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CENTER FOR MEDICARE & MEDICAID INNOVATION

The Center for Medicare and Medicaid Innovation (CMS Innovation Center)

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Disclaimer

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CMS support of health care will result in patient-centered, market-driven reforms that drive quality and improve outcomes

Key characteristics

- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

Key characteristics

- Patient-centered
- Incentives for outcomes
- Sustainable
- Market-driven
- Coordinated care

The CMS Innovation Center Statute

"The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles"

Three scenarios for success from Statute:

1. **Quality improves; cost neutral**
2. **Quality neutral; cost reduced**
3. **Quality improves; cost reduced (best case)**

If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking

CMS Innovation Center's range of impact

Beneficiaries touched

CMS Innovation Center–models impact over 26M beneficiaries[1,2] **in all 50 states**

Providers participating

Over 967,000 health care providers and provider groups[2] **across the nation** are participating in CMS Innovation Center programs

[1] Includes CMS beneficiaries (i.e., individuals with coverage through Medicare FFS, Medicaid, both Medicare and Medicaid (as Medicare-Medicaid enrollees), CHIP, and Medicare Advantage) and individuals with private insurance, including in multi-payer models

[2] Figures as of December 2019

Source: Innovation Center-Report to Congress, December 2018

CMS has adopted a framework that categorizes payments to providers

	Category 1: Fee for Service – No Link to Value	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models Built on Fee-for-Service Architecture	Category 4: Population-Based Payment
Description	▪ Payments are based on volume of services and not linked to quality or efficiency	▪ At least a portion of payments vary based on the quality or efficiency of health care delivery	▪ Some payment is linked to the effective management of a population or an episode of care ▪ Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk	▪ Payment is not directly triggered by service delivery so volume is not linked to payment ▪ Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)
Medicare Fee-for-Service examples	▪ Limited in Medicare fee-for-service ▪ Majority of Medicare payments now are linked to quality	▪ Hospital value-based purchasing ▪ Physician Value Modifier ▪ Readmissions / Hospital Acquired Condition Reduction Program	▪ Accountable Care Organizations ▪ Medical homes ▪ Bundled payments ▪ Comprehensive Primary Care initiative ▪ Comprehensive ESRD ▪ Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	▪ Eligible Pioneer Accountable Care Organizations in years 3-5 ▪ Maryland hospitals

Source: Rajkumar R, Conway PH, Tavenner M. CMS – engaging multiple payers in payment reform. JAMA 2014; 311: 1967-8.

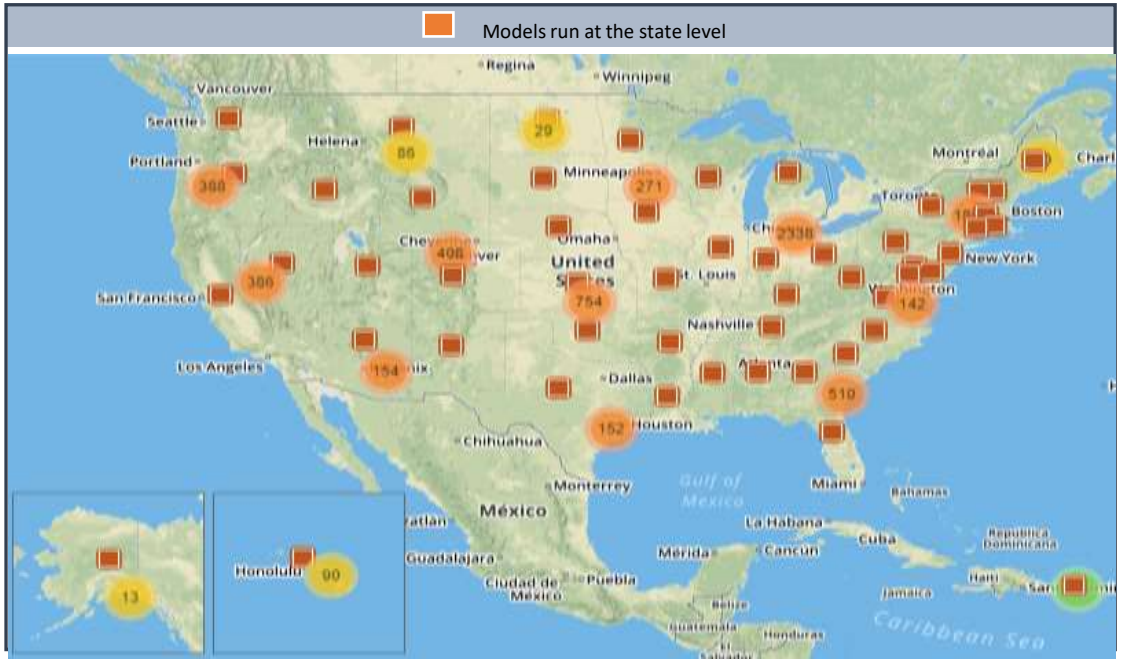
What is an Alternative Payment Model?

