AMERICAN SOCIETY FOR RADIATION ONCOLOGY

ASTRO Legislative Priorities

ASTRO

TARGETING CANCER CARE

2015

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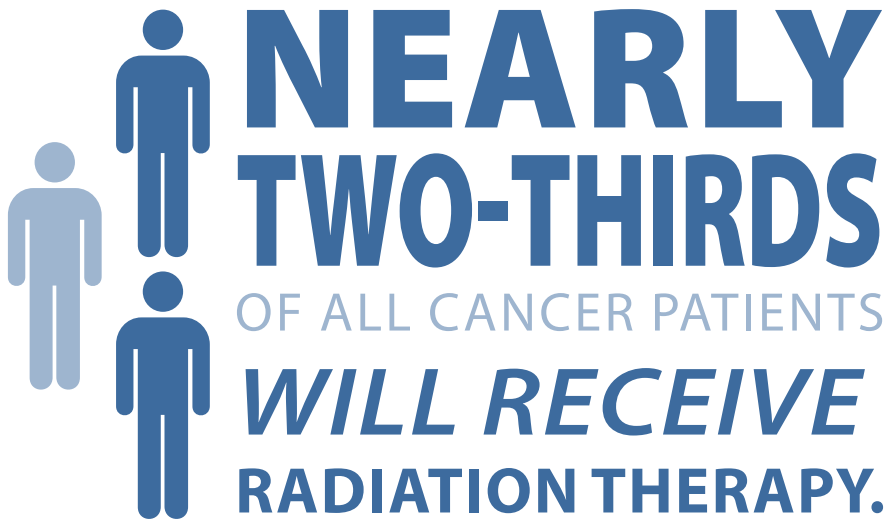
Radiation Oncology Overview



- Radiation oncology is one of the three primary treatments for cancer.
- Radiation can be given to cure cancer, either alone or in combination with surgery and/or chemotherapy.
- It may also be used to relieve pain for patients with incurable cancers.
- Breast, prostate and lung cancer patients make up more than half of all patients receiving radiation therapy.
- There are approximately 5,000 radiation oncologists in the United States.

Protect Patients and Medicare by Ending Self-referral Abuse

Protect Patients and Medicare by Ending Self-referral Abuse

The physician self-referral law, the Ethics in Patient Referrals Act, prohibits physicians from referring a patient to a medical facility in which he or she has a financial interest to ensure that medical decisions are made in the best interest of the patient without consideration of any financial gain that could be realized by the referring physician.

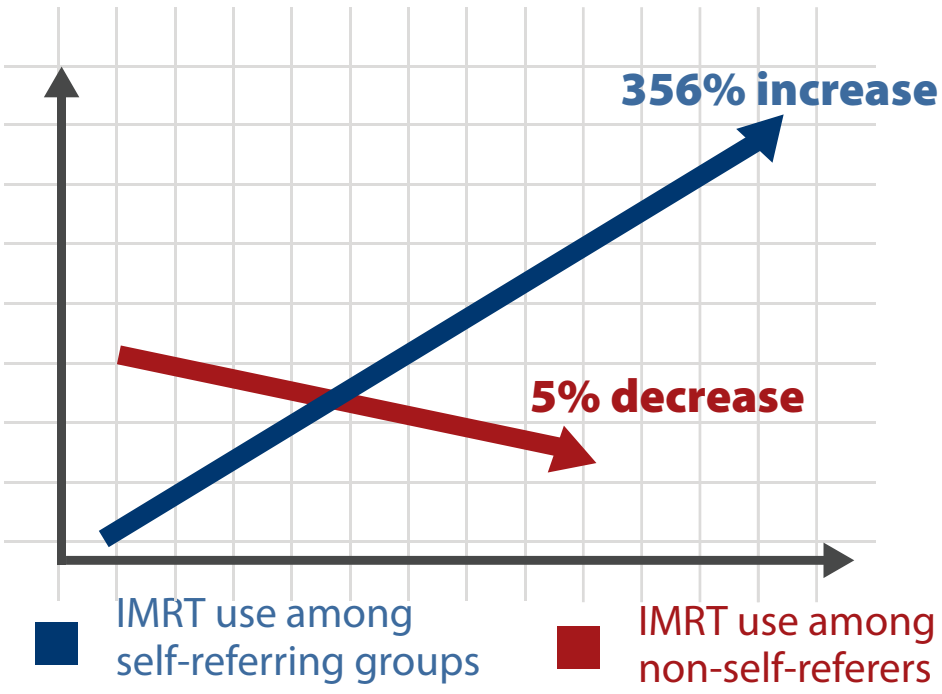
Unfortunately, a loophole—the in-office ancillary services (IOAS) exception—allows physicians to refer their patients for radiation oncology treatments and certain other services in which they have a financial interest.

Medicare is then billed for often more expensive services, regardless of whether or not these treatments are in the best interest of the patient.

