Radiation Oncology (RO) Model 101

Center for Medicare and Medicaid Innovation (CMMI)
Centers for Medicare & Medicaid Services (CMS)

Medicare Program; Specialty Care Models to Improve Quality of Care and Reduce Expenditures Final Rule

Date: October 15, 2020

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AGENDA

1. RO Model Overview
2. Model Performance Period
3. Eligible Participants
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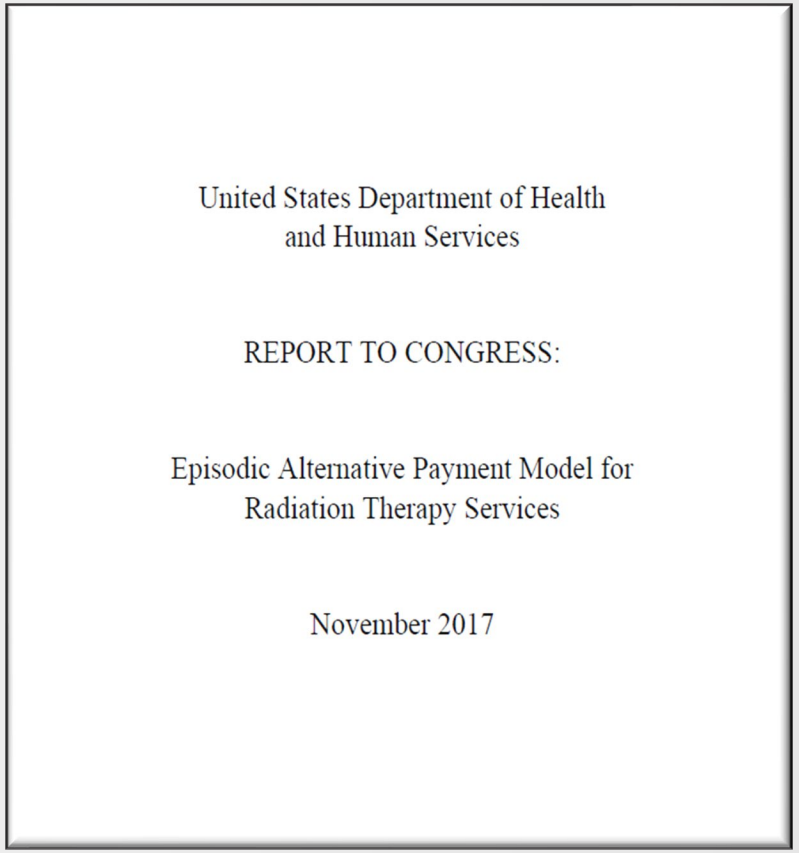
1. RO MODEL OVERVIEW

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

Model Framework

The Radiation Oncology (RO) Model will test whether prospective, site neutral, episode-based payments for radiotherapy (RT) episodes of care reduces Medicare program expenditures while preserving or enhancing quality of care for Medicare beneficiaries.

- Objectives:
  1. Support clinical practice transformation by encouraging physicians to provide high-quality, evidence-based care to drive better patient outcomes, decrease Medicare costs, and improve the beneficiary experience;
  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.

Site Neutrality

- The objectives of the site-neutral payment policy are to:
  - ✓Address the site-of-service payment differential that exists under the OPPS and PFS by establishing a common payment amount to pay for the same services regardless of where they are furnished.
  - ✓Offer RT providers and RT suppliers more certainty regarding the pricing of RT services
  - ✓Remove incentives that promote the provision of RT services at one site of service over another.

RO Model Design Elements

- Required participation for Physician Group Practices (PGPs), Freestanding Radiation Therapy Centers, and Hospital Outpatient Departments (HOPDs) that meet the following:
  - ✓ Operate in one or more of the randomly selected CBSAs
  - ✓ Provide radiation therapy services for 1 or more of 16 selected cancer types
  - ✓ Provided 20 or more episodes in the most recent calendar year across the randomly selected CBSAs, based on available claims data
- 90-day episodes for the Professional component and Technical component of radiation therapy (RT) services
- Prospective, site neutral episode payment with an annual retrospective payment reconciliation
- Advanced Alternative Payment Model (AAPM) and Merit-based Incentive Payment System (MIPS) APM under CMS Quality Payment Program (QPP)

