Radiation Therapy Bundles

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BUNDLED PAYMENTS MINI-SUMMIT

TUESDAY, JUNE 18, 2019

Agenda

- Radiation Oncology APM
- Private Sector Experience
- Challenges That Lie Ahead

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- Radiation Oncology APM

- Private Sector Experience

- Challenges That Lie Ahead

November 8, 2018

"We intend to revisit some of the episodic cardiac models that we pulled back, and are actively exploring new and improved episode-based models in other areas, including **radiation oncology.** We're not going to stop there: We will use all avenues available to us—including mandatory and voluntary episode-based payment models."

Alex Azar

HHS Secretary

April 25, 2019
NAACOS Spring Meeting

We are continuing to work on our model for oncology care, and we want to offer options for radiation oncology providers.

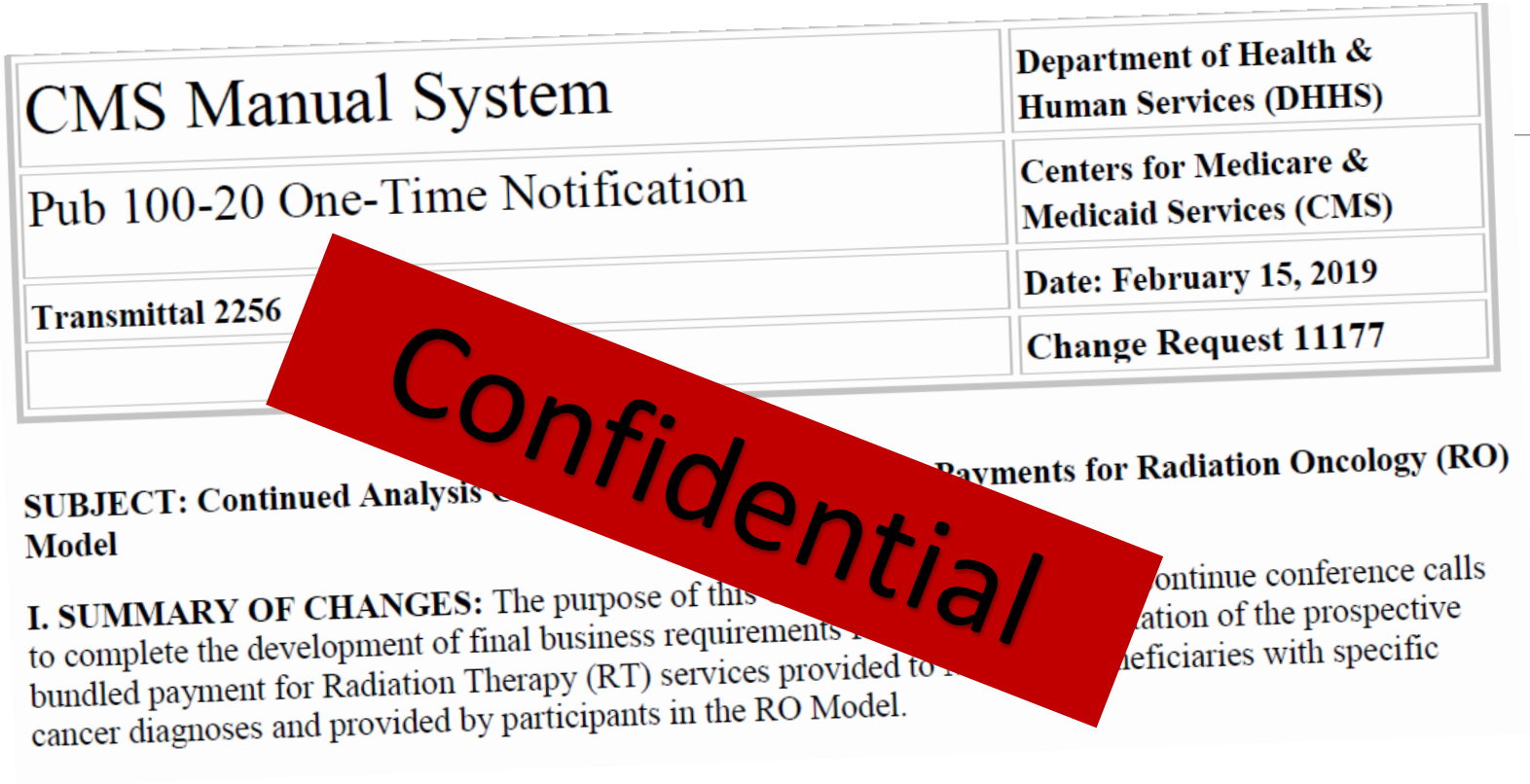
Seema Verma
CMS Administrator


Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation
2018 REPORT TO CONGRESS

