April 6, 2021

VIA ELECTRONIC MAIL

Elizabeth Fowler, J.D., Ph. D,
Director, Center for Medicare and Medicaid Innovation
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD, 21244

Re: Center for Medicare and Medicaid Innovation Radiation Oncology Model

Dear Director Fowler:

The Health Care Transformation Task Force (HCTTF or Task Force) thanks the Center for Medicare and Medicaid Innovation (CMMI) for the ongoing efforts to drive health care payment reforms and regular engagement with the Task Force on issues of model design and implementation. The Task Force supports CMMI's mission to reform the health care system and is submitting the following feedback in hopes of addressing HCTTF member concerns with the design of the Radiation Oncology (RO) model.

The Task Force is a consortium of nearly 40 private sector stakeholders that support accelerating the pace of transforming the delivery system into one that better pays for value. Representing a diverse set of organizations from various segments of the industry – including providers, health plans, employers, and consumers – we share a common commitment to transform our respective businesses and clinical models to deliver better health and better care at reduced costs. We strive to provide a critical mass of policy, operational, and technical support that, when combined with the work being done by the Centers for Medicare and Medicaid Service (CMS) and other public and private stakeholders, can increase the momentum of delivery system transformation.

We appreciate that CMS is committed to designing more Advanced Alternative Payment Models (Advanced APMs) that provide opportunities to specialists who currently have few options to participate in value-based payment models. HCTTF applauds CMS for acknowledging this issue and working to create openings for specialists to become Qualifying APM Participants (QPs).

The Task Force believes that episode-based payment models can promote high-quality, high-value and transparent care for Medicare beneficiaries and can encourage greater coordination among providers. HCTTF regularly provides CMS with constructive feedback regarding APMs, including a recent communication providing suggested design considerations

for mandatory models.[1,2,3] Our comments offered herein reflect a desire to communicate concerns about the design of the RO model raised by our members with the goal of increasing the probability of successfully accomplishing the core goals of incentivizing high quality and cost-efficient cancer care.

I. General Feedback

In September of 2019, the Task Force submitted comments in response to CMS proposed rule CMS-5527-P (Proposed Rule) titled *Specialty Care Models To Improve Quality of Care and Reduce Expenditures*. In that letter, HCTTF offered comments related to the RO model and the design and implementation of mandatory models more generally. Chief among these recommendations was the importance of CMS including stakeholders in the design of mandatory models through meaningful engagement opportunities throughout the process. We continue to believe that transparency, simplicity, and advanced notice of required participation are critical for smooth and efficient model implementation and success. We also encouraged CMS to ensure that models acknowledge the efforts of early adopters and practices that are already actively working to implement care delivery and efficiency reforms that align with CMS model goals and to incorporate opt-out and graduated risk options for small and low volume providers that are inexperienced with APMs. Finally, we requested that CMS evaluate the impacts of mandatory model overlaps with existing voluntary models and the potential to add unintended complexity and fragmentation.

We note that several of the key points raised by the Task Force and other organizations were not addressed in the final rule CMS-5527-F (Final Rule). Consequently, many stakeholders have come to view the RO model as primarily a rate reduction effort rather than a sincere attempt to reform care delivery in a manner that promotes the use of appropriate clinical pathways with a focus on improving quality. Given that the RO model rollout has been delayed, we take this opportunity to highlight some areas of ongoing concern in hopes that CMMI will take the additional time afforded by this delay to consider addressing these issues with the model design.

A. Pricing methodology

HCTTF appreciated the Final Rule's 0.25 percent reductions to the initially proposed professional and technical component discounts, however, we remain concerned about the potential impacts of the RO model pricing methodology. Specifically, the proposed discount factor on participant-specific payment amounts (3.75 percent for the professional component and 4.75 percent for the technical component) when combined with the upfront withholds is likely to negatively impact the financial stability of RO participants and adversely impact their

[1] https://hcttf.org/2015-9-23-task-force-consensus-comments-to-cms-regarding-proposed-comprehensive-care-for-joint-replacement-ccjr-program-pdf/
[2] https://hcttf.org/2017-10-18-task-force-provides-comments-to-cms-regarding-epm-cancellation-and-cjr-modifications/
[3] https://hcttf.org/recommendations-mandatory-models/

ability to improve efficiency and provide high-quality care to Medicare beneficiaries. This risk is particularly high for providers practicing in rural and low resource communities. Furthermore, the use of historical experience adjustments functionally penalizes providers who are currently delivering efficient care which is in line with the stated goals of the RO model.