Alternative Payment Models (APMs) are payment approaches, developed in partnership with the clinician community, that provide added incentives to deliver high-quality and cost-efficient care.

- The CMS Innovation Center develops new payment and service delivery models.
- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) defined APMs as:
  - Innovation Center models under Section 1115A authority
  - Demonstrations mandated by federal law (e.g., Rural Community Hospital Demonstration)
  - Medicare Shared Savings Program
  - Demonstration under the Health Care Quality Demonstration Program

- MACRA defined Advanced Alternative Payment Models, which must-meet three criteria: bear more than nominal financial risk or be a Medical Home Model expanded under the Innovation Center authority, bases payment on quality measures comparable to those used in MIPS, and require participants to use certified EHR technology.

CMS has engaged the health care delivery system and invested in innovation across the country



Source: CMS Innovation Center website, December 2017

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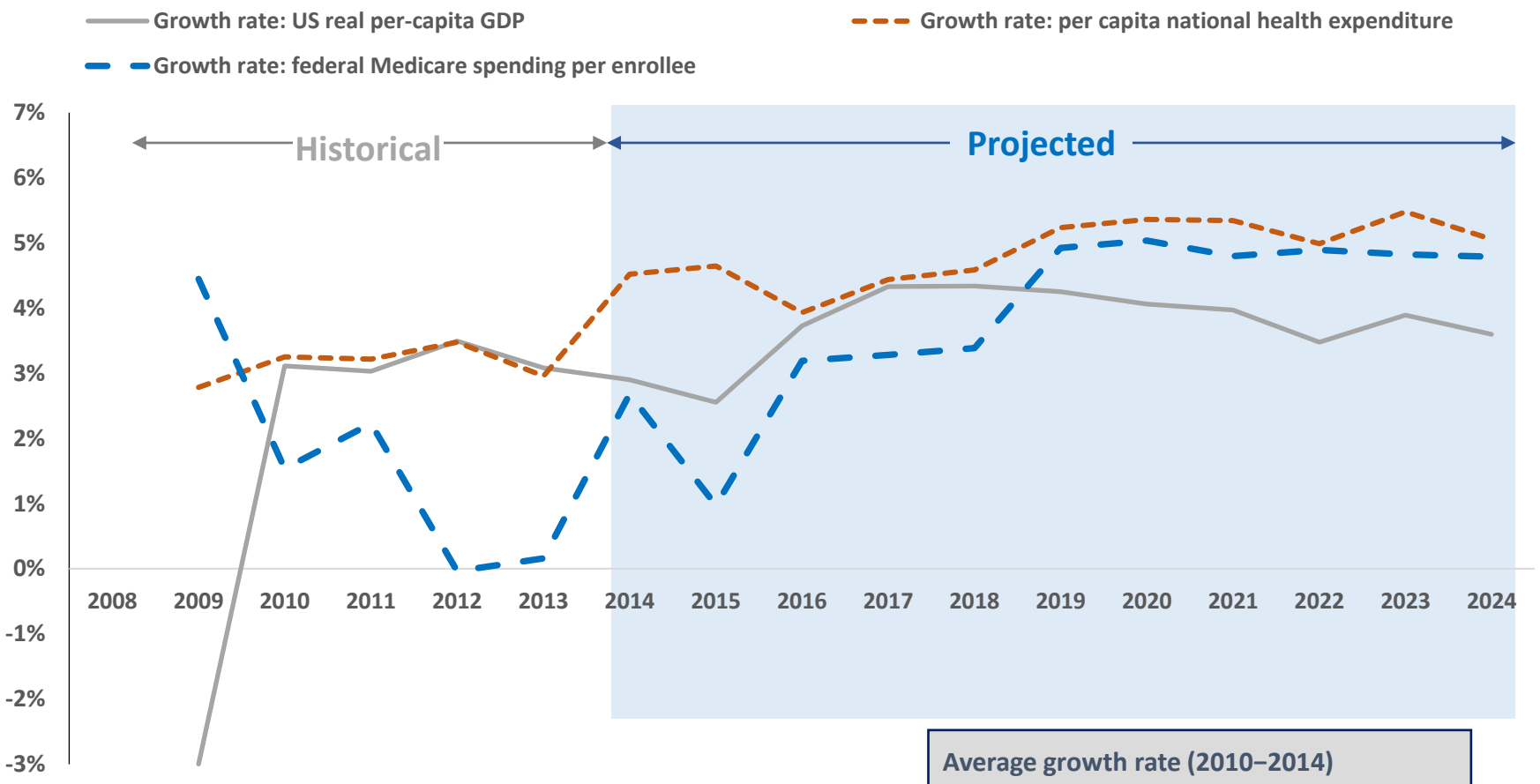
Medicare growth has fallen below GDP growth and national health expenditure growth since 2010 due, in part, to CMS policy changes and new models of care

Gap between growth in federal Medicare spending, GDP growth and national health expenditure growth



Average growth rate (2010–2014)

- Medicare/beneficiary: **1.3%**
- GDP / capita: **3.3%**
- National Health Expenditure/capita: **3.7%**

SOURCE: CMS Office of the Actuary National Health Expenditure Data (2014-2024 projections)

Population-based Payment Models

On the spectrum of APMs, population-based payment (PBP) models are the most comprehensive.

