Issue Brief

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CMS Proposes Mandatory Specialty Care Models to Improve Quality of Care and Reduce Expenditures

The Centers for Medicare & Medicaid Services issued a proposed rule to implement two new mandatory Medicare payment models under section 1115A of the Social Security Act — a Radiation Oncology Model (RO Model) and an End-Stage Renal Disease Treatment Choices Model (ETC Model). Further, President Trump announced additional kidney models that are mentioned at the end of this analysis.

"The goal for the proposed models is to preserve or enhance the quality of care furnished to beneficiaries while reducing program spending through enhanced financial accountability for model participants. We propose that the performance period of the proposed RO Model would begin in 2020 and end Dec. 31, 2024. We propose to implement the proposed payment adjustments under the proposed ETC Model over the course of six and a half years, beginning Jan. 1, 2020, and ending June 30, 2026."

A copy of the 413-page proposal currently is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-14902.pdf. The rule is scheduled to be published in the ***Federal Register*** on Thursday, July 18, upon which the above-cited link will be superseded. A 60-day comment period is provided.

Comment

As written, this is a complex rule. Participation for selected entities would be mandatory. The proposal does not identify selected entities. Those to be included would be announced in final rulemaking.

An overarching goal of the agency is program savings.

CMS says:

> "As detailed in Table 16A, we estimate a net impact of $260 million to the Medicare program due to the RO Model from Jan. 1, 2020, through Dec. 31, 2024, with a range of impacts between $50 million and $460 million in net Medicare savings. Alternatively, as detailed in Table 16B, we estimate a net impact of $250 million to the Medicare

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program due to the RO Model from April 1, 2020, through Dec. 31, 2024, with a range of impacts between $40 million and $450 million in net Medicare savings.

"As detailed in Table 17, we estimate the Medicare program would save a net total of $185 million from the Performance Payment Adjustment and Home Dialysis Payment Adjustment, which would be applied under the ETC Model between Jan. 1, 2020, through June 30, 2026. We also expect that the ETC Model would cost an additional $15 million, resulting from increases in education and training costs. Therefore, the net impact to Medicare spending is estimated to be $169 million in savings as a result of the ETC Model."

CMS spends considerable time describing the background of the payment issues, and why and how the agency developed its strategies and related positions. What is missing is a succinct description of the payment revisions, its elements and how the changes would affect providers.

Proposed Radiation Oncology Model

The aim of the RO Model, which would involve required participation, is to test whether prospective site-neutral, episode-based payments to physician group practices, hospital outpatient departments and freestanding radiation therapy centers for radiotherapy episodes of care would reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries.

Site Neutrality

Under Medicare fee-for-service, RT services furnished in a freestanding radiation therapy center are paid under the Medicare Physician Fee Schedule at the nonfacility rate, including payment for the professional and technical aspects of the services.

For RT services furnished in an outpatient department of a hospital, the facility services are paid under the Hospital Outpatient Prospective Payment System, and the professional services are paid under the PFS.

These payment systems determine payment rates for the same services in different ways, which, according to CMS, creates site-of-service payment differentials.

CMS says this difference in payment may incentivize Medicare providers and suppliers to deliver RT services in one setting over another even though the actual treatment and care received by Medicare beneficiaries for a given modality is the same in both settings.

Aligning Payments to Quality and Value, Rather than Volume

Incentives built into the current payment system promote volume of services over the value of services provided.

