

Congress of the United States
Washington, DC 20515

December 17, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-8013

Dear Administrator Brooks-LaSure:

We know CMS strives to “put beneficiaries first” by “empowering patients to work with their doctors to make health care decisions that are in their best interest.” Further, CMS consistently pledges to support innovative approaches to improve quality, access and affordability. Value-based care requires value-based payment for pathways that show cost savings and improved outcomes. That is why we are contacting CMS regarding coronary computed tomography angiography (CCTA). CCTA is one such approach that saves lives and improves diagnostic quality, all while also remaining cost-effective.

Heart disease is the leading cause of death in the United States. Approximately 655,000 Americans die from heart disease annually – roughly 25% of deaths, despite advances in treatment and diagnostic strategies for coronary artery disease (CAD). Over the past two decades, an effective test for CAD has emerged based on strong clinical science, cost-effectiveness and the ability to positively impact patient outcomes: coronary computed tomography angiography (CCTA). Despite this, Medicare reimbursement rates for CCTA remain significantly lower than both clinical value as well as hospitals' cost of providing the exam, resulting in a substantial barrier to patient access. The CY 2022 Hospital Outpatient Prospective Payment System (OPPS) proposed reimbursement once again fails to address the flawed methodology that leads to this inadequacy. We therefore urge you to work with stakeholders to address this problem by grouping CCTA with similar medical services, enabling hospitals to submit accurate charges and CMS to reimburse the test appropriately.

CCTA is a noninvasive imaging procedure that detects CAD and quantifies the narrowing of arteries among patients with chest pain. CCTA utilizes a CT scanner, intravenous contrast, and vasoactive agents such as beta-blockers and nitrates to slow the heart and obtain still-framed, high-resolution 3D pictures of a patient’s coronary arteries. Through this technology, CCTA detects blockages – both hard and the more difficult to find soft plaques – which may be more likely to cause heart attacks and death. Clinical data supporting CCTA as a first-line test that improves patient outcomes has matured to the point where clinical guidelines throughout the world have adopted this approach.

CCTA’s value to patients and the healthcare system has three main components:

1. Over 70% of patients referred for CCTA do not have significant coronary narrowing. These patients can be reassured that their symptoms are not coronary heart disease-related and have no additional cardiac testing is necessary, representing both peace of mind and systemic medical cost savings.

2. Patients with early stage CAD but without a significant blockage can be treated with medication for underlying CAD risk factors. This ability to visualize pre-clinical CAD and act upon it is the main driver behind improved outcomes following CCTA.
3. In patients where CCTA shows possible or definite blockage, doctors can appropriately order additional tests or procedures (such as FFRCT or cardiac catheterization with revascularization). CCTA allows more precise selection of patients who are most likely to benefit from additional procedures.

Thus, CCTA prevents test layering, identifies patients who will most benefit from appropriate medications, and can significantly decrease downstream costs by optimizing care and treatment for each patient. In fact, due to the cost savings of CCTA, several large private insurance companies in the U.S. now support its use as a first-line test.

Despite the value and effectiveness of CCTA, Medicare reimbursement for CCTA has fallen by 30% since 2017. Medicare reimbursement for CCTA has been less than the hospital's cost for performing the test for over a decade and renders providing the test to patients cost prohibitive, as hospitals will do so at a financial loss limiting the use and frequency.

The issue lies with CMS' methodology for determining reimbursement. CCTA's reimbursement is low because OPPS regulation requires hospitals to submit CCTA claims under **general CT services**. However, unlike general CT services, CCTA requires additional staff work to administer vasoactive medications prior to the scan, a specially trained technologist to acquire the scan, and special post-processing and 3D workstation software to interpret the study. CCTA has clinical and resource utilization that more closely mirrors SPECT and stress echocardiography. Generic CT costs do not sufficiently capture the complexity of cardiac CT services, which utilize approximately 2-3 times as many resources.

This failure of Medicare to capture the cost of providing CCTA is creating a disparity among beneficiaries. Healthcare consulting firm ADVI used 2019 hospital outpatient claims to explore specific health equity variables: race, income, and urban/rural location. Among the key findings of ADVI's claims analysis:

- Despite ischemic heart disease diagnoses being evenly distributed across incomes, wealthier Metropolitan Statistical Areas (MSAs) have higher testing rates than the lowest income MSAs.
- Cardiac CTs were predominately performed in urban areas at teaching hospitals.
 - 96% occurred in urban areas while approximately 77% of Medicare beneficiaries live in urban areas.¹
 - Per capita cardiac CT imaging rates were higher in urban areas than rural areas and testing rates were highest in the top income MSAs.
 - 70% of cardiac CTs were administered at teaching hospitals (major or minor teaching status).
- Despite non-white² beneficiaries making up ~20% of the Medicare population, they only account for 14% of cardiac CT procedures.

These findings suggest that inadequate cardiac CT reimbursement creates a barrier to non-white patients and those in rural settings. We believe that failure to address the inadequate payment for cardiac CT will further widen healthcare disparities and continue to hinder access for Medicare beneficiaries.

¹ Urban FFS beneficiaries (using MedPAC's definition of residing in MSAs), 2019 = 30.1M (77%) Rural FFS beneficiaries = 9.0M (23%)

² Non-white defined as Black, Hispanic, Asian, Native American Native, Other, and unknown

To address inadequate cardiac CT reimbursement, we urge CMS to group cardiac CT codes with services more similar in clinical intensity, resource utilization, and cost. To render better alignment with clinical homogeneity, we request that CMS move CPT® codes 75572 and 75573 (contrast-enhanced cardiac CT codes) to Ambulatory Payment Classification (APC) 5572 and move CPT® code 75574 to APC 5573 (stress cardiac MRI or stress echocardiography). Further, we urge CMS to provide hospitals and practices flexibility to submit charges for cardiac CT procedures under revenue codes outside of general CT. This will allow future cost estimates to more accurately reflect true cardiac CT costs.

We hope that CMS will put beneficiaries first and support this value-based approach to improve quality, access and affordability. We encourage CMS to use its authority to “right-size” cardiac CTA reimbursement in the near term AND allow for more accurate estimation of cost long term. We look forward to working with you to alter reimbursement methodology to incentivize increased access, so that all providers across the U.S. can offer the benefits of CCTA to their patients.

Thank you for your consideration.

Sincerely,



Ted W. Lieu
Member of Congress



Kim Schrier
Member of Congress



Ashley Hinson
Member of Congress



Jake Auchincloss
Member of Congress



Terri A. Sewell
Member of Congress



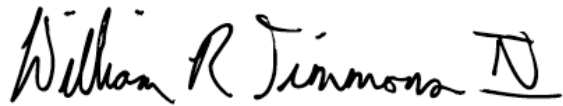
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