

Radiation Oncology APM

What we know, what we don't know and how to prepare.

Anne Hubbard, MBA
Director of Health Policy

Agenda

- Background – How did we get here?
- RO-APM - What we know
- What we don't know and what we think might happen.
- How ASTRO is getting ready and what you can do too.

Agenda

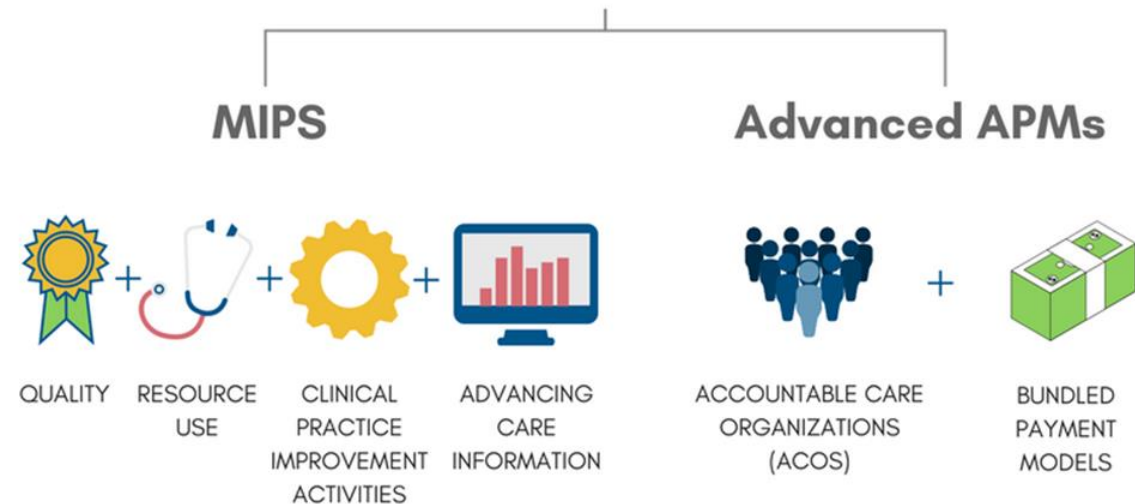
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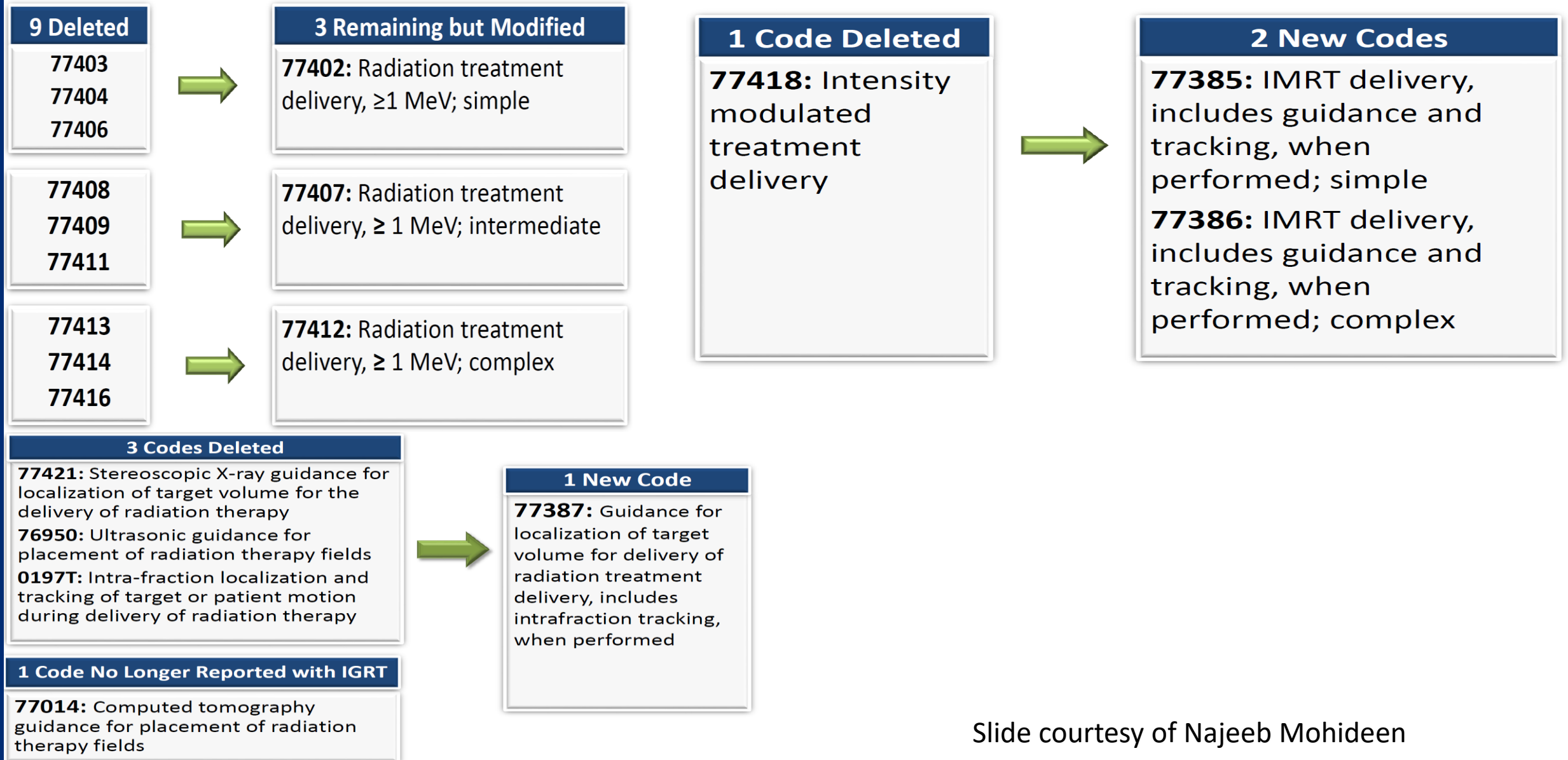
2015 Medicare and CHIP Reauthorization Act (MACRA)

- Replaced the Sustainable Growth Rate with the Quality Payment Program
 - Shifts Medicare payment from volume based to value based
 - Merit Based Incentive Payment Program (MIPS)
 - Alternative Payment Models (APM)

MACRA/QUALITY PAYMENT PROGRAM (QPP)



What we expected in 2015...



What we got in 2015...

Conventional Treatment Delivery

DELETED CPT CODE	2015-2018 HCPCS CODE
77402	G6003
77403	G6004
77404	G6005
77406	G6006
77407	G6007
77408	G6008
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77416	G6014

IMRT

DELETED CPT CODE	2015-2018 HCPCS CODE
77418	G6015
0073T	G6016

Image Guidance

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76950	G6001
77421	G6002
0197T	G6017



Background

2015 Patient Access and Medicare Protection Act (PAMPA)

- Froze radiation oncology treatment delivery, IMRT and IGRT payment rates
- Addressed payment stability issues in freestanding settings
- Required CMMI to issue report to Congress on viability of a RO-APM
 - Report was issued in November 2017
- Freeze was set to expire at the end of 2018
- ASTRO secured an extension through the end of 2019 to allow for a successful transition to a radiation oncology APM



Radiation Oncology Advanced APM

ASTRO has been working with stakeholders, including **CMMI**, to develop a **Radiation Oncology Alternative Payment Model (RO-APM)** that **drives GREATER VALUE IN CANCER CARE** and achieves the goals of **MACRA**.

