

Radiation Oncology Model (RO Model) Final Rule Initial Summary

On September 18, 2020, the Centers for Medicare and Medicaid Services (CMS) released their [Final Rule](#) on “Specialty Care Models to Improve Quality of Care and Reduce Expenditures” which includes a mandatory Radiation Oncology Model (RO Model) and End-Stage Renal Disease (ESRD) Treatment Choices Model (ETC Model). CMS believes these models will further their goal of shifting away from payment for volume and toward value and outcomes.

Certain radiation therapy (RT) providers and RT suppliers that furnish RT services within randomly selected Core Based Statistical Areas (CBSAs [geographic areas determined by zip code]) are required to participate in the RO Model. The RO Model will include 30% of RO episodes in eligible geographic areas. See Participating Zip Code List for randomly selected CBSAs on [RO Model Web Page](#).

Under the RO Model, Medicare will pay participating providers and suppliers a prospective, modality agnostic, site-neutral, episode-based payment for specified technical and professional RT services furnished during a 90-day episode to Medicare FFS beneficiaries diagnosed with 16 different cancer types. The base payment amounts for RT services included in the model will be the same for hospital outpatient departments (HOPDs) and freestanding radiation therapy centers. CMS believes a site-neutral payment will address the site-of-service payment differential that exists under the Hospital Outpatient Prospective Payment System (OPPS) and the Medicare Physician Fee Schedule (PFS) by establishing a common payment for the same services regardless of where they are furnished. The RO Model will determine whether these payments reduce Medicare program expenditures and preserve or enhance quality of care for beneficiaries.

This five-year model will begin on January 1, 2021, and end December 31, 2025. Performance years (PYs) will begin January 1 of each year and end after 12 months on December 31 of that year. CMS estimates savings of approximately \$230 million (as opposed to their proposed \$250-\$260 million estimate) over the Model’s five-year period, and CMS notes that due to the COVID-19 pandemic, these savings are subject to additional uncertainty.

The RO Model will qualify as an Advanced Alternative Payment Model (APM) under the Quality Payment Program (QPP). The RO Model will require participants to annually certify their intent to use Certified Electronic Health Record Technology (CEHRT), include quality measure performance as a factor when determining payments, and require RO participants to bear more than a nominal amount of financial risk. Within 30 days of the start of PY1, the RO participant would be required to certify its intent to use CEHRT. Participants, who do not meet the QP threshold, will not qualify for the APM incentive payment and, instead, will be assigned to a MIPS APM.

1) Scope of the model: required participants, episodes, and beneficiaries

CMS finalized a mandatory model design in which certain Medicare participating HOPDs, physician group practices (PGPs), and freestanding radiation therapy centers that furnish RT services within randomly selected Core Based Statistical Areas (CBSAs) will be required to participate in the model. The model will include Professional Participants, Technical Participants, and Dual Participants.

CMS did not finalize their proposal to include 17 different cancer types, and instead excluded kidney cancer and finalized 16 different cancer types in the model (anal cancer, bladder cancer, bone metastases, brain metastases, breast cancer, cervical cancer, CNS tumors, colorectal cancer, head and neck cancer, liver cancer, lung cancer, lymphoma, pancreatic cancer, prostate cancer, upper gastrointestinal cancer, and uterine cancer). CMS finalized their proposed episode length of 90 days. An episode will only be triggered if there is an initial treatment planning service and at least one radiation treatment service within 28 days. Furthermore, another episode may not be triggered until at least 28 days after the previous episode has ended, referred to as the “clean period.”

CMS finalized their proposal to include treatment planning, technical preparation and special services, treatment delivery, and treatment management as the RT services in an episode paid for by CMS. Evaluation and management (E&M) services will not be included in the episode. In the final rule, CMS stated that the Agency will undergo additional rulemaking to add new codes to account for new technologies and new equipment.

CMS finalized their proposal to include the following modalities: Various types of external beam RT, including 3-dimensional conformal radiotherapy (3DCRT), intensity-modulated radiotherapy (IMRT), stereotactic radiosurgery (SRS), stereotactic body radiotherapy (SBRT), and proton beam therapy (PBT); image-guided radiation therapy (IGRT); and brachytherapy. CMS did not finalize their proposal to include intraoperative radiotherapy (IORT).

CMS recognizes the importance of beneficiaries’ awareness that their RT providers and suppliers are participating in the RO Model. Therefore, all RO participants must provide a RO Model [Beneficiary Notification Letter](#) to RO beneficiaries who are included in the RO Model.