Identified Cancer Types and Corresponding ICD-9 and ICD-10 Codes		
Cancer Type	**ICD-9 Codes**	**ICD-10 Codes**
Anal Cancer	154.2x, 154.3x	C21.xx
Bladder Cancer	188.xx	C67.xx
Bone Metastases	198.5x	C79.5x
Brain Metastases	198.3x	C79.3x
Breast Cancer	174.xx, 175.xx, 233.0x	C50.xx, D05.xx
Cervical Cancer	180.xx	C53.xx
CNS Tumors	191.xx, 192.8x, 192.0x, 192.1x, 192.2x, 192.3x, 192.9x	C70.xx,C71.xx, C72.xx
Colorectal Cancer	153.xx, 154.0x, 154.1x, 154.8x	C18.xx, C19.xx, C20.xx
Head and Neck Cancer	140.xx, 141.0x, 141.1x, 141.2x, 141.3x, 141.4x, 141.5x, 141.6x, 141.8x, 141.9x, 142.0x, 142.1x, 142.2x, 142.8x, 142.9x, 143.xx, 144.xx, 145.0x, 145.1x, 145.2x, 145.3x, 145.4x, 145.5x, 145.6x, 145.8x, 145.9x, 146.0x, 146.1x, 146.2x, 146.3x, 146.4x, 146.5x, 146.6x, 146.7x, 146.8x, 146.9x 147.xx, 148.0x, 148.1x, 148.2x, 148.3x, 148.8x, 148.9x, 149.xx, 160.0x, 160.1x, 160.2x, 160.3x, 160.4x, 160.5x, 160.8x, 160.9x, 161.xx, 195.0x	C00.xx, C01.xx, C02.xx, C03.xx, C04.xx, C05.xx, C06.xx, C07.xx, C08.xx, C09.xx, C10.xx, C11.xx, C12.xx, C13.xx, C14.xx, C30.xx, C31.xx, C32.xx, C76.0x
Kidney Cancer	189.0x	C64.xx
Liver Cancer	155.xx, 156.0x, 156.1x, 156.2x, 156.8x, 156.9x	C22.xx, C23.xx, C24.xx
Lung Cancer	162.0x, 162.8x, 162.2x, 162.3x, 162.4x, 162.9x, 162.5x, 165.xx	C33.xx, C34.xx, C39.xx, C45.xx
Lymphoma	200.0x, 200.1x, 200.2x, 200.3x, 200.4x, 200.5x, 200.6x, 200.7x, 200.8x, 201.xx, 202.0x, 202.1x, 202.2x, 202.4x, 202.7x, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 203.80, 203.82, 273.3x	C81.xx, C82.xx, C83.xx, C84.xx, C85.xx, C86.xx, C88.xx, C91.4x
Pancreatic Cancer	157.xx	C25.xx
Prostate Cancer	185.xx	C61.xx
Upper GI Cancer	150.xx, 151.xx, 152.xx	C15.xx, C16.xx, C17.xx
Uterine Cancer	179.xx, 182.xx	C54.xx, C55.xx

Model Design

The proposed RO Model would make episode-based payments in a site-neutral manner for 17 different cancer types. They are identified in the table above.

The RO Model would require participation from RT providers and suppliers that furnish RT services within randomly selected core-based statistical areas.

Beneficiaries still would be able to receive care from any provider or supplier of their choice.

Model participants treating beneficiaries with one of the included cancer types would receive prospective, episode-based payment amounts for RT services furnished during a 90-day episode of care, instead of regular Medicare FFS payments, throughout the model performance period.

Model episode payments would be split into a professional component payment, which is meant to represent payment for the included RT services that may only be furnished by a physician, and the technical component payment, which is meant to represent payment

for the included RT services that are not furnished by a physician, including the provision of equipment, supplies, personnel and costs related to RT services. This division reflects the fact that RT professional and technical services sometimes are furnished by separate providers or suppliers.

Participant-specific payment amounts would be determined based on proposed national base rates, trend factors and adjustments for each participant's case-mix, historical experience and geographic location. CMS would further adjust payment amounts by applying a discount factor. "The discount factor, or the set percentage by which CMS reduces an episode payment amount, would reserve savings for Medicare and reduce beneficiary cost-sharing." The discount factor for the PC would be 4.0 percent, and the discount factor for the TC would be 5.0 percent. The payment amount also would be prospectively adjusted for withholds for incomplete episodes (2.0 percent for PC and TC), quality (2.0 percent for PC), and beneficiary experience (1.0 percent for TC starting in 2022).

RO participants would 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. The standard beneficiary coinsurance and sequestration requirements would remain in effect.

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

The following episodes would be excluded from calculations to determine the national base rates.

- episodes with any services furnished by a critical access hospital
- episodes without positive (>$0) total payment amounts for professional services or technical services
- episodes assigned a cancer type not identified as cancer types that meet CMS' criteria
- episodes that are not assigned a cancer type
- episodes with RT services furnished in Maryland, Vermont or a U.S. territory
- episodes in which a PPS-exempt cancer hospital furnishes the technical component (is the attributed technical provider)
- episodes in which a Medicare beneficiary does not meet the eligibility criteria

CMS would 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 payment year in which payments in such amounts would be made.

CMS' proposed national base rates for the model performance period based on the criteria set forth for cancer type inclusion are summarized in the following table.

