2019 ASTRO ADVOCACY DAY

LEGISLATIVE PRIORITIES
In the 2019 ASTRO Member Survey, both academic and private practice radiation oncologists named Prior Authorization as the greatest challenge facing the field. 

- **63%** of respondents have had to hire new staff to handle prior authorization requests.
- **44%** of radiation oncologists say they are typically required to submit prior authorization requests.
- **9 in 10** radiation oncologists report patient treatment delays due to prior authorization issues.
- **70%** of radiation oncologists report that patients regularly express concern to them about prior authorization delays.
- **44%** of respondents stated that peer-to-peer reviews are not typically performed by a radiation oncologist.
- Radiation oncologists report spending increasingly more time on prior authorization requests and appealing denials for life saving treatments.

Prior Authorization is linked to negative and harmful patient outcomes. Each week of delay in initiating cancer therapy corresponds to a 1.2 to 3.2% increase in mortality (depending on cancer type).
Fix Prior Authorization
Protect Patient Access to Life Saving Cancer Treatments

BACKGROUND

Prior authorization (PA) requires physicians to obtain approval from health insurance companies to prescribe a specific treatment, procedure or medication for patients. PA is used to minimize health care costs, but this can often be done at the expense of a patient’s well-being. In instances where PA is required, insurance companies will only pay physicians if the medical care has been pre-approved by the insurance company or a benefit manager.

Radiation oncology and cancer patients have been particularly hard hit by this unnecessary burden and interference in care decisions. Congress must put an end to restrictive prior authorization practices, particularly those employed by Radiation Oncology Benefit Managers (ROBMs), that oversimplify the process of individual patient care management and abrogate the professional and personal judgments of physicians and patients.

- In a December 2018 American Medical Association survey, 1 in 4 doctors said prior authorization had led to an adverse event, and nearly all respondents said prior authorization had a negative clinical impact.
- Nearly two-thirds of radiation oncologists said the majority of denials they receive from prior authorization review are ultimately overturned on appeal. Delays in care due to prior authorization are the greatest challenge radiation oncologists say they face in providing needed treatment for their patients.
- Prior authorization negatively impacts patient outcomes by taking away physicians’ time with their patients.
- Patients treated at rural and private practices are disproportionately burdened. These practices often have less staff to handle increased prior authorization requests, and radiation oncologists are forced to spend time on prior authorization paperwork that they could better spend on patient care.
- Radiation oncologists increasingly are restricted from exercising their clinical judgment in determining what is in the best interest of their patients; yet they are held accountable for treatment outcomes even in situations when care decisions have been taken out of their hands by ROBMs.
- The Office of the Inspector General of the Department of Health and Human Services has found that Medicare Advantage plans have been improperly denying “access to services and payment in an attempt to increase their profits.”
- Radiation oncologists report spending more time on prior authorization requests and are required to submit duplicative work.
- Nearly all radiation oncologists (93%) report that their patients experience delays in care due to obstructive prior authorization practices, and nearly 3 in 10 physicians say the delays last longer than five days.

CONGRESSIONAL REQUEST

- Legislation is needed to relieve radiation oncology patients and physicians of the serious stress, anxiety, burden and costs of restrictive prior authorization.
- Require selective application of prior authorization that excludes providers that meet evidence-based guidelines and have historically high prior authorization approval rates.
- Recommend regular reviews of prior authorization programs and adjustments based on findings. A regular review of the list of medical services that are subject to prior authorization requirements can help identify therapies that are sound science and no longer warrant prior authorization.
- Ensure effective and timely two-way communication channels between health plans, health care providers and patients to ensure timely resolution of prior authorization requests to minimize care delays. Require health plans to clearly articulate and make fully transparent prior authorization requirements, criteria, rationale and program changes.
- Exempt services provided under an advanced alternative payment model from prior authorization requirements.
- Contact the offices of Representatives Suzan DelBene (D-WA-1) and Mike Kelly (R-PA-16) to cosponsor forthcoming legislation to reform prior authorization.
Prior Authorization Negatively Impacts Patient Outcomes

In the 2019 ASTRO membership survey, both academic and private practice radiation oncologists named prior authorization as the greatest challenge encumbering the field. Prior authorization is linked to negative and harmful patient outcomes. Each week of delay in initiating cancer therapy corresponds to a 1.2 to 3.2 percent increase in mortality (depending on cancer type), according to research from the Cleveland Clinic. In a December 2018 American Medical Association (AMA) survey, one in four doctors said prior authorization had led to an adverse event, and nearly all respondents said prior authorization had a negative clinical impact. People with cancer are facing unnecessary treatment delays as a result of this obstructive practice. Seven in 10 radiation oncologists say their patients express concerns to them about treatment delays.

