RADIATION THERAPY ALLIANCE

21st Century Oncology, Alliance Oncology, Oncure Medical Corp., Physician Oncology Services, L.P., Radiation Oncology Services of America, Vantage Oncology, Inc.

1050 K Street | Suite 315 | Washington, DC 20001 | 202 442-3710

August 24, 2010

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services (CMS)
Attention: CMS-1503-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 2011 [CMS-1503-P]

Dear Dr. Berwick:

The Radiation Therapy Alliance (RTA) appreciates the opportunity, on behalf of physicians and staff at over 236 freestanding radiation therapy facilities in 24 states, to comment on the 2011 Proposed Physician Fee Schedule 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, Alliance Oncology, Oncure Medical Corp., Physician Oncology Services, L.P., Radiation Oncology Services of America, and Vantage Oncology, Inc.

This letter is focused on the following topics raised in the Proposed Rule: (1) updating the Medicare Economic Index (MEI), (2) updating the Geographic Practice Cost Index (GPCI) and (3) improving the physician feedback program and the forthcoming value-based payment modifier

Our views can be summarized as follows:

1. We urge CMS to proceed as proposed with the implementation of the new MEI (and RVU) updates because we believe that the current base year of 2000 is outdated.

2. We support CMS's decision to convene a technical advisory panel to study the MEI, as minor improvements in construction are always possible. However, CMS should not wait for the panel to conclude before rebasing the MEI.

3. We do not believe that CMS should implement the GPCI update as proposed as the methodology includes certain flaws and is not required until January 1, 2012.

4. The RTA agrees with CMS that careful and thorough stakeholder involvement in the development of quality metrics for the value-based modifier is critical and would appreciate the opportunity to be an active participant in that process, given that the RTA has already commenced its own quality initiative and has worked to identify proper outcome measures and reporting mechanisms.

Medicare Economic Index

For CY 2011, CMS proposes to rebase and revise the MEI and incorporate it into the CY 2011 physician fee schedule (PFS) update. Rebasing refers to moving the base year for the structure of costs of an input price index, while revising relates to other types of changes such as changing data sources, cost categories, or price proxies used in the input price index. CMS's proposed changes incorporate the most recently available, relevant, and appropriate information to develop the proposed MEI cost category weights and price proxies.

The MEI was last rebased and revised in the CY 2004 PFS final rule. The current base year for the MEI is 2000, which means that the cost weights in the index reflect physicians' expenses a decade ago. We agree with CMS that it is desirable to periodically rebase and revise the index so that the expense shares and their associated price proxies reflect more current conditions. The delivery of healthcare services is rapidly evolving, and the mix of labor and capital costs, office expenses, and other costs can shift significantly as technology and practice patterns shift.

Consistent with past practice when the MEI has been rebased, CMS proposes to make adjustments to ensure that estimates of aggregate CY 2011 PFS payments for work, practice expense (PE), and malpractice are in proportion to the weights for these categories in the rebased CY 2011 MEI. The table below summarizes the current and proposed percentages of the total RVUs assigned to each of the three types of RVUs: work, PE, and professional liability insurance (PLI).

Category	Current Percent of Total	Proposed Percent of Total	Percent Change
Work	52.5%	48.3%	–4.2%
PE	43.7%	47.4%	3.8%
PLI	3.9%	4.3%	0.4%

As noted in the proposed rule, in response to public comments made during prior rulemaking on issues related to scaling the work RVUs, CMS proposes to make the necessary MEI rebasing adjustments without adjusting the work RVUs. Instead, CMS proposes to increase the PE RVUs by an adjustment factor of 1.168 and the malpractice RVUs by an adjustment factor of 1.413. We support the CMS proposal and recommend that it be implemented in 2011 as proposed. To maintain budget neutrality as required by the statute, and following prior practice to minimize disruption, CMS proposes to make an

adjustment of 0.921 to the CY 2011 conversion factor to ensure that the adjustment to the PE RVUs and the malpractice RVUs do not cause an aggregate increase in CY 2011 PFS expenditures.

