[INSERT FULL NAME]
[INSERT STREET ADDRESS]
[INSERT CITY, STATE, ZIP]
[INSERT PHONE NUMBER]

August 2020

Dear [INSERT NAME OF CONGRESS REPRESENATIVE],

I am citizen living in [INSERT CITY & STATE] and I am deeply concerned about access to medical care in our state. Recently, I have been informed that the Center for Medicare & Medicare Services has lowered the facility reimbursement rate for a minimally invasive **treatment for prostate cancer known as HIFU (high intensity focused ultrasound)** by almost 50% at the beginning of this year.

I had prostate cancer.

I choose HIFU treatment because I wanted an effective treatment with less risk of side effects. I was back to my normal lifestyle within a few days.

My outcome was the cancer was eliminated and I haven’t had any side effects. My friends who chose surgery or radiation can’t tell the same story.

**I think HIFU should be an option for any man with prostate cancer and I am concerned that due to the low rate of reimbursement they can’t get it.**

* The low reimbursement rate makes it impossible for hospitals and surgery centers to offer HIFU treatment to Medicare patients.
* The rate **does not even cover** the cost of the materials, equipment and services to deliver the treatment.
* If a facility can’t cover the costs, they simply won’t offer it which means that it won’t be available for patient like me who want to choose HIFU as a treatment option.

**Limiting access to quality care is a serious concern for me.**

All men should have the ability, with their physician to make treatment decisions based on their own medical history and their diagnosis.

It is very unfortunate that this kind of reimbursement decision would literally push people away from minimally invasive treatment option for prostate cancer, thus eliminating it as an option for them if they are a Medicare patient.

As a prostate cancer patient, I spent a lot of time researching the different available treatment options that are covered by Medicare. I was discouraged by potential side effects of traditional treatment such as surgery and radiation. They often lead to sexual dysfunction and issues urinating. Studies show that the risk of these types of side effects are lower with HIFU and men recover more quickly. **That was my personal experience as well.**

It really doesn’t make sense to me why Medicare would provide adequate reimbursement for procedures that may lead to significant side effects, but won’t provide enough reimbursement for the HIFU procedure that is less expensive to deliver and won’t lead to more procedures (costs) to manage side effects.

Patients should have the ability to choose this option if its right for them – and if they do, it may even save the system money in the long run since there would be fewer follow up procedures that require Medicare coverage.

Since I am sure you have many issues brought to your attention on a daily basis, I thought it might be helpful to give you a **brief history on reimbursement for HIFU** and why I am reaching out NOW about the issue. At the end of my letter you will find a list of bullet points detailing the issues surrounding Medicare reimbursement for HIFU.

Lastly, I want to take the time to emphasize how large a health issue prostate cancer is in our country.

Of the almost 900,000 total cancer cases of men in the US, **nearly 20% of them are prostate cancer cases.** And half of those men are of Medicare age.This is a significant number of men affected.

Thank you in advance for your time and attention to this matter. I would love to opportunity to speak with you further about it and I urge you to take steps now to increase the reimbursement rate for HIFU. Please let me know if I may be of assistance in anyway at all.

Regards,

[INSERT NAME]
[INSERT PHONE NUMBER]

**HISTORY OF MEDICARE REIMBURSMENT FOR HIFU**

* + The Center for Medicare and Medicaid Services (CMS) established a C-code (C9747) effective July 1, 2017.
	+ The code was release with short notice and without any guidance as to how it was supposed to be processed. The sudden release of the code disrupted the care of hundreds of men because none of the active treatment location in the US at the time were ready to process Medicare patients.
	+ Some men had to wait 9 months for a center to start accepting patients after the change because all contracts had to be realigned to be compliant with regulations that became effective because of this code. This could have been avoided if CMS would have given a few months’ notice of the new code.
	+ In order to be compliant with all the regulations, Fair Market Valuations (FMV) had to be run. All contracts had to be re-written with the FMV pricing which created a hard cost to the treatment facility based on the equipment and disposable cost.
	+ The reimbursement amount of C9747 was already so low that some hospitals in low wage index states would barely break even doing a 3-4 hours procedure (not enough to break even on longer procedure).
	+ The situation was worse at the Ambulatory Surgery Centers (ASC) because the initial rate was below the FMV, which had them losing money on every patient. CMS made a change in October 2017 which brought the ASC reimbursement up to a point which made it possible for the ASC to cover hard cost for a procedure in high Wage Indexed states (although they still lost money on employee and other cost). This was the worse part of C9747 because nearly 50,000 men have been treatment around the world in ASC’s, and now because of CMS US men were being forced to be treated in the hospital taking away critical OR time away from procedures that need to be in the hospital.
	+ Because of the lack of guidance provided by CMS on how to process the new code, Hospitals called the Medicare Administrative Contractor (MAC) their CMS representative to learn how they should process the code. The hand full of hospitals in the US that were able to get everything going in 2017 billed according to what they were instructed by the MAC. Although the MAC failed to instruct the facilities to mark up their charges, so the bills weren’t marked up.
	+ It wasn’t until November 2018 when these errors came to light when CMS published the new reimbursement rates. By the time November 2018 came around it was too late to correct the error for 2017, and 10 months of 2018. Basically, meaning that roughly 80% of the procedures in 2018 had already been billed and were incorrect because of the MACs instructions.
	+ CMS then took the billed value and reduced it by a unknown markup ratio and brought CMS’s calculated cost down to well below the FMV of the hard cost for the procedure (and that is without considering facility overhead). Because CMS’s processes don’t have a procedure to audit for billing errors or for outliers, CMS has failed to entertain that the numbers they calculate were incorrect. CMS also failed to acknowledge any of the comments in the open comment period on how their action was killing a treatment option for men.
	+ Because CMS only pays an arbitrary percentage of the hospital rate versus actually doing the cost evaluation. The rate CMS is choosing is forcing a traditionally ASC procedure into a higher cost and higher risk hospital environment for no other reason than reimbursement.

*Provided by HIFU Prostate Services*

*HIFU Prostate Services (HPS) was founded to provide men access to a less invasive treatment option for prostate cancer that has the ability to eliminate cancer and preserve patient quality of life. Their mission is to deliver the highest quality of care, support, and technology to the patient and to the urology community for the treatment of localized prostate cancer. As the industry’s leading HIFU services provider, HPS continues to evaluate all HIFU technologies for the treatment of prostate cancer to ensure they are offering the safest and most effective HIFU technology on the market.*