

CMS PROPOSED MANDATORY PAYMENT MODELS FOR RADIATION ONCOLOGY AND ESRD

On July 10, 2019, CMS issued proposed **rulemaking** titled *Medicare Program; Specialty Care Models to Improve Quality of Care and Reduce Expenditures*. The rule proposes to implement two new **mandatory** Medicare payment models - the Radiation Oncology Model and the End-Stage Renal Disease ("ESRD") Treatment Choices Model. Comments on this proposed rule are due no later than September 16, 2019. These models could take effect as early as January 1, 2020.

THE RADIATION ONCOLOGY MODEL

The Radiation Oncology Model ("RO Model") would test whether **prospective** episode-based payments made to physician group practices, hospital outpatient departments and freestanding radiation therapy centers for radiotherapy ("RT") episodes of care would reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. CMS proposes that the RO Model would have a performance period of five calendar years, beginning in 2020 and ending December 31, 2024.

Payments under the RO Model would be site neutral among the various provider types, but the payments would be separated into professional and technical components. The term "professional component" or "PC" would mean included RT services that may only be furnished by a physician. The term "technical component" or "TC" would mean included RT services that are not furnished by a physician, including the provision of equipment, supplies, personnel and other costs related to RT services.

Participation would be mandatory for applicable providers located in certain selected geographic areas. *Importantly, the proposed rule does not identify the applicable geographic areas; instead, the mandatory participation areas will be selected by CMS through a randomized selection process at a later date and published with the final rule.* The proposed rule does, however, specify that the RO Model will not apply to radiotherapy providers in Maryland, Vermont or U.S. Territories; to ambulatory surgery centers, critical access hospitals or Prospective Payment System ("PPS") exempt cancer hospitals; or to hospitals that are either participating or eligible to participate in the Pennsylvania Rural Health Model.

The RO Model focuses on 17 cancer types for which RT is a common course of treatment.^[1] CMS proposes to include the following RT modalities in the model: various types of external beam RT, including 3-dimensional conformal radiotherapy, intensity-modulated radiotherapy, stereotactic radiosurgery, stereotactic body radiotherapy and proton beam therapy ("PBT"); intraoperative radiotherapy; image-guided radiation therapy; and brachytherapy. CMS questions the benefits of PBT, especially given its higher cost, and asks for comments as to whether the RO Model should exclude PBT except for RO beneficiaries participating in federally-funded, multi-institution and randomized control clinical trials to encourage the continued research into the efficacy of PBT.

The rule would define an episode of RT to include treatment planning, technical preparation and special services, treatment delivery and treatment management. CMS is explicitly proposing to exclude consultations from the episode of treatment, noting that claims history indicates many beneficiaries have multiple consultations associated with the diagnosis and evaluation of the cancer type before any treatment planning begins.

Each RT episode will be 90 days in length, based on 2014-2015 claims data indicating that 99 percent of Medicare beneficiaries completed their radiation treatment in that timeframe. The 90-day period would be considered an episode only if a Technical Participant^[2] or Dual Participant^[3] furnishes the technical component to a RO Model beneficiary within 28 days of when a Professional Participant^[4] or Dual Participant furnishes the professional component to such RO Model beneficiary. When those circumstances occur, the episode would begin on the date that the initial treatment planning service (submission of treatment planning HCPCS codes 77261-77263) was rendered. The proposed rule includes scenarios to address situations involving partial or incomplete episodes.

The base payment rates for the PC range from \$1,372 to \$3,779. The base payment rates for the TC range from \$5,568 to \$19,852.^[5] The base payment rate is subject to numerous adjustments, including trend factors, case mix, historical experience and an efficiency factor. Once adjusted, the PC will be discounted by 4 percent, and the TC will be discounted by 5 percent. Following application of the discounts, the

payment would be subject to three different "withholds" that the provider may earn back at the conclusion of each year if certain objectives are met. The proposed withholds include a 2 percent withhold for incorrect payments, a 2 percent withhold for quality and a 1 percent withhold for patient experience. Finally, the RO episode would be subject to a geographical adjustment, as well as a 2 percent sequestration adjustment, and the beneficiary's co-insurance responsibility amount would be subtracted. In CMS's example from the proposed rule, the base PC episode payment is \$2,155 for lung cancer. After all of the discounts, withholds and adjustments, the provider in the example would receive a total of \$2,376.76, assuming the provider collects the entire co-insurance amount from the beneficiary. The provider would receive its episode payment in two equal installments at the beginning and end of the episode.

CMS is proposing new model-specific HCPCS codes and a modifier indicating the start of an episode (the "SOE modifier") for the PC once the treatment planning service is furnished; there will also be model-specific HCPCS codes and a SOE modifier for the TC. Additionally, providers will be required to submit no-pay claims for the services under the previous HCPCS codes to allow CMS to track utilization of services under the RO Model.