Independent studies show that abuse of the IOAS exception has led to increased costs to patients and the Medicare program, as well as inappropriate use of diagnostic and therapeutic services.

Commissioned in 2010 by a bipartisan and bicameral congressional contingent, the GAO issued four reports demonstrating widespread abuse of the self-referral loophole, leading to increased costs for patients and Medicare.

The **GAO Report** Found From 2006-2010



- IMRT use among self-referring groups **increased by 356 percent.** Overall increases in IMRT utilization rates and spending were due entirely to services performed by limited-specialty urology groups. IMRT utilization among non-self-referrers **decreased by 5 percent**.

- The number of IMRT services performed by limited specialty urology groups **increased by 509 percent**, while true multi-specialty groups' IMRT use **decreased by 3.8 percent**.

- IMRT spending by self-referral groups **increased** by approximately **$138 million**, compared to a **$91 million decrease** in the non-self-referral group.

- Self-referring centers referred **more than 50 percent** of men over the age of 75 for IMRT at self-referring centers. For these men, guidelines recommend active surveillance of their disease and the avoidance of aggressive treatment such as IMRT.

A Study Published In ***The New England Journal of Medicine*** Found From 2005-2010

- Men seen by ***self-referring urologists*** were **2.79 times more likely** to receive IMRT than men seen by non-self-referring counterparts.
- Men were **6.18 times more likely** to receive IMRT when seen by ***self-referring urologists*** than those treated at NCCN Cancer centers.
- IMRT utilization among self-referring groups **increased from 13.1 percent to 32.3 percent** once they became self-referrers, an increase of 19.2 percentage points.
- Urologists who acquired ownership of IMRT services **increased** their use of IMRT **substantially** more than urologists who did not own radiation therapy services.
- There have been decreases in utilization of other effective, less expensive treatment options by self-referring urologists. Use of **brachytherapy decreased by 14.9 percentage** points to just 2.7 percent of patients receiving this treatment in self-referring urology practices.
- IMRT utilization among the subset of 11 self-referring urology practices near NCCN centers **increased from 9 percent to 42 percent**, an increase of 33 percentage points (367 percent).

THE PRESIDENT'S FY 2016 BUDGET *PROPOSED CLOSING* THE SELF-REFERRAL LOOPHOLE FOR THE THIRD CONSECUTIVE YEAR.

The Congressional Budget Office *estimates* a **savings** of

$3.5 billion

over 10 years

by closing the self-referral loophole.

Stakeholder Support

AARP endorsed closing the self-referral loophole in a December 2014 letter. AARP said it strongly supports ending the IOAS exception to protect patients from unnecessary care caused by abusive, profit-motivated practices.

> "Closing the in-office ancillary services exception for certain services will save taxpayers and Medicare beneficiaries money and reduce unnecessary care."

AARP
Real Possibilities

601 E Street, NW | Washington, DC 20049
202-434-2277 | 1-888-OUR-AARP | 1-888-687-2277 | TTY: 1-877-434-7598
www.aarp.org | twitter: @aarp | facebook.com/aarp | youtube.com/aarp

December 11, 2014

The Honorable Jackie Speier
House of Representatives
211 Cannon Office Building
Washington, DC 20515

Dear Representative Speier:

On behalf of AARP's nearly 38 million members and the millions more with Medicare, thank you for your continued work to close provider reimbursement loopholes. AARP agrees that restrictions on physician self-referral and provider-kickback schemes must be strengthened. Closing the in-office ancillary services exception for certain services will save taxpayers and Medicare beneficiaries money and reduce unnecessary care.

As you know, the in-office ancillary services exception was intended to allow physicians to perform services which can be completed in the physician's office while the patient is present and which aid in the diagnosis of the patient in order to minimize delays in patient care. Unfortunately, the exception has contributed to overutilization and rapid growth of certain services, particularly in radiation oncology, anatomic pathology, advanced imaging, and physical therapy. Closing the loophole will better serve patients and preserve Medicare's resources by saving approximately $6 billion over ten years for these services.

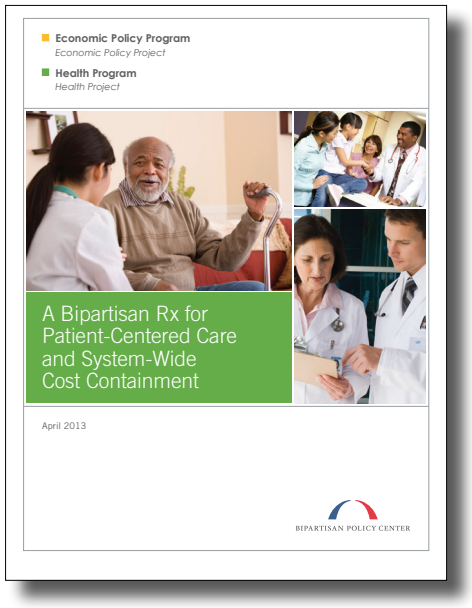
We look forward to working with you and your colleagues in both parties to improve Medicare and reduce health care spending. If you have any questions, please contact me or have your staff contact Ariel Gonzalez of our Government Affairs team, at agonzalez@aarp.org or 202-434-3770.

