Providing Leadership in Health Policy and Advocacy

September 16, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 314-G
Washington, D.C. 20201

SUBJECT: CMS-5527-P, Medicare Program; Specialty Care Models to Improve Quality of Care and Reduce Expenditures; Proposed Rule, Federal Register (Vol. 84, No.138), July 18, 2019

Dear Administrator Verma:

On behalf of our more than 400 member hospitals and health systems, including more than 120 that provide radiation oncology treatment, the California Hospital Association (CHA) is pleased to submit comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule to implement two new mandatory Medicare payment models — the Radiation Oncology Model (RO Model) and the End-Stage Renal Disease Treatment Choices Model. Our comments are limited to the proposed mandatory RO Model.

California's hospitals support evidence-based methods that streamline the provision of radiation oncology to improve quality and patient experience. In 2017, there were more than 6 million radiation oncology visits to California's hospitals and health system outpatient department settings for Medicare beneficiaries. These outpatient settings are a valuable path to oncology care. **However, the RO Model, if not modified, will likely have a number of unintended consequences that hinder access to oncology care in California.**

To preserve access to care, CHA urges CMS to consider the following:

- **Delay implementation of the RO Model for at least 12 months from the issuance of the final rule.**
- **Consider a phased approach to implementation so hospitals that are ready may opt in voluntarily.** This approach will provide time for CMS to build the infrastructure to administer this program effectively and scale as other providers come on board. Requiring immediate participation of 40 percent of radiation oncology episodes across the United States is far too aggressive for an untested model that needs significant refinement. In addition, the proposed model currently does not allow for the exclusion of low-volume hospitals or hardship exemptions, both of which are critical in a shared risk-based model of care.
- **Should CMS proceed with implementation, consider a retrospective model.** In large part because mandatory participation in California is challenging due to the state's ban on direct employment of physicians by hospitals, CHA does not support immediate implementation of a prospective, untested, mandatory alternative payment model on such a scale. Immediate

implementation would create complex operational challenges for a prospective episode payment for the vast majority of providers.

- **Modify the efficiency and discount factors.** As significant steps already have been taken to implement evidence-based guidelines that promote efficiencies and improve patient outcomes, this model should not penalize such practices with excessive cuts to achieve Medicare savings.
- **Modify the additional proposed documentation requirements to include only the most clinically relevant information for data collection in performance year two and beyond.**
- **Make participant level data available as soon as possible to assist the field in understanding CMS' proposals and begin to consider the operational issues that must be addressed prior to implementation.** The proposed 30 days in advance of program start, as proposed, is woefully inadequate.

Detailed feedback on each of these recommendations follows:

Background

The mandatory alternative payment model is designed to test whether prospective episode-based payments to radiation therapy centers for episodes of care would reduce Medicare expenditures while preserving or enhancing the quality of care for beneficiaries. The RO Model would include prospective payments for certain radiotherapy (RT) services furnished during a 90-day episode for cancer types that meet certain criteria. Based on these criteria, the model would include 17 types of cancer, including breast, prostate, lung, cervical, liver, and pancreatic. CMS proposes that the model begin on either January 1, 2020, or April 1, 2020, and end on December 31, 2024.

Prospective Payment Methodology

The model would include three types of provider participants: physician group practices (which include individual physicians), freestanding radiation therapy centers, and hospital outpatient departments. CMS would split episode prospective payments into two components: (1) the professional component, which covers the RT services provided by a physician and (2) the technical component, which covers the cost of equipment, supplies, and staff related to RT services. CMS proposes to create two separate payments because the professional and technical services of an episode are sometimes furnished by separate providers. Physician group practices would furnish the professional component of an episode; hospital outpatient departments would furnish the technical component; freestanding centers would furnish either the technical component or both components (freestanding centers that provide both components would be known as dual participants).

Administering a prospective payment methodology in outpatient settings is concerning for a number of reasons.

First, hospitals and health systems across California generally prefer a retrospective payment methodology if paid on an episode basis — it is far simpler to administer, and providers have experience with this model through the Comprehensive Joint Replacement Model and other models. However, this would be the first untested mandatory prospective outpatient model for an episode of care. Even California's most sophisticated hospitals and health systems question their ability to operationalize such a complex payment methodology within the proposed timelines.

