



**AMERICAN SOCIETY
FOR RADIATION ONCOLOGY**

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July 14, 2022

Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8013
7500 Security Boulevard
Baltimore, MD 21244-8013

Dear Administrator Brooks-LaSure,

The American Society for Radiation Oncology (ASTRO)¹ is taking this opportunity to provide comments on the “Enhancing Oncology Model” (EOM) introduced by the Centers for Medicare and Medicaid Innovation Center (CMMI) on Monday, June 27 as a request for application (RFA). ASTRO appreciates CMMI’s commitment to improving upon the recently expired Oncology Care Model (OCM) through the development of EOM; however, we are concerned that EOM does not address ASTRO’s concerns regarding the potential unintended consequences of including radiation therapy in a broader oncology episode of care. In addition, the EOM does not sufficiently recognize the multi-disciplinary approach to cancer care that often involves a radiation oncologist and a surgical oncologist, in addition to a medical oncologist.

Multi-disciplinary Cancer Treatment

According to the RFA, the purpose of the EOM is to drive transformation in oncology care by preserving or enhancing the quality of care furnished to beneficiaries undergoing treatment for cancer while reducing program spending under Medicare Fee-for-Service (FFS). This approach does not recognize the value of multi-disciplinary cancer care.

In many cases, chemotherapy may be given prior to radiation therapy or surgery, and often chemotherapy and radiation therapy are given together. Each of these approaches are often delivered with a curative-intent and require a team-based approach to oncology care, where no one member of the team is the lead but rather each member manages the complexities of cancer care associated with his/her area of expertise.

One of the tenets of value-based care is the development of alternative payment models that allow physicians to manage the costs that they can control. As it is designed, the EOM is a total cost of care (TCOC) model which includes all Part A, Part B and certain Part D services. Similar to the OCM, an episode is triggered with

¹ ASTRO members are medical professionals practicing at hospitals and cancer treatment centers in the United States and around the globe. They make up the radiation treatment teams that are critical in the fight against cancer. These teams include radiation oncologists, medical physicists, medical dosimetrists, radiation therapists, oncology nurses, nutritionists and social workers. They treat more than one million cancer patients each year. We believe this multi-disciplinary membership makes us uniquely qualified to provide input on the inherently complex issues related to Medicare payment policy and coding for radiation oncology services.

chemotherapy infusion through a six-month period, which may include radiation therapy services. The role of the radiation oncologist is limited to the optional “Care Partner” financial arrangement. Additionally, the use of radiation therapy is limited to its inclusion as a cost component associated with episode benchmark pricing.

Due to the chemotherapy infusion trigger, the OEM obligates the medical oncologists to value other therapies outside of their scopes of practice. If a patient requires and can benefit from radiation therapy services during that six-month episode, then the patient should be referred to a radiation oncologist for radiation therapy services. The model disincentivizes that appropriate referral. Even if appropriately referred, the medical oncologist will not have control over the treatment planning or cost associated with the delivery of radiation therapy treatments, which can be substantial, which places unfair pressure on both specialties.

By including radiation oncology in the six-month episode of care, CMMI has created an unintended incentive to reduce the utilization of curative and palliative local therapies, including radiation therapy, because of its relative cost--although its relative value in cancer care is substantial and overall, a small percentage of cancer care total expenditures. This unintended consequence is due to the inclusion of all Part A and B services, including radiation therapy, and the financial incentive to keep overall costs below the discount rate of 4% for Risk Arrangement 1 participants and 3% for Risk Arrangement 2 participants.

Without careful consideration for all the services delivered to a patient undergoing cancer treatment, CMS runs the risk of setting back all of the advances that have been made in cancer treatment over the last 50 years. A TCOC model must acknowledge and support the sound science associated with existing regimens of multimodality treatment (surgery, chemotherapy and radiation therapy) that have been proven time and again to cure roughly 60% of all cancer patients². CMS needs to commit to these existing standards of care and support their continued use through reasonable and stable payment rates that include payment for wrap around services that benefit the most vulnerable cancer patients. Cancer treatments that have already demonstrated high-value and quality for the majority of patients treated with cancer should be protected and secured well into the future. The significant costs of cancer care must be considered based on modality of treatment to ensure that the various providers involved in care can ensure that the patient is getting the best treatment based on their diagnosis and has control over the cost of the therapy that he or she is delivering. Simply putting another care provider “in charge” only risks quality care.

Commitment to Episode Based Payments for Radiation Oncology Services

ASTRO remains fully committed to the development of an alternative payment model for radiation oncology that establishes a simplified payment methodology ensuring fair and stable reimbursement that recognizes efficient delivery of care. An ideal payment model should recognize the important role associated with investments in the cancer treatment infrastructure to ensure that all patients have access to high quality care using advanced technology, as well as reduce unnecessary and burdensome reporting requirements that do not contribute to improved patient outcomes.

Additionally, mechanisms should be established in a payment model to identify and support patient populations with limited access to radiation therapy, to ensure initiation and completion of treatment. A commitment to evidence-based approaches to care and investment in wraparound services, including patient navigation and transportation, will improve care for people from historically marginalized populations.

Finally, TCOC models must establish specialty specific pathways that recognize the value and quality of radiation therapy within a broader continuum of cancer care. Multidisciplinary collaboration as part of the initiating service within a TCOC model, as well as the inclusion of discrete episodes that recognize the value of services, like radiation therapy, in multimodality treatment must be part of the equation.

² “Cancer Treatment & Survivorship Facts and Figures 2019-2021.” American Cancer Society, Inc.

<https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-treatment-and-survivorship-facts-and-figures/cancer-treatment-and-survivorship-facts-and-figures-2019-2021.pdf>

ASTRO looks forward to collaborating with CMS and other oncology care stakeholders on the development of payment models that recognize the value associated with radiation therapy. We appreciate the opportunity to comment on the proposed EOM. If you should have any questions or require additional information, please contact Anne Hubbard, Director of Health Policy, at 703-839-7394 or Anne.Hubbard@astro.org.

Sincerely,



Laura I. Thevenot
Chief Executive Officer



Laura Dawson, MD, FASTRO
Chair