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Hearing titled, “MACRA and Alternative Payment Models:

Developing Options for Value-based Care”

Testimony of:

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The American Society for Radiation Oncology (ASTRO) represents more than 10,000 people who strive to give cancer patients the best possible care and to advance the science of oncology.

ASTRO's membership includes radiation oncologists, nurses, cancer biologists, medical physicists, and other health care professionals who specialize in treating patients with radiation therapy. ASTRO's members work in various clinical settings including hospitals, freestanding community-based radiation oncology centers, and academic research institutes. Together, they make up the radiation therapy treatment teams that are critical in the fight against cancer. Of the estimated 1.7 million people diagnosed with cancer each year, ASTRO's medical professionals will treat more than one million of them, as close to 60 percent of all cancer patients will receive some form of radiation therapy as part of their treatment program. As the leading organization in radiation oncology, ASTRO is dedicated to improving patient care through professional education and training, support for clinical practice and health policy standards, the advancement of research, and advocacy.

### **Radiation Therapy**

Radiation therapy, or radiotherapy, is the use of ionizing radiation to treat cancer and certain other diseases. Radiation therapy is proven to be safe and effective across a broad spectrum of cancer types. Radiation therapy works by disrupting the genetic material that drives cancer cells to grow and spread. When these damaged cancer cells die, the body's natural healing processes remove them. Normal tissues are also affected by radiation, but they are able to repair themselves in ways that cancer cells cannot. Radiation therapy has many benefits, including allowing patients to maintain their quality of life during treatment. Almost

all radiation therapy treatments are delivered as out-patient procedures; thus, patients receive treatment without the need to be hospitalized.

Modern cancer care requires the coordination of multiple cancer disciplines and specialists who contribute to the overall care and well-being of the patient. For each patient, radiation oncologists develop and operationalize a multi-step, customized plan to deliver the radiation therapy exclusively to the tumor-bearing area while protecting the surrounding normal tissue to the maximum extent possible. Radiation therapy can be delivered in numerous ways: externally, internally, and through surface application. During external beam radiation therapy, the radiation oncology team uses a machine to direct high-energy x-rays or particle beams toward the cancer. Internal or surface radiation therapy, also called “brachytherapy,” involves placing radioactive material (i.e., radioactive seeds) inside the patient or on the surface of their body. Depending on patient-specific considerations, the total radiation dose prescribed for the patient may be given in one session or over the course of multiple sessions. Systemic therapies, such as chemotherapy or immunotherapy, are often strategically combined with radiation therapy to provide synergistic benefits for patients with certain types of cancer. Radiation therapy is used in some cases as the only modality directed locally to the tumor, and in other cases it is given pre- or post- surgery to maximize the chance of the complete eradication of a primary tumor.

### **Access to Radiation Oncology Care**

ASTRO is committed to always putting patients first and believes that moving away from fee-for-service to value-based health care will help patients and drive greater value in cancer care. The Society applauded the repeal of the Sustainable Growth Rate (SGR), which created

years of instability and uncertainty in health care, and supported the development of a new value-based Medicare physician payment system in the Medicare Access and CHIP Reauthorization Act (MACRA).

Radiation oncology centers differ from most other specialty centers in that they have extremely high fixed costs. The minimum total capital required to build a freestanding radiation oncology center is approximately \$5.5 million. These facilities require an additional minimum \$2 million in annual operating and personnel expenses. A linear accelerator is the primary machine used to provide radiation treatment, and it stands about nine feet tall and 15 feet long and weighs more than nine tons. The machine must be housed in a specially shielded room with thick concrete walls. As a result, it requires millions of dollars to install the basic machinery before the first patient exam room is even added. This substantial upfront capital investment, combined with required machine maintenance contracts and salaries for highly skilled technical staff, means that fixed costs in radiation oncology are significant. About 60 percent of patients treated with radiation therapy receive care in hospital outpatient departments, and the other 40 percent receive care in freestanding community-based centers. Radiation oncology reimbursement rates have sustained significant cuts in recent years, resulting in cumulative payment reductions totaling approximately 20 percent for freestanding community-based radiation oncology centers. The payment cuts created immense instability throughout the field, jeopardizing the continued viability of these centers and patient access to the high-level care the centers provide.

The onslaught of recent reimbursement reductions and future uncertainty is putting the profession at risk. ASTRO urges Congress to prevent any additional Medicare payment cuts to

community-based radiation oncology centers and preserve access to these critical services for the more than 400,000 cancer patients who are treated annually in community-based centers.