Sincerely,

Joyce A. Rogers

Joyce A. Rogers
Senior Vice President
Government Affairs

AARP Real Possibilities



Economic Policy Program
Economic Policy Project
Health Program
Health Project

A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment

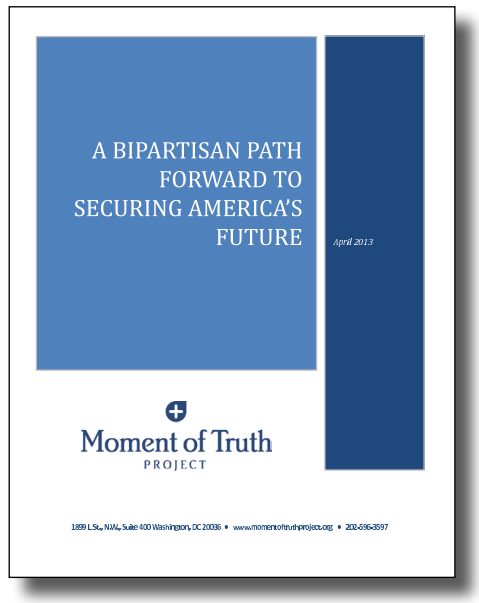
April 2013

BIPARTISAN POLICY CENTER

***April 2013:* The Bipartisan Policy Center** recommends limiting the self-referral exception to providers participating in advanced payment models.

***April 2013:* Erskine Bowles and Alan Simpson,** Moment of Truth Project.

> "Physician self-referrals should be further restricted and better monitored, including narrowing the ancillary service exception."



A BIPARTISAN PATH FORWARD TO SECURING AMERICA'S FUTURE

April 2013

Moment of Truth
PROJECT

1899 L St., NW, Suite 400 Washington, DC 20036 • www.momentoftruthproject.org • 202-596-3597

Self-referral Abuse: From the Patient Perspective

Self-referral care is not patient-centered care. Determining the most appropriate treatment option is an involved process that depends on the patient's preferences, age, concerns, comorbidities and physiology. Self-referral creates a conflict of interest where financial considerations can cloud clinical judgement. Following are just a few examples of the benefit of choosing health care services based on quality and expertise. Congress must protect patients by eliminating incentives that drive up costs and by ensuring patients receive the most appropriate and highest quality care.

Self-referral Abuse: From the Patient Perspective

OKLAHOMA

An 81-year-old man had been a loyal patient of his urologist for more than 20 years. This patient was diagnosed with a low-volume, low-risk prostate cancer. He asked his urologist about active surveillance and was told it was too risky so the urologist recommended IMRT. The patient sought a second opinion from a radiation oncologist, who recommended that the patient undergo active surveillance. The radiation oncologist sent his consult letter to the patient's urologist, who was not happy with the recommendation. The urologist called the patient and "fired" him from his practice.

Self-referral Abuse: From the Patient Perspective

ILLINOIS

A 69-year-old man was diagnosed with prostate cancer four years before opting for robotic surgery to remove the prostate. His urologist called him in January 2011 and told him he needed to get radiation therapy because his cancer had returned. The urologist referred him to a center where, as the patient later learned, his urologist has an ownership interest. He was told by this center that he would need 45 sessions (nine weeks) of radiation therapy to treat his cancer. The patient was also told that the treatment could wait until after he returned from his two-month vacation, which seemed odd to the patient. He got a second opinion and was told that his cancer had not returned. He then got a third opinion and was again told he did not require treatment and to come back in a year for screening. The patient was understandably upset about the emotional roller coaster he and his family had unnecessarily experienced. This man has contacted his member of Congress and reported the urologist to the Illinois Department of Financial and Professional Regulation.

Self-referral Abuse: From the Patient Perspective

ARIZONA

A 74-year-old prostate cancer patient was referred to a radiation oncologist by the local dermatologist who was treating his skin condition. The patient was complaining to the dermatologist about the 140-mile drive he was making for his daily radiation treatments for his prostate cancer. The patient has glaucoma and poor vision and admits he is not the best driver. The dermatologist told him about a radiation therapy center closer to his home, but the patient said he was unaware of it since his urologist only mentioned the radiation center he owned more than one hour away. The patient was intrigued about the idea of receiving radiation therapy in his hometown, but he felt significant pressure to receive treatment at the distant radiation center. After the patient was pulled over by the state police on the highway and was told he would lose his license if they saw him on a major highway again, he visited the local center for treatment. The switch saved the patient from having to travel a total of 3,500 miles—the equivilent of driving from Miami to Seattle—at a cost of more than $500 for gas.