Key Strategy	Core Premise	Structure
Moving from volume to value, these models reward providers for meeting population-level targets.	Providers are accountable for patient-centric care for a specific population over a fixed timeframe and across the full continuum of care.	Enable PBP models in both categories hold providers accountable for the full continuum of patient care, from preventive to end-of-life care, encourage providers to deliver high-quality, well-coordinated, person-centered care within a defined population-based budget

Link: https://hcp-lan.org/2016/05/pbp-models-overcoming-barriers-accelerating-adoption/

Primary Care Transformation

- Comprehensive Primary Care Plus
- Primary Care First
- Direct Contracting Model
- Independence at Home Demonstration

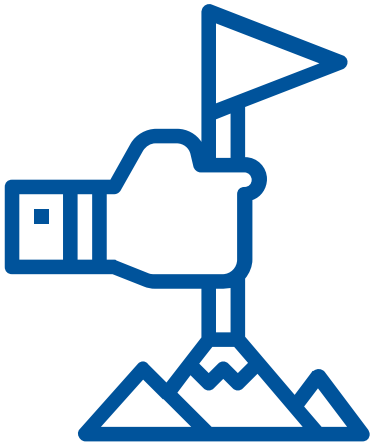
Population-based Models

Pioneer Accountable Care Organizations (years 3-5)

Maryland All-Payer Model

Maryland Total Cost of Care Model

Episode-Based Bundled Payment Model (EPM)



The Goal

Improving the quality of care for beneficiaries and lowering the total Medicare costs for an episode of care.

- Aligns incentives for practice transformation and care management across clinical specialties and health care settings.
- Payment is bundled for services provided during an episode of care that is defined in scope and duration.
- Providers are held accountable for the cost and quality of care beneficiaries receive during the episode.
- To balance incentives for cost reduction with incentives for improving the quality of care for beneficiaries, performance-based payments are adjusted based on the participants' performance on identified quality measures (e.g., patient outcomes, care coordination, communication, patient/caregiver-centered experience, clinical quality).

Episode-based Payment Initiatives

BPCI Models 2-4

BPCI Advanced

Comprehensive Care for Joint Replacement Model

Oncology Care Model

Potential Oncology Care First Model

Proposed Radiation Oncology Model

Kidney Care Choices Model

Bundled Payments for Care Improvement (BPCI)

BPCI was the precursor to BPCI Advanced and was created to incentivize providers to take **accountability for both cost and quality** of care

- **Four Models**
  - Model 1: Retrospective acute care hospital stay only
  - Model 2: Retrospective acute care hospital stay plus post-acute care
  - Model 3: Retrospective post-acute care only
  - Model 4: Prospective acute care hospital stay only
- At its peak, there were 360 Awardees and 1,755 Episode Initiators

- Duration of model:
  - Model 1: Awardees began Period of Performance in April 2013 and concluded in December 2016
  - Models 2, 3, 4: Awardees began Period of Performance in October 2013 and concluded in September 2018

BPCI Advanced - Objectives

1. Financial Accountability 
2. Care Redesign 
3. Data Analysis and Feedback 
4. Health Care Provider Engagement 
5. Patient and Caregiver Engagement 

Bundled Payment for Care Improvement Advanced - Overview

- Voluntary bundled payment model
- Qualifies as an **Advanced Alternative Payment Model (Advanced APM)** with payment tied to performance on quality measures.
- Runs **October 1, 2018** through **December 31, 2023**
- Single payment and risk track, with a 90-day episode period
  - 30 Inpatient Clinical Episodes
  - 3 Outpatient Clinical Episodes
  - 1 Multi-setting Clinical Episode
- Preliminary Target Prices provided prior to the start of the Performance Period

Who can participate?

- **Convener Participants** (Medicare enrolled/non-Medicare enrolled providers)
- **Non-Convener Participants** (Medicare enrolled providers only)

Who are the Episode Initiators (EI)?

