Health Industry Alert

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CMS Proposes New Payment Model for Radiation Oncology

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Key Points

- On July 18, 2019, the Centers for Medicare & Medicaid Services (CMS) and the Center for Medicare & Medicaid Innovation (CMMI) published a proposal to implement a new mandatory Medicare payment model in select geographic areas—the Radiation Oncology (RO) Model.[1] The RO Model would provide site-neutral, episode-based payments to providers and suppliers of certain radiation therapy services.
- Through the RO Model, CMS seeks to pay a set amount to model participants without regard to whether treatment is provided in a hospital outpatient department (HOPD) or a freestanding radiation therapy center. The model also does not take into account patient acuity levels.
- Additionally, CMS proposes to make fixed, bundled prospective payments to model participants for each 90-day episode of care. Model participants would earn additional payment for reporting clinical data and performance on certain quality and patient experience measures.
- Comments on the proposed RO Model are due September 16, 2019.

Background

Section 1115A of the Social Security Act authorizes CMS to test alternative payment models that have the potential to reduce Medicare spending while maintaining or improving quality of care.[2] In a 2017 report mandated by the Patient Access and Medicare Protection Act (PAMA), CMS found that an alternative payment model for radiation therapy could be used to address: (1) differences in payment between sites of care; (2) incentives that encourage a high volume of services; and (3) coding and payment challenges due to the high volume of services and the increasing use of new technologies.[3]

To develop its proposed RO Model, CMS conducted an analysis of Medicare fee-for-service (FFS) claims for radiation therapy services submitted between January 1, 2015, and December 31, 2017. CMS found that, during that time, 64 percent of radiation therapy treatment services were furnished in HOPDs and 36 percent were

Contact Information:

If you are interested in filing comments in response to CMS's proposed RO Model or if you would like to discuss the proposal in more detail, Akin Gump is ready to assist. Please reach out to one of the following for support:

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furnished in freestanding radiation therapy centers. This analysis revealed that freestanding radiation therapy centers, which are paid under the Medicare Physician Fee Schedule (PFS), were paid approximately 11 percent more per episode of care than HOPDs, which are paid under the Outpatient Prospective Payment System (OPPS).

Based on its review of claims data, CMS also concluded that FFS payment systems may incentivize providers to select a treatment plan with a longer course of radiation therapy (i.e., a higher volume of services), despite research that supports a shorter course of radiation therapy for certain cancer types, stages and characteristics.

Proposed RO Model Design

CMS proposes to implement an alternative payment model for radiation therapy services with the following characteristics:

- Mandatory Participation. CMS would require all radiation therapy providers and suppliers within randomly selected geographic areas to participate in the RO Model, with certain exclusions. CMS proposes to use the Office of Management and Budget's Core Based Statistical Areas (CBSAs) as the geographic unit of selection. CBSAs are geographic areas with: (1) a population of at least 10,000; (2) an urbanized core; and (3) adjacent counties with a high degree of social and economic integration with the core.
- Broad Coverage of Radiation Therapy Services. Under CMS's proposal, model participants would receive prospective payment for radiation therapy provided to treat a Medicare FFS beneficiary for certain types of cancer. CMS proposes to include cancer types commonly treated with radiation that have associated current ICD-10 codes with demonstrated pricing stability such that they could be accurately priced for prospective episode payments. CMS identified the following 17 cancer types as meeting this criteria:
  - Anal cancer
  - Bladder cancer
  - Bone metastases
  - Brain metastases
  - Breast cancer
  - Cervical cancer
  - Central nervous system tumors
  - Colorectal cancerHead and neck cancer
  - Kidney cancer
  - Liver cancer
  - Lung cancer
  - Lymphoma
  - Pancreatic cancer
  - Prostate cancer

- Upper GI cancer
- Uterine cancer.

The model would not account for total cost of all care provided to a beneficiary during the 90-day episode. Rather, the payment would cover only the following radiation therapy services provided to treat the cancer types listed above: treatment planning; technical preparation and special services; radiation treatment delivery; and treatment management.

