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October 31, 2022

The Honorable Ami Bera, MD
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The Honorable Kim Schrier, M.D.
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The Honorable Michael C. Burgess, M.D.
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The Honorable Brad R. Wenstrup, D.P.M.
United States House of Representatives
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Washington, DC 20515

The Honorable Mariannette Miller-Meeks
United States House of Representatives
1716 Longworth House Office Building
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Submitted Electronically: macra.rfi@mail.house.gov

Dear Representatives Bera, Bucshon, Schrier, Burgess, Blumenauer,
Wenstrup, Schneider, and Miller-Meeks:

The American Society for Radiation Oncology¹ (ASTRO) appreciates the opportunity to provide written comments in response to the request for information (RFI) issued on September 8, 2022, regarding the Medicare Access and CHIP Reauthorization Act (MACRA). ASTRO commends your bipartisan leadership in seeking ideas for reforms to the Medicare payment system, particularly the broken Medicare physician fee schedule. Radiation oncology has had a front row seat to witness the serious flaws in the physician fee schedule and difficulties in transitioning to value-based payments. As discussed below, radiation oncology payments under the fee schedule have dropped by an unsustainable rate of more than 20% over the last 10 years. At the same time, no medical specialty has pursued an alternative payment model more aggressively than radiation oncology; yet, despite broad bipartisan support from Congress, our efforts have been stymied by the Centers for Medicare and Medicaid Services' (CMS) excessive pursuit of payment cuts. ASTRO fully recognizes the need for

¹ ASTRO members are medical professionals, practicing at hospitals and cancer treatment centers in the United States and around the globe, and who make up the radiation therapy 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, and treat more than one million patients with cancer each year. We believe this multidisciplinary membership makes us uniquely qualified to provide input on the inherently complex issues related to Medicare payment policy.

major reforms to Medicare physician payments, and we are committed to working with you to ensure the law best serves beneficiaries, physicians, and taxpayers. In addition to our recommendations, we hope our experience is illustrative and informative for reform discussions.

As discussed in the RFI, incentive payments designed to encourage participation in Advanced Alternative Payment Models (APMs) are set to expire at the end of this year. To date there have been limited opportunities for physicians, particularly specialty physicians, to participate in Advanced APMs. We would assert that the deficit of APMs is not due to the lack of effort, but rather due to the Center for Medicare and Medicaid Innovation's (CMMI) overly strict interpretation of the requirements established in MACRA, which has made testing new payment model concepts challenging. Below we elaborate on the key issues that must be addressed to allow for greater flexibility and recognition of unique specialty circumstances that would allow for the creation of viable payment models that will ultimately ensure the future of value-based payment reform.

1. Effectiveness of MACRA

After years of legislative fixes to stabilize the Sustainable Growth Rate stable, Congress should be applauded for establishing MACRA, which served as a roadmap toward value-based payment. The Quality Payment Program (QPP), as outlined by MACRA, created a two-pronged approach toward achieving the goal of value-based payment with the establishment of the Merit Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models.

Unfortunately, efforts to shift toward value-based payment have been slow. More advanced APM opportunities need to be made available so that all medical specialties can effectively make that transition. Until then, many specialties, including radiation oncology, find themselves relegated to the unstable payment environment found within the Medicare Physician Fee Schedule (MPFS).

ASTRO agrees with the principals for physician payment reform led by the American Medical Association that focus on simplicity, relevance, alignment, and predictability for physician practices. Specifically, those principals are:

Ensuring financial stability and predictability.

- Provide financial stability through a baseline positive annual update reflecting inflation in practice costs, and eliminate, replace or revise budget neutrality requirements to allow for appropriate changes in spending growth.
- Recognize fiscal responsibility. Payment models should invest in and recognize physicians' contributions in providing high-value care and the associated savings and quality improvements across all parts of Medicare and the health care system (e.g., preventing hospitalizations).
- Encourage collaboration, competition and patient choice rather than consolidation through innovation, stability, and reduced complexity by eliminating the need for physicians to choose between retirement, selling their practices or suffering continued burnout.

