ASTRO
TARGETING CANCER CARE

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June 14, 2024

The Honorable Ron Wyden
Chairman
The Honorable Mike Crapo
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Re: Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B

Dear Chairman Wyden and Ranking Member Crapo,

The American Society for Radiation Oncology (ASTRO)[1] appreciates the opportunity to respond to the US Senate Committee on Finance white paper entitled "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B." As a trailblazing specialty in our commitment to shifting from fee-for-service to value-based payment, ASTRO applauds the Committee's dedication to enacting changes to the Medicare Physician Fee Schedule (MPFS) to ensure that the Medicare Part B reimbursement structure incentivizes and keeps pace with the cost of providing high value patient care.

The White Paper aptly covers the key issues of Medicare Physician Fee Schedule (MPFS) payment system which are failing physicians across the spectrum of care, from primary care to specialists like radiation oncology. **While addressing overall Medicare payment flaws, such as the conversion factor and budget neutrality, ASTRO urges the committee to resist the mythical "one-size-fits-all" payment reform solution, given the massive gulf in patient management and practice expense between primary care and specialty care. We recommend a more targeted approach that recognizes and supports those specialties that are most appropriate and uniquely ready for reform. To that end, ASTRO urges the Committee to work toward enactment of the Radiation Oncology Case Rate (ROCR) Value Based Payment Program Act and similar**

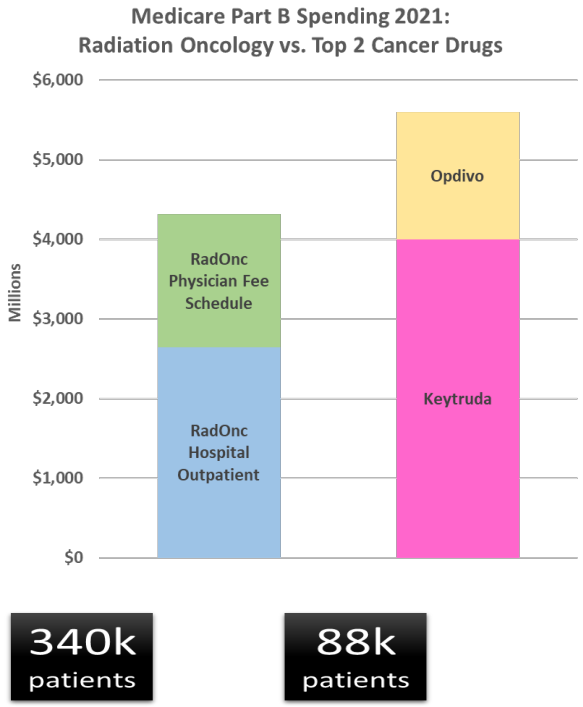
physician-driven innovative payment policies that improve access, enhance quality, reduce disparities, and lower costs.

[1] ASTRO members are medical professionals, who practice at hospitals and cancer treatment centers in the United States and around the globe and make up the radiation therapy treatment teams that are critical in the fight against cancer. These teams often include radiation oncologists, medical physicists, medical dosimetrists, radiation therapists, oncology nurses, nutritionists and social workers, and 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.

Radiation oncology services, in both hospitals and physician offices, are a prime example of how the existing payment systems do not support access to care, nor do they incentivize the best delivery of care. More than a decade of severe reimbursement cuts and payment incentives that run counter to clinical guidelines for this chronic disease are just two reasons why the radiation oncology community has aggressively pursued an alternative payment model that drives value-based care.

Conversion Factor (CF) fluctuations, cited in the White Paper, combined with the impact of budget neutrality, also cited, has shifted billions from specialty care to primary care services which have resulted in a 23% decline in MPFS payments for radiation therapy services since 2013. Freestanding radiation oncology practices are reeling from increased costs associated with patient care and growing administrative burden, forcing many to consolidate with larger practices or health systems. Between 2013 and 2017 the number of solo radiation oncology practices fell 11%, while at the same time, the number of large group practices increased by 50%.[2] Payment cuts and increased costs are unsustainable and contribute to practice closure and consolidation, creating access to care challenges for many communities, particularly those serving rural and underserved populations.