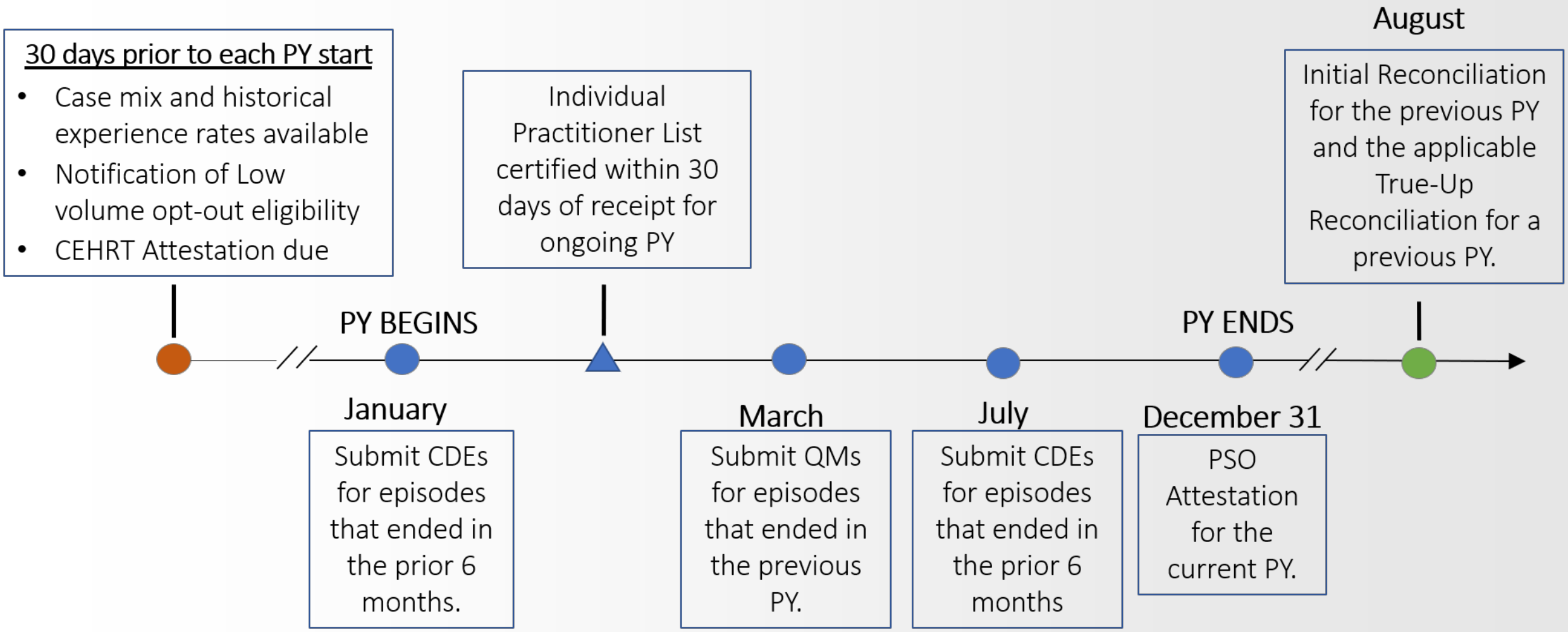
2. MODEL PERFORMANCE PERIOD

Performance Period

- The RO Model will begin on January 1, 2021
- Each Performance Year (PY) will run from January 1 – December 31
- Five PYs in total; Model will end on December 31, 2025
- No new episodes to begin after October 3, 2025

To capture all episodes that finish within the performance period, data collection, episode payments, and initial reconciliation will continue into calendar year 2026. The final true-up reconciliation will occur in 2027.

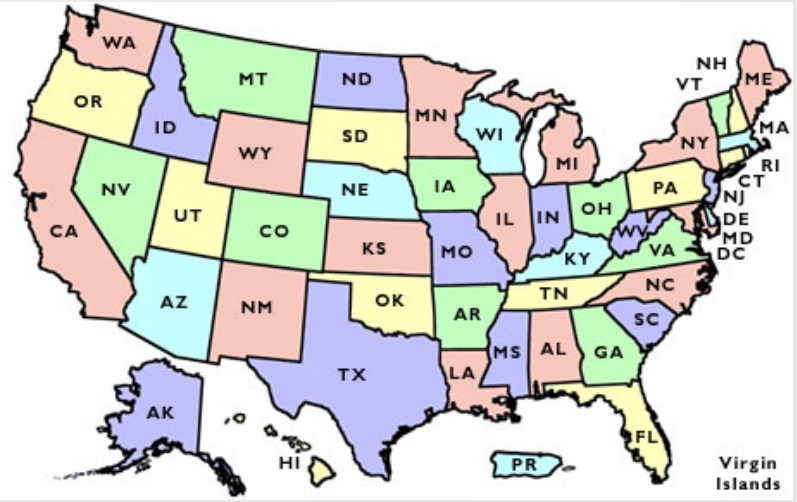
Performance Year (PY) Timeline



3. ELIGIBLE PARTICIPANTS

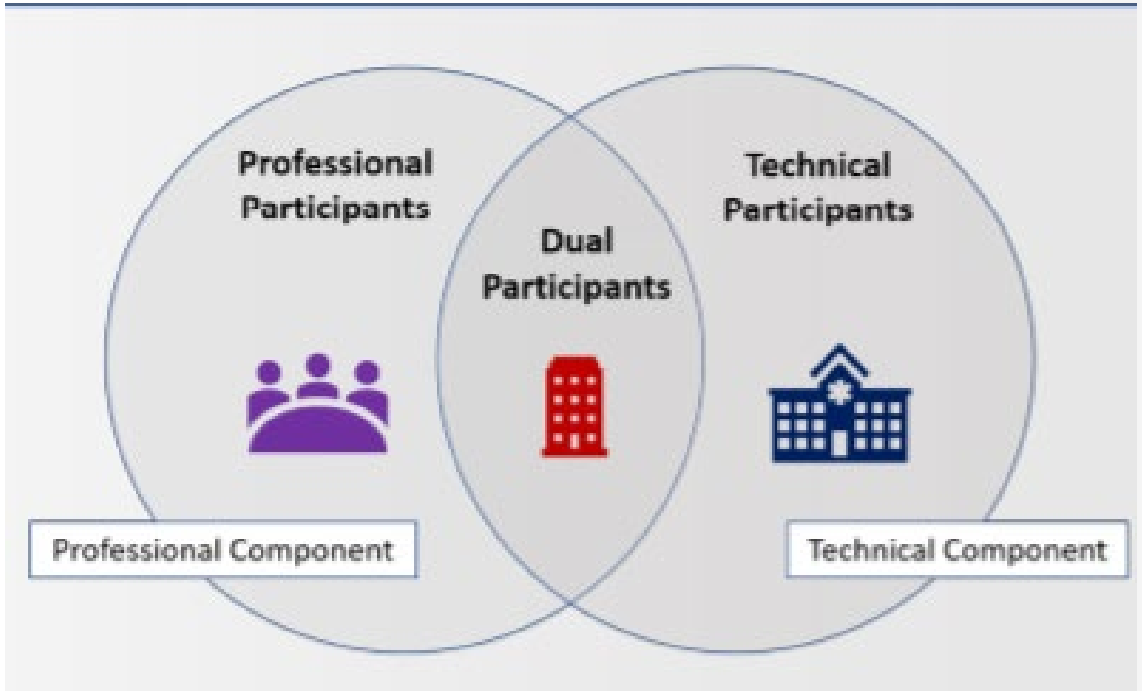
Model Service Areas

- Participation in the RO Model is required for all RT providers and RT suppliers within randomly-selected CBSAs. Participants may opt-out if they are eligible for the low volume opt-out and attest to opting out prior to the applicable PY.
- RT providers and RT suppliers are linked to a CBSA using the five-digit ZIP Code of the location where RT services are furnished.
- CMS uses 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 list of participating ZIP Codes is available on the RO Model Website: https://innovation.cms.gov/innovation-models/radiation-oncology-model



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.

