC recommended times for two pieces of equipment from 123 to 105 minutes.

- EF015, mayo stand
- ER035, hyperthermia system, ultrasound, external

***The equipment times should remain at the RUC recommended time of 123 minutes. These recommendations were closely reviewed at the RUC and standard times were allocated.***

Anomalous Supply Inputs

CMS is removing six items from the direct PE input database from CY2014 – including SK107 “fee, usage, cyclotron/accelerator, gammaknife, Linac SRS System” included in CPT codes 77423 and 77422, because they do not consider these disposable supplies. CMS believes these items are more appropriately categorized as indirect PE inputs. ASTRO believe this expense should be included in the equipment direct expense category with the appropriate minutes associated with each code, 77422/51 minutes and 77423/71 minutes. The fee relates directly to the procedures/equipment and is not an indirect expense. ***ASTRO requests CMS to add SK107 back into the PE database under the equipment direct expense category.***

Upon review of this issue we have identified that the equipment list is missing the RVS system and the laser targeting system – both of which were in the original RUC recommendations. The original CMS code for the RVS system was E51022. The laser targeting system code is ER040. ***ASTRO requests CMS to add back both pieces of equipment and the appropriate minutes associated with each code 77422/51 minutes and 77423/71 minutes.***

Physician Quality Reporting System (PQRS)

ASTRO would like to thank CMS for renewing the Oncology Measures Group for the 2014 Physician Quality Reporting System (PQRS) reporting period and for maintaining the minimum 20-patient reporting requirement for measures groups.

### Increased Minimum for Individual Measures Reported via Claims, Registry, or Qualified Clinical Data Registries

CMS finalized the proposal to increase the individual measures requirement for the 2014 PQRS program from a minimum of three measures to a minimum of nine measures that cover at least three National Quality Strategy (NQS) domains in order to align with the Electronic Health Records Incentive Programs' requirements. ASTRO supports CMS's goal to emphasize quality improvement activities in the domains specified by the NQS and to align the reporting requirements across the various reporting mechanisms and CMS programs. ASTRO has commenced work on developing measures that meet these requirements by creating a measures subcommittee. The subcommittee is responsible for working collaboratively with other stakeholders to develop radiation oncology-specific measures, and it is aligning its measure strategy goals with the NQS domains. However, measure development with National Quality Forum endorsement is a lengthy process that can take, at minimum, one year to complete, if not longer. For specialties like radiation oncology that lack a robust set of measures, the requirement for nine quality measures that cover at least three NQS domains is burdensome and will be difficult to meet despite our best efforts. ***In future rulemaking, ASTRO urges CMS to be more sensitive to the challenges faced by some specialties in the measure development process.***

### Qualified Clinical Data Registries

ASTRO supports the addition of Qualified Clinical Data Registries (QCDRs) as new reporting mechanisms under PQRS and the Electronic Health Records (EHR) Incentive Program. ASTRO is developing the National Radiation Oncology Registry (NROR), the first of its kind for radiation oncology. The intent of the NROR is to improve the care of cancer patients by collecting valuable quality data on radiation treatment delivery and health outcomes. ASTRO is considering its options for getting the NROR certified as a QCDR so that radiation oncologists will have more options to successfully participate in these CMS programs.

In the final rule, CMS finalized the proposed definition for QCDRs with minor modifications. Additionally, CMS finalized twelve of the fourteen proposed PQRS requirements for QCDRs. We appreciate the agency's decision to decrease the number of participants in half to fifty. However, ASTRO would like to stress that, although QCDRs are defined under PQRS, they should be thought of as distinct and separate entities that exist apart from PQRS. ***ASTRO recommends that the criteria and characteristics that have been finalized for the purposes of PQRS should not be the only acceptable criteria and characteristics for QCDRs.***

CMS agreed with comments that QCDRs are in the best position to decide what measures should be reported for quality of care provided by their participants, and therefore is giving QCDRs the ability to select quality measures. CMS specified that QCDRs must have at least nine measures covering at least three NQS domains, and at least one of the nine measures must be an outcome measure. ASTRO supports CMS's approach for QCDR measures selections, but would like to reiterate our above concerns about these onerous requirements. ASTRO is generally supportive of the definition and requirements for QCDRs, but we have some concerns. ***ASTRO would like to caution the agency to consider that QCDRs should serve roles that foster quality improvement, in addition to data collection and submission for CMS programs.***

**Electronic Health Records Incentive Program**

In the final rule, CMS finalized a policy that will allow providers more flexibility for participation in the 2014 EHR Incentive Program. CMS will accept reporting periods of different quarters for reporting of CQMs and for reporting of meaningful use functional objectives and measures. *ASTRO supports this flexibility that allows providers more options to successfully participate in the EHR Incentive Programs.*

**Physician Compare Website**

ASTRO supports the continuing development of Physician Compare into a valuable resource for Medicare beneficiaries. We believe that Physician Compare is an important tool for providing beneficiaries with comparable information on quality and patient measures. *ASTRO believes that it is important for CMS to continue to work collaboratively with specialty societies so that quality and useful information is provided to beneficiaries to help them make informed health care decisions.*

Thank you for the opportunity to comment on this final 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 Sheila Madhani, Assistant Director of Medicare Policy, ASTRO Government Relations Department at (703) 839-7372 or sheilam@astro.org.

Sincerely,



Laura I. Thevenot  
Chief Executive Officer

cc: Edith Hambrick, MD  
Steve Phurrough, MD  
Kathy Bryant