September 04, 2012

Marilyn Tavenner  
Acting 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, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013 (CMS-1590-P)

Dear Acting Administrator Tavenner:

The American College of Radiation Oncology (ACRO) is pleased to offer its comments to the Centers for Medicare and Medicaid Services (CMS) on the Proposed Rule: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013 (CMS-1590-P).1 ACRO represents radiation oncologists in the socioeconomic and political arenas. With a current membership of approximately 1,000, ACRO is dedicated to fostering radiation oncology education and science; improving patient care services; studying the socioeconomic aspects of the practice of radiation oncology; and encouraging education in radiation oncology.

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

- Significant Payment Cuts to Radiation Therapy;
- Impact of the Proposed Rule on Freestanding Radiation Therapy Centers;
- Valuation of IMRT and SBRT;
- Other Flaws in the Practice Expense Formula;
- Concerns with Interest Rate Assumptions in the Proposed Rule;
- Need for New Payment System.

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1 Proposed Rule: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013 (CMS-1590-P). Federal Register, 77 FR 44722
Significant Payment Cuts to Radiation Therapy

In the Proposed Rule, CMS indicates that the overall impact to “radiation oncology” and “radiation therapy centers” is due primarily to:

- Input changes for certain radiation therapy procedures (-7% / -8%);
- The fourth year of the four-year transition to the utilization of new Physician Practice Information Survey (PPIS) data (-3% / -4%);
- Updated equipment interest rate assumptions (-3% / -5%);
- New discharge care management proposals (-2% / -2%).

Table 1 shows the Proposed Rule’s impact in CY 2013 on radiation oncology specialty codes from the policies described above. These estimates do not include the effects of the scheduled 27 percent cut to the 2013 conversion factor.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>PPIS Final Year</th>
<th>New Interest Rate</th>
<th>Transition Care Management</th>
<th>Radiation Therapy Code-Specific Cuts</th>
<th>Total Impact on Allowed Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation Oncology</td>
<td>-3%</td>
<td>-3%</td>
<td>-2%</td>
<td>-7%</td>
<td>-15%</td>
</tr>
<tr>
<td>Radiation Therapy Centers</td>
<td>-4%</td>
<td>-5%</td>
<td>-2%</td>
<td>-8%</td>
<td>-19%</td>
</tr>
</tbody>
</table>

The precise estimate for any specific facility will depend on specific practice patterns (e.g. the relative utilization of IMRT and SBRT compared to other external beam techniques). It is important to note, however, because of the blending of payment rates in the PFS impact tables for hospital-based and freestanding radiation oncologists, the relative impact on freestanding radiation oncologists is significantly understated. These cuts likely would result in numerous closures of freestanding radiation therapy centers nationwide.

Impact of the Proposed Rule on Freestanding Radiation Therapy Centers

On August 1, 2012, the American Society for Radiation Oncology (ASTRO) released the results of a survey to determine how the cuts to radiation oncology would affect freestanding radiation therapy centers.² Findings from the survey include:

- *Potential Center Closures.* Cuts approaching 20 percent could result in 35 percent of practices closing and 64 percent of practices consolidating locations.

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² “Significant Medicare Cuts to Radiation Oncology Would Devastate Cancer Care,” ASTRO Fact Sheet. Retrieved [here](#) on 8/24/2012
- **Limits on Beneficiary Access.** Cuts approaching 20 percent could result in 70 percent of practices limiting their number of Medicare patients and 49 percent of practices not accepting new Medicare patients.

- **Impacts on Practices.** Cuts approaching 20 percent could result in 81 percent of practices laying off non-physician staff, 53 percent of practices reducing their complement of physicians, and 93 percent of practices delaying the purchase of new equipment.

**Valuation of IMRT and SBRT**

Strangely, and without appropriate validation, it appears these payment cuts and consequential center closures, in large part, are due to CMS’s use of “patient fact sheets” and internet searching to derive valuations for key “state-of-the-art” services used by radiation oncologists (Intensity Modulated Radiation Therapy [IMRT; CPT Code 77418] and Stereotactic Body Radiation Therapy [SBRT; CPT Code 77373]). This is in contrast to auditable cost data and other information CMS uses to derive payment rates for services in other Medicare payment systems.

