ASTRO
TARGETING CANCER CARE

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Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Wave 5 MIPS Cost Measure Development Proposal – Submitted electronically: macra-cost-measures-info@acumenllc.com

To Whom It May Concern:

The American Society for Radiation Oncology[1] is writing in response to the Wave 5 MIPS Cost Measure Development Proposal issued by the Centers for Medicare and Medicaid Services (CMS) and Acumen, LLC. The Wave 5 Measure Development document includes a proposal to establish a cost measure associated with prostate cancer. ASTRO appreciates the opportunity to provide comments on this segment of the overall proposal.

According to the proposal, a prostate cancer episode would be triggered by a pair of services billed by the same clinician group that indicate the start of a care relationship to treat prostate cancer, such as outpatient evaluation and management (E&M) services or chemotherapy when paired with prostate cancer diagnosis codes.

Before responding to the specific questions related to the measure, we recommend that CMS and Acumen acquaint themselves with the National Comprehensive Cancer Network (NCCN) guidelines specific to prostate cancer. Review of the guidelines will give CMS and Acumen a clear understanding of the variety of prostate cancer stages that exist, as well as the variety of treatment options that each stage may involve. Variation in the cost of treating prostate cancer can be attributed to these factors and must be considered as part of any measure development activity.

Question 1: Other cost measures have used algorithms as proxies to identify conditions of interest to account for differences in expected costs. For example, the diabetes cost measure that was added to MIPS in 2022 stratifies patients into sub-groups for Type 1 and Type 2 diabetes based on independent

[1] 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 patients with cancer each year. We believe this multidisciplinary membership makes us uniquely qualified to provide input on the inherently complex issues related to Medicare payment policy and coding for radiation oncology services.

indicators (e.g., share of Type 1 or Type 2 diagnosis codes over a year-long period), and the degree of agreement across these tests.

How should this measure account for differences in costs due to cancer severity using administrative claims data?

The proposal cites ICD-10 diagnosis codes in combination with or without secondary malignancy site codes, as well as a combination of ICD-10 data with hospitalizations or multiple outpatient visits as a potential for measuring cancer severity. While these claims-based data points may be helpful, they are limited and could potentially misinform the true severity of the disease if used as a proxy for staging prostate cancer.

Cancer staging is the most accurate way of understanding the severity of the diagnosis and the related treatment requirements associated with care delivery. For prostate cancer, staging as well as risk stratification, are the key considerations in understanding the differences in modality of treatment used, as well as the expected costs associated with treatment.

The proposal also states that it would compare any classification system against other indictors in claims data and check whether patients identified are receiving services that would be expected for that state or level of severity. In order to do this, CMS and Acumen need only refer to NCCN guidelines as a resource for determining the services expected by disease stage. Again, the challenge comes in collecting data on disease stage and risk category to make that determination.

Question 2: Are other types of cancer preferable for measure development, such as breast or lung cancer? Should we consider a broad cancer measure that stratifies patients by type of cancer and stage, and if so, what would that measure need to account for to ensure clinically meaningful comparisons?

Given that prostate cancer has a variety of stages and treatment scenarios that run the gamut between radical prostatectomy, which involves inpatient surgery, and radiation therapy, which is typically delivered in the outpatient setting, it may be reasonable to consider a more narrowly defined disease site with more distinct treatment regimes. Early-stage breast cancer for example may be worth exploring.

As a result of the Wave 1 cost measures development work, CMS and Acumen established the *Lumpectomy, Partial Mastectomy, Simple Mastectomy Measure*. This measure evaluates the risk-adjusted cost to Medicare for beneficiaries who undergo partial or total mastectomy for breast cancer during the performance period. The cost measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician's role in managing care during each episode from 30 days prior to the clinical event that opens, or "triggers," the episode through 90 days after the trigger.

Patients who are treated for breast cancer with a lumpectomy, partial mastectomy, or simple mastectomy are frequently referred to a radiation oncologist and/or a medical oncologist for further treatment with radiation therapy and/or chemotherapy. Because CMS and Acumen have already established the surgical cost measure, it would be reasonable to consider a post-surgical cost measure specific to the radiation oncology and medical oncology services that are delivered as part of the overall cancer care continuum.

Additionally, since patients are already identified under the surgical cost measure, this may alleviate the complexity of capturing the intended patient population. We would welcome a dialogue with CMS, Acumen and

our colleagues at the American Society for Clinical Oncology to further discuss how such a measure would be developed and implemented.

Question 3: Given that drug costs dominate costs of care across types of cancer, what are other opportunities for cost improvement? That is, what types of services are clinically related to the treatment and management of cancer that could distinguish variation in care?

As discussed in our response to Question 2, rather than focus on prostate cancer, an opportunity may exist with the establishment of a breast cancer cost measure to further explore the cost of drugs related to cancer treatment. We would encourage CMS and Acumen to give this further consideration.

Finally, while we recognize in this most recent proposal that CMS and Acumen are taking a different approach to selecting measures for development, we thought it important to revisit previous discussions. In Waves 1-3, Acumen obtained input on measure prioritization by convening experts in Clinical Subcommittees (CS), including one on urology that met in the spring of 2018. The CS discussed and voted on preferred episode groups which prioritized the groups for future measure development[2]. That exercise included prostate cancer treatment, which came in behind *Kidney Stone Removal or Destruction* and *Procedure Benign Prostatic Hyperplasia*. Work began on kidney stone removal, which resulted in the establishment of a *Renal or Ureteral Stone Surgical Treatment* measure. We are somewhat surprised that Acumen would decide to jump to prostate cancer rather than begin work on establishing a cost measure for *Procedure for Benign Prostatic Hyperplasia* or consider building on existing measures as suggested above.

Again, ASTRO thanks CMS and Acumen, LLC for the opportunity to comment. Should CMS and Acumen pursue the development of this measure, ASTRO would like to be included as part of the stakeholder engagement process. If you have any questions, please contact Anne Hubbard, Director of Health Policy, at Anne.Hubbard@ASTRO.org or 703-839-7394.

Sincerely,

Laura I. Thevenot
Chief Executive Officer

Laura Dawson, MD
Chair of the Board of Directors

[2] Episode Group Prioritization Survey Results – MACRA Episode-Based Cost Measures Clinical Subcommittees – Urologic Disease Management. April 2018