ACRO
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RADIATION ONCOLOGY
Integrating Science and Technology into Patient Care
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The Honorable Orrin Hatch
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
U.S. Senate
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of the American College of Radiation Oncology (ACRO), we appreciate the opportunity to comment on the May 22, 2015 Chronic Care Stakeholder Letter. ACRO represents radiation oncologists in the socioeconomic and political arenas. With a current membership of approximately 1,000, ACRO is dedicated to fostering radiation oncology science; improving patient care services; studying the socioeconomic aspects of the practice of radiation oncology; and encouraging education in radiation oncology.

In the Stakeholder Letter, the Senate Finance Committee requests feedback on specific areas, including "transformative policies that improve outcomes for patients living with chronic diseases …. by proposing new APM structures." In response to that request, we would like to continue to offer episode-based, bundled payments for radiation therapy services as an option that holds significant promise as a Medicare APM for the oncology sector. ACRO agrees the current fee-for-service system rewards complexity and volume rather than optimum cancer outcomes. Properly constructed, we believe a radiation oncology episodic payment model is consistent with the Committee's objectives of improving quality of care, reducing costs and moving away from "fee-for-service" towards "fee-for-value" systems.

Moreover, we believe radiation therapy centers, more akin to a "facility" than a physician office, have never been a good fit for the current fee-for-service Physician Fee Schedule. The narrower set of radiation therapy services make radiation therapy centers significantly more vulnerable to significant changes in a few codes relative to other specialties such as primary care. Moreover, the high-technology and rapidly changing nature of radiation therapy services make it difficult for the current fee-for-service system to properly value such services. As such, not only do we believe a radiation oncology episodic payment model could achieve a variety of positive outcomes for the Medicare program, such a model also could provide more payment stability for

radiation oncology providers that have been subject to considerable reimbursement volatility over the last decade.

Key Features of a Radiation Therapy Episodic Payment APM

In general, ACRO believes there are certain key factors that must be considered when designing a radiation oncology episode. These factors include: episode duration; episode services; episode participants; and the intent of treatment.

- **Episode Duration**: Most patient who receive radiation therapy treatment for cancer require between 3-5 weeks of care. However, some patients may require shorter therapy, especially if the treatment intent is palliative. Likewise, some patients may require more than 5 weeks of care. The episode-based bundled payment would need to allow for both shorter and longer than average episodes.

- **Episode Services**: Patients who receive radiation therapy treatment will largely receive a set of services that are directly related to the actual provision of radiation therapy. Any care received by these patients that is unrelated to radiation therapy should be excluded from any payment bundle. Services encompassed within each care episode would be based on the best available medical evidence and consensus group care-paths in order to ensure high-quality, high-value care. Bundled services will cross multiple medical specialties to include urologists, neurosurgeons, breast surgeons and others who may then better coordinate with the radiation oncologist in the delivery of a course of radiotherapy.

- **Episode Participants**: Radiation therapy can be provided in either a freestanding radiation therapy center or in a hospital outpatient department, where the costs of capital equipment, vault construction and shielding, and highly qualified clinical staff are equivalent. ACRO believes CMS should work with stakeholders from both hospitals and freestanding centers to develop consistent payment policies across both sites of services to reduce the risk that one site of service is so disadvantaged that it forces large shifts in care settings, forces consolidation and closures in communities, and limits patient access to innovative technologies that may only be available in a particular community in one setting.

- **Intent of Treatment**: Patients may receive radiation therapy for curative treatment or palliative relief of symptoms. Often, the intent of the treatment determines the number of sessions a patient will receive, which in turn determines the overall resources necessary for the episode. The episode should account for this intent as an upfront adjustment.

Radiation Therapy Episodic Payment APMs in the Private Sector

Radiation Therapy Episodic Payment APMs are not theoretical. Since 2012, a leading radiation therapy provider and payer have been engaged in a national agreement providing case rate

reimbursement for radiation therapy services.[1] Under this contract, a single prospective case rate is paid at the beginning of a radiation therapy episode for 13 different cancer diagnoses. These diagnoses include breast, lung, prostate, colorectal, and other cancers that account for over 90% of the members who present for radiation oncology services. The radiation therapy case rate covers external beam, stereotactic, and brachytherapy treatments and includes the vast majority of services required to complete a full course of therapy. Selected services as well as diagnoses falling outside of the 13 designated diseases are paid on a fee schedule.

This payer/provider relationship has the following characteristics:

National scope for both organizations. All domestic provider radiation therapy locations are included in the contract and all payer markets participate.

Broad product penetration. All of the payer's products pay under the bundled methodology for radiation therapy services.

Primarily automated contract management and adjudication. The agreed upon methodology enables both parties to automate billing, claims submission, and adjudication for the vast majority of transactions. A limited number of exceptions (mostly related to member transitions to or from other payers) are handled manually.

Reduced administrative costs related to utilization management. Aligned financial incentives have eliminated the need for onerous utilization review. Both parties benefit from elimination of these clinically and administratively intensive activities for episodes falling under the bundled payment methodology.

Seamless to patients. Patients receive the benefits of upfront transparent costs and reduced authorization procedures while being otherwise insulated from the modified reimbursement methodology.

Benefits of a Radiation Therapy Episodic Payment APM in Medicare

As noted above, radiation therapy episodic payments in the private sector have been shown to achieve real efficiencies which could be brought to bear to the Medicare Program. In addition, the model addresses several forms of risk, including treatment intensity risk and overutilization risk. In the case of treatment intensity risk (i.e. risk of utilization of more expensive modalities), episodic payments can be structured to eliminate differentiated reimbursement based on modality selection. In the case of overutilization risk (i.e. risk of too many treatments), bundled payments inherently protects against overutilization as more treatment does not generate more revenue. Finally, ACRO believes it would be critical to ensure as part of such an APM that there is strong

[1] Reuters, *21st Century Oncology and Humana Break New Ground with Case Rate Reimbursement Agreement*, 8 August 2012

guidelines adherence and outcomes data collection to protection from underutilization and to ensure patients meet appropriate treatment criteria.

ACRO envisions a 'bottoms-up' approach of seeking to complete a system of disease-specific, episodic payments for radiation therapy services first and later integrating surgical and medical oncology as alternative payments systems around those disciplines. We envision a modular method of constructing episode-based payments for specific conditions where the costs of appropriate services and supplies are determined for each discipline and then integrated and managed by a set of clinical and business rules that govern the care of the patient and ultimately the distribution of payments to the providers participating in that care. Ultimately, we believe this approach would further strengthen multidisciplinary cancer care and the benefits that derive therefrom. For example, literature suggests that patients who receive care in multidisciplinary cancer centers are more likely to choose active surveillance and less likely to choose more invasive options. This decision is often made in consultation with multiple specialists and results in more informed decision making on the part of patients and clear coordination of care.

Conclusion

ACRO strongly supports efforts to establish a new system for physician reimbursement in Medicare focused on quality, value and efficiency. We look forward to actively working with Congress and CMS on a bipartisan basis in support of proposals to create episode-based, bundled payments for radiation therapy services as an APM.

Sincerely,

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