Promoting value-based care.

- Reward the value of care provided to patients, rather than administrative activities--such as data entry--that may not be relevant to the service being provided or the patient receiving care.

- Encourage innovation, so practices and systems can be redesigned and continuously refined to provide high-value care and include historically non-covered services that improve care for all or a specific subset of patients, as well as for higher risk and higher cost populations.
- Offer a variety of payment models and incentives tailored to the distinct characteristics of different specialties and practice settings. Participation in new models must be voluntary and continue to be incentivized. A fee-for-service payment model must also remain a financially viable option.
- Provide timely, actionable data. Physicians need timely access to analyses of their claims data, so they can identify and reduce avoidable costs. Though Congress took action to give physicians access to their data, they still do not receive timely, actionable feedback on their resource use and attributed costs in Medicare. Physicians should be held accountable only for the costs they control or direct.
- Recognize the value of clinical data registries as a tool for improving quality of care, with their outcome measures and prompt feedback on performance.

Safeguarding access to high-quality care

- Advance health equity and reduce disparities. Payment model innovations should be risk-adjusted and recognize physicians' contributions to reducing health disparities, addressing social drivers of care, and tackling health inequities. Physicians need support as they care for historically marginalized, higher risk, hard to reach or sicker populations.
- Support practices where they are by recognizing that the high-value care is provided by both small practices and large systems, and in both rural and urban settings.

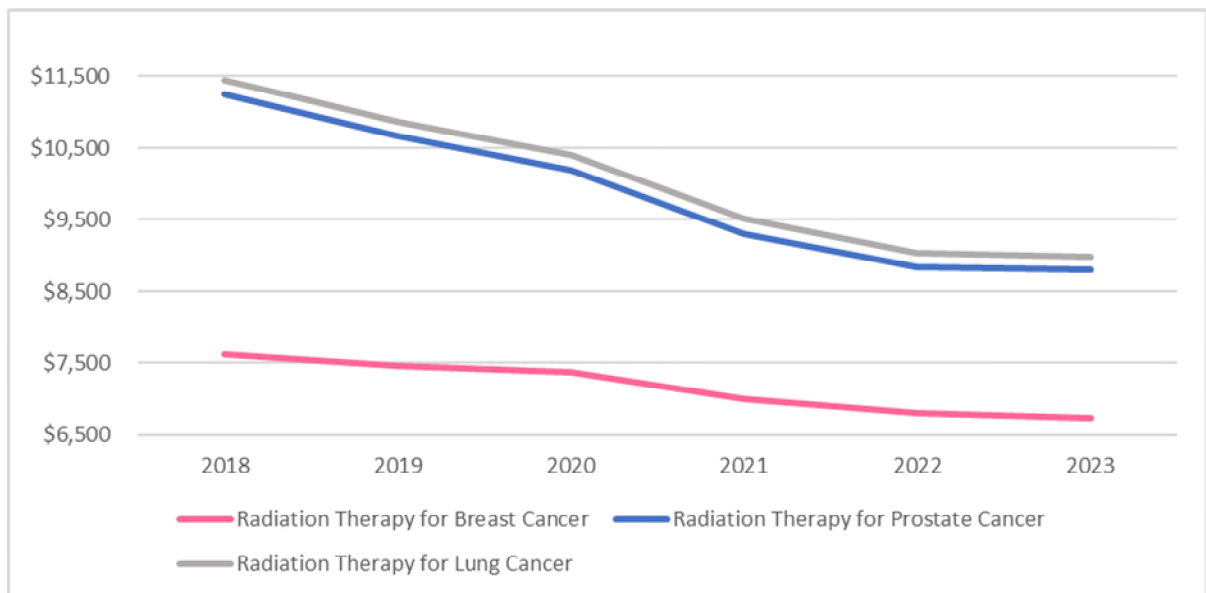
ASTRO is particularly concerned with recent trends in the MPFS that have shifted funds within the budget neutral system away from specialties, particularly those with expensive supplies and equipment. While we agree that the physician fee schedule should provide adequate payment for all specialties, including primary care, recent cuts and massive shifts are unsustainable and risk jeopardizing access to specialty care for many patients with cancer. Congress must address budget neutrality requirements under the physician fee schedule.

