ASTRO
TARGETING CANCER CARE

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Seema Verma
Administrator
Centers for Medicare and Medicaid Services
The U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Verma:

On behalf of the American Society for Radiation Oncology, I am writing to thank you for meeting with us to discuss our serious concerns with the implementation timeline and financial impact of the Radiation Oncology Alternative Payment Model (RO Model). As discussed during our call, radiation oncology practices that are compelled to participate in this model cannot possibly be ready by the January 1, 2021 implementation date, given the pandemic and other factors. Additionally, the combination of the payment cuts with the dire financial circumstances facing many radiation oncology practices due to COVID-19 are a recipe for disaster. Again, we ask that you please act with urgency to delay the model start date and reduce the discount factors.

Implementation Delay

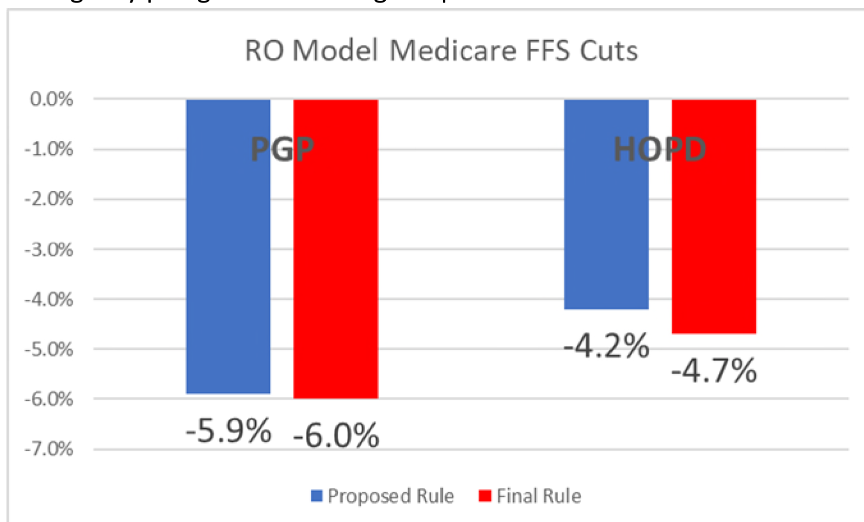
We urge CMS to delay the January 1, 2021 implementation date to July 1, 2021, while monitoring whether a further delay is needed if the Public Health Emergency (PHE) is extended. Radiation oncology practices across the country continue to feel the impact of COVID-19, which has led to declines in revenues of 20-30 percent due to decreased patient volumes. Additionally, practices have made significant investment in PPE and taken other precautionary measures to prevent the spread of the virus thus ensuring the safety of cancer patients that continue to require treatment. The implementation of the RO Model less than 100 days after the issuance of the final rule, represents an unwarranted disruption to radiation oncology practices as they struggle with a “new normal” during the public health emergency (PHE). Throughout the final rule, there are references to educational materials and webinars that will be produced to inform and educate participants on the new coding and billing requirements associated with the RO Model. This information has not been released, and it will take time for practices to gather this information and implement it within their existing systems. Additionally, many radiation oncology practices have had to lay-off non-clinical, administrative staff during COVID-19 due to declines in practice revenues. These are the staff people who would be necessary to carry out the new coding and billing requirements. Practices will have to either retrain existing staff or potentially hire additional staff to implement these new policies. It is important that CMS understand that not only does the educational component take time, but so does securing the correct staffing with the expertise necessary to carry out these new requirements. A rush to an arbitrary, aggressive start date could negatively impact patient care.

> "Our volume is still down from COVID, both for the current time as well as for the entire year. Revenues are way off. The CARES Act stimulus money was helpful but is no longer covering for lost revenue. Our centers were already talking about laying off or reducing staff. Implementation of the new model will only exacerbate this issue. The Jan 1 start date is awfully ambitious considering the amount of training and documentation that we need to implement to meet the programs requirements. That will be even harder with reduced staffing and more people working remotely due to the pandemic."
>
> --Radiation Oncologist in New England

Once staffing considerations have been addressed, practices will need time to understand the model and how it impacts existing business practices. This will be particularly challenging given that CMS decided not to provide practices with actual payment rate data, and instead will provide only the Case Mix Adjustment and Historical Adjustment, 30-days prior to the start of the first performance period. This lack of transparency, combined with the need to update systems and modify software to properly report quality data, puts undue and unnecessary stress on already strained practice resources. ASTRO urges CMS to consider a stepped approach to the implementation of the quality component of the RO Model that would allow practices to begin reporting at their own pace with a deadline for compliance one-year after the Model's start date. However, such a phased in approach on quality measures should not come in lieu of a full implementation delay.