These payment cuts fail to recognize that radiation oncology is a high-value form of cancer treatment. *All* of Medicare expenditures for radiation oncology services under Medicare Part B are less than the two top chemotherapy drugs, despite more than 340,000 beneficiaries receiving radiation therapy, nearly four times as many beneficiaries than are treated with those drugs.



[2] Milligan, Michael, MD MBA, Megan Hansen, BA, BS, Daniel Kim, MD, MBA, et al. "Practice Consolidation Among US Radiation Oncologists Over time." Radiation Oncology*Biology*Physics. Vol. 111, Issue 3, P610-618. June 18, 2021. https://doi.org/10.1016/j.ijrobp.2021.06.009

The ROCR Solution

ASTRO has long advocated for a shift from fee-for-service (FFS) to value-based payment through the development of episode-based payment for radiation oncology services, which would stabilize payment and protect access to care. Advances in radiation therapy have shortened the course of treatment for many disease sites, including breast and prostate cancer. These shorter courses of treatment involve the delivery of higher doses of radiation over shorter periods of time, yielding patient outcomes that are equivalent to or better than conventional courses of treatment. Shorter courses of care are more efficient and convenient for patients, but do not align with the current fee-for-service (FFS) system, which is tied to volume.

Starting in 2009, the Centers for Medicare and Medicaid Services (CMS) initiated a series of annual rate reductions for key radiation therapy services under the Medicare physician fee schedule. From 2009 to 2015, bipartisan Members of Congress urged CMS to stop – or at least scale back – these draconian cuts that reduced access to community-based radiation oncology.[3] In 2015, with additional cuts forthcoming, Congress passed the Patient Access and Medicare Protection Act (PAMPA) that, among other things, froze payments for key radiation therapy services and directed the Secretary of the Department of Health and Human Services to issue a report on the development of a radiation oncology alternative payment model.

ASTRO and the radiation oncology community actively engaged with CMS and the Center for Medicare and Medicaid Innovation (CMMI) on the report, outlining various proposals that included establishing episode-based payments. In 2017, CMS released the Congressionally directed report[4], noting that an alternative payment model (APM) could establish long warranted rate stability to ensure continued access to this vital and high-value form of cancer care, and described potential parameters for such a model.

In July 2019, CMMI proposed a mandatory radiation oncology alternative payment model (RO Model) to test whether changing payment from fee-for-service to a prospective, site neutral, episode-based model would incentivize physicians to deliver higher-value radiation therapy care. Unfortunately, this model would have resulted in steep payment reductions that would have jeopardized the financial viability of participating practices, and included onerous reporting requirements that would have imposed significant burdens on participating practices. There was widespread recognition of these challenges from the radiation oncology community, American Hospital Association, American Medical Association (AMA), and cancer patient groups.

Stakeholders submitted exhaustive comments through rulemaking on ways to mitigate these challenges and improve the RO Model, but very few adjustments were made, which resulted in significant anxiety for those practices forced to participate during the height of the COVID-19 public health emergency. Congress also wrote[5] CMS expressing concerns about the lack of balance in the RO Model and stepped in twice to pass legislation delaying the RO Model's implementation. In 2022, CMS indefinitely delayed the Model; yet the payment issues still exist for radiation oncology services and have only worsened in recent years because of conversion factor cuts and budget neutrality in the MPFS. Despite the demise of the RO Model, the radiation oncology community and its leading organizations remain committed to payment reform. In January 2024, the American Society for Radiation Oncology (ASTRO), American College of Radiation Oncology (ACRO),

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[3] Radiation Oncology APM: Why Us? Why Now?, *International Journal of Radiation Oncology, Biology, and Physics*, July 11, 2019, https://doi.org/10.1016/j.ijrobp.2019.07.002

[4] United States Department of Health and Human Services Report to Congress: Episodic Alternative Payment Model for Radiation Therapy Services, November 2017, https://www.cms.gov/priorities/innovation/Files/reports/radiationtherapy-apm-rtc.pdf

[5] Press Release: Senators and Representatives Unite to Call on CMS to Protect Patient Access to High-Quality Radiation Treatments, October 21, 2021. https://www.astro.org/news-and-publications/news-and-media-center/news-releases/2021/senators-and-representatives-unite-to-call-on-cms-to-protect-patient-access-to-high-quality-radiatio

American College of Radiology (ACR), and the Association of Clinical Oncology (ASCO) issued a joint statement[6] supporting payment reform in radiation oncology.