Providers under the RO Model must also submit quality data under four proposed measures: 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; and Treatment Summary Communication - Radiation Oncology. This quality data reporting process will cause the RO Model to be an Advanced Alternative Payment Model ("APM") and a Merit-based Incentive Payment System ("MIPS") APM for the Quality Payment Program. In addition, CMS proposes to require all Professional Participants and Dual Participants to submit clinical data in July and January of each year to report the number of RO Model beneficiaries who completed 90-day episodes within the previous six months. Finally, CMS proposes to require Professional Participants and Dual Participants to report, on a pay-for-reporting basis, clinical information not available in claims or captured in the proposed quality measures. This would include such information as cancer stage, disease involvement, treatment intent, and specific treatment plan information for RO Model beneficiaries being treated for prostate cancer, breast cancer, lung cancer, bone metastases and brain metastases.

CMS believes that participation in the current Oncology Care Model ("OCM") is not incompatible with participation in the RO Model. Thus, participants in the OCM Model could be required to also participate in the new RO Model. CMS is still reviewing whether there is any overlap between the RO Model and Accountable Care Organizations, and may address this in future rulemaking.

THE END-STAGE RENAL DISEASE TREATMENT CHOICES MODEL

The End-Stage Renal Disease Treatment Choices Model ("ETC Model") would test the effectiveness of adjusting certain Medicare payments to ESRD facilities and "Managing Clinicians" (i.e., clinicians who bill the Monthly Capitation Payment ("MCP") for managing ESRD Beneficiaries) to encourage greater utilization of home dialysis and kidney transplantation, support beneficiary modality choice, reduce Medicare expenditures and preserve or enhance the quality of care. In the proposed ETC Model, CMS would adjust Medicare payments under the ESRD PPS to ESRD facilities and payments under the Medicare Physician Fee Schedule to Managing Clinicians selected for participation in the ETC Model.

Specifically, CMS proposes two payment adjustments: (1) the "Home Dialysis Payment Adjustment" would be a positive adjustment on certain home dialysis and home dialysis-related claims during the initial three years of the model; and (2) the "Performance Payment Adjustment" would be a positive or negative adjustment on dialysis and dialysis-related Medicare payments, for both home dialysis and in-center dialysis, based on ESRD facilities' and Managing Clinicians' rates of kidney and kidney-pancreas transplants and home dialysis among attributed beneficiaries during the applicable model year. The Performance Payment Adjustment would apply throughout the model's five-year term, which would begin January 1, 2020 and end June 30, 2025.

The proposed payment adjustments would apply to all Medicare-certified ESRD facilities and all Medicare enrolled Managing Clinicians located within selected geographic areas. CMS proposes to apply the Home Dialysis Payment Adjustment to all ETC Participants, but the Performance Payment Adjustment would not apply to certain ESRD facilities, or to Managing Clinicians managing low volumes of adult ESRD Medicare beneficiaries.

Participation in the ETC Model would be mandatory for the applicable ESRD facilities and Managing Clinicians located in certain selected geographic areas. As with the RO Model noted above, *the proposed rule does not identify the geographic areas to which the ETC Model would apply. The areas will be selected by CMS at a later date through a randomized selection process.* CMS proposes to select ESRD facilities and Managing Clinicians to participate in the ETC Model so as to account for approximately 50 percent of adult ESRD beneficiaries

in all 50 states and the District of Columbia.

CMS proposes to randomly select Hospital Referral Regions ("HRRs") for inclusion in the ETC Model; in addition, CMS proposes to include all HRRs with at least 20 percent of all zip codes located in Maryland. All HRRs that are not selected geographic areas would be referred to as "comparison geographic area(s)" to be used for the purposes of constructing performance benchmarks. ESRD facilities and Managing Clinicians located in the selected geographic areas would be required to participate in the ETC Model and would be assessed on the rates of kidney and kidney-pancreas transplant and home dialysis among their attributed beneficiaries during each model year. CMS would then adjust certain Medicare payments for ETC Model participants upwards or downwards during the corresponding performance payment adjustment period. Managing Clinicians and ESRD facilities located in the selected geographic areas would also receive a positive adjustment on their home dialysis claims for the first three years of the ETC Model.

PRACTICAL TAKEAWAYS

- RO and ESRD providers should consider submitting comments on the proposed rule, especially in areas where CMS has asked for comments.
- Given the short window until the proposed January 1, 2020 effective date, providers should begin to evaluate administrative adjustments needed to comply with the new requirements for both models.

If you have questions or would like assistance preparing comments to the proposed rule, please contact:

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[1] The 17 cancer types include anal cancer, bladder cancer, bone metastases, brain metastases, brain cancer, cervical cancer, central nervous system tumors, colorectal cancer, head and neck cancer, kidney cancer, lung cancer, lymphoma, pancreatic cancer, prostate cancer, upper gastrointestinal cancer and uterine cancer. The specific ICD-10 codes can be found [here](#).

[2] "Technical Participant" would mean a RO participant that is a Medicare-enrolled hospital outpatient department or freestanding radiation therapy center, identified by a single CMS Certification Number or tax payer identification number, which furnishes only the TC of an episode.

[3] "Dual Participant" would mean a RO participant that furnishes both the professional component and technical component of RT services through a freestanding radiation therapy center, identified by a single tax payer identification number.

[4] "Professional Participant" would mean a RO participant that is a Medicare-enrolled physician group practice identified by a single tax payer identification number that furnishes only the PC of an episode.

[5] The complete proposed table of base rate payments can be found [here](#) (see Table 3).