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PAYMENT MODELS

Alternative Payment
Models Can Stabilize
and Improve Practice
Radiation ReimbursementHOW VALUE-BASED CARE IS CHANGING
RADIATION ONCOLOGY FOR THE BETTER

Courtney Dean, MBA

TODAY'S EVOLVING HEALTH CARE landscape has created a challenging environment for radiation oncologists—one that makes revenue streams unpredictable and increases the administrative hassle associated with the delivery of quality care. Medicare radiation reimbursement rates declined 24% from 2008 to 2017, with an initial 7% to 8% additional payment cut projected for 2022 based on an American Society for Radiation Oncology (ASTRO) analysis of the 2022 Medicare Physician Fee Schedule,¹ which was subsequently mitigated by The Protecting Medicare & American Farmers from Sequester Cuts Act signed in December 2021.² Cuts to radiation therapy reimbursement are recommended yearly by CMS.

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PRACTICE TRANSFORMATION

Telehealth at Minnesota Oncology:
Tackling COVID-19, Educating Patients,
and Overcoming the Weather

Mary Caffrey

THE RISE OF TELEHEALTH during the COVID-19 pandemic has been an important topic at oncology conferences, with surveys showing various levels of satisfaction on the part of providers and patients, as well as concerns about disparities in the level of access to technology.^{1,2}

Reimbursement barriers to telehealth adoption came down during COVID-19, allowing oncology practices to see for the first time where its use made sense and where it did not. The American Society of Clinical Oncology (ASCO) responded with guidelines for telehealth use, suggesting that the technology likely will be part of the treatment landscape for good.³

A consensus is emerging. When it comes to diagnosing cancer, telehealth can never replace the in-person visit. But during a pandemic, it is highly useful—and perhaps better—for some elements of cancer care, because it can increase the number of touch points in areas such as survivorship care and nutrition, which would otherwise require a separate visit to the office.

For some practices, however, telehealth could prove a game changer when dealing with a problem that no quality measure or technology upgrade can fix: the weather.

CONTINUED ON SP84 »



Kite Pharma officials say a new manufacturing facility in Frederick County, Maryland, will help ensure timely turnaround of customized products for chimeric antigen receptor T-cell therapy.

IMMUNO-ONCOLOGY

With Approval for Axi-cel in Second-line
on the Horizon, CAR T-Cell Therapy
Poised to Enter New Phase

Mary Caffrey

WHEN THE FDA APPROVED the first 2 chimeric antigen receptor (CAR) T-cell therapies in late 2017, the scientific world cheered. Cell-based gene therapies had arrived, offering hope to patients who had run out of options to manage their blood cancers.

CAR T-cell therapy promised to transform cancer treatment; then-FDA Commissioner Scott Gottlieb, MD, heralded “a new frontier in medical innovation with the ability to reprogram a patient's own cells to attack a deadly cancer.”¹

CONTINUED ON SP85 »

Alternative Payment Models Can Stabilize and Improve Practice Radiation Reimbursement

HOW VALUE-BASED CARE IS CHANGING RADIATION ONCOLOGY FOR THE BETTER

COURTNEY DEAN, MBA



DEAN

Courtney Dean, MBA, managed care contracting regional director, The US Oncology Network.

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Additionally, 30% of all Medicare beneficiaries are slated to be in the Radiation Oncology Alternative Payment Model (RO APM), which despite ongoing delays is a looming threat to reimbursement; it is now scheduled to start in January 2023. Commercial payments are often tied to Medicare reimbursement, thus exacerbating declining reimbursement. Increased prior authorizations and complexity of care, declining referrals, and rising equipment costs compound the negative effects on managing a radiation oncology practice. Radiation oncology, according to the results of one study, had the highest risk of prior authorization, with administrative costs for authorization alone accounting for more than \$40 million.^{3,4} ASTRO also reported that the majority of treatments subject to prior authorization are approved, yet they delay care for patients with cancer.

Practices can act today to gain some control over how these emerging trends will impact their viability and independence in the future. By developing value-based APMs for commercial payers, practices can employ reimbursement models that more accurately align incentives with the care provided while minimizing known and unknown threats to future reimbursement. Commercial radiation APMs are detailed contracts between practices and private payers that establish fixed payment rates per episode of care (EOC) based on historical rates and utilization, protecting against negative reimbursement pressure from changes in treatment patterns and Medicare code revaluation. Once a trusting relationship has been established between a payer and provider, discussions may also be possible concerning issues such as preferred provider status, patient steerage, and streamlined or eliminated prior authorizations. The ultimate goal is to align reimbursement with high-quality, patient-centric, guideline-based care.

