Radiation Oncology Model

Frequently Asked Questions (FAQs)

Version 5 (January 2022)

Disclaimer

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

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Contents

I. Acronyms

Abbreviation	Term
3DCRT	3-Dimensional Conformal Radiotherapy
ACO	Accountable Care Organization
AHRQ	Agency for Healthcare Research and Quality
APM	Alternative Payment Model
AQS	Aggregate Quality Score
ASC	Ambulatory Surgical Center
BFCC-QIO	Beneficiary and Family Centered Care-Quality Improvement Organization
BPCI	Bundled Payments for Care Improvement
CAH	Critical Access Hospital
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CBSA	Core Based Statistical Area
CCN	CMS Certification Number
CDE	Clinical Data Element
CEHRT	Certified Electronic Health Record Technology
CHART	Community Health Access and Rural Transformation
CHIP	Children's Health Insurance Program
CMMI	The Center for Medicare & Medicaid Innovation (the Innovation Center)
CMS	Centers for Medicare & Medicaid Services
CNS	Central Nervous System
CWF	Common Working File
CY	Calendar Year
DRA	Data Request and Attestation
EOE	End-of-Episode
EUC	Extreme and Uncontrollable Circumstance
FAQ	Frequently Asked Question
FFS	Fee-for-Service
HCPCS	Healthcare Common Procedure Coding System
HOPD	Hospital Outpatient Department
HRSA	Health Resources and Services Administration
ICD-10	International Classification of Diseases, Tenth Revision, Clinical Modification
IDM	CMS Identity Management
IPL	Individual Practitioner List
MAC	Medicare Administrative Contractor
MIPS	Merit-based Incentive Payment System
MLN	Medicare Learning Network
NPI	National Provider Identifier
OCM	Oncology Care Model

Abbreviation	Term
OMB	Office of Management and Budget
OPPS	Outpatient Prospective Payment System
PACE	Programs of All-Inclusive Care for the Elderly
PAMPA	Patient Access and Medicare Protection Act
PARHM	Pennsylvania Rural Health Model
PC	Professional Component
PFS	Medicare Physician Fee Schedule
PGP	Physician Group Practice
PHE	Public Health Emergency
PII	Personally Identifiable Information
POC	Point of Contact
PPS	Prospective Payment System
PSO	Patient Safety Organization
PY	Performance Year
QP	Qualifying APM participant
QPP	Quality Payment Program
RO	Radiation Oncology
ROAP	Radiation Oncology Administrative Portal
RT	Radiotherapy or Radiation Therapy
SBRT	Stereotactic Body Radiotherapy
SOE	Start-of-episode
SRS	Stereotactic Radiosurgery
TC	Technical Component
TIN	Tax Identification Number
TNM	Tumor, Node, and Metastasis

II. Frequently Asked Questions

The RO Model will regularly update these frequently asked questions (FAQs) as new questions come in through the Help Desk, webinars, and office hours. This version has been updated to reflect the finalized modifications in the calendar year (CY) 2022 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule with comment period (CMS-1753-FC), and the delayed start date of the RO Model under the Protecting Medicare and American Farmers from Sequester Cuts Act (P.L. 117-71) enacted on December 10, 2021.

The Center for Medicare & Medicaid Services Innovation (the Innovation Center)

1. What statute authorizes CMS to develop and test the RO Model?

Section 1115A of the Social Security Act (the Act) authorizes the Innovation Center to test innovative payment and service delivery models expected to reduce Medicare, Medicaid, and Children's Health Insurance Program (CHIP) expenditures while preserving or enhancing the quality of care furnished for beneficiaries of such programs. The Innovation Center designed the RO Model as a patient-centric model for Medicare fee-for-service beneficiaries receiving RT services for cancer care.

RO Model Start Date

2. [NEW] Has the start date for the RO Model been delayed?

Yes, the start date for the RO Model has been delayed.

The Protecting Medicare and American Farmers from Sequester Cuts Act (P.L. 117-71) enacted on December 10, 2021 includes a provision that prohibits implementation of the RO Model prior to January 1, 2023. Thus, the RO Model did not begin on January 1, 2022. More information about the implications of the delay will be forthcoming.

RO Model Overview

3. What is the goal of the RO Model?

The RO Model will test whether prospective, episode-based payments to physician group practices, including freestanding radiation therapy centers, and hospital outpatient departments, for RT episodes of care will reduce Medicare program expenditures and preserve or enhance quality of care for Medicare beneficiaries.

4. How will the RO Model support the goals of reducing Medicare expenditures?

The RO Model will advance CMS' goal of increasingly paying for value and outcomes, rather than for volume of services alone. By promoting the alignment of financial and other incentives for RT providers and RT suppliers caring for beneficiaries receiving RT services for cancer, the Model will offer RO participants the opportunity to examine and better understand their own care processes and patterns, which we believe may lead to significant opportunities to redesign care and improve the quality of care furnished to beneficiaries.