A recent analysis of Medicare reimbursement for radiation oncology services confirms that radiation oncology has faced year-over-year fee schedule payment reductions that exceed other specialties and are unsustainable. According to the analysis, Medicare reimbursement for radiation therapy declined by 27% between 2010 and 2019, when adjusted for inflation and utilization.² Additional payment cuts have continued since 2019, which is having a significant impact on the ability of community-based practices to provide state of the art care close to patients' homes. Since last year, radiation oncology practices are now reporting that their overhead costs have increased by 10-20% due to inflationary pressures.

The impact of these cuts can be seen through significant declines in payment across three common disease sites: breast, prostate, and lung cancer. According to an ASTRO analysis of common radiation

² Hogan, BS, Jacob, Amit Roy, MD, Patricia Karraker, MD, et al. "Decreases in Radiation Oncology Reimbursement over time: Analysis by Billing Code." *Radiation Oncology*Biography*Physics*. Vol. 114, Issue 1, P47-56. May 21, 2022. <https://doi.org/10.1016/j.ijrobp.2022.05.018>

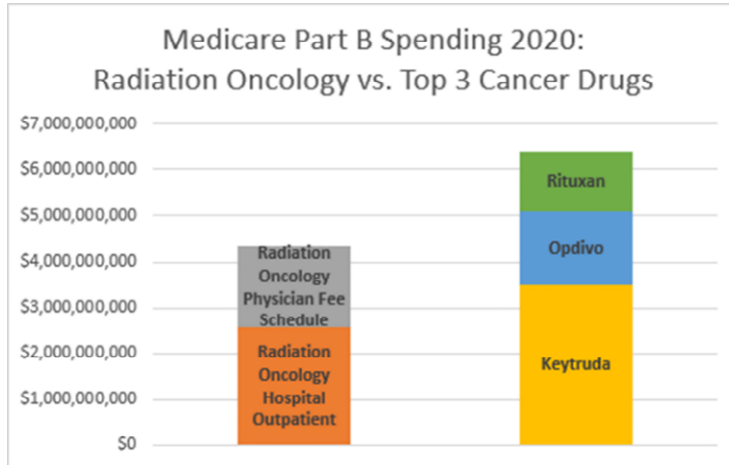
treatment scenarios, breast cancer payments have declined by 13%, prostate cancer payments by 28%, and lung cancer by 27% since 2018.



Practices are reeling from increased costs associated with patient care and growing administrative burden, forcing many to consolidate with larger practices or health systems. Between 2013 and 2017 the number of solo radiation oncology practices fell 11%, while at the same time, the number of large practices increased by 50%.³ Payment cuts of this magnitude are unsustainable and contribute to practice closure and consolidation, creating access to care for many communities across the country.

These payment cuts fail to recognize that radiation oncology is a high-value form of cancer treatment. Medicare expenditures for radiation oncology services under Medicare Part B are less than the three top chemotherapy drugs, despite more than 270,000 beneficiaries receiving radiation therapy, nearly twice as many beneficiaries than are treated with those drugs.

³ Milligan, Michael, MD MBA, Megan Hansen, BA, BS, Daniel Kim, MD, MBA, et al. "Practice Consolidation Among US Radiation Oncologists Over time." *Radiation Oncology*Biography*Physics*. Vol. 111, Issue 3, P610-618. June 18, 2021. <https://doi.org/10.1016/j.ijrobp.2021.06.009>



Unfortunately, cuts of this magnitude will make tried and true radiation therapy treatments that cure the majority of cancers inaccessible. Radiation therapy is already highly cost-effective, and continued cuts will only serve to threaten the value provided by the nation’s radiation oncology team. The MPFS is failing patients with cancer in need of radiation therapy by making state-of-the-art care close to home a thing of the past. Urgent, major reforms are needed, and ASTRO is ready to work with Congress to achieve payment stability and higher quality care through alternative payment models.

