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October 7, 2019

The Honorable Seema Verma
Centers for Medicare and Medicaid Services
200 Independence Ave SW
Washington, DC 20201

Dear Administrator Verma:

I write today to offer comments regarding the proposed rule recently released by the Centers for Medicare and Medicaid Services (CMS), “Specialty Care Models to Improve Quality of Care and Reduce Expenditures CMS-5527-P,” in which the agency outlines an Alternative Payment Model (APM) for radiation oncology services.

Since the enactment of the Patient Access and Medicare Protection Act (PAMPA) in 2015, Congress has been supportive of the development of an APM for radiation oncology (RO) services in Medicare. In a 2017 report to Congress mandated by PAMPA, CMS found that a RO APM could address several existing issues in RO care, including site-of-service payment differentials and financial incentives to furnish higher-cost services, while providing benefits to patients, providers, and Medicare. The proposed Radiation Oncology Model represents an important step towards increasing the quality of patient care, providing stable payments for providers, and rewarding value, rather than volume, of radiation oncology services. There are several elements of the proposed model, however, that the agency should consider altering prior to final implementation in order to ensure providers are not overly burdened and patient access to RO services is not negatively impacted.

I have heard from stakeholders who have expressed significant concerns regarding the mandatory nature of the RO Model. CMS proposes that all RO providers and suppliers within particular geographic areas be required to participate in the model using randomly selected Core-Based Statistical Areas (CBSAs) to define where mandatory participation would apply. Using this method, the agency plans to include 40 percent of all eligible RO episodes of care. This captures a significant number of RO practices at the very outset of a model that is yet untested. I ask that CMS consider making the model voluntary or allow for a phased-in approach to allow for any issues to be addressed before requiring such a large contingent of RO providers to participate. If the agency does decide to move forward with a mandatory model, I would ask that the magnitude and type of discounts, withholds, and adjustments to the model’s payment calculation be reevaluated, as I am concerned that the reductions in payments that would result from the proposed methodology would be too severe for many RO practices to be required to bear.

While I support CMS's decision to make payments for episodes of RO care prospective, there are several aspects of the methodology by which episodic payments would be calculated that could be improved. Radiation oncology services are typically delivered in either the hospital outpatient department (HOPD) or in a freestanding RO clinic. Services furnished in a HOPD are reimbursed via both the Outpatient Prospective Payment System (OPPS) and Medicare Physician Fee Schedule (MPFS), while those furnished in a freestanding clinic are paid solely via the MPFS. The proposed RO Model would make payments site-neutral, establishing the same payment rate regardless of the care delivery setting. However, CMS proposes calculating national base rates for the professional component (PC) and technical component (TC) of the model using only OPPS data. Stakeholders have voiced concerns that this approach would lead to undervaluing certain RO services, particularly professional services. A blend of OPPS and MPFS data would more be more appropriate and more accurately value professional services across radiation oncology care.

CMS proposes several discounts and adjustments to the payment calculation that could pose a substantial burden to RO providers, particularly given the mandatory nature of the proposed model. The proposed model includes a significant discount factor on both the PC and TC aspects of the payment of 4 percent and 5 percent, respectively, which could potentially destabilize some RO practices. Such large cuts are also outside of the norm for similar APMs. For example, the only other APM dealing directly with cancer care, the Oncology Care Model (OCM), includes a 2.75 percent discount factor for the original 2-sided risk model and a mere 2.5 percent discount factor for the alternative 2-sided risk model. Reducing the discount factors for the RO Model and bringing them more in line with other existing models would strike a more appropriate balance between achieving overall savings and encouraging more efficient care while not imposing excessive financial strain on the RO practices that will be required to participate.

CMS also proposes applying an efficiency factor to payments in order to take into account practices that are already providing care efficiently and gradually bring more inefficient practices in line with the national base rates. Although the intent behind the efficiency factor is laudable, I am concerned that as currently constructed, the efficiency factor does not adequately protect efficient practices from further payment cuts. I urge CMS to reconsider the design of the efficiency factor so that it does not unduly reduce payments for already-efficient practices.

Under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), qualified participants in Advanced APMs can earn 5 percent of estimated aggregate payments for covered professional services from the previous year. MACRA offers this payment to providers as a way of incentivizing them to not only participate in APMs, but to assume risk under the models as well. CMS proposes waiving the 5 percent bonus payment that would apply to the technical component payments to freestanding RO clinics. This poses a potentially untenable financial proposition for freestanding clinics when coupled with the 5 percent TC discount these practices would already face. I would ask the agency to remove this waiver and allow freestanding RO clinics to receive the APM incentive payment.

The RO Model includes a set of proposed quality measures on which RO practices would need to report to evaluate quality and efficiency of care, patient experiences and outcomes, and other

factors. I understand the necessity and value of quality measure reporting and other data collection associated with the model; however, I ask that CMS heed the recommendations of providers and other radiation oncology stakeholders in order to make sure that the data being collected is meaningful and does not create unnecessary administrative burden on model participants.

Finally, I would encourage the agency to reevaluate how the model treats the continued improvement and innovation of technology in the field of radiation oncology. Advancements in radiation oncology have resulted in significantly improved outcomes and lessened side effects for patients undergoing treatment, but are also quite costly for practices to implement. The proposed model does not include an explicit carve out for new technologies, which may deter practices from investing in the latest innovations that would offer patients the highest quality care.

Thank you for your attention to this important issue. I recognize the opportunity to improve care and reduce Medicare expenditures presented by the proposed RO Model and hope that the agency, as it deliberates further on its parameters, carefully hones it on these considerations I raise. I look forward to working with you to ensure that the RO Model is designed and implemented in a way that allows patients to receive the highest quality care while increasing efficiency and savings in our health care system.

Sincerely,



Brian Higgins
Member of Congress