National Base Rates by Cancer Type (in 2017 Dollars)			
RO Model-Specific Placeholder Codes	**Professional or Technical**	**Cancer Type**	**Base Rate**
MXXXX	Professional	Anal Cancer	$2,968
MXXXX	Technical	Anal Cancer	$16,006
MXXXX	Professional	Bladder Cancer	$2,637
MXXXX	Technical	Bladder Cancer	$12,556
MXXXX	Professional	Bone Metastases	$1,372
MXXXX	Technical	Bone Metastases	$5,568
MXXXX	Professional	Brain Metastases	$1,566
MXXXX	Technical	Brain Metastases	$9,217
MXXXX	Professional	Breast Cancer	$2,074
MXXXX	Technical	Breast Cancer	$9,740
MXXXX	Professional	Cervical Cancer	$3,779
MXXXX	Technical	Cervical Cancer	$16,955
MXXXX	Professional	CNS Tumor	$2,463
MXXXX	Technical	CNS Tumor	$14,193
MXXXX	Professional	Colorectal Cancer	$2,369
MXXXX	Technical	Colorectal Cancer	$11,589
MXXXX	Professional	Head and Neck Cancer	$2,947
MXXXX	Technical	Head and Neck Cancer	$16,708
MXXXX	Professional	Kidney Cancer	$1,550
MXXXX	Technical	Kidney Cancer	$7,656
MXXXX	Professional	Liver Cancer	$1,515
MXXXX	Technical	Liver Cancer	$14,650
MXXXX	Professional	Lung Cancer	$2,155
MXXXX	Technical	Lung Cancer	$11,451
MXXXX	Professional	Lymphoma	$1,662
MXXXX	Technical	Lymphoma	$7,444
MXXXX	Professional	Pancreatic Cancer	$2,380
MXXXX	Technical	Pancreatic Cancer	$13,070
MXXXX	Professional	Prostate Cancer	$3,228
MXXXX	Technical	Prostate Cancer	$19,852
MXXXX	Professional	Upper GI Cancer	$2,500
MXXXX	Technical	Upper GI Cancer	$12,619
MXXXX	Professional	Uterine Cancer	$2,376
MXXXX	Technical	Uterine Cancer	$11,221

Quality Payment Program

The RO Model would require RO participants to annually certify their intent to use Certified Electronic Health Record Technology, include quality measure performance as a factor when determining payments and require RO participants to bear more than a nominal amount of financial risk. RO participants who are alternative payment model entities and eligible clinicians seeking Qualifying APM Participant status in an Advanced APM must comply with all RO Model requirements to be eligible for Advanced APM incentive payments. Participants who do not meet the QP threshold would not qualify for the APM incentive payment and instead would be in a Merit-based Incentive Payment System.

CMS proposes the following measures for the RO Model beginning in PY1 and continuing thereafter.

- 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

The following table includes the four proposed RO Model quality measures and CAHPS® Cancer Care Survey, the level at which measures would be reported, and the measures' status as pay-for-reporting or pay-for-performance.

RO Participant Quality Measure, Clinical Data and Patient Experience Submission Requirements

RO Participant Data Submission Requirements	Level of Reporting	Pay-for-Reporting	Pay-for-Performance
1. Oncology: Medical and Radiation	Professional	Anal Cancer	$2,968
- Plan of Care for Pain - NQF #0383; CMS Quality ID #144	Aggregate	N/A	PYs 1-5
	Professional	Bladder Cancer	$2,637
2. Preventive Care and Screening: Screening for Depression and Follow-Up Plan - NQF #0418; CMS Quality ID #134	Aggregate	N/A	PYs 1-5
3. Advance Care Plan - NQF #0326;	Professional	Bone Metastases	$1,372
CMS Quality ID #047	Aggregate	N/A	PYs 1-5
4. Treatment Summary Communication – Radiation Oncology	Aggregate	PYs 1-2	PYs 3-5
5. CAHPS® Cancer Care Survey	N/A:	Brain Metastases	$9,217
Patient-Reported	N/A	PYs 3-5	$2,074
Clinical Data Elements	Beneficiary-Level	PYs 1-5	N/A

Proposed End-Stage Renal Disease Treatment Choices Mandatory Model

CMS is proposing an End-Stage Renal Disease Treatment Choices Model to encourage greater use of home dialysis and kidney transplants for Medicare beneficiaries with ESRD, "while reducing Medicare expenditures."

Home Dialysis Payment Adjustment

CMS proposes that the ETC Model would include two types of payment adjustments: the Home Dialysis Payment Adjustment and the Performance Payment Adjustment.

