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The Center for Medicare and Medicaid Innovation (CMMI) Radiation Oncology Alternative Payment Model (RO-APM) – Proposed Rule Summary

On July 10, 2019, the Centers for Medicare & Medicaid Services (CMS) announced new details of a proposed bundled payment model for radiation oncology services ("RO Model"), which would make fundamental (but temporary) changes to the way that Medicare pays for radiation therapy in certain randomly chosen geographic areas. Under the proposed model, Medicare would pay providers a pre-determined, site-neutral bundled rate for most services provided in a 90-day episode of radiation therapy, rather than paying for each service individually. The proposed model would be **mandatory** for providers selected to participate and is intended to incentivize providers to deliver radiation therapy services more cost-effectively while maintaining or improving the quality of care delivered.

Below is a summary of the key features of the proposed RO Model and potential implications for providers and manufacturers offering radiation therapy services and products. Based on the proposed rule's expected publication date in the Federal Register, comments on the proposal will be due **September 16, 2019**.

Timing

- The RO Model would run for 5 years, beginning on January 1, 2020, and ending December 31, 2024. An alternative proposal included in the rule would give providers more time to adjust and would not begin until April 1, 2020, but would still run through December 31, 2024.

Select Cancers, Most Modalities, Random Geographies

- The RO Model would apply only to payments for radiation therapy used to treat 17 specific cancers, which would be identified based on the diagnosis codes associated with the provider's claim. These are cancers that are typically treated using radiation therapy and for which CMS has sufficient claims data to establish reliable pricing benchmarks. (See Table 1 at the end of this summary for details.)
- The RO Model would apply to most radiation therapy modalities, including:
    - External beam radiation therapy, including 3-D conformal radiotherapy, intensity-modulated radiotherapy (IMRT), stereotactic radiosurgery (SRS), stereotactic body radiotherapy (SBRT), and proton beam therapy (PBT)
    - Intraoperative radiotherapy (IORT)
    - Image-guided radiation therapy (IGRT)
    - Brachytherapy
- The RO Model would apply only to providers that furnish radiation therapy services in specific geographic areas, which would be selected at random.
    - CMS would apply the RO Model to enough geographic areas to capture approximately 40% of eligible radiation therapy episodes. In a simulated sample, this resulted in

selection of 616 physician group practices (including 325 freestanding radiation therapy centers) and 541 hospital outpatient departments.
    - The geographic areas subject to the RO Model would be selected and published after the proposed rule is finalized.
    - The following providers would be excluded from the model: Providers that furnish radiation therapy services only in Maryland, in Vermont, or in US territories; providers that participate or are eligible to participate in the Pennsylvania Rural Health Model; providers classified as ambulatory surgical centers (ASCs); critical access hospitals (CAHs); and Prospective Payment System (PPS) exempt cancer hospitals.
- The RO Model would apply only to radiation therapy services billed under Medicare fee-for-service.

Bundled Payment for Radiation Therapy Services During an Episode

- Under the RO Model, radiation therapy providers would be paid a pre-determined, site-neutral bundled rate for all radiation therapy services furnished during an "episode of care," rather than being reimbursed separately for each service as they are now.
- An episode of care would be defined as a 90-day period beginning on the day that a provider furnishes the initial radiation therapy treatment planning service (Day 1 of the episode).
    - Note that if no radiation therapy treatment is actually provided within 28 days of Day 1, then the episode would be treated as an "incomplete episode" and any payments made to the provider under the RO Model would be reconciled later.
- The episode of care would include most services related to the radiation therapy – for all of these services, providers would not be reimbursed separately and would receive only the bundled payment for the episode. These bundled services would include:
    - Treatment planning
    - Technical preparation and special services, such as radiation dose planning, medical radiation physics, dosimetry, and calibration of treatment devices
    - Radiation treatment delivery
    - Treatment management, such as review of port films, review and changes to dosimetry, dose delivery, treatment parameters, review of patient setup, patient examination, and follow-up care.
- The episode of care would <u>not</u> include evaluation and management (E/M) services, which CMS notes are often furnished by providers other than the provider furnishing the radiation therapy services (e.g., primary care physicians, general oncologists, other specialists). E/M services would continue to be paid separately under the Physician Fee Schedule (PFS) or Outpatient Prospective Payment System (OPPS).

