American Hospital Association™
Advancing Health in America

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June 6, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: CMS–5527–P2: Radiation Oncology Model Proposed Rule (Vol. 87, No. 68), April 8, 2022.

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Radiation Oncology (RO) Model proposed rule.

The AHA strongly supports CMS' efforts to transform the delivery of cancer care. We also support the original intent of the RO Model, which was to protect access to care by ensuring fair, predictable payment for radiation oncologists. However, this important goal of the original RO Model has been marred by the incorporation of significant payment cuts and substantial administrative burdens for those participating in this mandatory model. **As such, the AHA supports CMS's proposal to delay the start date of the RO model from Jan. 1, 2023 to a date to be determined through future rulemaking.**

The AHA, in the past, has recommended certain modifications to the RO model, including adopting a risk versus reward equation that is much more appropriately balanced. These changes, which are summarized below, remain outstanding; should the agency move forward with an RO or similar model in the future, we urge it to consider their incorporation. It would be difficult for us to support a model — particularly a mandatory model — absent these critical modifications.

Discount Factor. The RO Model included discount factors of 3.5% for the professional component (PC) and 4.5% for the technical component (TC). The amount and application of these discount amounts, and the uneven playing field they created both within the model and between participants and those excluded from the model, was extremely concerning to us — as well as others. Indeed, CMS notes in this proposed rule that *not one commenter* agreed with its discounts of 3.5% and 4.5%. Their size was particularly concerning given that they are the largest CMS has ever set forth in any bundled payment model and that the agency built in significant additional savings for itself through the withholds, immediate down-side risk and mandatory nature of the model. **We also remain extremely puzzled as to why the TC discount factor was higher than the PC discount factor.** This was quite concerning to us given that hospital TC providers have little ability to impact the treatment plan/episode cost and make all the capital investments for radiation therapy. Yet at the same time, they could not earn a 5% advanced APM bonus under the Quality Payment Program through participation in this model, unlike PC providers. **We continue to believe that lower TC and PC discounts at 3% or less are much more appropriate and would help ensure all patients retain access to radiation therapy services.**

Stop-loss Policy. CMS's stop-loss policy was also of concern because it applied only to participants with 60 or fewer episodes during the baseline period. We do not understand this limitation — the number of episodes a participant performs is unrelated to case complexity, for which stop-loss policies are designed to account. We are worried that under this policy, outlier patients could have lost access to services either at their home facility or at highly specialized locations to which they travel for care. **As such, we urge CMS to apply future stop-loss policies to all participants.**

Included Cancer Types. We believe that with 15 included cancer types, the model was too broad for a mandatory program. Hospitals and health systems are at many different points along the transition to value. To succeed in the RO model, they would have to make significant changes to the care processes and policies they have built around current regulatory payment structures. As discussed above, with the reimbursement cuts that would result from the discount factors and other design elements in this model, some may not have had funds left for investments of this magnitude. We therefore urge CMS to, in the future, include only cancers for which there is strong clinical evidence for a range of treatment alternatives, such as prostate, breast and lung cancers.

Quality and Clinical Data Reporting. The RO Model's quality measures, as well as the burden of reporting they would have presented, were also of concern to us. We continue to encourage CMS to use only measures endorsed by the NQF. We also urge the agency to consider using a pay-for-reporting approach in the first year of any model, before transitioning to a performance-based calculation. In addition, we note that the requirement in this model to report basic clinical information that is not available in claims or captured in the four quality measures would have created a significant burden without much benefit to patients or use to CMS, especially as the requirements apply for non-Medicare beneficiaries as well.

We appreciate your consideration of these issues. Please contact me if you have questions or feel free to have a member of your team contact Joanna Hiatt Kim, vice president of payment policy, at jkim@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President