American Hospital Association™
Advancing Health in America

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October 20, 2020

The Honorable Brad Smith
Director
Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

RE: CMS-5527-F, Medicare Program; Specialty Care Models to Improve Quality of Care and Reduce Expenditures

Dear Mr. Smith:

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) is writing to request that you delay the start of the Radiation Oncology alternative payment model (RO APM) until Jan. 1, 2022, as well as make other modifications to model parameters.

The AHA is deeply supportive of the Centers for Medicare & Medicaid Services' (CMS) efforts to shift the health care system toward the provision of more accountable, coordinated care. As detailed in our Sept. 16, 2019 letter, we support CMS' development of models that could help further these efforts to transform cancer care delivery. **However, we are very concerned about several elements of the RO APM as finalized, especially the start date. A mandatory model of this complexity should not be rushed into existence in such a short amount of time with so many details on its parameters still forthcoming.**

The Center for Medicare & Medicaid Innovation (CMMI) intends to launch the RO APM on Jan. 1, 2021, when the nation will be 10 months into a global pandemic. This model – which includes 16 cancer types, six treatment modalities and the four services generally part of every radiotherapy (RT) episode of care – would be difficult to implement in three months in the best of circumstances; it will be nearly impossible to implement in three months during a public health emergency (PHE). We had urged the agency to provide participants 12 months between a final rule and the launch of the model. Doing so is necessary to ensure they have sufficient time to operationalize

changes necessary to comply with the coding and billing requirements of this model. **In light of the pandemic, we urge you to go a step further and delay the model until Jan 1, 2022. For all the reasons explained below, providing this additional time would be in the best interests of the agency, the participants, and most importantly, the patients.**

Over the past nearly eight months, hospitals and health systems have been on the front lines fighting the COVID-19 pandemic. This work has involved significant adaptation to deliver safe patient care, including making staffing and other changes to meet demand. Those changes will need to remain in place indefinitely, especially with a potential second wave of the virus coming this fall and winter. Now is not the time to ask hospitals, health systems and other mandatory participants to divert attention to an incredibly complex model for which CMMI itself is still determining many pertinent details.

The final rule for this model was released on Sept. 21. The first CMMI special listening session for the model was Oct. 8, and several key questions raised on the call did not receive answers. As of Oct. 15 – nearly a month after the model was finalized – several of our members have indicated they are unable to get into the model portal, without which they have no ability to begin analyzing its financial impact and preparing. Even once they can access the portal, they will need additional details that CMMI has announced it will provide in an Oct. 29 webinar, which will help them understand the highly complex eight-step payment process of the model. Participants then must retrain billing staff on the components of the model and rework their billing systems to comply. Even if everything were clear from a single CMMI financial methodology webinar, participants would have barely eight weeks to operationalize this overhaul, all while continuing to meet the challenges of the PHE.

Of course, financial analysis is only one step in preparing for the RO APM. Many other significant operational challenges exist. For example, the model requires participants to modify their quality reporting systems to capture the model's required quality metrics. Given the scope of the model, including that participants must report quality metrics for *all* patients, not just those in the model, our members need to be able to automate quality reporting. Compounding this undertaking is the fact that hospitals, health systems and independent practices often have two electronic health record (EHR) systems for radiation oncology patients. Specifically, due to the complexity and length of RT treatment, they have a standard EHR and another that is specific to radiation oncology. This means they will have to make changes across not one but two platforms to operationalize participation in the model.

In addition, as you are likely aware, nearly all providers rely on vendors for their EHR modifications. When making any changes to EHRs and other electronic platforms, vendors have to develop, test, and validate the change and only then can they roll it out. This simply cannot be done in 90 days. Moreover, many vendors group together all

changes to a platform and roll them out once or twice a year. This means several participants will not have the support of their vendors and will not be able to automate the quality reporting for this model until sometime next year, potentially resulting in inaccuracies that do not reflect the quality of the care actually delivered. This burden threatens to be so significant that some hospitals have received calls from freestanding radiation centers asking to be acquired. These practices have indicated that due to the model requirements, they either need to be acquired by a larger system that has the capacity and resources to participate in the model, or they need to close their doors.

Practices required to participate in this model also need time to educate clinicians on the changes to oncology care that will be required for success. Moreover, participants need education from CMMI given the changes to clinical practice the model is testing. This education is particularly important in light of the concerns we have heard from our members that some elements of the model disrupt the incentives for high-quality patient care. For example, if a model participant does not have the capability for a particular type of RT that is the best course of treatment for a patient, and the participant therefore sends the patient to a center that does have the treatment ability, but happens to be located outside the model's core-based statistical areas, the model participant will be penalized with an incomplete episode. This is a concerning result, as it does not make clinical or financial sense for every RT center to maintain capacity for every type of RT treatment. To ensure the model does not incentivize a departure from appropriate clinical care, we strongly urge you to help clinicians understand how they can still provide high-quality care using their clinical judgement under this model.

Additionally, and as also detailed in our Sept. 16, 2019 letter, we remain concerned about the level of the discounts that will be applied to the professional component (PC) and technical component (TC) of the model. While we understand that you reduced the overall size of the model from 40% to 30% of eligible Medicare fee-for-service RT episodes nationwide, we continue to be alarmed by the extremely high discount levels of 3.75% and 4.75% for the PC and TC, respectively. Given the very short time frame for launching this model, these discounts will make it particularly challenging for participants to achieve savings even if they provide efficient and high-quality care.

Again, we thank you for your focus on improving value for patients and providers and for your consideration of our comments. If you have any questions, please feel free to contact me or have a member of your team contact Shira Hollander, senior associate director of payment policy, at 202-626-2329 or shollander@aha.org.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President, Public Policy Analysis & Development