**BACKGROUND**

Three patients in the last year [who] had prior authorization completed their care exactly as stated. The authorization was later revoked, leaving the patient and their entire bill(s) unpaid.

Cervical cancer in a 32-year-old with symptoms. [Treatment] plan was initiated urgently due to bleeding. [Peer-to-peer] review took two weeks and final approval took four weeks. Meanwhile, the patient continued under therapy with significant anxiety that her treatments were going to be denied by her insurance company.

For many of my patients the prior authorization process adds significant stress and concerns over financial liabilities associated with treatment. When an initial submission is denied or delayed, and a peer-to-peer consultation is requested, this adds to the stress level. In these increasingly frequent instances, the authorization is not obtained for several days and can even exceed a week. Denials for a particular service are most traumatic experiences and I had several patients break down in tears fearing that they would now have to receive an inferior treatment.

In some situations, patients with severe acute problems such as obstructive tumors, painful tumors, rapid review still is multiple days. Certainly, this can lead to patients not overcoming a severe situation and [instead] dying from it. However, in addition, this can leave patients with very severe symptoms while waiting for their treatment authorization to occur. The system is made to put off treatment for days at a time, which is very unfortunate. It is not right, it is inhumane.

Patients have experienced financial toxicity as treatments have been initiated [with] approval only to retroactively be rejected. Most frustrating is “peer-to-peer” by non-radiation oncologists who simply state, “The policy is to reject this,” with no ability to discuss the clinical case or provide medical judgement — not a fair representation of what “peer-to-peer” should be.

This can be extremely negative from the psychological point of view. Patients are very anxious to get [treatment] started, and some have even had panic attacks during this process. It places stress on [radiation oncologists] to get multiple plans done quickly – rushing an already complicated process. There is no transparency or effective way to expedite treatment.
ASTRO has been working with stakeholders, including CMMI, to develop a Radiation Oncology Alternative Payment Model (RO-APM) that drives GREATER VALUE IN CANCER CARE and achieves the goals of MACRA.

In the US, over one million cancer patients are treated with radiation therapies each year. An RO-APM would HELP ENSURE ACCESS TO CARE for cancer patients.

TO REALIZE THE GOALS OF MACRA, IT IS CRITICAL THAT AN RO-APM BE IMPLEMENTED THIS YEAR.

ENSURE TRANSPARENCY in the design, scope and goals of advanced alternative payment models.

INCORPORATE stakeholder INPUT THROUGH the rule making process.

ASTRO APPRECIATES CONGRESSIONAL SUPPORT FOR A RO-APM. WE URGE CONGRESS TO WORK WITH THE ADMINISTRATION TO MOVE FORWARD EXPEDITIOUSLY WITH THE LAUNCH OF A VALUE-BASED RO-APM THAT ALIGNS CLOSELY WITH PROPOSALS PUT FORWARD BY ASTRO AND THE RADIATION ONCOLOGY COMMUNITY.
Background

In 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) reformed the health care system by moving away from the traditional fee-for-service model. MACRA established the Quality Payment Program (QPP), which is designed to create incentives to participate in new care delivery models that increase quality care, reduce cost, and shift the focus from volume to value in patient care. The program represents a significant change in the way all physicians, including radiation oncologists, are paid by Medicare. ASTRO worked with Congress to successfully freeze the 2016 payment rates for radiation therapy treatment delivery and image guidance after many years of instability. That freeze was set to expire at the end of 2018, but Congress extended the freeze through 2019 to allow for the successful transition to a radiation oncology APM.

Quality Payment Program

Radiation oncologists can participate in QPP through one of two pathways: the Merit-based Incentive Payment System (MIPS) or through an Alternative Payment Model (APM). ASTRO has been working to educate members of the radiation therapy team about the participation requirements associated with MIPS. ASTRO has also developed and submitted to CMS a voluntary RO-APM.

Radiation Oncology Alternative Payment Model

ASTRO has been working for several years on an RO-APM that would serve as a voluntary alternative to MIPS. An RO-APM would incentivize radiation oncologists for participation and performance in quality initiatives that improve health care outcomes. It would also ensure fair and stable payments for radiation oncologists in both hospital and community-based cancer clinics to help protect cancer patients’ access to care, as well as ensure adherence to clinical guidelines that guide the appropriate use of cancer treatments. In 2017, CMS issued a Congressionally-mandated report on an RO-APM that aligned well with ASTRO’s proposed model, and in 2018, HHS Secretary Azar announced that an RO-APM was forthcoming, but indicated that the model may be mandatory for some practices. ASTRO continues working with CMMI to develop and launch the RO-APM. The current legislative freeze on key radiation therapy Medicare payments expires on December 31, 2019. To ensure payment stability for radiation therapy services, an RO APM is needed before the freeze expires.