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2256	**Date: February 15, 2019**
	Change Request 11177

SUBJECT: Continued Analysis Calls for Prospective Bundled Payments for Radiation Oncology (RO) Model

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to continue conference calls to complete the development of final business requirements for timely implementation of the prospective bundled payment for Radiation Therapy (RT) services provided to Medicare beneficiaries with specific cancer diagnoses and provided by participants in the RO Model.



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Confidential

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What we know….

17 Disease Sites

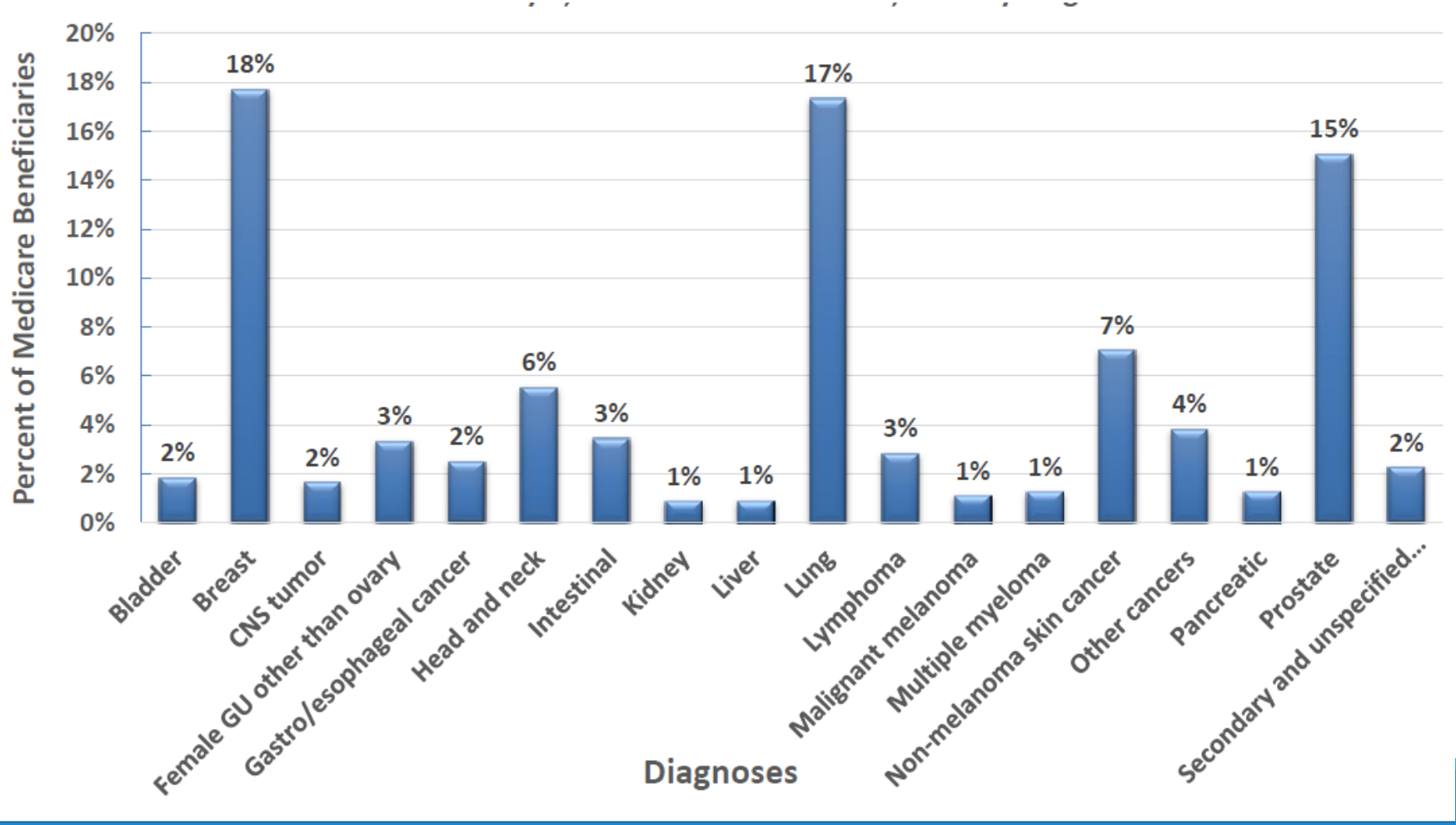
90 day Episode of Care

Applicable in both freestanding and hospital based setting

Prospective payment

Mandatory for select CBSA's

What we know…. 17 Disease Sites



What we know…. 90 Day Episode of Care

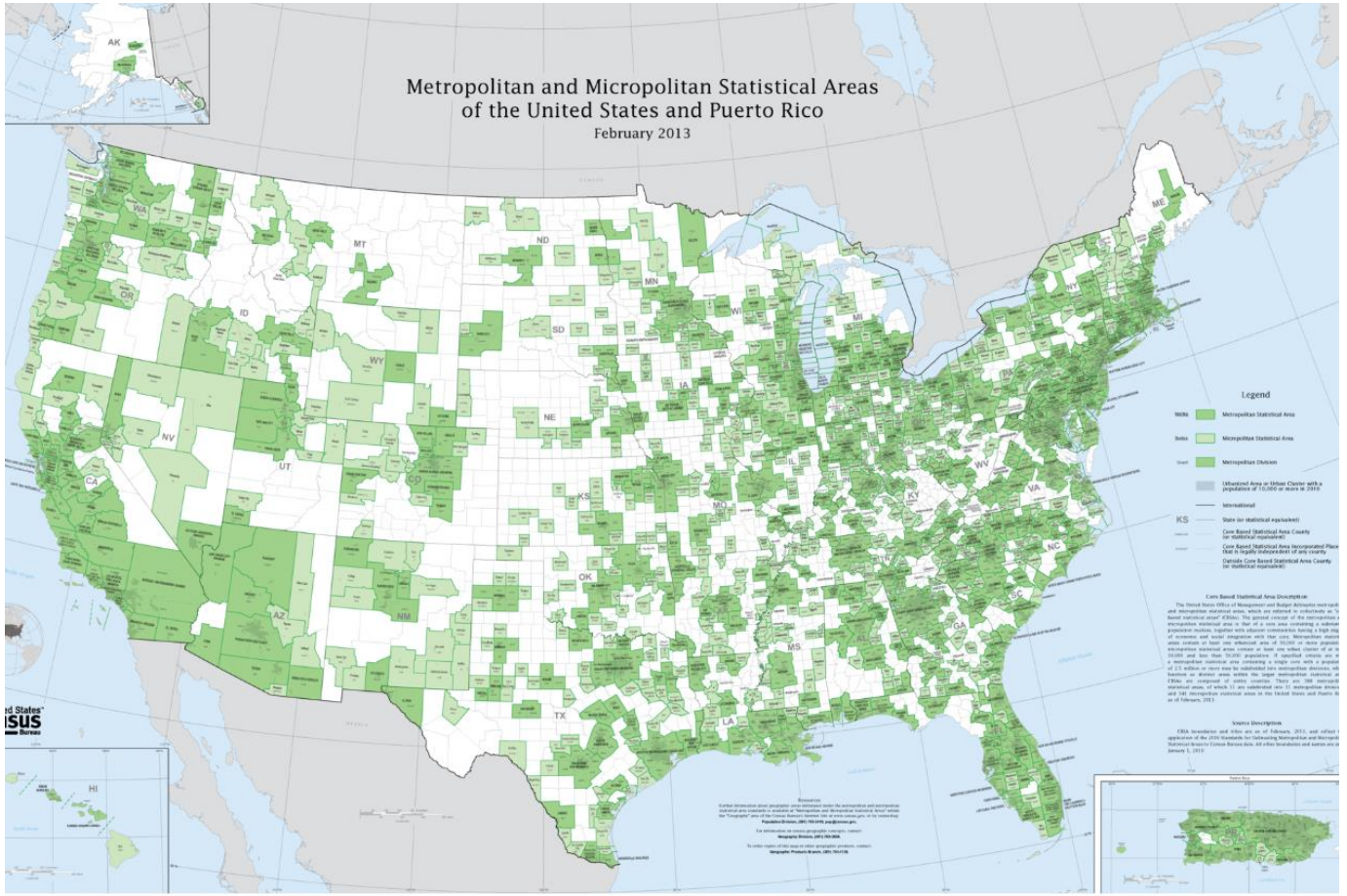
What we know….

