



August 21, 2023

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Electronically Submitted: <https://www.cms.gov/medicare-coverage-database/view/medicare-coverage-document.aspx?mcdid=35&docTypeId=-1&status=open&sortBy=title&bc=16>

Re: **Public Comment on Proposed Coverage with Evidence Development Guidance Document**

Dear Dr. Chin:

The American College of Radiology (ACR) representing more than 41,000 diagnostic radiologists, radiation oncologists, interventional radiologists, nuclear medicine physicians, and medical physicists, appreciates the opportunity to submit public comments in response to the Centers for Medicare and Medicaid Services (CMS) proposed Coverage with Evidence Development (CED) guidance document. We strongly support updates to factors CMS considers in making National Coverage Determinations (NCDs) using the CED framework to provide more predictable and transparent evidence development. ACR participated in the February 2023 Medicare Evidence Development & Coverage Advisory Committee (MEDCAC) public meeting to examine general requirements for clinical studies submitted for CMS coverage under CED.

We believe an NCD that requires CED as a condition of coverage should not last indefinitely and appropriate clinical end-points need to be included as part of the CED. CMS must ensure a clear pathway from CED to a coverage determination. CMS must also use reported CED results to inform new or revised coverage decisions. Once sufficient evidence is generated, the outcome should result in a coverage decision of either 1) sufficient evidence for a coverage NCD; 2) sufficient evidence for a non-coverage NCD; or 3) a decision to defer the coverage decision to a Medicare Administrative Contractor (MAC). **Improving the predictability of the CED process by setting start and end dates with a specific and transparent timeline would address stakeholder concerns with the current CED criteria.**

We fully understand that when the available evidence is insufficient to demonstrate that items and services are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, CED has been used to support evidence development that is likely to show benefit for the Medicare population. Over the years, many

innovative technologies have reached the market with limited or developing evidence for coverage purposes. CMS relies heavily on health outcomes data before proposing an NCD. There is rarely sufficient clinical evidence for new technologies to support broad national coverage. **We recommend that CMS establish appropriate outcome measures that better evaluate advanced imaging and specialty products (such as diagnostic radiopharmaceuticals) and their impact on patient management and clinical outcomes. ACR supports updates to the CED process to better reflect clinical practice using scientific rigor to ensure Medicare beneficiaries have access to care. Additionally, clarifying the process that will enable CMS and investigators to agree on the evidentiary threshold to discontinue the CED condition is important.**

The CED process has been assessed over time and improvements are necessary to ensure coverage decisions are reached after sufficient evidence is generated. Notably, a recent study identified the “wide range of program duration for the 4 programs with retired data collection requirements (4 to 12 years) and the long duration of CED programs resulting in NCD revocation (10 and 13 years).”¹ Another article, discussing the CMS decision to cover FDA-approved monoclonal antibodies directed against amyloid for the treatment of Alzheimer’s disease, noted the need for a “timeframe for CED completion and for a decision on whether coverage should be modified or withdrawn, based on the results, and mechanisms to ensure that results are published in the peer-reviewed literature.”² **The ACR believes that for any technology or service provided coverage through CED, an endpoint should be established for when the process is complete.**

We urge CMS to improve the current process by using the CED selectively to provide evidence-based coverage, establish specific and transparent timelines, and allow stakeholder input to incentivize innovation and afford timely access to services for Medicare beneficiaries. ACR has extensive experience with the CED process. The ACR is a professional organization committed to advancing the science and quality of radiological care for patients. As part of that commitment, the ACR Center for Research and Innovation is a prominent CED study sponsor and operation leader. In May 2006, the ACR launched the CED-approved National Oncologic PET Registry (NOPR), with collaboration from the Academy for Molecular Imaging, The American Society of Clinical Oncology, and the Society for Nuclear Medicine. Studies published in the *Journal of Clinical Oncology* the *Journal of Nuclear Medicine* and *Cancer* analyzed data from more than 41,000 NOPR cases and found that results of PET scans led to an intended change in cancer management of nearly 40 percent of patients³. Approximately 10 percent of all Medicare-covered PET scans in 2007 were performed under the auspices of the NOPR. In 2009, CMS duly expanded access and coverage of PET scans

¹ <https://www.ajmc.com/view/coverage-with-evidence-development-where-are-we-now->

² <https://www.healthaffairs.org/content/forefront/medicare-coverage-evidence-development-leaps-into-spotlight-cms-draft-national-coverage>

³ Impact of Positron Emission Tomography/Computed Tomography and Positron Emission Tomography (PET) Alone on Expected Management of Patients With Cancer: Initial Results From the National Oncologic PET Registry
Bruce E. Hillner, Barry A. Siegel, et.al. *Journal of Clinical Oncology* 2008 26:13, 2155-2161.

performed in both the initial and subsequent evaluation of patients with many types of cancer. This decision was based on significant clinical evidence regarding the effectiveness of PET for the management of patients with cancer gleaned from the NOPR.

