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For more than 18 years, Oncology Management Consulting Group has provided the finest professional consulting services to oncology providers across the US. Our highly knowledgeable consultants are nationally recognized specialists that assist organizations to achieve their business goals and to maximize their organizational performance. With solutions tailored to each client's very precise needs, OMC Group offers the leadership, vision, and collaboration that oncology organizations need to adapt to and to succeed in the rapidly changing healthcare industry.

- Financial and Market Analyses
- New Center Development
- Hospital/Physician Integration
- Performance and Financial Benchmarking
- Strategic Planning
- Operational Assessments
- Revenue Cycle Reviews
- Implementation and Interim Leadership

Stay tuned, the webinar will begin shortly

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CMS' Proposed Radiation Bundling: Disaster Or Boon?

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Sally Luehring, MSL, RHIA

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Teri U. Guidi, MBA, FAAMA

Teri U. Guidi is the President and CEO of Oncology Management Consulting Group based in Tampa, Florida. With decades of experience in oncology management, OMC Group is expert in the areas of strategic planning, reimbursement, program development, and market assessment. OMC experts have assisted countless health networks, hospitals, private practices, and many pharmaceutical/biotech firms. Recent projects include strategic and business planning, joint venture development, hospital/physician alignment, educational programs, comprehensive revenue cycle reviews and program assessments.

Prior to establishing OMC Group in 2001, Ms. Guidi held positions at institutions ranging from NCI-designated comprehensive cancer centers to large teaching hospitals in integrated health systems to small community hospitals. She has served as Executive Director and System Vice President of cancer service lines, and as Vice President of health system-owned medical oncology, gynecologic oncology and surgical oncology practices.

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Agenda

- Background
- Current proposal
- Financial projections
- Other impacts

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A Little History

- Before 2000
  - CMS payments for hospital outpatient services based on costs using Cost Reports
- 1997 – 2000
  - CMS proposes Ambulatory Patient Groups as prospective outpatient payment system, similar to DRGs for inpatients

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More history

- APGs essentially proposed to bundle all services delivered at one visit into one fixed payment rate
- “Feed them lobster or feed them dry toast, no matter. Same pay.”
- Enormous outcry, especially from medical oncology

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APCs Evolved

CODE	1998 APG	1999 APC	2002 APC
77261	750		
77262	750		
77263	750		
77280	752	5611	304
77285	752	5612	305
77290	752	5612	305
77295	752	5613	310
77299	751	5611	
77300	751	5611	304
77301		5613	712
77305	751		304
77306		5612	
77307		5612	
77310	751		304
77315	751		305
77316		5612	
77317		5612	
77318		5612	
77321	751	5612	305
77326	751		305
77327	751		305
77328	751		305
77331	751	5611	304
77332	751	5611	303
77333	751	5611	303
77334	751	5612	303
77336	750	5611	304
77338		5612	

CODE	1998 APG	1999 APC	2002 APC
77370	750	5611	305
77371		5627	
77372		5627	
77373		5626	
77385		5623	
77386		5623	
77399	757	5611	304
77401	757	5621	300
77402	757	5621	300
77403	757		300
77404	757		300
77406	757		300
77407	757	5622	300
77408	757		300
77409	757		300
77411	757		300
77412	757	5622	300
77413	757		300
77414	757		300
77416	757		300
77417	700		260
77418			710
77423		5623	
77424		5627	
77425		5627	
77431	750		
77432	750		
77470	757	5623	299

CODE	1998 APG	1999 APC	2002 APC
77499			
77520		5623	710
77522		5625	710
77523		5625	712
77525		5625	712
77600	758	5622	314
77605	758	5624	314
77610	758	5623	314
77615	758	5623	314
77620	758	5623	314
77750	759	5622	301
77761	759	5623	312
77762	759	5623	312
77763	759	5624	312
77767		5622	
77768		5622	
77770		5624	
77771		5624	
77772		5624	
77776	759		312
77777	759		312
77778	759	5624	312
77781	759		313
77782	759		313
77783	759		313
77784	759		313
77789	759	5621	300
77799	759	5621	313

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Refinement?

1998 APG
700
750
751
752
757
758
758
759

1999 APC
5611
5612
5612
5613
5621
5622
5623
5624
5625
5626
5627

2002 APC
260
299
300
301
303
304
305
310
312
313
314
710
712

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Bundling versus Packaging

- Bundling is where one or more codes are considered included in another code and so should not be billed together
- Packaging is where one or more codes are included in the payment for another code but they can (and should) still be billed separately

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Current Proposition

- Package a WHOLE lot of codes into a single technical and a single professional payment
- Pay the same for technical services regardless of site of care

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What's Included?