Self-referral Abuse: From the Patient Perspective

MARYLAND

A 65-year-old hospital security guard was diagnosed with intermediate-risk prostate cancer. He was told by the urologist that he was not a good candidate for surgery and that he would be given an appointment to discuss radiation treatments with a doctor at a urology-owned center. He asked his urologist if he could be treated at the hospital where he works, since he would be able to have his treatments performed during his break and not be forced to miss work. The urologist said that this was not an option, so the patient took it upon himself to contact the radiation oncology department at the hospital where he works and received his treatment there.

Rural Access to Care

CLOSING THE SELF-REFERRAL LOOPHOLE WOULD NOT LIMIT CARE FOR PATIENTS IN RURAL AREAS.

Promotes Delivery System Reform

Closing the self-referral loophole would continue allowing physician groups participating in Accountable Care Organizations (ACOs) and other new payment models to provide integrated services.

ASTRO stands committed to promoting delivery system reform and supporting new payment reform models. Closing the loophole does not limit truly integrated practices focused on quality and value.

Self-referral in The News

Bloomberg Businessweek

THE ARIZONA REPUBLIC
azcentral.com

NJ

Medscape

The Boston Globe

JAMA The Journal of the American Medical Association

THE WALL STREET JOURNAL.

Forbes

Recently physician self-referral abuse has been the subject of numerous news articles and opinion pieces, including a recent editorial in the *Journal of the American Medical Association* calling on Congress to curtail physician self-referral. A 2014 article in the *Arizona Republic* revealed troubling stories of elderly prostate cancer patients who were directed to radiation treatment centers owned by urologists that required patients to drive long distances, passing other treatment centers.

Stabilize Medicare Physician Payments and Protect Access to Radiation Oncology Services

