

February 15, 2016

Andrew Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244-1850

*TRANSMITTED VIA EMAIL TO [episodegroups@cms.hhs.gov](mailto:episodegroups@cms.hhs.gov)*

**Re: Request for Comment on Episode Groups and on Specific Clinical Criteria and Patient Characteristics to Classify Patients into Care Episode and Patient Condition Groups**

Dear Acting Administrator Slavitt:

The Radiation Therapy Alliance (RTA) appreciates the opportunity to submit comments in response to your recent request for comment on episode groups and on specific clinical criteria and patient characteristics to classify patients into care episode and patient condition groups. The RTA represents 296 freestanding facilities in 35 states and was established to provide policymakers and the public with a greater understanding of the value of community-based radiation therapy facilities and the importance of logical, predictable payment reform to align incentives and ensure patient access to high-quality cancer care. RTA members include 21<sup>st</sup> Century Oncology, Association of Freestanding Radiation Oncology Centers (AFROC), Large Urology Group Practice Association (LUGPA), and Vantage Oncology.

The Medicare Access and CHIP Reauthorization Act (MACRA) requires qualifying alternative payment model (APM) participants to have 25 percent of Medicare revenues from APMs in 2019–2020, 50 percent in 2021–2022, and 75 percent in 2023 and subsequent years. In this letter, we propose twelve simple episode groupers that represent 96 percent of all radiation oncology revenues in the freestanding setting.

We believe that radiotherapy services are very well suited for APMs, and the RTA is committed to working cooperatively with CMS to ensure their development. In particular, we believe that radiation oncology APMs are feasible and desirable for three reasons: 1) the relatively small number of care episode groups (twelve) that capture a very large share of revenues (96 percent), 2) a clear start (trigger) and end to the care episode groups, and 3) the lack of necessity for finer categorization or episode adjustments based on patient co-morbidities.

In the remainder of this letter, the RTA provides responses to the questions posed in CMS's November 10, 2015, request for comment on episode groups.

## **RTA Responses to CMS Questions**

**Within a specialty, a limited number of conditions and procedures account for the bulk of spending. Focusing on the top conditions and procedures for a specialty, what care episode groups and patient condition groups would you suggest?**

Based on an analysis by Avalere Health of the 2013 Medicare 5 percent claims data, just 12 care episode groups (listed below) can capture approximately 96 percent of Medicare revenues for freestanding radiation oncologists and 95 percent of their Medicare patients. Please note that the fifth grouper—radiation for palliation of symptoms of metastatic cancer—will capture all palliative radiotherapy care, regardless of the cancer site.

|     | <b>Care Episode Group</b>  | <b>Percent of Free-Standing Radiation Oncology Cases</b> | <b>Percent of Free-Standing Radiation Oncology Spending</b> |
|-----|--|--|---|
| 1.  | Radiotherapeutic Management of Prostate Cancer                                 | 21.1%  | 36.4%   |
| 2.  | Radiotherapeutic Management of Breast Cancer                                   | 14.0%  | 13.9%   |
| 3.  | Radiotherapeutic Management of Lung Cancer                                     | 13.0%  | 12.1%   |
| 4.  | Radiotherapeutic Management of Head and Neck Cancer                            | 7.5%   | 8.7%  |
| 5.  | Radiation for Palliation of Symptoms of Metastatic Cancer                      | 15.6%  | 7.6%  |
| 6.  | Radiotherapeutic Management of Non-Melanocytic Skin Cancer                     | 11.9%  | 5.8%  |
| 7.  | Radiotherapeutic Management of Rectal Cancer                                   | 2.9%   | 3.1%  |
| 8.  | Radiotherapeutic Management of Other GU Malignancies (Kidney, Bladder, Ureter) | 3.1%   | 3.0%  |
| 9.  | Radiotherapeutic Management of Hodgkin's and Non-Hodgkin's Lymphoma            | 3.3%   | 2.6%  |
| 10. | Radiotherapeutic Management of Pancreatic and Gastric Cancer                   | 1.8%   | 1.9%  |
| 11. | Radiotherapeutic Management of Endometrial Cancer                              | 0.5%   | 0.5%  |
| 12. | Radiotherapeutic Management of Cervical Cancer                                 | 0.4%   | 0.4%  |

**What specific clinical criteria and patient characteristics should be used to classify patients into care episode groups and patient condition groups?**

To simplify the groupers, the clinical criteria that should be used to classify the patient into the care episode group should be a combination of the ICD-10 code and all of the radiation oncology services associated with that code (those services included in the 77XXX series and associated G-codes). It is our opinion that patient condition groups are not relevant or necessary. If the patient is sufficiently fit to undergo a course of (usually curative) radiation therapy, the common co-morbidities would not sufficiently alter the course of care so as to change the resource allocation. We believe that the lack of need for patient condition groups is a significant simplification for the development of APMs for radiation oncology.

