RADIATION THERAPY ALLIANCE

21st Century Oncology, Vantage Oncology, Inc., The University of Pittsburgh Medical Center, Accuray, C&G Technologies

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January 27, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014 (CMS-1600-FC)

Dear Administrator Tavenner:

The Radiation Therapy Alliance (RTA) appreciates the opportunity to submit comments regarding the CY 2014 Physician Fee Schedule (PFS) Final Rule. The RTA represents 244 community-based cancer care facilities in 22 states caring for approximately 98,000 patients annually. The RTA was established to provide policymakers and the public with a greater understanding of the value that community-based radiation therapy facilities bring to their patients and of the importance of logical, predictable payment reform to align incentives and ensure patient access to quality cancer care. RTA members include provider companies 21st Century Oncology, UPMC Cancer Centers, and Vantage Oncology, as well as equipment manufacturers Accuray and C&G Technologies.

As this letter details, the RTA remains concerned about three matters: 1) the impact of the Final Rule on the widening disparity between freestanding and hospital-based providers, 2) the OPD/ASC cap and, and 3) the appropriate value of the radiation therapy vault and the service and maintenance costs for linear accelerators.

Before discussing our concerns, we wish to thank CMS for adjusting the price for the laser diode probe (ER040), which had a direct PE input database price of $7,678, to the corrected price of $18,160. The RTA raised this issue with CMS in our December 31, 2012, comment letter to the CY 2013 PFS Final Rule, and we appreciate the agency's finalizing this adjustment in the CY 2014 PFS Final Rule.

1. Impact of Final Rule on disparity between freestanding and hospital-based providers

The impact of the PFS Proposed Rule on freestanding radiation oncology would have been a substantial cut of 7.7%, primarily due to the OPD/ASC cap proposal. The Final Rule increases freestanding radiation oncology payments 0.2%, primarily because of CMS's decision not to finalize the OPD/ASC cap proposal. The RTA appreciates this decision, as the consequences would have included significant disruptions to our practice of community-based medicine.

Because the Proposed and Final Rules estimated the combined impact on freestanding and hospital-based radiation oncology, they masked the distinct impact on each provider type. While the Final Rule resulted in no cut on freestanding radiation oncology providers, hospital-based radiation therapy providers received a 4% increase. We remain concerned about the growing disparity in payment rates across provider type. According to an Avalere Health analysis, Medicare reimbursement for freestanding radiation therapy has been reduced by nearly 19% since 2004, while reimbursement for hospital-based radiation therapy providers has increased 7%. The RTA remains concerned about this disparity, as it creates incentives for hospitals to acquire freestanding facilities, exercise pricing power in local markets, and increase overall Medicare spending.

2. Agency's withdrawal of OPD/ASC cap

The RTA urged CMS in our comment letter on the Proposed Rule not to finalize the proposed OPD/ASC cap, an opinion shared by a large number of commenters. As we noted, it is not appropriate to compare reimbursement rates for specific services under markedly different payment methodologies. The data and methodologies underlying the construction and determination of rates are complex and vary significantly across payment rules. We appreciate CMS's decision to accept this recommendation.

However, we are concerned about beliefs that CMS expressed in the Final Rule:

> We also continue to believe that if the total Medicare payment when a service is furnished in the physician office setting exceeds the total Medicare payment when a service is furnished in an HOPD or an ASC, this is generally not the result of appropriate payment differentials between the services furnished in different settings. Rather, we continue to believe that it is primarily due to anomalies in the data we use under the PFS and in the application of our resource-based PE methodology to the particular services.

The RTA respectfully disagrees with this perspective and urges CMS to comprehensively evaluate payments across settings in radiation oncology for an episode of care rather than an individual service. Such an episode-based comparison indicates that for an average case episode consisting of 25 or more radiotherapy sessions, freestanding providers are reimbursed approximately 90% of what hospital-based providers are reimbursed. As noted above, that disparity increased in 2014 relative to 2013.