Second, the vast majority of hospitals and health systems in California are not able to employ their physicians and, therefore, are generally not billing for the professional component of the services provided. The billing and coding changes required are significant and will take time to prepare for and to implement, likely at considerable costs. **A delay in implementation is critical, and CMS should consider making this a retrospective payment model to allow for reconciliation at the end of the performance year, and to limit the administrative costs that will be largely borne by providers.**

Episode Pricing Methodology
CMS proposes to determine the episode payment amount for each component (professional and technical) and cancer type using a national base rate, with adjustments for a trend factor and the case mix, historic experience, and geographic location of each model participant (i.e., a physician group practice, hospital outpatient department, or freestanding center). CMS proposes site-neutral base rates for each component and cancer type based on historic average payments for an episode of care in the outpatient setting using data from 2015 through 2017. The base rate would be the same whether the episode is provided in a hospital outpatient department or in a freestanding radiation therapy center. Freestanding radiation therapy centers are currently paid under the physician fee schedule. CMS states that it plans to use hospital outpatient department payment rates instead of physician rates to set the base payments for two reasons: (1) hospital outpatient rates have been more stable over time, and (2) they have a stronger empirical foundation than physician rates because they are derived from hospital cost report data.

In the rule, CMS explains that despite providing more RT episodes nationally from 2015 through 2017, hospital outpatient departments furnished a lower volume of services within such episodes than freestanding centers. In light of these data, CMS proposed to use the more efficient sites of service — hospital outpatient departments — to build the national base rate. In doing so, CMS has built significant savings into the model from the outset. The agency should recognize this when making policy decisions regarding the expected level of additional savings by participants. **CMS' proposed adjustments to the national base rates, as well as the proposed discounts and withholds, now *far exceed those in any other alternative payment model*. When these adjustments are combined with the already built-in savings, they may render providers unable to reasonably achieve savings and force efficient providers to look for potential savings where none exist. Such an approach could reduce patient access to RT by causing significant financial issues for such a capital-intensive specialty.**

CHA supports many of the recommendations advanced by ASTRO and the American Hospital Association, and urges CMS to consider the following changes to the pricing methodology:

- Clarify how CMS would calculate the physician component and technical component trend factors in more detail so participants can assess the complete financial impact.
- **Provide additional information on the case mix methodology.** It is unclear why CMS uses cancer type as a factor in determining the case-mix adjustment for each model participant if there will be separate payment rates for each cancer type. In addition, CMS should consider other risk adjustments to the model to account for different modalities of RO provided to ensure access to highly specialized care.
- **Eliminate the proposed historical experience and efficiency factor adjustments**. The historical experience adjustment would reward inefficient providers and penalize efficient providers, which would undermine the intent of the model. Including a transparent and robust case-mix adjustment

should be the agency's primary mechanism to adjust the episode payment for factors beyond a provider's control. In addition, CMS should, similar to other programs, blend the participant's historical performance and national and regional average performance to adjust national base rates.

- **Lower the discount rates and phase them in over time.** CMS proposes to apply a 4% discount factor to the physician component payment and a 5% discount factor to the technical component payment. They are the largest discounts from CMS for any bundled payment model and are particularly problematic as CMS proposes this to be a mandatory payment model with 100% risk to providers in year one.

Extreme and Uncontrollable Circumstances

CMS explains in the rule that it is not proposing a hardship exemption for the RO Model because its pricing methodology gives significant weight to historical experience in determining the participant-specific payment amounts. The model also does not exempt low-volume providers, but proposes an adjustment for providers with 60 cases or fewer.

CHA disagrees with CMS' assumption that a prospective payment methodology based on historical experience is a sufficient mechanism for preventing the unintended consequences of extreme and uncontrollable circumstances. **As noted above, CHA urges CMS to consider a retrospective payment methodology. In addition, CMS should exclude providers with low volumes of cases and make exemptions for participants facing state and or federal public health emergencies, such as natural disasters, to ensure those providers are not unfairly penalized.**

Quality Reporting Requirements

In addition to the quality measures found in all alternative payment models, CMS proposes to require participants to report clinical information that is not available in claims data, and must be extracted from electronic medical records and reported via a yet-to-be-developed web portal. Specifically, CMS proposes to require providers to report data such as cancer stage, disease involvement, treatment intent, and treatment plan, although CMS has not determined the exact elements and standards for reporting. **These requirements will be burdensome, and it is not clear from CMS how the data will be used or how reporting might benefit patients. Providers already incorporate much of this information in their plans of care and, without additional policy rationale for collection and submission, the administrative burden is not warranted. CHA urges CMS to modify the additional proposed documentation requirements to include only the most clinically relevant information for data collection in performance year two and beyond.**

The four quality measures on which CMS would require reporting include:

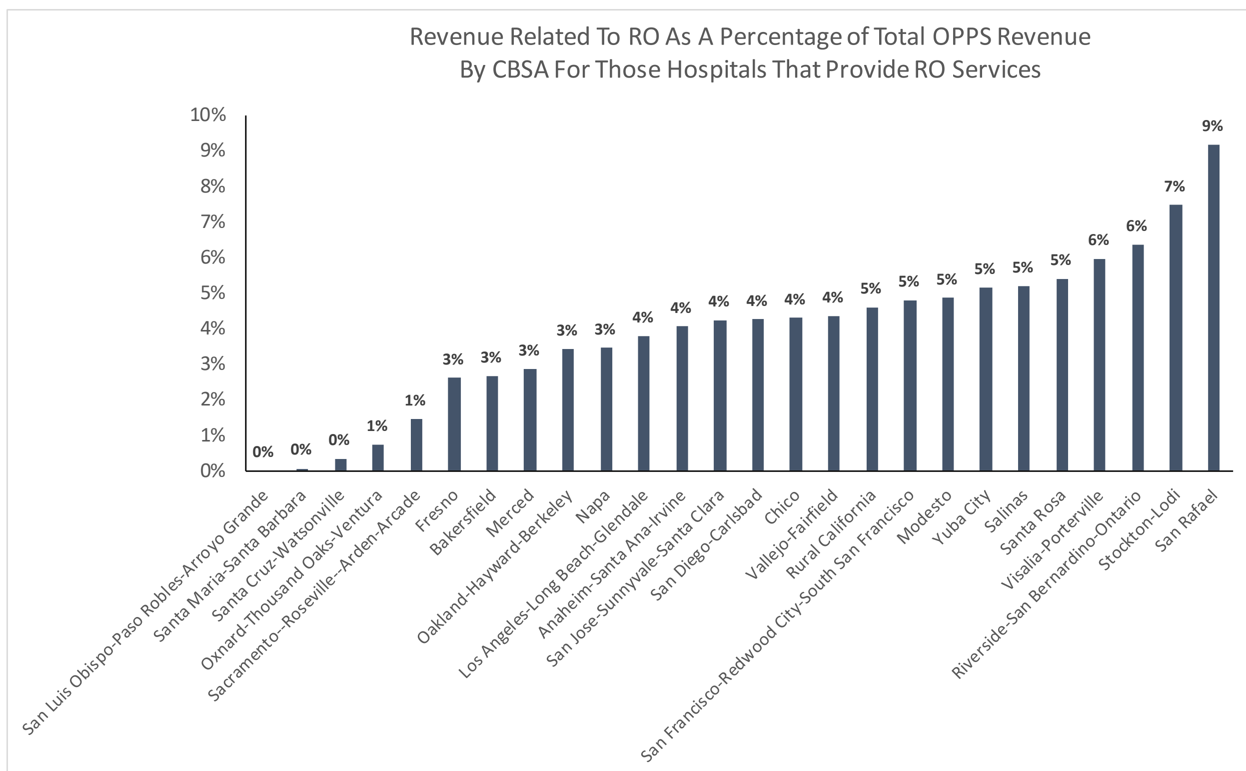
- Oncology: Medical and Radiation – Plan of Care for Pain
- Preventive Care and Screening: Screening for Depression and Follow-up Plan
- Advance Care Plan
- Treatment Summary Communication – Radiation Oncology

The first three measures are endorsed by the National Quality Forum (NQF) and are currently in use in the Oncology Care Model and MIPS. The fourth, Treatment Summary Communication, is neither NQF-

endorsed nor used in any other CMS program. **CHA urges CMS to use only measures endorsed by the NQF for purposes of the quality score calculation. Further, it is appropriate for CMS to consider pay-for-reporting in the first year and pay-for-performance in out years, as participants increase their familiarity with the measures and are able to operationalize them into workflow processes.**

Model Overlap

Last, many providers continue to be confused about episode and alternative model overlap. CHA urges CMS to detail in the final rule a comprehensive explanation of the differences and similarities, with a number of examples to help facilitate shared understanding of episode overlap and attribution. In addition, looking at the metropolitan statistical areas across the state (Figure 1), we anticipate that several markets that may be selected by CMS for mandatory program participation may also overlap with the Comprehensive Joint Replacement payment program, creating additional operational complexities and administrative burden for those providers. We strongly urge CMS to consider model overlap in selection of core-based statistical areas.



Source: Medicare Standard Analytic File, 2017.

CHA appreciates the opportunity to comment on the RO Model proposed rule. If you have any questions, please contact me at akeefe@calhospital.org or (202) 488-4688.

Sincerely,
/s/
Alyssa Keefe
Vice President, Federal Regulatory Affairs