Reduce Payment Cuts

We also ask that CMS reduce the significant cuts that are being imposed on practices that are mandated to participate in the RO Model. In the proposed rule, CMS estimated that Medicare FFS payments to Physician Group Practices (PGPs) would be reduced by 5.9 percent and Medicare FFS payments to Hospital Outpatient Departments (HOPDs) would be reduced by 4.2 percent. In the final rule, the Agency modified its estimate stating that reductions will increase for both PGP and HOPD practices; PGPs will experience a 6 percent reduction and HOPDs will experience a 4.7 percent reduction. Why is the Agency piling on cuts during the pandemic?



We find it extremely concerning that the Agency has released a payment model that reduces the number of participating episodes, but increases the cuts experienced by those who are compelled to participate. ASTRO urges CMS to reduce the discount factors from 3.75 percent for the PC and 4.75 percent for the TC to 3 percent or less so that they are in alignment with the Medicaid Access and CHIP Reauthorization Act (MACRA) nominal risk requirements of 3 percent. Additionally, this would also bring the RO Model into alignment with other alternative payment models, which currently have nominal-risk requirements set at 3 percent or less. We are very concerned that the current discount factors have the potential to put many practices at financial risk, particularly those with thin operating margins.

> "Our volume is down 35% this year over last and our supply expenses are up 14% thanks to COVID-19. Consequently, this seems like the worst possible time to implement such a radical change… With the challenges private practices are already facing this could be disastrous for the foreseeable future, and one that we may or may not be able to survive due to the inequity imposed."
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> --Radiation Oncology Practice Administrator in Florida

Furthermore, our analysis of the final rule reveals that the disastrous cuts to radiation oncology in the proposed 2021 Medicare Physician Fee Schedule rule would likely compound payment cuts under the RO Model. The budget neutrality requirements stemming from the evaluation and management code changes in the proposed rule could dramatically skew the calculation of the RO Model trend factor, which relies heavily on 2021 payment rates outside the model. These combined factors and more negate any hint of the "upside" you mentioned in our conversation.

The Agency asserts that the financial impact could be less given that it has established an opt-out for practices that provide care for 20 or fewer episodes in the previous year. While we understand that CMS' intent is to offer low volume practices an opportunity to opt-out of the participation requirement, the 20-episode threshold is so low that no practice could possibly take advantage of it.

<u>Model Stability</u>

CMS staff have stated that the RO Model will establish revenue stability for practices during the PHE. While we appreciate this sentiment and agree with the goal, we need to state definitively that that the RO Model does NOT achieve stability. Value-based payment arrangements that prospectively pay for services based on attributed patient populations do establish revenue stability in that they pay the physician for services regardless of patient activity, i.e. monthly care management fees, etc. These types of arrangements work quite well for primary care physicians and others who are involved in larger population health arrangements where the goal is to manage patient care and reduce costs associated with chronic conditions, etc. While the RO Model is also a prospectively paid value-based payment arrangement, it does not provide practices with prospective payments until after an episode of care has already started. In fact, prospective payment may actually be a misnomer here because the payment is not made until treatment planning and the first delivery of treatment have taken place. The RO Model provides rate stability only if patients continue to actively seek care in participating clinics and if the rates are appropriately set, which they are not.

Again, we appreciate you taking the time to speak with the ASTRO team. We remain committed to making the transition to value-based payment, but we need your commitment to immediate changes that avoid punishing selected participants. Therefore, we respectfully request that you immediately delay the implementation of the RO Model. We look forward to working with you to address these key issues. If you have any questions, please contact Anne Hubbard, Director of Health Policy at 703-839-7394 or Anne.Hubbard@ASTRO.org.

Sincerely,

Laura I. Thevenot
Chief Executive Officer

Alex Azar, Secretary, Department of Health and Human Services
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