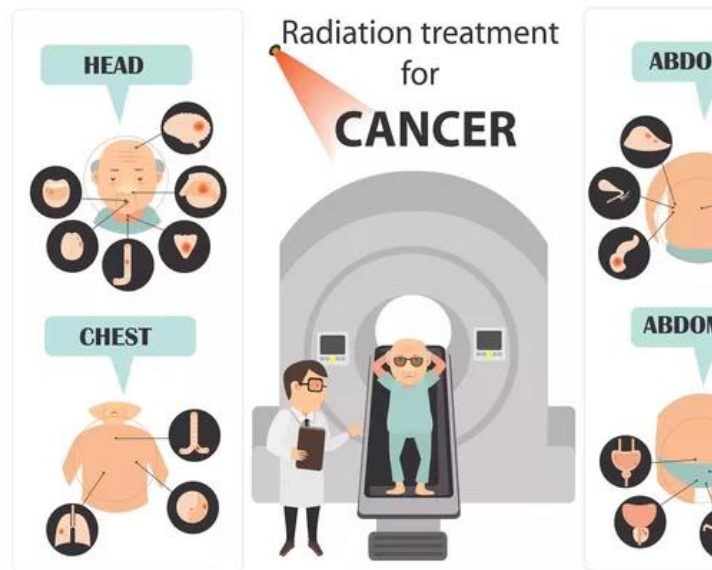
TO REALIZE **THE GOALS OF MACRA**, IT IS **CRITICAL** THAT AN **RO-APM** BE **IMPLEMENTED THIS YEAR**.

RO-APM

In the US, **over one million cancer patients** are **treated with radiation therapies** each year. An **RO-APM** would **HELP ENSURE ACCESS TO CARE** for cancer patients.

ENSURE TRANSPARENCY in the design, scope and goals of **advanced alternative payment models**. **INCORPORATE** stakeholder **INPUT THROUGH** the rule making process.

Guideline-Driven Radiation Oncology APM



- Guidelines adherence will improve quality and reduce unnecessary care and waste
 - ASTRO and NCCN guidelines, as well as Choosing Wisely guidance
- Standard APM payment framework applicable to all disease sites
- Applicable in Freestanding and Hospital Based Settings
- Quality Measures
 - MIPS Radiation Oncology Measures Set
 - APEx Accreditation or equivalent standards
 - Measures that determine compliance with guidelines
- Certified Electronic Health Records Technology

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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.

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 Online Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2250	Date: February 15, 2019
	Change Request 11177

Confidential

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

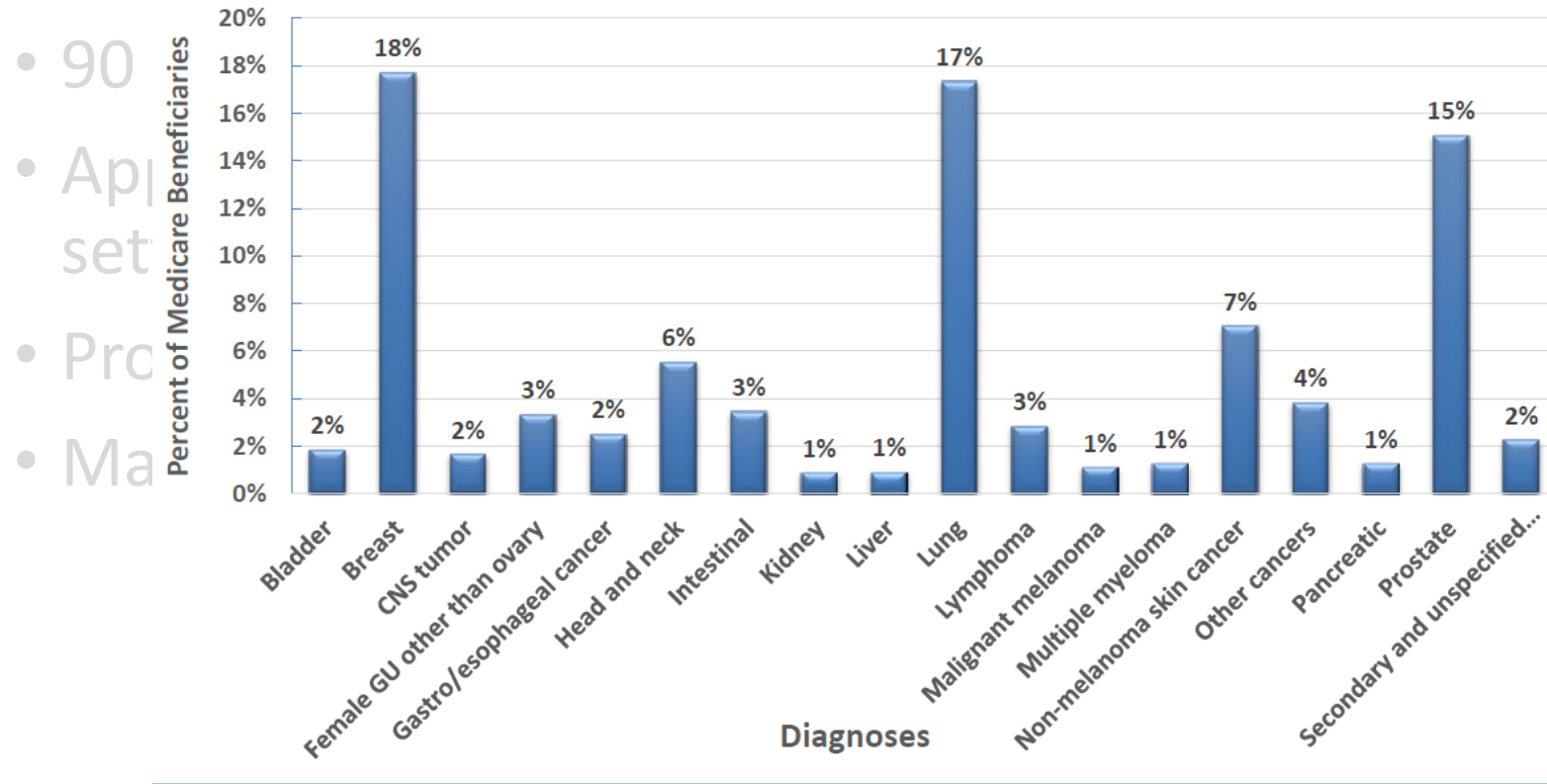
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What we know....

- 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....

- 17 Disease Sites
- 90 day Episode of Care



- 2nd installment at the end of an episode
- Mandatory for select CBSA's

What we know....

- 17 Disease Sites
- 90 day Episode of Care
- Applicable in both freestanding and hospital based setting

- Prc

- Ma

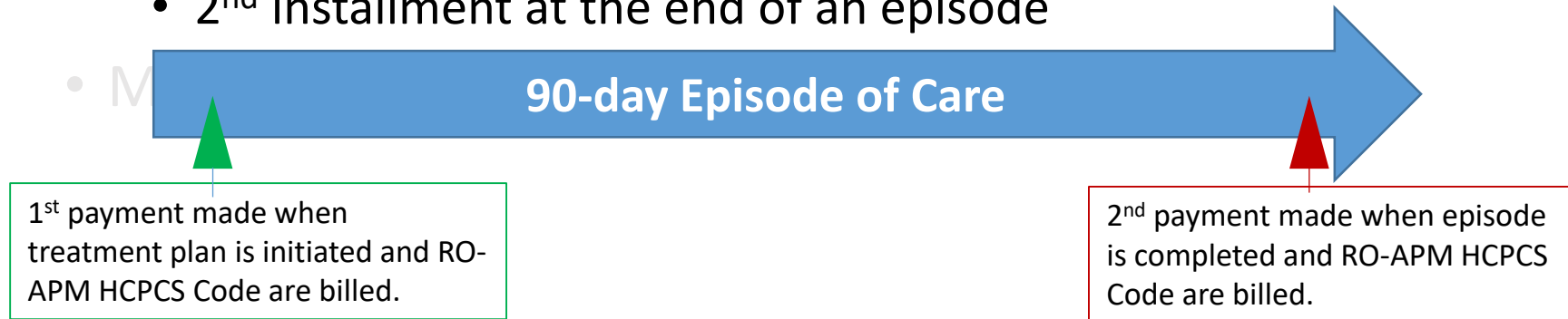


CBSA's



What we know....