5. How will the RO Model help beneficiaries?

The RO Model incentivizes the delivery of higher-value RT care, allowing physicians to select the type and amount of radiation treatment that offer patients the best value in terms of cost and quality. By eliminating financial incentives to provide extended fractionation treatment schedules in the current payment systems, participants in the RO Model have the flexibility to provide fewer fractions of radiation when clinically appropriate. Beneficiaries will benefit from receiving high quality treatment in fewer encounters, improved quality of life during RT treatment, and reductions in cost-sharing. The shorter courses of RT will be equally effective and potentially less costly for the Medicare program, improving the overall patient experience. Finally, the RO Model aims to support clinical practice transformation, reduce administrative burden through a simplified and predictable payment system that moves Medicare toward site-neutrality, and improve beneficiary experience by rewarding high-quality, patient-centered care.

6. What are the defining elements of the RO Model?

The RO Model's design offers site-neutral, prospective, modality-agnostic, episode-based payments to physician group practices, hospital outpatient departments, and freestanding radiation therapy centers for the 15 included cancer types. These episode-based payments will replace fee-for-service payments for certain RT services included in a 90-day episode. The RO Model will be evaluated to determine if a prospective episode-based payment model can improve the quality of care cancer patients receive and improve patient experience by rewarding high quality care that results in better outcomes. Another defining element of the RO Model is that it is mandatory, so all eligible participants furnishing RT services in a randomly selected Core-Based Statistical Area will be required to participate.

7. How does the RO Model define an episode?

The RO Model distinguishes between an "RO episode" and an "episode."

An "RO episode" is defined as the 90-day period that begins on the date of service that a Professional participant or a Dual participant furnishes an initial treatment planning service to an RO beneficiary in a freestanding radiation therapy center or a hospital outpatient department, provided that a Technical participant or the same Dual participant furnishes a technical component (TC) of RT services to the RO beneficiary within 28 days of such RT treatment planning service. An "RO episode" requires that RT services be furnished by an RO participant to an RO beneficiary, and always occurs during the model performance period.

In contrast, an "episode" is defined as the 90-day period of RT services that begins on the date of service that an RT provider or RT supplier that is not an RO participant furnishes an initial treatment planning service to a beneficiary, provided that an RT provider or RT supplier furnishes a TC RT service to the beneficiary within 28 days of such initial treatment planning service. For example, an "episode" could result if the initial treatment planning service defining the start of an "episode" occurred prior to the start of the model performance period. An "episode" could also result because the RT provider or RT supplier did not furnish RT services in a Core-Based Statistical Area selected for participation in the RO Model. Episodes determine an RO participant's historical experience adjustment(s) for the model performance period and, like "RO episodes," "episodes" can determine the case mix adjustment(s) and low volume opt-out eligibility, depending on the performance year and the period used to determine that adjustment or eligibility.

8. Who participates in the RO Model?

The RO Model requires participation from RT providers and RT suppliers that furnish RT services 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 RT episodes nationally. An RO participant can be a physician group practice, a freestanding radiation therapy center, or a hospital outpatient department that furnishes RT services in a CBSA that is randomly selected for participation. A ZIP Code look-up tool, which provides all five-digit ZIP Codes linked to these selected CBSAs, is available on the RO Model website (https://innovation.cms.gov/initiatives/radiation-oncology-model/).

All RO participants are designated as one of the following:

- Professional participant: one that furnishes only the professional component (PC) of RT services, such as the treatment planning and management services.
- Technical participant: one that furnishes only the technical component (TC) of RT services, such as providing external beam therapy.
- Dual participant: one that furnishes both the PC and TC of RT services.

9. What is the difference between a Professional participant, Technical participant, and Dual participant?

A Professional participant is a Medicare-enrolled physician group practice (PGP), identified by a single TIN that furnishes only the professional component (PC) of RT services at either a freestanding radiation therapy center or a hospital outpatient department (HOPD).

A Technical participant is a HOPD or freestanding radiation therapy center, identified by a CCN or TIN, which furnishes only the technical component (TC) of RT services.

A Dual participant furnishes both the PC and TC of an RO episode for RT services through a freestanding radiation therapy center, identified by a single TIN. This distinction between the PC and the TC of RT services reflects the fact that these services are sometimes furnished by separate RT providers and RT suppliers and paid for through different payment systems (namely, the Medicare Physician Fee Schedule and Outpatient Prospective Payment System).

For example, a Medicare beneficiary needs RT services for breast cancer, an included cancer type. The Professional participant is the PGP that furnishes services in a participating ZIP Code and bills for the treatment planning and management services. Generally, the Technical participant furnishes the treatment delivery services (e.g., the external beam therapy) to treat the cancer, at a HOPD. If both the PC and TC are furnished and billed under the same TIN, then the RO participant is a Dual participant.