- Acute Care Hospitals (ACHs)
- Physician Group Practices (PGPs)

BPCI Advanced Model – **Clinical Episode Definition**

- **Anchor Stay:** inpatient stay at an ACH with a qualifying MS-DRG billed to Medicare FFS by an EI
  - *Clinical Episode length: Anchor Stay + 90 days, with 90 days starting on the day of discharge*

- **Anchor Procedure :** outpatient procedure (identified by a HCPCS code) on an associated hospital outpatient facility claim billed to Medicare FFS by an EI
  - *Clinical Episode length: Anchor Procedure + 90 days beginning on the day of completion of the outpatient procedure*

- **Clinical Episodes include Part A and Part B non-excluded items and services furnished:**
  - during the Anchor Stay or Anchor Procedure
  - 90-day period following the Anchor Stay or Anchor Procedure, including hospice services and related and unrelated readmissions

Key Differences: **BPCI vs. BPCI Advanced**

BPCI	BPCI Advanced
48 Inpatient (IP) Clinical Episodes	30 IP, 3 OP, and 1 multi-setting Clinical Episodes
Not an Advanced APM since lacking CEHRT requirement and quality not tied to payment	Model is an Advanced APM
No quality measures required for payment purposes	Quality measures are reportable and performance on these measures will be tied to payment
Excludes cost of care associated with services according to 13 unique exclusion listings of "unrelated" care	Limited exclusions; Excludes the Part A & B costs associated with ACH readmissions qualifying based on a limited set of MS-DRGs, some Part B drugs, and Cardiac Rehabilitation
Model 3 includes PAC providers triggering episodes in the post-discharge period	No equivalent for Model 3; design is similar to Model 2 with PGPs and ACHs as EIs; PAC Providers, and other Medicare-enrolled, as well as non-Medicare-enrolled entities can participate as Convener Participants
Risk corridor of 20% of spending above the upper limit of the selected risk track	One risk track Risk is capped at +/-20%
Target Prices provided at reconciliation	Preliminary Target Prices provided prospectively, before the start of each Model Year

BPCI Advanced Participation

There are currently 1,086 active Participants in BPCI Advanced

Non-Convener Participants Total: 251	Convener Participants Total: 1,045 Episode Initiators
Acute Care Hospitals- 119	Acute Care Hospital EIs- 597
Physician Group Practices- 132	Physician Group Practices- 448

Top 5 Clinical Episodes in BPCI Advanced
Sepsis
Major Joint Replacement of the Lower Extremity
Congestive Heart Failure
Simple pneumonia and respiratory infections
Chronic obstructive pulmonary disease, bronchitis, asthma

Comprehensive Care for Joint Replacement (CJR) Model

The CJR model started on **April 1, 2016** and is currently in its fourth performance year. It is scheduled to run for 5 years in total; ending December 2020.

CJR is an episode-based payment model for inpatient lower extremity joint replacement (LEJR) procedures for Medicare fee-for-service beneficiaries. CJR episodes include:

- Hospitalization for LEJR procedure assigned MS-DRG 469 or 470 and 90 days post-discharge.
- All Part A and Part B services, with the exception of certain excluded services that are clinically unrelated to the episode.

CJR model was implemented in **67** metropolitan statistical areas (MSAs)

- All participant hospitals in these selected MSAs are acute care hospitals paid under the IPPS & not currently participating in Model 1 or Models 2 or 4 of the Bundled Payments for Care Improvement (BPCI) initiative for LEJR episodes
- Initial Evaluation Results for PY 1 & PY2 are available at: https://innovation.cms.gov/initiatives/cjr

CJR Participation Changes

- Participation was mandatory for all participants for model years 1 & 2
- CJR model participation requirements changes were proposed and finalized in a final rule effective January 1, 2018
- Rural and low volume providers and providers in **33 of the 67 CJR geographic areas** were able to voluntarily opt into the model between January 1st and January 31, 2018

489 total number of participating hospitals as of November 1, 2018

403 of these 489 hospitals are located in the 34 **mandatory** MSAs

86 of these 489 providers are located in the **voluntary** MSAs

CJR Model - Reconciliation

Each CJR performance year is reconciled 2 months after the close of the performance year and then again 14 months later to allow for claim run out and updated data files.

Reconciliation payment information by provider is posted on the CJR webpage:

For **Performance Year (PY) 1**, 360 providers who had actual episode spending below the target price and who achieved a minimum composite quality score earned final reconciliation payments; **for PY2**, 491 providers earned final reconciliation payments; we anticipate posting **PY3** initial payment reconciliation information on the CJR model webpage in the next few weeks.

Financial arrangements to allow gainsharing are permitted under the model.

Participant downside risk by performance year (py)

PY 1: 0%
PY 2: 5%
PY 3: 10%
PY 4: 20%
PY 5: 20%

Evaluation of the CJR Model Year 1 & 2 Performance

Results from the first two performance years of the CJR model are promising and indicate that a mandatory episode based payment approach for LEJR episodes can achieve per episode payment reductions while maintaining quality for both planned LEJR episodes and those due to fracture.

GROSS REDUCTIONS IN SPENDING

Reductions in total episode payments were largely driven by reductions in the use of more intensive post-acute care settings and shorter lengths of stay.

