Administration Issues New Round of Mandatory Models Including Release of Radiation Oncology Model Proposed Rule

The Centers for Medicare & Medicaid Services (CMS) published a proposed rule on July 10, 2019 on specialty care models that includes the highly anticipated Radiation Oncology Alternative Payment Model (RO Model).[1] This model represents a more active effort by the administration to (1) move providers into value-based models and (2) shift financial risk from the federal government onto providers. According to CMS, the RO Model seeks to maintain or enhance the quality of radiation therapy services received by Medicare beneficiaries while reducing Medicare program spending through enhanced provider and supplier financial accountability.

BACKGROUND

CMS has been seeking pathways to test an episode-based alternative payment model for radiation therapy for years. An impetus for the RO Model was the Patient Access and Medicare Protection Act of 2015 (PAMPA), which froze payments for radiation therapy services until January 1, 2019 (extended to January 1, 2020, by the Bipartisan Budget Act of 2018), and allowed for a transition to an alternative payment model for those services in 2020. CMS cited three perceived "challenges" as additional compelling arguments for the necessity of the RO Model:

1. Disparity in payment amounts across settings creates financial incentives to furnish care in one setting compared to another regardless of appropriateness.
2. Current payment structure gives incentives for volume of services without aligning payment with the value of services rendered.
3. It is difficult to determine appropriate payment rates for radiation therapy services, particularly given the increasing use of new technologies in a growing specialty.

As proposed, the model is scheduled to run from 2020 through 2024 and would save an estimated $250 to $260 million over the five-year period. Read on for highlights from the RO Model Proposed Rule.

Comments are due September 16, 2019.

[1] The Specialty Care Models to Improve Quality of Care and Reduce Expenditures Proposed Rule also proposes to implement a second mandatory model, the End-Stage Renal Disease (ESRD) Treatment Choices Model (ETC Model), and four voluntary kidney models, Kidney Care First (KCF) and Comprehensive Kidney Care Contracting (CKCC) Graduated, Professional, and Global Models. Details on the ETC Model and the voluntary kidney models can be found here and here respectively.

CMS Proposes a Mandatory, Nationwide Model for Radiation Therapy

In the proposed rule, the RO Model would begin January 1, 2020, and run through December 31, 2024. The model would be nationwide, with CMS randomly selecting the geographic areas defined as Core Base Statistical Areas (CBSAs). As of September 2018, there were 938 distinct CBSAs covering the vast majority of the United States, except for what CMS has described as "extreme rural areas." Based on the targeted savings for the model, CMS is seeking to capture approximately 40% of the radiation oncology episodes of care in the selected geographic areas. The affected CBSAs will not be disclosed until the publication of the final rule.

Appreciating the time necessary to prepare for participation in the RO Model, CMS is seeking input from stakeholders on whether the start date should be delayed until April 1, 2020. Based on the actual implementation timeline for the last mandatory model in 2016, it is unlikely that the model would be effective prior to April 2020 with or without stakeholder support.[2]

The RO Model proposes to create a 90-day episode of care for services furnished in or by hospital outpatient departments, physician group practices and freestanding radiation therapy centers. The model would apply for the following 17 different types of cancer commonly treated by radiation therapy:

Anal cancer	Bladder cancer	Bone metastases	Brain metastases
Breast cancer	Cervical cancer	CNS tumors	Colorectal cancer
Head and neck cancer	Kidney cancer	Liver cancer	Lung cancer
Lymphoma	Pancreatic cancer	Prostate cancer	Upper GI cancer
Uterine cancer			

As proposed, the model would apply to the majority of radiation therapy modalities including:

- 3-dimensional conformal radiotherapy
- Intensity-modulated radiotherapy
- Stereotactic radiosurgery
- Stereotactic body radiotherapy
- Proton beam therapy
- Intraoperative radiotherapy
- Image-guided radiation therapy
- Brachytherapy

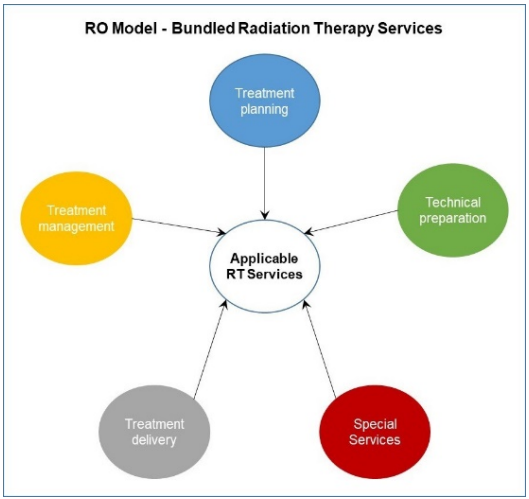
The model would apply to radiation therapy services furnished during the 90-day episode as defined by HCPCS codes specifically listed in the model. While the majority of radiation therapy services are incorporated in the bundle, a subset of low-volume services are excluded, including brachytherapy surgical procedures, neutron therapy, hypothermia treatment, and radiopharmaceuticals. It is important to note that CMS does not define the low-volume threshold in the proposed rule.

While payment for radiation therapy services is bundled, non-radiation therapy services such as evaluation and management visits are separately reimbursable.

