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Summary of the Proposed Radiation Oncology Mandatory Demonstration Model

Vizient Office of Public Policy and Government Relations
Regulatory Update: CMS Notice of Proposed Rule Making – Medicare Program: Specialty Care Models to Improve Quality of Care and Reduce Expenditures

July 22, 2019

On Wednesday, July 10, the Centers for Medicare and Medicaid (CMS) issued a proposed rule to implement and test two new mandatory payment models. The first proposed model – the Radiation Oncology Model (RO Model) will test prospective, episode-based payments for radiotherapy (RT) care. The second proposed model – the End-Stage Renal Disease (ESRD) Treatment Choices Model (ETC Model) intends to encourage increased use of home dialysis and kidney transplants to Medicare beneficiaries. Both proposed models have the goal of enhancing quality of care while encouraging providers to take on greater financial accountability in an effort to reduce Medicare spending. The two areas of focus were chosen because the agency believes that they offer considerable potential to redesign and improve the quality of care for these clinical services. For the purposes of this summary, content is focused primarily on the RO Model and does not include details related to the ETC Model. CMS is seeking and accepting public comments on these proposals until September 16, 2019.

Background & Summary

The proposed RO model will test whether prospective episode-based payments made to a variety of providers – including physician group practices (PGPs), hospital outpatient provider departments (HOPDs), and freestanding radiation therapy centers – will reduce overall Medicare spending, while preserving or increasing quality of care. A goal of this model is to provide greater predictability in payment by eliminating fee-for-service payment incentives while encouraging providers to treat patients with the most appropriate and high value modalities. CMS is proposing a five calendar year (CY) performance period for the RO Model – which would begin on January 1, 2020 and end Dec. 31, 2024, but is considering an alternative start date of April 1, 2020, if it is determined that participants and the agency need additional time to prepare. The agency is also proposing to define "performance year" (PY) as the 12-month period beginning on Jan. 1 and ending on Dec. 31 of each year during the model performance period, with a final data submission in 2025 to account for episodes ending in 2024.

The proposed RO Model would include 17 cancer types (listed in Table 1 on page 34498 of the proposed rule) that are commonly treated with RT and have specific ICD-9 and ICD-10 diagnosis codes. CMS is proposing to include prospective payments for RT services that are furnished during a 90-day episode for these 17 included cancer types, for certain Medicare beneficiaries. The agency notes that the payments are not meant to be inclusive of all of the care a beneficiary receives during these 90 day periods, only care associated with RT for the 17 cancer types will be included.

These episode payments will be divided into two components – the professional component (PC) and the technical component (TC). The former reflects payments for services that can only be provided by a physician with the latter including services such as supplies, equipment, personnel and other costs related to RT services. The separate payment amounts (both for the PC and the TC of each cancer type included in the model) would be determined "based on proposed national base rates, trend factors, and adjustments for each participant's case-mix, historical experience, and geographic location." However, CMS plans to withhold a percentage of the total episode payments to account for payment issues and to

create incentives to provide high quality, patient-centered care. CMS proposes withholding 2 percent of both the PC and the TC to address any overpayments that may occur and 2 percent from the PC as a "proposed quality withhold" related to payments to participants under the terms of an Advance Payment Model. They further propose to withhold 1 percent for the TC to account for patient experience. However, RO participants would have the "ability to earn back a portion of the quality and patient experience withholds based on their reporting of clinical data, their reporting and performance on quality measures, and, as of PY 3, performance on the beneficiary-reported Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Cancer Care Radiation Therapy Survey."

CMS is proposing that RT providers and suppliers that furnish RT services within a random selection of Core Based Statistical Areas (CBSAs) would be required to participate in the RO Model. CMS is proposing to link RT providers and suppliers to a CBSA by using the five digit ZIP Code of the location where services are furnished as a geographic unit of selection. CMS is planning to sample "40 percent of all eligible RO episodes in eligible CBSAs nationwide", which the agency believes will provide a sufficient sample size and enable them to evaluate the impact of the Model with confidence. Finally, CMS is proposing that the CBSAs would be selected at random – and those CBSAs and the ZIP Codes selected for participation would be published on the RO Model website when the final rule is published.

Participants would participate in the proposed model as a professional, technical or a dual participant. Professional participants include Medicare-enrolled PGPs that deliver only the PC of RT services at a freestanding radiation therapy center or a HOPD. Technical participants would be a Medicare-enrolled HOPD or freestanding radiation therapy center that delivers only the TC of RT services. Dual participants would be those that deliver both the PC and TC of RT services through a freestanding radiation therapy center. Under the proposed rule, CMS plans to test site-neutral payment rates by providing the same, episode-based reimbursement to all participants, thus eliminating the incentive to provide RT services at one site of service over another.

Lastly, CMS is also proposing that the RO Model would meet the requirements for an Advanced Alternative Payment Model (Advanced APM) and a Merit-based Incentive Payment System APM (MIPS APM) under the Quality Payment Program (QPP).

What's Next?

Comments are due by September 16, 2019. Vizient's Office of Public Policy and Government Relations looks forward to hearing continued member feedback on this proposed rule. Stakeholder input plays a major role in shaping future changes to policy. We encourage you to reach out to our office if you have any questions regarding any aspects of this proposed regulation – both positive reactions and provisions that cause you concern.

As always, it is possible that we'll see substantial shifts between the proposed and final rule based on public comments and further analysis by CMS.

Additional Resources

Chelsea Arnone, Regulatory Affairs and Government Relations Director in Vizient's Washington, D.C. office, can be reached at (202) 354-2608, and is monitoring the rule and other regulatory developments at CMS. Please reach out to her if you have any questions or if Vizient can provide any assistance as you consider these issues.