On Friday, June 15, the Medicare Payment Advisory Commission (MedPAC) issued its June 2018 *Medicare and Health Care Delivery System* report to Congress. MedPAC is an independent Congressional agency established by the Balanced Budget Act of 1997. The 17-member Commission is tasked with advising the United States Congress on issues affecting the Medicare program, as well as analyzing other issues including access to care and quality of care. Its recommendations do not necessarily make it into regulations or law. In this report, MedPAC makes recommendations in three key areas that impact radiation oncology:

1) Medicare coverage policy and use of low-value care
2) Rebalancing Medicare’s physician fee schedule toward ambulatory evaluation and management services
3) Medicare accountable care organizations models: Recent performance and long-term issues

What follows is a summary of each of the three key areas and discussion regarding the impact on radiation oncology.

**Medicare coverage policy and use of low-value care**

The MedPAC report analyzes selected services including proton beam therapy (PBT), which the Commission deems “low value”. According to the report, these are services that “have little or no clinical benefit or care in which the risk of harm from the service outweighs the potential benefit.” In its analysis of PBT, the MedPAC report focuses on the use of PBT for the treatment of prostate cancer. It also summarizes the current coverage policies of several Medicare Administrative Contractors (MACs), as well as private payers, which demonstrate a great deal of variation in coverage across plans.

The Commission identifies six tools for Medicare to consider adopting to address the issue of low-value care:

1) Requiring prior authorization for certain types of services
2) Implementing clinician decision support and provider education
3) Altering beneficiary cost sharing
4) Establishing new payment models that foster delivery of system reform
5) Revisiting coverage determinations on an ongoing basis
6) Linking Fee-for-Service coverage and payment to clinical comparative effectiveness and cost-effectiveness information

While ASTRO agrees with efforts to address inappropriate utilization of services that do not benefit patient care, PBT is considered reasonable in instances where sparing the surrounding normal tissue cannot adequately be achieved with photon-based radiotherapy and is of added clinical benefit to the patient. Proton beam therapy is an effective, evidence based, treatment for a specific group of clinical indications such as ocular tumors, chordomas, chondrosarcomas,
primary or metastatic tumors of the spine, hepatocellular cancer, and malignant and benign primary CNS tumors just to name a few.

As for the tools that MedPAC recommends for addressing the use of low value services, ASTRO strongly urges the Commission to consider an alternative to prior authorization. In the experience of our members prior authorization has become an administrative burden that has led to unnecessary denials and an increase in administrative burden. Patient care is delayed while these reviews take place and denials are frequently overturned. The use of prior authorization is a low value tool for assessing appropriate utilization and should be avoided for ensuring appropriate coverage.

We appreciate the importance of implementing clinician decision support and provider education on the appropriate utilization of specific modalities of care. ASTRO urges MedPAC to consider the expertise of medical societies and other stakeholder groups when identifying resources for clinician education. As an example, the 2013 ASTRO Choosing Wisely initiative included “Don’t routinely recommend proton beam therapy for prostate cancer outside of a prospective clinical trial or registry” as one of five recommendations. Other resources include ASTRO guidelines, as well as NCCN guidelines that frequently address appropriate care pathways. Additionally, ASTRO publishes a distinct series of model policies to efficiently communicate correct coverage policies for radiation oncology services, including PBT. ASTRO’s PBT model policy was most recently updated in 2017.

ASTRO encourages the Commission to avoid changes in beneficiary cost sharing particularly for cancer care. Cancer patients can experience significant financial distress due to the expenses associated with cancer care. Financial toxicity has become a reality for many patients as the cost of their treatments grow and coverage for those treatments is diminished by restrictive payer coverage policies. Increased beneficiary cost sharing exacerbates this issue without really addressing the core problem.

ASTRO is supportive of the concept that establishes payment models to encourage the delivery of high value care. ASTRO has proposed a Radiation Oncology Alternative Payment Model (RO-APM) that would establish one payment regardless of modality of treatment chosen, so the physician is less incentivized by reimbursement based on the MPFS but more incentivized to provide the best possible care that meets or beats the predetermined target rate. These types of mechanisms are more effective for changing incentives and behavioral patterns rather than burdensome prior authorization processes which waste time and money.