### **Patient Access and Medicare Protection Act (PAMPA)**

ASTRO and the radiation oncology community remain extremely grateful for the bipartisan, unanimous passage of the Patient Access and Medicare Protection Act of 2015 (PAMPA), which temporarily halted cuts to Medicare payments for radiation oncology through the end of 2018. PAMPA created a more stable environment for ASTRO to work with the Centers for Medicare and Medicaid Services (CMS) on an alternative payment model (APM) and valuation issues involving key radiation treatment delivery and image guidance codes. However, it is not a permanent solution, and time is running out. Fortunately, MACRA has provided the radiation oncology specialty with an exciting opportunity to pursue an APM that could achieve the goal of incentivizing high-quality, high-value care while also offering a long-term solution to this instability. ASTRO has used the temporary stability provided by the payment freeze in PAMPA to enthusiastically pursue a Radiation Oncology Alternative Payment Model (RO-APM). It is critical that radiation oncologists have an opportunity to participate in an APM to realize the goals of MACRA.

PAMPA also included a mandate for the Center for Medicare & Medicaid Innovation (CMMI) to research and develop a report on an alternative payment model for radiation oncology. On November 3, 2017, CMMI released their report to Congress, “Episodic Alternative Payment Model for Radiation Therapy Services.” The CMMI report outlined important payment model design considerations for implementing an Advanced APM in radiation oncology. The report describes the delivery of radiation therapy services, why Medicare beneficiaries may

need radiation therapy services, and how Medicare pays for these services. The report also described several APM design considerations: the rationale for such a model, expectations of clinical practice transformation, the potential scale and alignment with other initiatives, and the measurement of improved clinical quality and patient experience. The report also noted that the model could address many of the challenges with the current payment systems and that it has the potential to provide stability in radiation therapy payments.

ASTRO appreciates that the CMMI report identifies the key model design elements and provides a viable path forward to ensure the field of radiation oncology can be at the forefront of efforts to improve the patient experience, elevate treatment quality, and lower overall costs for cancer patients. ASTRO was pleased that the report aligned with the ASTRO-proposed RO-APM. We believe the RO-APM will incentivize the appropriate use of cancer treatments that result in the highest quality of care and best patient outcomes. In addition to the enhanced patient experience, ASTRO supports the sentiments expressed in the report aimed at providing stability in radiation therapy payments by creating the RO-APM to address the unique needs of the profession.

### **Radiation Oncology Alternative Payment Model (RO-APM)**

Currently, there is only one oncology-focused model in the Advanced APM portfolio: the Oncology Care Model (OCM). While the OCM is a step in the right direction, there is a risk that it could inadvertently discourage optimal multidisciplinary care coordination. The OCM's potential unintended consequence is to incentivize an overly minimalist approach. As a result, practices may be rewarded for excluding certain therapies, including radiation therapy, within each six-month episode of care. ASTRO believes that the RO-APM will complement and build

upon the foundation set forth by the OCM and encourage the interdisciplinary coordination of care for cancer patients' overall well-being.

ASTRO embraces the spirit and goals of MACRA and is committed to ensuring that radiation oncology can fully participate in an APM that drives greater value in cancer care. ASTRO has been working with stakeholders to develop the RO-APM in a form consistent with the goals of MACRA. The Society believes the recent report from CMMI validates the collaborative process and diligent efforts that were undertaken to construct the RO-APM.

The RO-APM would provide the field of radiation oncology with a meaningful and viable opportunity to participate in the evolving world of health care payment reform as initiated by MACRA. The model has three primary goals:

1. To reward radiation oncologists for participation and performance in quality initiatives that improve the value of health care for patients.
2. To ensure fair, predictable payment for the radiation oncologist in both hospital and freestanding community-based cancer centers to protect cancer patients' access to care in all settings.
3. To incentivize the appropriate use of cancer treatments that result in the highest quality of care and best patient outcomes.

Stakeholders involved in the development of the RO-APM include leading members of the radiation oncology community who practice in hospital and/or freestanding community-based radiation oncology centers. In addition to engaging key stakeholders, ASTRO has closely monitored the activities of the Physician-Focused Payment Model Technical Advisory Committee (PTAC). ASTRO also met with the CMS Innovation Center on multiple occasions to

solicit advice and guidance from agency experts regarding the development of Advanced APMs. It is ASTRO's goal to provide stability to the delivery of radiation therapy for patients, and the radiation oncologists who treat them, by attaining implementation of the RO-APM before January 1, 2019.

The American Cancer Society estimates there were 1.7 million new cancer cases in 2016. Among these cancer patients, 250,000 were diagnosed with breast cancer; 225,000 were diagnosed with lung cancer; 181,000 were diagnosed with prostate cancer; 95,000 were diagnosed with colorectal cancer; and 72,100 were diagnosed with head and neck cancer. Medicare SEER data analysis indicates that, of the Medicare patients receiving radiation therapy, 83 percent had one of the five primary disease sites, accounting for 93 percent of the total Medicare spend on radiation therapy services between 2007 and 2012.