RO Model Participant Types



- **Physician Group Practices (PGPs)** are identified by a single Tax ID Number (TIN) and furnish the professional component of RT services.
- **Hospital Outpatient Departments (HOPDs)** are identified by a single CMS Certification Number (CCN) and furnish only the technical component of RT services
- **Freestanding Radiation Therapy Centers** are identified by a single TIN and can furnish both the professional and technical components of RT services.

Model Participant Exclusions

- Ambulatory Surgery Centers (ASC)
- 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, an RO participant will be excluded if its status changes based on the exclusion criteria. Conversely, an excluded entity in the randomly-selected CBSAs will be required to participate if the exclusion criteria no longer applies to that entity.

Clarifying Participation Requirements

- A PGP who furnishes RT services only at an excluded facility (PCH, CAH, or ASC) will not be an RO participant.

- RT services that are furnished at an excluded facility (PCH, CAH, or ASC) will be paid FFS.

4. BENEFICIARY POPULATION

Beneficiary Population

An individual is an RO beneficiary if they:

- Receive included RT services from an RO participant for the PC or TC of an RO episode during the Model performance period for an included cancer type
- At the time that the initial treatment planning service of an RO episode is furnished by an RO participant, the individual:
  - ✓ 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

An individual enrolled in a clinical trial for RT services for which Medicare pays routine costs is an RO beneficiary, provided that the individual satisfies all of the beneficiary inclusion criteria listed

An otherwise-eligible RO beneficiary has the right to choose his or her RT provider or RT supplier, including those not participating in the RO Model.

Beneficiary Communications

- Professional participants and Dual participants will provide written notice to each RO beneficiary during the treatment planning session.
- Notifications must include:
  - ✓ RO participant's contact information and logo
  - ✓ Information regarding RO beneficiary cost-sharing responsibilities
  - ✓ A RO beneficiary's right to refuse having his or her data shared

Beneficiaries with questions or concerns with their physicians can do the following:

- Contact CMS using 1–800–MEDICARE, or
- Reach out to their local Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIOs): https://www.qioprogram.org/locate-your-qio

Beneficiary Cost Sharing

- **Complete Episode**: Beneficiaries are responsible for **20 percent of the episode payments.**
- **Incomplete Episode:** Beneficiary is responsible for **20 percent of the FFS amounts** that would have been paid in the absence of the RO Model, except when the RO beneficiary ceases to have traditional FFS Medicare as his or her primary payer at any time after the initial treatment planning service is furnished and before the episode has ended.
  - In this case, the RO beneficiary will be responsible for 20% of the first installment of the episode.
- **Duplicate Service**: Beneficiary is responsible for **20 percent of the FFS amount** for RT services furnished by the RT provider and/or RT supplier for one or more duplicate RT services.

Treatment Planning for Beneficiaries

- As a condition of participation, RO participants must:
  - ✓ Discuss goals of care with each beneficiary before initiating treatment, and communicate to the RO beneficiary whether treatment intent is curative or palliative.
  - ✓ Furnish care that is consistent with and adheres to evidence-based clinical treatment guidelines when appropriate.
  - ✓ Assess beneficiaries' tumor, node, and metastasis cancer stage for the CMS-specified cancer diagnosis.

CMS will monitor for unintended consequences that impact RO beneficiaries.

5. EPISODE DESIGN

Prospective Payment Episode

Prospective payments for certain RT services furnished during a 90-day episode of care for 16 cancer types.

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

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

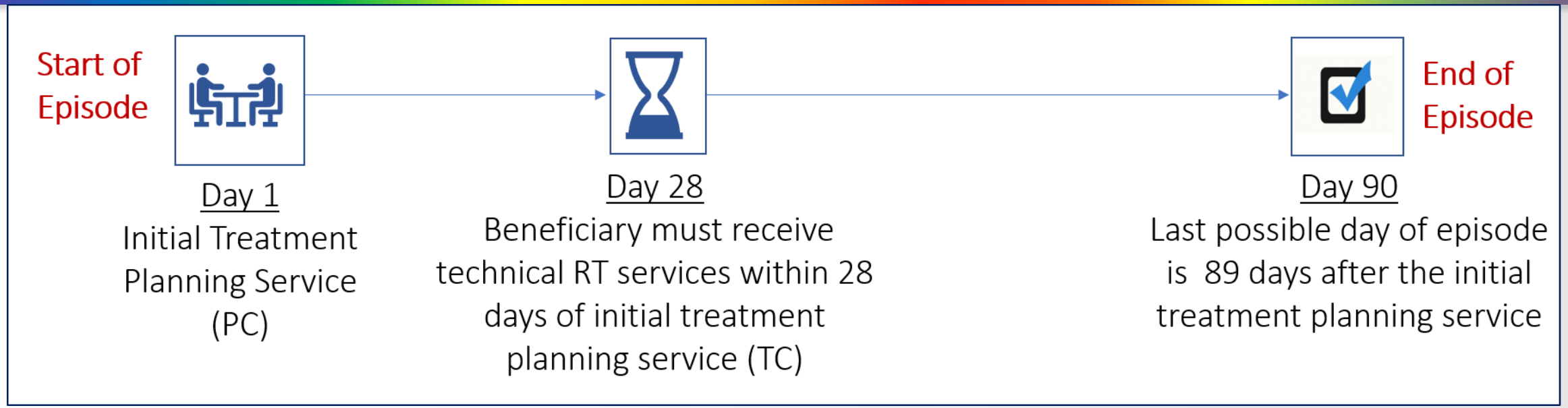
Episode payments made in two installments, 50% at the start of the episode and 50% when radiation treatment has ended

(no sooner than day 28 of the episode).