The HDPA would be a positive payment adjustment on home dialysis and home dialysis-related claims during the initial three years of the Model, to provide an up-front incentive for ETC participants to provide additional support to beneficiaries choosing to dialyze at home. The PPA would be a positive or negative payment adjustment, which would increase over time, on dialysis and dialysis-related claims, both home and in-center, based on the ETC participant's home dialysis rates and transplant rates during a measurement year in comparison to achievement and improvement benchmarks, with the aim of increasing the percent of ESRD beneficiaries either having received a kidney transplant or receiving home dialysis over the course of the ETC Model.

The magnitude of the HDPA would decrease as the magnitude of the PPA increases, to shift from a process-based incentive approach (the HDPA) to an outcomes-based incentive approach (the PPA).

The proposed payment adjustments under the ETC Model would apply to all Medicare-certified ESRD facilities and managing clinicians enrolled in Medicare located within selected geographic areas. While CMS proposes to apply the HDPA to all ETC participants, the PPA would not apply to certain ESRD facilities and managing clinicians managing low volumes of adult ESRD Medicare beneficiaries.

One or both of the payment adjustments under the proposed ETC Model would apply to payments on claims for dialysis and certain dialysis-related services with through dates from Jan. 1, 2020, through June 30, 2026.

In particular, the proposed model would apply payment adjustments to the adjusted ESRD Prospective Payment System per treatment base rate under the ESRD PPS to selected ESRD facilities, as well as the monthly capitation payment to selected managing clinicians. "These payment adjustments would offer the incentive to participating ESRD facilities and managing clinicians to work with beneficiaries and caregivers in the choice of treatment modality, and to provide additional resources to support greater utilization of home dialysis and kidney transplants."

Participant Selection for the ETC Model

CMS would select ESRD facilities and managing clinicians to participate in the proposed model according to their location in randomly selected geographic areas, stratified by region, to account for approximately 50 percent of adult ESRD beneficiaries in all 50 states and the District of Columbia. The geographic unit of selection would be the hospital referral region.

An HRR is a unit of analysis created by the Dartmouth Atlas Project to distinguish the referral patterns to tertiary care for Medicare beneficiaries, and is composed of groups of ZIP codes.

The Dartmouth Atlas Project data source is publicly available at: https://www.dartmouthatlas.org/. There are 306 HRRs in the U.S.

Beneficiary Population and Attribution

To standardize comparisons between ESRD facilities and managing clinicians with sicker patients and those with healthier patients, the model would risk-adjust these rates. CMS would monitor for potential coercion, steering and inappropriate referrals to the targeted modalities, and assess the impacts of the model on mortality and hospitalizations. Beneficiaries would maintain freedom of choice among health care providers and all other current protections afforded by law. An ESRD facility or managing clinician selected for participation in the model would be required to post a notification to that effect, and no change in beneficiary cost sharing amounts would apply.

Quality Measures

CMS is proposing two ESRD facility quality measures for the ETC Model.

- Standardized Mortality Ratio; NQF #0369 – Risk-adjusted SMR of the number of observed deaths to the number of expected deaths for patients at the ESRD facility.

- Standardized Hospitalization Ratio; NQF #1463 – Risk-adjusted SHR of the number of observed hospitalizations to the number of expected hospitalizations for patients at the ESRD facility.

Kidney Care First and Comprehensive Kidney Care Contracting Models

In addition to the ETC model, the president also announced additional kidney models. The Kidney Care First, and Comprehensive Kidney Care Contracting, Graduated, Professional and Global Models

Participation is optional for health care providers.

The models are expected to run from Jan. 1, 2020, through Dec. 31, 2023, with the option for one or two additional performance years at CMS' discretion. Health care providers interested in participating will apply to participate in the fall of 2019, and if selected, begin model participation in 2020. However, financial accountability will not begin until 2021. During 2020, or Year 0, model participants will focus on building necessary care relationships and infrastructure.

Final Thoughts

This is a very difficult rule to analyze inasmuch as it lacks many specifics regarding payment mechanisms, adjustments and which entities would be affected.

The rule fails to provide adequate information for providers to simulate and access impacts on their organizations to provide true meaningful comments.

The rule is sloppy in that it does not have a table of contents, fails to even provide a list of acronyms used in the dialogue and does not have page numbers. This seems to be a new standard in the way CMS promulgates its rules.

The material includes too much historical information, while lacking specific references to the operation of the proposed models. Providers and the agency would be better served if the proposal directed information on the operational aspects of what is being sought, how it would work and not CMS' efforts to simply save on outlays.

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