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CMS' Proposed Radiation "Bundling": Disaster Or Boon?

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A note on timing

- The original session was recorded on 9/1/2020. CMS released the final rule on 9/18 and on 10/21 announced a delay in implementation. The content below has been updated to the best of our abilities to reflect the changes from the proposed to the final rule. At release of this slide set, we are unaware of any additional changes other than the implementation date change announced in October.

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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	APC
77261	750	
77262	750	
77263	750	
77280	752	5611
77285	752	5612
77290	752	5612
77295	752	5613
77299	751	5611
77300	751	5611
77301		5613
77305	751	
77306		5612
77307		5612
77310	751	
77315	751	
77316		5612
77317		5612
77318		5612
77321	751	5612
77326	751	
77327	751	
77328	751	
77331	751	5611
77332	751	5611
77333	751	5611
77334	751	5612
77336	750	5611
77338		5612

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

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

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Refinement?

APGs
700
750
751
752
757
758
758
759

APCs
5611
5612
5612
5613
5621
5622
5623
5624
5625
5626
5627

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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 Situation (10/28/20)

- The September final rule established a “bundled” payment system for 30% of Medicare radiation oncology by packing a WHOLE lot of codes into a single technical and a single professional payment
- All services would be paid the same, regardless of the site of care (hospital or free-standing)
- Originally, CMS was targeting an implementation date as early as Jan. 1, 2020, but the on 10/21/2020 announced the implementation date as 7/1/2021.

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What's Included?

- All services in a 90 day period beginning with initial planning
- 16 Disease groups
  - Anal, Bladder, Bone Mets, Brain Mets, Breast, Cervical, CNS, Colorectal, Head and Neck, Liver, Lung, Lymphoma, Pancreatic, Prostate, Upper GI, Uterine

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Codes Included

APM CODE				
55920	77317	77427	77790	G0340
57155	77318	77431	77799	G6001
57156	77321	77432	A9527	G6002
58346	77331	77435	C1716	G6003
77014	77332	77470	C1717	G6004
77021	77333	77499	C1719	G6005
77261	77334	77520	C2634	G6006
77262	77336	77522	C2635	G6007
77263	77338	77523	C2636	G6008
77280	77370	77525	C2638	G6009
77285	77371	77761	C2639	G6010
77290	77372	77762	C2640	G6011
77293	77373	77763	C2641	G6012
77295	77385	77767	C2642	G6013
77299	77386	77768	C2643	G6014
77300	77399	77770	C2644	G6015
77301	77402	77771	C2645	G6016
77306	77407	77772	C2698	G6017
77307	77412	77778	C2699	Q3001
77316	77417	77789	G0339	

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Who Is Included?

- Good question
  - Hospital centers
  - Physician practices
  - Freestanding centers
  - “Mandatory” for providers in specific geographies (available at https://innovation.cms.gov/innovation-models/radiation-oncology-model)

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Payment Rates

DX Group	Professional	Technical
ANAL	$3,001.19	$16,543.53
BLADDER	$2,688.35	$13,291.62
BONE METS	$1,398.14	$5,971.73
BRAIN METS	$1,601.70	$9,648.92
BREAST	$2,081.47	$10,128.61
CERVICAL	$3,829.34	$17,581.18
CNS	$2,510.55	$14,711.14
COLORECTAL	$2,449.38	$12,039.84
H/N	$3,019.00	$17,485.19
LIVER	$2,082.23	$11,976.09
LUNG	$2,181.23	$11,993.83
LYMPH	$1,690.41	$7,854.53
PANCREAS	$2,394.14	$13,384.14
PROST	$3,260.97	$20,248.82
UP GI	$2,585.57	$13,530.21
UTERINE	$2,435.59	$11,869.29

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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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Sample: Simple, Right?

Note: the sample in the final rule did not reflect the changes from the proposed rule

TABLE 8: EXAMPLE: PARTICIPANT-SPECIFIC PROFESSIONAL EPISODE PAYMENT FOR LUNG CANCER PY1 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
SPLIT for SOE/EOE payments (d)	$1,120.60	d =c/2
Geographic Adjustment (e)	1.02	
Subtotal1 (f)	$1,143.01	f = d * e
Case Mix Adjustment (g)	0.02	For example (102-100) / 100
Historical Experience Adjuster (h)	0.14	For example (116-102) / 100
PY1 Blend (i)	0.90	
Adjustments combined (j)	1.15	j = g + (h * i) + 1
Subtotal (k)	$1,309.89	k = j * f
Discount Factor (l)	0.0375	
Subtotal (m)	$1,260.77	m = (1-l) * k
Withhold #1 (Incorrect Payment) (n)	0.01	
Withhold #2 (Quality Performance) (o)	0.02	
Total Withhold (p)	0.03	p = n + o
Half of Total Episode Payment to RO Participant without sequestration (q)	$1,222.95	q = (1-p) * m
Beneficiary Coinsurance for SOE payment Determined (r)	$244.59	r = q * 0.20
SOE Participant Payment	$978.36	s = q * 0.80
Sequestration Claims Payment Adjustment to Participant Payment (t) [t = half of the total participant-specific professional episode payment]	$958.79	t = s * 0.98
Episode Payment 1: SOE (u)*	**$958.79**	**u = t**
Episode Payment 2: EOE (v)*	**$958.79**	**v = t**
Total Episode Payment to RO Participant (w)	**$2,406.76**	**w = u+v+2r**