What is the Bundled Payment Rate for Each Episode?

- For each episode, a provider would receive a base payment specific to the patient's cancer and the individual provider's claim and case mix history, discounted by 4% or 5%, with additional payment withholds for incorrect payments and performance on quality or patient experience measures, and finally adjustments for geography, patient coinsurance, and sequestration.
- The episode payment would be divided into a Professional Component (PC) – radiation therapy services that can be furnished only by a physician – and a Technical Component (TC) – radiation therapy services that are not furnished by a physician. Depending on the type of provider and services rendered, a provider could receive either the PC, the TC, or both.

- CMS would calculate a separate national base payment for the PC and TC of each cancer subject to the RO Model – 34 base payments in all. The proposed base rates are listed in Table 2 below.
- The base rates would be calculated based on OPPS payments for radiation therapy episodes, using Medicare claims data from 2015 through 2017. The base rates are site-neutral, meaning that Medicare pays the same rate to hospital-based and freestanding radiation therapy providers.
    - CMS proposes to use only OPPS claims data to set the base rates because "OPPS payments have been more stable over time and have stronger empirical foundation than those under the PFS." CMS specifically cites its uncertainty about the accuracy of PFS rates for "services involving capital equipment."
- The national base rates would be adjusted based on recent trends in PFS and OPPS rates for radiation therapy when used to treat that specific cancer. Each participating provider's base rate also would be adjusted based on the provider's historical experience and case mix history.
- CMS then would apply an across-the-board "discount factor" (i.e., cut) of 4% for the PC and 5% for the TC.
- CMS then would withhold the following amounts:
    - 2% to reserve money for overpayments due to duplicate radiation therapy services or incomplete episodes;
    - 2% to incentivize providers to meet and perform well on quality measures; and
    - Beginning in CY 2022, an additional 1% to incentivize providers to perform well on patient experience measures.
- Finally, CMS would apply geographic adjustments, subtract 20% for patient coinsurance, and subtract 2% for sequestration.
- The remaining amount would be paid to the provider for the episode of care as an initial payment.
- The amounts withheld for overpayments and for quality and patient experience measures also could be paid to the provider after reconciliation, which would occur annually.

Quality and Patient Experience Measures

- RO Model participants would be required to report four quality measures:
    - Oncology: Medical and Radiation – Plan of Care for Pain (NQF #0383; CMS Quality ID #144)
    - Preventive Care and Screening: Screening for Depression and Follow-up Plan (NQF #0418; CMS Quality ID #134;)
    - Advance Care Plan (NQF #0326; CMS Quality ID #047)
    - Treatment Summary Communication – Radiation Oncology
- Participants would get a portion of the 2% quality withholding back based on their performance on these quality measures, as calculated in an aggregate composite score. For example, a provider that scores 100% would get the full 2% back, while a provider that scores 75% would only get 1.5% back.
- CMS proposes to add patient experience measures in CY 2022 based on the CAHPS® Cancer Care Survey for Radiation Therapy for inclusion as pay-for-performance measures.

Interaction with Other Value-Based Systems

- Interaction with the Quality Payment Program (QPP):
    - CMS indicates that the RO Model would qualify as an Advanced Alternative Payment Model (APM) under the QPP, meaning that individual practitioners who successfully