Applicable in both freestanding and hospital based settings

What we know…. Prospectively Paid

New RO model-specific HCPCS code modifiers will denote beginning and end of episode of care

What we know…. Mandatory

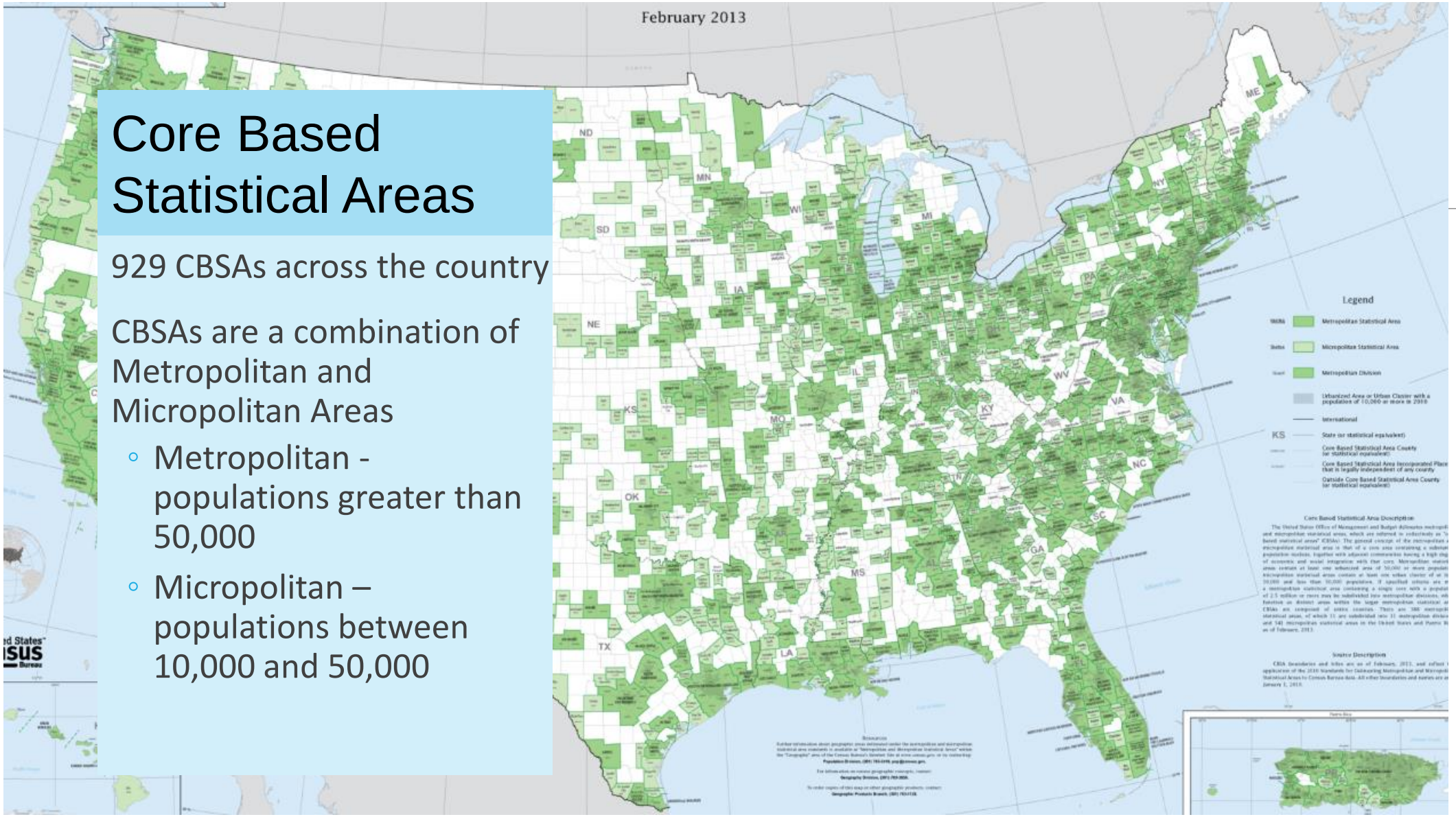


Core Based Statistical Areas

929 CBSAs across the country

CBSAs are a combination of Metropolitan and Micropolitan Areas

- Metropolitan - populations greater than 50,000
- Micropolitan – populations between 10,000 and 50,000



ASTRO

AMERICAN SOCIETY FOR RADIATION ONCOLOGY

www.astro.org

Statement in response to HHS Secretary Azar's comments on a radiation oncology alternative payment model

While ASTRO is enthusiastic about the prospects for a RO-APM, we have concerns about the possibility of launching a model that requires mandatory participation from all radiation oncology practices at the outset. ASTRO recognizes that mandatory and voluntary models can take many different forms, and we look forward to working with Secretary Azar and CMMI to determine the best approach for the field of radiation oncology.