^ 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 (12/2019):
  - 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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REVISED THEORETICAL RESULTS

	DX GROUP	CURRENT PMTS	APM PMTS	% VARIANCE
TECHNICAL SERVICES (VS. OPPS)	ANAL	16,955	36,443	215%
	BLADDER	11,584	43,920	379%
	BONE METS	110,672	322,296	291%
	BRAIN METS	104,004	233,808	225%
	BREAST	523,135	1,907,677	365%
	CERVICAL	84,255	135,552	161%
	CNS	64,521	145,830	226%
	COLORECTAI	58,663	159,133	271%
	H/N	144,005	597,023	415%
	LIVER	17,337	39,573	228%
	LUNG	225,807	581,259	257%
	LYMPH	64,389	138,420	215%
	PANCREAS	42,850	73,709	172%
	PROST	380,142	981,321	258%
	UP GI	70,415	163,929	233%
	UTERINE	107,583	248,392	231%
	TOTAL	2,026,317	5,808,285	287%

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REVISED THEORETICAL RESULTS

	DX GROUP	CURRENT PMTS	APM PMTS	% VARIANCE
RAD ONC PRO FEES (VS. FACILITY-BASED)	ANAL	7,845	6,704	85%
	BLADDER	6,326	9,007	142%
	BONE METS	65,079	76,513	118%
	BRAIN METS	42,700	39,354	92%
	BREAST	286,191	397,514	139%
	CERVICAL	33,863	29,937	88%
	CNS	30,480	25,235	83%
	COLORECTAI	30,527	32,826	108%
	H/N	70,712	104,523	148%
	LIVER	7,848	6,976	89%
	LUNG	117,590	107,186	91%
	LYMPH	33,069	30,206	91%
	PANCREAS	21,502	13,369	62%
	PROST	171,507	160,245	93%
	UP GI	35,945	31,764	88%
	UTERINE	47,162	51,682	110%
	TOTAL	1,008,346	1,123,042	111%

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REVISED THEORETICAL RESULTS

	DX GROUP	CURRENT PMTS	APM PMTS	% VARIANCE
FREESTANDING GLOBAL	ANAL	39,280	43,147	110%
	BLADDER	27,242	52,927	194%
	BONE METS	232,384	398,809	172%
	BRAIN METS	168,854	273,163	162%
	BREAST	1,222,487	2,305,191	189%
	CERVICAL	105,874	165,489	156%
	CNS	160,336	171,065	107%
	COLORECTAI	151,181	191,960	127%
	H/N	357,535	701,545	196%
	LIVER	40,283	46,549	116%
	LUNG	539,975	688,445	127%
	LYMPH	139,277	168,626	121%
	PANCREAS	102,782	87,078	85%
	PROST	915,388	1,141,567	125%
	UP GI	174,250	195,693	112%
	UTERINE	194,998	300,074	154%
	TOTAL	4,572,127	6,931,327	152%

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Winners and Losers?

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

DISEASE GROUP	OPPS CHANGE	PROF CHANGE	GLOBAL CHANGE
ANAL	215%	85%	110%
BLADDER	379%	142%	194%
BONE METS	291%	118%	172%
BRAIN METS	225%	92%	162%
BREAST	365%	139%	189%
CERVICAL	161%	88%	156%
CNS	226%	83%	107%
COLORECTAL	271%	108%	127%
H/N	415%	148%	196%
LIVER	228%	89%	116%
LUNG	257%	91%	127%
LYMPH	215%	91%	121%
PANCREAS	172%	62%	85%
PROST	258%	93%	125%
UP GI	233%	88%	112%
UTERINE	231%	110%	154%
TOTAL	287%	111%	152%

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WHAT IMPACT *BESIDES* FINANCIALS?

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Matt Sherer is the Executive Director, Spencer Cancer Center at East Alabama Medical Center in Opelika, Alabama. An experienced healthcare executive with 16 years of oncology focus and over 25 years of management experience, he has a successful track record of growing services, creating/managing budgets, improving volumes, and growing operating margins as well as creating and implementing strategic plans, clinical and business operations, and more. Matt has successfully achieved accreditations from The Joint Commission, the ACOS/Commission on Cancer, NAPBC, ACR Breast Center of Excellence, and the ACRO.

Matt has served on the Board of Trustees and several committees for the Association of Community Cancer Centers (ACCC), as President of the Association of Cancer Executives (ACE), in multiple roles with the American Cancer Society and on the American College of Surgeons/Commission on Cancer Board of Directors. He received his Bachelor of Science degree from The University of Alabama in Business Administration, has an MBA from The University of Mississippi and a MSHA from the University of Alabama – Birmingham.

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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
- MIPS experience in oncology will be an advantage
- 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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