Since Sept. 27, 2013, CMS has covered beta-amyloid PET imaging under CED. The ACR has worked with CMS over the last decade to generate the evidence necessary to expand coverage and access to this critical diagnostic tool for patients suffering from cognitive decline. The hallmark molecular biomarker of Alzheimer's disease (AD), beta-amyloid protein, can be non-invasively detected by PET. The ACR serves as the sponsor and operating center for the Imaging Dementia – Evidence for Amyloid Scanning (IDEAS) Study and subsequent New IDEAS study. These studies were developed to address the CED requirements of CMS's 2013 NCD 220.6.20. Building upon the momentum of the IDEAS Study, the research team launched the New IDEAS study in December 2020 to analyze the clinical utility of beta-amyloid PET imaging of the brain in a diverse cohort of individuals diagnosed with mild cognitive impairment (MCI) or dementia. Without the insights provided by a diverse cohort, the clinical utility and effectiveness of beta-amyloid PET are less likely to be fully understood. For example, genetic, medical, and lifestyle factors are known risks for dementia, although the evidence has been developed from mostly white cohorts. In contrast, racial adversity, vascular disease, education disparities, and inequitable health care access, all play important roles in the excess risk of AD in African Americans.⁴ Hence, the inclusion of New IDEAS data is critical to ensure the representativeness of the subject population, effective clinical management, and advancement of health equity within the cohort. As of July 27, 2023, the study has enrolled a total of 4,414 participants, of whom over 3,539 have already received their beta-amyloid PET scan. The national site network for the study includes 146 dementia practices and 126 PET imaging facilities. New IDEAS is still active and accepting applications for participating PET imaging facilities and dementia practices. However, coverage was not expanded despite clinical evidence and publications until the Agency's recent proposed decision to remove CED and allow local coverage decisions. The ACR's experience in conducting CMS-approved CED studies allows for insight into real-world barriers faced by the physician community since 2013.

In addition to our CED activities, since 2009, the ACR has requested several times that CMS Coverage and Analysis Group (CAG) include CT Colonography (CTC) as a covered exam for colorectal cancer screening in Medicare beneficiaries.⁵ A formal reconsideration request was submitted in 2022, presenting new supporting evidence and reflecting our ongoing concerns. CMS indicated that the additional evidence that was submitted was insufficient to support a reconsideration as it would not change the existing NCD. The ACR has provided ample evidence addressing the concerns raised by the coverage team over the past 14 years, but still, our formal reconsideration requests both past and present have not been accepted. CTC is the only American Cancer Society (ACS) and U.S. Preventive Services Task Force (USPSTF) that recommended

⁴ Barnes LL. Alzheimer disease in African American individuals: increased incidence or not enough data? *Nat Rev Neurol.* 2022 Jan;18(1):56-62. doi: 10.1038/s41582-021-00589-3. Epub 2021 Dec 6. PMID: 34873310; PMCID: PMC8647782.

⁵ [Screening Computed Tomography Colonography \(CTC\) for Colorectal Cancer.](#)

colorectal screening exam not covered by Medicare. **The ACR believes it is reasonable for CMS to conduct a National Coverage Analysis (NCA) to evaluate the available evidence for screening CTC and determine that a national coverage determination is warranted.**

ACR supports this proposed CED guidance to provide a more transparent and evidence-based framework to facilitate Medicare coverage. **CMS must remain flexible and work with sponsors/investigators to execute a written plan of agreed-upon key study milestones to ensure the timely completion of the CED process. Study design, protocols, outcome measures, and results should be made publicly available. Both AHRQ and CMS should meet regularly with the study sponsor to ensure sufficient evidence is generated and results are interpreted correctly.** Investigators may need additional guidance from CMS on outcomes of interest and study duration to decide on an effective study methodology that would generate the types of evidence that CMS would need to make a coverage determination decision and end CED. The proposed requirements will support early engagement between CMS, sponsors, FDA, and other stakeholders, and ultimately allow CMS to efficiently identify evidence gaps, provide guidance on study design, and complete the process in a timely and predictable manner. It will be imperative that CMS has adequate resources to ensure it can engage with stakeholders and provide detailed guidance on CED studies.

In its analysis, CMS mentions that the NCD process, in general, is a transparent one, and that requesters may meet with CMS informally and frequently. A tracking sheet is posted on the CMS website for the public to monitor the progress of the review. **ACR requests that CMS update the dashboard of CMS' NCD requests that are either under review, requests that have been reviewed and not yet opened (referred to as the NCD Wait List), open with a national coverage analysis underway, or finalized within the past 12 months.** The NCD Wait List is an alphabetical list of the complete, formal NCD requests that have been accepted by CMS that it intends to open in the future. This file was last updated in September 2020 so the public is not aware of future NCD requests. This dashboard should be updated with CED content quarterly to allow the public to monitor what is being considered. We encourage CMS to maintain information on ongoing CED research studies on its website, along with links to the ClinicalTrials.gov website.

We appreciate CMS recognizing the limitations of randomized controlled trials (RCTs) as it relates to items and services. There are ethical concerns about withholding treatment from the control group. CMS recognizes that not all studies can be single- or double-blinded. In cases where blinding is not possible or not used, CMS will closely examine the study design and analysis elements to mitigate the risk of bias. **ACR would like to suggest that when looking at outcome measures for diagnostic technologies, CMS should focus on the impact on patient management. CMS should also consider the need for randomized controlled trials when prospective registries that can incorporate real-world evidence would suffice. Limiting evidence review to only randomized controlled trials can raise ethical issues and could lead to uneven coverage of beneficiaries.** The proposed requirements would support innovation in real-world evidence-gathering strategies that support fit-for-purpose studies, allowing CMS to

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evaluate appropriate coverage in a predictable, transparent, and timely manner. We support the inclusion of real-world data when randomized control trials do not yield expected results. CMS may benefit more by moving towards more opportunities to incorporate real-world evidence through claims data, electronic health records, and other systems.

Thank you for your willingness to consider our comments on the clinical study standards for CED. ACR welcomes the opportunity to provide CMS with additional clinical or other information to assist CMS with its coverage policy decisions. If you have any questions or comments on our letter, please do not hesitate to contact Alicia Blakey MS, Principal Economic Policy Analyst, at ablakey@acr.org.

Respectfully submitted,



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Chief Executive Officer