- All services in a 90 day period beginning with initial planning
- 17 Disease groups
  - Anal, Bladder, Bone Mets, Brain Mets, Breast, Cervical, CNS, Colorectal, Head and Neck, Kidney, Liver, Lung, Lymphoma, Pancreatic, Prostate, Upper GI, Uterine
- Codes 55920, 57155-6, 58346, 77014, 77021, 77261-77799, C code for Brachy, G0339-40, G6001-17, Q3001

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Who Is Included?

- Good question
  - Hospital centers
  - Physician practices
  - Freestanding centers
  - “Mandatory” for providers in specific geographies TBA

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Payment Rates

Type of cancer	Professional component	Technical component
Anal	$2,968	$16,006
Bladder	$2,637	$12,556
Bone metastases	$1,372	$5,568
Brain metastases	$1,566	$9,217
Breast	$2,074	$9,740
Cervical	$3,779	$16,955
CNS tumor	$2,463	$14,193
Colorectal	$2,369	$11,589
Head and neck	$2,947	$16,708
Kidney	$1,550	$7,656
Liver	$1,515	$14,650
Lung	$2,155	$11,451
Lymphoma	$1,662	$7,444
Pancreatic	$2,380	$13,070
Prostate	$3,228	$19,852
Upper GI	$2,500	$12,619
Uterine	$2,376	$11,221

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Adjustments

- Trend Factor: adjustment applied to the national base rates that updates those rates to reflect current trends in the OPPS and PFS rates for RT services
- Case Mix and Historical: each Participant's historical experience and case mix history
- Efficiency factor: if a RO participant's episodes (from the retrospectively constructed episodes from 2015-2017 claims data) have historically been more or less costly than the national base rates

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More Adjustments

- Discount Factor: reserve savings for Medicare and reduce beneficiary cost-sharing
- Withhold Incorrect Payment: reserve money for purposes of reconciling duplicate RT services and incomplete episodes
- Withhold Quality/Patient Experience:
  - Pro: to allow the Model to include quality measure results
  - Tech: not until year 3
- Geographic Adjustment

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And About Those Adjustments

- How far in advance will CMS release the figures and how will they be calculated (especially the participant-specific ones)?
- Will all or just some be specific to a disease group?
- Will there be a mechanism to challenge participant-specific numbers?
- We need to be able to know these things in order to budget and forecast

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Current Adjustments

- OPPS:

  Rate * .6 * *Wage Index*

  + Rate * .4

  Payment

- PFS

  wRVU * *work GPCI*

  + PE RVU * *PE GPCI*

  + MP RVU * *MP GPCI*

  Subtotal * CF = Payment

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Proposed: Simple, Right?

TABLE 5 EXAMPLE: PARTICIPANT-SPECIFIC PROFESSIONAL EPISODE PAYMENT FOR LUNG CANCER
ALL NUMBERS ARE ILLUSTRATIVE ONLY

	Professional Component	
	Amount	**Formula**
National Base Rate (a)	$2,155.00	
Trend Factor (b)	1.04	
Subtotal (c)	$2,241.20	c = a * b
Case Mix Adjustment (d)	0.02	For example (102-100) / 100
Historical Experience Adjuster (e)	0.14	For example (116-102) / 100
Year 1 Efficiency Factor (f)	0.90	
Adjustments combined (g)	1.15	g = d + (e * f) + 1
Subtotal (h)	$2,568.42	h = c * g
Discount Factor (i)	0.96	
Subtotal (j)	$2,465.68	j = i * h
Withhold #1 (Incorrect Payment) (k)	0.98	
Withhold #2 (Quality Performance) (l)	0.98	
Subtotal2 (m)	$2,368.04	m = j * k * l
Geographic Adjustment (n)	1.02	
2019 Total Episode Payment to Participant including Coinsurance owed by RO beneficiary (o)	$2,415.40	o = m * n
20% Beneficiary Coinsurance Determined (p)	**$483.08**	**p = o * 0.20**
80% Participant Payment (q)	$1,932.32	q = o * 0.80
Sequestration Claims Payment Adjustment to Participant Payment (r) [r = participant-specific professional episode payment]	$1,893.67	r = q * 0.98
Episode Payment 1 (s)*	**$946.84**	**s = r / 2**
Episode Payment 2 (t)*	**$946.84**	**t = r / 2**

^ .All numbers are rounded to two decimal places.