77% of CJR participant hospitals earned reconciliation payments in one or both performance years. All different types of hospitals were able to be successful under the CJR model.

Utilization

Among elective episodes, fewer patients are being discharged to inpatient rehabilitation facilities (IRF), and a relative larger proportion are being discharged directly home with home health agency services.

Among fracture episodes, utilization analyses suggest the substitution of SNF for IRF care.

Both elective and fracture patients are spending fewer days in SNF.

The shift to less intense post-acute care did not impact readmission rates, emergency department visits, and mortality.

Oncology Care Model

1.6 million people annually diagnosed with cancer; a significant proportion are over 65 years

- Major opportunity to improve care & reduce cost starting July 1, 2016, through June 30, 2021

175 participating practices
7000+ practitioners
10 participating payers
200,000 Medicare FFS beneficiaries/year, estimated
$6 billion in care included in 6-month episodes

- **Model Objective**: Provide beneficiaries with **improved care coordination to improve quality and decrease cost**
  - Implement six practice redesign activities
  - Create two-part **financial incentive** with $160 PBPM payment and potential for performance-based payment
  - Institute robust **quality** measurement
  - Engage **multiple payers**

Oncology Care Model

Practice Redesign Activities

- ❑ Patient navigation
- ❑ Care plan with 13 components based on IOM Care Management Plan
- ❑ 24/7 access to clinician with real-time access to medical records
- ❑ Use of therapies consistent with national guidelines
- ❑ Data-driven continuous quality improvement
- ❑ Use of certified EHR technology

Potential Oncology Care First Model

The CMS Innovation Center is exploring a future oncology payment and service delivery model that builds on the lessons learned to date in OCM and incorporates feedback from stakeholders.

- Informal Request for Information (I-RFI) https://innovation.cms.gov/Files/x/ocf-informalrfi.pdf.

- Feedback on the I-RFI due by Friday, December 13, 2019 to OCF@cms.hhs.gov

- Recording of the November 4, 2019 Public Listening Session:
  - **Part 1:** https://www.youtube.com/watch?v=Nv6okv25-p4
  - **Part 2:** https://www.youtube.com/watch?v=1R8Afyma49Y

Potential Oncology Care First Model

As currently conceptualized —

- Test whether an innovative approach to **prospectively paying for management and drug administration services provided by oncology practitioners, together with a total cost of care accountability**, reduces program expenditures while preserving or enhancing the quality of care for Medicare beneficiaries with cancer or a cancer-related diagnosis.

- Be a distinct model from current OCM test
- Anticipate a voluntary, five-year model
- January 2021 to December 2025
- Test throughout the United States

Proposed Radiation Oncology (RO) Model

Background

- In December 2015, Congress passed the Patient Access and Medicare Protection Act (PAMPA) (P.L. 114-115), which required the Secretary of HHS to submit a report on "the development of an episodic alternative payment model" for radiotherapy services.

- The report is available here: https://innovation.cms.gov/Files/reports/radiationtherapy-apm-rtc.pdf

- The report identified three key reasons why radiation therapy is ready for payment and service delivery reform:
  - *Site neutrality*
  - *Aligning payments to quality and value, rather than volume*
  - *CMS coding and payment challenges*


United States Department of Health and Human Services

REPORT TO CONGRESS

Episodic Alternative Payment Model for Radiation Therapy Services

November 2017

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Proposed Radiation Oncology (RO) Model Overview

Expenditures Notice of Proposed Rule Making (CMS-5527-P)

- Prospective, site neutral episode payment for radiation therapy services; annual retrospective payment reconciliation
- 90-day episodes for radiation therapy (RT) services for 17 cancer types
- Bundled payments would be:
  - Nationally based, trended to performance year dollars
  - Adjusted based on participant experience and case mix
  - Triggered by provision of the treatment planning service
  - Modality-agnostic (includes proton beam therapy)
  - Split into professional and technical component payments
- Required participation in randomly selected Core-based Statistical Areas (CBSAs) with 40% of eligible episodes
- Participants furnish professional RT services, technical RT services, or both.
  - Physician group practices (PGPs), including freestanding radiation therapy centers (FRTCs)
  - Hospital outpatient departments (HOPDs)
- Advanced Alternative Payment Model (Advanced APM) under CMS Quality Payment Program (QPP)

Proposed RO Model Framework

The Radiation Oncology (RO) Model would test whether prospective episode-based payments for RT services would reduce Medicare program expenditures and preserve or enhance quality of care for Medicare beneficiaries.

Model Objectives:

1. Support clinical practice transformation by encouraging physicians to provide high-quality, evidence-based care to drive better patient outcomes and decrease Medicare costs;
2. Reduce administrative burden through a simplified and predictable payment system that moves Medicare toward site-neutrality; and,
3. Improve beneficiary experience by rewarding high-quality patient-centered care, and incentivize high-value RT that results in better quality of care and patient outcomes.