10. How do I know if my organization is a Dual participant or a Professional participant and a Technical participant?

RO participation is determined at the TIN or CCN level.

If your organization furnishes both the professional component (PC) and technical component (TC) of an RO episode through a freestanding radiation therapy center, identified by a single TIN, your organization will be a Dual participant with a single RO Model ID.

If your organization furnishes only the PC of an RO episode through a physician group practice (PGP), identified by a TIN, that PGP will be a Professional participant with a single RO Model ID. PGPs, identified by a TIN, that furnish only the TC through hospital outpatient departments, identified by a CCN, are Technical participants each with unique RO Model IDs. If your organization furnishes included RT services in any or all of these ways, each unique TIN and each unique CCN will be considered a separate RO participant.

For more information on types of RO participant see FAQ "What is the difference between a Professional participant, Technical participant, and Dual participant?"

11. A hospital outpatient department (HOPD) has a business relationship with a physician group practice (PGP). What type of participant is this?

HOPDs bill under a CCN and are always Technical participants. PGPs that bill under a TIN can be any of the three types of RO participants. A PGP that does not have RT machines and only furnishes and bills for the professional component (PC) would always be a Professional participant. Freestanding radiation therapy centers are PGPs that have the machines used to furnish radiotherapy services. Freestanding radiation therapy centers are Dual participants when they furnish and bill both the PC and technical component (TC) for an RO episode. A freestanding radiation therapy center that furnishes and bills only the TC of an RO episode, meaning they bill for the use of RT machines to furnish included RT services, would be a Technical participant. In the case where a physician affiliated with a freestanding radiation therapy center furnishes and bills the PC for an RO episode under the freestanding radiation therapy center's TIN, while a HOPD furnishes and bills for the TC, that freestanding radiation therapy center would be a Professional participant for that RO episode.

12. Why is participation required under the RO Model?

Through discussions with RT experts, evaluation experts, and actuaries, CMS determined that required participation is the best approach to test the episodic payment effectively by ensuring sufficient proportional participation of both hospital outpatient departments and freestanding radiation therapy centers, which is necessary to obtain a diverse, representative sample of RT providers and RT suppliers and to support a statistically robust test of the prospective episode payments made under the RO Model. Testing the RO Model in this manner also allows CMS to learn more about patterns of utilization of health care services and how to incentivize the improvement of quality for RT services. For these reasons, required participation is the best way to detect and observe the impact of the prospective episode-based payments made under the RO Model.

13. In which facilities will the RO Model be implemented?

The RO Model will be implemented in physician group practices (PGPs), hospital outpatient departments (HOPDs), and freestanding radiation therapy centers that furnish RT services in Core-Based Statistical Areas (CBSAs) randomly selected for participation. A ZIP Code look-up tool, which provides all five-digit ZIP Codes linked to the selected CBSAs, is available on the RO Model website (https://innovation.cms.gov/initiatives/radiation-oncology-model/). The RO Model will be implemented in PGPs, HOPDs, and freestanding radiation therapy centers furnishing RT services in one or more of those ZIP Codes. CMS learned through its engagement with RT stakeholders that there is strong support for site-neutral payment system for RT. Because RT services do not differ

based on the site of service, the RO Model creates an opportunity to test a new site neutral payment structure that is both logically sound and supported by the industry.

14. [REVISED] When does the RO Model start and end?

The start date for the RO Model has been delayed.

The Protecting Medicare and American Farmers from Sequester Cuts Act (P.L. 117-71) enacted on December 10, 2021 includes a provision that prohibits implementation of the RO Model prior to January 1, 2023. Thus, the RO Model did not begin on January 1, 2022.

More information about the implications of the delay will be forthcoming.

15. [REVISED] What are the major requirement deadlines for an RO participant throughout a performance year (PY)?

- RO participants who are eligible for the RO Model but meet the low volume opt-out policy requirements must notify CMS of their decision to opt-out before the start of the PY. This can be done on the Radiation Oncology Administrative Portal (ROAP). This must be done every PY that a participant is eligible. To make an informed decision, we encourage all RO participants that are eligible for the low volume opt-out option to review their case mix and historical experience adjustments when they are available before opting out of the RO Model for the upcoming PY.
- Professional participants and Dual participants must attest that they are using CEHRT within 30 days of the start of the PY, that is, between December 1 and January 31 .
- Professional participants, Dual participants, and Technical participants that are freestanding radiation therapy centers must review and certify the Individual Practitioner List (IPL) by the last QP determination snapshot date. This will occur in early fall. RO participants will be able to review their IPLs, and add or drop NPIs from the IPLs, in ROAP anytime.
- Dual participants and Technical participants must actively participate with a patient safety organization (PSO) and attest to participation on ROAP before the end of each PY.

