

SROA Soundboard: Episode 1 – Radiation Oncology Payment Model: What You Need to Know with Anne Hubbard

Tammy: This is Tammy McCausland. Thank you for joining me for SROA Soundboard, SROA's new podcast series. I'm joined here in conversation today with Anne Hubbard, Director of Health Policy at ASTRO. Welcome, Anne.

Anne: Thanks, Tammy, for having me. Really enjoy being here this morning.

Tammy: Is the RO APM what people were hoping for?

Anne: That's a really good question. ASTRO has been working on the development of a Radiation Oncology Alternative Payment Model for a number of years now, and this all kind of started back in 2015 when Congress passed the Patient Access and Medicare Protection Act that included a clause that required CMS to report to Congress on the development of an APM for Radiation Oncology. That report was issued in November of 2017.

Anne: Prior to the report being issued, ASTRO had engaged with the agency, shared a concept paper in May of 2017 really kind of outlining what we thought would be an appropriate payment model for Radiation Oncology services. So, we have known for quite some time that the agency was working on something, and we're pleased that they finally released their proposal in July of this year. While we're pleased that the model is out, we do believe it has a lot of challenges, particularly the mandatory requirement and the significant cuts associated with the discount factors and the withholds.

Tammy: Will the RO APM impact quality of care?

Anne: So, I think it will impact quality of care. There are some quality measures components to it, as well as some monitoring requirements that are all very quality based. I think that because it establishes one episode of payment regardless of the modality chosen, it will provide physicians with that opportunity to choose what is most appropriate as far as care is concerned for their patients based on patient need. So I do think it will shift more attention to providing high quality, high value care to patients.

Tammy: How will the 40% trial sample get selected, and will there be an option to opt out?

Anne: So, it's interesting. In the proposed rule, the agency did not provide any details with regard to which core-based statistical areas would be selected to participate in the model. The only thing that the proposed rule did explain was that the agency was seeking to save 3%, or 250 to 260 million, over a five-year period, based on mandating the model on 40% of eligible episodes in the selected areas that would be required to participate. We don't know which areas those will be, but we do believe it would probably be about a third of practices across the country.

Tammy: What will the additional or decrease in workload on the staff be if they are chosen to participate, and will they still submit CPT codes as they have in the past?

Anne: So, a lot of that remains to be seen, but I do believe that practices will still be required to submit CPT codes, and I think that'll be required because the agency will want to monitor the services that are delivered to Medicare Fee-For-Service beneficiaries to make sure that there isn't any decrease or under-care associated with the proposed rule.

Anne: The other issue associated with this that we're concerned about is the added burden associated with the quality measures, as well as the monitoring requirements associated with the model.

Tammy: How will the RO APM impact the economics for physicians and hospital-based programs?

Anne: So, it will impact the economics of free-standing as well as hospital-based settings because it changes the payment methodology. Basically you're going from a fee-for-service payment methodology to an episode-based payment methodology. And so whereas in the past you would bill for each service that was delivered, in this situation under the RO model, you would be billing for an episode of care, and that episode of care would have a set reimbursement rate, so it's really a modification from fee-for-service to an episode paid bundle.

Tammy: Will there be case rates for different treatment modalities, or will it be solely by cancer type?

Anne: That's a great question. The model is modality agnostic, so each of the 17 cancer sites that have been identified in the model will have an episode payment, and the episode payment is split between a professional component and the technical component. That includes all of the modalities of care that may be used to treat that specific cancer type.

Tammy: How will clinical data information be reported?

Anne: Clinical data elements are required as part of the quality measures reporting component; however, in the proposed rule, the agency did not provide any detail with regard to how they want those data elements collected or the specifics around the exact data elements they're interested in collecting. ASTRO has reached out to Varian and Elekta about the MOSAIQ and ARIA systems to find out how those systems can be modified to collect even the most basic data elements that could be of use to the model, and we have learned that not only is this a significant resource undertaking, but it's also something that will take quite a bit of time to upgrade software, to implement software, and to do training around any kind of software changes that would need to take place in order to collect this data. So we're hopeful that the agency will slow walk that clinical data requirement.

