October 30, 2023

Michael E. Chernew, PhD
Chair
Amole Navathe, MD, PhD
Vice Chair
Medicare Payment Advisory Commission
425 I Street NW, Suite 701
Washington, DC 20001

Submitted electronically: info@medpac.gov

Dear Drs. Chernew and Navathe,

The American Society for Radiation Oncology¹ (ASTRO) appreciates the opportunity to submit comments to the Medicare Payment Advisory Commission (MedPAC) in response to the Commission’s October 5th discussion on “Considering current law updates to Medicare’s payment rates for clinician services.”

Radiation oncology has had a front row seat to witness the serious flaws in the Medicare Physician Fee Schedule (MPFS) and difficulties in transitioning to value-based payments. As discussed below, radiation oncology payments under the fee schedule have dropped by an unsustainable 25% since 2013. At the same time, no medical specialty has pursued value-based payment more aggressively than radiation oncology. ASTRO has proposed a value-based payment solution, described below, to address numerous policy challenges identified by MedPAC and others.

Access to Radiation Oncology Services in Freestanding Settings

During the meeting a Commissioner asked, “If I have cancer and I have a severe cancer, do I go to a freestanding oncology group? Do I go to a cancer center? Do I go to an academic medical center? I’m going to have very different outcomes and very different options based on those choices.”

Radiation oncology is heavily dependent on technology. Technology investment is linked to reimbursement, and draconian cuts impede investment, ultimately impacting care. Reimbursement has to keep pace with increased costs, otherwise access to care is jeopardized as care is

¹ ASTRO members are medical professionals, practicing at hospitals and cancer treatment centers in the United States and around the globe, and who make up the radiation therapy 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, and treat more than one million patients with cancer each year. We believe this multidisciplinary membership makes us uniquely qualified to provide input on the inherently complex issues related to Medicare payment policy.
consolidated in larger centers, where the cost of care can be spread out over larger patient volumes and a variety of services lines making it financially viable. Unfortunately, this exacerbates healthcare disparities, creating access to care issues for the most vulnerable populations.

Radiation oncology has taken the brunt of the Centers for Medicare and Medicaid Services’ (CMS) efforts to shift payment to primary care and preventative healthcare services within the budget neutral MPFS. While ASTRO appreciates the need to adequately pay for these services, the increases in payment for primary care and preventative healthcare services have resulted in significant payment cuts for radiation oncology related cancer care and other specialties with high fixed capital costs.

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%. 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.

![Chart showing Medicare Part B spending on radiation oncology vs. top 2 cancer drugs](image)

Unfortunately, cuts of this magnitude will make proven radiation therapy treatments that cure the majority of cancers inaccessible. Radiation therapy is highly cost-effective, but continued cuts only serve to threaten the value provided by the nation’s radiation oncology teams. The MPFS is failing patients

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with cancer in need of radiation therapy by making state-of-the-art care close to home a thing of the past.

The Radiation Oncology Case Rate (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 FFS system, which is tied to volume.

ASTRO engaged with CMS on the development of the proposed Radiation Oncology Alternative Payment Model (RO Model) beginning with the introduction of the 2017 Report to Congress: Episodic Alternative Payment Model for Radiation Therapy Services, which ultimately resulted in the issuance of the proposed RO Model in 2019. However, the RO Model failed to achieve the goal of improving or maintaining quality of care while reducing costs due to significant cuts found in the payment methodology and burdensome reporting requirements. After multiple attempts at reforming the RO Model, CMS issued a final rule in August 2022 putting it on an indefinite hold.

ASTRO remains committed to securing episode-based payment for radiation therapy services, which will shift payment from per fraction (or treatment) to per patient, supporting growing use of shorter courses of therapy, when appropriate. The Radiation Oncology Case Rate (ROCR) program proposal was introduced this summer as a bold legislative initiative that is designed to establish stable payment rates, improve upon the already excellent quality and value that radiation therapy brings to cancer care, and change radiation oncology payment from per fraction to per patient. 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 claimed more adequately accounted for 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 five years of the program.

