RADIATION THERAPY ALLIANCE

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

1050 K Street | Suite 315 | Washington, DC 2001 | 202 442-3710

December 30, 2014

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1612-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-1612-FC, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Final Rule

Dear Administrator Tavenner:

The Radiation Therapy Alliance (RTA) appreciates the opportunity to submit comments regarding the CY 2015 Physician Fee Schedule (PFS) Final Rule (CMS-1612-FC). The RTA represents 244 freestanding cancer care facilities in 22 states caring for over 100,000 patients annually. The RTA was established to provide policymakers and the public with a greater understanding of the value that community-based freestanding 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.

The RTA would like to express its appreciation for two critical decisions in the PFS Final Rule: the continued inclusion of the radiation treatment vault as a direct expense and the delayed implementation of new codes for radiation therapy until CY 2016. We also appreciate CMS's decision to preserve the G codes for important radiosurgery codes. The RTA remains concerned about the disparity in Medicare reimbursement for radiation therapy services between freestanding and hospital-based providers. This letter addresses these points in greater detail.

Radiation Therapy Vault

As the RTA has previously described to CMS, the radiation treatment vault is a direct expense due to its integral role in the provision of care and we appreciate CMS's acknowledging "the essential nature of the vault in the provision of radiation therapy services and its uniqueness to a particular piece of medical equipment." Recognizing that CMS intends to continue to study this issue for future rulemaking, including further study of the impact of the removal of the vault as a direct practice expense (PE) on the indirect PE for affected CPT codes, the RTA looks forward to the opportunity to continued discussions with CMS on this important matter. As we have before, we stand ready to provide additional information, including cost data regarding the vault, to CMS to assist in its review.

Valuing New, Revised, and Potentially Misvalued Codes

With regard to changes affecting the process for valuing new, revised, and potentially misvalued codes, we note CMS's acknowledgement:

> *Several commenters, including those with major code revisions for CY 2015, such as codes for radiation therapy and upper gastrointestinal procedures, suggested that we should implement the new process immediately, and thus, delay implementation of the new code sets and values so that they could be issued as proposals in the CY 2016 proposed rule.*

Even more so, we commend CMS for its decision to defer implementation of coding changes to allow for public comment in the proposed 2016 rule, next year. We appreciate CMS's response on this important matter:

> *As we consider the most appropriate time frame for implementation, we believe that flexibility in implementation offers the optimal solution. Accordingly, we are delaying the adoption of two new codes sets (radiation therapy and lower gastrointestinal endoscopies) until CY 2016 as requested by affected stakeholders so that those most affected by these significant changes have the opportunity to comment on our proposals for valuing these codes sets before they are implemented . . .*
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> *The coding changes [for radiation therapy] for CY 2015 involve significant changes in how radiation therapy services and associated image guidance are reported. There is substantial work to be done to assure the new valuations for these codes accurately reflect the coding changes. Accordingly we are delaying the use of the revised radiation therapy code set until CY 2016 when we will be able to include proposals in the proposed rule for their valuation. We are maintaining the inputs for radiation therapy codes at the CY 2014 levels.*

We recognize that CMS' decision does not come without any administrative burden and appreciate the agency's willingness to accommodate this in the interest of a more transparent and deliberative process. RTA member companies are in the process of working with commercial insurers to ensure an orderly transition to 2015 claims processing given the establishment of temporary codes as a result of this decision.

Robotic Radiosurgery

We appreciate CMS's decision not to delete contractor pricing for two robotic radiosurgery codes (G0339 and G0340). As CMS describes:

> *After consideration of the comments regarding the appropriate inputs to use in pricing the SRS services, we have concluded that at this time, we lack sufficient information to make a determination about the appropriateness of deleting the G-codes and paying for all SRS/SBRT services using the CPT codes. Therefore, we will not delete the G-codes for 2015, but will instead work with stakeholders to identify an alternate approach and reconsider this issue in future rulemaking.*

The RTA would be pleased to work with CMS on identifying alternate approaches.

Continued Payment Disparity between Freestanding and Hospital-Based Radiation Oncology

As the RTA has noted previously, freestanding radiation therapy providers are reimbursed less than providers in the hospital outpatient setting for the same services. Based on an analysis of CMS claims data and 2015 reimbursement rates, Avalere Health estimates that reimbursement in the hospital outpatient setting is $2,902 greater for an average full course of radiation therapy treatment using IMRT. Put differently, freestanding providers are reimbursed 88 percent of the amount paid in the hospital outpatient setting for the same services. This disparity is little changed from 2014.

As we noted in our comment to the Proposed Rule, the RTA continues to believe that "disparity in payment between freestanding and hospital-based radiation oncology (in conjunction with inadequate free-standing reimbursement) will lead some facilities to be acquired by hospitals. This trend, an acknowledged concern of CMS and MedPAC alike, will result in increased costs for Medicare given the higher reimbursement in this setting." Furthermore, we would like to stress that inadequate reimbursement for freestanding providers will also adversely affect providers' ability to properly maintain and update equipment. As evidence of the impact of the differential in reimbursement across settings we note that virtually all recent sales of linear accelerators in the U.S. are to hospitals and virtually none to free-standing facilities. Hospital outpatient providers' market share is roughly twice that of free-standing providers, yet they made approximately 95 percent of all new linear accelerator purchases last year.

Conclusion

The RTA appreciates CMS's decision to not finalize a number of proposals made in the PFS 2015 Proposed Rule. However, we remain concerned that uncertainty and volatility created in the annual PFS process are a significant burden on the ability of the freestanding radiation oncology industry to provide quality care to patients.

We urge CMS to pursue reforms to the Medicare payment system to incentivize quality outcomes instead of the current fee-for-service structure, which incentivizes 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