- Tammy: How will add-on payments for new technologies be impacted?
- Anne: So, it's interesting because the model did not provide any detail regarding how it would pay for new technology or for situations in which practices want to establish a new service line or buy new equipment such as a new linear accelerator for their practice. So ASTRO is recommending that the agency pay for any new technology that's not currently represented by a CPT code as fee-for-service. That should just be kept completely out of the model. We don't want to be in a situation where the model potentially prevents practices from adopting new technologies.
- Anne: As for the need for new service lines and existing technology that a practice might want to begin providing its patients, or the need for new equipment or equipment upgrades, we're asking that the agency consider a rate review process by which practices can go to the agency and say, "We're looking to establish a new service line," or, "We're buying this new piece of equipment to replace our old, outdated linear accelerator, and we need a new rate review to recognize the added cost associated with those services." Because the way the model develops those episode-based payments is on your historical data, between 2015 and 2017. So if that data does not include the accurate information regarding the cost associated with a new service line or with a new piece of equipment, practices ought to have a mechanism by which they can go to the agency and seek a rate review.
- Tammy: Will CMS provide a reconciliation of the payment calculation for each episode of care for each beneficiary?
- Anne: So, this model is prospectively paid. So, it's prospectively paid, which means that the episode payment will take place in two components. There'll be two installations, one at the beginning of care and one at the end of care. The only reconciliation aspect associated with this model involves the withholds. There's a 2% withhold for incomplete payments and a 2% withhold for quality measures performance.
- Anne: The reconciliation associated with that total 4% doesn't happen until 20 months after the end of your performance period. So, if you can imagine, your performance period for year one ends on December 31st of 2020. You would not receive the reconciled payments associated with that 4% withhold until August of 2022. That's a significant amount of time for practices to have money withheld. It could cause cash flow problems, particularly for practices that have very thin operating margins, so one of the things ASTRO's recommending that the agency do is something similar to MIPS where you get through your performance period, and as the agency looks at the reconciliation associated with any incorrect payments or with quality measures performance, those services or those values for those payments are taken in future years as opposed to the performance year, so you're not out that amount of money during that 20-month period of time.

Tammy: Are PC episode payments calculated by provider or by practice?

Anne: So, each of the episode-based payments, as I mentioned, has a PC component and a TC component. Both of those components are calculated based on your historical experience so you, as a physician, your historical experience is calculated using the historical data between 2015 and 2017, and that becomes your professional and your technical component that's blended with a national rate. Now, your historical experience counts for 90% of your episode-based payment, and the national experience counts for 10% of your episode-based payment.

Tammy: Do you think there will be a lot of change between the proposed model that came out in July and the model when it actually comes out, when the final rules are made?

Anne: I do think that the agency is going to make quite a few changes. I know that our comment letter is 40-some-odd pages long, and it has a lot of recommended revisions to the model. We really feel like the agency needs to do a couple of things. They need to dial back mandatory, first of all. We think it would be reasonable to consider a phase-in over a period of time, similar to the Comprehensive Joint Replacement Model, but mandatory from the outset, particularly for something that has not been tested, is very concerning. Particularly in 40% of episodes, a third of practices, we're hopeful that the agency will dial all of that back.

Anne: The payment methodology itself is way too complex. While we can appreciate that they want to base much of the episode payment on historical experience, there are aspects of the payment methodology that are troublesome. The efficiency factor, for example, has the potential to harm efficient practices, in addition to bringing inefficient practices in line with the national base rate. So we have some concerns with how that was calculated.

Anne: The other issues associated with the payment methodology include the methodology in which they use to establish those national base rates, the 4 and 5% discounts, which we think are too high, the withholds that I mentioned earlier. So there are a number of pieces associated with the payment methodology that we feel really need to change, and I think the agency was definitely listening to us when we met with them on a couple of occasions during the comment period.

Anne: And finally, the quality measures piece. While we can appreciate the need to do quality measures reporting, we want to make sure that it's done in such a way that it's not burdensome on practices.

Tammy: Is there a CMS budget reduction target with the bundling methodology?

Anne: So, it's interesting. In the proposed rule, the agency indicated they were seeking to save 3%, and that would equate to 250 to 260 million over the five-year period. ASTRO did its own analysis with the folks at Avalere Health, and when we did our own analysis, based on how the rule is proposed, this would be a \$320 million reduction on payments to practices, almost 6% over the five-year period. So there's a significant difference

between what they're saying in the proposed rule and what we're seeing based on our analysis, so we're hopeful that, again, the agency will dial this back.

Tammy: What will be the speed of reimbursement, and will they truly be prospective based on diagnosis for the episode payments, inherently decreasing DSO?

Anne: So, the model is designed to be prospectively paid, and as I mentioned, there are two installments of those payments. The first installment comes when you trigger a treatment planning code in combination with a treatment delivery code, and that trigger has to happen within a 28-day period. So, your treatment planning code is dropped, and then 28 days later you have your treatment delivery code. That triggers the first payment.

Anne: The second payment is triggered at the end of treatment, and so once you hit that end of treatment, if there's any additional cost or services that are delivered after that payment, they will not be paid for during that 90-day period. If you have a patient who exceeds the 90-day period and continues to need care in the 28-day clean period after the episode of care, all of that service would be paid fee-for-service. So, we do believe, because it's prospectively paid, practices will be paid at a faster rate than they currently are.

Tammy: So if you could provide two or three takeaways for Radiation Oncology administrators, what would you tell them?

Anne: I would tell Radiation Oncology administrators that this change is coming. I think some of the aspects associated with current coding and billing will stay in place because the agency's going to want to monitor how practices are delivering care, but there will be new practices put in place associated with the prospective payments and these triggers associated with the beginning and the end of an episode of care.

Anne: When I asked the agency how they would go about educating the billing and coding professionals and practice administrators, they said they were putting together webinars to educate folks, and as soon as I learn about those webinars, I will definitely let my friends at SROA know so that you all can get the word out to your membership about these changes.

Tammy: That's great. It's been a pleasure to speak with you today, Anne. Thank you for your insights.

Anne: Thanks, Tammy. It's been great to be with you.

Tammy: For more information, visit www.sroa.org.