We encourage CMS to: 1) reevaluate the downside-only design of the discount and withhold process and consider incorporating upside incentives for improving quality and efficiency, 2) incorporate a glide path structure that allows providers with less APM experience to accept increasing risk over time, and 3) evaluate the potential adverse impacts on historically efficient providers and providers serving under resourced communities to ensure that access to care is not adversely impacted under the model. While the Task Force is not offering a specific discount amount recommendation, several other organizations have proposed more favorable discount amounts that we encourage CMS to consider. Furthermore, there is mounting evidence that the COVID-19 pandemic has resulted in many patients delaying care and presenting with more advanced stage disease. Consequently, we believe it would be prudent for CMMI to establish a COVID-19 adjustment to account for this increased patient complexity. This includes consideration for how pandemic related reductions in revenue and patient volume will impact the Case Mix Adjustment if or when 2020 is included in the rolling three-year average.

B. Coordination between separate episode components

CMS has proposed to trigger an episode only if a technical participant or dual participant furnishes the technical component (TC) to an RO beneficiary within 28 days of when a Professional participant or Dual participant furnishes the professional component (PC) to such RO beneficiary. HCTTF members have expressed concern regarding the impact of the model on the use of guideline concordant, multi-modality treatments in situations where multiple physicians or sites of service are involved in a patient's treatment. The treatment of cervical cancer, where a patient may receive external beam treatment at a freestanding setting and then be referred to a hospital-based practice for brachytherapy, has been flagged as an example of this issue. In this example, guideline concordant, multi-modality treatment is disincentivized in the RO Model due to both the potential for undervaluing guideline concordant care in the National Base Rate and because the PC and TC associated with the brachytherapy will be paid FFS and then deducted from the RO Participant's Payment Withhold during reconciliation. While CMS states that it will not deduct an amount greater than the episode payment, there is no parameter in place that ensures that proper payment is made for guideline concordant care delivered by the RO Model participant. **We continue to believe that CMS should offer a solution to support improved coordination and the delivery of guideline concordant care, including sharing claims data as close to real-time as possible to ensure that proper payment is made for the services delivered**.

C. Quality measures and withhold

The Task Force supports CMS's efforts to identify and test metrics that measure performance improvement and patient experience. However, the 1 percent quality withhold applicable to professional participants requires reporting on clinical data elements (CDEs) for 95 percent of all patients with one of five cancer types (prostate, breast, lung, bone metastases, and brain metastases) that are not currently captured in structured fields by all major electronic health record vendors. Furthermore, CMS has structured this as a pass/fail measure to earn back the quality withhold but has not established any clinical or payment-related rationale to support the collection of this patient-identifiable data. CMS stated that this data collection is required to support the development of future quality measures, yet CMS has collected CDEs for years under the OCM model with little transparency regarding how that data in informing measure development. The collection and reporting of this data are time consuming and costly for providers so CDE collection under the RO Model should at a minimum be used for risk adjustment, as it is used in administering OCM. **Therefore, we do not believe CMS should mandate that participants report this data because it will impose a redundant reporting burden and expense for participants to extract this data without any reasonably justified CMS need for the data.**

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We appreciate CMMI's ongoing receptivity to Task Force feedback. As noted above, the Task Force is concerned about the lack of transparency regarding mandatory model participants and the ability to ensure the delivery of appropriate clinical care and patient safety under the RO model. We reiterate our desire to offer ongoing support to CMMI efforts to implement successful APMs and hope you consider the feedback on the identified issues. Please contact HCTTF Executive Director Jeff Micklos (jeff.micklos@hcttf.org or 202.774.1415) with questions related to this statement.

Sincerely,

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