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. Liver Cancer
11. Lung Cancer
12. Lymphoma
13. Pancreatic Cancer
14. Prostate Cancer
15. Upper GI Cancer
16. Uterine Cancer

Episode Length



- The 28-days after an episode has ended is the Clean Period, during which time a RO participant will bill 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 services from a RO participant within 28 days of initial treatment planning service then the requirements for triggering an episode are not met and the incomplete episode policy takes effect.

Treatment: Included and Excluded Services

Included in the Episode

Treatment Planning

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

Tech Prep & 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

Excluded Services (to be billed FFS)

- Initial consultation (typically billed using E&M service)
- 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 a HOPD or Freestanding Radiation Therapy Center
- RT provided by entities operating in RO Model CBSAs but are not RO participants

Modalities

- The RO model includes the most commonly used modalities to treat the 16 included cancer types.
- Included Modalities:
  - 3-Dimensional Conformal Radiotherapy (3DCRT)
  - Intensity-Modulated Radiotherapy (IMRT)
  - Stereotactic Radio Surgery (SRS)
  - Stereotactic Body Radio Therapy (SBRT)
  - Proton Beam Therapy (PBT)*
  - Image-Guided Radiation Therapy (IGRT)
  - Brachytherapy

**The RO Model does not include PBT that is furnished to an RO beneficiary participating in a federally-funded, multi-institution, randomized control clinical trial for PBT.*

6. EPISODE PAYMENT AMOUNT

Episode Payment Amount Definitions

Participant-Specific Professional Episode Payment

A payment made by CMS to a **Professional participant** (PGP or Freestanding Radiation Therapy Center) or **Dual participant** (Freestanding Radiation Therapy Center) for the provision of the professional component of RT services to a RO beneficiary during an episode.

Participant-Specific Technical Episode Payment

A payment made by CMS to a **Technical participant** (HOPD or Freestanding Radiation Therapy Center) or **Dual participant** (Freestanding Radiation Therapy Center) for the provision of the technical component of RT services to a RO beneficiary during an episode.

Payment Process Overview

Experience	National Base Rate	Trend Factor	Claims Processing
Case Mix: Addresses differences in participants' beneficiary populations (e.g., sex and age) **Historical Experience:** Addresses differences in participants' historical care patterns ▪ Blend of 0.90 in PY1 90% of episode payment in PY1 determined by what participant received historically under FFS.	▪ Establish national base rates using only HOPD episodes initiated during 2016-2018. ▪ Calculate amounts by cancer type for both professional and technical components.	▪ 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)	▪ 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 treatment (no sooner than day 28 of episode)

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

Discounts and Withholds

Discounts and Withholds	Professional Component	Technical Component
Discount Rate	3.75%	4.75%
Incorrect Payment Withhold	1%	1%
Quality Withhold	2%	N/A
Patient Experience Withhold	N/A*	1% (beginning in PY3)

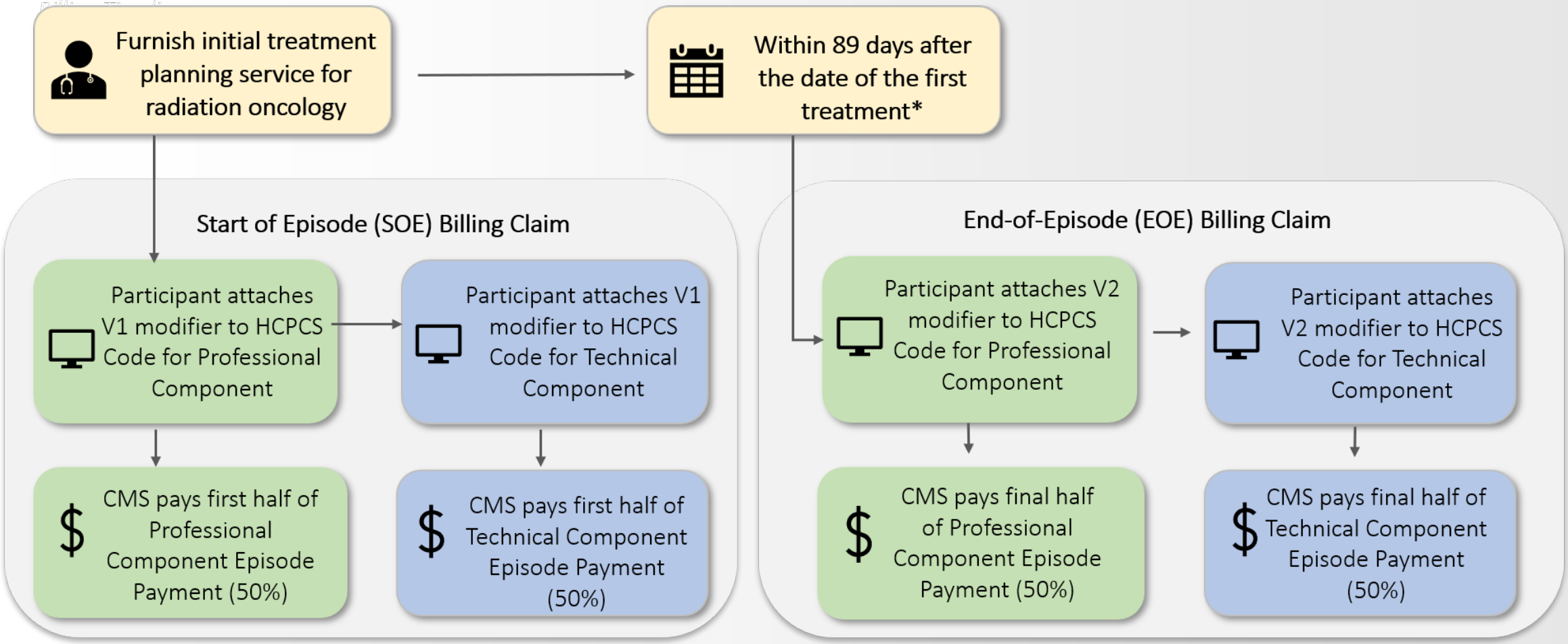
**Patient experience measures are included in the quality withhold.*
Note that payment may increase above 93.25% following the reconciliation process that allows RO participants to earn back a portion of the withholds

Low Volume Considerations

- RO participants that have fewer than 60 episodes in the baseline period do not have sufficient historical volume to calculate a reliable adjustment.
- These participants do not qualify to receive an historical experience adjustment and as a result may see greater payment increases or reductions as compared to what they were historically paid under FFS
- To address this, the RO Model includes a stop-loss limit of 20 percent for RO participants that have fewer than 60 episodes in the baseline period and were furnishing included RT services in the CBSAs selected for participation at the time of the effective date, November 30, 2020, of the final rule.