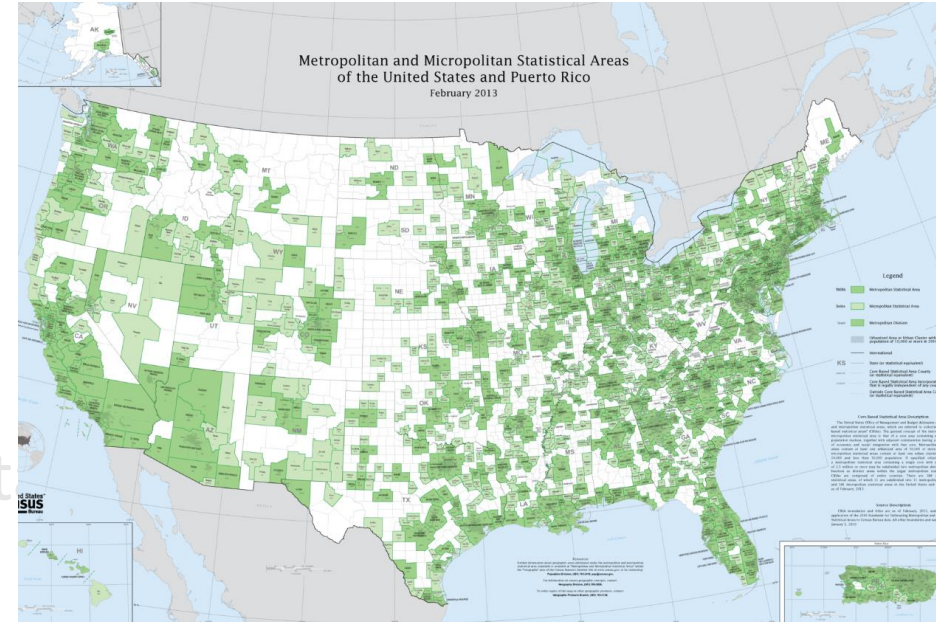
- 17 Disease Sites
- 90 day Episode of Care
- Applicable in both freestanding and hospital based setting
- **Prospective payment**
 - 1st installment at the beginning of an episode
 - 2nd installment at the end of an episode



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

What we know....

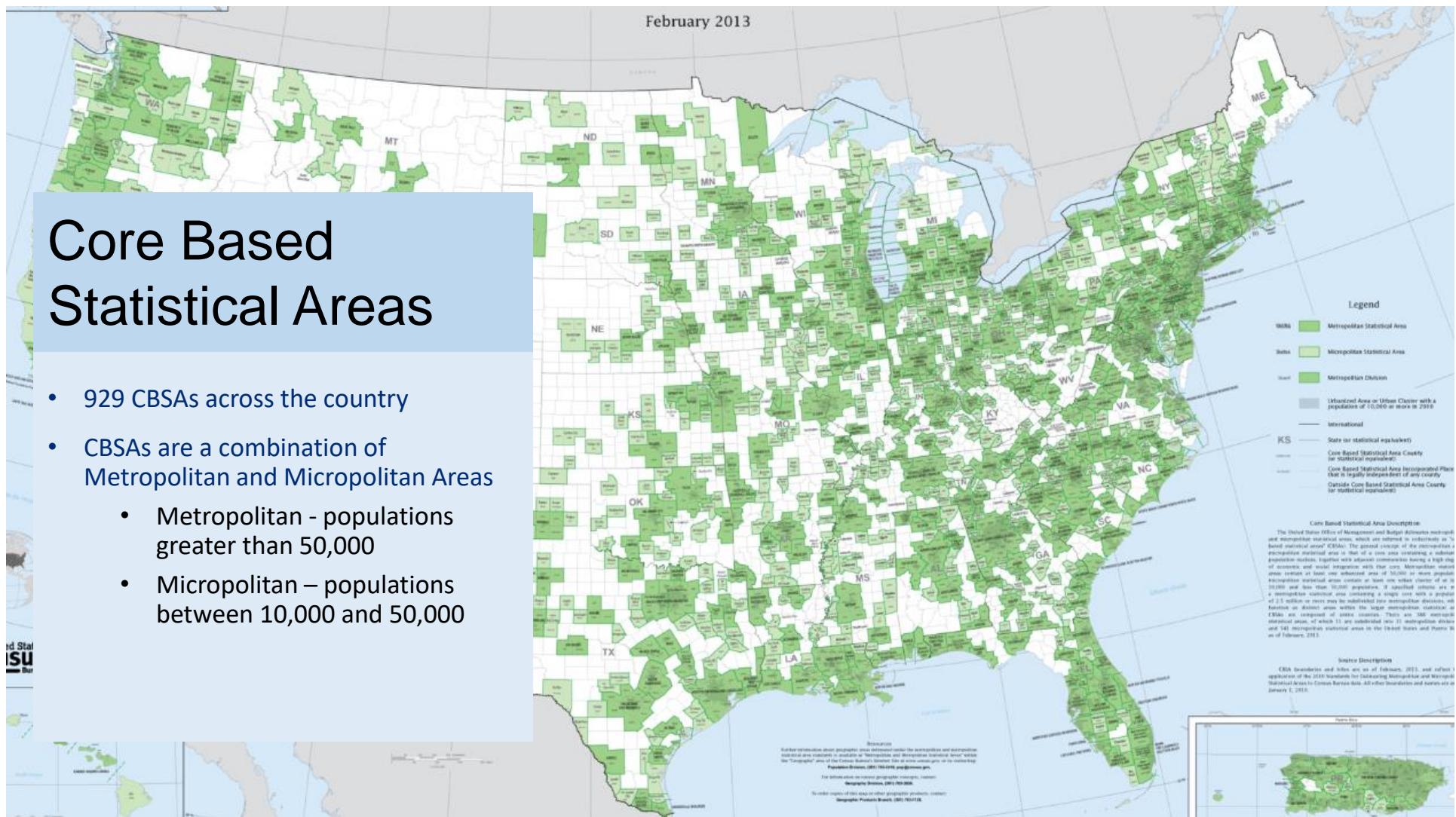
- 17 Disease Sites
- 90 day Episode of Care
- Applicable in both freestanding setting
- Prospective payment
- **Mandatory for select CBSA's**
 - What is a CBSA?



February 2013

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



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 Administration³—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/s/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>.