The radiation oncology community has continued to work on payment reform, drawing on the strengths of the RO Model – specifically the use of episode-based payments – and seeking to address its weaknesses, including steep payment cuts, burdensome quality requirements, and the absence of an approach to reduce known disparities. In June 2023, ASTRO unveiled the Radiation Oncology Case Rate (ROCR) program to change payments from volume-based to value-based with the goals of increasing access, enhancing quality, and reducing disparities while achieving Medicare savings.

ASTRO is grateful that bipartisan Members of Congress have recognized the opportunity to support radiation oncology payment reform through the introduction in May of the Radiation Oncology Case Rate (ROCR) Value-Based Payment Program Act (S.4330/HR 8404)), by Senate Finance Committee member Thom Tillis (R-NC) and Reps. Brian Fitzpatrick (R-PA), Jimmy Panetta (D-CA), John Joyce, MD (R-PA), and Paul Tonko (D-NY). Supported by more than 50 radiation oncology organizations, including professional societies, freestanding clinics, community hospitals, and academic centers, the ROCR Act is designed to address the flaws of the Medicare physician payment system for radiation oncology before additional cuts further jeopardize access to high quality care.

<u>ROCR and Adequate Payments</u>

The ROCR Act addresses many of the issues discussed in the White Paper and represents the best chance to secure long-term rate stability and continue to deliver cutting-edge care to cancer patients close to home. ROCR establishes stable payment rates through episode-based payments, creates a structure and incentives that improve upon already excellent quality, reduces known disparities through additional payments to underserved populations, and is fiscally responsible—reducing total Medicare spending and patient costs.

ROCR payments are based on the M code case rates that CMS introduced as part of the RO Model in the 2022 MPFS Final Rule. The M code case rates are based on Hospital Outpatient Prospective Payment System (HOPPS) claims data, which the Agency stated was a more accurate assessment of the cost associated with the delivery of radiation therapy. The ROCR payment program builds off those M code case rates, which are applied nationwide to the physician offices and hospital clinics where radiation therapy is delivered, while generating over $200 million in savings over the first ten years of the program.

To accomplish this, the ROCR payment methodology includes regular inflationary updates using indexes discussed in the report, paired with a savings adjustment. The Professional Component (PC) of the payment is tied to the Medicare Economic Index (MEI) and the Technical Component (TC) payment is tied to the Hospital Inpatient Market Basket update. The inflationary updates recognize the significant capital and workforce investment required to operationalize a radiation oncology clinic. Inflationary updates support stable payments for radiation oncology services that enable practices to keep their doors open, avoid consolidation, and invest in new state-of-the-art technology needed to deliver high-quality care to cancer patients. Recognizing the need to contribute savings to support Medicare sustainability, the ROCR payment methodology also applies a savings adjustment to generate approximately $200 million in savings.

[6] Press Release: Radiation Oncology Physician Groups Unite to Ensure Patient Access to Cancer Care, January 9, 2024, https://www.astro.org/news-and-publications/news-and-media-center/news-releases/2024/radiation-oncology-physician-groups-unite-to-ensure-patient-access-to-cancer-care

Ensuring High Quality Radiation Therapy

ROCR also enhances quality care through practice accreditation. Accreditation ensures that practices are following appropriate guidelines and will meet safety and other quality standards that are set by any one of the three existing accrediting bodies. Currently, half of radiation oncology clinics are accredited, demonstrating both its acceptance as the gold-standard for quality in radiation oncology and an opportunity for further quality gains. The ROCR policy encourages adoption of an accreditation program through the application of a 0.5% increase in payment over the first three years of the program, which then transitions to a 1% decrement in subsequent years for those who remain unaccredited.

