# AFRO CCOMMENTS ON EPISODE-BASED PAYMENT FOR CANCER CARE

Statement of the Association of Freestanding Radiation Oncology Centers on Episode-Based Payment for Radiation Therapy under the Medicare Program

May 22, 2017

The Association of Freestanding Radiation Oncology Centers (AFROC) is pleased to have the opportunity to submit these comments on episode-based payment for radiation oncology services. AFROC is an association of non-hospital radiation oncology centers dedicated to the provision of high quality radiation oncology services to cancer patients in community settings throughout the country.

AFROC strongly believes that episode based payment for radiation oncology services has the potential to substantially reduce administrative costs and that savings can be achieved for both patients and for the Medicare program through the more efficient delivery of radiation therapy services that episode based payment would encourage. We are aware of private payer models that provide payment for radiation therapy services based on episodes of care differentiated based on the type of cancer involved (e.g. prostate, breast, lung) and the intent of treatment (curative vs. palliative), and we believe that it would be prudent for the Medicare program to study the impact and cost savings achievable through the models used by private payers in designing any new radiation oncology specific episode-based payment model for use in the Medicare program.

In designing any episode-based payment system that focuses exclusively on radiation oncology services, CMS should consider a number of unique features of radiation oncology services specifically and cancer care services generally. First, cancer care is undeniably a “team sport” and care should be taken to ensure that any episode-based payment methodology for radiation oncology services does not implicitly or indirectly inhibit or disincentivize care coordination: Cancer care is already fragmented and care should be taken to ensure that episode-based payment (whether for radiation, medical oncology, surgery, or any other specialty) does not strengthen the existing “silos.” Second, outcomes measurement in cancer care—including but not limited to radiation treatment—is extremely difficult within the time periods typically used to define the duration of “episodes”: Ultimate health care outcomes may not be measurable until some considerable time after treatment is complete. Therefore, it may be necessary to utilize surrogate outcomes measures in assessing the quality of radiation oncology services provided during a radiation oncology episode. Third, radiation oncology services are typically furnished in both hospital outpatient and freestanding (non-hospital) settings, and the Medicare payment methodologies differ depending on the site of service involved. Any episode-based payment methodology should be equally accessible to both types of providers and to the many practices that provide radiation treatment in both sites of care. Finally, to the extent that accreditation is used as a quality indicator or as a condition of participation, CMS should take into account all of the various accreditation organizations available for radiation oncology centers and refrain from limiting accreditation to a single option.

In the event that CMS determines that episode-based payment for radiation oncology services alone is impracticable in light of the complexity and multi-disciplinary nature of cancer care, we strongly urge CMS to consider substantially revising the structure and scope of the current Oncology Care Model, such that participants would not be limited to medical oncology providers but rather would consist of collaborative entities (Comprehensive Cancer Care Collaboratives) that include representation from surgery, radiation oncology and medical oncology—the three specialty areas generally involved in the provision of comprehensive cancer care. Under such a model, a cancer care episode would be triggered not only by the inception of chemotherapy (as under the current oncology care model) but also by the provision of radiation therapy and specific surgical trigger codes (e.g. treatment planning in the case of radiation therapy or mastectomy in the case of surgery). Multi-disciplinary governance and clinical committees could be required

as a condition of participation, and established care coordination quality measures could be used. Payment for all services provided to Medicare patients assigned to the model would be made to providers participating in the Collaborative and to all other providers, based on Medicare's otherwise applicable payment rates; however, the Collaborative would be eligible for shared savings (and, ultimately, shared losses) to the extent that Medicare payments are less than (or exceed) targets established based on a mix of provider-specific and regional/national episode costs. Any shared savings or losses would be distributed by the Collaborative to participating providers in accordance with a formula determined by the participating providers in advance. As under the current Oncology Care Model, a patient management fee would be payable to the Collaborative for care coordination and management services. In the event that CMS determines that a radiation-specific episode group model is impracticable, we believe that this alternative model has the potential to more fully reflect the multi-specialty nature of cancer treatment and to reinforce care coordination among the various providers involved.

We appreciate the opportunity to comment on the potential for radiation oncology episode group payment models in the Medicare program, and would be pleased to answer any questions that you may have regarding AFROC's position on this important policy matter. If you have any questions, please do not hesitate to contact Michael J. Katin(mjkatin@yahoo.com; 239-9400436) or AFROC's Washington counsel, Diane Millman (dmillman@PowersLaw.com; 202-872-6725).