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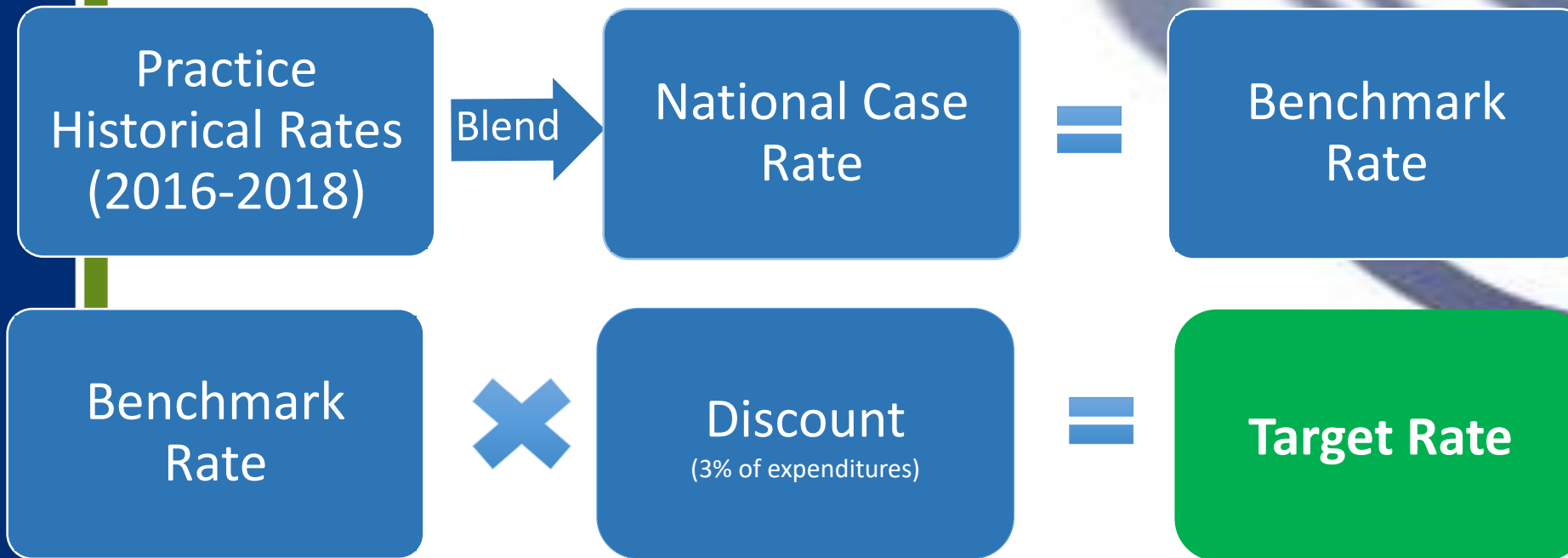
What we don't know...

Payment Methodology



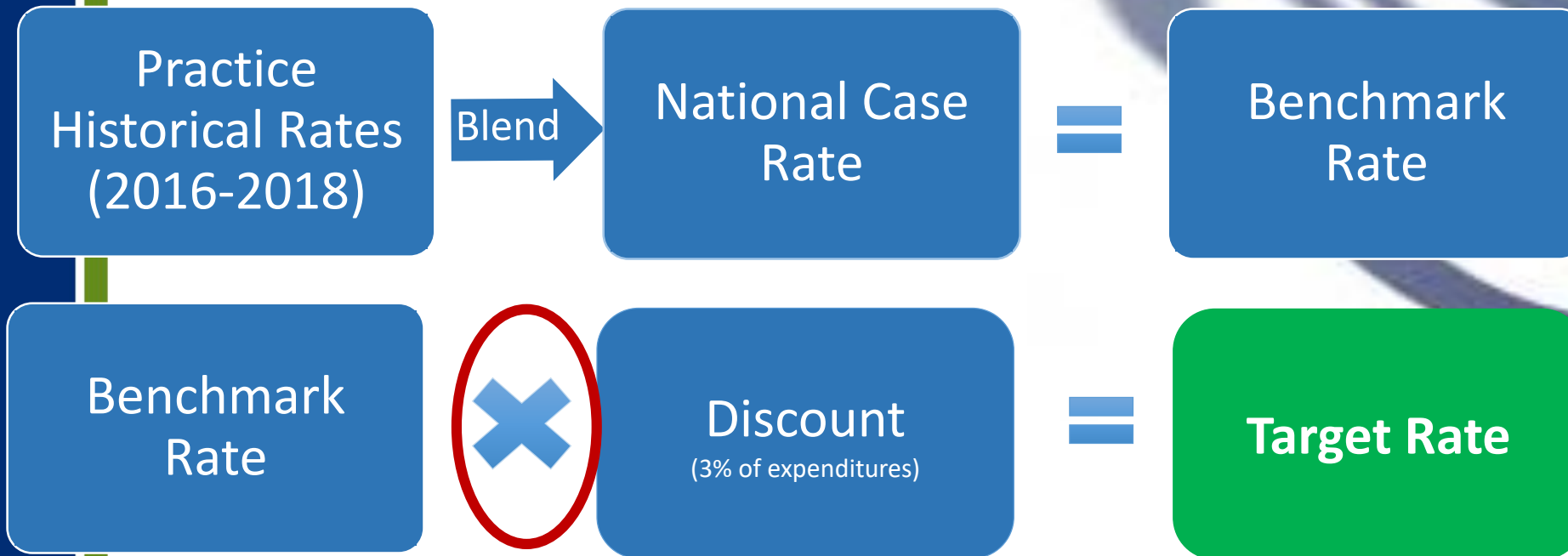
What we think might happen...

Payment Methodology



What we think might happen...

Payment Methodology



What we think might happen...

Payment Methodology

Benchmark
Rate



Discount
(3% of expenditures)



Target Rate

- Patient Case Mix Adjustment
 - Patient Characteristics (demographics, dual eligible status)
 - Hierarchical Condition Categories
- Efficiency Adjustment
 - Practice efficiency relative to other practices



What we don't know...

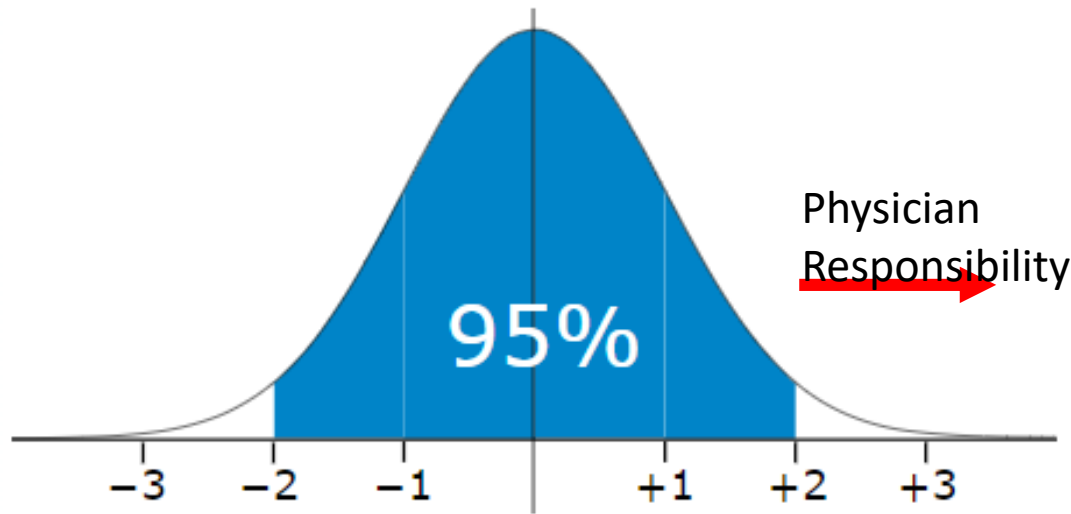
Two-Sided Risk



What we think might happen...