- Prospective, Site-Neutral, Episode-Based Payment. CMS would pay model participants prospective, episode-based amounts for radiation therapy services furnished during a 90-day episode of care, instead of regular Medicare FFS payments.
  - Model payments would be split into a professional component (PC) payment and a technical component (TC) payment to account for the fact that these components are sometimes furnished by separate providers or suppliers and paid for through different payment systems (i.e., PFS and OPPS). For example, under the RO Model, a participating HOPD would have at least one physician group practice furnish radiation therapy services at the HOPD.
    - The physician group practice would furnish the PC as a professional participant and a HOPD would furnish the TC as a technical participant.
    - The physician group practice and the HOPD would be participants in the RO Model, furnishing separate components of the same episode.
    - Participants would also have the opportunity to elect to furnish both the PC and TC as a dual participant through one entity, such as a freestanding radiation therapy center.
    - CMS would determine participant-specific payment amounts based on national base rates, trend factors and adjustments for each participant's case mix, historical experience and geographic location. Site of care would not be taken into account. CMS would also apply a discount factor and withhold a certain payment amount for participants to earn back by demonstrating high-quality care.
  - Quality Measures. As part of the proposed RO Model, CMS would assess participants' performance on measures of quality and patient experience. Model participants would be paid for reporting clinical data in accordance with proposed reporting requirements. Additionally, they would be paid for performance on three proposed quality measures and paid to report on one proposed quality measure. Beginning in the third year of the performance period, CMS would add a set of patient experience measures to be included as pay-for-performance measures.
  - Five-Year Performance Period. CMS proposes that the RO Model would begin in 2020 and end December 31, 2024.

Issues Ripe for Comment

We anticipate that the agency may receive comments on the following areas:

- Mandatory Nature of Proposed Model. This proposed model, along with the proposed, mandatory End-Stage Renal Disease Treatment Choices Model,

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evidence a shift in agency thinking regarding mandatory payment models under Health and Human Services (HHS) Secretary Alex Azar. Under former HHS Secretary Tom Price, who was critical of mandatory payment models, CMS canceled the planned implementation of mandatory models for hip fracture and cardiac care and scaled back the mandatory Comprehensive Care for Joint Replacement Model. Secretary Azar, however, has stated that mandatory payment models are an effective way to evaluate whether bundles can reduce costs and improve quality of care.

Some have indicated that, in developing mandatory alternative payment models, CMS may be overstepping its statutory authority and not reducing patient risk by requiring provider participation in untested programs. We expect that comments on the proposed RO Model will likely reiterate these arguments.

- Model Design. CMS is also likely to receive comments regarding whether its focus on radiation oncology, as opposed to other services such as those involved in the previously proposed hip fracture and cardiac care models, is appropriate. In addition, commenters may wish to engage on whether it is appropriate to reduce payments to providers for treating patients with higher acuity levels and more advanced stages of the disease.
- Site-Neutral Payments. CMS estimates that freestanding radiation therapy centers, which are paid under the PFS, were paid approximately 11% more per episode of care than HOPDs for furnishing radiation oncology services. CMS's proposal to provide the same level of payments to HOPDs and freestanding radiation therapy centersin the proposed RO Model is a continuation of the agency's focus on creating site-neutral payments and will likely draw comments.

[1] 84 Fed. Reg. 34,478 (July 18, 2019), https://www.govinfo.gov/content/pkg/FR-2019-07-18/pdf/2019-14902.pdf.

[2] 42 U.S.C. § 1315a(a).

[3] Patient Access and Medicare Protection Act, Pub. L. No. 114-115, § 3(b), 129 Stat 3131, 3133 (2015); HHS, Report to Congress: Episodic Alternative Payment Model for Radiation Therapy Services (Nov. 2017), https://innovation.cms.gov/Files/reports/radiationtherapy-apm-rtc.pdf.

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