Beneficiaries are still responsible for cost-sharing as under the traditional payment systems (e.g., typically 20 percent of the Medicare-approved amount for services), but because CMS is applying a discount to each of these components, beneficiary cost-sharing may be, on average, lower relative to what is typically paid under traditional Medicare FFS.

2) Pricing methodology

CMS finalized their proposed national base rate methodology with a modification that changes the baseline from 2015-2017 to 2016-2018 and a modification to exclude episodes from the baseline in which either the PC or TC is attributed to a provider with a Maryland, Vermont, or US Territory service location. CMS will create national base rates for the PC and TC of each of the 16 cancer types, resulting in 32 national base rates. Each of the national base rates represents the historical average cost for an episode of care for each of the cancer types. CMS will publish the national base rates and provide each RO participant its participant-specific professional episode payment and/or its participant specific technical episode payment for each cancer type no later than 30 days before the start of the PY in which payments would be made.

CMS will apply a trend factor to the 32 different national base rates to update those amounts to reflect current trends in RT payment and the volume of those services outside of the model under the PFS and OPPs. Each PY, CMS will calculate separate trend factors for the PC and TC of

each cancer type using data from HOPDs and freestanding RT centers not in the model. In the final rule, CMS made a technical change to apply the geographic adjustment to the trended national base rates prior to the case mix and historical experience adjustments and prior to the discount factor and withholds.

CMS finalized their proposal to adjust the trended national base rates to account for each participant's historical experience and case mix history, with one modification. For calculating the expected payment for each RO participant, rather than using average Winsorized episode payments for each cancer type as proposed, CMS will use a second regression model that calculates expected payment amounts based on cancer type alone. In the final rule, CMS is renaming the efficiency factor to the "blend" to help clarify what it represents and its purpose. The case mix adjustment will be developed by measuring the occurrence of the case mix variables among the beneficiary population that each RO participant has treated historically compared to the variables occurrence in the national beneficiary profile. CMS made a technical change in the final rule: CMS will provide each RO participant its case mix and historical experience adjustments for both the PC and TC in advance of the PY, rather than their participant-specific professional and technical episode payment amounts.

CMS did not finalize their proposal to apply a discount factor of 4% for PC and 5% for TC, and instead reduced the discount factors to 3.75% for PC and 4.75% for TC. This is the set percentage that CMS will reduce an episode payment amount, after the trend factor and adjustments are applied, and will reserve Medicare savings and reduce beneficiary cost sharing.

CMS reduced their proposed incorrect payment withhold of 2% to a 1% withhold of the episode payments for both the PC and TC of each cancer type. CMS finalized their proposal to apply a 2% quality withhold for the PC to the applicable trended national base rates after the case mix and historical experience adjustments and discount factor have been applied. CMS finalized their proposal to withhold 1% of the TC to the applicable trended national base rates after the case mix and historical experience adjustments and discount factor have been applied starting in PY3 to account for patient experience in the model. RO participants have the ability to earn back a portion of the quality and patient experience withholds based on clinical data reporting, quality measure reporting and performance, and the beneficiary-reported Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Cancer Care Radiation Therapy Survey.

CMS finalized their proposal to calculate the coinsurance amount for an RO beneficiary after applying the proposed case mix and historical experience adjustments, withholds, discount factors, and geographic adjustments to the trended national base rates for the cancer type billed by the RO participant for the RO beneficiary's treatment. However, CMS is not finalizing their coinsurance proposal with respect to a subset of incomplete episodes, specifically those in which: (1) the TC is not initiated within 28 days following the PC; (2) the RO beneficiary ceases to have traditional FFS Medicare prior to the date upon which a TC is initiated, even if that date is within 28 days following the PC; or (3) the RO beneficiary switches RT provider or RT supplier before all RT services in the RO episode have been furnished.

CMS finalized their proposal to pay for the episode in two installments: one tied to when the episode begins, and the other tied to when the episode ends. A professional participant would

receive two installment payments for furnishing the PC, a technical participant would receive two installment payments for furnishing the TC, and a dual participant would receive two installment payments for furnishing the PC and TC of an episode. Participants will bill for new RO Model-specific HCPCS codes and modifier to indicate an episode has begun (which will result in half of payment) and bill the same codes and modifier to indicate episode has ended (and then paid the second half of the payment).