16. The Specialty Care Models Technical Correction Notice (CMS–5527–CN) cited a calculation error regarding the distribution of payment changes to physician group practices (PGPs) and hospital outpatient departments (HOPDs). What does this mean? How has it changed in the CY 2022 OPPS/ASC Payment System final rule with comment period (CMS-1753-FC)?

In the Specialty Care Models final rule (85 FR 61114), as well as in the Notice of Proposed Rulemaking (NPRM) (84 FR 34478), the Regulatory Impact Analysis for the RO Model included a calculation error regarding the distribution of payment changes for both physician group practices (PGPs) and hospital outpatient departments (HOPDs). The calculation was revised in the technical correction notice (CMS-5527-CN) to properly value this effect, and this revised calculation was included in the calendar year (CY) 2021 OPPS/ASC Payment Program final rule with comment period (CMS-1736-IFC).

An updated estimate regarding the distribution of payment changes for both PGPs and HOPDs is included in the CY 2022 OPPS/ASC Payment System final rule with comment period (CMS-1753-FC). See table below that includes the expected impacts by year. The impact for HOPDs and PGPs has to do with a combination of the RO discount combined with the RO trend factor, which blends

changes in Outpatient Prospective Payment System (OPPS) and Medicare Physician Fee Schedule (MPFS) payment rates. Given that PFS rates are not expected to increase over time, whereas the OPPS rates are, blending these together leads to an average increase expected for PGPs and an average decrease for HOPDs (because HOPDs that are RO participants will not get the full OPPS rate increase but rather a trend that blends OPPS with MPFS).

RO Model PGP vs HOPD Allowed Charge Impacts 2022-2026

% Impact	2022	2023	2024	2025	2026	2022 to 2026
PGP	13.1%	4.5%	6.0%	7.4%	8.9%	6.3%
HOPD	-7.8%	-8.8%	-9.6%	-10.6%	-11.6%	-9.9%

Finalized Modifications to the RO Model in the CY 2022 OPPS/ASC final rule with comment period

17. [REVISED] What provisions were included in the CY 2022 OPPS/ASC final rule with comment period?

The Protecting Medicare and American Farmers from Sequester Cuts Act (P.L. 117-71) enacted on December 10, 2021, includes a provision that prohibits implementation of the RO Model prior to January 1, 2023. Thus, the RO Model did not begin on January 1, 2022. More information about the implications of the delay will be forthcoming.

In the CY 2022 OPPS/ASC final rule with comment period (CMS-1753-FC):

- We finalized a start date of January 1, 2022, with a 5-year model performance period that ends December 31, 2026.
- We removed liver cancer from the included cancer types and made revisions to the inclusion criteria for included cancer types.
- We removed brachytherapy from the list of included modalities.
- We finalized 2017-2019 to be the baseline period.
- We finalized the discount for the professional component at 3.5 percent and the discount factor for the technical component at 4.5 percent.
- We finalized that in cases where a beneficiary switches from traditional Medicare to Medicare Advantage during an episode, before treatment is complete, we will consider this an incomplete episode and RT services will be paid traditional Medicare fee-for-service rates as opposed to the bundled payment.
- We finalized changes to our Pennsylvania Rural Health Model (PARHM) exclusion so that only those participating in the PARHM are excluded from the RO Model, not just those eligible for the PARHM. We also finalized that hospitals that were participating in PARHM, but leave, will join the RO Model at the next calendar year quarter they are eligible. Hospitals that were not participating in PARHM, but join PARHM, will be excluded from participation in the RO Model at the next calendar year quarter.

- To better align the RO Model with QPP, and in response to comments, we created three categories for RO participants, "Track One," Track Two," and "Track Three." Track One will include Professional participants and Dual participants who meet all RO Model requirements, including CEHRT use. We expect that Track One will qualify as an Advanced APM and MIPS APM. Track Two will include Professional participants and Dual participants who meet all RO Model requirements, except for the CEHRT requirement. We expect that Track Two will qualify as a MIPS APM only. Track Three will include all other RO participants, specifically Professional participants and Dual participants, who fail to meet the RO Model requirements including CEHRT, and Technical participants. Track Three will not be an Advanced APM or MIPS APM.
- We finalized that hospitals that are participating in the community track of the Community Health Access and Rural Transformation (CHART) Model are excluded from the RO Model once the CHART community track model performance period begins.
- We finalized an Extreme and Uncontrollable Circumstances policy. This policy gives the CMS the ability to waive certain RO Model requirements in the event of extreme circumstances, such as weather.

18. [REVISED] Is CMS invoking the Extreme and Uncontrollable Circumstances (EUC) policy for performance year 1?

CMS previously announced that it intended to invoke the EUC based on the ongoing COVID-19 public health emergency. However, The Protecting Medicare and American Farmers from Sequester Cuts Act (P.L. 117-71) enacted on December 10, 2021, includes a provision that prohibits implementation of the RO Model prior to January 1, 2023. Thus, the RO Model did not begin on January 1, 2022.