Proposed RO Model -- **Site-Neutral Payment Policy**

- The proposed RO Model would test whether site-neutral prospective bundled payments for RT services would reduce Medicare expenditures while preserving or enhancing the quality of care for beneficiaries.

- Site-neutral payment policy would address the site-of-service payment differential that exists under the Outpatient Prospective Payment System (OPPS) and Physician Fee Schedule (PFS) by establishing a common payment amount to pay for the same services regardless of where they are furnished.

- Site-neutral payments would offer RT providers and RT suppliers more certainty regarding the pricing of RT services and remove incentives that promote the provision of RT services at one site of service over another.

Proposed RO Model-- **Timeline**

Report to Congress	November 2017
Model Design	January 2018 – July 9, 2019
NPRM Public Comment Period	July 10 – September 16, 2019
RO Model Launch	(January 1 or) April 1, 2020
RO Model Concludes	December 31, 2024
PY 5 Data Final Submission & Reconciliation	2025
Final True-Up Reconciliation	2026

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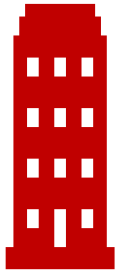
Proposed RO Model-- **Participants**

Physician Group Practices (PGPs)

Hospital Outpatient Departments (HOPDs)



Freestanding Radiation Therapy Centers (FRTC)

RO Model participants will fall into one of three categories:

- Professional Participant
- Technical Participant
- Dual Participant

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Proposed RO Model -- **Participant Exclusions**

- Ambulatory Surgery Centers (ASCs)
- Critical Access Hospitals (CAHs)
- PPS-exempt Cancer Hospitals (PCHs)
- Providers furnishing RT only in the following locations:
  - Maryland
  - Vermont
  - U.S. Territories
- Providers that participate in or are identified as eligible to participate in the Pennsylvania Rural Health Model

During the model performance period, a RO participant would be excluded if its status changes based on the exclusion criteria. Conversely, an excluded provider in the randomly-selected CBSAs would be required to participate if the exclusion criteria no longer applies to the provider.

Proposed RO Model– **Service Areas**

A CBSA is a statistical geographic area with a population of at least 10,000, which consists of a county or counties anchored by at least one core, plus adjacent counties having a high degree of social and economic integration with the core.

- The geographic unit of selection for the RO Model would be OMB's Core Based Statistical Areas (CBSAs).
- Participation in the RO Model would be required for all RT providers and suppliers within the randomly-selected CBSAs.
- Using CBSAs would enable CMS to analyze groups of RT providers and suppliers in areas selected to participate in the Model and compare them to groups of RT providers and suppliers not participating in the Model.
- To simplify the notification process, CMS would use an RT provider or RT supplier's service location five-digit ZIP Code found on the claim submissions to CMS to link them to CBSAs selected under the model.
- A crosswalk of included ZIP codes would be posted on the RO Model website when the final rule displays.

Proposed RO Model—
Professional, Technical, and Dual Participants

As proposed, eligible participants would furnish and bill for one or both of the following components of radiation therapy services:

- Professional Participant: a PGP, identified by a single Tax Identification Number (TIN), that furnishes only the professional component of RT services
- Technical Participant: a HOPD or FRTC, identified by a single CMS Certification Number (CCN) or TIN, which furnishes only the technical component of RT services
- Dual Participant: a FRTC, identified by a single TIN, that furnishes both the professional and technical component of RT services.

Proposed RO Model – **Medicare Beneficiary Population**

Inclusion Criteria

- Beneficiary receives included RT services in a five-digit ZIP code linked to a selected CBSA from an RO participant during the model performance period for a cancer type included in the RO Model.
- At the time of initial treatment planning, the beneficiary:
  - Is eligible for Medicare Part A and enrolled in Medicare Part B
  - Has traditional Medicare FFS as his or her primary payer;
  - Is not in a Medicare hospice benefit period

Exclusion Criteria

- At the time of initial treatment planning, the beneficiary:
  - Is enrolled in any Medicare managed care organization, including, but not limited to, Medicare Advantage plans;
  - Is enrolled in a PACE plan;
  - Is in a Medicare hospice benefit period; or
  - Is covered under United Mine Workers.

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Proposed RO Model-- **Included Cancer Types**

1. Anal Cancer
2. Bladder Cancer
3. Bone Metastases
4. Brain Metastases
5. Breast Cancer
6. Cervical Cancer
7. CNS Tumors
8. Colorectal Cancer
9. Head and Neck Cancer
10. Kidney Cancer
11. Liver Cancer
12. Lung Cancer
13. Lymphoma
14. Pancreatic Cancer
15. Prostate Cancer
16. Upper GI Cancer
17. Uterine Cancer

Proposed RO Model-- **Episode Triger and Length**

Start of Episode

End of Episode

<u>Day 1</u>: Initial treatment planning service

<u>Day 28</u>: Beneficiary must receive RT treatment within 28 days of initial treatment planning service

<u>Day 90</u>: The episode lasted for 89 days starting from the day after the initial treatment planning service

- Clean Period is the 28-day period after an episode has ended, during which time a RO participant will bill for medically necessary RT services furnished to a RO beneficiary in accordance with Medicare FFS billing rules
- If clinically appropriate, a RO participant may initiate another episode for the same beneficiary after the 28-day clean period has ended
- If a beneficiary does not receive RT treatment from an RO Model participant within 28 days of initial treatment planning then the requirements for triggering an episode would not have been met and the proposed incomplete episode policy would take effect.