[2] The Comprehensive Joint Replacement (CJR) Model Proposed Rule was issued in July 2015, the Final Rule was issued in late November 2015, and the first plan year did not begin until April 2016.

In the proposed rule, CMS defines the three different types of participants:

- **Professional**: physician groups or freestanding centers rendering the professional component of radiation therapy services
- **Technical**: hospital outpatient departments or freestanding centers for rendering the technical component of radiation therapy services
- **Dual**: freestanding centers that furnish the professional and technical components.



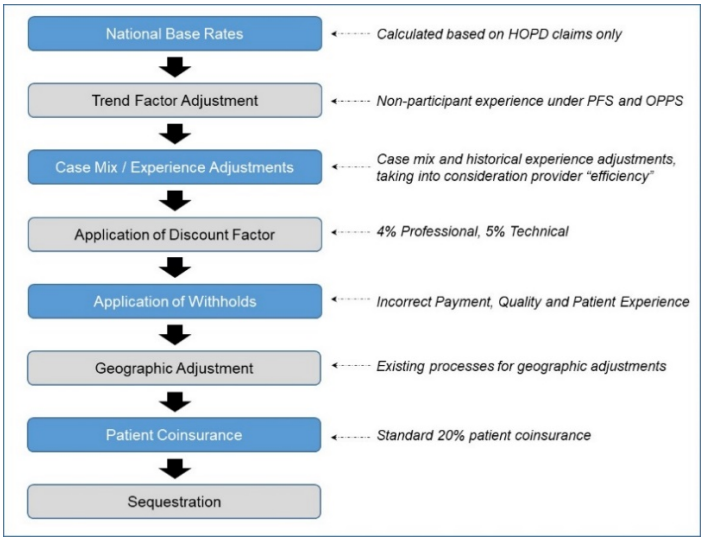
Under the proposed rule, an episode of care is triggered by a patient receiving treatment planning services furnished by a professional or dual participant, followed by treatment delivery services furnished by a technical or dual participant within 28 days of the planning service. Day 1 of the episode is defined as the day of treatment planning services. Once completed, the participant cannot initiate another episode for the same beneficiary for at least 28 days.

	Included in Model	Excluded from Model
Participants	▪ Hospital outpatient departments ▪ Physician group practices ▪ Freestanding radiation therapy centers	▪ PPS exempt cancer hospitals ▪ Critical access hospitals ▪ Ambulatory surgical centers ▪ Participants with service areas in MD, VT and US territories ▪ Participants enrolled in or eligible to be enrolled in the PA Rural Health Model
Beneficiaries	▪ Medicare FFS as primary payer ▪ Receiving services from a RO Model participant in a selected CBSA ▪ Enrolled in a clinical trial for which Medicare is paying routine costs	▪ Enrolled in Medicare managed care organization including MA plan ▪ Enrolled in PACE plan ▪ In a Medicare hospice benefit period ▪ Covered under United Mine Workers

CMS Applies Multiple Adjustments in the Payment Methodology

Under the Proposed Model, participants receive payment for an episode of care based on the type of cancer and whether the participant furnishes the professional and/or the technical component of the radiation therapy services. There is no differentiation in payment for services rendered in a hospital setting versus a freestanding center; payments are site neutral.

Proposed Payment Methodology



The total payment is split into two equal installments, with participants receiving 50% of the calculated payment rate at the beginning of the episode and 50% at the end of the episode. Payment is triggered by the participant submitting a model-specific HCPCS code, defined by cancer type and participant type, with appropriate Start of Episode and End of Episode modifiers. Similar to other models, CMS proposes an annual true-up reconciliation process in August following the plan year to determine any payment to, or recoupment from, the participant. Payment or recoupment would be calculated taking into consideration the following:

- Incorrect payment withhold accounted for in the payment rates
- Payments for duplicate billing and incomplete episodes
- Quality withhold and quality performance

Participants bear the financial risk for any costs above the payment rate (net reconciliation).

CMS designed the proposed model in a manner such that it qualifies as an Advanced APM under the Quality Payment Program. Therefore, professional participants would be eligible for the 5% bonus, provided that they met the other criteria.

SUMMARY

The RO Model represents a return to the mandatory model and furthers the administration's goal to move toward performance-based reimbursement. While the proposed rule outlines many components of the model, there are still unanswered questions and areas of potential concern among providers including the following:

- How will CMS ensure that the novel payment model meets the model goals, including maintaining or enhancing quality?
- Why has CMS decided to make this a mandatory model, covering so many episodes of care?
- What is the impact of calculating base rates using only hospital-based claims?
- What threshold does CMS use to define low-volume services?
- How will this model take into consideration new technology and innovation?
- Will CMS allow participants to opt in to the model if they are not in a selected geographic area? Why is there no hardship exemption (opt-out) for participants in selected areas?

- What is the effect of having no cap on the financial risk born by participants, and what effect will this have on provider financial viability?
- How is CMS intending to measure the impact of the model on outcomes in both the short and long terms?

Stakeholders may submit their comments and concerns to CMS until September 18, 2019.

For more information on the RO model, please contact Deborah Godes, Mara McDermott or Jason Caron.