HMA Summary of CMS Innovation Models Pertaining to ESRD and Radiation Oncology

On September 18, 2020, the Centers for Medicare & Medicaid Services (CMS), through the Center for Medicare and Medicaid Innovation (CMMI), finalized two new mandatory payment model demonstrations addressing radiation oncology and end-stage renal disease (ESRD). This is the first time CMS has proposed and finalized a mandatory model since the hip fracture and cardiac bundled payment models, which were cancelled in 2017.

The newly-finalized models offer an array of opportunities for radiation therapy providers and suppliers as well as nephrologists and dialysis facilities to take on risk for the services they provide to Medicare beneficiaries. The table below outlines the key parameters of these new payment models:

Table 1: Key Parameters of New Payment Models

	Radiation oncology (RO)	ESRD Treatment Choices (ETC)
Participation	Mandatory in defined regions of the US	Mandatory in defined regions of the US
Timeline	2021 to 2025	2021 to 2027
Eligible participants	Radiation oncology providers and suppliers	Nephrologists and other clinicians managing beneficiaries with ESRD ("Managing Clinicians") and ESRD facilities
Eligible Medicare beneficiaries	Beneficiaries with any of 16 cancer types	Adult ESRD patients
Payment method	Site-neutral, prospective, modality agnostic, 90-day episode-based payment	**Home Dialysis Payment Adjustment (January 2021- December 2023):** Upward adjustments on home dialysis-related claims **Home Dialysis and Transplant Performance Assessment and Performance Payment Adjustment (July 2024 – June 2027)**: Upward or downward adjustments (of increasing magnitude over time) based on home dialysis and kidney transplant rates
Benefit expansions/waivers	No	Yes: kidney disease education benefit

HMA continues to analyze these payment and care delivery models including modeling the payment impact of these changes for our clients. We will monitor any additional announcements from CMS related to these payment models. For more information or questions please contact Eric Hammelman, Narda Ipakchi, or Jennifer Podulka.

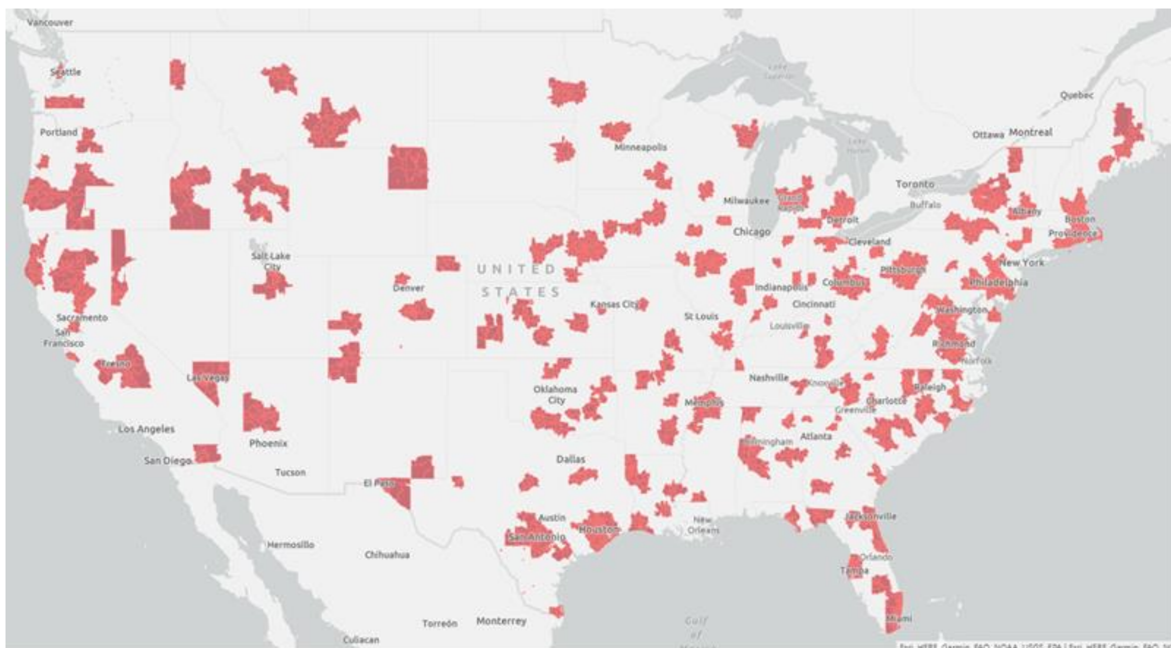
Mandatory Radiation Oncology Model

CMS's Radiation Oncology (RO) model will test prospective, site-neutral, modality agnostic, episode-based payments for radiotherapy services (RT) services. The RO model aims to better align incentives to provide RT services, reduce provider burden by moving toward a simplified and predictable payment system, and improve the quality of care for cancer patients receiving RT treatment.