participate in the RO Model would be exempt from payment adjustments under the Merit-Based Incentive Payment System (MIPS) and automatically eligible for a 5% bonus to Part B payments.
    - Under the QPP, a practitioner is exempt from MIPS and receives the 5% bonus only if the practitioner receives at least 50% of Medicare Part B payments or sees at least 35% of Medicare patients through an Advanced APM. If a practitioner receives at least 40% of Part B payments or sees at least 25% of Medicare patients through an Advanced APM, the practitioner is still exempt from MIPS but does not receive the 5% bonus.
- Participants in the Oncology Care Model (OCM), Accountable Care Organizations (ACOs), or other voluntary APMs would not be exempted from the RO Model, although CMS proposes limited policies to address OCM overlap and would review the need for policies to address overlap between models once the RO Model begins.
    - With respect to OCM participants, if an RO Model episode occurs entirely within a 6-month OCM episode, CMS proposes that the 4% or 5% "discount" and the withholding amounts subtracted from the RO Model base payment would be <u>included</u> in the total cost of the OCM episode "to ensure there is no double counting of savings and no double payment of the withhold amounts between the two models." For RO Model episodes that partially overlap an OCM episode, CMS would prorate these amounts.
- RO Model participants would be exempt from adjustments under the Hospital Outpatient Quality Reporting (OQR) Program.

<u>Early Thoughts on Potential Impact</u>

- CMS's proposal to use OPPS claims history to calculate base rates could disproportionately affect freestanding treatment facilities, which currently receive payment based on PFS reimbursement rates. This disproportionate impact may be especially acute for cancers and modalities where current PFS rates are substantially higher than current OPPS rates.
- The RO Model also may have a disproportionate impact on providers with a significant volume of services using modalities with relatively high current PFS or OPPS payments, because base rates for each cancer are calculated based on an average of OPPS claims history across all modalities.
- The same disproportionate effect may be felt by manufacturers and suppliers of equipment used in services with relatively high current payment, or with more users in freestanding treatment facilities.
- CMS's proposal to apply an across-the-board cut of 4% for the PC and 5% for the TC would require all selected providers to look for new cost efficiencies in order to maintain current margins. This could have follow-on effects for all manufacturers and suppliers of radiation therapy equipment.
- Providers that are not currently reporting or tracking performance on the four quality measures identified in the proposed rule would need to take steps to ensure their ability to report and perform well on those measures, to avoid the 2% withhold becoming a permanent cut.
- CMS's proposal to exclude E/M services from bundled payments may mitigate the impact of the RO Model on providers that offer diversified or comprehensive cancer care, because those E/M services will continue to be reimbursed separately and at current rates.
- Providers should consider how participation in the RO Model would interact with their participation in the QPP. Simply being selected for participation in the RO Model would not be enough to exempt a provider from MIPS – the provider would be exempt (and/or receive the 5% bonus) only if the provider receives a sufficient amount of Part B reimbursement or treats a sufficient number of Medicare patients through the RO Model. (See thresholds above.)

- Providers participating in voluntary alternative payment models like the OCM or an ACO also should consider the potential impact of participation in the RO Model on their participation and performance under these other models.