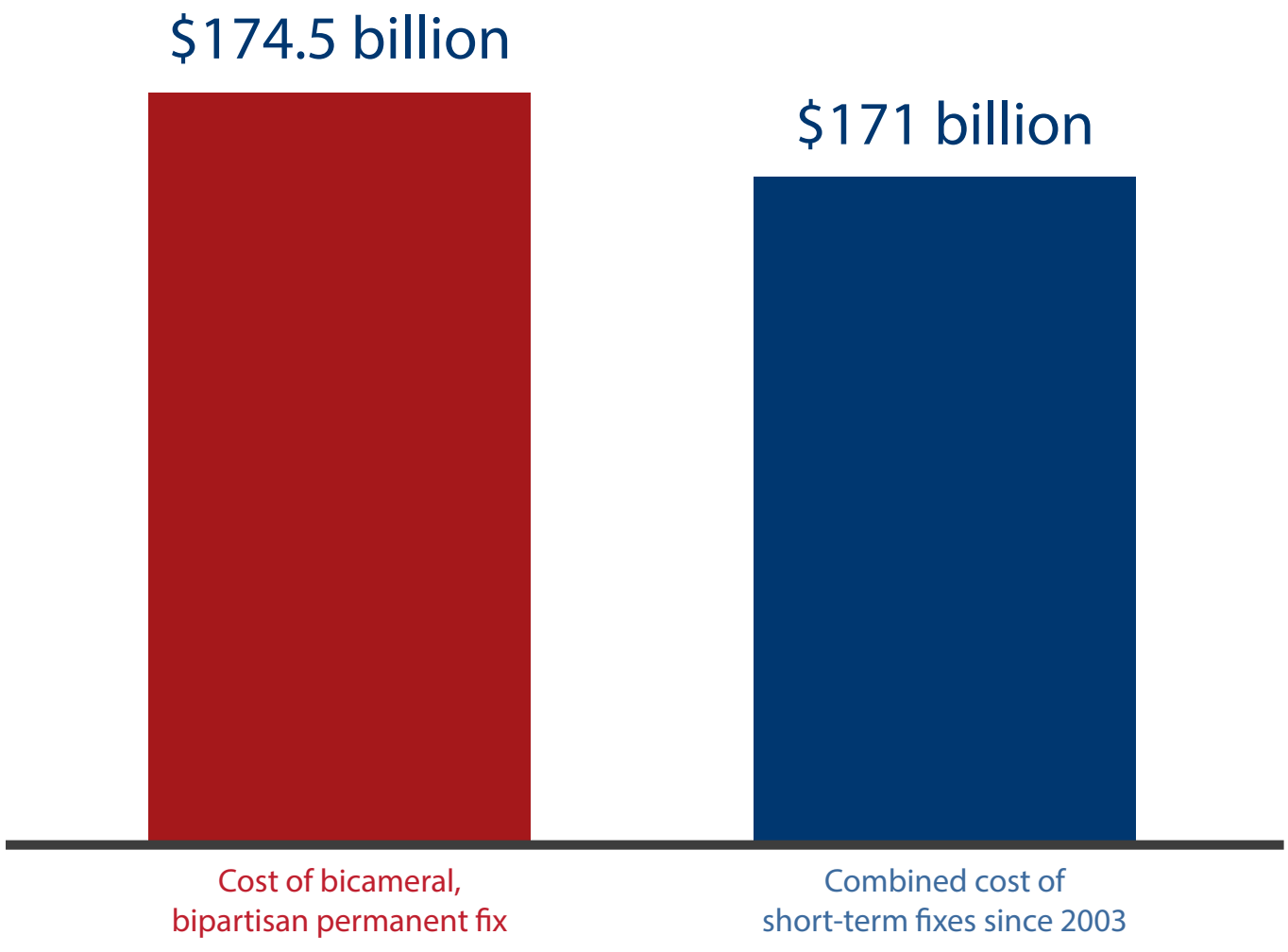
Stabilize Medicare Physician Payments

NOW is the time to permanently fix the flawed Medicare SGR formula and provide a framework for physician payment reform.

According to the Congressional Budget Office (CBO), the cost to replace and repeal the Sustainable Growth Rate (SGR) is now $174.5 billion over 10 years, up from $144 billion last year.

Cost Difference Between Combined 10 Year Short-term SGR fixes and Permanent SGR Fix

(in billions of dollars)



Savings from Closing the Self-referral Loophole Could Help Pay for Repealing the SGR

CLOSING THE **IOAS LOOPHOLE** WOULD GENERATE

$3.5 BILLION

IN **SAVINGS** FOR

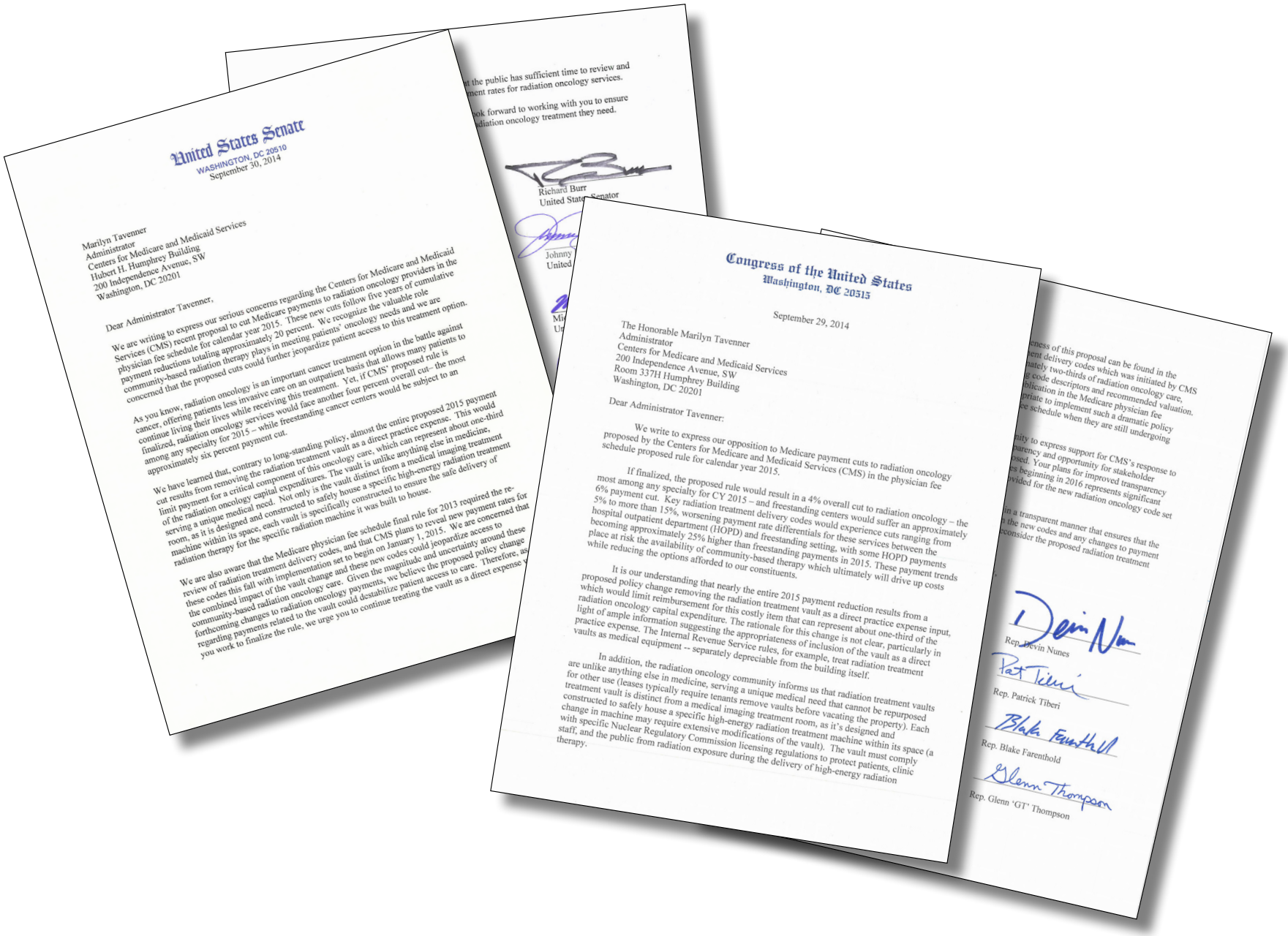
MEDICARE.