To accomplish this, the ROCR payment methodology includes regular inflationary updates paired with savings adjustments. After establishing national case rates for the professional component (PC) and technical component (TC) of 15 distinct cancer types, PC payment is tied to the Medicare Economic Index and the 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 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, growing from 3% in year 1 to 8% in year 5, before returning to 3% going forward. A ROCR analysis reveals that this would generate a balanced amount of savings of about 1% per year from Part B radiation oncology spending over the first 5 years, or approximately $200 million.
During the Oct. 5 meeting, it was pointed out that practice costs associated with Medicare beneficiary services would increase by 35% over the next several years, while payments under the fee schedule will increase by only 2-5% under the current methodology of differential updates, which is unsustainable. The application of inflation adjusted updates was raised as a potential solution, and with ROCR, we are consistent with MedPAC’s thinking. The chart below depicts CMS’ anticipated yearly inflationary updates, which are compounded year over year, along with the savings adjustments, that are applied to both the PC and TC payments:

<table>
<thead>
<tr>
<th>Year</th>
<th>PC Update</th>
<th>TC Update</th>
<th>Savings Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2024</td>
<td>+2.80%</td>
<td>+3.10%</td>
<td>-3.0%</td>
</tr>
<tr>
<td>2025</td>
<td>+2.50%</td>
<td>+2.90%</td>
<td>-5.0%</td>
</tr>
<tr>
<td>2026</td>
<td>+2.50%</td>
<td>+2.80%</td>
<td>-7.0%</td>
</tr>
<tr>
<td>2027</td>
<td>+2.30%</td>
<td>+2.90%</td>
<td>-7.5%</td>
</tr>
<tr>
<td>2028</td>
<td>+2.30%</td>
<td>+2.90%</td>
<td>-8.0%</td>
</tr>
</tbody>
</table>

In addition to establishing stable payment rates, ROCR also seeks to protect the delivery of high-quality care through 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.

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.3,4 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 an RO provider than people in urban tracts.5 To reduce health disparities and to support patients in accessing and completing their treatments, the ROCR TC payment is increased by a $500 through a Health Equity Achievement in Radiation Therapy (HEART) payment for those patients who experience transportation barriers.

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

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from getting things needed for daily living? Providers will use a Z-Code for this screening question and the coded response will trigger the HEART payment. The HEART payment will not duplicate other transportation benefits provided under Medicare or Medicaid. Removing barriers, particularly transportation, can improve access to care and reduce the disparity in treatment completion across Medicare populations.

ASTRO urges the Commission to recommend that Congress enact ROCR and similar physician-driven innovative payment policies. 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. Given recent clinical and payment trends, radiation oncology is uniquely positioned and primed to make the leap into value-based care.

MPFS Payment Reform Efforts

ASTRO also agrees with MPFS reform proposals put forth by the American Medical Association and others. ASTRO supports legislation such as The Provider Reimbursement Stability Act of 2023 (discussion draft), which addresses the shortcomings in the MPFS by increasing the budget neutrality threshold, allowing for corrections associated with over- and under-estimations in service utilization, regular updates to direct practice expense costs, and limiting year-to-year variation in the conversion factor establishing greater payment stability. Additionally, ASTRO supports tying physician payment updates to inflation via the MEI through the Strengthening Medicare for Patients and Providers Act (HR 2474), which is consistent with MedPAC’s recent recommendation and ASTRO’s ROCR proposal. Annual MEI adjustments will not only secure rate stability but recognize changes in the cost of care that justify payment updates for health care services.

MedPAC Assessment of Payment Adequacy

Finally, ASTRO wishes to address MedPACs current practice for determining MPFS payment adequacy. Each year, the Commission reviews various measures to indicate whether Medicare’s fee-for-service payment rates are adequate, placing a high premium on beneficiary access to care. The Commission does this by surveying Medicare beneficiaries about their ability to access care and compares responses with the experience of enrollees in commercial plans. These surveys indicate that Medicare beneficiaries’ access to care is similar, meaning that Medicare’s lower payment rates are not negatively affecting access to care.

ASTRO believes 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.

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Additionally, we agree with the points made during the meeting about the fact that more Medicare beneficiaries are selecting Medicare Advantage plans, which use prior authorization policies as a blunt tool to reduce the cost of care. Prior authorization policies have a significant impact on how physicians practice medicine. For radiation oncology, this frequently results in delayed treatment and care denials, which make treating beneficiaries more challenging, less cost effective. If there ever were a reason to walk away from the Medicare program, it would be due to a combination of lower reimbursement rates and onerous prior authorization policies brought on by the growth in Medicare Advantage.\(^7\)

**The Commission should consider these factors when assessing payment adequacy. Additionally, ASTRO urges the Commission to advocate for the prior authorization reform policies included in the *Advancing Interoperability and Improving Prior Authorization Processes* proposed rule, which has yet to be finalized by CMS.**

ASTRO appreciates the opportunity to provide written comments and would like to meet with MedPAC to further discuss ROCR. Anne Hubbard, Director of Health Policy, will be reaching out to schedule a meeting. In the meantime, should you have any questions you can contact her at 703-839-7394 or Anne.Hubbard@astro.org.

Sincerely,

Laura I. Thevenot

CEO

cc: Paul B. Masi, MPP, MedPAC Executive Director
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