ASTRO appreciates Congressional support for an RO-APM, and urges Congress to use its legislative and oversight authority to:

- Encourage the Administration to move forward expeditiously with the launch of a value-based RO-APM that aligns closely with proposals put forward by ASTRO and the radiation oncology community.
- Work closely with ASTRO and the radiation oncology community to assess and respond to potential mandatory participation in the RO-APM to ensure that patients and practices are not unfairly disadvantaged.
- Ensure that CMS adheres to complete transparency in releasing the details of the RO-APM and incorporates stakeholder feedback to avoid unintended consequences.
- Ensure continuation of incentives for physicians to participate in Advanced APMs.
Protecting Patients in Health Care Reform

ASTRO recommends that the following bipartisan principles act as a guidepost for Congress as it considers alternative approaches to provide cancer patients and all Americans with quality care. If your office hosts health care roundtables, consider including a radiation oncologist.

Access
- Maintain bans on pre-existing condition exclusions and annual and lifetime limit caps
- Preserve guaranteed issue and guaranteed renewability
- Access to clinical trials
- Safeguard access to cancer screening and prevention programs

Affordability
- Prohibit cost-shifting to cancer patients and providers to cover uncompensated or underfunded care
- Provide sufficient funds for public health, preventive services, and patient navigator services for cancer patients

Quality and Efficiency
- Simplify burdensome systems to reduce costs, create a more efficient system, and maximize funding for health care services
- Ensure that patient safety and quality programs improve quality and enhance the doctor/patient relationship and are meaningful to patient and physician alike

Network and Benefit Design
- Provide access to specialty care, provider choice, and the range of services that cancer patients need
- Health plans must provide useful, understandable information about health plan options, physician specialist networks, and transparent provider network participation criteria
- Improve the prior authorization process to ensure timely and transparent reviews that don’t interfere with evidence-based doctor-patient treatment decisions
In 2017, NIH funding produced over $68 billion in economic output nationwide according to the Milken Institute.

Every $1 in grants from NIH generates $2.21 in economic growth across the U.S.

In 2019, 1.76 million new cancer cases (4,800 new cases per day) will be treated with radiation therapy. Roughly 1 million will be treated with radiation therapy.

606,880 deaths from cancer (1,700 cancer deaths per day).

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2019

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(1,700 cancer deaths per day)

*C each figure represents 176,000 patients

Targeting Cancer Care

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Targeting Cancer Care

Cancer research funding

NCI predicts that there will be 20.3 million cancer survivors by 2026.

Cures will come from combinations of treatments.

Cancer mortality has decreased 27% over the past 25 years but disparities between genders and socioeconomic groups are widening.

Total number of averted deaths is larger for men than women.

Less than 2% of NCI’s budget goes to radiation oncology research.

Return on this investment is vast and affects every segment of our society.

Research has contributed to averting 2.4 million deaths.
ASTRO applauds Congress' long-standing support for biomedical research and funding for cancer research at the National Institutes of Health (NIH) and the National Cancer Institute (NCI). The additional funding and structural improvement will help drive advancements in cancer treatment. The federal investment in cancer research has played a role in every major innovation in the fight against cancer, including significant advances in radiation oncology, and has led to a decline in the overall number of cancer deaths in the United States.

**BACKGROUND**

There will be an estimated 1.76 million new cancer cases (4,800 cases per day) diagnosed in 2019.

An estimated 606,800 people will die from cancer in 2019 (1,700 patients per day).

Cancer death rates are down 27% over the past 25 years (as of 2016). Research has contributed to averting 2.4 million cancer deaths (1.8 million in men; 825,000 in women). The total number of averted deaths is greater for men than women because the total decline in cancer mortality is steeper for men than women.

Uneven decreases in mortality between men and women and between poor versus wealthy socioeconomic groups are growing. This is especially true in preventable cancer types. It is estimated that approximately 34% of cancer deaths in the US (in those between 25 and 74 years) could be averted with the elimination of socioeconomic disparities.

Data show that treatments including combinations of radiation and drugs or immunotherapy are more effective than any single treatment alone, but many unanswered questions remain. ASTRO is prioritizing these questions, and other research topics outlined in our 2019 research agenda.

In 2017, NIH funding produced over $68 billion in economic output nationwide.