To best prepare participating practices, The US Oncology Network (The Network), a large network of independent physicians dedicated to delivering value-based, integrated care to patients close to home, has developed radiation APM design options that fall into 2 categories: episode-based payments and capitation. The episode-based model is designed to be flexible, anchored by either a disease site- or stage-based or a modality-based framework. Some commercial payers may prefer one framework over the other based on the ability to implement and administer the payment model within the constraints of their claims system.

The disease site- or stage-based framework involves prospective payment for a defined, single EOC based on the patient's disease site or stage. The most common disease sites treated with radiation—ie, prostate and breast cancer—are a good starting point for radiation case rates based on disease site. This option provides payers with predictability and protection against uncontrolled increases due to advanced technology adoption. The modality-based framework involves a prospective payment for a single EOC based on various radiation technologies, including 3-dimensional (3-D) conformal therapy, intensity-modulated radiation therapy, stereotactic radiosurgery/stereotactic body radiotherapy, and high-dose rate/low-dose rate brachytherapy. For example, a modality-based, 3-D conformal case rate would have

a single payment regardless of what cancer type the patient has vs a disease site-based model that would have a single payment regardless of what type of technology was used to treat the patient. The modality-based model tends to capture a higher amount of the total radiation episodes with a fewer number of case rates, which payers and practices may find easier to administer.

In a capitation model, providers take on more financial risk because they are paid on a per-member per-month (PMPM) basis for all radiation services rendered to a certain payer population and not on an episode- or utilization-based reimbursement methodology. In this model, a practice should have sufficient capacity and scale to provide a commercial payer population with access to convenient and quality care in a defined geographic area. If a practice and payer have not historically partnered closely together in a market, starting with an episode-based model and moving to a capitation model in the future would be an appropriate glide path to build trust and the relationship between the payer and provider.

By developing value-based alternative payment models (APMs) for commercial payers, physicians can employ reimbursement models that more accurately align incentives with the care provided while minimizing known and unknown threats to future reimbursement. Commercial radiation APMs are detailed contracts between practices and private payers that establish fixed payment rates per episode of care (EOC) based on historical rates and utilization, protecting against negative reimbursement pressure from changes in treatment patterns and Medicare code revaluation.

Both radiation payment models provide a payer with predictable spend and enhanced value based on shared financial risk with the practice in the form of defined case rates or a PMPM model. The models are built to reward the combination of cost efficiencies and quality outcomes. They allow physicians to practice medicine while encouraging treatment optimization by adhering to evidence-based clinical pathways. Payers can provide value to the provider through these models by incorporating steerage and reducing administrative burden on practices by eliminating prior authorization for radiation services. Payers can explore technologies, tools, and analytics to reduce paperwork and redundancy, and to enhance communication with providers. Many practices in The Network have found that value is created for patients with more prompt access to care, with a streamlined billing process that allows for paying out-of-pocket expenses on

one bill or explanation of benefits, vs the continuous fees applied and collected as part of a fee-for-service model.

New York Oncology Hematology (NYOH), a practice in The Network, offers an excellent case study in how to develop and expand RO APMs. In 2016, NYOH started slowly with its new commercial APM, pitching the concept to 1 payer, a large insurer in the Albany market that provides Managed Medicare, Medicaid, and Marketplace plans, representing 7% of the NYOH payer mix. Negotiations lasted a year, and by the end of 2017, the new APM was up and running smoothly.

The successful pilot provided proof of concept, demonstrating financial stability for the practice and an enhanced experience for the patient, and gave NYOH confidence to move forward with other payers. Next, the practice began negotiations with a large New York nonprofit insurer that represented 32% of the NYOH payer mix. Discussions lasted just 10 months, with new radiation case rates taking effect in January 2019. Currently, NYOH is working to expand the pilot payer agreement to cover additional disease sites under the case rate model, in addition to renewing and extending their second commercial payer case rate agreement.

Looking back at how success was achieved, NYOH identified several crucial activities that will help other practices transition to the new APM payment methodology. To begin, they established 1 successful case rate pilot to demonstrate proof of concept and patient, physician, and payer benefits. To maintain a high visibility of case rate performance, radiation leadership continuously monitored and presented the results to practice leadership. Another factor leading to success was having a key radiation oncologist champion the radiation APM strategy within the practice. Early alignment of key stakeholders on processes to match practice and payer capabilities was instrumental in success.

