RADIATION THERAPY ALLIANCE
21st Century Oncology, Oncure Medical Corp.,
Radiation Oncology Services of America, Vantage Oncology, Inc.
1050 K Street | Suite 315 | Washington, DC 20001 | 202 442-3710

August 30, 2011

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services (CMS)
Attention: CMS-1524-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Proposed Rule: Medicare Program; Payment Policies Under the Physician Fee Schedule for CY 2012 [CMS-1524-P]

Dear Dr. Berwick:

The Radiation Therapy Alliance (RTA) appreciates the opportunity, on behalf of physicians and staff at over 207 freestanding radiation therapy facilities in 21 states serving approximately 75,000 patients annually, to comment on the 2012 Proposed Physician Fee Schedule (PFS) Rule as it relates to proposed changes affecting freestanding radiation therapy providers. The RTA is an organization that represents for-profit, freestanding radiation therapy facilities, including 21st Century Oncology, Oncure Medical Corp., Radiation Oncology Services of America, and Vantage Oncology, Inc.

The members of the RTA strongly believe that fair, stable, and predictable reimbursement policy is critical for the development and delivery of the community-based cancer care that we and other freestanding radiation oncology providers offer to our patients. While the RTA continues to pursue opportunities with CMS to develop innovative payment reform for the delivery of quality care and stable, predictable reimbursement, we also provide this comment letter with the hope that through existing rulemaking authority CMS can pursue both stable and predictable reimbursement and improvements in the incentives for quality care.

The nature of quality cancer care in the radiation oncology sector requires acquisition and financing of expensive, long-lived equipment. While seeking to provide convenient access to care for all patients, including those in rural communities, the uncertainty posed by annual reimbursement risk in Medicare can discourage the investment in new equipment and construction of new facilities. Transparency, payment stability, and predictability can reduce this risk and lead, over time, to greater patient access.

We offer four comments on specific provisions of the PFS for your consideration.

1. Continued Shift in Site of Service Necessitates Reweighting of the PEHR for Radiation Oncology

Over the past several years, the share of radiation oncology patients treated outside of the hospital setting has increased relative to the share treated in the hospital. The RTA believes this is appropriate, as patients can receive their radiation treatment in a more convenient and lower-cost setting.

As CMS is aware, the calculation of the Indirect Practice Cost Index (IPCI) in the PERVU Methodology is the ratio between estimated indirect costs calculated via the PEHR to estimated indirect costs calculated via the PERVU. For each specialty, the IPCI numerator is the product of three factors for every code billed: the total number of services billed, the indirect practice expense from the PEHR, and the physician minutes associated with the service. The PEHR for radiation oncology is the blended average of practice costs for hospital-based radiation oncologists and those based in freestanding locations. There is a significant difference in practice costs between these two settings, as freestanding oncologists have costs associated with treatment delivery, whereas hospital-based oncologists only have costs associated with treatment planning. The ratio used to blend the two disparate PEHRs reflects the percentage of radiation oncologists practicing in each setting.

For the numerator of the IPCI to be correct, the PEHR must correctly weight hospital-based radiation oncologists and those based at freestanding facilities. Radiation oncology societies have provided evidence in the past of the impact of the shift in site of care, and CMS responded by adjusting the weight of practice costs in the calculation of the PEHR. As Table 1 demonstrates, this shift has continued, which suggests that the PEHR for radiation oncology also needs to adjust in order to prevent inappropriate downward pressure on the IPCI.

Table 1: Radiation Oncology Physician Minutes

Rule year	2007	2008	2009	2010	2011	2012
Data year	2005	2006	2007	2008	2009	2010
Total minutes of physician services						
Facility	245,508,667	249,903,083	250,367,262	241,600,266	201,305,784	191,521,377
Non-facility	151,190,793	158,524,290	171,757,043	177,698,870	154,808,281	151,836,441
Total	396,699,459	408,427,372	422,124,305	419,299,136	356,114,065	343,357,818
Ratio						
Facility/Total	62%	61%	59%	58%	57%	56%
Non-facility/Total	38%	39%	41%	42%	43%	44%
Source: Avalere Health analysis of CMS Utilization Data Crosswalk File published with CY 2007-2011 Final Physician Fee Schedule rules and CY 2012 Proposed Physician Fee Schedule rule, matched to CMS PE physician time data from the same final or proposed rule.						

The RTA requests that CMS reweight the PEHR for radiation oncology to reflect the most recent data concerning the ratio of minutes worked in the non-hospital setting relative to the hospital setting. This change will be consistent with the methodology CMS used when first implementing the PPIS data in calculating the PEHR. In addition, the RTA requests that CMS monitor this ratio each year and make the appropriate changes.

2. Value-Based Payment Modifier

The Affordable Care Act ("ACA") requires the Secretary to establish a budget-neutral value-based payment modifier that provides for differential payments to physicians based on the quality of care compared to cost of care. CMS notes in the Proposed Rule that the value modifier is important in transitioning how it pays for physician services under Medicare. Indeed, CMS notes that value-based payment adjustments for hospitals and other healthcare providers are underway, and views the physician value modifier "as the companion value-based payment mechanism for physicians." Because the ACA requires the Secretary to begin applying the value modifier to certain physicians on January 1, 2015, CMS proposes CY 2013 as the initial performance period for the modifier. The ACA also requires, not later than January 2012, that the Secretary publish measures of quality of care and costs.