Due to this delay, CMS did not invoke the EUC policy on January 1, 2022. More information about the implications of the delay will be forthcoming.

RO Model Operational Support

19. [REVISED] What do I do if I furnish RT services in a participating ZIP Code?

RO participants must first call or email the RO Model Help Desk to receive their RO Model ID. The Help Desk can be reached at 1-844-711-2664, option 5 and the email is RadiationTherapy@cms.hhs.gov. Participants must provide their 9-digit TIN if they are a physician group practice or freestanding radiation therapy center, or their six-digit CCN if they are a hospital outpatient department to be able to retrieve their RO Model ID from the Help Desk. It must be the TIN that the entity bills Medicare under. Please note that participants may provide their CCN by email, but participants must not communicate TINs via email as this is considered Personally Identifiable Information.

Participants will also need to supply the first name, last name, and email address of a Primary Point of Contact. For security purposes, we need to preload this information into each RO Model-specific data portal. To register for any of these portals, RO participants will need to use this same information (name and email) along with their RO Model ID and CCN or TIN.

The RO Model ID is critical; it is what will give RO participants the ability to log into the Radiation Oncology Administrative Portal (ROAP), the RO Model Secure Data Portal, and RO Connect. If an RO participant does not ascertain their RO Model ID, by default they will not be able to meet certain RO Model requirements or submit quality measure and clinical data elements, which will then not allow participants the opportunity to earn back a portion of the quality and patient experience withholds.

Please review the RO Model Portal Overview on the RO Model website for assistance with this process (https://innovation.cms.gov/innovation-models/radiation-oncology-model).

The Protecting Medicare and American Farmers from Sequester Cuts Act (P.L. 117-71) enacted on December 10, 2021, includes a provision that prohibits implementation of the RO Model prior to January 1, 2023. Regardless of this delay, we encourage participants to attain their RO Model ID and log on to ROAP as soon as possible.

20. What is the Radiation Oncology Administrative Portal (ROAP)?

Radiation Oncology Administrative Portal (ROAP) is an online platform that CMS uses to track participant information through the participant profile page. For RO participants, ROAP provides access to the following functions:

- Access and review organizational data;
- Access participant specific data, including historical experience and case mix adjustments, and Performance Reports;
- Update participant information and contacts;
- Download and submit Data Request and Attestation forms;
- Attest to the use of CEHRT and to participating with a Patient Safety Organization; and
- Revise the Individual Practitioner Lists; and
- Notify CMS of the RO participant's intention to opt out of the upcoming performance year, if they qualify.

21. How do RO participants access the Radiation Oncology Administrative Portal (ROAP)?

To access the Radiation Oncology Administrative Portal, you first need your RO Model ID. Once you have acquired your RO Model ID, navigate to the login page (https://app.innovation.cms.gov/ROAP/IDMLogin?startURL=%2FROAP), and select "New User Registration." You will be prompted to either create a CMS Identity Management (IDM) account username and password or log-in to your existing IDM account. If you have registered for other CMMI Models, such as the Oncology Care Model, you might already have an IDM account.

22. I received an email from CMS asking for personal information, such as my social security number. Is this a legitimate request?

The CMS Enterprise Portal (which includes the Radiation Oncology Administrative Portal and the RO Model Secure Data Portal) collects your personal information, described as data that is unique to you as an individual, such as name, address, telephone number, Social Security Number, and date of birth. The CMS Enterprise Portal uses this personal information only to verify your identity. Your information will be sent to Experian, an external identity verification provider, to help us

confirm your identity. If collected, CMS will validate your Social Security Number with Experian only for the purpose of verifying your identity. Experian verifies the information you give us against their records and may present you with questions based on your credit profile, called out-of-wallet questions. The out-of-wallet questions and answers, including financial history, are strictly between you and the RIDP service Experian; neither the CMS Enterprise Portal will store them. Experian is required by law to securely maintain this data for seven years. For more information regarding how CMS uses the information you provide, please read the CMS Privacy Act Statement.

This process is called Remote Identity Proofing (RIDP) which is the process that is used to confirm a person's identity. Most users will be required to complete RIDP as part of the process of being approved for a RO Model-specific role. RIDP is also called Identity Verification. Users may have three opportunities to verify their identity. Verification occurs in the following order:

- Online Proofing - An identity verification procedure that uses Experian's computer-based Identity Verification service.
- Phone Proofing - An identity proofing procedure that uses Experian's telephone-based Identity Verification service. Phone proofing is only available if the user is unable to verify their identity using online proofing.
- Manual Proofing - An identity proofing procedure that is performed by an Application (Tier 1) Help Desk in accordance with their policies. Manual proofing is not offered by every application and is only available if the user is unable to first verify their identity through online proofing and phone proofing.