Small practices, unable to achieve accreditation status, will be able to pursue a quality-based audit in order to meet the accreditation requirement. They will benefit from a .25% payment update but will not be financially penalized for non-accreditation status. This is preferred over remaining in the MIPS program which has been a significant burden for many practices with no patient care benefit.

Reducing Disparities in Access

Delays in the time to treatment initiation are associated with absolute increased risk of mortality ranging from 1.2−3.2% per week, and Black, Hispanic, and Native American Medicare beneficiaries were less likely to initiate radiation treatment.[7,8] Some Medicare beneficiaries also experience access challenges because of where they live. People who reside in isolated rural census tracts account for approximately 9.4 million people in the US and had a nearly one hour longer travel time to a radiation oncology provider than people in urban tracts.[9] To reduce health disparities and to support patients in accessing and completing their treatments, the ROCR TC payment is increased by $500 through a Health Equity Achievement in Radiation Therapy (HEART) payment for those patients who experience transportation barriers. HEART is consistent with MedPAC's recommendation for add-on payments for services furnished to beneficiaries with lower incomes.

Beneficiary transportation need will be determined by the following transportation screening question from the Accountable Health Communities health-related social needs screening tool: *In the past 2 months, has a lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?*[10] The HEART payment will not duplicate other transportation benefits provided under

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[7] Khorana AA, Tullio K, Elson P, Pennell NA, et al. Time to initial cancer treatment in the United States and association with survival over time: An observational study. PLoS One. 2019 Mar 1;14(3):e0213209. doi: 10.1371/journal.pone.0213209. Erratum in: PLoS One. 2019 Apr 4;14(4):e0215108. PMID: 30822350; PMCID: PMC6396925.

[8] Samuel Cykert, Eugenia Eng, Matthew A. Manning, Linda B. Robertson, Dwight E. Heron, Nora S. Jones, Jennifer C. Schaal, Alexandra Lightfoot, Haibo Zhou, Christina Yongue, Ziya Gizlice, A Multi-faceted Intervention Aimed at Black-White Disparities in the Treatment of Early Stage Cancers: The ACCURE Pragmatic Quality Improvement trial, Journal of the National Medical Association, Volume 112, Issue 5, 2020, Pages 468-477, ISSN 0027-9684, https://doi.org/10.1016/j.jnma.2019.03.001.(https://www.sciencedirect.com/science/article/pii/S0027968418301913)

[9] Joshua N. Herb, Rachael T. Wolff, Philip M. McDaniel, G. Mark Holmes, Trevor J. Royce, Karyn B. Stitzenberg, Travel Time to Radiation Oncology Facilities in the United States and the Influence of Certificate of Need Policies, International Journal of Radiation Oncology*Biology*Physics, Volume 109, Issue 2, 2021, Pages 344-351, ISSN 0360-3016, https://doi.org/10.1016/j.ijrobp.2020.08.059. (https://www.sciencedirect.com/science/article/pii/S0360301620342188)

[10] https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

Medicare or Medicaid. Removing barriers, particularly transportation, can improve access to care and reduce the disparity in treatment completion across Medicare populations.

Other Key Areas for Consideration

In addition to sharing an overview of ROCR, please find below responses to other key areas of the White Paper that relate to ASTRO's work.

MedPAC Payment Adequacy Assessment

ASTRO appreciates that the Medicare Payment Advisory Commission (MedPAC) has raised concern about the significant gap between Medicare Economic Index (MEI) growth and MPFS updates in recent years. The Commission's recommendation for a Conversion Factor update of 50% of the projected increase in MEI for 2025 is a step in the right direction; however, this may not fully address the complexity associated with delivering patient care, particularly for those specialties with significant capital expenditure requirements such as radiation oncology. We believe a more nuanced approach is required. In addition to considering adjustments that recognize the challenges associated with delivering care to socioeconomically disadvantaged communities, there should also be adjustments to account for the capital investment and labor costs required for some services, otherwise access to care issues will be exacerbated, particularly in rural areas.