**What rules should be used to aggregate clinical care into an episode group?**

The trigger code in all of these episodes would be the radiotherapy treatment planning code. The APM would then “look back” and include the other services of the primary provider up to and including the E/M code for the initial visit. Services would include all 77XXX codes, G-codes, 99XXX codes, and associated radiation oncology codes managed by the primary provider or members of his or her medical group out to the lesser of a) 180 days after the trigger code or b) the second follow-up visit E/M service after the series of radiotherapy codes.

**When should an episode be split into finer categories? Should multiple, simultaneous episodes be allowed?**

The resource consumption of early- and late-stage malignancies treated with radiation is sufficiently similar such that an episode need not be split into finer categories. Multiple simultaneous episodes should not be allowed.

**Medicare beneficiaries often have multiple co-morbidities. Recognizing the challenge of distinguishing the services furnished for any one condition in the care of patients with multiple chronic conditions, how should CMS approach development of patient condition groups for patients with multiple chronic care conditions?**

For radiotherapy episodes, there would be no need for allocation of services for other co-morbidities, as the resource intensity of these episodes exhibits minimal variation for patients with multiple co-morbidities.

**Given that these co-morbidities are often inter-related, what approaches can be used to determine whether a service or claim should be included in an episode?**

Beyond “radiotherapy specific codes,” the only other claims that would be included would be those related to the management of morbidity and side-effect management secondary to the radiation.

**What should be the duration of patient condition groups for chronic conditions (e.g., shorter or longer than a year)?**

Shorter than one year. Specifically, the lesser of a) 180 days after the trigger code or b) the second E/M service after the last radiotherapy treatment.

**How can care coordination be addressed in measuring resource use?**

Care coordination would be included in the episode by CPT 77427, the weekly management code and, when appropriate, by CPT 77470.

**CMS has received public comment encouraging CMS to align resource use measures (which utilize episode grouping) with clinical quality measures. How can episodes be designed to achieve this goal?**

At the completion of the episode, the provider will be required to provide outcome data to CMS as part of a Qualified Clinical Data Registry (QCDR). The RTA envisions the new episode-based model would specify that reporting to a qualified clinical data registry would consist of (1) adherence to physician decision-making to consensus medical guidelines, (2) collection of process of care quality data and (3) collection of meaningful outcomes and related clinical quality data for the development of real-time, evidence-based guidelines that continuously evolve alongside advancements in cancer care.

**Information that is not in the claims data may be needed to create a more reliable episode. For example, the stage of a cancer and responsiveness history may be useful in defining cancer episodes. How can the validity of an episode be maximized without such clinical information?**

Administrative data linked to data from a QCDR are feasible for radiation therapy providers and will give CMS and providers useful information in this regard.

**How can complications, severity of illness, potentially avoidable occurrences and other consequences of care be addressed in measuring resource use?**

Management of radiotherapy-related complications should be included in the episode.

**Reliability of resource use measures are impacted by sample size. How should low volume patient condition groups and care episodes be handled?**

Resource consumption should be similar for low- and high-volume patient condition groups.

**How should the resources be reported for an episode that is truncated (cut short, likely resulting in a resource usage reduction) by death or the onset of another related episode? Should imputed values be used to add resources to the truncated episode (for comparison purposes)?**

Yes, imputed values should be used. In addition, truncated episodes should be documented in the QCDR.

### **Additional Considerations**

**Method A vs. Method B.** The RTA believes that either Method A or Method B could be used for the development of APMs for radiation therapy services. If Method A is used, we recommend that it be modified to permit the opening trigger options set forth in Method B.

**Payments.** Given historical Medicare payment volatility in the freestanding radiation oncology setting, it is imperative that the resource inputs for APMs not be based on year-by-year changes in the underlying Physician Fee Schedule. Rather, we recommend that CMS use a base of payments in a particular base year so that total payments under the new APM equal the base year (as updated by the APM conversion factor).

### **Conclusion**

Thank you for the opportunity to submit comments on episode groups and on specific clinical criteria and patient characteristics to classify patients into care episode and patient condition groups. The RTA believes that radiation therapy is a well-suited modality for the payment reforms intended by MACRA, and we look forward to working collaboratively with CMS as these models are developed. 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,

A handwritten signature in black ink that reads "Christopher M. Rose". The signature is written in a cursive, flowing style.

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