In 2014, ASTRO began working on the establishment of an alternative payment model for radiation oncology, committing significant resources to the effort. This work was spurred by both the Patient Access and Medicare Protection Act of 2015, which froze payments for key radiation therapy services and required CMMI to report to Congress on the viability of an alternative payment model for radiation oncology, and the passage of MACRA. We also pursued thoughtful and collaborative discussions with CMMI on the development of an alternative payment model for the field of radiation oncology. ASTRO entered into these discussions because we believed that:

- Radiation oncologists should have the opportunity to fully participate in the Quality Payment Program and be rewarded for participation and performance in initiatives that improve the value of health care for patients.
- An alternative payment model for radiation oncology should ensure fair, predictable payment for the radiation oncologist in both hospital and freestanding cancer clinics to protect cancer patients’ access to care across all settings.
- An alternative payment model should incentivize the appropriate use of cancer treatments that result in the highest quality of care and best patient outcomes.

Early in the process, the CMMI recognized that radiation oncology faced payment instability due to its reliance on significant capital costs. According to the November 2017 Report to Congress, the Agency believed that an alternative payment model could establish long warranted rate stability to ensure continued access to this vital and high-value form of cancer care:

“A potential model could also test more stable pricing for freestanding radiation therapy centers paid under the Medicare Physician Fee Schedule... CMS faces certain challenges in determining accurate prices for services that involve expensive capital equipment. Consequently, PFS rates for services involving external beam radiation have fluctuated over

the last decade. Under an episode payment model, more stable prices for radiation therapy services could be tested to determine if they reduce expenditures while maintaining or enhancing quality of care.”⁴

After additional discussions with the Agency, CMMI proposed the Radiation Oncology Model (RO Model) in July 2019. It was immediately evident that CMMI sacrificed payment stability and quality improvement by layering significant payment cuts and reporting requirements. Participation in the RO Model would have been untenable for many physician practices, particularly for those who provide care for patient populations who are socioeconomically disadvantaged or experience healthcare disparities. We applaud Congress for working with the radiation oncology community to delay the RO Model twice, with hundreds of bipartisan Members of Congress sending letters to CMS urging reforms to the RO Model. Unfortunately, that additional time and requests of Congress yielded little change due to CMMI’s interpretation and application of MACRA.

More recently, CMMI has begun to shift its focus toward a Total Cost of Care (TCOC) or Accountable Care Organization (ACO) type concepts for oncology services. These concepts do not take into consideration the appropriateness of episode-based payment within broader TCOC and ACO models. 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. Episode-based models are appropriate for distinct segments of care that are delivered within a specific period. We believe that radiation therapy continues to be an appropriate candidate for episode-based payment, since it is a distinct component of care within the broader cancer care continuum. It involves a unique treatment, delivered over a specific period of time, that involves medical professionals with specific levels of expertise, such as the medical physicist, and expensive capital resources that are not found elsewhere in medicine.

2. Regulatory, statutory, and implementation barriers that need to be addressed for MACRA to fulfill its purpose of increasing value in the U.S. health care system

As previously mentioned, we believe CMMI’s strict interpretation of MACRA prevented commonsense reforms to the RO Model, leading to arbitrary waivers of the law and a lack of flexibility to recognize the unique circumstances associated with operating a clinic with high fixed costs and expensive capital equipment. Below is a summary of the key barriers:

Mandatory Participation

CMMI required mandatory participation of selected Core Based Statistical Areas (CBSAs) for participation in the RO Model. This sample size was selected to achieve 3% in Medicare savings. Mandatory participation is not supported by Section 1115A of the Social Security Act, which authorizes CMMI to “test” a new payment and service delivery model. As such the RO Model exceeded the limits of CMMI’s authority in that it mandated participation by radiation therapy providers in randomly selected zip codes,⁵ with only limited exclusions,⁶ for a five-year performance period. The mandatory participation requirement goes far beyond any other demonstration program and is beyond the scope

⁴ United States Department of Health and Human Services, “[Report to Congress: Episodic Alternative Payment Model for Radiation Therapy Services](#),” November 2017.

