

December 29, 2015

Andrew Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS–1631–FC  
P.O. Box 8013  
Baltimore, MD 21244-8013

RE: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016, **CMS–1631–FC**

Dear Acting Administrator Slavitt:

The Radiation Therapy Alliance (RTA) appreciates the opportunity to submit comments regarding the 2016 Physician Fee Schedule (PFS) Final Rule. The RTA represents approximately 300 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 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 RTA would like to express our views regarding four matters related to the 2016 PFS Final Rule:

- 1. The RTA is pleased that CMS chose to extend into 2016 the temporary radiation oncology G-codes, established in the 2015 PFS Final Rule, instead of implementing the new treatment codes as had been proposed.** As the RTA noted in our comment to the Proposed Rule, the “designation of IMRT as ‘simple’ for all prostate and breast cancer and ‘complex’ for every other cancer is incorrect and does not reflect differences in work, capital, and labor inputs to deliver the therapy.” In addition, CMS’s decision not to impose the new codes will mitigate the widening disparity in reimbursement between the freestanding and hospital-based settings, a matter CMS has previously expressed concern over generally. As we noted in our previous correspondence, “Bifurcating IMRT reimbursement in one setting while maintaining a single reimbursement rate for both CPT codes in a different setting is likely to induce unintended consequences in the delivery of care, further exacerbate payment disparities across settings, and encourage further industry consolidation among freestanding providers that perform a disproportionate share of simple IMRT.”

2. **We appreciate CMS’s acknowledgement (FR 70953) that the appropriate cost of the radiation treatment vault may be higher than assumed but disagree with the suggestion that a portion of that cost should be considered indirect.** While we appreciate the agency’s continued consideration of the RTA’s comments that the vault would most appropriately be depreciated over seven years and that the service costs associated with treatment delivery are much higher than currently assumed, categorizing even a portion of the vault cost would reflect a misunderstanding of the integral role of the vault in the delivery of patient care.
  
3. **We are troubled and disappointed by CMS’s decision to increase the assumed utilization rate for linear accelerators from 50 percent to 70 percent.** We believe the actual average utilization rate of linear accelerators in the freestanding setting is approximately 50 percent and that there is not convincing evidence to support CMS’s changed assumption. The RTA undertook an extensive survey of more than 240 freestanding radiation oncology facilities across the United States and concluded that the average utilization rate of linear accelerators was 46.7 percent. Numerous other commenters referenced this survey work, yet CMS ignored these comments entirely, failing even to acknowledge them in the Final Rule. The RTA also supplied evidence from a clinical perspective that supports our contention that equipment utilization rates are not increasing, and these comments were also not addressed by CMS.

We urge CMS, as part of their stated commitment to “engag[e] in market research to develop independent estimates of utilization and pricing for linear accelerators and image guidance used in furnishing radiation treatment services,” to considered the survey data collected by the RTA and work with a spectrum of industry stakeholders, including the RTA, to gather data to inform CMS about this matter.

4. **As a result of the 10-percentage-point increase in the assumed equipment utilization rate for linear accelerators for 2016, freestanding radiation oncology providers will face a 2.7 percent reduction in net, aggregate reimbursement.** This impact, while considerably less than the proposed cut of 5.8 percent, is nevertheless a concerning result and one that will exacerbate the disparity across sites of service and further impede providers’ ability to finance new investments. As we have noted in multiple comment letters in previous years, CMS does not disaggregate the impact of the rule between freestanding and hospital-based radiation oncology providers. In 2016, as in previous years, the negative impact on freestanding facilities is larger than reported by CMS, and the positive impact on hospital-based radiation oncology providers is not reported.

Relatedly, we note that CMS requested comment on a suggestion by one commenter to “no longer display specialty level impacts for ‘radiation therapy centers’ in the proposed and final rule.” The RTA opposes this suggested change as the impact for “radiation therapy centers” serves, generally, as a more useful proxy for the impact on freestanding radiation oncology providers than the impact on radiation oncology broadly. The RTA disagrees with the suggestion that providing less information about the impact of the Proposed Rule serves the

interests of the public. If CMS were to contemplate changing the presentation of the impact of the Proposed and Final Rules, the RTA strongly encourages CMS to provide more, not less, detail. Specifically, the RTA recommends that CMS report the impact on freestanding and hospital-based radiation oncology providers separately. If CMS provided this level of detail, the public would have been informed that the impact on radiation oncology, reported by CMS to be -2 percent, was actually +0.2 percent for facility-based providers and -2.7 percent for freestanding providers.

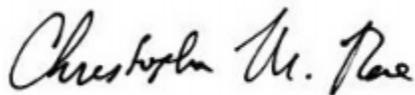
## **Conclusion**

The RTA is pleased by CMS's decision to extend the G-codes for radiation oncology into 2016. While the RTA disagrees with CMS's increase in the assumed equipment utilization rate for linear accelerators, we look forward to engaging with the agency in the coming year as you seek new and reliable data on the costs associated with constructing, owning, and operating a freestanding radiation oncology facility.

More broadly, the RTA continues to advocate for fundamental payment reform for freestanding radiation oncology and believes strongly that freestanding radiation therapy providers would be excellent candidates for episode-based, bundled payments with an appropriate registry. We will continue to work with policymakers to pursue the goal of establishing payment stability and improved incentives for quality care, and we always welcome the opportunity to discuss the opportunities for payment reform with CMS.

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