In the Proposed Rule, CMS provides three primary rationales for its significant negative reductions to the RVUs for IMRT and SBRT. First, CMS states that there are wide discrepancies between the procedure time assumptions used in establishing nonfacility PE RVUs for these services and the procedure times made widely available to the general public. Second, CMS highlights concerns over ancillary services as evidence of overpayments for IMRT. Third, CMS indicates that IMRT payments have been higher in the freestanding setting than the hospital outpatient setting in recent years. Consequently, CMS proposes “to adjust the procedure time assumption for IMRT delivery (CPT code 77418) to 30 minutes” and “to adjust the procedure time assumption for SBRT delivery (CPT code 77373) to 60 minutes.” However, CMS also proposes to allocate minutes to equipment items for these codes to account for their use immediately before and following the procedure (e.g. preparing the equipment, positioning the patient, or cleaning the room). Actual minutes shown in the equipment direct cost database for IMRT and SBRT are 37 minutes for IMRT (down from 60 minutes in 2012) and 84 minutes for SBRT (down from 114 minutes in 2012).

**Discrepancy in CMS Procedure Time Assumptions and Procedure Times Available to the Public**

CMS states, “while we generally have not used publicly available resources to establish procedure time assumptions,” it needs to reconcile “vast discrepancies” between CMS’s current assumptions and “more accurate information.” CMS also states this need outweighs the potential value in maintaining relativity offered by only considering data from one source (i.e. the AMA RUC). However, the “more accurate information” cited by CMS takes the form of professional society patient brochures in the case of IMRT (e.g. “treatment is delivered in a series of daily sessions, each about 15 minutes long”) and professional society website information in the case of SBRT (e.g. “treatment can take up to one hour”). **ACRO believes the use of patient fact sheets and internet searching to set Medicare payment rates is unprecedented and urges CMS to use reliable, verifiable data to set Medicare payment rates. CMS fails to take into account that these educational brochures are not meant to be definitive descriptions of the process of care and its multiple elements, but instead, are developed to give patients and families a general idea as to the care they will encounter.**
Analysis of IMRT Utilization

CMS cites recent articles in the Washington Post and Wall Street Journal stating the articles “encouraged us to consider the possibility that potential overuse of IMRT services may be partially attributable to financial incentives resulting from inappropriate payment rates.” ACRO notes, however, that CMS is missing a critical point with respect to IMRT utilization over the last several years: IMRT is a superior technology which is replacing older “traditional” forms of technology (e.g. “three-dimensional, conformal radiation therapy”) and leading to fewer side effects in the long term. Our member physicians use this judiciously when it benefits patients. As Figure 1 below shows, increases in IMRT treatments have corresponded to similar decreases in traditional treatments and total external-beam radiation therapy (EBRT) treatments per capita actually have decreased.

Figure 1

IMRT Is An Improved Technology Which Is Replacing Traditional EBRT

-Total EBRT/capita has decreased from 19.5% to 18.3% over the past 10 years
Physician Fee Schedule Rates Versus Hospital Outpatient Rates

In the Proposed Rule, CMS makes several general claims regarding the costs and patient acuity in the hospital setting relative to the freestanding setting, including: (1) hospitals generally incur higher overhead costs, (2) hospitals generally maintain a 24 hour, 7 day per week capacity, and (3) hospitals generally furnish services to higher acuity patients than freestanding clinics. While CMS provides no data to support these claims, ACRO believes (1) freestanding centers generally are equipped with similar technology and the cost structure for the provision of radiation therapy is generally the same for both settings, (2) neither radiation therapy departments nor freestanding centers maintain a 24 hour, 7 day per week capacity, although both hospital and freestanding settings are capable of emergency radiation therapy treatments when necessary, and (3) the acuity of disease and service is generally the same in both settings, which are outpatient.

Moreover, ACRO would take issue with assumptions CMS might have regarding indirect costs for hospitals relative to freestanding facilities generally relating to capacity or other regulatory requirements. First, it is unclear to us whether CMS can distinguish whether such excess overhead for a given hospital is evidence of inefficiency or evidence of the need for greater capacity. Second, if CMS intends to pay hospitals more than freestanding facilities generally, it should make an explicit policy to do so and not use presumed indirect cost differentials as a rationale to drastically reduce payments for a single procedure in a single specialty. Third, and most important, we believe there is no verifiable way for CMS to determine what those presumed incremental indirect cost differentials might be for a hospital radiation therapy department relative to a freestanding facility. Reincorporating the seven inadvertently dropped inputs from IMRT, such payments were scheduled to be about $451 for freestanding radiation therapy centers in 2013 (absent the proposals contained in the CY 2013 PFS Proposed Rule to cut IMRT).³ This previously proposed payment amount for freestanding radiation therapy centers already was about 7 percent less than what is proposed for the hospital-based setting in the CY 2013 Hospital Outpatient PPS (e.g. $484) and might well be sufficient to address any general presumptions by CMS about potentially higher indirect costs for hospitals.

