Congress of the United States
Washington, DC 20515

October 20, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
200 Independence Ave SW
Washington, DC 20201

Dear Administrator Brooks-LaSure-

We write today in support of our nation's radiation oncology treatment teams that provide patients access to high-quality cancer care in community-based centers and hospitals across the country. Radiation oncology has been resilient throughout the COVID-19 pandemic, providing safe and effective treatments to patients. The field of radiation oncology boasts an impressive combination of skilled clinicians and state-of-the art technologies that have made great progress in the fight against cancer.

Therefore, we are concerned about the combined impact of two recent Medicare proposals which would result in reduced Medicare payments to critical radiation therapy cancer treatment services by an estimated $300 million annually. These cuts would threaten the ability of patients, particularly underserved populations, to receive state-of-the-art care close to home. We urge the Centers for Medicare and Medicaid Services (CMS) to avoid these significant payment cuts to radiation oncology before finalizing the Medicare physician fee schedule (PFS) and the parameters of the Radiation Oncology Alternative Payment Model (RO Model).

On July 13, CMS proposed changes to the Calendar Year 2022 Medicare physician fee schedule that would reduce radiation oncology payments by an estimated 8.75 percent, or approximately $140 million in 2022. This includes the expiration of the 3.75 percent conversion factor increase from the Consolidated Appropriations Act of 2021. The reductions stem from proposed updates to clinical labor pricing and lead to lower payments for the life-saving advanced technology used by radiation oncologists to treat cancer. Radiation oncology, along with a few other specialties, are bearing the brunt of this approximately $3.5 billion shift in fee schedule payments.

According to an analysis commissioned by the American Society for Radiation Oncology (ASTRO), if finalized, these cuts will culminate in a 25 percent decline in radiation oncology payments under the physician fee schedule since 2012. This is a significant decrease for any specialty, but particularly for one with such high practice costs. The proposed cuts for 2022 follow an average of 8 percent reduction in revenues for radiation oncology clinics in 2020 due to COVID-19 according to the American Medical Association. Emerging from COVID-19, radiation oncologists are struggling to treat patients that missed screenings and now require more complex treatments for more advanced cancers. The burden of these reductions will fall hardest on those clinics that serve rural and underserved patients, threatening to further exacerbate

disparities in care. We ask that the Administration work with stakeholders to address various issues with the clinical labor payment policy, including inadequate valuation of radiation therapy medical physicists.

We are also concerned that CMS's proposed parameters under the RO Model still do not adequately address the impact on access to care, and that proposed payment cuts to hospitals and community-based clinics, which would reduce payments to mandated participants by an estimated $160 million over 5 years, could limit the model's effectiveness. Concerns about the model's impact on patients led Congress to delay the model's start until January 1, 2022 so the Administration could work with the radiation oncology community to address model shortcomings, including the discount factor cuts and administrative burdens that risk hurting quality. While CMS reduced the discount factors slightly in the revision issued July 20, we are disappointed that agency did not go further to conform with prior Congressional requests. In fact, the fee schedule cuts discussed above flow into the model and have a cumulative impact on model participants, undermining one of the main goals of the model: payment stability for RO providers. We urge the Administration to reduce the discount factors to no more than 3 percent and address the burdensome data collection and reporting requirements under the model.

In a recent piece for *Health Affairs*, you emphasized the importance of using the Innovation Center to advance health equity, and iterated CMS's commitment to prioritize equity and "embed equity in every aspect of [the Innovation Center's] models."[1] We strongly agree with this laudable goal. However, we are concerned, that some of the parameters in the RO model may end up exacerbating disparities for minority and rural patients, who often face greater barriers to accessing and completing their radiation treatments.

We were disappointed that the revised RO Model did not address recommendations from the radiation oncology community on ways to invest in wraparound services to help underserved populations via innovative data collection and quality measure reporting. Rather than require radiation oncology practices to collect quality measure reporting data that has a limited impact on the quality of care delivered during the episode, practices should have the opportunity to proactively identify at-risk patient populations and intervene with the provision of wraparound services designed to help patients successfully access and complete radiation treatments.

To that end, ASTRO has developed and proposed a Health Equity Achievement in Radiation Therapy (HEART) score for each Medicare fee-for-service beneficiary who seeks treatment at an RO Model participant facility. The HEART score, similar to an ECOG Performance Status scoring system, would establish standard criteria for measuring whether the patient is at high risk for experiencing health care disparities during their course of radiation therapy treatment and follow up. A HEART score that meets a specific threshold would trigger a HEART payment modifier that will be appended to the Start of Episode claim, generating an additional payment for wraparound services to address health care disparities that are currently not billable. These services could include, among other things, providing nutrition, transportation, housing, and financial support for patients. This would help improve patient quality of life, lower overall

[1] https://www.healthaffairs.org/do/10.1377/hblog20210812.211558/full/

health care costs, and address many social determinants of health factors that contribute to health disparities but are not included as traditionally covered Medicare services.

By collecting data on which RO care episodes have a HEART payment, the RO Model could be used to test the effectiveness of interventions to close health disparities and help guide future intervention and coverage design. Unfortunately, the continued cuts and inability to support these critical services represent a missed opportunity to reduce health disparities and ensure cancer patients can access high-value radiation treatments.

Furthermore, the impact of the COVID-19 pandemic on radiation oncology providers and the patients they treat has been significant. In a recent survey, 66 percent of radiation oncologists said new patients were presenting with more advanced-stage cancers. In the same survey, 73 percent of physicians said patients in their practices were not receiving cancer screenings, and 66 percent also said existing patients experienced an interruption in their radiation treatments due to the pandemic.

Like you, we remain committed to an alternative payment model for radiation therapy services that improves quality, stabilizes reimbursement, and reduces disparities, but we are concerned that these severe cuts create instability and undermine the transition to value-based payment. We look forward to working with you to ensure Medicare beneficiaries have access to these life-saving cancer treatment services.

Sincerely,

Brian Higgins
Member of Congress

Brian Fitzpatrick
Member of Congress

Angie Craig
Member of Congress

Rodney Davis
Member of Congress

David B. McKinley P.E.
Member of Congress

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