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Examples

- Data based on actual services billed as "split" services (hospital and professional) for:

DX GROUP	# OF PTS
ANAL	2
BLADDER	3
BONE METS	49
BRAIN METS	22
BREAST	171
CERVICAL	7
CNS	9
COLORECTAL	12
H/N	31

DX GROUP	# OF PTS
KIDNEY	1
LIVER	3
LUNG	44
LYMPH	16
PANCREAS	5
PROST	44
UP GI	11
UTERINE	19

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Adjustment Assumptions

- The “before” data:
  - Work GPCI 1.00
  - Practice Expense 0.96
  - Malpractice Expense 0.35
  - OPPS Wage Index 0.93
- The APM data:
  - Factors as in CMS samples except geography at OPPS wage index

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Results for Technical Services

	DX GROUP	CURRENT PMTS	APM PMTS	% VARIANCE
TECHNICAL SERVICES (VS. OPPS)	ANAL	39,284	32,353	82%
	BLADDER	26,771	38,069	142%
	BONE METS	255,075	275,738	108%
	BRAIN METS	239,532	204,934	86%
	BREAST	1,204,100	1,683,281	140%
	CERVICAL	168,796	119,949	71%
	CNS	149,360	129,098	86%
	COLORECTAL	134,705	140,659	104%
	H/N	333,064	523,465	157%
	KIDNEY	11,838	7,738	65%
	LIVER	40,163	44,418	111%
	LUNG	521,572	509,211	98%
	LYMPH	148,219	120,373	81%
	PANCREAS	99,169	66,046	67%
	PROST	880,112	882,792	100%
	UP GI	162,771	140,288	86%
	UTERINE	248,910	215,470	87%
	TOTAL	4,663,441	5,133,882	110%

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Results for Professional Services

	DX GROUP	CURRENT PMTS	APM PMTS	% VARIANCE
RAD ONC PRO FEES (VS. FACILITY-BASED)	ANAL	7,078	6,082	86%
	BLADDER	5,793	6,355	110%
	BONE METS	61,634	54,003	88%
	BRAIN METS	40,383	27,674	69%
	BREAST	271,863	284,885	105%
	CERVICAL	35,716	21,249	59%
	CNS	26,285	17,806	68%
	COLORECTAI	28,872	22,836	79%
	H/N	62,561	73,385	117%
	KIDNEY	2,613	1,245	48%
	LIVER	7,113	3,651	51%
	LUNG	105,648	76,167	72%
	LYMPH	31,221	21,361	68%
	PANCREAS	19,153	9,559	50%
	PROST	150,376	114,091	76%
	UP GI	31,677	22,090	70%
	UTERINE	58,735	36,263	62%
	TOTAL	946,722	798,701	84%

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Results for Freestanding "Global" Services

	DX GROUP	CURRENT PMTS	APM PMTS	% VARIANCE
FREESTANDING GLOBAL	ANAL	36,548	38,435	105%
	BLADDER	25,573	44,424	174%
	BONE METS	230,220	329,741	143%
	BRAIN METS	163,222	232,608	143%
	BREAST	1,277,204	1,968,167	154%
	CERVICAL	113,918	141,198	124%
	CNS	148,326	146,904	99%
	COLORECTAL	168,785	163,494	97%
	H/N	336,304	596,850	177%
	KIDNEY	12,922	8,983	70%
	LIVER	37,525	48,069	128%
	LUNG	535,879	585,378	109%
	LYMPH	161,213	141,733	88%
	PANCREAS	103,703	75,605	73%
	PROST	848,102	996,883	118%
	UP GI	174,717	162,378	93%
	UTERINE	209,835	251,733	120%
	TOTAL	4,583,995	5,932,583	129%

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Winners and Losers?

- Frankly, some look too good to be true:
  - Overly generous assumptions?
  - Billing issues in the data?