7. BILLING AND PAYMENT

Billing Timeline



Billing Process: Professional Component Services

1. **Professional participants and Dual participants are required to bill an 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.
2. **CMS pays the first half of the payment for the PC of the episode to the Professional participant or Dual participant** upon submission of a claim with a RO Model-specific HCPCS codes and SOE modifier (V1).
3. **The Professional participant provides the Technical participant** with a signed and dated radiation prescription and the final treatment plan. This will inform the Technical participant of when the episode began and allowing them to determine the date for end-of-episode (EOE).
4. **When the RO episode is complete, a Professional participant or Dual participant** bills the same RO Model-specific HCPCS code that initiated the episode, this time with an EOE modifier (V2).
5. **The EOE claim can be submitted and paid as early as day 28 of the 90-day episode** if the Professional participant is certain the treatment plan is complete.
6. **CMS pays the second half of the payment for the PC of the episode at the end of the episode** when the same RO Model-specific HCPCS code is billed with the V2 modifier indicating that the episode has ended. Payment for the PC is made through the MPFS.

Billing Process: Technical Component Services

1. **Technical participants or Dual participants that furnish the TC of an episode must bill** an RO Model-specific HCPCS code with a SOE modifier (V1).
2. **The PC will provide the Technical participant with a signed and dated radiation prescription and the final treatment plan** to inform the Technical participant of when the episode began and allowing them to determine the date for the EOE. The submission and payment of TC claims is not dependent on the submission of PC claims. If the TC claim with the SOE modifier (V1) is received first, the claims system will estimate the first day of the episode.
3. **CMS pays the first half of the payment for the TC of the episode** when a Technical participant or Dual participant furnishes the TC of the episode and bills for it using a RO Model-specific HCPCs code with a SOE modifier (V1).
4. **When the RO episode is complete, a Technical participant or Dual participant** bills the same RO Model-specific HCPCS code that initiated the episode, this time with an EOE modifier (V2).
5. **The EOE claim can be submitted and paid as early as day 28 of the 90-day episode** if the RO participant is certain that the treatment plan is complete.
6. **CMS pays the second half of the payment for the TC of the episode at the end of the episode** when the same RO Model-specific HCPCS code is billed with the V2 modifier indicating that the episode has ended. Payment for the TC is made through the MPFS or OPPS.

8. QUALITY MEASURES

Quality Requirements Overview

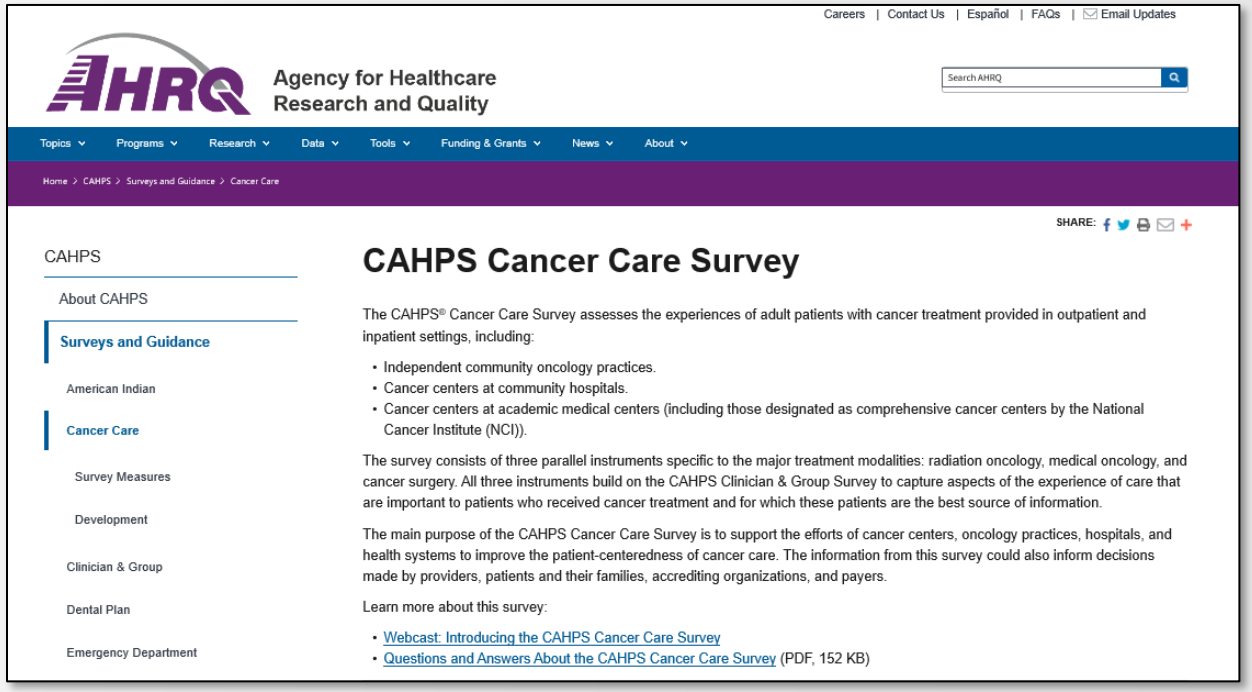
Quality Measures

To qualify as an Advanced APM and to earn back any portion of their Quality Withhold, Professional participants and Dual participants will be required to submit data on four quality measures starting in PY1:

1. Oncology: Medical and Radiation - Plan of Care for Pain
2. Preventive Care and Screening: Screening for Depression and Follow-Up Plan
3. Advance Care Plan
4. Treatment Summary Communication – Radiation Oncology

CAHPS® Cancer Care Survey

- Starting in PY3
  - Results from selected patient experience measures based on the CAHPS® Cancer Care survey will be incorporated into the AQS for Professional and Dual participants
  - For Technical participants, results from these patient experience measures will be incorporated into the AQS and applied to the patient experience withhold



Quality Reporting Measures

RO Participant Data Submission Requirements	Level of Reporting	Pay-for-Reporting	Pay-for-Performance
1. Oncology: Medical and Radiation - Plan of Care for Pain: NQF #0383; CMS Quality ID #144	Aggregate	N/A	PYs 1-5
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; 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: Patient-Reported	N/A	PYs 3-5
Clinical Data Elements	Beneficiary Level	PYs 1-5	N/A

Clinical Data Elements

- Professional participants and Dual participants are 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 to earn back any portion of their Quality Withhold.
- Beginning in PY1, clinical data elements reporting is required on RO beneficiaries treated for five types of cancer under the Model:
    1. Prostate
    2. Breast
    3. Lung
    4. Bone metastases
    5. Brain metastases

Data Submission Timing

Professional participants and Dual participants data submission requirements include:

- Quality Measure Data
  - Submit by March 31 of the year following a Performance Year
  - Example: PY1 quality measure data will be submitted by March 31, 2022
- Clinical Data Elements
  - Submit biannually for RO beneficiaries that completed their 90-day episode within the previous six months

Clinical Data Elements Submission

- ✓ The first submission of PY1 data will be in July 2021.
- ✓ The second submission of PY1 data will be in January 2022.
- ✓ The same submission schedule will occur for the following PYs, with the final submission for PY5 occurring in January 2026.

Aggregate Quality Score (AQS)

- As part of the annual reconciliation process, an aggregate quality score (AQS) will be calculated for each RO participant, using a methodology that combines reporting of clinical data elements together with pay-for-performance and pay-for-reporting quality measure data.
  - The AQS will 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 where the participant meets minimum case requirements.
  - The AQS methodology will weight all four quality measures equally and aggregate them as half of the AQS.
  - The AQS methodology is 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)

AQS and Quality Withhold Earn-Back

- Professional participants and Dual participants can earn back some -- or all -- of the quality withhold by achieving the following:
  - ✓ Demonstrate successful performance on the pay-for-performance quality measures, compared to benchmarks
  - ✓ Report data on one specified quality measure that does not yet have a national benchmark (pay-for-reporting)
  - ✓ Report on specified clinical data elements.
- Beginning in PY3, results from selected patient experience measures based on the CAHPS® Cancer Care survey will be incorporated into the AQS for Professional participants and Dual participants; For Technical participants, these results will be incorporated into the AQS and applied to the patient experience withhold.
- AQS calculations will be processed as early as August of the following PY, concurrent with the reconciliation process (e.g. PY1 AQS calculations will be done in August 2022.)
  - ✓ Any portion of the quality withhold that is earned back will be distributed in an annual lump sum during the reconciliation process, calculated against funds that the participant may owe CMS for incorrect payments.

9. RO MODEL AS AN ADVANCED APM AND MIPS APM

RO Model as an APM

The RO Model qualifies as an Advanced APM by requiring the following:

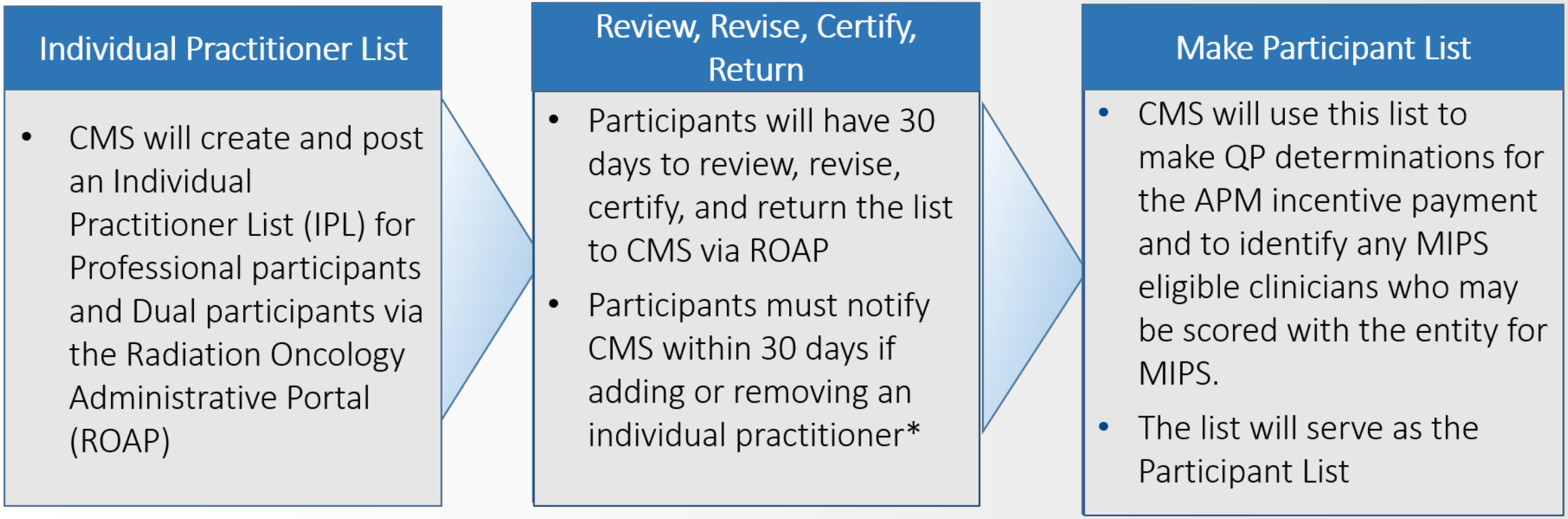
1. Use of certified EHR technology (CEHRT);
2. Inclusion of quality measure performance as a determination of payment to participants for covered professional services;
   - At least one quality measure that is finalized on the MIPS final list of measures (42 CFR 414.1330), and
   - Endorsed by a consensus-based entity or determined by CMS to be evidence-based, reliable, and valid;
3. APM Entities bear financial risk for monetary losses of more than a nominal amount.
   - In accordance with 42 CFR 414.1415; RO participants will be at risk for all RT services beyond the episode payment amount

The RO Model also qualifies as a MIPS APM.