Additionally, we would like to point out that the MedPAC clinician payment adequacy indicator analysis, which assesses Medicare beneficiary access to clinician services, may be flawed. This simplified approach to gauging beneficiary access to care does not take into consideration how utilization of Medicare covered services varies by medical specialty. Utilization of some forms of specialty care, such as oncology services, is overwhelmingly consumed by the 65+ population, which has a significant impact on payer mix for those specialties. Providers with greater than 50% of their payer mix tied to Medicare would be significantly disadvantaged if they were to limit Medicare beneficiary access regardless of the lower reimbursement rates. This is particularly significant for rural based practices, which have higher rates of Medicare payer mix than those found in urban areas. ASTRO has raised this concern with MedPAC and continues to believe this methodology needs to be reassessed.

RVS Update Committee (RUC) Refinement Panel Process

For two decades, the RUC Refinement Panel Process operated as an appeals process within the RBRVS system for stakeholders to adjudicate CMS assigned values to healthcare services. The Panels were comprised of approximately 8-10 physicians representing the specialties that perform the procedure under review, physicians from related specialties, primary care physicians and contractor medical directors. In 2016, CMS permanently eliminated its Refinement Panel process. The years immediately prior to the elimination of the Panels were fraught with difficulties. For example, CMS modified the process to only consider codes for which new *clinical* information was provided in the appeals request. In addition, CMS began to ignore Refinement Panel recommendations, with little to no explanation.

Stakeholders should be afforded an RBRVS appeals process. As such, CMS should reestablish the Refinement Panel process, which will allow for a transparent appeals process. It is imperative that the appeals process include the expertise from practicing physicians and other practicing health care professionals in order to appropriately evaluate the resources utilized in the provision of healthcare services.

Addressing Concerns regarding Budget Neutrality in the PFS

ASTRO supports the H.R. 6371 – Provider Reimbursement Stability Act of 2023. Introduced in the House last fall, this legislative proposal is the product of a comprehensive reform effort lead by the American Medical Association that will address budget neutrality policies that decrease Medicare physician payment.

The bill would ensure that budget neutrality adjustments are based on actual utilization of new codes, rather than assumptions which has resulted in overestimated utilization assumptions and significant payment cuts. A lookback period would allow CMS to reconcile utilization projections with actual claims data and adjust the conversion factor as appropriate.

The bill will also update the spending threshold that initiates budget neutrality from $20 million to $53 million. This would allow for greater flexibility in determining pricing and policy changes without triggering significant payment cuts across the payment system.

Finally, budget neutrality would be limited to 2.5% each year, providing greater stability and predictability from year-to-year. Enactment of these policies will benefit all physician practices and improve access to Medicare services for beneficiaries.

Incentivizing Participation in Alternative Payment Models

Since its inception in 2015, the Medicare Access and CHIP Reauthorization Act (MACRA), which established parameters for Advanced APMs, has yielded few opportunities for physicians to participate in value-based payment initiatives. As previously mentioned, the RO Model, which was introduced in 2019, was plagued with challenges, many of which were due to the restrictive APM requirements in MACRA. Key among them were the significant discounts required to meet the nominal risk requirement and the numerous quality measures and reporting requirements. Not only was the RO Model burdensome to participate in but it would have also put many practices in financial jeopardy.

Despite our disappointment that we were unable to secure meaningful changes to the RO Model, ASTRO was grateful for the opportunity pursue model development with the Agency. Radiation oncology is one of very few specialties that has had a front row seat to the process of APM development. To make the process more successful, we recommend the following:

1. Stakeholder Engagement – CMMI needs to more effectively engage with stakeholders and utilize the Physician Focused Payment Model Technical Advisory Group (PTAC) to launch models that have been developed and vetted by specialty group stakeholders.
2. Payment Methodology – MACRA's Advanced APM payment methodology requirements are one-size-fits-all, which became a significant hurdle for the RO Model. The nominal risk requirement should be adjusted to recognize significant capital and labor costs, as well as existing high-value care, without penalizing top-performers.
3. Quality –Quality measures, if necessary, should only be used if they result in improved patient outcomes. Otherwise, quality requirements can be met through accreditation and other methods that are less burdensome but more meaningful.
4. Cost of Operationalizing APMs – Shifting from FFS to an Advanced APM payment system takes time and money. Participating practices have to make operational changes in order to efficiently deliver care under a new payment system, whether that's hiring more care navigators for patient care coordination, keeping their doors open longer to accommodate growing patient volumes, or investing in technology for electronic reporting purposes. Current APM constructs do not recognize

these significant investments but should if they want to see practices succeed in a value-based payment world.