Please refer to this list of FAQs (https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETSHPGRIDPMFAFAQ.pdf) that should further help you understand this process.

23. When you are logged into ROAP, the RO Model ID selection page will list all the RO Model IDs that are associated with your registered email. What do I do if I need help with the Radiation Oncology Administrative Portal (ROAP)?

For further instructions on logging in to ROAP, please find the ROAP User Manual on the RO Model website (https://innovation.cms.gov/innovation-models/radiation-oncology-model).

Help Desk Support: If you have issues logging onto ROAP, please contact CMMIForceSupport@cms.hhs.gov or call 1-888-734-6422, option 5.

If you would like to be added as a Point of Contact to your organization's RO Model ID, email the Help Desk with your RO Model ID, your name, and email address and let them know you would like to be added as a Point of Contact. You can contact the RO Model Help Desk by phone: 1-844-711-2664, Option 5 or email RadiationTherapy@cms.hhs.gov. You may also ask the Primary Point of Contact at your organization to add you as a Point of Contact.

24. What is the difference between Primary, Secondary, and Legal Point of Contacts?

Primary Point of Contact (PPOC): A PPOC is necessary to register for the Radiation Oncology Administrative Portal (ROAP) the first time. Please call the Help Desk (1-844-711-2664, Option 5; RadiationTherapy@cms.hhs.gov) with the PPOC's name and email if you do not have your RO

Model ID(s). To register for ROAP, you will need to use this same information along with your RO Model ID and TIN or CCN. Once you access ROAP, a PPOC can:

- Add, delete, or edit contact information including contact type and phone number for other Primary Contacts, and for Legal and Secondary Contacts. Please note, you are not able to edit the contact's first name, last name, or email after this contact had been registered in ROAP. Please contact the Help Desk (1-844-711-2664, Option 5; RadiationTherapy@cms.hhs.gov) if you need to edit this information;
- Edit profile information (not able to edit Legal Name, RO Model ID, and CCN or TIN);
- Add or drop practitioners on the Individual Practitioner List (IPL);
- Add a sanction;
- Answer the optional administrative questions; and
- Add organizational changes.

Legal Point of Contact (LPOC): Every RO Model ID must have at least one LPOC in ROAP. A LPOC is the person granted authority by the organization to make attestations and change the organization's legal name in ROAP. They should be an individual with the authority to legally bind the RO participant. A LPOC can:

- Add, delete, or edit contact information including contact type and phone number for other Legal Contacts, and for Primary and Secondary Contacts. Please note you are not able to edit the contact's first name, last name, or email after this contact had been registered in ROAP. Please contact the Help Desk if you need to edit this information;
- Edit profile information, including Legal Name (Not able to edit RO Model ID, CCN or TIN);
- Download the Data Request and Attestation (DRA) template and upload the completed DRA form;
- Attest to the use of CEHRT during the specified period;
- Add or drop practitioners on the IPL;
- Attest to the accuracy of the IPL during the specified period;
- Attest to active participation in a Patient Safety Organization during the specified period;
- Upload a Corrective Action Plan;
- Add a sanction;
- Answer the optional administrative questions;
- Choose to opt out of the RO Model if the participant is eligible for the low volume opt-out;
- Add organizational changes; and
- Inform CMS of RO beneficiaries who choose to opt out of sharing their data with CMS.

A Secondary Point of Contact can:

- View information in ROAP for their RO Model ID, but they cannot edit information.

All contacts can:

- Download performance, compliance, and reconciliation reports; and
- Download the case mix and historical experience adjustments.

Please Note: To register for ROAP, every RO Model ID must have a PPOC. Within ROAP, every RO Model ID must also have a LPOC to complete certain tasks, like upload the DRA form, make attestations, and select the low volume opt-out if eligible. If there is only one person at your organization that will be accessing ROAP, you can toggle between being a PPOC and LPOC.

25. Can I have more than one Primary, Secondary, or Legal Point of Contact?

You can add up to 15 contacts per RO Model ID, specifically:

- Up to five Primary Points of Contact (PPOC)
- Up to five Legal Points of Contact (LPOC)
- Up to five Secondary Points of Contact

PPOCs and LPOCs can add additional primary, legal and secondary contacts for their RO Model ID(s). Once a new contact has been added, they will need to register for ROAP as described in the FAQ "How do RO participants access the Radiation Oncology Administrative Portal (ROAP)?"

26. What do I do if I only have one person who will handle the portals for my RO Model ID?

If you are an RO participant who only has one point of contact for your RO Model ID, you will be added as a Primary Point of Contact when you first register for Radiation Oncology Administrative Portal (ROAP). If there is no one else in your practice who can serve as the Legal Point of Contact (LPOC), you can also identify yourself as the LPOC in ROAP. Please note the LPOC is whoever your organization grants authority to make attestations or change your legal name. Navigate to the Contacts section within the Profile tab and click on your name. Change your contact type from "Primary Contact" to "Legal Contact." If you are having any issues with this change, please contact CMMIForceSupport@cms.hhs.gov or call 1-888-734-6433, option 5.

