

December 13, 2019

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8013
7500 Security Boulevard
Baltimore, MD 21244-8013

Submitted electronically: OCF@cms.hhs.gov

Dear Administrator Verma,

The American Society for Radiation Oncology (ASTRO)¹ appreciates the opportunity to provide written comments on the “Oncology Care First” model introduced by the Centers for Medicare and Medicaid Innovation Center (CMMI) on Friday, November 1st as an informal request for information (RFI). ASTRO appreciates CMMI’s commitment to improving upon the existing Oncology Care Model (OCM) through the development of the Oncology Care First (OCF) model; however, we are concerned that OCF does not address ASTRO’s concerns regarding the potential unintended consequences of including radiation therapy in a broader oncology episode of care. In addition, the OCF does not sufficiently recognize the multi-disciplinary approach to cancer care that often involves a radiation oncologist and a surgical oncologist, in addition to a medical oncologist.

Multi-disciplinary Cancer Treatment

According to the RFI, the model is proposed to test whether an innovative approach to prospectively paying for management and drug administration services provided by oncology practitioners, together with a total cost of care accountability, reduces program expenditures while enhancing the quality of care for Medicare beneficiaries with cancer or a cancer-related diagnosis. This approach does not recognize the multi-disciplinary approach to cancer care.

In many cases, chemotherapy may be given prior to radiation therapy or surgery, and often

¹ ASTRO members are medical professionals practicing at hospitals and cancer treatment centers in the United States and around the globe. They make up the radiation 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. They 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.

chemotherapy and radiation therapy are given together. Each of these approaches are often delivered with a curative-intent and require a team-based approach to oncology care, where no one member of the team is the lead but rather each member manages the complexities of cancer care associated with his/her area of expertise.

One of the tenets of value-based care is the development of alternative payment models that allow physicians to manage the costs that they can control. As it is designed, the OCF prospectively pays for patient care management and drug administration service. The inclusion of drug administration services infers that the medical oncologists are the recipients of those prospective payments. Additionally, an OCF Performance Based Payment (PBP) episode is triggered at the infusion of chemotherapy and includes six months of care, including all Part A and Part B services, as well as certain Part D expenditures.

Due to the chemotherapy infusion trigger, the OCF obligates the medical oncologists to value other therapies outside of their scopes of practice. If a patient requires and can benefit from radiation therapy services during that six-month episode, then the patient should be referred to a radiation oncologist for radiation therapy services. The model disincentivizes that appropriate referral. Even if appropriately referred, the medical oncologist will not have control over the treatment planning or cost associated with the delivery of radiation therapy treatments, which can be substantial, and places unfair pressure on both specialties.

By including radiation oncology in the six-month episode of care, CMMI has created an unintended incentive to reduce the utilization of curative and palliative local therapies, including radiation therapy, because of its relative cost--although its relative value in cancer care is substantial and overall a small percentage of cancer care total expenditures. This unintended consequence is due to the inclusion of all Part A and B services, including radiation therapy, and the financial incentive to keep overall costs below the proposed discount rate of between 3 percent and 4 percent.

OCM Evaluation Evidence

The [OCM Evaluation Performance Period One](#) report that was issued in December 2018 demonstrates this unintended consequence in the existing OCM program². According to the report, the cost of drugs (Part A and B) alone increased from 54 percent to 59 percent of the total cost of care. At the same time, the evaluation report demonstrates in Exhibit 16 that baseline radiation therapy costs in the OCM group were \$808 per episode and \$883 per episode in the comparison group, a 9.3 percent difference between the two. During the evaluation period, the OCM group experienced a 9 percent decrease in radiation therapy cost per episode between the base line and the intervention period. The comparison group experienced a 6.75 percent decrease in radiation therapy cost per episode.

² Hassol, Andrea. "Evaluation of the Oncology Care Model – Performance Period One." December 2018

Additionally, a separate Milliman report on the “Cost Drivers of Cancer Care” indicates that radiation therapy is 4 percent of the total cost of cancer care³. The OCM Evaluation Performance Period One report indicates that radiation therapy costs, in OCM participating practices, were 3 percent of the total cost of care at the baseline. Subsequent analysis indicates that radiation therapy costs declined to 2.5 percent during the first evaluation period. OCM practices consistently use about 23 percent less radiation therapy than the national baseline to date, which points to selection bias of practices participating in the OCM.

While it is not clear why OCM groups experience a greater decrease in radiation therapy cost per episode during the evaluation period, it is reasonable to believe that those reductions could be due to efforts to meet or beat the OCM target rate by reducing use of radiation therapy services. We urge CMMI to modify the OCF so that certain non-drug therapeutic services (i.e., radiation therapy and surgery) that are outside of the control of the medical oncologist are excluded from the six-month total cost of care calculation and instead paid for through the pending Radiation Oncology Alternative Payment Model or fee-for-service rates..