⁵ 84 Fed. Reg. 34478, 34568.

⁶ 84 Fed. Reg. 34478, 34494.

of what is needed to test CMMI's objectives. It appeared to be driven solely by the desire to meet a 3% savings estimate.⁷ Revisions to MACRA should clearly allow for a voluntary participation period that allows practices to transition into value-based payment programs as they are ready.

Savings

MACRA authorized CMMI to conduct tests "while preserving or enhancing the quality of care." In other words, any model or test that decreases quality of care will exceed CMMI's statutory authority. The RO Model payment cuts would have jeopardized access to safe and effective radiation treatments by putting too much financial strain on radiation oncology practices that have no choice but to participate. Furthermore, the RO Model's focus on reducing Medicare expenditures at such a high level disregards the opportunities that exist to improve quality of care through realigned incentives that encourage the use of guideline concordant care that leads to less variation in treatment, greater efficiency, patient convenience, and improved clinical outcomes.

The MACRA "nominal risk" requirement, set at 3% of expenditures or 8% of revenues, was achieved in the RO Model through the application of prohibitively high discount factors. The MACRA nominal risk requirement thresholds fail to recognize that radiation oncology services rely heavily on the use of advanced technology and equipment, as well as highly skilled staff that require a significant financial investment, which is likely beyond that of anything else in medicine. For those practices with thin operating margins, the financial implications would have been significant. While it is important to reduce the cost of care and drive value in healthcare, it is also important to ensure that efforts to generate savings do not cause financial hardship and access to care issues for patients by limiting practices' ability to offer state-of-the-art radiation therapy delivered by expert clinical staff. MACRA's requirements and CMMI's strict interpretation created unachievable standards, undermining a tailor-made opportunity for radiation oncology to transition to value-based payment.

CMS has since seemed to recognize this issue with regard to the Bundled Payments for Improvement (BPCI)-Advanced model. The Agency excluded cardiac rehabilitation (home-based, long-term care) and intensive rehabilitation (hospital-based) from the BPCI-A model for cardiology services in the third model year. The Agency recognized that patients who receive care at cardiac rehabilitation facilities have better overall outcomes, yet when these services were included in the BPCI-Advanced model, it was difficult for participants to meet pricing targets, disincentivizing providers from prescribing the service despite its clinical relevance.⁸ Additionally, CMS has announced that as part of the extension of the BPCI-A demonstration, it will reduce the pay cut for episodes of care from 3% to 2% and make other payment methodology adjustments. According to Premier, which operates a Bundled Payments Collaborative, "These models require significant investment in redesigning care through new technologies, data analytics and additional staff⁹."

⁷ 84 Fed. Reg. 34478, 34568.

⁸ "CMS brings much needed changes to rules on TAVRs and Cardiac Rehab in BPCI Advanced." Archway Health. Accessed May 12, 2022, <https://www.archwayhealth.com/bundled-payments-blog/2019/8/cms-brings-much-needed-changes-to-rules-on-tavrs-and-cardiac-rehab-in-bpci-advanced>

⁹ Edwards, Seth. Statement on the Extension of Bundled Payments for Care Improvement (BPCI) Advanced. October 13, 2022. <https://premierinc.com/newsroom/policy/statement-on-the-extension-of-bundled-payments-for-care-improvement-bpci-advanced>

Finally, the RO Model did not recognize the cost of social interventions that ensure patients have access to care. The statutory language associated with value-based payment is a barrier because it requires savings, which creates challenges to providing many patients with the navigation and support services that are needed yet underfunded or not funded at all. A Mayo Clinic analysis of the RO Model indicated that practices caring for socioeconomically disadvantaged populations would face significant revenue reductions, resulting in access to care issues for the communities they serve.¹⁰ Additional analysis of Medicare data shows that minority patients are nearly one-third more likely than White patients to not even begin their radiation therapy treatments, despite having completed the complex treatment planning process. The analysis demonstrates that the factors contributing to an inability to initiate or complete treatment vary by disease site. The RO Model not only disregarded these concerns, but also striped resources from practices to achieve its cost-savings goals.