We note that the Physician Practice Information Survey (PPIS) data are used by CMS to calculate PE RVUs. As stated by CMS in the 2010 final rule, the PPIS data are the most comprehensive, multi-specialty, contemporaneous, consistently collected data available. And as MedPAC noted in a comment letter to CMS on August 31, 2009, "The PPIS is a more current and comprehensive source of PE data than the [data previously] relied on." While the RTA has previously expressed concern about the PPIS with regard to PE/HR data within radiation oncology (a concern we still hold), we consider the aggregate results from the recent PPIS to be the best cost information currently available for physicians and we consider them a significant improvement relative to the data currently employed.

It has been six years since the MEI was rebased, and the new PPIS data confirm what the physician community has recognized for many years. Specifically, PE and malpractice expense as percentages of total expense have increased. This fact should be reflected in the MEI and the aggregate CY 2011 PFS payments for work, PE, and malpractice.

Technical Advisory Panel

CMS also proposes to convene a technical advisory panel to assist the work already accomplished by the CMS Office of the Actuary later this year to review all aspects of the MEI, including the inputs, input weights, price-measurement proxies, and productivity adjustment. We urge CMS not to delay implementation of the rebased MEI pending the review of any recommendations that the panel might make. We believe it is highly unlikely that the panel's recommendations will significantly alter the distribution of work, PE, and malpractice expense that has been determined by the PPIS. Further, a delay of at least a year would be an additional, unnecessary delay since we believe a valid argument could be made that the rebasing should have been done last year when the PPIS data were first available.

In addition to a general review of weights, price-measurement proxies, and productivity adjustments for the MEI, we recommend that the technical advisory panel carefully study cost of capital proxies and explore if proxies better than the Consumer Price Index for Owner's Equivalent Rent and the Producer Price Index for Machinery and Equipment can be developed by the Bureau of Labor Statistics (BLS). Furthermore, we would encourage the technical advisory panel to consider the optimal periodicity for rebasing and revising the MEI in the future, as maintaining an up-to-date MEI will improve the accuracy of Medicare payments. Given that the employment cost index (ECI) is a critical input into the MEI, as well as an important component in a range of public policy decisions including monetary policy and setting federal and active-duty pay, the panel may want to coordinate with other agencies outside of CMS to ensure that ECI accuracy and timeliness are continually improved. We note that the President's FY 2011 Budget for BLS includes a proposed increase in funding related to the

Occupational Employment Statistics program, a survey that is critical for the ECI's own periodic updating.

In conclusion, we support the CMS proposal to rebase the MEI in 2011 based on PPIS data. We agree with the statement of the American Medical Association in their April 30, 2010, letter to CMS regarding the MEI when they indicate, "A comprehensive revision of the MEI is long overdue. We urge CMS to begin working on such a revision for implementation in 2011." While additional work beyond the rebasing and revising of MEI may be appropriate depending on the conclusions reached by the technical advisory panel, we believe that finalizing the changes in the proposed rule is a critical first step. Finally, we ask that implementation not be delayed pending the review of the MEI by a technical advisory panel later this year.

Geographic Practice Cost Indices (GPCIs)

The statute requires CMS to develop separate Geographic Practice Cost Indices (GPCIs) to measure resource cost differences among localities compared to the national average for each of the three fee schedule components (that is, work, PE, and malpractice). The statute also requires that the PE and malpractice GPCIs reflect the full relative cost differences, but that the physician work GPCIs reflect only one-quarter of the relative cost differences compared to the national average. Section 3102(b) of the Affordable Care Act ("ACA") requires the Secretary to "analyze current methods of establishing practice expense adjustments under subparagraph (A)(i) and evaluate data that fairly and reliably establishes distinctions in the cost of operating a medical practice in different fee schedule areas." This section also requires the Secretary to make appropriate adjustments to the PE GPCIs by **no later than January 1, 2012**. For CY 2011, CMS proposes to make adjustments to GPCI not required at this time.

In the Regulatory Impact Analysis section of the proposed rule, CMS states that with regard to the GPCI proposals: "The most significant changes would occur in 12 payment localities, where the GAF increases by more than 1 percent or decreases by more than 2 percent." We believe that this description of the impact is incomplete. Supplemental GPCI information for the proposed rule indicates that 28 localities will experience decreases of 2 percent or more when the changes are fully transitioned in CY 2012 with Puerto Rico and Metropolitan Boston projected for decreases of 11.3% and 6.4%, respectively. Four localities in California (Ventura, Los Angeles, San Mateo and San Francisco) will experience decreases between -3.3 and -3.9%.