5. Risk and Reward – Physicians who are participating in all-payer APMs are shouldering financial risk that has been shifted from payers. Currently, payers have no skin in the APM game, yet prior authorization continues to plague physicians trying to do the best by their patients and year-over-year premiums increase making Americans choose between coverage and other necessities. Payers should offset some of the cost associated with operationalizing APMs and supporting practices that are willing to make the shift to value-based payment. Additionally, practices participating in value-based payment arrangements should not be subjected to onerous prior authorization requirements.

Reducing Physician Burden Related to MIPS

While the goals of the MIPS concept are laudable, they do not recognize that there is a dearth of quality measures, particularly outcomes measures for a variety of specialty services including radiation therapy. Below are the existing quality measures for radiation therapy. All but the Preventative Care and Screening measure are considered high-priority. Those high-priority measures are process measures and have limited impact on patient outcomes.

Quality Measures

Oncology: Medical and Radiation – Pain Intensity Quantified

Oncology: Medical and Radiation – Plan of Care for Pain

Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cance Patients

Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention

Many radiation oncologists would argue that none of these measures are a meaningful indicator of high value/high-quality care. In the White Paper, the Committee asks if there are other policies that would appropriately encourage improvement in quality of care delivered by clinicians. For radiation oncology, a far more accurate, meaningful indicator of quality is practice accreditation. Radiation oncology practice accreditation requires meeting rigorous standards that demonstrate high-quality care is consistently delivered.

Improving Primary Care and Chronic Care Collaboration

Variation in primary care provider engagement associated with cancer care is usually due to limited initial exposure to oncology care as part of medical education, as well as a lack of resources and time necessary to stay abreast of a rapidly changing and complex field of medicine. Additionally, once established, collaborative partnerships vary based on each patient's unique care needs, underscoring the importance of guideline-based care and appropriate referrals.

Unfortunately, many efforts to pursue collaborative care are stymied by a lack of resources and incentives to support collaborative team-based approaches. These challenges can be met with the establishment of reimbursed quality metrics that encourage collaboration between primary care physicians and oncologists. However, even quality-based incentives won't address some of the overarching challenges that exist, such as Electronic Health Records systems that don't allow for seamless transfer of clinical information, time-consuming prior authorization requirements, and other related administrative burdens. Until each of these pressure points are addressed, it will be difficult to achieve the goal of patient-centered care through improved provider collaboration.

Ensuring Beneficiaries' Continued Access to Telehealth

The role of telehealth has expanded as a result of the COVID-19 public health emergency. For radiation oncology, the use of real-time audio-video technology that satisfied patient supervision requirements was initially critical to ensuring that patients with cancer could continue receiving radiation treatments, while also limiting COVID exposure. However, as radiation oncology clinics established protocols for limiting COVID exposure and were able to secure adequate PPE, the need for real-time audio-video supervision of care diminished significantly.

While expanded use of telehealth may be appropriate for some aspects of primary care and some specialty services, such as initial consults and follow up care, regular in-person monitoring and assessment of patient tolerance and response to radiation treatment is important to the safety and maintenance of high quality care.

ASTRO appreciates the opportunity to provide comments on the White Paper. We are submitting these comments for broad distribution among interested offices and welcome the opportunity to discuss any questions. Please reach out to Anne Hubbard, Director of Health Policy, at Anne.Hubbard@astro.org or 703-839-7394.

Sincerely,

Laura Thevenot

Jeff Michalski, MD

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Chief Executive Officer

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