In forming this model, CMS intends to resolve three specific concerns about the existing RT payment system. CMS intends to 1) eliminate incentives to steer patients to higher-paying settings, 2) resolve difficulties in coding RT services and in setting payment rates appropriately for RT services, and 3) improve the patient experience by rewarding high-quality patient-centered care and provide incentives for the provision of high-value RT that results in better patient outcomes.

Participation in this model will be mandatory for all physician group practices, hospital outpatient departments, and freestanding radiation therapy centers that provide RT within randomly selected Core-Based Statistical Areas (CBSAs). The CBSAs selected for the RO Model contain approximately 30 percent of all eligible Medicare fee-for-service (FFS) radiotherapy episodes nationally (Figure 1). The model is limited to a distinct set of RT services that are provided for 16 different cancer types (Table 2).

Figure 1: Regions Selected for RO Model



Source: Radiation Oncology Model Participating Zip Code List

Table 2: Types of Cancer Included in the Radiation Oncology Model

Anal Cancer	Breast Cancer	Head and Neck Cancer	Pancreatic Cancer
Bladder Cancer	Cervical Cancer	Liver Cancer	Prostate Cancer
Bone Metastases	CNS Tumors	Lung Cancer	Upper GI Cancer
Brain Metastases	Colorectal Cancer	Lymphoma	Uterine Cancer

Notes: CNS (central nervous system), GI (gastrointestinal).
Source: CMS, Medicare Program; Specialty Care Models to Improve Quality of Care and Reduce Expenditures, Final rule, September 29, 2020.

Providers will receive prospective episode-based payment amounts covering a 90-day episode of care that will vary based on the type of cancer. The episode payments will be split into a professional component (PC) and a technical component (TC), and provider-specific payment amounts will be determined based on national base rates, trend factors, and adjustments for each RO participant's case-mix, historical experience, and geographic location. Noting that the technical/facility payments for RT are lower for freestanding RT locations than for hospital outpatient departments (HOPD), CMS will use the average payment rates received by HOPDs in constructing the initial cancer-specific base rates.

CMS will apply two adjustments to address perceived payment disparities for RT. First, to move all providers' payments closer to the national average, providers that historically have had higher-than-average episode costs will receive a downward adjustment that will become larger over the five years of the demonstration, while providers that historically have had lower-than-average episode costs will receive an upward adjustment that will remain constant during the demonstration. Second, the episode payment will be reduced by a discount factor, which will reserve savings for the Medicare program and reduce beneficiary cost-sharing. The discount factor will be 3.75 percent of the PC and 4.75 percent of the TC.

Finally, CMS will apply payment adjustments for withholds for incorrect payments (1 percent for PC and TC), quality (2 percent for PC), and patient experience (1 percent for TC starting in 2023). RO participants can earn back all or some of the incorrect payment withhold based on the amount of incorrect payments during the previous year. RO participants have an opportunity 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 RO Model will qualify as an Advanced APM and a Merit-based Incentive Payment System (MIPS) APM for purposes of the Physician Quality Payment Program (QPP).