In the Proposed Rule, CMS notes that it views the requirement for the Secretary to establish quality measures for the value modifier by January 1, 2012, as "the first step in identifying a robust core set of measures of the quality of care furnished by physicians for use in the value modifier." For 2012, CMS proposes (1) measures in the core set of the Physician Quality Report System (PQRS), (2) all measures in the PQRS Group Practice Reporting Option, (3) the core measures and alternate core measures, and (4) 38 additional measures in the Electronic Health Record (EHR) Incentive Program.

As indicated in response to previous rulemaking on the PFS, the RTA continues to be concerned that quality measures contained in the PQRS and the EHR Incentive Program are inadequate for radiation therapy. As such, we are encouraged that CMS states in the Proposed Rule that one of its goals "is to start a discussion about potential measures that could provide a richer picture of the quality of care furnished by a physician" and that CMS is "very interested in quality measures that assess the care provided by specialists." We also are encouraged that CMS is interested in quality measures that reflect outcomes, patient experience, and patient safety. We believe the RTA's ongoing research into these and other areas (such as quality measures that measure adherence to guidelines) will prove valuable to CMS.

With respect to the development of cost measures, the RTA believes it is a logical approach for CMS to develop episode groupers, which combine separate but clinically related items and services. Moreover, the RTA agrees with CMS's intent to select certain high-cost, high-volume conditions for which to develop episode groupers over a four-year period. Here again, the RTA's ongoing work in this area should prove valuable. Finally, the RTA notes that CMS plans to coordinate the value modifier with the Physician Feedback Program, the PQRS, and the EHR Incentive Program. We believe this is appropriate and suggest

that physicians subject to the value modifier not be subject to payment adjustments under other such programs under the PFS.

3. Geographic Practice Cost Indices (GPCI)

The GPCI has significant impacts upon reimbursement across regions. Given the nature of radiation oncology's large fixed (immobile) cost structure, this uncertainty and variation can discourage the development of new facilities as well as undermine the ability of radiation oncologists to provide continuing care to current Medicare patients. Beyond the fluctuation in reimbursement from the general impact of the PFS, changes in GPCI can add an additional layer of investment risk that can discourage development. The combined impact of the expiration of the statutory GPCI 1.0 work floor and the partial floor related to PE GPCI values on December 31, 2011 in conjunction with the GPCI changes in the Proposed Rule would result in large payment reductions in virtually all of the 21 states in which we operate. For some codes important to the provision of radiation therapy (e.g., 77418, 77300, 77314, and 77427), reductions will exceed 14–18 percent in some localities. The RTA urges CMS to recognize the potentially damaging impact of such payment volatility and encourages CMS to utilize any available administrative remedies to mitigate this dramatic impact should it occur as scheduled.

While the RTA supports the proposed reweighting of work, PE, and malpractice weights in the GPCI calculation to be consistent with the weights for the Medicare Economic Index (MEI), the broader impact of projected reductions in certain localities would have a harmful effect on the decision to make and maintain costly, long-lived investment in radiation therapy equipment.

4. Payment Incentives and Adjustment for Electronic Prescribing (eRx)

Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) established that Medicare shall provide incentive payments and penalty payments ("adjustments") for eligible professionals (EPs) who succeed or fail to succeed at electronically prescribing. The RTA agrees with CMS that "an incentive should be broadly available to encourage the widest possible adoption of electronic prescribing . . . [but] that a payment adjustment should be applied primarily to assure that those who have a large volume of prescribing do so electronically, without penalizing those for whom the adoption and use of an electronic prescribing system may be impractical given the low volume of prescribing."

With regard to circumstances under which payment adjustments would not apply because "adoption and use of an electronic prescribing system may be impractical given the low volume of prescribing," one exception that CMS proposes is that the payment adjustment to EPs for the eRx incentive or penalty may, after a case-by-case review of a hardship exception, not apply to EPs who prescribe fewer than 100 prescriptions during a 6-month period for 2013 and 2014.

In our estimation, a majority of radiation oncologists in freestanding facilities have prescribing volumes very near the 100/6-month threshold. The RTA requests that CMS revise this threshold upward from 100

to 150 prescriptions/6-month to more fairly and equitably delineate between low- and high-volume prescribing. RTA is also seeking clarification on the necessary documentation and justification for application for exception according to the low-volume level. The RTA believes that a rigid criteria for applying for an exception, such as proposed, when set to a threshold that coincides with the average prescribing pattern may result in some low-volume physicians (e.g., 90 scripts in 6 months) receiving an exemption while other similarly situated providers with similar prescribing patterns (e.g., 105 scripts in 6 months) may face penalties. Similarly, a radiation oncologist's prescribing pattern may fluctuate such that he or she may prescribe more than 100 scripts in the 6-month reporting period used to determine eligibility for application for an exception but may then proceed to prescribe below that level in subsequent periods.

Moreover, the RTA is concerned that physicians may be subject to penalties but not eligible for incentive payments due to the limited number of "trigger codes" associated with the eRx program that are applicable to the prescribing patterns of radiation oncology. The RTA believes that such an outcome would not be consistent with the intent of the eRx program. As such, the RTA urges CMS to make explicit in the final rule that any EP not eligible for an incentive payment also not be subject to a negative payment adjustment.

Conclusion

We thank CMS for the opportunity to comment on the CY 2012 Physician Payment Rule. We would be happy to discuss any of these matters further. If you have additional questions regarding these matters and the views of the RTA, please contact RTA Executive Director Andrew Woods at (202) 442-3710.

Sincerely,

Christopher M. Rose, M.D., FASTRO
Chair, Radiation Therapy Alliance Policy Committee