3) Quality Measures for scoring performance

CMS finalized their proposed quality measures for the RO Model. These include:

- Oncology: Medical and Radiation—Plan of Care for Pain—NQF41 #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
- CAHPS Cancer Care Survey

CMS finalized, with one modification in regard to the start date, their proposal to include a set of four quality measures for PY1. Instead of submitting quality measures data beginning in March 2021 as proposed, RO participants will submit data beginning in March 2022, based on RO episodes in PY1 (January 1, 2021, through December 31, 2021), consistent with other changes to the timing of Model implementation. CMS also finalized their proposal to have a CMS-approved contractor administer the CAHPS® Cancer Care Survey for Radiation Therapy, with a modification that the survey will be administered beginning in April 2021 rather than in 2020. The survey will be administered starting in 2021 to determine patient experience measures used in performance year 3-5.

CMS received comments that national accreditation through the American College of Radiology (ACR) or American Society for Radiation Oncology (ASTRO) should be sufficient to meet quality standards for the Model and that accredited PGP in the Model should not need to report additional quality data to CMS. CMS agreed with the commenters that accreditation by nationally recognized organizations, such as the ACR, ACRO, and ASTRO, may be an indicator of the overall quality of care provided by a RT provider or RT supplier. However, CMS does not believe that accreditation provides a full picture of quality care delivery in radiation oncology. As stated in the final rule, the Model must include a set of quality measures to qualify as a MIPS APM and an Advanced APM, and as such, accreditation is not able to replace the RO quality measures without compromising the Model's qualification as a MIPS APM and Advanced APM. While CMS is not using accreditation status as a proxy for quality, they may at some point use an optional web-based survey to gather data from participants on administrative data points, including their accreditation status, indicating the importance of this information to understanding participants' activities.

CMS did not finalize their proposed waiver of the requirement to apply the MIPS payment adjustment factors for the PC of RO Model payments. CMS is finalizing that the MIPS payment adjustment factors will apply to participant-specific professional episode payments for the PC of RT services furnished by a MIPS eligible clinician. CMS will only waive the MIPS payment adjustment factors for the TC of the RO Model payments. CMS finalized their proposed waiver of the requirement to include technical component payments in calculation of the APM incentive payment amount.

4) The process for payment reconciliation

CMS finalized their proposal to conduct an annual reconciliation for each RO participant after each PY to reconcile payments due to the RO participant with payments owed to CMS due to the withhold policies. In the final rule, CMS made the following clarification: CMS uses the reconciliation process to identify any reconciliation payment owed to an RO participant or any repayment amount owed by an RO participant to CMS. The reconciliation period would occur in August following a PY. CMS finalized their proposal to conduct an annual true-up of reconciliation for each PY, which would calculate additional payments or repayments for incomplete episodes and duplicate RT services. This would occur one year after the original reconciliation results were calculated.

5) Data collection and sharing

The RO Administrative Portal (ROAP) is an online platform that will be used to track RO participant information through the participant profile page and to allow users to access and review organizational data; update participant information and contacts. The RO Model secure data portal will serve as a data submission system and for RO participants to access claims data requests. The process for submitting data through the RO Model secure data portal will be provided via technical support and education efforts that take place following the final rule publication, so all RO participants have time to become familiar with the infrastructure and processes prior to required reporting.

CMS proposed requiring RO participants to submit additional administrative data upon request from CMS through annual web-based surveys. CMS finalized this proposal with modification: requests by CMS for administrative data related to the cost of providing care, frequency of equipment use, EHR vendors, and accreditation status will be optional for RO participants. RO participants are also required to submit clinical data elements for five cancer types (bone, brain, breast, lung, prostate) biannually. The clinical data requirements will be provided to RO participants prior to the start of PY1.

In an effort to shepherd the development of new outcome measures in radiation oncology, explore opportunities to inform pricing for episodes in the RO Model, and inform monitoring of care quality during the RO Model, the Innovation Center will collect clinical data elements (CDEs) from RO participants beginning in Performance Year (PY) 1 (January 1, 2021 - December 31, 2021). The Innovation Center solicits comment from the general public [on the suggested CDEs](#) by October 19, 2020. Written feedback can be sent to RadiationTherapy@cms.hhs.gov until the close of the feedback period.

Additionally, all professional participants and dual participants are required to document in the medical record that they have complied with seven monitoring requirements. CMS determined that the local coverage determinations (LCDs) will still apply to all radiation therapy services provided in an episode.

The ACR will review this final rule in detail in the coming weeks in coordination with its MACRA Committee and the Radiation Oncology Commission. Go to the CMS.gov webpage devoted to the [Radiation Oncology Model](#) to learn more about the model.