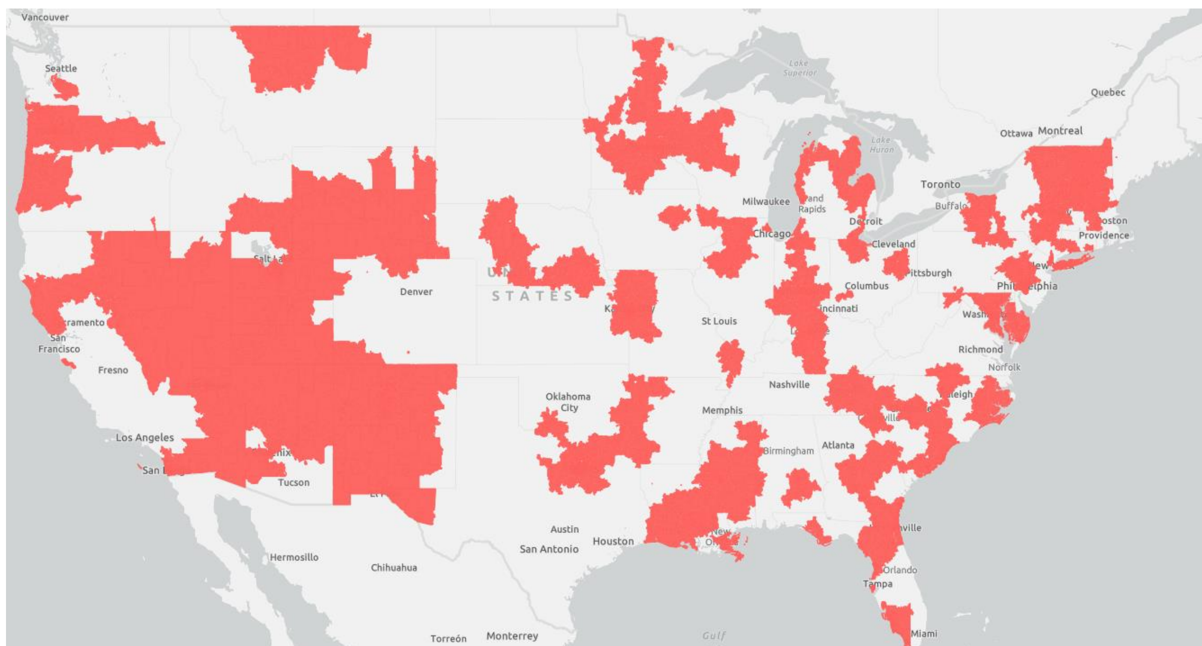
The RO Model will begin January 1, 2021, and run through December 31, 2025. CMS estimates the RO model will reduce total Medicare spending by $230 million over five years.

Mandatory End-Stage Renal Disease Treatment Choices Model

The End-Stage Renal Disease Treatment Choices (ETC) Model aims to encourage greater use of home dialysis and kidney transplants for Medicare beneficiaries with ESRD. According to CMS, home dialysis and kidney transplant are viewed by dialysis patients and physicians as preferable alternatives to in-center dialysis for patients and physicians, but is not widely used in the U.S., particularly when compared to other developed countries. Under the ETC Model, CMS will adjust existing payment rates made to ESRD facilities and to the monthly capitation payments made to create incentives for clinicians and facilities to work with beneficiaries and other caregivers to consider the use of home dialysis and kidney transplant.

Participation in the ETC Model is mandatory within a select set of hospital referral regions (HRR) across the country (Figure 2), but low-volume ESRD service providers are excluded. According to CMS, the selected HRRs encompass 30 percent of all adult ESRD beneficiaries. CMS will attribute ESRD beneficiaries to participating providers on a month-to-month basis based on where the beneficiary receives the most dialysis treatments. Beneficiaries who are under 18 years of age, enrolled in hospice care, residing in skilled nursing facilities or nursing facilities, diagnosed with dementia, or receiving dialysis due to acute kidney injury, are excluded from the model.

Figure 2: HRRs Selected for ETC Model



Note: Alaska not pictured but all zip codes in state are included in the model

Source: ETC Model Participating HRR Zip Code List

During the initial three years of the ETC Model, CMS will increase payments, including the per treatment facility payment rate and the monthly capitation payment (MCP), for each patient receiving home dialysis services. The adjustment is 3 percent in 2021, 2 percent in 2022, and 1 percent in 2023. Starting in 2024, CMS will adjust payments based on an ETC participant's home dialysis rate and transplant rate compared to its own historical performance as well as compared to other participants in the same HRR.

These adjustments could be positive or negative, ranging from +8 percent to -10 percent for facilities and +8 percent to -9 percent for clinicians in the final periods.

CMS stated that providers participating in the ETC model are able to participate in other voluntary ESRD payment models, including Comprehensive Kidney Care Contracting (CKCC). Payment adjustments under the ETC would count as part of the payments measured in these other demonstrations.

The ETC Model will operate from January 1, 2021, to June 30, 2027. The Agency estimates the ETC model will reduce total Medicare program spending by $23 million over the demonstration period.