Closing the self-referral loophole can help to stabilize the current fee-for-service system as we accelerate Medicare toward value-based payments, acting as a bridge to payment reform.

Protect Access to Radiation Oncology

ASTRO thanks the 166 Members of Congress that supported radiation oncology by successfully urging Medicare to stop proposed cuts to cancer care in 2014.

Medicare may revisit these payment cuts later this year, in which case **we will need congressional support to maintain patient access to radiation oncology care**.



United States Senate
WASHINGTON, DC 20510
September 30, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Tavenner,

We are writing to express our serious concerns regarding the Centers for Medicare and Medicaid Services (CMS) recent proposal to cut Medicare payments to radiation oncology providers in the physician fee schedule for calendar year 2015. These new cuts follow five years of cumulative payment reductions totaling approximately 20 percent. We recognize the valuable role community-based radiation therapy plays in meeting patients' oncology needs and we are concerned that the proposed cuts could further jeopardize patient access to this treatment option.

As you know, radiation oncology is an important cancer treatment option in the battle against cancer, offering patients less invasive care on an outpatient basis that allows many patients to continue living their lives while receiving this treatment. Yet, if CMS' proposed rule is finalized, radiation oncology services would face another four percent overall cut– the most among any specialty for 2015 – while freestanding cancer centers would be subject to an approximately six percent payment cut.

We have learned that, contrary to long-standing policy, almost the entire proposed 2015 payment cut results from removing the radiation treatment vault as a direct practice expense. This would limit payment for a critical component of this oncology care, which can represent about one-third of the radiation oncology capital expenditures. The vault is unlike anything else in medicine, serving a unique medical need. Not only is the vault distinct from a medical imaging treatment room, as it is designed and constructed to safely house a specific high-energy radiation treatment machine within its space, each vault is specifically constructed to ensure the safe delivery of radiation therapy for the specific radiation machine it was built to house.

We are also aware that the Medicare physician fee schedule final rule for 2013 required the review of radiation treatment delivery codes, and that CMS plans to reveal new payment rates for these codes this fall with implementation set to begin on January 1, 2015. We are concerned that the combined impact of the vault change and these new codes could jeopardize access to community-based radiation oncology care. Given the magnitude and uncertainty around these forthcoming changes to radiation oncology payments, we believe the proposed policy change regarding payments related to the vault could destabilize patient access to care. Therefore, as you work to finalize the rule, we urge you to continue treating the vault as a direct expense v

t the public has sufficient time to review and
ment rates for radiation oncology services.

ook forward to working with you to ensure
diation oncology treatment they need.

Richard Burr
United State Senator

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Congress of the United States
Washington, DC 20515

September 29, 2014

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Room 337H Humphrey Building
Washington, DC 20201

Dear Administrator Tavenner:

We write to express our opposition to Medicare payment cuts to radiation oncology proposed by the Centers for Medicare and Medicaid Services (CMS) in the physician fee schedule proposed rule for calendar year 2015.

If finalized, the proposed rule would result in a 4% overall cut to radiation oncology – the most among any specialty for CY 2015 – and freestanding centers would suffer an approximately 6% payment cut. Key radiation treatment delivery codes would experience cuts ranging from 5% to more than 15%, worsening payment rate differentials for these services between the hospital outpatient department (HOPD) and freestanding setting, with some HOPD payments becoming approximately 25% higher than freestanding payments in 2015. These payment trends place at risk the availability of community-based therapy which ultimately will drive up costs while reducing the options afforded to our constituents.

It is our understanding that nearly the entire 2015 payment reduction results from a proposed policy change removing the radiation treatment vault as a direct practice expense input, which would limit reimbursement for this costly item that can represent about one-third of the radiation oncology capital expenditure. The rationale for this change is not clear, particularly in light of ample information suggesting the appropriateness of inclusion of the vault as a direct practice expense. The Internal Revenue Service rules, for example, treat radiation treatment vaults as medical equipment -- separately depreciable from the building itself.