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Proposed RO Model-- **Included and Excluded Services**

- The RO Model will include most RT services furnished in HOPDs and FRTCs.
- Services furnished within an episode, and excluded services, under this Model include:

Consultation

- Initial consultation typically billed using E&M service

EXCLUDED

Treatment Planning

- Determine treatment modality, parts of the body that must be radiated, and plan for radiation treatment
- Ex. Radiation Therapy Planning

Technical Preparation and Special Services

- Technical preparation to ensure radiation dosing is accurate, machine is prepared, treatment aids are constructed
- Ex. Radiation Treatment Aids

Treatment Delivery

- Radiation delivered to patient in one or more sessions
- Ex. Radiation Treatment Delivery, and Apply Intracavity Radiation-Brachytherapy

Treatment Management

- Patient monitoring, treatment adjusted according to outcomes
- Ex. Radiation Treatment Management x 5 treatments

ALSO EXCLUDED

- Experimental and low volume treatments (neutron beam, hyperthermia)
- Surgical services supporting brachytherapy placement
- General imaging not related to radiation prep
- RT provided in any setting other than HOPD or freestanding radiation center

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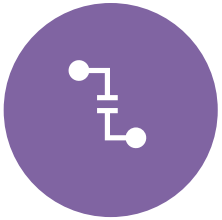
Proposed RO Model -- **Included Modalities**

The RO Model would include the most commonly used modalities to treat the 17 included cancer types to allow CMS to determine whether the RO Model is able to impact RT holistically, rather than testing a limited subset of services. They include:

- external beam RT including 3-dimensional conformal radiotherapy (3DCRT)
- intensity-modulated radiotherapy (IMRT)
- stereotactic radiosurgery (SRS) and stereotactic body radiotherapy (SBRT)
- proton beam therapy (PBT)
- brachytherapy
- intraoperative radiotherapy (IORT)

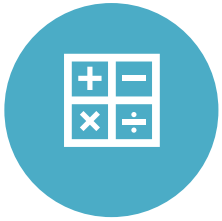
Proposed RO Model–
Prospective Episode Payment Proposals

Prospective payments for certain RT services furnished during a 90-day episode of care for 17 cancer types.



Episodes would be split into two components – the Professional Component (PC) and the Technical Component (TC).

Payments would cover select RT services furnished during an episode; not total cost of all care.



Episode payments would be made in two installments, 50% at the start of the episode and 50% at the end of the episode.

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Proposed RO Model-- **Payment Process Overview**

SITE NEUTRAL 90-DAY EPISODE PAYMENTS FOR RADIATION THERAPY FOLLOWED BY A 28-DAY CLEAN PERIOD

Experience

Case Mix

- Addresses differences in participants' beneficiary populations (such as sex and age)

Historical Experience

- Addresses differences in participants' historical care patterns
- Efficiency Factor of 0.90 in Performance Year 1

90% of episode payment in PY1 determined by what participant received historically under FFS.

National Base Rate

- Establish national base rates using only HOPD episodes initiated during 2015-2017.
- Calculate amounts by cancer type for both professional and technical components.

Trend Factor

- Accounts for volume and payment trends outside of the Model under OPPS and MPFS.
- Use recent claims data to calculate the volume of RT services and corresponding payment rates of non-participants (HOPD and freestanding radiation therapy centers)

Claims Processing

- Apply geographic adjustment, discounts, withholds
- Apply sequestration and cost-sharing
- 50% of bundle paid at the start of episode; 50% paid at the end of episode

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Proposed Billing Process: Professional Component Services

The following process would apply to professional and dual participants billing for professional component services:

Professional participants and Dual participants would be required to bill a RO Model-specific HCPCS code and a modifier indicating the start of an episode (SOE modifier) for the PC once the treatment planning service is furnished.

Upon submission of a claim with a RO Model-specific HCPCS codes and SOE modifier, CMS would pay the first half of the payment for the PC of the episode to the Professional participant or Dual participant.

A Professional participant or Dual participant would be required to bill the same RO Model-specific HCPCS code that initiated the episode with a modifier indicating the end of an episode (EOE) after the end of the 90-day episode.

Upon submission of a claim with a RO Model-specific HCPCS codes and SOE modifier CMS would pay the second half of the payment for the PC of the episode to the Professional participant or Dual participant.