CMS is imposing numerous changes to the GPCI both through the incorporation of new data and methodology and as the result of statutory requirements from the ACA and the precise impact of each change is difficult to disentangle. However, the RTA has identified two specific concerns with the proposed rule:

First, although CMS might reasonably argue that certain medical equipment and supplies should be considered a national market, such an argument is not appropriate in the case of labor-related costs,

such as those for security and janitorial services. And while it might be reasonable to break out office-related costs into finer categories for purposes of identifying good price or cost proxies and determining changes in the Medicare Economic Index (MEI), we do not believe it is equitable to use this framework to deny appropriate geographic adjustments.

Second, a major contributor to the decreased GAFs for those areas appears to be related to the CMS decision to disaggregate the broader office expenses component into nine new cost categories. We recognize that this proposed change is in response to the ACA requirement to "analyze current methods of establishing practice expense adjustments … and evaluate data that fairly and reliably establishes distinctions in the cost of operating a medical practice in different fee schedule areas." However, we also note that this statutory provision does not need to be implemented any sooner than January 1, 2012 nor are we persuaded that the proposed methodology is what the Congress had in mind.

The RTA recommends that for CY 2011, CMS should focus on what is immediately required by statute: revising the methodology for calculating the PE GPCIs so that the employee compensation and rent portions of the PE GPCIs reflect only one-half of the relative cost differences for each locality compared to the national average and holding harmless those localities that would otherwise be negatively affected by this change in the methodology. This will benefit lower cost locales while not penalizing physician practices in higher cost areas. We urge CMS not to proceed with other, unnecessary changes proposed to the GPCI including the revised weights and broader disaggregation of office expense categories.

Physician Feedback Program and Value-Based Payment Modifier

The Affordable Care Act continues and expands the Physician Resource Use Measurement & Reporting (RUR) Program and, phased in from January 1, 2015, to January 1, 2017, requires the creation of a budget-neutral payment modifier based on relative quality and cost of care provided. As CMS acknowledges in the proposed rule, “such a payment modifier will have an impact on the delivery of care to Medicare beneficiaries,” one that the RTA believes will be positive if appropriate quality metrics are developed for the specific services rendered by providers.

The RTA supports CMS’s efforts in this regard and agrees strongly that stakeholder involvement will be critical to the development and implementation of a successful program. The RTA, uniquely situated as the representative of 236 freestanding radiation therapy facilities, looks forward to working closely with CMS on the construction of appropriate quality measures. Already, the RTA has been working to develop its own quality initiative to track quality data for various cancer treatments. Such measures should interface with patient cohorts treated with other modalities (chemotherapy, surgery, or active surveillance), and thus the RTA considers it critical that a broad base of stakeholders be

consulted throughout the development of this process to ensure that consistent and appropriate measures, applicable across providers, are constructed.

CMS proposes in Phase II of the RUR Program, for prostate cancer and certain other chronic diseases, to report per-capita cost information as opposed to per-episode data due to limitations identified from the proprietary episode grouping software used by CMS previously. Furthermore, CMS proposes not including Physician Quality Reporting Initiative (PQRI) data with this cost information and instead using measures developed by CMS in the Generating Medicare Physician Quality Performance Measurement Results (GEM) project. The RTA agrees with the assessment by CMS that use of PQRI data would be difficult for "meaningful peer comparisons for purposes of these reports." In addition to the limitation of being restricted to 2007 data (as noted by CMS) the RTA also believes that the PQRI measures are inadequate for radiation therapy.

However, the RTA is concerned with the use of GEM measures as an alternative to PQRI, as GEM does not contain any measures for prostate cancer, and the breast cancer and colorectal cancer measures are only related to screening. The RTA encourages CMS to work expeditiously with stakeholders to improve quality measures as related to the RUR Program. We believe that the RTA's ongoing research in this area may prove useful to CMS, and we look forward to discussing these measures in greater detail when appropriate.

Conclusion

We thank CMS for the opportunity to comment on the CY 2011 Physician Payment Rule and to express our support for rebasing and revising the MEI as well as for the need for thorough and appropriate quality metrics tailored to radiation therapy. With regard to GPCI, we hope that CMS restrict its modifications only to those required by statute for CY 2011. We would be happy to discuss any of these matters further. If you have additional questions regarding these issues 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