RADIATION THERAPY ALLIANCE
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September 6, 2016

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1654–P
7500 Security Boulevard
P.O. Box 8013
Baltimore, MD 21244–8013

RE: CMS–1654–P, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model

Dear Acting Administrator Slavitt:

The Radiation Therapy Alliance (RTA) appreciates the opportunity to submit comments regarding the 2017 Proposed Physician Fee Schedule (PFS) Rule. The RTA represents 235 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.

The RTA appreciates this opportunity to comment on the proposed regulations. This letter will comment on the following issues:

- Overview of the CY 2017 Physician Fee Schedule Proposed Rule
- Conversion Factor / Elimination of Physician Payment Increase
- Treatment Delivery Codes

I. Overview of the CY 2017 Physician Fee Schedule Proposed Rule

The impact of the Proposed Rule to the overall radiation oncology specialty is 0%. As in past years, however, the Physician Fee Schedule combines the effect on freestanding and hospital-based providers, thereby masking the effect on freestanding providers. The impact of the Proposed Rule to freestanding providers is – 1%.

The disaggregated effects of the rule to the different settings are reflected in the tables below.

Impact of Proposed CY 2017 PFS Rule on Total Allowed Charges (By Setting, in Millions)			
	CY 2016 Payments	**CY 2017 Payments**	**% Change**
Total	$1,735.40	$1,735.00	-0.02%
Facility	$418.00	$432.00	3.35%
Non-Facility	**$1,317.30**	**$1,303.00**	**-1.09%**

Freestanding centers are currently paid at 87% of overall hospital rates even though direct costs for services are identical. This proposed rule would further exacerbate the site-of-service payment differential for radiation therapy services.

II. Conversion Factor / Elimination of Physician Payment Increase

Pursuant to the Medicare Access and CHIP Reauthorization Act of 2015, Medicare payments to physicians under the Physician Fee Schedule were to be updated by 0.5% for each of the years of 2016 through 2019. However, in the proposed rule, CMS proposes to create a new add-on code that could be billed with E/M codes for physicians treating people with mobility-related impairments. This proposal is funded with an across-the-board cut in payment rates which eliminates the 0.5% legislated update for 2017. **While the RTA supports improving access to care for patients with mobility impairments, we urge CMS to utilize alternative approaches which will not increase out-of-pocket costs for patients with mobility impairments or undercut the intention of Congress to provide a payment update for physicians in 2017.**

III. Treatment Delivery Codes

In the Patient Access and Medicare Protection Act (Public Law 114–115), Congress provided a special rule for certain radiation therapy services as follows:

- *SPECIAL RULE FOR CERTAIN RADIATION THERAPY SERVICES.— The code definitions, the work relative value units under subsection (c)(2)(C)(i), and the direct inputs for the practice expense relative value units under subsection (c)(2)(C)(ii) for radiation treatment delivery and related imaging services (identified in 2016 by HCPCS G-codes G6001 through G6015) for the fee schedule established under this subsection for services furnished in 2017 and 2018 shall be the same as such definitions, units, and inputs for such services for the fee schedule established for services furnished in 2016.*

As a result of this provision, treatment delivery code definitions and valuations in the CY 2017 PFS Proposed Rule are generally consistent with those contained in the CY 2016 PFS Final Rule. One exception is G6011 (a conventional treatment delivery code) which is reduced by about 11 percent. Not only is the reduction inconsistent with the law, we believe this reduction is an error by CMS. Avalere Health has noted the following with respect to inputs for G6011 in the CY 2017 PFS Proposed Rule:

- Direct Practice Expense Inputs for the HCPCS code remained the same from FR 2016 and NPRM 2017;
- There were no changes in the specialty level Practice Expense Per Hour for Radiation Oncology;
- There were no duration of service changes for the HCPCS Code; and
- The change in the Indirect Practice Expense Index for Radiation Therapy went up slightly, which, given other factors would cause reimbursement to go up, not down.

Based on these findings, we believe the reduction to G6011 is an error and we urge CMS to fix this error in the CY 2017 PFS Final Rule.

IV. Conclusion

The RTA thanks CMS for the opportunity to comment on the CY 2017 PFS Proposed Rule. As we have explained in previous correspondence and discussions with CMS, the simple economics of operating a freestanding radiation oncology facility necessitate adequate reimbursement to provide critical treatments to oncology patients. Current reimbursement rates are insufficient to finance new facilities, yet the number of Medicare beneficiaries is projected to increase sharply in the coming decade. At current reimbursement rates, only facilities that have older equipment and are debt free or have high patient volumes can remain viable. And even these facilities cannot afford to upgrade to new technologies as they become available.

It is for these reasons 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 payments. 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 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) 827-6494.

Sincerely,

Michael J. Katin, MD
Chair, Radiation Therapy Alliance Policy Committee