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

January 9, 2019

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Verma,

We write to urge the Centers for Medicare & Medicaid Services (CMS) to increase transparency in the Center for Medicare and Medicaid Innovation (CMMI) and reform its processes to incorporate greater opportunity for public input as models are developed. Congress established CMMI to test different innovative delivery system and payment models to improve quality and reduce costs for Medicare and Medicaid beneficiaries. In carrying out its duties, CMMI is required to "consult representatives of relevant Federal agencies, and clinical and analytical experts with expertise in medicine and health care management. The [CMMI] shall use open door forums or other mechanisms to seek input from interested parties."[1]

We have long been advocates for health care innovation. However, significant policy changes made unilaterally by the executive branch without sufficient transparency could yield unintended negative consequences for beneficiaries and the health care community. We strongly urge the Agency to provide more sunshine in this process, and allow Congress, beneficiaries, and stakeholders greater opportunity to provide feedback into the policies that CMMI tests that affect millions of Americans with Medicare.

CMMI model development process has historically been opaque to Congress and to stakeholders. CMMI does not always use the traditional rulemaking cycle in which the public may provide comment to CMS to better inform and perfect the regulatory process. Moreover, over the last few years, CMMI rulemaking has been narrowed to topics that only include mandatory models, rather than an opportunity to better understand how all models would affect patients and the Medicare program.

Congress allowed the Secretary to waive certain Medicare rules, so long as the model is expected to improve quality and reduce spending or reduce spending without reducing quality.[2] As a result— and consistent with CMMI's own guiding principles under this Administration[3]— it is

[1] 42 U.S.C. §1315a(a)(3)
[2] 42 U.S.C. § 1315a(a)
[3] Centers for Medicare & Medicaid Services, "CMMI: Innovation Center New Direction." Accessed on January 3, 2019. https://innovation.cms.gov/Files/x/newdirection-rfi.pdf

United States Senate
WASHINGTON, DC 20510

February 14, 2019

The Honorable Alex Azar
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar,

We write today to encourage you to continue advancing paying for health care based on value, rather than volume of services, and to request information about the Department of Health and Human Service's efforts to use mandatory payment models to test innovative ways of delivering and paying for health care. While mandatory models need to be used thoughtfully and with input from doctors, patients, and caregivers we believe mandatory models can generate evidence to help determine how to pay for and provide health care in a way that improves the quality of health care and reduces spending.

U.S. taxpayers spent an estimated $3.5 trillion on healthcare in 2017—an amount that is expected to reach $5.7 trillion by 2026.[1] As health care costs continue to rise, the federal government should continue efforts to deliver high-quality care to Medicare and Medicaid beneficiaries while lowering spending.

The Center for Medicare and Medicaid Innovation (CMMI) plays a critical role in identifying and assessing different ways to pay for health care to reduce health care spending. CMMI has initiated a number of alternative payment models, including demonstrations testing bundled payments. Unlike traditional fee-for-service models in which insurers pay for each health care service provided, bundled payment models provide doctors and hospitals with a single, "bundled" payment to cover all the services provided in an episode of care, such as a surgery.[2] Experts have testified before the United States Committee on Health, Education, Labor, and Pensions (HELP) that bundled payment models provide doctors and hospitals with strong incentives to keep health care costs down and provide high-quality health care.[3]

[1] Centers for Medicare & Medicaid Services, "National Health Expenditure Projections 2017-2026: Forecast Summary," 2016. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf.
[2] David Blumenthal, M.D., and David Squires, "The Promise and Pitfalls of Bundled Payments," The Commonwealth Fund, September 7, 2016, https://www.commonwealthfund.org/blog/2016/promise-and-pitfalls-bundled-payments.
[3] U.S. Senate Committee on Health, Education, Labor & Pensions, *Reducing Health Care Costs: Eliminating Excess Health Care Spending and Improving Quality and Value for Patients* (Full Committee Hearing), July 17, 2018, https://www.help.senate.gov/hearings/reducing-health-care-costs-eliminating-excess-health-care-spending-and-improving-quality-and-value-for-patients.

