ASTRO
TARGETING CANCER CARE

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March 13, 2020

Christine Ritter
Director, Patient Care Models Group
Center for Medicare and Medicaid Innovation
2810 Lord Baltimore Drive
Windsor Mill, MD 21244

Dear Ms. Ritter,

The American Society for Radiation Oncology (ASTRO)[1] has greatly appreciated the opportunity to engage with the Centers for Medicare and Medicaid Innovation (CMMI) on the development of an alternative payment model for radiation oncology, and it's important that our partnership continue now to support cancer care and America's response to COVID-19 by delaying the launch of the Radiation Oncology Model.

Earlier this week, we were pleased to see the *Specialty Care Models to Improve Quality of Care and Reduce Expenditures* final rule listed for final review on the Office of Management and Budget website, indicating that implementation of the model is imminent. We remain very supportive of moving forward with the RO Model, with our recommended reforms that have been echoed by bipartisan Congressional leaders. While we do not know the content of the final rule, we anticipate that the Agency is seeking a July 1, 2020 implementation date. ASTRO has previously expressed concerns about this aggressive implementation timeline--particularly if practices are mandated to participate July 1--but our concerns have been magnified in recent days as radiation oncology clinics nationwide face the unprecedented challenge and uncertainty of managing the care of complex cancer patients while doing their part to address the COVID-19 outbreak.

On its face, one would not immediately think of radiation oncology's involvement in the COVID-19 response, but in fact the infection is dramatically impacting radiation oncology clinics and likely will continue to do so. Additionally, the epidemic is expected to peak in July, the same time that the RO Model is expected to be launched[2]. ASTRO is hearing from both freestanding centers and hospital-based clinics that the combined burden of the COVID-19 and

[1] *ASTRO members are medical professionals, who practice at hospitals and cancer treatment centers in the United States and around the globe and make up the radiation therapy treatment teams that are critical in the fight against cancer. These teams often include radiation oncologists, medical physicists, medical dosimetrists, radiation therapists, oncology nurses, nutritionists and social workers, and 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.*

[2] Kristof, Nicholas and Stuart A. Thompson, "How Much Worse the COVID-19 Could Get, in Charts" New York Times, Friday, March 13, 2020 https://www.nytimes.com/interactive/2020/03/13/opinion/COVID-19-trump-response.html?action=click&module=Opinion&pgtype=Homepage

implementing the (likely) mandatory RO model would be overwhelming, particularly as both clinical staff and administrative staff responsible for implementing the model are being diverted to COVID-19 related activities. Data from China indicates that cancer patients are at greater risk of contracting COVID-19 and have poorer outcomes once infected. Needless to say, radiation oncologists and their care team members are also at risk of infection given their direct interaction with patients. ASTRO is seeking guidance from CDC on specific COVID-19 infection control advice for oncology clinics. In the meantime, radiation oncology practices are making significant COVID-19-related preparations and changes. These changes are evolving on a minute-to-minute basis and we expect that to continue as this crisis worsens, as predicted by public health experts.

In addition to developing practice specific escalation plans, such as the one attached, many practices are diverting physicians, clinical care, and non-clinical teams to address the COVID-19. Below are several examples of how COVID-19 is impacting radiation oncology services across the country:

- Senior radiation oncology leadership and staff diverted to COVID-19 response planning; this requires multiple meetings per day.
- Members of the radiation oncology care team are being diverted to COVID-19 response to perform entry point screening, document travel history, etc.
- Radiation oncologists and other care team members will be transitioned to inpatient support, if necessary.
- Radiation oncologists are being asked to review all patient lists and postpone any nonessential visits. All follow up visits are being rescheduled 2-3 months out.
- Practices are reducing tumor board meetings to essential faculty only and asking others to participate remotely.
- There have been reductions in staff per shift and staggered shifts to reduce exposure.
- Administrative and research staff have been encouraged to telework, if feasible. Many administrative staff will be responsible setting up the coding and billing requirements under the RO Model. This will be difficult to do under the current circumstances.
- Practices are engaging with vendors to ensure all equipment and supply lines are maintained, particularly those originating from outside of the country.
- School closures and childcare consequences have led to a reduction in staff availability.
- Non-radiation oncology hospital administrative leadership and staff are completely consumed with responding to COVID-19.

Once the RO Model is issued, a significant effort will need to be launched at each radiation oncology practice in order to ready practices for operationalization of the new program. While it is not entirely clear what will be required of practices, ASTRO members have been thinking about practice impact based on what was described in the proposed rule. Below is a list of key implementation efforts that may be impacted by COVID-19 response efforts:

- Cancer patients are also facing issues associated with COVID-19, including uncertainty about the need to attend appointments and the risk of infection. This is happening at the same time that they are balancing the news of their cancer diagnosis. The additional

stress over learning about a new payment model at this time (when healthcare systems will be stressed as well) may add to overall patient anxiety, particularly given that the RO Model will likely modify their copayment.

- Administrative/billing staff will be responsible for identifying eligible Medicare FFS beneficiaries for the RO Model. Reduced staff, due to COVID-19, will lead to fewer administrative/billing staff available to identify eligible patients and may lead to misattribution (patients who should have been RO Model patients not being flagged and instead being billed out as FFS but only to get reconciled in the future due to misattribution).
- Non-clinical staff will be assigned to secure data sharing agreements with RO Model Medicare Beneficiary participants, as well as assign appropriate HCPCS codes to identify episode start and end dates. Without adequate staff or training, due to efforts to address COVID-19, there will be a high likelihood that key steps will be missed in the practice workflow.
- Frontline staff will need to have the opportunity to discuss the financial implications of the model to patients. As mentioned previously, copayments will be different and without adequate frontline staff, such patient communication may be limited, leaving patients with more uncertainty as to how the RO Model would affect them.
- Limited, onsite, IT and billing staff will delay changes to existing billing systems and EHR workflows.
- Clinical and non-clinical staff will need to be trained on new billing and EHR clinical workload based on final rule specifications. With reduced staffing such training may not happen or may be ineffective due to insufficient attendance (staff not coming to work or not being available for remote training even due to childcare needs).
- It is unclear how COVID-19 will affect the responsiveness of EHR, billing software and other vendors who will need to retool systems to meet RO Model specifications.
- Larger, multi-disciplinary centers may have centralized billing services and limited ability to influence staffing of such centers when there are shortages due to COVID-19 efforts.

Given the fluidity of the situation and the inability for radiation oncology to receive education and make necessary practice changes related to the RO Model, ASTRO recommends CMMI to postpone the implementation of the RO Model until January 1, 2021. ASTRO remains committed to the successful implementation of the RO Model, and we believe this delay will provide radiation oncology clinics the time necessary to support the COVID-19 response and then transition to value-based care. We appreciate your consideration and look forward to continued opportunities to engage on the implementation of this important initiative.

Sincerely,

Laura Thevenot

Laura I. Thevenot
Chief Executive Officer

Cc:
Lara Strawbridge, Director Division of Ambulatory Payment Models
Marcie O'Reilly, Health Insurance Specialist
Claire Kihn, Social Science Research Analyst

Attached: UVA Policy