“NYOH is thrilled with the implementation and outcomes associated with our case rate agreements. They have stabilized costs of care and reimbursement to the practice all while lowering the out-of-pocket costs for the patient,” explained Todd Doyle, MD, a radiation oncologist at NYOH. “We show payers high-quality care with adherence to evidence-based pathways, and we simultaneously receive reduced administrative burdens with ‘gold carding.’ We are free to just be doctors again.”

Moving to a whole new way of doing business was not easy, and there were obstacles to overcome. NYOH succeeded by identifying the problems that they were encountering and promptly developing concise strategies to overcome them. To ensure that all practice leadership understood the radiation APM strategy, monthly reporting of case rate performance compared with fee-for-service was done, demonstrating that performance was on target while educating leadership on the financial benefits. Operational changes were essential to successfully administer radiation case rate methodology. Operational playbooks were created for both the practice and the payer based on key stakeholder input to align crucial implementation processes. Necessary changes to processes and workflows were made and monitored until new behavior patterns were firmly established. In some instances, payers could have trouble implementing APMs due to their own administrative challenges. To overcome this obstacle, practices and payers worked collaboratively to resolve administrative limitations and establish modality-based case rates.

CMS will launch the RO APM, an example of a disease site-based framework. The RO APM is designed to test an APM in radiation oncology for a 5-year measurement period, which is now set to begin on January 1, 2023. Participation in the RO APM is mandatory for both physician group practices and hospital outpatient departments practicing in randomly selected zip codes across the country. Key aspects of the model include site-neutral, prospective, disease site-based EOC payments in addition to clinical and quality reporting metrics and performance measurement. The model will test whether the APM will lower cost for Medicare, while preserving or improving quality of care for Medicare patients. Episode-based payments will be based on national base rates, trend factors, and adjustments for each RO participant’s case-mix, historical experience, and geographic location.⁵ The bundled payment amounts will be reduced in the form of a fixed discount factor set by CMS. Additional withholdings will be applied for incorrect payments and quality and patient experience, which the practice can earn back through quality measure reporting and performance outcomes.

The Network will have 13 practices participating in the RO APM starting in 2023. Because this is a mandatory, government-controlled program, »

CLINICAL PATHWAYS

ASTRO Offers Guidance on EBRT for Primary Liver Cancers

By EBO Staff

THE AMERICAN SOCIETY FOR RADIATION ONCOLOGY

(ASTRO) has released a guideline on the use of radiation therapy to treat adult patients with primary liver cancers using external beam radiation therapy (EBRT). Evidence-based recommendations in the guideline outline indications and optimal EBRT dosing, techniques, and treatment planning for patients with hepatocellular carcinoma (HCC) and intrahepatic cholangiocarcinoma (IHC), with a strong emphasis on multidisciplinary care. EBRT aims high doses of targeted radiation at tumor sites from outside the body with noninvasive techniques and, in some cases, has been underutilized in treatment where it could be effective.

The EBRT guideline, ASTRO’s first for primary liver cancers, was published in the January issue of *Practical Radiation Oncology*.¹ It was based on a systemic literature review of articles published from January 2000 through February 2020.

Primary liver cancers are among the most commonly diagnosed types of cancer and the fourth leading cause of cancer death worldwide. Incidence rates in the United States have more than tripled since 1980, rising approximately 2% each year in the past 2 decades, according to the American Cancer Society. An estimated 42,230 new cases were diagnosed last year.² Mortality rates from HCC and IHC also continue to rise, despite the growing availability of screening for HCC and improved prevention and treatment of diseases that lead to liver cancer (ie, hepatitis B, hepatitis C, nonalcoholic fatty liver disease).

“Patients diagnosed with liver cancer often have a number of treatment options available to them, and they should be presented with each of them before a treatment course is decided. The different disciplines—hepatology, surgical oncology, interventional radiology, and radiation oncology—should all be involved in multidisciplinary treatment discussions to determine what might be best for each patient,” said Smith Apisarnthanarax, MD, vice chair of the guideline task force, medical director of the Seattle Cancer Care Alliance, and professor of radiation oncology at the University of Washington in Seattle. “We feel this guideline is an important milestone in the management of primary liver cancers, as we hope to provide practitioners and the public with a systematic and evidence-based foundation of where EBRT might fit into the overall complex picture of treating these challenging cases.”