Final CMS determinations of Advanced APMs and MIPS APMs for the 2021 performance period will be announced via the Quality Payment Program website at https://www.qpp.cms.gov

RO Model Initial Participant List Requirements

Professional participants and Dual participants will be the APM Entity.



*RO Participants must notify CMS within 30 days if they are adding or removing an individual practitioner who will be or ceases to be a Medicare-enrolled supplier that bills for RT services under a billing number assigned to the TIN of the RO Participant.

Additional Requirements

- CMS may, based on the results of our monitoring policy, deny an eligible clinician who is participating in the RO Model QP status if the eligible clinician or the eligible clinician's APM entity (that is, the respective RO participant) is non-compliant with RO Model requirements.
- Technical component payments under the RO Model will not be included in the aggregate payment amount for covered professional services that is used to calculate the amount of the APM Incentive Payment.
- MIPS adjustments are only applied to the Professional component payments of RO Model claims.

10. RECONCILIATION PROCESS

Annual Reconciliation

- An annual reconciliation will be conducted because incomplete episodes and duplicate RT services may result in additional payment owed to an RO participant or owed to CMS for RT services furnished to an RO beneficiary in those cases. Also, the AQS calculation may result in additional payment owed to an RO participant.
- A Professional participant or Dual participant will have their incorrect episode payment amount added to their quality reconciliation amount. The quality reconciliation amount is determined by multiplying the participant's AQS against the quality withhold. This process will apply to Technical participants starting in PY3.
- The initial annual reconciliation could occur as early as August the year following a PY.
- Each RO participant receives a reconciliation report that indicates the reconciliation payment amount they are due, or the repayment amount owed to CMS. RO participants have 45 days to submit a timely error notice to CMS if they believe there is an error in the reconciliation calculation.

Reconciliation Scenarios

Duplicate RT Service

- A duplicate RT service is any included RT service that is furnished to a single RO beneficiary by a RT provider or RT supplier that is not excluded from participation in the RO Model, and that did not initiate the PC or TC of the episode.
- An RT service furnished to a RO beneficiary by a RT provider or RT supplier not operating in an included CBSA, but not otherwise excluded from participation in the Model, is considered a duplicate RT service.

Incomplete Episodes

- An incomplete episode is one in which:
  - The Technical component is not initiated within 28 days following the Professional component
  - The RO beneficiary ceases to have traditional FFS Medicare prior to the date upon which a Technical component is initiated, even if that date is within 28 days following the Professional component.
  - A RO beneficiary switches RT provider or RT supplier before all RT services in the RO episode have been furnished.

True-Up Process

- CMS will conduct an annual true-up of reconciliation for each PY to calculate additional payments or repayments for incomplete episodes and duplicate RT services that are identified after claims run-out. The true-up does not include a quality reconciliation payment amount or a patient experience reconciliation amount.
- The timing will align the initial reconciliation of the upcoming year with the True-up of the prior year and will address the issue of delayed claims for RT services for beneficiaries that are in the middle of a radiation episode.

Model Performance Year	Initial Reconciliation	Reconciliation True Up
1/1/2021-12/31/2021 (PY1)	August 2022	August 2023
1/1/2022-12/31/2022 (PY2)	August 2023	August 2024
1/1/2023-12/31/2023 (PY3)	August 2024	August 2025
1/1/2024-12/31/204 (PY4)	August 2025	August 2026
1/1/2025-12/31/2025 (PY5)	August 2026	August 2027

Reconciliation and Beneficiary Coinsurance

- When a RO participant owes CMS money (reconciliation repayment) or CMS owes the RO participant money (reconciliation payment), neither the RO participant nor CMS shall collect coinsurance on these amounts.

11. PARTICIPATION REQUIREMENTS

General Participation Requirements

- Notify beneficiaries of participation in the RO Model
- Discuss with each RO beneficiary prior to treatment delivery his or her inclusion in, and cost-sharing responsibilities under, the RO Model
- Meet all applicable state and federal licensure and certification requirements
- Submit claims in accordance with RO Model billing instructions to receiving prospective episode-based payments for RO episodes in lieu of traditional Medicare FFS payments, and submitting no-pay claims.
- Implement all applicable participation requirements, including:
  - ✓ Clinical and quality data reporting
  - ✓ Care coordination requirements
  - ✓ Patient-centered care requirements
  - ✓ Use certified electronic health record technology (CEHRT)
  - ✓ Attest to active participation in an AHRQ-listed patient safety organization (PSO)

Participant-Specific Requirements

Professional Participants and Dual Participants

- Furnish care that is consistent with nationally recognized clinical treatment guidelines when appropriate
- Assess RO beneficiaries' tumor, node, and metastasis cancer stage
- Assess the RO beneficiaries' performance status as a quantitative measure determined by the physician
- Send a treatment summary to each model beneficiary's referrer within three months of the end of treatment
- Engage in peer review of treatment plans for 50% of all radiation therapy patients, to increase by 5% each performance year.