Finally, CMS states, in recent years, PFS nonfacility payment rates for IMRT have exceeded payment rates in the Hospital Outpatient Prospective Payment System (HOPPS) setting. In fact, payment rates for IMRT in 2012 are in virtual parity. As Figure 2 below shows, under the Proposed Rule, CMS proposes to pay $285 for IMRT or about 40 percent less than HOPPS rates.

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³ This payment is the result of the “fully-implemented” 13.26 RVUs in the CY 2012 Physician Fee Schedule Proposed Rule multiplied by the conversion factor ($34.0376).
ACRO Strongly Requests CMS to Use a Holistic Approach to Setting Payment Rates

A review of Table 3 of the Proposed Rule shows CMS’s complicated 28-part methodology for setting practice expense relative value units (PERVUs) under Medicare. Equipment, supply and labor inputs are used as the primary inputs for the development of PERVUs. These inputs themselves are based on multiple inputs that include, among other things, calculations based on surveys for procedure times and the necessary equipment, supplies and labor to provide those procedures. In the Proposed Rule, CMS states with respect to IMRT, “The AMA RUC’s most recent direct PE input recommendations reflect the same procedure time assumptions used in developing the recommendations for CY 2002.” While we would agree that this is true, we would urge collection of data as to direct cost inputs (which has increased significantly) prior to proceeding revising this payment rate. For example, the price of a linear accelerator included in CMS’s CY 2013 equipment database is $1,832,941, which is the same price it has been since its inclusion in CMS’s CY 2005 equipment database. We understand that updated data from equipment manufacturers shows that today’s prices are more than $1 million higher. Other inputs directly related to the cost of medical equipment (e.g. service contracts, water chiller) appear to be missing from 77418 altogether. **ACRO strongly requests that CMS and/or RUC collect all available data for IMRT and other codes to update not only the procedures times for these services, but all other inputs including equipment prices, supplies, maintenance and labor costs.**

ACRO notes that in the CY 2011 Physician Fee Schedule Final Rule, CMS finalized a proposal to establish a regular and more transparent process for considering public requests for changes to
PE database price inputs for supplies and equipment used in existing codes. Under this process, CMS accepts requests for updating the price inputs for equipment and supplies on an ongoing basis no later than December 31 of each calendar year to be considered for inclusion in the next proposed rule and finalizes changes in the final rule with comment period for the upcoming calendar year. Rather than adopt piecemeal changes to IMRT and SBRT, ACRO urges CMS to request updated equipment and supply data and update IMRT and SBRT holistically and according to the regular order adopted in the CY 2011 PFS Final Rule.

Other Flaws in the Practice Expense Methodology

The values for any CPT code within the PFS are necessarily a snapshot in time and the above discussion shows the compelling need to update all inputs for a code when its value is reviewed. However, the complexity of CMS’s practice expense methodology itself is at issue since the methodology disadvantages freestanding radiation oncology centers in several ways. First, since 2010, the dynamics of the indirect practice cost index (IPCI) have resulted in payment reductions and instability for the specialty. Second, the complexity of the methodology itself lends itself to error as evidenced by inappropriately low payment levels resulting from dropped equipment inputs during the CY 2012 AMA RUC cycle. Finally, the budget neutrality of the PFS system contributes to additional payment instability and unpredictability from year to year.

Indirect Practice Cost Index

At a macro-level, PERVU values consist of two components: (1) direct costs and (2) indirect costs. Direct cost inputs are derived from the AMA RUC, although these inputs may be “refined” by CMS. Indirect costs are derived from a complicated formula that is initially based on direct cost inputs and adjusted through several calculations including (1) the incorporation of specialty-specific PE/HR data from the PPIS survey and (2) an indirect practice cost index (IPCI), which is meant to reflect the relative indirect cost to specialties performing a service.

Under the formula, a higher IPCI results in higher indirect costs (and, therefore, a higher PERVU amount). Conversely, a lower IPCI results in a lower PERVU amount. From 2010 through 2012, the radiation oncology IPCI dropped 19 percent (from 1.18 to 0.96). This has resulted in an unexpected reduction in the value of many radiation oncology codes and a diminution of overall Medicare reimbursement for radiation oncology. Under the Proposed Rule, the drastic cuts to IMRT actually result in an increase in the IPCI to 1.13 and a relatively minor increase to other radiation oncology codes (although the cuts to radiation oncology are still huge overall). These changes to other radiation oncology codes, however, have nothing to do with the actual real-world valuation of services and simply underscore the variability and unpredictability of the PE methodology.