27. What do I do if my organizational information, such as business name, is incorrect in the Radiation Oncology Administrative Portal (ROAP)?

Primary Points of Contact (PPOC) and Legal Points of Contact (LPOC) can update organizational information in ROAP. Both PPOC and LPOC can update the Doing Business As Name. Only LPOCs can update the Legal Name. Secondary Contacts cannot update any information.

The RO Model Team preloaded information into ROAP from PECOS, including the Organization Legal Name. In addition to updating organizational information in ROAP, we encourage each RO participant to update their PECOS profile to ensure it is accurate.

See FAQ "What is the difference between Primary, Secondary, and Legal Contacts?" for more information about the functionalities available to each contact type in ROAP.

28. [REVISED] What is the Data Request and Attestation (DRA) form?

RO participants request to receive different types of data, that is beneficiary line-level claims data, episode-level data, and participant-level data, by completing the Data Request and Attestation (DRA) form and submitting it via the Radiation Oncology Administrative Portal (ROAP). The

specific data fields that will be included in each of these types of data are described in detail in a document entitled "Data Dictionary for Participant-Specific Data – Data Request and Attestation (DRA)" located on the RO Model website (https://innovation.cms.gov/innovation-models/radiation-oncology-model). Once the DRA form has been completed and submitted by the RO participant, CMS must approve the form. Then, the RO participant will receive that data through the RO Model Secure Data Portal.

Due to the delay in the RO Model, Data Request and Attestation (DRA) forms are not being processed at this time and the DRA form has been removed from ROAP. More information about the implications of the delay will be forthcoming.

29. What is the RO Model Secure Data Portal?

RO participants who request beneficiary line-level claims data, episode-level data, and participant-level data will receive that data through the RO Model Secure Data Portal once a completed Data Request and Attestation (DRA) form is submitted via the Radiation Oncology Administrative Portal (ROAP) and approved by CMS. The updated DRA is now available on ROAP.

Throughout the model performance period, RO participants may request to continue to receive this data until the initial reconciliation and true-up reconciliation have been completed if they continue to use such data for care coordination and quality improvement purposes. At the conclusion of this process, the RO participant would be required to maintain or destroy all data in its possession in accordance with the DRA and applicable law.

RO participants also will use the RO Model Secure Data Portal to submit Clinical Data Element (CDE) files and quality measure data. Guidance for submitting quality measure and CDE data, including the process for uploading files, submission deadlines, and data validation, can be found in the RO Model Quality Measure and Clinical Data Element Collection and Submission Guide on the RO Model website (https://innovation.cms.gov/innovation-models/radiation-oncology-model).

To get started with the RO Model Secure Data Portal, see the RO Model Portal Overview on the RO Model website (https://innovation.cms.gov/innovation-models/radiation-oncology-model). For specific questions on how to use the RO Model Secure Data Portal, see the RO Model Secure Data Portal User Manual on the RO Model website (https://innovation.cms.gov/innovation-models/radiation-oncology-model).

30. [REVISED] Do the points of contact for the Radiation Oncology Administrative Portal (ROAP) and the RO Model Secure Data Portal need to be the same?

There are three types of points of contact in ROAP: Primary Point of Contact (PPOC), Legal Point of Contact (LPOC), and Secondary Point of Contact (SPOC). You may have five of each type of contact, for a total of 15 contacts. Only the LPOC can upload a completed Data Request and Attestation (DRA) form and make attestations.

There are two roles that you may request in the RO Model Secure Data Portal: RO Model Participant and Data Requestor.

The RO Model Participant role will be able to download and upload clinical and quality data. All persons requesting one of these roles must also be listed as a point of contact in ROAP, but it does not matter what type of contact (PPOC, LPOC, SPOC).

The Data Requestor Role should be the person listed on the DRA form as the data custodian and must be a Point of Contact in ROAP. Only the Data Requestor role can download claims data from the RO Model Secure Data Portal. Please refer to the RO Model Secure Data Portal User Manual on the RO Model website (https://innovation.cms.gov/innovation-models/radiation-oncology-model).

31. What is RO Connect?

The RO Connect site is a collaborative resource site for the RO Model. The goal of this online learning community is to encourage peer-to-peer learning, collaboration and sharing of knowledge among RO participants.

RO participants and the RO Model team use this site for sharing documents, participating in online discussions, and receiving updates about RO Model activities, among other features. The RO Connect Library contains technical and operational resource documents important for program implementation, as well as audio-visual recordings and transcripts of RO Model learning events. A link to register for RO Connect is available in the Helpful Links section of the Radiation Oncology Administrative Portal (ROAP). Please click that link and self-register for the RO Connect.