ASTRO is fully committed to the development of alternative payment models for oncology care. However, we are concerned that OCF introduces incentives that may jeopardize cancer patients’ access to curative therapies, and consequently result in poor patient outcomes over the long term.

Areas Requiring Clarification

While ASTRO is opposed to the inclusion of radiation therapy services in the OCF, we believe that if the Agency is to pursue this model with the inclusion of radiation therapy services, there need to be clarification based on the limited amount of information in the RFI.

Monthly Population Payment (MPP)

With the proposed establishment of the Monthly Population Payment (MPP), CMMI is expanding the patient population beyond that which was established for the OCM. The MPP is paid for any Medicare FFS beneficiary with cancer or a cancer-related diagnosis attributed to a physician group practice. The MPP includes payment for evaluation and management services (E/M), enhanced services required under the model, and drug administration services, even if no systemic therapy is given.

The RFI does not take into consideration situations in which cancer patients only require radiation therapy for their treatment. The radiation oncologists would be the primary physician providing E/M services and related radiation therapy treatment. Would the radiation

³ Fitch, Kathryn, RN, MEd., et al. “Cost Drivers of Cancer Care: A Retrospective Analysis of Medicare and Commercially Insured Population Claim Data 2004-2014”. Commissioned by the Community Oncology Alliance. April 2016.

oncologists receive the MPP? In multi-disciplinary practices with radiation oncologists and medical oncologists in the same TIN, if the medical oncologist provided consultation but is not involved in the patient's care, would the radiation oncologist still receive payment for E/M services through the MPP? Patients receiving only radiation therapy, hormonal therapy and other non-systemic therapy will be in OCF, but they will not trigger an episode of care based on the model's design. This could have significant implications on multispecialty practices billing under the same TIN.

Risk Stratification

CMMI is proposing a risk stratification methodology that applies to all cancers, but a more nuanced risk strategy for a subset of cancers, including prostate, breast and bladder cancer. Because claims data does not include staging or other clinical information indicating risk, the Agency is proposing to stratify cancer types based on whether chemotherapy is administered. A high-risk stratification is assigned if chemotherapy is administered in any cancer type. A low risk stratification is assigned if hormonal therapy is delivered for breast, bladder and prostate (only these three) or if no hormonal therapy or chemotherapy are delivered for any cancer type.

This risk stratification methodology does not recognize the many complex scenarios involving cancer treatment and has the potential to miss some truly high-risk patients. Examples include, a high-risk prostate cancer patient who requires multiple lines of androgen axis inhibitors but does not receive chemotherapy; a triple negative breast cancer patient who refuses chemotherapy; a locally advanced lung cancer patient who is not a candidate for chemotherapy but requires radiation therapy, among other clinically complex scenarios. These patients would be excluded from the high-risk stratification category simply because they aren't receiving chemotherapy. Additionally, ASTRO is concerned that the use of radiation therapy as a treatment option is not included as a stratification factor. The risk stratification methodology should be reconsidered. If the Agency is focused on the use of chemotherapy as a risk stratification measure, then the overall model should reflect that by omitting all non-drug therapeutic services.

Data Sharing

During the November 4 CMMI Listening Session, ASTRO was pleased to hear Agency officials commit to more timely data sharing. ASTRO applauds efforts that enable practices to secure real time data so that practices can make improvements in order to better understand ongoing episode costs, as well as improve quality measures performance. ASTRO urges the Agency to make this a priority across all payment models in place or under development within CMMI.

Alignment with RO Model

ASTRO reiterates its commitment to the development and implementation of an alternative payment model for radiation oncology. We were pleased to see the Radiation Oncology Model (RO Model) that was issued in July and believe that with modifications based on our September 16th comment letter, the model serves as an opportunity for radiation oncologists to fully

engage in value based payment through the provision of efficient, high quality care⁴. If CMMI decides to implement OCF as proposed with the inclusion of radiation therapy services, we urge the Agency to omit OCF practice data from the trend factor analysis used to annually update the RO Model national case rates. In order to establish a clean trend factor for the RO Model, CMS should only include non-RO Model practices that also do not participate in a separate APM such as the OCF.

We appreciate the opportunity to comment on the proposed OCF. If you should have any questions or require additional information, please contact Anne Hubbard, Director of Health Policy, at 703-839-7394 or Anne.Hubbard@astro.org.

Sincerely,

A handwritten signature in black ink that reads "Laura Thevenot". The signature is written in a cursive, flowing style.

Laura I. Thevenot

Chief Executive Officer

⁴ Thevenot, Laura T. ASTRO [Comment Letter](#) on "Medicare Program; Specialty Care Models to Improve Quality of Care and Reduce Expenditures". September 16, 2019.