21st centurymedicine

VIA electronic mail to Glenn.McGuirk@cms.hhs.gov

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: New Clinical Diagnostic Laboratory Test Codes for the Clinical Laboratory Fee Schedule for Calendar Year 2015.

Dear Administrator Tavenner:

On behalf of the Coalition for 21st Century Medicine, and in follow-up to the comments we presented during the public meeting held on July 14, 2014, we are pleased to submit these additional comments for your consideration as you finalize your CY2015 Clinical Laboratory Fee Schedule (CLFS) Preliminary Payment Determinations.

The Coalition comprises many of the world's most innovative diagnostic technology companies, clinical laboratories, physicians, venture capital companies, and patient advocacy groups. Given the Coalition's mission to facilitate development and commercialization of innovative diagnostics to inform important patient management decisions, we have a keen interest in the agency's CLFS payment policies and determinations—especially those addressing coding and payment for: (1) Multianalyte Assays with Algorithmic Analyses and (2) Genomic Sequencing Procedures and other Molecular Multianalyte Assays.

Coalition member labs have developed diagnostics that make personalized medicine possible. By understanding the molecular nature of disease, these new tests allow clinicians and patients to select individualized treatment options, rather than basing treatment choices on broad assessment of what works best for a population. Member tests, among other things, assess cancer risk, identify productive chemotherapies, and predict the likelihood of cancer recurrence.

At the public meeting, the Coalition commented on two code categories under consideration by CMS: (1) Multianalyte Assays with Algorithmic Analyses and (2) Genomic Sequencing Procedures and other Molecular Multianalyte Assays. The comments that follow further elaborate on the Coalition's recommendations regarding codes in these two categories.

A. Multianalyte Assays with Algorithmic Analyses

Multianalyte Assays with Algorithmic Analyses (MAAAs) are developed by clinical laboratories or *in vitro* diagnostic manufacturers to address specific clinical questions or issues, such as (1) the likelihood that a tumor will recur in the future, (2) the likelihood that a tumor will respond to a particular drug treatment regimen, (3) whether or not a patient is experiencing rejection of a heart transplant, (4) the activity of disease in patients with rheumatoid arthritis, and (5) the likelihood that a nodule in the thyroid is benign. In each case, the laboratory develops an assay in which clinical laboratory methods are used to analyze tissue, blood, or other specimen or combination of specimens and produce a patient-specific report which the treating physician uses in the management of the patient.

Because MAAAs address biologically complex clinical questions for which values from multiple analytes must be considered, these assays require bioinformatics to translate the individual biomarker values into a single patient-specific result that can be readily interpreted by a treating physician. In this regard, MAAAs are like all other laboratory tests—the raw output from the test is not what produces the patient-specific report. With essentially all tests, raw signals require algorithmic or bioinformatic translation to decipher raw signals to a patient reportable result. The same is true for the MAAAs.

We commend CMS for the significant efforts made in the past few years to gain a greater understanding of MAAA tests and their importance to clinical practice in oncology and other fields where their use helps to answer biologically complex diagnostic questions. We likewise commend and support CMS's policy position articulated last year to set Medicare payment by gap-fill when the Medicare contractor determines the code is payable. The Coalition urges CMS to continue this policy now in determining the payment amount for the Category I MAAA test subject to the agency's review this year.

We also agree that gap-fill remains the preferred method to establish payment amounts for MAAAs. Working on a case-by-case basis with these tests over the past several years, MACs have developed approaches to set fair and reasonable payment for MAAAs. For the most part, the MACs have followed a gap-fill-like process.[1] Following this process, the MACs have looked at the following kinds of factors in rate-setting: (1) laboratory charges, (2) rates paid for the test by other payers considering contracts with private payers as well as median or mean payments on fully-adjudicated claims, (3) resources, including laboratory operations and research and development costs to develop the tests, and (4) the health economic impact of the information provided by the test in patient management. Where these distinct factors point to similar rate ranges, the MACs have determined a payment rate within that range. This process has been developed most fully by Palmetto GBA under the MolDx program, but other contractors have

[1] The process has not strictly fallen under the gap-fill regulations because the tests often have been billed using an unlisted service code or an unlisted service code combined with a combination of established codes—not a new/revised code under the national gap-fill process. *See* 42 C.F.R. § 414.508(b).

employed similar approaches. Most recently, a similar process was endorsed and established by Congress as the method for determining payment for lab services on a going-forward basis.

Several Medicare contractors that have extensive experience processing claims for MAAAs have developed reimbursement policy processes that involve close scrutiny of the laboratory and test, including site visits to the laboratory, evaluation of the diagnostic process, examination of underlying clinical validation studies through review of comprehensive dossiers of the clinical evidence supporting the use of the assays, and consideration of widely accepted analyses of resources required to develop and perform the test as well as the health economic impact of the test. Because such extensive interaction is necessary and already occurring as part of the coverage evaluation, the local contractor is best positioned to make the payment decision.

Other presenters also suggested that the appropriate process for pricing MAAA codes was to allow local contractors to use a gap-filling methodology within their jurisdiction. These presenters recognized the unique nature of this test and acknowledged that no existing code or set of codes completely and accurately describes this test.

In summary, the Coalition recommends that CMS allow the applicable MAC to determine the payment rate for MAAA tests, and that it be directed to do so using the gap-fill methodology. AMA established MAAA codes to bring more granularity to coding to enable payors to more specifically price tests, and to know what they are paying for. CMS should advance the AMA's objective by ensuring that each code and its associated payment applies to a single test described by that code.