Timeline

ASTRO
AMERICAN SOCIETY FOR RADIATION ONCOLOGY
www.astro.org

June/July 2019

Proposed Rule

- Model the model
- Analyze impact on different practice types
- Provide constructive feedback

November 2019

Final Rule

- Assess impact on different practice types
- Develop tools for successful implementation

January-April 2020

Implementation

- Evaluate and provide feedback on implementation to CMS
- Engage Agency on future model revisions

Agenda

- Radiation Oncology APM
- Private Sector Experience
- Challenges That Lie Ahead

Radiation Therapy Bundles
Private Sector Experience

2019 National Bundled Payment Summit

Constantine Mantz MD

Chief Policy Officer

21st Century Oncology

21st Century Oncology

Large privately-held provider of multispecialty cancer care services

> 1,000 physicians across all practice settings and specialties related to cancer care

Radiation oncology service line

- 160 facilities in 17 states
- 48,000 new cases annually
- 10% revenues follow alternative payment agreements

In 2012, 21C executed an agreement for the first comprehensive APM for radiation therapy with a major commercial payer.

The model includes as many diagnoses and procedures as possible and is organized by diagnosis group.

Payment schedule includes all common cancer diagnoses and services, covering > 98% of all radiotherapy episodes.

- 14 condition groups are defined at the ICD10 level (e.g. breast cancer, lung cancer, prostate cancer, etc.).
- Included services encompass all E/M, radiation dosimetry, device construction, imaging and treatment delivery performed during episode.
- Uncommon diagnoses and services are excluded and paid per FFS.
- New radiotherapy services are considered annually for inclusion.

Curative Treatment APM Disease Groups

	Breast Cancer	Lung Cancer	Prostate Cancer	Upper Gastrointestinal Cancer	Lower Gastrointestinal Cancer	Gynecologic Cancer	Head & Neck Cancer	Skin Cancer	Nervous System Cancer	Lymphoma	Other Primary Cancers
Included ICD10s	C50 D05	C33–C34	C61	C15–C17 C22–C25	C18–C21	C51–C57	C01–C14 C30–C32 C77.0	C44	C70–C72 C75.1–C75.3 D32–D33 D35.2–D35.3	C81–C83 C84.4–C84.9 C85.1–C85.9	all other ICD10s
Comments	all invasive and in situ disease	all NSCLC and SCLC		esophagus, stomach, small bowel, liver, biliary, pancreas	large bowel, rectum, anus	endometrium, cervix, vagina, vulva		excludes non-SCC and non-BCC	includes benign disease		

Palliative Treatment APM Disease Groups

	Bone Metastasis	Brain Metastasis	Other Metastasis
Included ICD10s	C79.5 C90.0	C79.3	C78 C77.1–C77.9 C78 C79.0–C79.2 C79.4

Payments are truly “bundled” to simplify model operation.

Full episode payment is made immediately by the payer (less deductible and co-insurance) upon receipt of claim that reports:

- ICD-10 diagnosis code covered under the agreement
- single trigger code (i.e., 77261, 77262 or 77263)

No inlier/outlier provisions or risk adjustments are made: same full rate is paid regardless of the number of treatments or risk factors.

Accounting is simplified: revenue recognition, cash flow and bad debt are determined much more straight-forwardly.

Bundled payment period is 90 days, and individual services continue to be reported using FFS claims infrastructure.

If a patient requires treatment for a same diagnosis treated and reimbursed within the prior 90 days, then the payer does not make another payment to the provider.

Separate bundled payments are made for separate episodes.

Reconciliations for incomplete care episodes occur biannually.

- pro rata payments to payer
- incomplete episodes are infrequent: 2% of all cases

Services are reported using existing claims management systems and pended for comparisons to performance benchmarks and quality reporting.