Technical Participants and Dual Participants

- Attest annually, at such times and in the form and manner specified by CMS, 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

12. MONITORING AND EVALUATION

RO Participant Monitoring

- RO participants will be monitored to ensure compliance with the participation requirements
- CMS will monitor RO participants using onsite and virtual site visits, audits of claims and services, and/or use of the Quality Improvement Organization to assess for quality issues, investigate allegations of patient harm, and monitor the impact of the RO Model quality metrics.
- Site visits may be used to understand how RO participants manage services, use evidence-based care, and practice patient-centered care.
- Lack of compliance will jeopardize an APM Incentive Payment.

RO Model Evaluation

- RO participants are required to cooperate with efforts to conduct an independent evaluation of the Model, which may include the following:
  - ✓Surveys
  - ✓Interviews
  - ✓Site visits
  - ✓Other activities needed to conduct a comprehensive evaluation
- An annual Evaluation Report will be publicly released for each year of the RO Model, providing an assessment on the RO Model's impact on quality, expenditures, utilization, RO beneficiary and RO participant experiences with RT service use and quality of care, and costs to RO beneficiaries and to Medicare.

13. RESOURCES

Acquiring Model ID Through the Help Desk

The Help Desk can be reached at 1-844-711-2664, option 5

- RO participants must first call the RO Model Help Desk to receive their Model ID number. **Be ready to provide your TIN or CCN number to receive your ID (Note that you may provide your CCN by email but you may never provide your TIN by email). You will also need to supply the first and last name of a primary contact and their email.**
- The Model ID number is critical; RO participants need it to log into the Radiation Oncology Administrative Portal (ROAP), the RO Model Secure Data Portal, and the Radiation Oncology Connect site.

Radiation Oncology Administrative Portal (ROAP)

The ROAP is an online platform that is used to:

- Track participant information through the participant profile page
- Access and review organizational data
- Update participant information and contacts
- Download and submit Data Request and Attestation (DRA) forms
- Access participant specific data, including Historical Experience and Case Mix adjustments, and Performance Reports.
- Attest to CEHRT, revise the IPL, and attest to PSO

https://app.innovation.cms.gov/ROAP

Accessing ROAP

- It is important that you access the ROAP to:
  - ✓ Add/update points of contact
  - ✓ Confirm the information in the participant list
  - ✓ Indicate if you will choose the low-volume opt-out option, if you are eligible
- To access the ROAP, navigate to the https://app.innovation.cms.gov/ROAP and select **"Register Here."**

TO REGISTER:

You will need to enter in:

- ✓ Model ID
- ✓ Taxpayer Identification Number (TIN) or CMS Certification Number (CCN)
- ✓ First name of POC
- ✓ Last name of POC
- ✓ Email address

RO Model Secure Data Portal

- The RO Model Secure Data Portal is the platform via which RO participants have the opportunity to receive different types of files from CMS, including beneficiary line-level claims data, episode-level data, and participant-level clinical and quality data.
- To request this data, RO participants will use a Participant Data Request and Attestation (DRA) form, which will be available on the Radiation Oncology Administrative Portal (ROAP).
- The RO Model Secure Data Portal is the vehicle through which RO participants will submit quality measures and clinical data elements.

https://portal.cms.gov

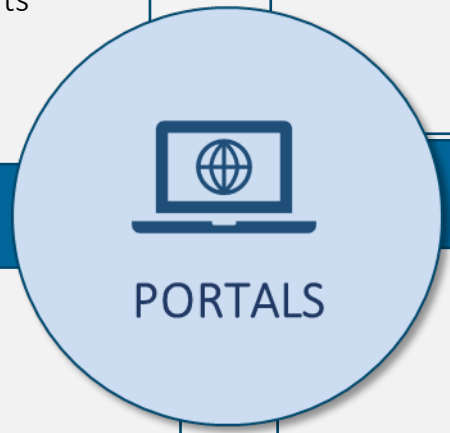
Portals Overview

Radiation Oncology Administrative Portal (ROAP)

- Track and update participant information and contacts through the participant profile page
- Download and submit Data Request and Attestation (DRA) forms
- Access participant specific data, including Historical Experience and Case Mix adjustments, and Performance Reports
- Submit RO Model Deliverables to CMS, such as the Individual Practitioner Lists, CEHRT and PSO Attestations

RO Model Secure Data Portal

- Use to receive different types of claims data from CMS by completing the DRA forms located on the ROAP; files include:
  - ✓ beneficiary line-level claims data
  - ✓ episode-level data
  - ✓ participant-level clinical and quality
- Submit QM and CDE data.



Radiation Oncology Connect Site

- Use for communicating with other RO participants, sharing documents, participating in online discussions, and receiving updates about RO Model activities, among other features
- Contains technical and operational resource documents important for program implementation, as well as audio-visual recordings and transcripts of RO Model learning events

CMS Enterprise Data Portal

- Use as an entry point for several CMS systems
  - ✓ One EID will be used for each RO Model-specific portal. ROAP and the RO Connect site have the same credentials as the data portal
  - ✓ Unique URLs for each portal
  - ✓ Must register for each portal

Resources

Radiation Oncology website: www.innovation.cms.gov/initiatives/radiation-oncology-model/

Available Now!

- ✓ RO Model Fact Sheet
- ✓ Participating ZIP Code List
- ✓ RO Beneficiary Letter
- ✓ RO Clinical Data Elements Informal Request for Information
- ✓ Frequently Asked Questions (FAQs)
- ✓ Regulations and Notices
  - ✓ Medicare Program Specialty Care Models to Improve Quality of Care and Reduce Expenditures Final Rule (2020)

Forthcoming…

Portals

- RO Model Secure Data Portal
- RO Connect Site

Payment Resources

- RO Included HCPCS Codes
- RO Trended National Base Rates

Educational Resources

- RO Model Billing Guide
- Quality Measure and Clinical Data Element Collection Guide

Webinars

- RO Model Billing Webinar

Help Desk

RO Model Help Desk

Model design and policy questions

RadiationTherapy@cms.hhs.gov

1-844-711-2664, option 5

QUESTIONS?


RO
MODEL
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