Proposed Billing Process: Technical Component Services

The following process would apply to technical and dual participants billing for technical component services:

Technical participants or a Dual participants that furnish the TC of an episode would be required to bill a RO Model-specific HCPCS code with a SOE modifier once the first treatment is furnished.

Upon submission of a claim with a RO Model-specific HCPCS codes and SOE modifier, CMS would pay the first half of the payment for the TC of the episode to the Technical or Dual participant.

The Technical participant or Dual participant would be required to bill the same RO Model-specific HCPCS code with an EOE modifier that initiated the episode. This would indicate that the episode has ended.

CMS would pay the second half of the payment for the TC of the episode after the end of the episode.

Proposed RO Model-- Quality Requirements

- To earn back some or all of the quality withhold, Professional participants and Dual participants would need to:
  - Demonstrate successful performance on three specified quality measures, compared to benchmarks (pay-for-performance);
  - Report data on one specified quality measure that does not yet have a national benchmark (pay-for-reporting); and
  - Report on specified clinical data elements.
- As part of the annual reconciliation process, an aggregate quality score (AQS) would be created for each RO participant, using a methodology that combines reporting of clinical data elements together with pay-for-performance and pay-for-reporting data.

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Proposed Clinical Data Elements

Professional and Dual participants would be required to report basic clinical information not available in claims or captured in the quality measures, such as: cancer stage, disease involvement, treatment intent, and specific treatment plan information, on RO beneficiaries treated for five types of cancer under the Model:

1. prostate
2. breast
3. lung
4. bone metastases
5. brain metastases

The RO Model would establish reporting standards that require all Professional participants and Dual participants to submit clinical data information biannually, in July and January, each PY for RO beneficiaries that completed their 90-day episode within the previous six months.

Proposed RO Model-- **Aggregate Quality Score**

- AQS would weight 50 percent on the successful reporting of required clinical data, and the other 50 percent on quality measure reporting and, where applicable, performance on those measures.
- The AQS methodology would weight all four quality measures equally.

- The AQS methodology would be expressed as follows:

Aggregate Quality Score
=
Quality Measures (0 to 50 points based on weighted measure scores and reporting) +
Clinical data (50 points when data is submitted for ≥95% of applicable RO beneficiaries)

Proposed RO Model **Participant-Specific Requirements**

Professional Participants & Dual Participants

- Discuss goals of care (e.g. whether treatment intent is curative or palliative)
- Care consistent with nationally recognized clinical guidelines
- Assesses RO beneficiaries' cancer stage (TNM)
- Assesses RO beneficiaries' performance status
- Send a treatment summary to each model beneficiary's referrer within three months of the EOE
- Discusses with each RO beneficiary prior to treatment delivery cost-sharing responsibilities
- Peer review of treatment plans for 50% of all radiation therapy patients, to increase by 5% each performance year.

Technical Participants and Dual Participants

- Annually attest to active participation in a radiation oncology-specific Agency for Healthcare Research and Quality (AHRQ) Patient Safety Organization (PSO)

- Starting in PY3, accountable for patient experience via the patient-reported CAHPS® Cancer Care Radiation Therapy survey administered by a CMS contractor

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Kidney Care Choices (KCC) Builds on CEC Model

Comprehensive ESRD Care (CEC) Model

- CEC Model began in October 2015 and will run through December 31, 2020.
- Accountable Care Organizations (ACOs) formed by dialysis facilities, nephrologists, and other Medicare providers and suppliers work together with the goal to improve outcomes and reduce per capita expenditures for aligned ESRD beneficiaries.
- Results for the Model showed lower spending relative to benchmark group and improvements on some utilization and quality measures.

Kidney Care Choices (KCC) Model

- The KCC model will begin in 2020 and will run through 2023 with the option for CMMI to extend the Model for one or two additional years.
- Single set of providers and suppliers responsible for patient's care from CKD Stages 4,5 through dialysis, transplantation, or end of life care.

Overview of the KCC Model Options

Payment Options	Overview	Participants
Kidney Care First (KCF) Option	Based on the Primary Care First (PCF) Model – nephrology practices will be eligible to receive bonus payments for effective management of beneficiaries	Nephrologists/nephrology practices only
Graduated Option	Based on existing CEC Model One-Sided Risk Track – allowing certain participants to begin under a lower-reward one-sided model and incrementally phase in risk and additional potential reward	Must include nephrologists and nephrology practices; may also include transplant providers, dialysis facilities, and other kidney care providers on an optional basis
Professional Option	Based on the Professional Population-Based Payment option of the Direct Contracting Model – with 50% of shared savings or shared losses in the total cost of care for Part A and B services	
Global Option	Based on the Global Population-Based Payment option of the Direct Contracting Model – with risk for 100% of the total cost of care for all Part A and B services for aligned beneficiaries	

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