B. Genomic Sequencing Procedures (GSPs) and other Molecular Multianalyte Assays

The Genomic Sequencing Procedures subject to review by CMS for 2015 look across few or many targeted genes to broad swaths of the human genome, sometimes the whole genome, to identify clinically actionable variants revealed through multi-gene sequencing. These variants are genetic (i.e. germline) or genomic (i.e. somatic) abnormalities that can diagnose heart disease or better inform cancer treatment options, among other many clinically useful applications.

The Coalition also recommends that CMS defer to local contractors to determine payment amounts through a gap-filling approach for GSP tests when the contractor determines that a code is payable. Deferring to local contractors to determine the payment amount is the right approach for GSP tests. GSP tests tend to be complex tests that require a deep inquiry into the multiple components of and benefits derived from the test to evaluate Medicare coverage. That inquiry requires extended dialogue between the laboratory or manufacturer and the entity making the coverage determination. Moreover, GSP tests typically are developed by and are unique to a single clinical laboratory or, in certain cases, a single manufacturer. As such, oftentimes all or virtually all of the claims for that test are processed through one contractor. Several Medicare contractors are actively developing and/or finalizing GSP reimbursement

policy processes that involve close scrutiny of the laboratory and test(s), including site visits to the laboratory, evaluation of the diagnostic process, examination of underlying analytic and clinical validation plus clinical utility studies through review of comprehensive dossiers of the clinical evidence supporting the use of the assays, and consideration of widely accepted analyses of all resources required to develop and perform the test as well as the health economic impact of the test. Because such extensive interaction is necessary and already occurring as part of the coverage evaluation, the local contractor is best positioned to make the payment decision as well.

GSP codes approved by the AMA differ from MAAA codes in that they are non-specific, and without sufficient granularity to accurately differentiate among the wide variety of GSP tests. In addition, tests reported under GSP codes do not involve an algorithmic transformation of the component results to derive a risk or probability score per se. Each GSP code can apply to a wide variety of tests each uniquely designed to answer a multitude of clinical questions. Performance, defined as sensitivity, specificity and clinical utility, of this wide variety of tests can vary substantially, and as such, each GSP test must be reviewed and considered separately as part of the coverage evaluation.

Because GSP tests address biologically complex clinical questions for which values from multiple analytes must be considered, these assays often require robust computational biology algorithms with extensive bioinformatic analysis and report curation to accurately translate the individual biomarker values into patient-specific results that can be interpreted and acted upon by a treating physician. With essentially all GSP tests, raw signals from the laboratory sequencers often require both algorithmic analysis (to aid in selecting potentially actionable from non-actionable genetic or genomic variants) combined with extensive bioinformatic and medical translation to accurately decipher the high volume of raw data from the sequencer to yield patient reportable result(s). Additionally, many GSP tests require consistent updating of the gene sequences, computational algorithms and bioinformatics knowledgebase used for variant result interpretation and patient-specific reporting to reflect the current state of the evolving clinical evidence and associated treatment options. For these reasons, extended dialogue between the laboratory/manufacturer and the applicable MAC making the coverage determination is necessary to ensure that an appropriate coverage decision is made. Because such extensive interaction is necessary and occurring at the local contractor level, the local contractor is best positioned to also make the payment determination.

Similar to the MAAA codes subject to CMS's review this year, there are no analogues in the CLFS Tier 1 or Tier 2 codes that can be used as a cross-walk to describe the GSP tests subject to CMS's review. Only through transformation of the unique results utilizing technically and clinically validated algorithms and bioinformatics along with expert medical review and approval can one obtain the clinically actionable result(s) necessary to guide patient treatment and that accurately reflect the current state of the clinical evidence. As such, a gap-filling process remains the best option for determining the payment amount for these tests.

Finally, CMS should encourage contractors to establish and use unique test identifiers where appropriate to associate particular GSP tests with a payment amount. By their very nature, the GSP codes are non-specific, and many tests can appropriately map to a single code. Medicare payers need to be clear on what they are paying for, and to establish test-specific payment amounts that ensure appropriate program payment for a given test. Unique test identifiers allow CMS and its contractors to more accurately identify the GSP tests submitted for payment, and to act as responsible stewards of Medicare dollars.

During the July meeting, some presenters suggested various combinations of codes as potential crosswalk alternatives for the new GSP codes. While we acknowledge that crosswalking is an administratively simple and more transparent pricing methodology, we believe that the new GSP codes are sufficiently distinct from all existing test codes and should not be crosswalked. Setting the 2015 payment rates via crosswalking could have a chilling effect on dialog between laboratories, manufacturers and the local contractors which in turn could affect access to these services.

In summary the Coalition recommends that CMS allow the applicable MAC to determine the payment rate for GSP tests, and that it be directed to do so using the gap-fill methodology. Moreover, as with the MAAA codes, as part of the gap-fill process to determine payment, CMS and its contractors should review and consider commercial payer rates, among other data points, to inform Medicare payment amounts.

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The Coalition appreciates the opportunity to provide comments on the New CLFS Codes for CY 2015. If you have any questions about these comments, please contact me at 202.756.8148 or via electronic mail to ezimmerman@mwe.com.

Sincerely yours,

Eric Zimmerman