LEGISLATIVE PRIORITIES
Radiation Oncology Alternative Payment Model-RO-APM 1, 2

Protect Patients in Health Care Reform 3

Cancer Research Funding 4, 5

Protect Access to Radioactive isotopes 6

Prior Authorization 8

Preserve Stable Medicare Statements 9, 10
ALLOW RADIATION ONCOLOGISTS TO PARTICIPATE IN AN ADVANCED ALTERNATIVE PAYMENT MODEL

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.

TO REALIZE THE GOALS OF MACRA, IT IS CRITICAL THAT A RO-APM BE DEVELOPED AND IMPLEMENTED.

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.

IN THE US, OVER 1 MILLION CANCER PATIENTS ARE TREATED WITH RADIATION THERAPIES EACH YEAR. A RO-APM WOULD HELP ENSURE ACCESS TO CARE FOR CANCER PATIENTS.
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, reduces cost, and shifts 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.

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; and continues to communicate with the Centers for Medicare & Medicaid Services (CMS) on recommended program improvements. Additionally, ASTRO has been immersed in the development of a radiation oncology alternative payment model (RO-APM).

Radiation Oncology Alternative Payment Model

ASTRO has been working for several years on a 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, The Center for Medicare and Medicaid Innovation (CMMI) issued a Congressionally-mandated report on policy considerations for a radiation oncology APM that aligned well with ASTRO’s proposed model. ASTRO continues working with CMMI to develop and launch the RO-APM. In 2018, Congress extended a temporary legislative freeze on key radiation therapy Medicare payments to allow CMS more time to launch the RO-APM.

ASTRO appreciates Congressional support for a 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.
- Fund CMMI at appropriate levels to develop and launch APMs.
- Remove burdensome QPP reporting requirements that have a chilling effect on MIPS participation.
- Scale back the Quality Performance Category reporting period under MIPS from one year to 90 days.
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
Cancer Research Funding

**2018**

**1.7 Million** New Cancer Cases

**Roughly 1 Million** will be treated with Radiation Therapy

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Congress should prioritize funding for projects that leverage effective existing treatments, such as radiation therapy, and novel treatments to improve cure rates and patient outcomes.

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

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**Success** will come from combinations of treatments.

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Effective treatment includes combinations of drugs and radiation; no single treatment alone is enough.

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Active research funding is too low.

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The fight against cancer is not finished.

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Investing in cancer research is investing in our economic prosperity.

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According to the Milken Institute, every $1 in grants from NIH generates $2.21 in economic growth across US.

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**NCI’s FY18 budget is $5.97 Billion**

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In 2018:

- **1.7 Million** New Cancer Cases
- **Roughly 1 Million** will be treated with Radiation Therapy

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**NCI’s budget**

- Less than 2% of NCI’s budget goes to Radiation Oncology Research
ASTRO applauds Congress' long-standing support for biomedical research and appreciates its increase in funding for cancer research at the National Institutes of Health (NIH) and the National Cancer Institute (NCI) in the Bipartisan Budget Act of 2018. 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.

Cancer deaths are down 23% in the last 21 years. NCI estimates that there will be 20.3 million cancer survivors by 2026. Treatments including radiation therapy are improving.

Over the past 30 years, the five-year survival rate for all cancers has increased 20% for Caucasians and 24% for African Americans.

Unpredictable funding that results from Continuing Resolutions halts cancer research programs, research planning and hiring of new researchers.

Data show that treatments including combinations of radiation and drugs or immunotherapy are more effective than any single treatment alone.

The President’s budget proposes cutting $2.3 billion from the $37 billion NIH budget for FY19, which could lead to a $300 million cut in NCI’s $5.97 billion budget.

We ask that Congress reject any proposed cuts to NIH/NCI and instead support an increase in NIH’s total budget of $2.2 billion, with a $410 million increase for NCI.
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 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.

1.7 million new cancer cases will be diagnosed in 2018. 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 1 million Americans will be treated with radiation therapies in 2018. 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 Nuclear Regulatory Commission (NRC) analysis\(^1\) 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 cost-effective treatments that often cure cancer 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**

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.

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

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.

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.

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.

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.

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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REDUCE PHYSICIAN BURDEN
REIN IN PRIOR AUTHORIZATION

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, and 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 practices from prior authorization groups, such as Radiation Oncology Benefit Managers (ROBMs), that oversimplify the process of individual patient management and abrogate the professional and personal judgments of physicians and patients.

- According to a recent survey by the AMA, 92 percent of physicians say that prior authorization negatively impacts patient outcomes.
- Of physicians who were surveyed, 78 percent say it can lead to abandoning treatment.
- Radiation oncologists increasingly are restricted from exercising their clinical judgment in what is in the best interest of the patient; yet they are held accountable for the outcomes of treatments where decisions have been taken out of their hands by ROBMs.
- Radiation oncologists will continue to share stories of patients whose condition worsened while awaiting treatment authorization until Congress steps in to protect patients from excessive prior authorization procedures.
From 2009-2014, radiation oncology Medicare reimbursement rates sustained significant cuts resulting in cumulative payment reductions totaling approximately 20 percent for freestanding cancer centers. ASTRO strongly supports recent bipartisan legislation that has kept reimbursement rates frozen at 2016 levels through the end of 2019. This has temporarily created a more stable environment to allow the Centers for Medicare and Medicaid Services (CMS) to work with radiation oncology stakeholders on critical coding issues and the development of a Radiation Oncology Alternative Payment Model (RO-APM).

Congress must prevent any additional payment cuts to community-based radiation therapy centers and preserve access to these critical services.

In the U.S., most cancer patients are older Americans who are Medicare beneficiaries. Next year, CMS will revalue major radiation therapy service codes, and it is critical that the agency closely follow radiation oncology recommendations to ensure continued access to care for cancer patients.
The American Society for Radiation Oncology (ASTRO) represents more than 10,000 individuals striving to give cancer patients the best possible care. Members include radiation oncologists, nurses, medical physicists and other health care professionals. It is estimated that 1.7 million new cancer cases will be diagnosed in 2018. Close to one million cancer patients will receive radiation therapy during the course of their treatment.

Radiation therapy is safe and effective. It works by damaging a cancer cell’s genetic material, thus stopping its growth. When the injured cancer cells die, the body’s natural healing processes remove them. Most treatments are given as outpatient procedures, so patients can maintain a good quality of life while receiving treatment.

About ASTRO

Most cancer patients are Medicare beneficiaries. Therefore, stable Medicare payments are critical to ensuring access to care for more patients who need treatment.

It is important to prevent any additional payment cuts to community-based radiation therapy centers and preserve access to life-saving radiation therapy services. Inadequate payment rates could create access issues in rural and underserved areas.

Radiation therapy clinics have very high fixed costs, and the minimum capital required to build a center is approximately $5.5 million. Medicare payment cuts create instability, jeopardizing the viability of these centers and patient access to care.

Next year, CMS will revalue major radiation therapy service codes, and it is critical that the agency closely follow recommendations made by radiation oncology stakeholders to create a stable foundation for the creation of an RO-APM.

If those reimbursement rates are not fully reflective of the true costs of providing care, access to cancer treatments will be jeopardized and progress toward value-based care will be compromised.

ASTRO appreciates Congressional passage of bipartisan radiation oncology legislation and urges continued oversight to protect patient access to high quality radiation treatments.