Bundled Price Build

Assign all included ICD10s into defined condition categories

↓

Determine recent historical payments for each condition category using claims data

↓

Audit data for incomplete care episodes and inappropriate resource utilization

↓ weight-average validated episode payments

THE BUNDLE PRICE

Other Model Features

For Payers

REDUCED UNIT COSTS

episode rates negotiated to yield an aggregate decrease

MITIGATED TREATMENT INTENSITY RISK

episode rates constant regardless of technology utilized or number of treatments

DECREASED ADMINISTRATIVE COSTS

eliminates payer's need for pre-authorizations as operational model changes to pre-notification

For Patients

TRANSPARENT COSTS

nearly all patient liability can be quantified prospectively

LESS HASSLE

patients not nuisanced by authorization decisions and subsequent delays

For Practices

PAYMENT PREDICTABILITY AND STABILITY

reimbursement uncoupled from CMS fee schedule updates

REDUCED ADMINISTRATIVE BURDEN

no requirement to submit clinical documentation or participate in peer-to-peer reviews and elevated appeals processes

Principles of Success

- Keep the mechanics simple to ease implementation and maintenance
- Use existing claims management systems as much as possible
- Include as many services and procedures as possible within an episode payment
- Develop episode payment rates for as many diagnoses as possible to spread risk and simplify contract administration

Agenda

- Radiation Oncology APM
- Private Sector Experience
- Challenges That Lie Ahead

Bundled Payment Mini Summit II

Radiation Therapy Bundles

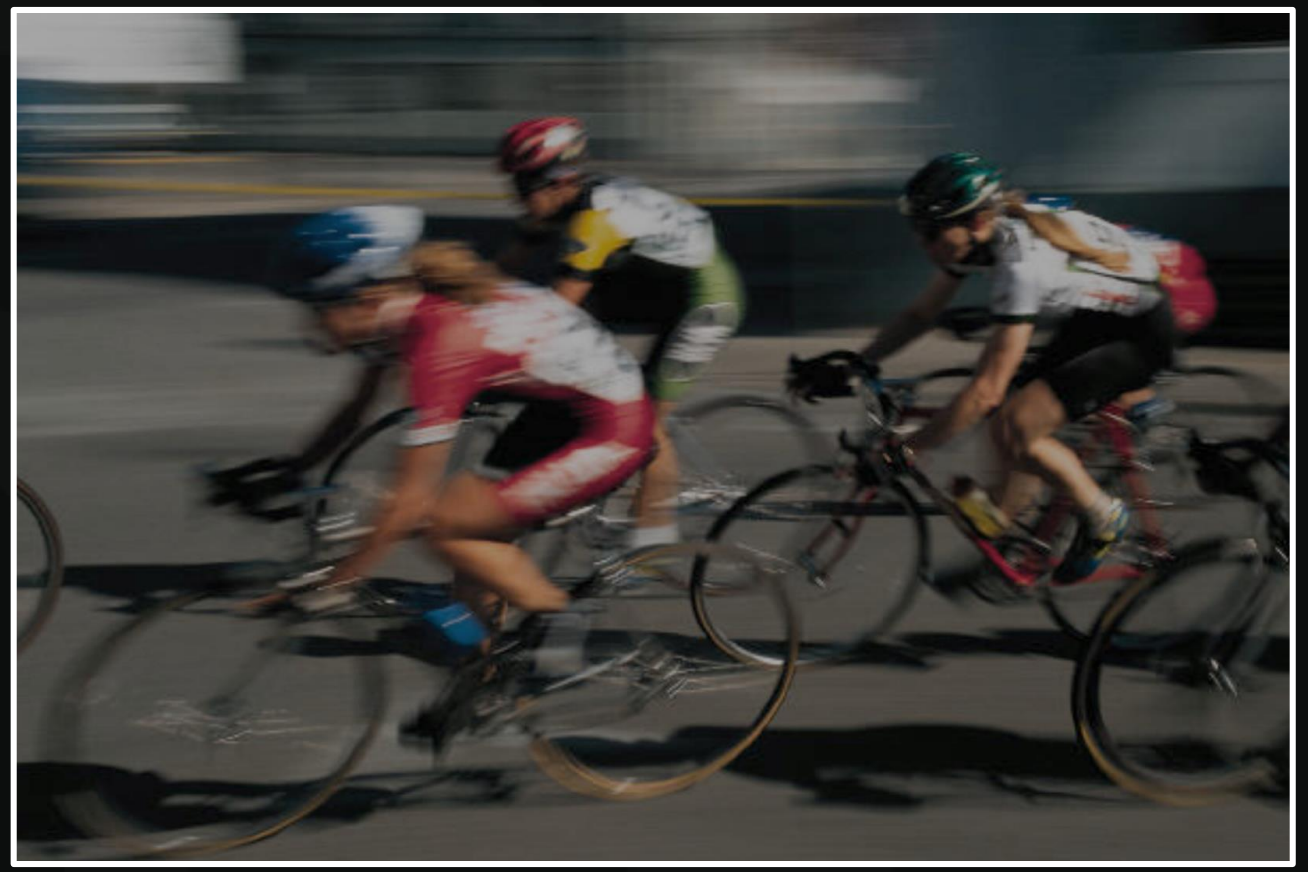
Sheila Rege MD
President, American College of Radiation Oncology (ACRO)

