

September 21, 2020

Alex M. Azar, II, Secretary
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 Secretary Azar and Administrator Verma:

On behalf of the American Society for Radiation Oncology, I am writing to express serious concerns and seek immediate changes to the Radiation Oncology Alternative Payment Model (RO Model) final rule released on September 18, 2020, with an effective date of January 1, 2021. Specifically, we ask that you use your regulatory authority to delay the launch date of the model and reduce the excessive payment cuts to the mandated radiation oncology participants.

No professional society and medical specialty has pursued an alternatively payment model (APM) more aggressively than ASTRO. In 2015, following the passage of the Medicare Access and CHIP Reauthorization Act, we successfully lobbied for passage of the Patient Access and Medicare Protection Act (PAMPA), which initiated CMMI's work on a radiation oncology alternative payment model (ROAPM). In April 2017, after years of internal work and frequent collaboration with CMMI, ASTRO proposed to CMMI an ROAPM, from which many concepts in the CMS RO Model can be found. When CMMI needed more time to develop the RO Model, we again lobbied Congress for language in the Bipartisan Budget Act to provide more time for CMMI to issue the proposed RO Model. Despite our significant concerns with the proposed RO Model, we provided more than 40 pages of constructive comments and recommendations, which were echoed by the radiation oncology community, broader health care stakeholders, and numerous bipartisan Congressional leaders. In recent months, as the pandemic struck, we communicated to CMS our continued commitment to the RO Model, while making recommendations to account for the impact of the pandemic, including sufficient time from final rule publication to start date.

Given this history, we are disheartened that most of our recommendations were dismissed and very few were incorporated into the final rule. Furthermore, we are stunned that the Agency is disregarding the pandemic by requiring a January 1, 2021 launch date, which is within the declared Public Health Emergency (PHE) under section 319 of the Public Health Service Act. As we have communicated to the Agency, radiation oncology practices have suffered significant revenue losses and staff layoffs due to the pandemic. To mandate many of these same struggling practices participate in the model AND require them to dramatically change their operations in 100 days is totally unworkable. This implementation timeframe would have been inappropriate before the pandemic, and it is completely untenable during the PHE. This disregard for the real conditions on the ground facing radiation oncology practices requires urgent attention and correction by delaying the launch date at least until July 1, 2021 and possibly longer if conditions deteriorate in coming months.

In addition to RO Model launch timing, we are frustrated by the excessive payment cuts in the RO Model. While we acknowledge that, from the proposed rule, CMS minimally reduced the “discount factor” cuts by .25%, respectively, and the savings level dropped by \$20 million, these payment reductions turn the Radiation Oncology Alternative Payment **Model** into a Radiation Oncology Alternative Payment **Cut**.

Driven mostly by sizeable discount factors on professional and technical payments, CMS estimates that the RO Model will save \$230 million over 5 years. We cannot ignore how this compares to the savings target in the End-Stage Renal Disease Treatment Choices (ETC) model also released in tandem with the RO Model on September 18. The ETC model states that Medicare spends \$114 billion per year on kidney disease, yet the ETC model is estimated to save **\$25 million over 5 years**. In stark contrast, Medicare spends less than \$5 billion per year on radiation oncology services, yet, again, the RO Model will save **\$230 million over 5 years**. This contrast is all the more striking when you consider how many more providers are required to participate in the ETC model than the RO Model. The 9-fold difference in savings estimates between the two models does not make sense, and clearly demonstrates the punitive nature of the RO Model.

To address this imbalance quickly and simply, CMS should reduce the RO Model savings target to \$100 million over 5 years by further reducing the discount factors. This change would still represent significant savings to Medicare, particularly in proportion to total Medicare spending on radiation oncology services, while balancing the model in a way that ensures radiation oncologists in the model are not punished relative to their radiation oncology peers or other Medicare providers.

I was disappointed not to be able to speak directly to Administrator Verma or CMMI Director Brad Smith immediately upon release of the model on September 18, despite a scheduled call, to communicate these concerns. This inability to communicate with decisionmakers on serious topics bodes poorly for the success of the model. Despite our many concerns, ASTRO is fully committed to moving forward with the RO Model, but we first must see the launch delayed and cuts reduced. We would like to meet with you both in coming weeks to discuss these concerns and the path forward.

Sincerely,



Laura I. Thevenot
Chief Executive Officer

cc:

Brad Smith, Deputy Administrator and Director, CMS Center for Medicare and Medicaid Innovation (CMMI)

Amy Bassano, Deputy Director, CMMI

Christina Ritter, Director, CMMI Patient Care Models

Lara Strawbridge, Director, CMMI Division of Ambulatory Models

Marcie O'Reilly, Health Insurance Specialist, CMMI