The RO-APM applies to the five primary disease sites: breast, lung, prostate, colorectal, and head and neck. Individual disease sites are not divided further for the purposes of payment (e.g., all breast cancer cases have the same modeled payment). The model also applies to two secondary disease sites: bone metastases and brain metastases. The primary disease sites usually involve curative treatment, while the secondary disease sites typically involve symptom-relieving palliative intent. The RO-APM replaces fee-for-service payment with an episode-based payment that remains the same regardless of the course, modality, or length of treatment. Through this structure, the RO-APM meets the goal of replacing volume-based care with value-based patient care. With many hurdles along the way, ASTRO believes that technical assistance from PTAC, and data sharing from CMS, would be beneficial for all organizations looking to create an APM, as access to CMS data was critical in creating the RO-APM.



According to the RO-APM, when a patient has an International Classification of Diseases (ICD-10) diagnosis code corresponding to one of the seven disease sites included in the model, eligibility is established. After the patient gives informed consent to be treated with radiation therapy, an episode is triggered by one of three distinct radiation therapy treatment planning codes: Current Procedural Terminology (CPT) codes 77261, 77262, or 77263. The episode of care begins at this time and concludes 90 days after the last radiation therapy treatment. Throughout the episode, participating physicians must adhere to well-vetted clinical practice guidelines, including ASTRO guidelines, where applicable, and the National Comprehensive Cancer Network (NCCN) guidelines. ASTRO believes that the requirement for guideline adherence is a major strength of the RO-APM. These guidelines help to ensure that patient care is appropriate and of the highest quality without over- or under-treating patients who need radiation therapy.

Medicare claims data from a specific reference period will be used to determine payments per episode within a disease site. A participating provider's target rate will be based on a blended average of his or her own practice's historical reimbursement rate, along with regional and national benchmark rates for the same episode of care. The provider will be paid a portion of the target rate once an episode is triggered and a portion of the target rate at the completion of the episode. The model features a two-sided risk corridor, in which a provider may share in savings if spending is lower than the target. However, providers who exceed the target would be responsible for any overpayment up to a specific amount. These tenets are part of the built-in guardrails to ensure that appropriate care is being provided throughout the treatment delivery process.

The quality component of the RO-APM is comprehensive. It begins with a patient engagement component that involves shared decision making, nurse care management, care plan development, specialty care communication, and survivorship planning. ASTRO has established the Accreditation Program for Excellence (APEX), and to achieve APEX certification requires meeting or exceeding a series of standards relating to the quality performance of a radiation oncology practice. To be recognized for the highest level of quality in the RO-APM, APEX accreditation or accreditation through a similarly rigorous program is necessary. Additional quality measures based on guidelines that are disease-site-specific will be layered on top of accreditation. The purpose of these quality measures is to track how frequently participating practices are adhering to the specific guidelines identified as part of the model. Adherence to clinical guidelines can improve the quality, outcomes and cost effectiveness of health care. After a pay-for-reporting period to establish a benchmark for quality data, a pay-for-performance mechanism will be implemented. This mechanism will modify payment in future years based on quality performance. Similar to the Bundled Payments for Care Improvement (BPCI) model, the base rate discount will be modified in future years based on quality measures' performance in a prior year.

We believe the RO-APM is consistent with Advanced APM characteristics stated in the Quality Payment Program (QPP). We are further encouraged by the recent CMMI report to Congress endorsing that physicians should assume accountability for controlling the total cost of Medicare spending related to the treatment of cancer with radiation therapy, as well as the total cost of Medicare spending on all services the patient receives during the episode of care.

## Conclusion

ASTRO appreciates Congress' longstanding strong support of radiation oncology, which has contributed substantially to better cancer outcomes while protecting access to care. The Society has devoted significant resources to the development of the RO-APM and is committed to ensuring that radiation oncology can meaningfully and fully participate in Advanced APMs to drive greater value in cancer care. ASTRO believes that the RO-APM:

- Incentivizes the use of appropriate cancer treatments that produce the highest quality and best outcomes.
- Helps physicians assume accountability for controlling the total cost of Medicare spending related to cancer during the episode of care.
- Can stand on its own or dovetail with other oncology alternative payment models.
- Requires adherence to nationally recognized clinical guidelines.
- Contains patient engagement components including shared decision-making, nurse care management, care plan development, specialty care communication, and survivorship planning.

After experiencing significant payment cuts under Medicare fee-for-service in recent years, the field of radiation oncology needs long-term payment stability and predictability to secure patient access to care. It is critical that there is an Advanced APM option available to radiation oncologists before the PAMPA payment freeze expires December 31, 2018. ASTRO believes the RO-APM is a smarter way to pay for radiation oncology services and will lead to better value for Medicare and patients. ASTRO looks forward to continued opportunities to work with Congress and CMMI to refine and implement this model.