3. Appropriate value of radiation therapy vault and service and maintenance costs for linear accelerators

The RTA believes that CMS continues to undervalue payments to freestanding radiation therapy providers due to outmoded vault costs and service costs associated with the linear accelerator. On December 31, 2013, the RTA, through a contract with Avalere Health, submitted updated equipment costs pursuant to the process CMS established in the CY 2011 PFS. The data indicate that CMS's assumed cost of $773,104 for putting a vault system in place is currently undervalued by over $121,000. The median cost (based on 4 recent vault costs) was $894,806 compared to the cost assumed by CMS, $773,104. We request that the updated vault cost be included for all relevant service codes (77402–77416, 77418, 77373, and 77372). As detailed in our comment letter on the CY 2013 PFS Final Rule, we believe for multiple reasons that the vault system is a direct expense and, because it is integral to the

linear accelerator, should be depreciated in a similar manner and therefore treated as a seven-year asset.

Furthermore, the RTA has analyzed the average annual maintenance cost for a linear accelerator and finds that this also is undervalued. According to Avalere Health:

> Using the CMS assumption that the equipment is used for 75,000 minutes per year, this would suggest a total annual maintenance cost of $132,089 for the linear accelerator is currently accounted for in the CMS PERVU process… [Based on invoices submitted to CMS], the annual cost of service contracts for actual linear accelerators ranges from $170,000 to nearly $250,000, with a median cost of $228,723. Compared to the calculated maintenance cost in the PERVU process, the actual service contracts are approximately $96,634 higher per year.

There are several potential remedies to this situation. First, given that the linear accelerator is assumed a seven year life and that the maintenance costs are generally waived in the first year that a linear accelerator is placed in service, CMS could increase the assumed cost of the linear accelerator by an amount six times the incremental annual underestimate, $579,804. Alternatively, CMS could add a separate line item, with a one-year life, to the PERVU methodology to reflect the amount by which maintenance costs are underestimated ($96,634). The RTA requests that the updated service costs be included for radiation treatment delivery codes 77402–77416 and 77418.

The RTA also requests that the updated linear accelerator price ($2,641,783, ER089) be added to 3DCRT codes (77402— 77416), as machines in the market today perform both services. Data currently in the CMS equipment database for 3DCRT for linear accelerators is from 2004. Given changes in the marketplace, it is no longer appropriate to include linear accelerator inputs based on scales of megavoltage. Today's linear accelerators can be "dialed" up or down to a given megavoltage. Older machines traditionally thought of as "3DCRT" linear accelerators such as Varian's "UNIQUE" machine are no longer even sold in the U.S. [1]

Finally, the RTA notes it will continue to work with manufacturers to research service costs for SRS and SBRT. The RTA further notes that the aforementioned service costs relate only to hardware. Software service costs also are far in excess of current Medicare reimbursement and the RTA intends to research this issue as well in 2014.

Conclusion

The uncertainty and volatility that the annual PFS process creates are a significant burden on the ability of the freestanding radiation oncology industry to provide quality care to patients. While the financial impact of the Final Rule was relatively small, the potentially large cut in the Proposed Rule as well as numerous other proposed and actual cuts in recent years increase the uncertainty for providers and distract from our efforts to improve the quality of care we provide.

[1] See for example: http://newsroom.varian.com/index.php?s=31868&item=103180

Quality care is of critical importance to the RTA and the physicians we work with. We urge CMS to pursue reforms to the Medicare payment system to incentivize quality outcomes instead of the current fee-for-service structure, which incentives volume. The RTA remains committed to the pursuit of payment reform in the form of an episode-based, bundled payment combined with appropriate quality metrics and a patient registry. As we have maintained since the establishment of the RTA in 2010, only fundamental payment reform can create the proper incentives and the predictability necessary to improve outcomes and control costs.

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