Two-Sided Risk

- Phased in
- Amount linked regional costs



\$39,979.49
Mid-Atlantic
Regional Target Rate



What we don't know...

Quality Measures



What we think might happen...

Quality Measures

- MIPS Radiation Oncology Measures Set
- CAHPS Cancer Care Survey



What we think might happen...

Quality Measures

- MIPS Radiation Oncology Measures Set
 - Pain intensity Quantified
 - Plan of Care for Pain
 - Avoidance of Bone Scan for Low Risk Prostate Cancer



What we think might happen...

Quality Measures

- MIPS Radiation Oncology Measures Set
- CAHPS Cancer Care Survey



What we don't know...

Treatment Delivery, IMRT
& IGRT G-Codes



DATES OF SERVICE	PROCEDURE CODE	
	82272	PU
	94010	PULMO
	94375	CARDIOVASCUL
	93000	VENIPUNCTUR
	36410	

What we think might happen...

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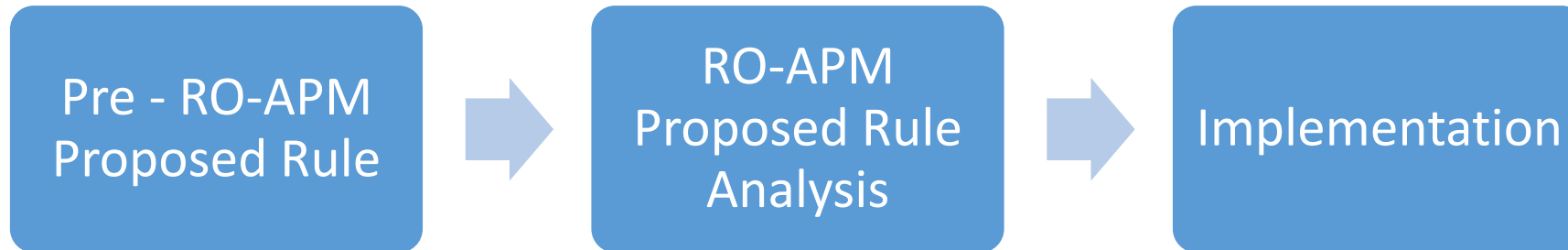
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Retained During Transition Period?

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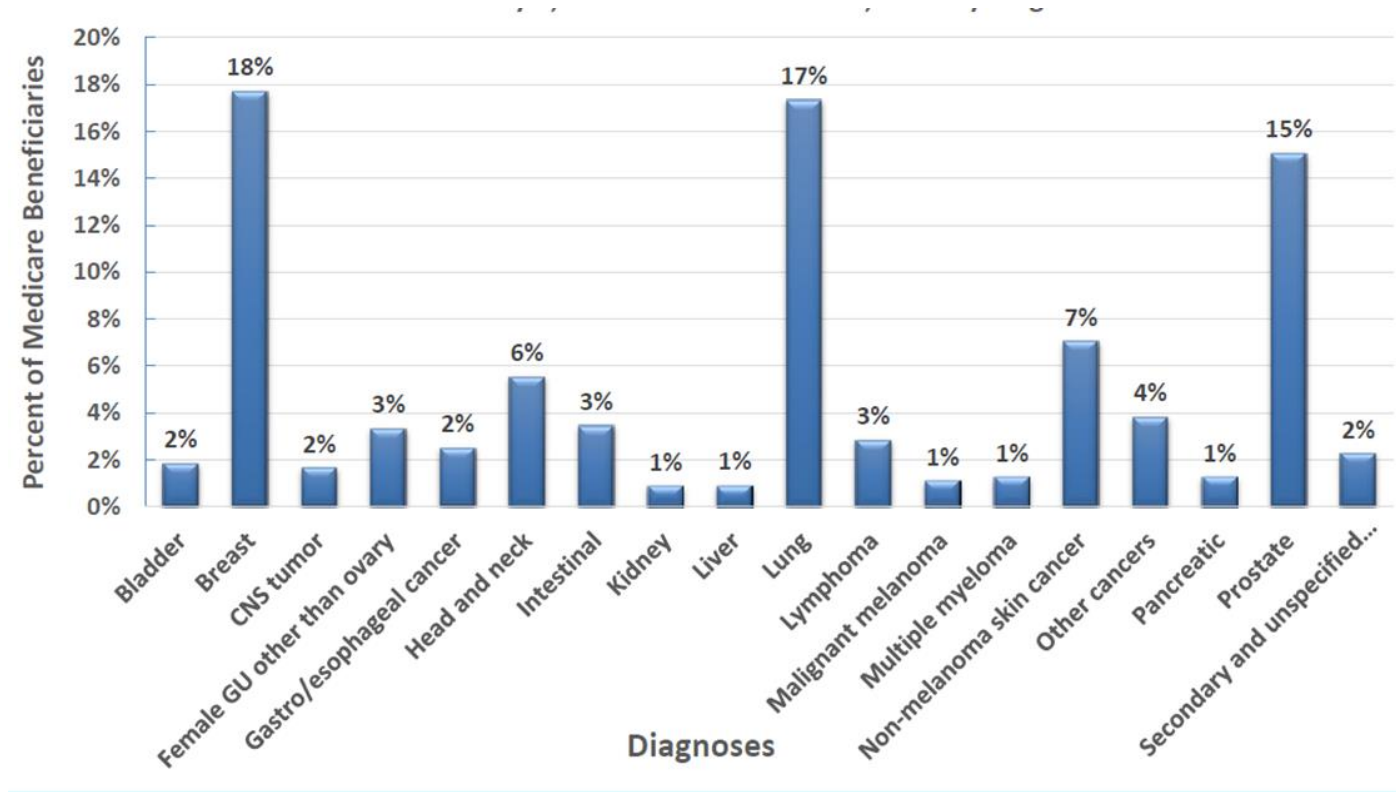
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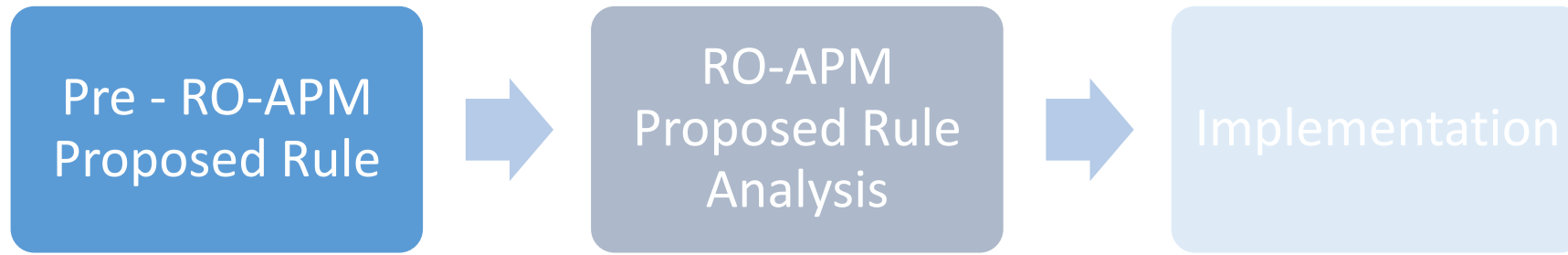
Preparation is Key