Patients with liver cancer typically have multiple comorbidities, which can complicate diagnosis, staging, and treatment decision-making. Among the key considerations is whether a patient has underlying cirrhosis, which is present in approximately 90% of patients with HCC.

For patients whose primary HCC is confined to the liver, treatment options can include a liver transplant, tumor removal through surgery, thermal ablation, and catheter-based therapies. If cancer is advanced, patients and clinicians can consider systemic therapy, including targeted therapy and/or immunotherapy. For IHC, standard treatment includes a combination of surgery and chemotherapy with or without radiation. A study presented at the 2021 ASTRO Annual Meeting found that just 4% of eligible patients received EBRT as a bridging therapy before liver transplant.³

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“Historically, low utilization rates for external beam radiation were due to technological limitations that made it challenging to avoid healthy liver tissue. However, with significant advances in imaging and radiation treatment delivery over the past 15 years and improved understanding of how the liver responds to radiation, we now have an increasing amount of clinical data on the role that EBRT can play for patients with these diseases,” said Higinia Cardenes, MD, PhD, chair of the guideline task force and a professor of clinical radiation oncology at Weill Cornell Medicine in New York, New York.

Recommendations cover patient selection, planning and delivery techniques for EBRT in various clinical situations, and palliative treatment settings. Key recommendations include the following:

EBRT is strongly recommended in the following circumstances:

- A potential first-line treatment for patients with HCC confined to the liver who are not candidates for curative therapy.
- A consolidative therapy for patients with incomplete responses to other liver-directed treatments.
- A salvage therapy option for patients with local recurrences after other treatment.

In addition, EBRT is conditionally recommended in the following circumstances:

- For patients with multifocal or unresectable HCC confined to the liver.
- For patients with macrovascular invasion, when sequenced with systemic or catheter-based therapies. The guideline features treatment algorithms to manage HCC contained in liver and for HCC with macrovascular invasion.
- In the palliative setting for symptomatic primary HCC and/or HCC that has invaded a blood vessel.
- As a bridging therapy prior to liver transplant or before surgery in select patients.

Other recommendations include the following:

- EBRT should be considered for patients with unresectable IHC, with or without chemotherapy, typically after systemic therapy. For patients with resected IHC and high-risk features, adjuvant EBRT is conditionally recommended. Treatment algorithms are provided.
- The guideline addresses optimal dosing, fractionation, treatment planning and delivery techniques, and calls for individualized care that considers the location of the tumor and how advanced the cancer is, as well as liver function. ♦

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we anticipate many challenges when implementing the RO APM that will cause administrative complexities and increase operational costs. These include:

- **DETERMINING ELIGIBILITY AND TIMING** of the EOC start for those patients who are included in the model will be a challenge, as not all locations and patients are included in the model.
- **COLLECTING AND SUBMITTING QUALITY MEASURES** and clinical data elements will be a time-consuming, manual process at the beginning, as vendors refine offerings to streamline these processes.
- **REVENUE CYCLE CHALLENGES** are expected, as we work through split payment billing and coordinating payment with secondary payers. In commercial models, these challenges should be overcome prior to model implementation.

We do expect that participating practices in The Network will build valuable experience through participation in the RO APM that will help prepare them for future success in value-based care models in oncology.

Over the years, The Network has cultivated key learnings through experience with developing and implementing radiation APMs at practices across the country. We have learned that radiation APM contracts can be successfully negotiated and administered by community practices. The Network currently supports more than 25 radiation APMs. We have proven that APMs can stabilize or improve practice radiation reimbursement, and we have found that exclusivity, preferred provider status, or elimination of prior authorization requirements adds significant value under radiation APM contracts.

The Network has experienced recent wins and is in the process of continuing to expand its radiation APM footprint. In 2020, Minnesota Oncology entered their first radiation APM contract, a disease site-based case rate with Blue Cross Blue Shield of Minnesota. More recently, additional Network practices in Maryland and Ohio are planning to finalize their first radiation APM contracts with commercial payers in early 2022.

The US Oncology Network has shown that radiation APMs can fulfill our goal of aligning payment to improved patient care while reducing administrative burden. Physicians, practices, and payers find value in these models, while patients receive guideline-based therapy without unnecessary delays. Developing APMs can be daunting, but with time, expertise is developed to make more rapid deployment of these models easier. We will continue to work with payers and practices to continually enhance development of radiation APMs. ♦

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New Drug Combo May Improve Outcomes in Unresectable Liver Cancer
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