Missing Inputs

In the Proposed Rule, CMS acknowledges that seven equipment inputs had been “inadvertently omitted” for IMRT and states “we are proposing to include the seven equipment items omitted from the RUC recommendation for CPT code 77418.” ACRO was aware of this omission and urged CMS to address the issue for payments under the CY 2012 PFS. While ACRO is appreciative of CMS’s proposal to re-include these equipment inputs to the valuation of 77418

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4 75 FR 73205 – 73207
for CY 2013, we note this is yet another example of a broken system. ACRO understands that the reason for these missing inputs literally was due to a missing page which was lost in transmission and then was not made evident until almost a year later (when CMS adopted the value for the CY 2012 PFS). Notwithstanding universal agreement that an error occurred, radiation oncologists have been forced to endure reduced payment rates for the entirety of 2012.

Reductions in Payments Due to Budget Neutrality of Transition Care Management Code

In the CY 2013 PFS Proposed Rule, CMS proposes to create a HCPCS G-code to describe care management involving the transition of a beneficiary from care furnished by a treating physician during a hospital or other institutional stay to care furnished by the beneficiary’s primary physician in the community. CMS estimates that primary care physicians and practitioners would provide post-discharge transitional care management services for 10 million discharges in CY 2013. Family practice physicians receive a 5 percent increase in payments from this policy, but most non-primary physicians receive reductions due to budget-neutrality. While ACRO supports primary care, we note that this policy (which reduces payment to radiation oncology by 2 percent) continues to divorce payments to radiation oncology providers from actual practice expense costs.

Concerns with the Interest Rate Assumptions in the Proposed Rule

Currently, the interest rate assumption for equipment costs under the PFS is 11 percent. In the CY 2013 PFS Proposed Rule, CMS proposes a “sliding scale” approach that varies the interest rate based on the equipment cost, useful life, and Small Business Administration maximum interest rates for different categories of loan size and maturity. As shown in Table 2 below, the proposed sliding scale would equal the Prime Rate (currently 3.25 percent) plus a percentage ranging from 2.25 percent to 4.75 percent depending on price of the equipment (less than $25,000; $25,000 – $50,000; greater than $50,000) and life of the equipment (less than 7 years; more than 7 years). Lowering the interest rate from 11 percent to a range of 5.5 percent to 8 percent reduces equipment direct cost inputs and, consequently, reduces certain radiation oncology PERVUs.

<table>
<thead>
<tr>
<th>Table 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loan Type</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Loans of $50,000 or more</td>
</tr>
<tr>
<td>Loans between $25,000 and $50,000</td>
</tr>
<tr>
<td>Loans of $25,000 or less</td>
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</table>

ACRO has several concerns with this proposal. First, ACRO is not aware of any radiation oncology facilities funded with SBA-backed financing. Second, in contrast to the interest rate assumption proposed in the CY 2013 PFS Proposed Rule, ACRO believes that the existing capital stock was financed under higher borrowing costs. Third, commercial loans over $1,000,000 have interest rates which are higher than most other commercial loans and much higher than SBA loans.
We believe this interest rate proposal is yet another example of payment unpredictability in the PFS. Rather than institute a significant one-year change in a key component of the PERVU methodology, alternative approaches (e.g. an interest rate assumption based on historical averages) could smooth year-to-year interest rate fluctuations.

**Need for New Payment System**

The CY 2013 PFS Proposed Rule represents the fifth time over the last ten years radiation oncologists have been subject to payment reductions caused by questionable methodological issues. As is the case this year, sometimes these payment reductions have been extreme. We believe this situation continues to underscore the need for fundamental payment reform in the physician fee schedule that is reflective of physician work and effective treatment. Under such scenarios, we strongly believe radiotherapy will be proven to be one of the most cost-effective modalities available.

In this light, we note that Congress mandated as part of the H.R. 3630, the “Middle Class Tax Relief and Job Creation Act of 2012,” that CMS conduct a study to examine options under the physician fee schedule for chronic conditions such as cancer and report to the Congress not later than January 1, 2013 on recommendations on suitable alternative payment options. *ACRO looks forward to the results of this study and has offered to work with CMS on alternative payment reform options.*

**Conclusion**

ACRO’s comments on the Physician Fee Schedule regulations seek to ensure ongoing access to high-quality, state-of-the-art radiation oncology services. Maintaining patient access is crucial to quality healthcare delivery since most of our patients require services five days a week for many weeks of life-saving therapy. Patient accessibility and continuity through a complete course of therapy are key components of the care continuum. ACRO appreciates the opportunity to comment on the proposed regulations. We hope that our comments highlight our sincere interest in making radiation oncology services cost-effective, properly reimbursed, and readily accessible to cancer patients. We look forward to continuing to work with CMS to guarantee quality oncology services can be provided by our specialty to every Medicare patient.

Sincerely,

J. Michael Kerley, M.D., FACRO  
President  
American College of Radiation Oncology

Sheila Rege, M.D., FACRO  
Chair, Economics Committee  
American College of Radiation Oncology