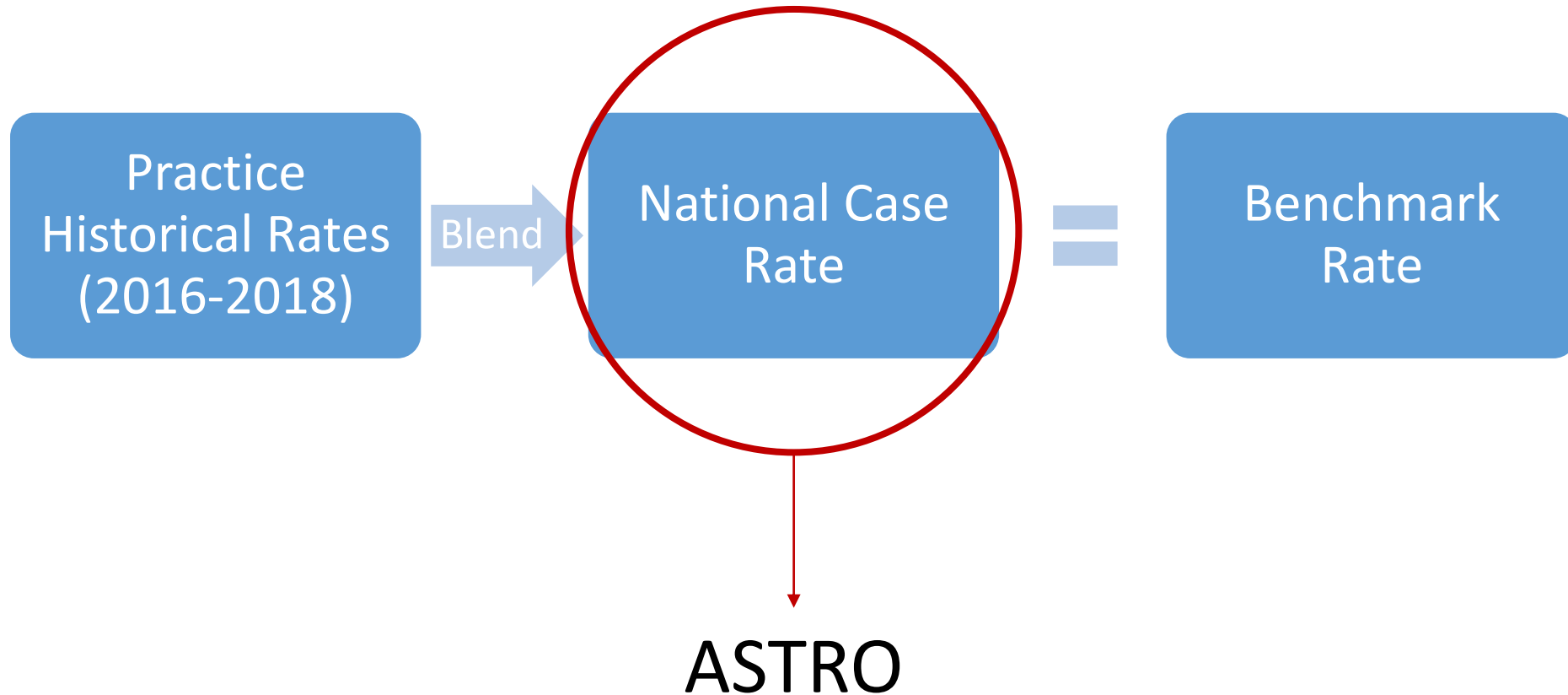


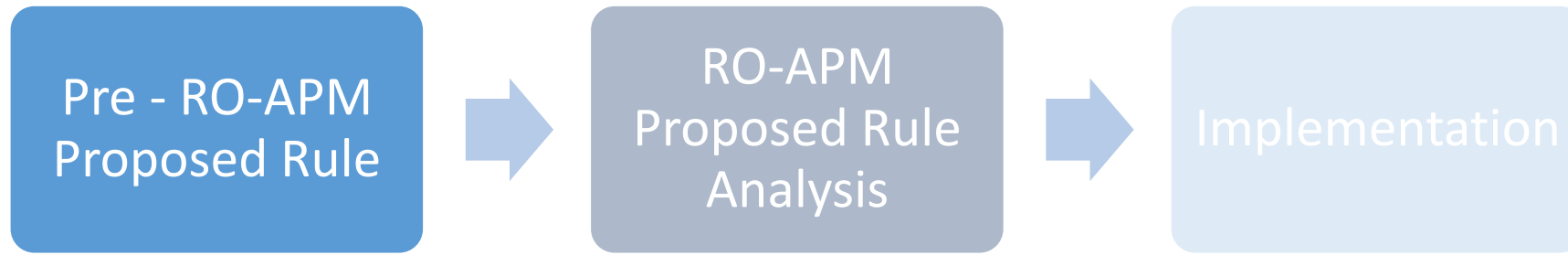
Develop National Case Rates



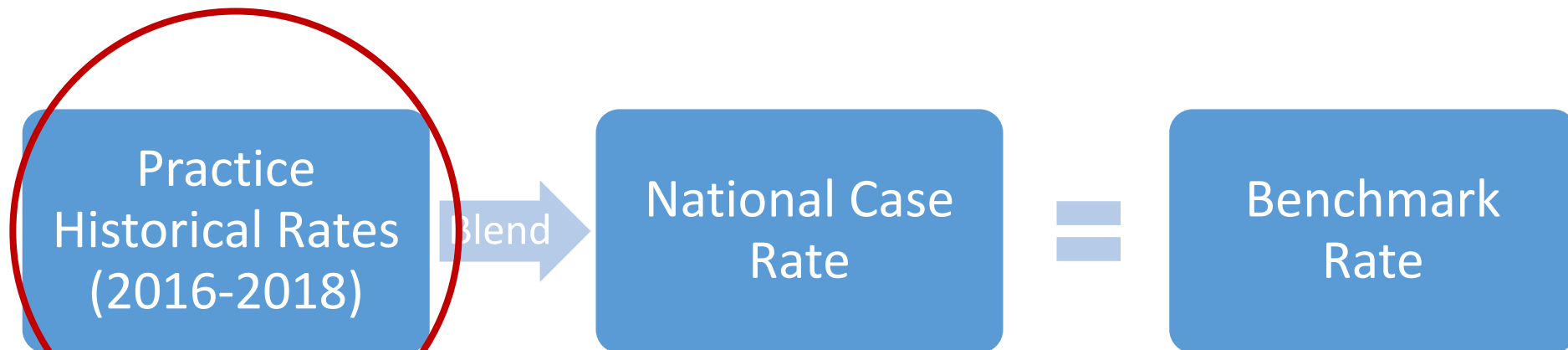


Develop National Case Rates

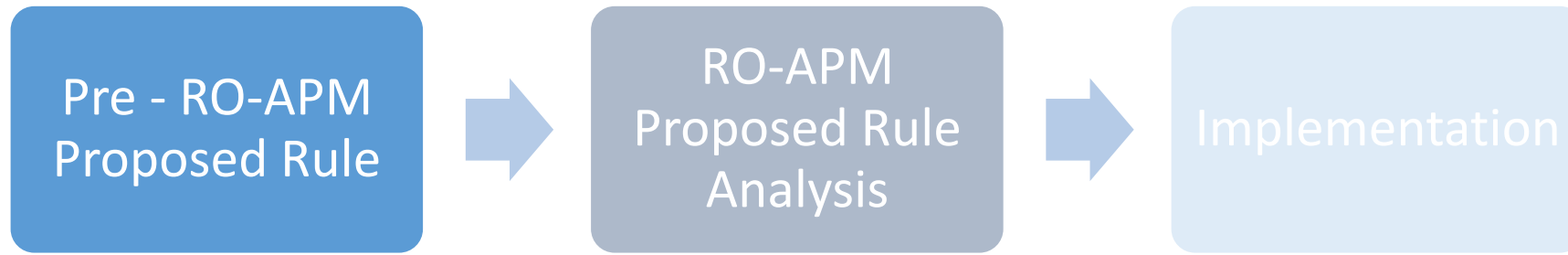




Develop National Case Rates



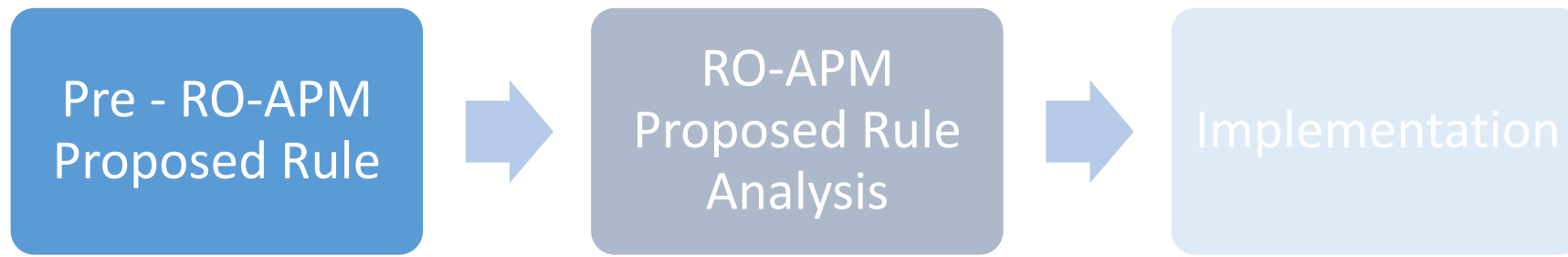
RO Practices



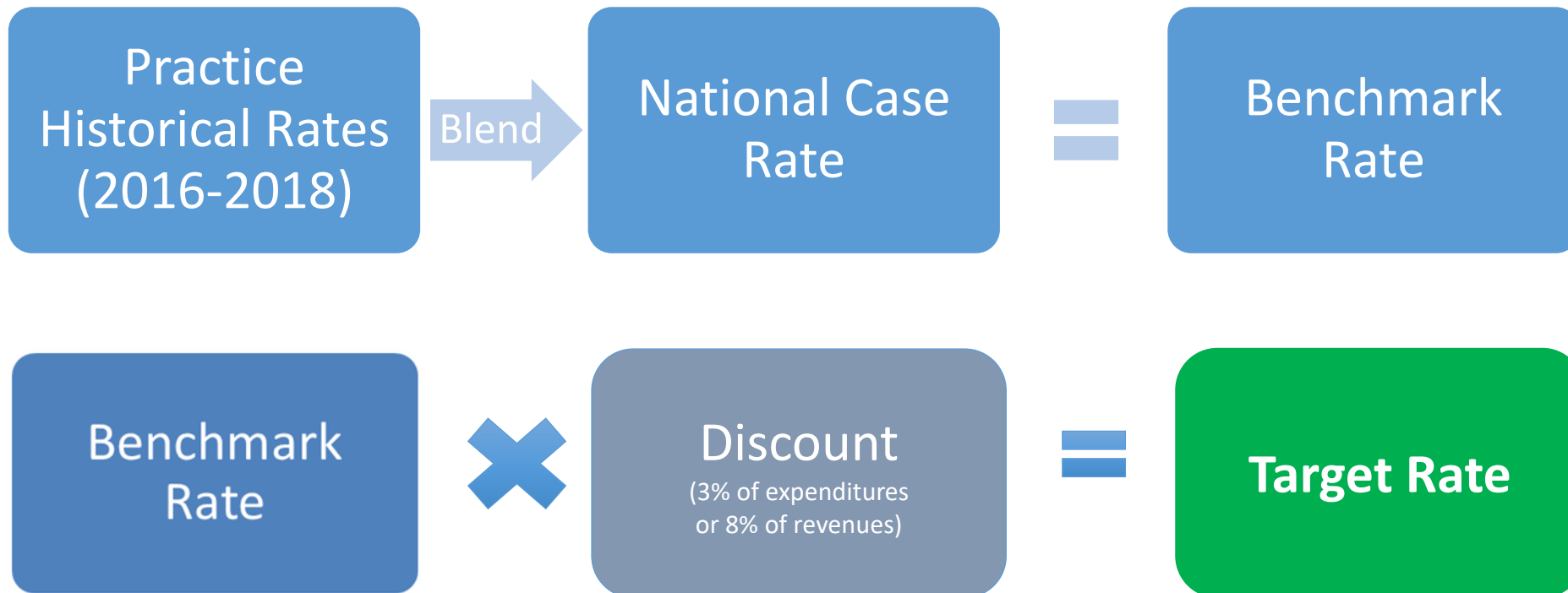