MACRA must be revised to recognize that different types of medical services involve different cost structures and community investments that are critical to ensuring access to high-value, high-quality care. Nominal risk standards should be established that take into consideration the ratio between variable and fixed cost for participating practices, as well as the social needs of the communities served. Strict savings parameters will limit participation and create barriers to care for those communities who are most at need. Future model development must take into consideration these costs to ensure that quality is not compromised in an effort to save money.

Quality Measures and Monitoring Requirements

The RO Model included four quality measures that were identified as Merit-based Incentive Payment System (MIPS) comparable measures. However, we were frustrated that CMMI disregarded the processes and mechanisms for reporting these measures that were already laid out in MIPS. Each of the four measures are electronically specified and can be collected and reported by vendor systems. MIPS allows for multiple submission mechanisms; however, the RO Model only allowed for a manual reporting option which would have been a significant burden for participating practices.

Additionally, CMMI issued a Clinical Data Elements reporting requirement that would have aided in the development of new quality measures for radiation oncology. While ASTRO appreciated the need to collect data to inform future quality measure development, the process that CMMI laid out involved a specialized National Cancer Data Base coding system, which requires trained cancer registrars. Additionally, the specialized coding system did not align with existing electronic health record (EHR) and MIPS reporting requirements. Furthermore, the Agency did not reimburse for the financial resources and time that would be required to comply with the requirements in the RO Model payment methodology. Again, the model was mandatory, so practices had no choice but to participate.

Finally, the RO Model included a series of monitoring requirements, including adherence to nationally recognized guidelines, assessment of patient performance status, treatment summary dissemination,

¹⁰ Waddle, MD, MR, Stross, MD, WC, Vallow, MD, LA, et al. "Impact of Patient Stage and Disease Characteristics on the proposed Radiation Oncology Alternative Payment Model (RO-APM)." *Int J Radiation Oncol Biol Phys*, Vol. 106, No. 5, pp. 905-911, 2020. <https://doi.org/10.1016/j.ijrobp.2019.12.012>

etc. While ASTRO appreciates the value of the activities included, there was no reimbursement associated with the monitoring requirements—again only the excessive payment cuts described in the payment methodology. The monitoring requirements represented another unfunded mandate and an administrative burden for practices. The related financial costs that participants would have incurred due to forced participation in the RO Model would have been overwhelming for many practices. MACRA should be revised to either eliminate burdensome requirements or fund the upfront costs that many practices will be faced with as they transition to value-based payment.

Technical Component Waiver

In the RO Model, CMMI waived MACRA requirements by removing Technical Component Payments from the calculation of the 5% APM incentive payment. According to MACRA, Qualified Advanced APM Participants are eligible to receive 5% of prior year estimated aggregate payments for covered professional services. Covered professional services include payments made under the physician fee schedule, which for radiation oncology includes both professional and technical payments. CMMI asserted that it was necessary to exclude payments for the technical RO Model-specific HCPCS codes from the estimated aggregate payment amounts for covered professional services used to calculate the APM incentive payment because those services are considered “technical” in nature and represent the cost of the equipment, supplies and personnel used to perform the procedure.

The waiver was particularly egregious given the significant discount on RO Model technical component payments. The technical component for radiation therapy services includes the fixed costs associated with practice expenses for the equipment and personnel involved in the delivery of radiation therapy services. As previously mentioned, radiation oncology clinics are an example of a practice type in which the ratio of fixed costs far exceeds variable costs. Excluding technical component payments from the Advanced APM bonus calculation would have created significant financial hardship or practices compelled to participate in the RO Model. MACRA should prevent CMMI from pursuing waivers that penalize Advanced APM participants.

Advanced APM/MIPS-APM Status

CMMI intended for the RO Model to qualify as an Advanced APM.¹¹ One way of meeting the financial risk standard is through capitated arrangement as described in 42 C.F.R. § 414.1415(c)(6) “a full capitation arrangement means a payment arrangement in which a per capita or otherwise predetermined payment is made under the APM for all items and services furnished to a population of beneficiaries during a fixed period of time, and no settlement is performed to reconcile or share losses included or savings earned by the APM entity.” The RO Model established episode-based payments that met the criteria set forth in MACRA, yet CMMI never recognized this regulatory application, which would have prevented practices from achieving Advanced APM status.

