2024 – No. 1 – The Status of Bundled Payment Models

The goal of this series of articles is to ensure that radiation oncologists are aware of and provided with the knowledge to ensure day-to-day processes are being addressed in a compliant manner. This installment will discuss the status and impact of bundled payment models on radiation oncology. The information contained within this ACROinsights article is meant as general guidance and is not intended to replace appropriate legal or authoritative guidance.

Background on Bundled Payment Models

Bundled payment models and discussions about their place in healthcare are not a new concept but have gained traction over the last few years around the specialty of radiation oncology, which is one of the few remaining specialties in medicine that still uses primarily unbundled billing. The Centers for Medicare and Medicaid Services (CMS) has employed disease-based bundled payment models since 2013, and there have been other episode-based payment models dating as far back as 2008. Bundled payment models for healthcare services have been frequently employed outside the USA. The Commonwealth Fund Report *Bundled-Payment Models Around the World: How They Work and What Their Impact Has Been*[i] compared bundled payment models and their success between those in U.S., Taiwan, England, the Netherlands, Portugal, Denmark, New Zealand, and Sweden.

CMS' approach in developing the various bundled payment models over the last several years is to stress quality of care and a patient-centric approach vs. quantity and a siloed approach to treating the patient. In their design and intention, most of the bundled payment models aim to replace the traditional fee-for-service (FFS) approach employed for healthcare services payments since World War II. In the U.S. and around the globe, public and private payers are moving from FFS to alternative payment models (APMs). Many payers believe if the providers are properly incentivized, payment under an APM will result in reduced waste and overutilization of services and promote coordinated care. This hypothesis has proven to be a difficult paradigm shift in payment policy for providers and payers alike.

In a January 2020 report by CMS, *CMS Innovation Center Episode Payment Models*[ii], CMS reviewed data reports from seven episode bundled payment models to identify themes and outcomes shared across the bundled payment models. They found some positives: some did in fact result in reduction in utilization of services and episode costs while quality of care remained high, however, they did not result in the anticipated savings CMS had anticipated.

Bundled Payment Model Structure

Bundled payment models tend to have a common structure, and it is the elements included in the structure which can determine the success or failure of the model.

Design Element	Examples
Covered services	Surgical care: Presurgical visit, surgery, inpatient stay, follow-up care cancer care: Services for intake, diagnosis, and staging (imaging, biopsy, pathology), treatment (surgery, chemotherapy, radiation), and follow-up chronic care (diabetes): Diabetes services provided in primary care setting; regular checkups including annual consultation and subsequent consultations related to diabetes (e.g., dietary counseling, eye exam, foot exam)

Payment methodology	Prospective; retrospective; mix of both
Accountable entity	Typically, provider-led entity, such as hospital or independent practice
Episode of care definition	Length of time (e.g., one year); breadth of services (e.g., preoperative visit through follow-up visit)
Risk sharing	Savings shared 50/50 between providers and insurers; providers bear 100% of risk; provider risk increases gradually
Risk adjustment	Severity-adjusted budget per episode; risk-stratified by diagnosis and major comorbidities
Distribution of payments among participating providers	Incentive payments weighted for resource management, clinical performance, and patient satisfaction
Linkage of payments to quality concerns	Quality standards must be met to participate in shared savings

Source: Jeroen N. Struijs et al., *Bundled-Payment Models Around the World: How They Work and What Their Impact Has Been* (Commonwealth Fund, Apr. 2020). https://doi.org/10.26099/936s-0y65

Challenges of Bundled Payment Models

CMS and payment entities are aware the structured components of a bundled payment model ultimately determine the success of failure, but it is clearly a delicate balance in establishing the structure. The following are some of the key areas which can profoundly affect provider buy-in and success of any bundled payment model.

Covered Services and Episode of Care Definition - Most bundled payment models have a defined set of covered services and pre-determined episode of care duration. One way to ensure success is to limit the possibilities of coverage with an easily defined episode of care. Too many variables of covered conditions, diseases, or procedures to apply to a bundled payment model creates confusion for many providers who already face challenges in determining the best treatment or management of the patient. Add in a bundled payment model that is challenging to understand and providers may decide to change to who, and how they provide care.

It is not uncommon in any model for providers to cherry pick patients for whom they will provide services. Providers may decide that if they must participate in the model, they will determine what strategy is to their benefit, selecting patients who may or may not be the sickest, depending on the model, and criteria to make the reporting as easy as possible. Care opportunities may be unavailable to patients some providers might normally see in order to maintain their advantage in the bundled payment model.

Payment Methodology - This establishes a delicate balance for any bundled payment model and for voluntary models can be the reason providers elect to participate or not. Prospective models create the challenge of providers being paid upfront and then required to provide services which are the least costly or ensure the most payment incentive regardless of the quality of care. Retrospective payments create scenarios where providers provide necessary and appropriate care, only to be shortchanged because the risk or cost of the services was higher than the allotted payment.

A mix of both payment methodologies may work, but the level of payments and administrative burden to track and calculate payments owed to the provider or back to the payer can be significant. The structure of the

payment methodology may also lead to cherry picking of patients to ensure maximized payments. This concern is especially true for providers used to a FFS payment structure. The transition from quantity to quality-based payments creates a different approach to healthcare and business plans.

Risk Sharing and Adjustment - A component of any episode payment methodology is always a risk that the cost of the services provided will be greater than the payments received. Bundled payment models typically have a one-sided or two-sided risk as part of their structure.

