CANCER LEADERSHIP COUNCIL

A PATIENT-CENTERED FORUM OF NATIONAL ADVOCACY ORGANIZATIONS ADDRESSING PUBLIC POLICY ISSUES IN CANCER

March 30, 2021

Elizabeth Richter
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Richter:

The Cancer Leadership Council, a coalition of cancer patient, provider, and research organizations, is writing regarding the rulemaking process related to the Radiation Oncology (RO) Model. We urge the Centers for Medicare & Medicaid Services (CMS) to employ a transparent process that seeks input from all stakeholders in the radiation oncology community as you refine the rule defining the RO model.

CLC organizations have dedicated significant time, resources, and creativity to addressing the effects of the coronavirus pandemic on cancer survivors. The pandemic has disrupted cancer care, screening, and research, with very significant impact on cancer patients, their health care providers, and researchers pursuing new treatments. In fact, we will not understand for some time the full impact of the pandemic on cancer care and research.

On the other hand, through use of telehealth, aggressive risk mitigation by cancer care providers, and innovative approaches to research challenges, the cancer community has significantly restored access to timely care. Now, cancer stakeholders are undertaking policy, education, and outreach efforts to ensure prompt access to vaccines for cancer patients, who have been rightly identified in the vaccine schedule as high-risk individuals who should be vaccinated in phase 1 of the vaccination program.

We describe our experience during the coronavirus pandemic because it relates directly to our concerns about the design of the RO Model. Despite the overall strength of the cancer care system and research enterprise in this country and impressive advances in cancer treatments,

CONTACT: 2446 39TH STREET NW · WASHINGTON, D.C. 20007
Phone: 202-333-4041 · www.cancerleadership.org

the pandemic underscored vulnerabilities in our system. Overall access to care has been disrupted, and disparities in access to care have been exacerbated by the pandemic. Patients and providers are still shouldering financial burdens associated with their responses to the pandemic. We do not want to experience additional disruptions to the system if the RO Model is not well-designed and responsive to the cancer care system during the pandemic.

With our pandemic experience in mind, we offer these observations about the rulemaking process and issues that may arise in that process.

- As referenced above, we urge the agency to consult with radiation oncology stakeholders, including patients, during the rulemaking process. This is a critical part of a rulemaking process that will result in a proposed payment model that significantly changes radiation oncology reimbursement. It is essential that the process be transparent and open, as these changes will be proposed during a pandemic that has already created dislocations in radiation oncology care.

- We are concerned that efforts to generate substantial savings in the RO model, particularly through excessive discount factor cuts, could affect patient access to care, including access to state-of-art care in certain locations. We understand the difficult balance of designing a sustainable system that protects access and encourages innovation, but it is a balance that must be pursued.

- We urge that CMS consider revaluing the National Base Rates based on cases with curative intent and to establish a separate episode of care for palliative treatment. Including palliative care cases in the National Base Rates will result in an undervaluation of curative cases. Our recommended change would best protect patient access to quality care, including quality palliative care.

- CMS should ensure that the National Base Rates use data that rewards the delivery of guideline-concordant care. We are concerned that the current methodology does not reflect the costs of guideline-concordant care for cervical cancer, which requires both external beam therapy and brachytherapy. Creating any barrier to access to quality cervical cancer care will further exacerbate disparities in care for this cancer.

- We urge the agency to assess the financial burdens that will be borne by practices participating in the RO model. These include electronic health records costs, quality reporting responsibilities, and other data collection and reporting requirements. These responsibilities and requirements will be substantial for all participating practices but may be felt most acutely by small and rural practices. And that burden may in turn create access problems for patients served by those small and rural practices.

The undersigned organizations support the movement toward an RO Model. We have also been involved in the design and implementation of the Oncology Care Model and look forward to next steps on the Oncology Care First Model. In all cases, we have appreciated CMS consultation with stakeholders and look forward to consultation on critical issues related to reforms of the RO Model.

Sincerely,

Cancer Leadership Council

American Society for Radiation Oncology
Association for Clinical Oncology
Children's Cancer Cause
International Myeloma Foundation
Lymphoma Research Foundation
National Coalition for Cancer Survivorship
Ovarian Cancer Research Alliance
Prevent Cancer Foundation
Susan G. Komen

cc: Liz Fowler, Director, CMMI

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