June 7, 2022

VIA ELECTRONIC SUBMISSION THROUGH www.regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5527-P2
P.O. Box 8013
Baltimore, MD 21244-8013

Dear Administrator Brooks-LaSure,

On behalf of The US Oncology Network ("The Network"), one of the nation's largest and most innovative networks of community-based oncology physicians, treating over a million cancer patients annually in more than 450 locations across 25 states, thank you for the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposal to indefinitely delay the Radiation Oncology (RO) Model (CMS-5527-P2).

The Network has long been a strong proponent of and leader in value-based care. This leadership is demonstrated by the more than 900 Network physicians voluntarily participating in the Oncology Care Model (OCM) through the Center for Medicare and Medicaid Innovation (CMMI), who are successfully bending the cost curve in oncology, achieving nearly $250 million in savings to the Medicare program. With OCM set to sunset at the end of this month, we look forward to learning more about CMMI's plans for a future oncology model.

The Network has also strongly supported the development of an alternative payment model (APM) to improve quality and provide payment stability in radiation oncology. Beginning with the May 2017 CMMI listening session on the development of the report to Congress on an APM for radiation therapy (RT) services, The Network has actively provided feedback to CMS on the development of the RO Model. We are disappointed that CMS ultimately decided not to incorporate feedback from the stakeholder community and is, instead, proposing to indefinitely delay the model. The Network believes the conditions that created the impetus for an APM in radiation oncology still exist and we remain committed to working with CMS to identify solutions to advance meaningful practice transformation while maintaining patient access to high-quality, affordable care in the most efficient setting.

One aspect of the RO Model we were highly anticipating was the implementation of site neutral payments for RT services. Existing payment policies are driving higher reimbursement in the hospital outpatient department (HOPD) setting for the exact same services provided in the physician office (PO) setting. This payment disparity increases costs to Medicare beneficiaries and the Medicare program and contributes to the growing trend of consolidation in community oncology. As recently as 2017, HOPDs paid under the Hospital Outpatient Prospective Payment System (HOPPS) received 17 percent higher payments for the same RT services provided by freestanding radiation practices paid on the Physician Fee Schedule. Today, in 2022, that disparity has grown to a 36 percent higher reimbursement for RT services provided in the HOPD setting in comparison to the PO setting. According to the Congressional Budget Office (CBO), this trend will only grow. In its March 2020 baseline, CBO projected OPPS payments would grow by 100 percent over the next decade; by comparison, PFS payments are only expected to grow by 28

percent. In fact, physician payments are frozen under current law and subject to the 2% Medicare sequester. This payment disparity is simply unsustainable and will only encourage further consolidation into the more expensive HOPD setting.

That said, the other design elements of the RO Model would have placed tremendous financial and operational burden on freestanding radiation practices. The Network, along with other stakeholders in the RO community, had advocated for a model that would provide payment stability and enable long-term practice transformation. The Network has also emphasized the need for payment stability due to the fixed-cost nature of the RO business, cautioning that significant payment variability makes it difficult for practices to make necessary investments in new technology. Unfortunately, the RO Model's discount factor, undervalued base rates, withholds, adjustments, and waiver of the 5 percent APM incentive payment on technical component services would result in a payment reduction to practices well beyond the Medicare Access and CHIP Reauthorization Act nominal risk requirement and the discounts seen in other Advanced APMs. This payment cut is exacerbated by the trend factor, which ensures that practices required to participate in the RO Model are still subject to fluctuations in the PFS.

The RO Model is also unnecessarily complex, creating operational burdens for participants and taking time and resources away from patients. For example, The Network has practices with multiple locations, where some sites are located in ZIP codes selected for participation and others are not, creating complications in workflows and billing. In another example, the current Clinical Data Element collection requirement is manual and time consuming; a lower threshold and ramp-up period would give the electronic health record technology vendors time to leverage forthcoming technical mandates around healthcare data standardization that will provide a streamlined method to capture and report the data.

The Network encourages CMS to revisit a potential value-based care model for RO. A voluntary model developed in close collaboration with the stakeholder community that incentivizes practice transformation and focuses on improved patient care can still result in meaningful savings. Our experience in standing up value-based care models in both Medicare and in commercial plans has taught us that there is typically significant investment required in software and staff training. A voluntary model could be phased-in and iterative to allow the most sophisticated practices to test the model before expanding it to practices that may have less resources. In this manner, innovation can drive cost savings without sacrificing patient access.

Two-way dialogue and transparency between CMS and interested practices is also crucial to model success. A primary shortcoming of the RO Model was the lack of communication between CMS and participating practices. Even though the model was set to start within weeks, CMS had yet to provide claims data, detailed billing guidance, or critical pieces of the model's financial methodology to participants, making it impossible for practices to fully prepare for implementation and creating tremendous uncertainty.

Open communication also allows for the sharing of best practices which would ultimately help any model succeed. Several Network practices have entered into value-based care arrangements with commercial payers and are seeing mutual benefits for patients, the practice, and the payers. For example, New York Oncology Hematology (NYOH) has had a successful arrangement with a commercial payer and breast cancer patients in the payer's Medicare Advantage, Medicaid Managed Care, and Health Exchange plans in place since 2016. NYOH's experience in this more targeted contract paved the way for a larger arrangement with a regional payer focused on modality-based episodes of care. The latter contract features a single copay per episode for patients as well as removal of prior authorization requirements

which improved patient and physician satisfaction. Preparation, including communication between practice stakeholders and financial projections, as well as regular communication between the practice and the payer were key to this contract's success.

The Network remains committed to the pursuit of value-based care in oncology and we offer our expertise to CMS to help achieve its vision of promoting high quality cancer care and improving outcomes for Medicare beneficiaries while reducing costs. We welcome the opportunity to discuss the issues outlined above and other critical issues impacting community cancer care with you and your staff. Should you have any questions, please contact Ben Jones, Vice President of Government Relations and Public Policy, at Ben.Jones@usoncology.com.

Sincerely,

Vivek S. Kavadi, MD, MBA, FASTRO
Chief Radiation Oncology Officer
The US Oncology Network