In on-sided risk bundled payment models the provider takes on the potential risk where the services provided may cost more than the reimbursement, but if the services provided are less than the defined payment amount, the insurer pays the provider a defined amount for the savings generated, such as a bonus payment.

In two-sided risk bundled payment models, where the cost of services or the true-up at the completion of the episode are calculated to be greater than the allotted payment amount, the provider must pay the insurer a defined amount to cover this overage. As with the one-sided risk, if the services provided are less than the defined payment amount, the insurer pays the provider a defined amount for the savings generated, such as a bonus payment.

Calculating the risk for any provider participating in or deciding to participate in a risk adjusted bundled payment model can be challenging. To accurately determine risk, a radiation oncology provider must know precise details of their own practice patterns and patient population: diseases they treat, typical fractionation and protraction, modalities, and payer mix to name a few. Without this knowledge a provider may head into participation in a bundled payment model blindly and without a full understanding of how the impact will be on their total practice revenues.

Distribution of Payments – This will vary depending on whether the provider is part of a group or is a solo practitioner. How the monies are distributed for any payments or bonuses may vary especially if the episode includes services provided by different specialties, and how the ratios of revenue distribution are determined. Just as with calculating risk, providers must understand that payment for services may be delayed based on the structure of the model or the full payment may not be made until well after the episode is completed. For many providers this delay in payments can create financial hardships in maintaining the cost of staff salaries, malpractice insurance, equipment, and supplies.

Quality of Care - In many episode payment models, patient satisfaction is a factor which payers focus on, but few measure. In various reports related to the impact of bundled payment models, patient satisfaction was rarely measured. When it was, in many instances patients would recommend their provider, but that was the extent of the feedback.

CMS has several systems in place to measure the quality of care (i.e., Quality Payment Program (QPP) provided to beneficiaries. Prior to and since the implementation of the QPP CMS continues to be concerned that FFS systems incentivize providers to bill for more quantity-based than quality-based services.

Future of Bundled Payment Models

In July 2019, CMS proposed the Radiation Oncology Alternative Payment Model (RO APM). The RO APM was designed as an episode-based, mandatory, bundled payment model. Designed to be site of service agnostic, it was expected to align the discrepancies which CMS identified in claims data from 2015-2017 for services billed in the hospital outpatient department (HOPD) vs. the freestanding center.

According to CMS the claims data highlighted discrepancies and concerns with FFS payment systems. HOPDs provided 64 percent of episodes of care nationally and freestanding centers provided 36 percent, but freestanding centers furnished and billed for higher volumes of services than HOPDs. On average over the 3-year period, freestanding centers were paid 11 percent more (~$1,800) by Medicare than episodes furnished in

HOPDs. Freestanding centers used more IMRT and performed more fractions of treatment than HOPDs. CMS indicated they were not aware of any clinical rationale for billing of more services in the freestanding center vs. the HOPD and these higher volumes continued even though the rates per unit were lower for freestanding centers vs. HOPDs.

Due partly to the COVID-related public health emergency (PHE), and significant pushback from radiation oncology providers and stakeholder organizations, the RO APM was never implemented. This leaves the future of payments for radiation oncology with more questions than answers.

Legislation included as part of the Medicare Access and CHIP Reauthorization Act (MACRA)[iii] signed into law on April 16, 2015, addressed a restructure of payments under the Medicare Physician Fee Schedule (MPFS). One specific provision was that beginning January 1, 2026, physicians who are "qualifying APM participants" would be paid a higher rate than those physicians who were not.

Legislation has been introduced and requests have been made to Congress from various societies to address the rapidly advancing deadline for physicians to join qualifying APMs. Currently, the American Society for Radiation Oncology (ASTRO) has proposed the Radiation Oncology Case Rate (ROCR) program and CMS replaced the Oncology Care Model (OCM) with the current iteration Enhanced Oncology Model (EOM). CMS also has the Bundled Payments for Care Improvement (BPCI) Initiative still in place, but this does not really apply to oncology services.

The Take Home Message

Where does that leave radiation oncologists and the future of payment policy? Right now, with significant uncertainty. We understand that payment reform is inevitable, but its implementation is difficult. CMS and legislation continue to implement payment cuts and any gains made through grassroots advocacy efforts may be merely temporizing efforts.

Significant questions must be answered in the design of any successful episode payment model:

- Exactly what patients and diseases are included in each episode calculation.
- How payments are made for episode outliers
- How the model implements introduction of new technologies
- Whether the episode includes a risk-adjustment calculation
- How the model implements risk and benefit payments
- Whether the model is compulsory, and potential penalties to non-participants
- Timing of implementation of the model

As a specialty, radiation oncology has some decisions to make. Do we hold out as long as we can, hoping that the ultimate episode model is not too painful or should we be proactive, and generate discussions about practice patterns, outliers, and how to ensure radiation oncologists have a voice in the decisions, and seat at the table to move the policies forward. Change is never easy and there is always give and take, but the potential is there to move our specialty forward.

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[i] Jeroen N. Struijs et al., *Bundled-Payment Models Around the World: How They Work and What Their Impact Has Been* (Commonwealth Fund, Apr. 2020). https://doi.org/10.26099/936s-0y65

[ii] The Centers for Medicare and Medicaid Services, CMS Innovation Center Episode Payment Models January 2020, https://www.cms.gov/files/document/episode-payment-models-wppdf.pdf

[iii] The Centers for Medicare and Medicaid Services, Value-Based programs, Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) https://www.cms.gov/medicare/quality/value-based-programs/chip-reauthorization-act