**CONGRESSIONAL REQUEST**

We are grateful for the bipartisan support that Congress has shown the NIH over the past four years. Despite the recent funding increases, NIH and NCI are still feeling the effects of 12 years of stagnant budgets that followed the end of the five-year doubling effort in FY 2003. If NIH funding had simply kept up with biomedical inflation since the end of the doubling, its budget would be 8.4%, or $3.6 billion higher than it is today. We join the research community in requesting that Congress increase funding for NIH by at least $2.5 billion, for a total of $41.6 billion; and increase funding for NCI by $378 million, for a total of $6.5 billion.
Physician compliance with health information technology (HIT) regulatory requirements, including those required by the Quality Payment Program (QPP) and other interoperability programs, requires significant investment of both physician time and resources. According to a 2017 study*, nearly two-thirds of respondents reported that administrative duties negatively affect their ability to deliver high-quality care. In addition, the physician is often at the mercy of the HIT vendor and is held accountable if requirements are not fulfilled.

ASTRO urges Congress to use its legislative and oversight authority to:

• Apply pressure on HIT vendors to not shift the burden onto radiation oncologists or other clinicians for costs associated with added functionality to comply with federal HIT requirements. These unfunded mandates undercut the potential benefits of HIT and disproportionately hurt small and rural cancer clinics.

• Mandate HIT vendors comply with the requirements set forth in the QPP and other interoperability programs. Radiation oncologists and other physicians should not be held accountable for the lack of interoperability.

• Harmonize reporting requirements across federally funded programs. Having one set of submission requirements, data elements and electronic submission portals would significantly reduce burden on those clinicians required to report across multiple programs. Reforms would allow radiation oncologists to focus more on patient care.

The culture of safety and quality is woven through every step of the radiation therapy process to ensure that the safest and most effective care is delivered to patients.

The Nuclear Regulatory Commission (NRC) is the only federal government agency required to measure both the risks and the benefits of radioactive isotopes through the licensing process, which ensures safety and security for all domestic radioisotope users.

Enacting government mandates to abandon radioactive source-based technology in health care or overly restricting access would put cancer patients at risk.

Renewed authorization and funding for low-dose radiation research, coupled with the availability of new technology, would allow researchers to reap the full benefits of cutting-edge cancer treatments.

1.76 million new cancer cases will be diagnosed in 2019. Roughly 1 million will be treated with radiation therapy.

Health care providers use sealed source isotopes to deliver radiation therapy and also for equipment sterilization.
In the United States, it is estimated that more than one million Americans will be treated with radiation therapies in 2019. Radiation therapy requires strict adherence to policies and procedures that ensure secure storage, handling, use and disposal of radioactive materials used in cancer treatment. A 2016 Nuclear Regulatory Commission (NRC) report found that, for the past 30 years, there have been no violations with safety or security consequences, and the nation’s robust regulatory infrastructure has appropriately managed the protection of materials. Despite radiation oncology’s culture that prioritizes safety and security, there have been attempts to limit access to these curative cost-effective cancer treatments by those concerned about potential radiologic incidents. Misinformation can lead to fear-driven policies that could reduce access to radiation therapy. Additionally, pressures to abandon these technologies in favor of “replacement technologies” fail to consider that, in most cases, there are no equivalent technologies.

**BACKGROUND**

1. ASTRO seeks to ensure continued safe and secure access to radiological sources and supports laws and policies that are informed, science-based and support the highest levels of public health and safety.

2. Radiation oncologists and medical physicists receive extensive training in the safe use of radioactive isotopes.

3. The NRC has a strong track record and is uniquely situated to maintain safety and security for all domestic radioisotope users, including the medical use of radioactive isotopes. Further, it is the only agency within the federal government required to measure both the risks and benefits of radioactive isotopes through its licensing process.

4. ASTRO supports renewed authorization and funding for low-dose radiation research. Research, coupled with the availability of new technology, would allow for the comprehensive application of cutting-edge cancer treatments and medical technologies.

5. Cancer care is highly personalized and having access to all therapies ensures the most successful outcome. Limiting access to radiation therapy could result in lower overall effectiveness, higher mortality and recurrence rates, and would represent a major step back in cancer care. Calls to abandon radioactive source-based technology in health care could interfere with physician and patient treatment decisions, leading to less effective cancer treatments.

6. In addition to being one of the leading treatments available in the fight against cancer, the industry also contributes to the financial health of the country by employing tens of thousands of individuals. In addition to health care, radioisotopes play a vital role in all aspects of our economy, including agriculture, gas and manufacturing.

7. We are committed to promoting policies that enhance the safe and effective use of radioisotopes. We ask that Congress and the administration strive for the same goals.

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