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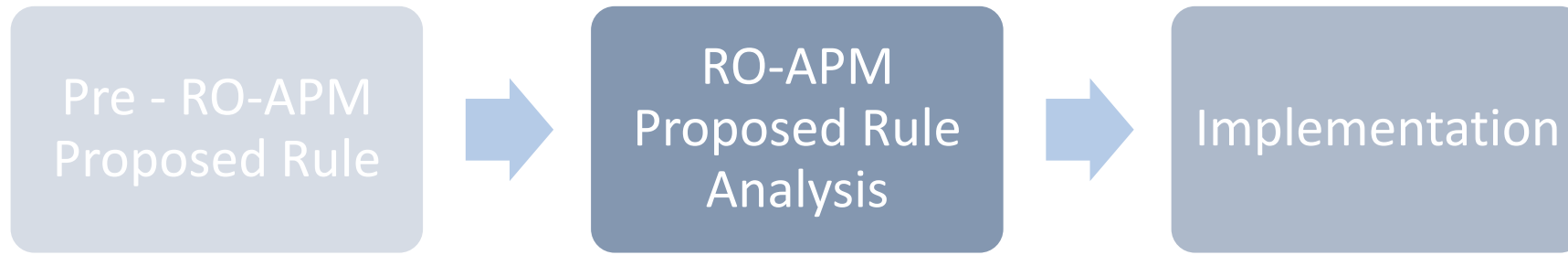


RO practices should be analyzing historical revenues by disease site and modality use within each disease site



Develop National Case Rates

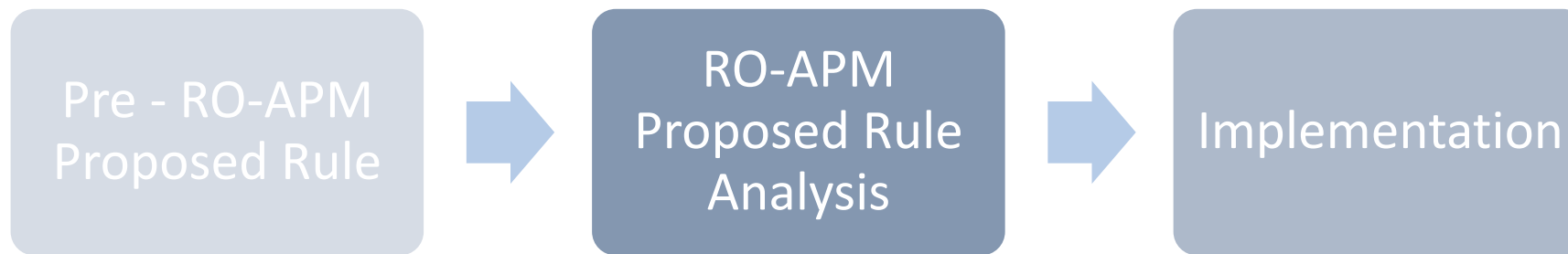




FEDERAL REGISTER
The Daily Journal of the United States Government

Anticipate release in June or July as a “Notice of Proposed Rule Making”