Based on an ASTRO analysis, these policy decisions resulted in a payment model that created more “losers” than “winners.” While we can appreciate that a shift toward episode-based payment through a

¹¹ 84 Fed. Reg. 34514 (“[W]e intend for the RO Model to qualify as an Advanced APM, and also meet the criteria to be a MIPS APM.”)

value-based construct will result in winners and losers, the spread should be more equal on both sides of the equation than what the RO model would have created (see below).

APM v FFS		
Impact (PY1-5)	PC Providers	TC Providers
< - 20%	0.0%	0.0%
-20% to < -10%	0.8%	22.7%
-10% to < -5%	12.1%	45.4%
-5% to < -1%	39.7%	1.4%
-1% to < +1%	25.9%	0.8%
+1% to < +5%	19.0%	10.9%
+5% to < +10%	1.9%	16.5%
+10% to < +20%	0.3%	2.2%
=> +20%	0.2%	0.1%

Unfortunately, with the RO Model CMMI repeatedly took steps to maximize the savings from an already very high value form of cancer treatment, particularly when compared to other modalities of cancer treatment. We would assert that this excessive level of savings was not Congress’ intent when it passed MACRA.

3. How to increase provider participation in value-based payment models

Participation in value-based payment models is incumbent on there being an adequate number of payment models available for physicians to actively participate in the transition from FFS to value-based payment. This includes payment models that represent a broad range of payment constructs, including episode-based payment, TCOC, ACO, shared savings, etc. Each of these constructs recognizes that there is no “one-size fits all” approach to value-based payment. More importantly, they also ensure that even the most defined specialty service can be recognized in a broader TCOC or ACO type concept through the establishment of an episode-based payment model that aligns with broader payment model concepts.

As previously stated, radiation therapy is an appropriate candidate for episode-based payment since it is a distinct component of care within the broader cancer care continuum. It involves a unique treatment, delivered over a specific period of time, that involves medical professionals with specific levels of expertise, such as the medical physicist, and expensive capital resources that are not found elsewhere in medicine. Thus far, the only opportunity for radiation oncologists to participate in value-based payment initiative has been through the Oncology Care Model (OCM) and the pending Enhancing Oncology Model (EOM). However, because the medical oncologist has been put “in charge” of the total cost of care associated with OCM, the role of the radiation oncologist is a passive one, leaving the radiation oncologist with no opportunity to actively participate in value-based payment.

All physicians should have the opportunity to actively participate in value-based care through payment models that are designed to recognize the important role that guideline concordant care plays in

achieving optimal patient outcomes. Payment models should be developed through a collaborative process involving CMMI and physician stakeholders. This collaborative process should yield payment models that are designed to recognize the unique attributes of the specialty involved, as well as the types of patients treated, including the capital costs associated with the delivery of care and the complexity of the treatment being delivered. Additionally, there should be avoidance of prior authorization and reporting requirements that frequently waste physician time that is better spent on care delivery. Overall, emphasis should be placed on driving value through expanded access to high-quality care, rather than cost savings.

Revisions to MACRA should allow for greater flexibility in model design and application that also recognizes practice readiness and the resource requirements associated with transitioning to value-based care. Establishing different pathways that allow for full implementation over time ensures practice viability and protects patient access that could otherwise be jeopardized.

Finally, there must be recognition for the significant shift in risk bearing responsibility that occurs when physician's take on greater accountability for the cost of care delivery. Physicians are experts in identifying and pursuing the most efficient and effective course of treatment for their patients. However, their efforts to efficiently deliver more effective courses of treatment are often hampered due to the antiquated fee-for-service payment system, which provides limited resources for practice investment in equipment and technology. More resources need to be identified to enable physicians to reinvest in their practices so that they can recognize efficiencies, while at the same time taking on more risk for patient outcomes. This is particularly important for those physicians who provide care to patients in rural communities and those who are socioeconomically disadvantaged.