DISEASE GROUP	OPPS CHANGE	PROF CHANGE	GLOBAL CHANGE
ANAL	82%	86%	105%
BLADDER	142%	110%	174%
BONE METS	108%	88%	143%
BRAIN METS	86%	69%	143%
BREAST	140%	105%	154%
CERVICAL	71%	59%	124%
CNS	86%	68%	99%
COLORECTAL	104%	79%	97%
H/N	157%	117%	177%
KIDNEY	65%	48%	70%
LIVER	111%	51%	128%
LUNG	98%	72%	109%
LYMPH	81%	68%	88%
PANCREAS	67%	50%	73%
PROST	100%	76%	118%
UP GI	86%	70%	93%
UTERINE	87%	62%	120%
TOTAL	110%	84%	129%

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WHAT IMPACT *BESIDES* FINANCIALS?

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Sally Luehring, MSL, RHIA

Sally Luehring currently serves as Executive Director, Cancer Services & Clinical Research for the Hospital Sisters Health System (HSHS) – Eastern Wisconsin Division which includes St. Vincent Hospital and St. Mary's Hospital Medical Center in Green Bay, WI, St. Clare Memorial Hospital in Oconto Falls, WI and St. Nicholas Hospital in Sheboygan, WI.

In her role as executive director, Sally is responsible for developing and executing strategic plans and objectives for the cancer service line. She manages business development and oversees financial, quality, safety, accreditation, regulatory, performance improvement, human resource and contractual objectives throughout the service line. She also assists in the development and coordination of marketing plans for regional cancer services.

Sally holds a Bachelor's Degree in Health Care Administration and a Masters' Degree in Strategic Leadership. In addition to her tenure in cancer services, her background experience includes various leadership roles in Health Information Management and HIPAA compliance.

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Operational Barriers to Implementation

- Short timeline for implementation
- Budgeting: We are already in the fiscal year to be impacted; impact on budgeted revenue for next fiscal year.
- Multiple radiation oncology centers in our system with variety of business models; mix of participant models to manage.
- Many, many processes to establish for collection of quality measures
- EHR build
- Learning curve to understand if we're being paid accurately
- Cash flow changes

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Quality Measures – Barriers

- Shortage of details:
  - Confusing as to which version of measure to use
- OCM participants will have an advantage (we are not in OCM)
- MIPS experience in oncology will be an advantage
  - (We are folded under a large multispecialty practice)
- Collect for ALL patients; not just Medicare
- Impacts the professional payment
- Resources, resources, resources!
  - Impact on provider time
  - Non-provider resources to support the data capture/measures processes
- Clinical Data Reporting:
  - Resources to submit clinical data (2x/year)

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Implementation concerns: *Plan of Care for Pain*

- Applies to treatment management visits
- “Moderate to severe pain”
- What type of pain is included? Cancer-related pain? Any pain? Arthritis? Stubbed toe?
- Documented plan to address pain:
  - Content?
  - Who can contribute to this besides the provider?
  - Nursing role?

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Implementation concerns:
Depression Screening and Follow Up Plan

- Validated “age appropriate” tool
  - PHQ-9 vs PHQ-2
  - Pediatric patients - where applicable
- Once per episode; Linked to E&M visit – consult or follow up
- Follow up plan must be documented on same date
- Access to additional resources (social work) immediately
- Alignment with Joint Commission requirements for suicide risk assessment
- Alignment with CoC accreditation requirements

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Implementation concerns:
Advance Care Plan

- Assess at least once per episode; linked to E&M visit – consult or follow up
- Patients ≥ 65
- More than "do you have an advance directive?"
- Documentation of discussion, verification advance directive is in the chart, validation it's still appropriate
- If patient doesn't want to discuss, need to document why
- Not just POA-HC or Advance Care Plans…. oral conversations properly documented

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Implementation concerns:
Treatment Summary Communication

- Monitoring completion within one month of tx completion
  - Who will monitor? RO Department? Health Information Mgmt?
- Send summary to continuing care provider… more than one?

  Medical oncology Surgeon Primary Care
- Send summary to patient:
  - Released via electronic record portal?
  - Do we need to validate they opened it?
  - Is it a patient friendly format?

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Implementation concerns: *CAHPS Survey for Cancer Care*

- Impacts technical component reimbursement
- Will be administered via CMS approved contractor
- Our RO departments are currently using Press Ganey – not CAHPS surveys
- Do we change our routine survey to CAHPS to better monitor?
- Does it require a contract change?
- Proposed to phase in Year 3

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Questions?

Please feel free to contact us if you find later that you still have questions.

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Thank You!

- Sincere thanks to all of you for joining us today. We hope that you will keep OMC Group in mind when consulting needs arise in the future.

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