It's Here...CMS Unveils Radiation Oncology Model

BY BLAIR BURNETT

On July 10, 2019, the Centers for Medicare & Medicaid Services (CMS) revealed new details of a proposed bundled payment model for radiation oncology services ("RO Model"). If finalized as proposed, the model would make fundamental changes to how radiation oncology is delivered for Medicare beneficiaries in the United States. Participation in the proposed five-year model would be mandatory for radiation therapy providers and suppliers that furnish radiation therapy services within randomly selected geographical areas. Although the agency has not yet identified these core-based statistical areas (CBSAs), the model is expected to apply to about 40 percent of radiation therapy episodes in to-be-announced geographic areas.

The proposed RO Model is intended to incentivize providers to deliver radiation therapy episodes in a more cost-efficient manner, with a focus on value over volume. Under the proposal, Medicare would pay providers a predetermined, site-neutral bundled rate for most services provided in a 90-day episode of radiation therapy, rather than paying for each service individually. Below is a summary of takeaways, based on our initial analysis of the model:

- As proposed, the RO Model would run for five years, very similar to the timing of the Center for Medicare and Medicaid Innovation's Oncology Care Model (OCM). In its July announcement, CMS proposes a Jan. 1, 2020, through Dec. 31, 2024 time frame; however, due to anticipated robust comments from stakeholders, it is more likely that we will see an April or July 2020 start date.
- The RO Model would be based on radiation therapy services furnished in randomly selected CBSAs and would be mandatory in those CBSAs. As mentioned above, it is expected that 40 percent of eligible radiation therapy episodes would be included, and a simulated analysis showcased a selection of 616 physician group practices and 541 hospital outpatient departments. CMS is not expected to announce the CBSAs required to participate until the proposed rule is finalized.
- The RO Model would apply to 17 different cancer types for radiation therapy services furnished through 90-day episodes with prospective episode-based payment (i.e., bundled) based upon a patient's diagnosis. Inclusion of these 17 cancer types is based on CMS claims data for cancers that are typically treated using radiation therapy.
- Episode payments in this proposal would be split into two areas—professional and technical—"to allow for use of current claims systems for PFS [physician fee schedule] and OPPS [Outpatient Prospective Payment System] to be used to adjudicate RO Model claims and be consistent with existing business relationships." This would amount to 34 base payments in all.
- The RO Model would only apply to provision of radiation therapy services billed as a part of Medicare fee-for-service.
- The 90-day episodes of care used for bundled payment in the model would encompass most services related to radiation therapy, including treatment planning, technical preparation and special services, and radiation treatment delivery, as well as treatment management and follow-up care.
- The 90-day episode of care would not include evaluation and management services. These would continue to be paid separately under the PFS or OPPS.
- All programs participating in the RO Model would be required to report four quality measures, and CMS proposes to add additional patient experience measures to the model in 2022 as potential pay-for-performance measures.
- This model would provide physicians the opportunity to participate in an advanced alternative payment model under the Quality Payment Program, meaning that participants would be exempt from payment adjustments under the Merit-Based Incentive Payment System and would be eligible for the 5 percent bonus as a part of the program.
- Any practices already participating in the OCM or any other voluntary alternative payment model are not proposed to be exempt from the RO Model, but CMS does note its intention to review policies and procedures with significant overlap once the model begins.

Due to the mandatory nature of this proposal, programs should be cognizant of any overlap with other value-based care arrangements in which they are participating, as well as the significant operational costs that this model will entail. ACCC's Policy Team submitted comments to CMS on behalf of our membership in coordination with many other provider advocacy organizations.

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