Congress Must Act to Protect Patient Access to Radiation Oncology and Drive Value-Based Care

Pass Reforms to the Medicare Radiation Oncology Alternative Payment Model (RO Model)

- Start Model No Sooner Then July 1, 2021
- Reduce Discount Factor Payment Cuts to 3%.

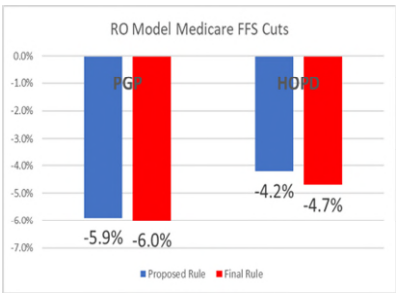
Background:

Congress has acted in a bipartisan manner numerous times to protect patient access to radiation therapy. In 2015, Congress passed legislation requiring that Medicare maintain payment rates while CMS worked with the radiation oncology community to develop an alternative payment model (APM) to ensure access to RO services. Congress acted in 2018 to extend the payment freeze to provide additional time for the development of the APM, including continued engagement with stakeholders.

After release of the CMS proposed RO Model in 2019, bipartisan Senators and Representatives wrote CMS to express concern that the model did not balance the incentive to participate with decreases in payment rates. Congress asked CMS to address the scope, implementation, and payment structure of the model, including allowing more time for practices to implement the model and reductions in the proposed discount factor payment reductions. Congressional concerns were largely ignored in the final RO Model released Sept. 18.

Issue:

- The RO Model is a mandatory payment model designed to test whether prospective 90-day episode-based payments to 950 radiation oncology physician group practices and hospital outpatient departments will reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries.
- The Radiation Oncology Alternative Payment Model should be renamed the Radiation Oncology Alternative Payment Cut. It is a payment cut disguised as a model test, and it violates the spirit and intent of Congress and the Medicare Access and CHIP Reauthorization Act (MACRA).
- After experiencing significant revenue declines of 20-30% and staff layoffs during the COVID-19 pandemic, practices are now *required* to participate in a model that risks access to care for cancer patients.
- The RO Model would cut Medicare Fee-for-Service payments to participating radiation oncology group practices by 6% and radiation oncology hospital outpatient departments by 4.7%, larger cuts than in the proposed rule. These cuts go far beyond any other CMMI model.



- CMS estimates the RO Model will reduce Medicare spending by $230 million over 5 years (Medicare spends less than $5 billion per year on radiation oncology). In contrast, CMS estimates a new end stage renal disease (ESRD) model, also released Sept. 18, will reduce Medicare spending by $25 million over 5 years (Medicare spends $114 billion per year on ESRD). About 1,000 more providers will participate in the ESRD model than the RO Model.
- The radiation oncology community is 100% committed to moving forward with an RO Model that balances the needs of participants and patients with APM requirements.

Legislative Solution:

- Provide mandated participants more time to cope with the pandemic and adopt the model.
    - Start the model no sooner then July 1, 2021, while monitoring the pandemic.
- Reduce the discount factor cuts to 3%, a level consistent with MACRA's intent and other payment models.

<u>CONGRESS MUST PASS LEGISLATION BEFORE THE END OF THE YEAR</u>
<u>TO REDUCE PAYMENT CUTS AND PROTECT ACCESS TO CARE</u>

STORIES FROM THE FRONTLINES

The combination of dramatic cuts in payments and the increased requirements of documentation and data entry for this mandatory program will break us. My staff and I are stretched to the limit. This has been the worst year of my professional life. That the agency would spring this on frontline providers during a pandemic is just cruel. Practices will close. Patients will be harmed.

--Virginia Radiation Oncologist

The proposed model is extremely complex and confusing. The amount of time and training to ensure that we have revenue personnel who are trained to accurately comply with all of these proposed changes will be extraordinary. The very burdensome requirements of the APM, coupled with the likelihood of having to operate a simultaneous and parallel FFS operation with private payors, means that we will likely need to hire a dedicated FTE to coordinate this transition.

--New Jersey Radiation Oncologist

Our volume is still down from COVID, both for the current time as well as for the entire year. Revenues are way off… Our centers were already talking about laying off or reducing staff.

--Massachusetts Radiation Oncologist

Our volume is down 35% 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.

--Florida Practice Administrator