In addition, the radiation oncology community informs us that radiation treatment vaults are unlike anything else in medicine, serving a unique medical need that cannot be repurposed for other use (leases typically require tenants remove vaults before vacating the property). Each treatment vault is distinct from a medical imaging treatment room, as it's designed and constructed to safely house a specific high-energy radiation treatment machine within its space (a change in machine may require extensive modifications of the vault). The vault must comply with specific Nuclear Regulatory Commission licensing regulations to protect patients, clinic staff, and the public from radiation exposure during the delivery of high-energy radiation therapy.

eness of this proposal can be found in the
ent delivery codes which was initiated by CMS
ately two-thirds of radiation oncology care,
g code descriptors and recommended valuation.
blication in the Medicare physician fee
priate to implement such a dramatic policy
ee schedule when they are still undergoing

ity to express support for CMS's response to
parency and opportunity for stakeholder
osed. Your plans for improved transparency
es beginning in 2016 represents significant
vided for the new radiation oncology code set

in a transparent manner that ensures that the
the new codes and any changes to payment
consider the proposed radiation treatment

Rep. Devin Nunes

Rep. Patrick Tiberi

Rep. Blake Farenthold

Rep. Glenn 'GT' Thompson

Payment Reform Initiative

ASTRO supports efforts to move toward a Medicare payment system driven by quality rather than volume.

ASTRO supports payment reforms for radiation oncology and cancer treatment that improve the quality of care, reduce variations in care and decrease overall costs.

ASTRO'S Medicare Payment Reform Action Plan

- Revise current radiation oncology codes to more accurately reflect clinical practice and package together services typically billed at the same time;
- Reward radiation oncologists for improving quality while lowering costs; and
- Incentivize the use of treatments that result in the best patient care and outcomes.

Increase Investments in Radiation Oncology Research

Fight Cancer by Supporting Increased Radiation Oncology Research Funding

It is estimated that *nearly* **1.7 million people** in the U.S. will be **diagnosed with cancer** this year.

More than **589,000 Americans will die** from the disease in 2015, which translates to *more than* **1,600 people each day**.

Annual cancer incidence rates are projected to increase by 31 percent during the next decade, growing to 2.1 million people diagnosed in 2025.

Innovative research is the best hope for improving patient outcomes and quality of life; therefore, more resources are needed for the National Cancer Institute (NCI) and the National Institutes of Health (NIH).

ASTRO is asking Congress to pass legislation that would raise the NIH budget caps to support a 10 percent increase for NIH in FY 2016, for a total budget request of $33 billion. Within that amount, ASTRO requests that funding for NCI be prioritized and receive at least a 10 percent increase ($5.75 billion).

IN 2014 NIH DETERMINED THAT ONLY ABOUT .9 PERCENT OF THE TOTAL BUDGET FUNDED RADIATION ONCOLOGY RESEARCH.

ASTRO applauds Congress' long-standing support for biomedical research and appreciates the critical role this funding has played in every major innovation in the fight against cancer, including significant advances in radiation oncology.

This support has led to a decline in the number of cancer deaths in the United States. Now, thanks to radiation oncology and other breakthroughs, more than **two-thirds** of cancer patients survive five years or longer after their cancer diagnosis.

Direct NIH and NCI to Prioritize Radiation Oncology Research

Given that **more than half** of all cancer patients are treated with radiation therapy, the current level of funding for radiation therapy research is not adequate to sustain new discoveries in the field to advance treatment for patients. It is also insufficient for young investigators trained in radiation oncology to build scientific careers in research that will ultimately yield the next treatment advances.

ASTRO urges Congress to direct The National Cancer Institute to work with experts in the field of radiation oncology and other cancer disciplines to determine a more appropriate funding level for radiation oncology research projects as a percentage of the overall NCI budget. NCI should then begin a process of reprioritizing radiation oncology research and reallocating a greater share of its current funding to radiation oncology research projects.

Preserve and Increase Funding and Residency Slots for Graduate Medical Education

Preserve and Increase Graduate Medical Education Funding

The Graduate Medical Education (GME) program is the process by which physicians, after medical school, gain the practical skills and knowledge in their chosen field of medicine.

As more individuals are diagnosed with cancer, the demand for radiation therapy will increase. ASTRO is concerned that proposals to decrease payments to this program and continuing to cap the publically funded residency positions could result in patient access issues.

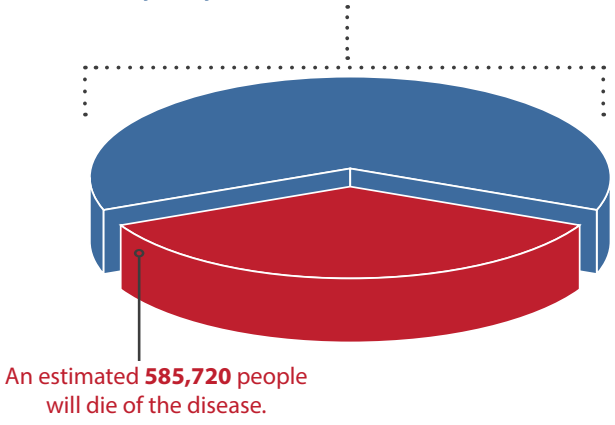
ASTRO URGES CONGRESS
TO PRESERVE CRITICAL FUNDING
FOR **MEDICAL RESIDENCY PROGRAMS.** TRAINING THE
NEXT GENERATION OF CANCER DOCTORS
MUST BE A PRIORITY.