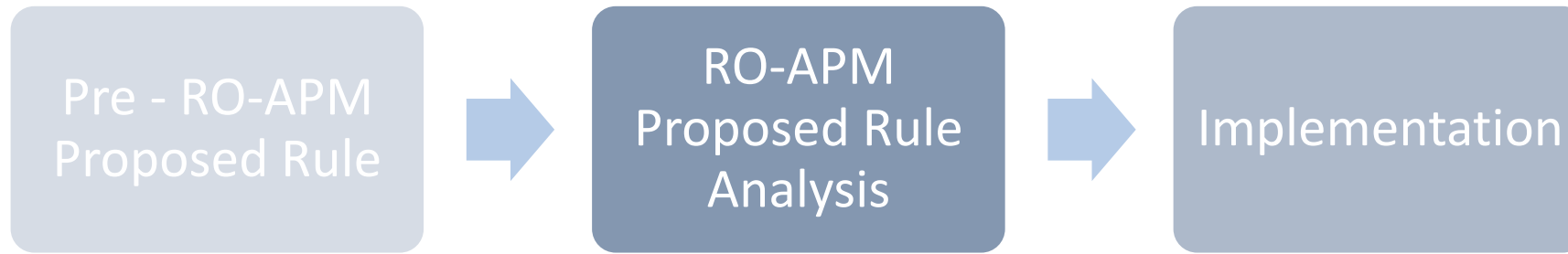
A proposed rule, or Notice of Proposed Rule Making (NPRM), is the official document that announces and explains the Agency’s plan to address a problem or accomplish a goal. All proposed rules must be published in the Federal Register to notify the public and to give them an opportunity to submit comments. The proposed rule and the public comments received on it for the basis of a final rule.



Level of Detail will Dictate Analysis

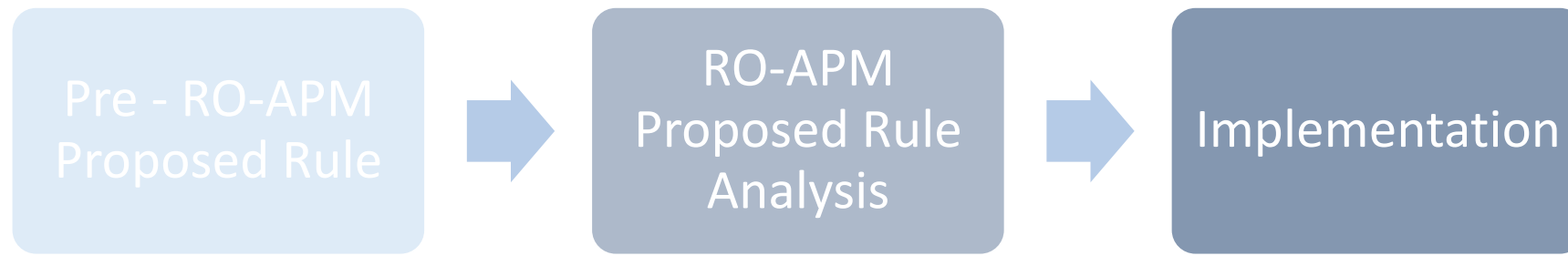
- CJR model released in 2015 was pretty detailed.
- Recent model roll outs have been light on detail.
 - BPCI Advanced issued in January 2018. Details on payment methodology weren't issued until May 2018.
 - Primary Care First issued in April 2019 also light on details.
- Difference may be that CJR was a proposed rule and recent models have been RFAs.





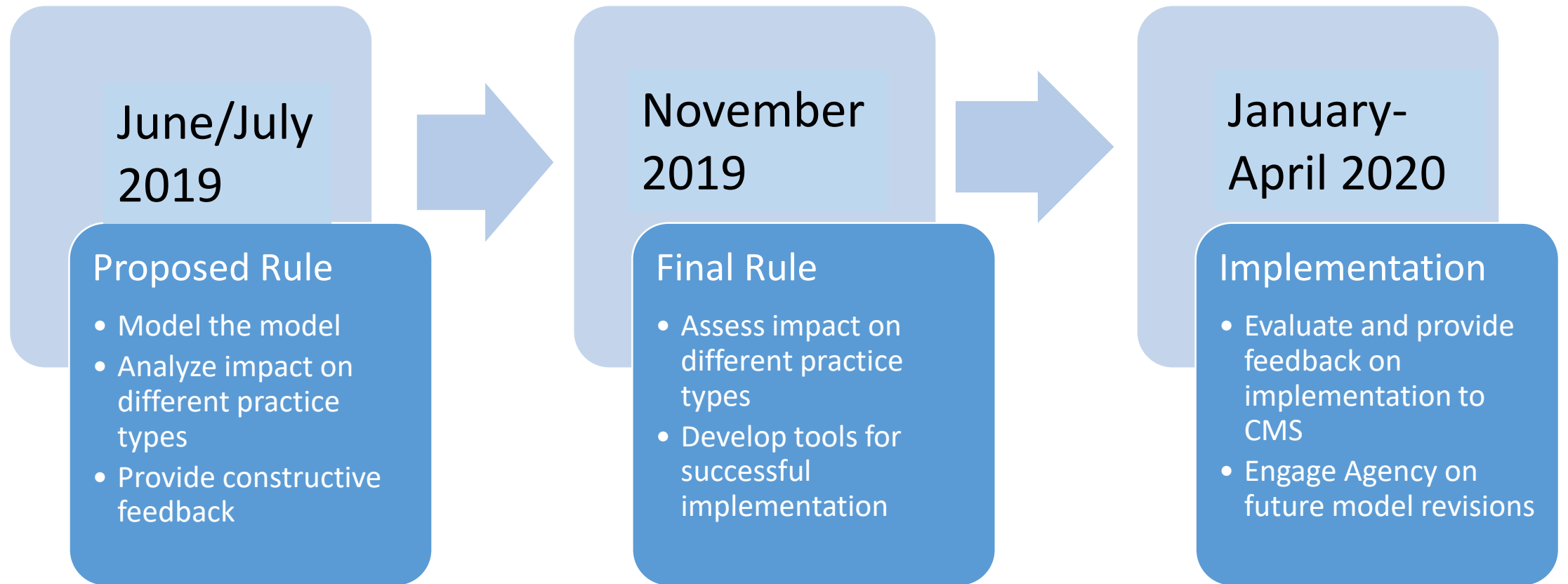
- Model the RO-APM described in the proposed rule
- Replicate the payment methodology
- Determine impact on freestanding and hospital based practices
- Assist CMMI in the refinement of the RO-APM proposal
- Submit comments to CMS during 60-day comment period





- Educate ASTRO members and stakeholder groups on RO-APM implementation
- Monitor implementation process
- Establish focus groups representative of freestanding, academic medical center and community based practices
 - Evaluate issues and costs associated with operationalization
 - Identify issues of common concern that should be raised with CMMI
- Work with CMMI to refine the RO-APM during the implementation period and beyond

Timeline



Questions

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