APM Basic

- APM Goal – provide high-quality and cost efficient care
- APMs Can Apply To *specific clinical condition *care episode *population
- Subsets of APMs *MIPS APMs *aAPMs
- aAPM Bonus Payments 5% incentive lump bonus until end of 2022 performance period (Paid in 2024 per MACRA)

Lots of Practice Types (Stakeholders)

Strategy



Multiple RO Practice Types within the "APM" zipcodes

Hospital new to APM – RO is employee or contracted

Hospital with mulitple APMs – RO is employee or contracted

Non Hospital Clinics– most smaller who may be new to APM

SPECIAL:

RURAL

PROTON

Multiple RO Practice Types OUTSIDE of the "APM" zipcodes

Hospital new to APM

Hospital with other APMs

Non Hospital Clinics – most smaller who may be new to APM

SPECIAL:

RURAL

PROTON

FFS versus APM

- FFS may face possible PFS payment Cuts
  - The “Freeze” where Treatment and related imaging services (G6001-6015) codes were explicitly frozen at 2016 payment level ends in 2019.
    - Protected against reductions to “simple” IMRT
    - Protected from further increase in equipment utlization rate
    - Protected from cuts to radiation treatment vault
    - E/M code restructuring

From the Nov. 2017 Report to Congress: “CMS Innovation Center sets the episode price. CMS commonly uses more than one year of historical data in setting this baseline to create greater payment stability.”

APM

Patient Centered Health

RO APM vs. OCM

OCM: 178 Practices – reduced ER visits; care coordination, behavioral and financial counselors plus national treatment guidelines for care. ~~Per-member per-month extra dollars~~.

"Re-engineer so physician practices work under payment arrangements that include financial and performance accountability for chemotherapy treatment and the care surrounding those patients."*

RO APM:

Radiation Oncologist free to choose modality (e.g. IMRT, Proton?, brachytherapy, etc)

No Pre-Authorizations?

Payment Rates better than FFS (under PFS) since based on past year rates?

*https://www.modernhealthcare.com/article/20181105/NEWS/181109963

ACRO

CMS Transmittal 2256

- If a claim is submitted with a RO Model-specific HCPCS code for a site of service that is located within one of the randomly selected CBSAs as identified by zip code, but the CMS Certification Number (CCN) or TIN is not on the participant list, the claim should be paid using the rate assigned to that RO Model-specific HCPCS code (without Payment Model Adjustments (PMA)).

Stakeholder Engagement Results

ACRO Request	Feb. 15 Transmittal	Result
Prospective; development of new RO APM case rate codes, Payment made to radiation oncologist	Prospective; rates assigned to RO Model-specific HCPCS codes Payment made to radiation oncologist (PC) and Facility (TC)	√
Episode/Trigger	90-day episode; payment would cover ALL RT services needed within the 90-day period	√
15 Disease Sites	17 Disease sites (not specified)	√
Voluntary	Mandatory	x
Nationwide	Randomly Selected Core-Based Statistical Areas (CBSA) based on zipcodes	x

Worries

RO APM Group.
Control Group for RO APM.
OPPS Group
PFS Group

Worries

Special Circumstances

No Additional $ for Care Coordination

- Vulnerable Populations need additional resources (e.g. mental health counseling). A fixed payment system based on historic rates may inadvertently penalize physicians for meeting these patient needs.
- Inadequate Data on Correct Risk Adjustment (e.g. genetics) – difficult to capture via claims data.
- Overlap with other APMs (e.g. OCM) which may be currently be profitable for larger systems.
- Inadequate time: RO Bundle has not been released June 2019 and difficult to imagine roll out in January 2020.

Strategy

(Revenue/Growth)

Strategy

- **RO APM has to have adequate quality measures, reduced paperwork burden and flexibility especially in systems with other APMs in place.**
- **Systems Outside of APM Zipcodes should be protected against potential payment cuts**

Report to Congress: Episodic APM for Radiation Therapy Services Nov 2017

Questions