The President's FY 2016 Budget proposes to reduce the indirect medical education (IME) adjustment by 10 percent, beginning in FY 2016. This would cut funding to teaching hospitals by approximately $16.3 billion over 10 years. Cutting these payments comes at a critical time when many hospitals currently cannot fund their current residents.

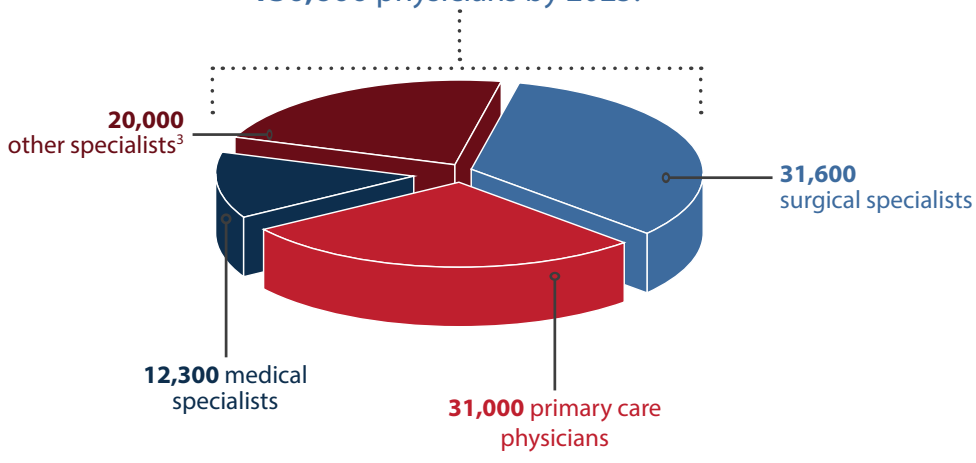
CANCER DIAGNOSES ON THE RISE

It is projected that the number of individuals diagnosed with cancer in the United States will increase dramatically during the next 20 years. This is primarily due to increases in insurance coverage and the aging of the population.

In 2014, it is estimated that there will be **1,665,540** new cases of cancer.[1]



The United States is facing a shortage of **130,600** physicians by 2025.[2]



THE PHYSICIAN SHORTAGE

The general perception among radiation oncologists is that there is sufficient supply to treat patients today; however, as the number of cancer diagnoses steadily increases, there are concerns that the supply of physicians may not increase sufficiently to treat the patients of tomorrow as demand for treatment grows.

There are **87 radiation oncology residency programs accredited by the ACGME** for the 2014/2015 academic year offering **186 training positions** for U.S. senior medical school students. In 2014, **20** U.S. senior medical school students ***did not match*** into one of these programs.

ASTRO urges Congress to support legislation that will increase the number of residency slots available each year, ultimately increasing the number of practicing physicians.

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[1] SEER Cancer Statistics Factsheets: All Cancer Sites. National Cancer Institute. Bethesda, MD,http://seer.cancer.gov/statfacts/html/all.html
[2] Association of American Medical Colleges (AAMC): The Complexities of Physician Supply and Demand: Projections from 2013 to 2025. March 2015.
[3] The **other specialties** category consists of anesthesiology, emergency medicine, neurology, pathology, physical medicine and rehabilitation, psychiatry, radiology, and all other specialties including radiation oncology

ASTRO's ***Target Safely*** Initiative

ASTRO launched *Target Safely* in 2010. It focuses on improving patient safety and reducing the chances of medical errors during radiation therapy treatments. *Target Safely* includes RO-ILS, APEx and IHE-RO.

> "These initiatives are designed to improve all of the steps in the process of care, creating a culture of safety as the highest priority, thus increasing quality of care and reducing the chances of errors."

RO•ILS

RADIATION ONCOLOGY™
INCIDENT LEARNING SYSTEM

Sponsored by ASTRO and AAPM

RO-ILS: Radiation Oncology Incident Learning System

ASTRO developed the first medical specialty society-sponsored incident learning system for radiation oncology to facilitate safer and higher quality care, providing a mechanism for shared learning in a secure and non-punitive environment.

ASTRO launched RO-ILS on June 19, 2014 at a congressional briefing sponsored by Representatives Frank Pallone (D-N.J.) and Ed Whitfield (R-Kan.); and 82 practices are currently reporting.

APEx is the Integration of ASTRO's Quality Efforts

APEx
ASTRO Accreditation Program for Excellence
Safety and quality for radiation oncology practice
™

APEx is ASTRO's **new** practice accreditation program. APEx was created to ensure accountability in radiation therapy practices. The program provides an objective review by practicing radiation oncology professionals of essential functions and processes of radiation oncology practices. It offers transparent, measurable, evidence- and consensus-based standards that emphasize a professional commitment to safety and quality.

APEx began accepting applications in December 2014; and 39 institutions have begun or applied to begin the accreditation process.

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