Finally, the Commission recommends more frequent review and updates for National Coverage Determinations (NCDs) and linking coverage to clinical effectiveness. ASTRO supports more frequent review of NCDs and we reiterate the importance of stakeholder engagement and reliance on existing resources as described above. Linking coverage to clinical effectiveness has its merits, however we caution the Commission in the application of this concept to cancer care. True comparisons of different modalities of treatment can take years to complete, potentially

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slowing innovation and implementation of new technologies. These issues must be carefully considered.

**Rebalancing Medicare’s physician fee schedule toward ambulatory evaluation and management services**

MedPAC has long expressed concern regarding the fact that ambulatory evaluation and management (E&M) services, such as clinician office and hospital outpatient visits, are comparatively underpriced in the Medicare Physician Fee Schedule (MPFS). The Commission believes that continued underpricing of these services will lead to access to care issues as they potentially influence the pipeline of physicians considering careers in specialties which rely heavily on E&M codes.

The Commission recognizes that CMS has made efforts to address this issue through the misvalued codes review process; however, they are concerned that the process is insufficient because it takes several years to revalue a service. Additionally, the Commission believes that the CMS process is hampered by the lack of current, accurate and objective data on clinician work time and practice expenses. For these reasons, MedPAC remains concerned that some services continue to be overvalued. In an effort to address this issue, while maintaining MPFS budget neutrality, the Commission is recommending a one-time rebalancing of the fee schedule. The recommendation involves increasing payment rates for E&M services by 10 percent, which results in a reduction in payment rates for all other services by an average of 3.8 percent.

According to the report, the reduction to radiation oncology services would be 3.2 percent, which is a significant reduction in payment. MedPAC proposes that this could be implemented in a one-time reduction or phased in over multiple years. While ASTRO appreciates that cancer care often begins with diagnosis and imaging that take place in the primary care setting, which deserve adequate reimbursement, we believe the idea of rebalancing the MPFS by reducing reimbursement for cancer treatment is short sighted. A reduction in payment of this magnitude does not take into consideration the complexities associated with the delivery of radiation oncology, let alone the many factors involved with operating a radiation oncology clinic including the significant overhead expenses associated with the facility and the equipment required to deliver treatment. A cut of this magnitude has the potential to make practicing in radiation oncology financially unviable. MedPAC neglects to consider that such a cut would have similar access to care issues for cancer patients seeking radiation therapy treatment that they are trying to address for primary care and internal medicine.

**Medicare accountable care organizations models: Recent performance and long-term issues**

Medicare Accountable Care Organizations (ACOs) were developed to moderate the growth in Medicare spending and improve quality of care. There are five unique CMS ACO programs that share a common risk construct and are either one-sided risk or two-sided risk models. Asymmetric models, or one-sided risk models, provide opportunities for shared savings but do not hold participants responsible for losses. The Commission recognizes that two-sided risk models (those that have both upside and down side risk) save more money, however those
savings come at the risk of diminishing returns over time. Newer ACO concepts such as the Track 1+ ACO are demonstrating savings through an approach that applies a 50 percent savings rate and a 30 percent loss rate (i.e. participants split any savings with Medicare but are only responsible for 30 percent of losses – both earnings and losses are capped as a percentage of the benchmark). This type of model may ease transition to a full two-sided risk approach, however the Commission is concerned that this type of risk construct could cost CMS money.

In its report, MedPAC also expresses concern that “benchmarks” based on historical payment rates may not be an effective measure for cost savings. Of primary concern is the fact that ACOs must continuously improve over their past performance to achieve savings, this creates diminishing returns and potentially discourages participation in the ACO program.

Finally, the report also discusses the Merit Based Incentive Program (MIPS) and reiterates MedPACs recommendation that MIPS be replaced with a voluntary value program that will encourage physicians to be measured for cost and quality measures as a way of transitioning them to Advanced Alternative Payment Models (A-APMs) in the future. The Commission questions whether the qualified A-APM participant (QP) payment and patient thresholds are necessary for clinicians to receive the 5 percent bonus on all MPFS payments. The Commission suggests that application of the 5 percent bonus on MPFS payments derived from an A-APM will make the incentive more equitable and encourage greater physician participation.

ASTRO is in agreement with the recommendation to remove the A-APM threshold requirement and to apply the A-APM bonus to those payments derived from an A-APM. Not only would it encourage greater physician participation, but it would also allow physicians to determine which services are most appropriate for an A-APM. This would make the program more flexible and it would also remove the uncertainty of meeting the threshold requirements and reduce administrative burden associated with tracking patients and payments tied to the A-APM.