Table 1

Cancer Type	ICD-9 Codes	ICD-10 Codes
Anal Cancer	154.2x, 154.3x	C21.xx
Bladder Cancer	188.xx	C67.xx
Bone Metastases	198.5x	C79.5x
Brain Metastases	198.3x	C79.3x
Breast Cancer	174.xx, 175.xx, 233.0x	C50.xx, D05.xx
Cervical Cancer	180.xx	C53.xx
CNS Tumors	191.xx, 192.0x, 192.1x, 192.2x, 192.3x, 192.8x, 192.9x	C70.xx, C71.xx, C72.xx
Colorectal Cancer	153.xx, 154.0x, 154.1x, 154.8x	C18.xx, C19.xx, C20.xx
Head and Neck Cancer	140.xx, 141.0x, 141.1x, 141.2x, 141.3x, 141.4x, 141.5x, 141.6x, 141.8x, 141.9x, 142.0x, 142.1x, 142.2x, 142.8x, 142.9x, 143.xx, 144.xx, 145.0x, 145.1x, 145.2x, 145.3x, 145.4x, 145.5x, 145.6x, 145.8x, 145.9x, 146.0x, 146.1x, 146.2x, 146.3x, 146.4x, 146.5x, 146.6x, 146.7x, 146.8x, 146.9x 147.xx, 148.0x, 148.1x, 148.2x, 148.3x, 148.8x, 148.9x, 149.xx, 160.0x, 160.1x, 160.2x, 160.3x, 160.4x, 160.5x, 160.8x, 160.9x, 161.xx, 195.0x	C00.xx, C01.xx, C02.xx, C03.xx, C04.xx, C05.xx, C06.xx, C07.xx, C08.xx, C09.xx, C10.xx, C11.xx, C12.xx, C13.xx, C14.xx, C30.xx, C31.xx, C32.xx, C76.0x
Kidney Cancer	189.0x	C64.xx
Liver Cancer	155.xx, 156.0x, 156.1x, 156.2x, 156.8x, 156.9x	C22.xx, C23.xx, C24.xx
Lung Cancer	162.0x, 162.2x, 162.3x, 162.4x, 162.5x, 162.8x, 162.9x, 165.xx	C33.xx, C34.xx, C39.xx, C45.xx
Lymphoma	202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 203.80, 203.82, 200.0x, 200.1x, 200.2x, 200.3x, 200.4x, 200.5x, 200.6x, 200.7x, 200.8x, 201.xx, 202.0x, 202.1x, 202.2x, 202.4x, 202.7x, 273.3x	C81.xx, C82.xx, C83.xx, C84.xx, C85.xx, C86.xx, C88.xx, C91.4x
Pancreatic Cancer	157.xx	C25.xx
Prostate Cancer	185.xx	C61.xx
Upper GI Cancer	150.xx, 151.xx, 152.xx	C15.xx, C16.xx, C17.xx
Uterine Cancer	179.xx, 182.xx	C54.xx, C55.xx

Table 2

RO Model-Specific Placeholder Codes	Professional or Technical	Cancer Type	Base Rate
MXXXX	Professional	Anal Cancer	$2,968
MXXXX	Technical	Anal Cancer	$16,006
MXXXX	Professional	Bladder Cancer	$2,637
MXXXX	Technical	Bladder Cancer	$12,556
MXXXX	Professional	Bone Metastases	$1,372
MXXXX	Technical	Bone Metastases	$5,568
MXXXX	Professional	Brain Metastases	$1,566
MXXXX	Technical	Brain Metastases	$9,217
MXXXX	Professional	Breast Cancer	$2,074
MXXXX	Technical	Breast Cancer	$9,740
MXXXX	Professional	Cervical Cancer	$3,779
MXXXX	Technical	Cervical Cancer	$16,955
MXXXX	Professional	CNS Tumor	$2,463
MXXXX	Technical	CNS Tumor	$14,193
MXXXX	Professional	Colorectal Cancer	$2,369
MXXXX	Technical	Colorectal Cancer	$11,589
MXXXX	Professional	Head and Neck Cancer	$2,947
MXXXX	Technical	Head and Neck Cancer	$16,708
MXXXX	Professional	Kidney Cancer	$1,550
MXXXX	Technical	Kidney Cancer	$7,656
MXXXX	Professional	Liver Cancer	$1,515
MXXXX	Technical	Liver Cancer	$14,650
MXXXX	Professional	Lung Cancer	$2,155
MXXXX	Technical	Lung Cancer	$11,451
MXXXX	Professional	Lymphoma	$1,662
MXXXX	Technical	Lymphoma	$7,444
MXXXX	Professional	Pancreatic Cancer	$2,380
MXXXX	Technical	Pancreatic Cancer	$13,070
MXXXX	Professional	Prostate Cancer	$3,228
MXXXX	Technical	Prostate Cancer	$19,852
MXXXX	Professional	Upper GI Cancer	$2,500
MXXXX	Technical	Upper GI Cancer	$12,619
MXXXX	Professional	Uterine Cancer	$2,376
MXXXX	Technical	Uterine Cancer	$11,221

The ACCC Policy Team is still reviewing details of this proposal and plans to comment on behalf of our membership to CMS. Please send your thoughts, concerns, considerations, and questions to Blair Burnett, ACCC Senior Policy Analyst, at bburnett@accc-cancer.org.