4. Recommendations to improve MIPS and APM programs

When introduced, MIPS represented a transitional approach to value-based payment. Rather than invest in more viable APMs, CMS continues to introduce new iterations of the MIPS concept, such as the MVP program. We believe this is a waste of time and resources for both physicians and CMMI. It's time to cast off the tethers of FFS and commit to value-based payment through the development of alternative payment models that recognize the key role that physicians bring to comprehensive patient care.

One of the reasons CMS has failed to successfully implement the RO Model is due to an overemphasis on guaranteeing model savings. We would argue that the shift to value-based payment should focus heavily on quality and practice transformation, which will lead to lower costs in the long run. As has been previously mentioned, the delivery of radiation therapy relies heavily on significant capital investments, there are limited variable costs from which to generate significant savings. However, there is a critical opportunity to improve the quality of care and achieve practice transformation, with subsequent incremental savings, through the adoption of shorter course treatments that are guideline concordant.

Today, ASTRO members are burdened by MIPS reporting requirements associated with quality measures that do not meaningfully represent improved patient care. They must invest in EHR systems that are supposed to make their lives easier, but still require their individual attention, not to mention an

investment of scarce resources. In addition, eligible clinicians are penalized for not achieving stated EHR requirements when they do not have control over the EHR products produced by vendors. The onus on updating required software should rest solely on the vendor, not the clinician. Additionally, when vendors are required to upgrade their products to maintain compliance with federal regulations, it requires significant investment in products. However, these costs are often passed on directly to physicians. We are concerned that vendors will use every new, regulatorily-required update or module as an opportunity to generate additional charges and fees for their product. These excess charges are a financial burden for many practices, especially for small and rural practices, which often find these costs prohibitive. All the while they contend with payers and benefits management companies who disregard their treatment decisions and supplant those decisions, backed with a medical degree and years of hands-on experience, with the least expensive option all in the name of healthcare savings.

Radiation oncologists continue to adopt new guideline concordant treatment approaches, including shorter, more convenient treatment regimens for patients, that reduce treatment times and allow patients to resume a normal life after a cancer diagnosis—even though these approaches conflict with the need to generate more revenue to offset the rising cost of overhead expenses, staffing and equipment.

MACRA must be reformed to better support alignment around what's best for the patient. For instance, an improved radiation oncology alternative payment model could establish a simplified payment methodology ensuring fair and stable reimbursement that recognizes the efficient delivery of care. There should be investments in the cancer treatment infrastructure to ensure that all patients have access to high quality care using advanced technology, which provide clinical and financial benefits. Unnecessary and burdensome reporting requirements that do not contribute to improved patient outcomes, including reliance on prior authorization as a blunt tool for reducing costs, should be eliminated. Mechanisms should be established in a payment model to identify and support patient populations with limited access to radiation therapy, to ensure initiation and completion of treatment. Additionally, a commitment to evidence-based approaches to care and investment in wraparound services, including patient navigation and transportation, will improve care for people from historically marginalized populations.

These are all very achievable goals, yet we have not been able to make them a reality under the current legal and regulatory construct. The last seven years have been a learning experience for everyone committed to value-based payment transformation, including radiation oncology. The path forward will require greater flexibility and up-front investment to achieve the goal of total practice transformation. Given that radiation oncology remains ripe for an alternative payment model, ASTRO is working on a new approach to value-based payment. Our goals are to improve quality, reduce costs, and advance equity, and we look forward to sharing this approach with Congress, as it deliberates Medicare physician payment reforms. We expect physician payment reform will be a lengthy and complex process, so we urge Congress to support moving forward with credible value-based payment approaches during this process.

ASTRO stands ready to work with Congress to make this happen for its members and the patients they serve. Again, we appreciate the opportunity to provide comment in response to the RFI. If you have any questions, please contact Dave Adler, ASTRO Vice President of Advocacy at 703-839-7362.

Sincerely,

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

Laura Thevenot
Chief Executive Officer