Please note, technical issues and policy questions directed to the RO Model Team (not to other RO participants) should be sent to the RO Model Help Desk at RadiationTherapy@cms.hhs.gov.

32. How do I access RO Connect and who do I contact if I need assistance gaining access to RO Connect?

A link to register for RO Connect is found in the Radiation Oncology Administrative Portal (ROAP). Navigate to the Helpful Links section on the right-hand side of the home page and click on "RO Connect." If you are an existing Connect user, please click on "Existing User Verification", and follow the prompts to complete the registration process. If you are a new Connect user, please click on "New User Registration" to start the registration process. Select "RO Connect" in the dropdown and fill in your contact information. Your information (name and email address) must match what is in ROAP to be granted access to RO Connect.

If you need help registering for RO Connect, please contact the Help Desk by calling 1-844-711-2664, Option 5 or emailing RadiationTherapy@cms.hhs.gov. If you have other technical questions, please email CMMIForceSupport@cms.hhs.gov.

33. [REVISED] How do I subscribe to email updates about the RO Model? How do I unsubscribe?

If you are affiliated with an RO participant and are interested in receiving RO Model email updates, such as RO Model newsletters and webinar invitations, you should be added as a point of contact in the Radiation Oncology Administrative Portal (ROAP) for your organization. Primary Points of Contact (PPOC) and Legal Points of Contacts (LPOC) in ROAP can add additional PPOCs, Secondary Points of Contact, and LPOCs.

If you are not affiliated with an RO participant and would like to receive RO Model email updates, please contact the RO Model Help Desk with your request. The Help Desk can be reached at RadiationTherapy@cms.hhs.gov or by calling 1-844-711-2664, option 5.

If you no longer wish to receive updates about the RO Model and are affiliated with an RO participant, you will need to be removed as a contact in ROAP. PPOCs and LPOCs can remove

existing contacts. You cannot remove yourself as a contact. If you are a PPOC or LPOC for your organization, you must find someone to replace you and PPOC or LPOC before you can be removed.

If you no longer wish to receive updates about the RO Model and are not affiliated with an RO participant, please contact the RO Model Help Desk with your request. The Help Desk can be reached at RadiationTherapy@cms.hhs.gov or by calling 1-844-711-2664, option 5.

See FAQs "How do RO participants access the Radiation Oncology Administrative Portal (ROAP)?" and "Can I have more than one primary, secondary, or legal contact?" for more information.

RT Provider and RT Supplier Eligibility in the RO Model

34. In which geographic areas will CMS operate the RO Model?

The RO Model will operate in defined, randomly selected, stratified Core-Based Statistical Areas (CBSAs). 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 (i.e., urbanized area or urban cluster), plus adjacent counties having a high degree of social and economic integration with the core (as measured through commuting ties with the counties containing the core). CBSAs are large enough to capture relevant markets and referral patterns in a geographic area. CBSAs capture the diversity of RT providers and RT suppliers that may be affected by the RO Model without including rural RT providers and RT suppliers as designated by CMS and Health Resources and Services Administration (HRSA). There are very few RT providers and RT suppliers in these areas such that, if included, the areas would likely not have enough RO beneficiaries, and thus not generate enough RO episodes, for inclusion in the statistical analysis.

35. How do I know if I am required to participate in the RO Model?

A ZIP Code look-up tool on the RO Model website (https://innovation.cms.gov/initiatives/radiation-oncology-model/) provides all five-digit ZIP Codes linked to the selected Core-Based Statistical Areas (CBSAs). Any Medicare-enrolled physician group practice (PGP), freestanding radiation therapy center, or hospital outpatient department (HOPD) that furnishes included RT services in any of those ZIP Codes, and do not meet any exclusion criteria (§ 512.210(b)) or qualify for the low volume opt-out (§ 512.210(c)) set forth in the CY 2022 OPPS/ASC Payment System final rule with comment period (CMS-1753-FC), will be required to participate in the RO Model.

36. What anchors an episode to a ZIP Code to determine if the episode is included in (i.e., paid for under) the RO Model?

Both the professional component (PC) and the technical component (TC) of the RT services must be furnished within an included ZIP Code for the RO episode to be counted in the RO Model. In other words, the address of the service location where the PC and TC are furnished must be in an included ZIP Code as opposed to the billing address.

37. What happens if my practice has multiple locations, some in an included ZIP Code and some in an excluded ZIP Code?

If your practice has multiple locations that bill under the same TIN, only those with site of service addresses in a participating ZIP Code will be RO participants. Having one participating ZIP Code does not automatically mean all locations are in the RO Model. The billing address also does not determine participation.

In other words, if your organization furnishes RT services in various locations, only those furnishing included RT services within participating ZIP Codes are RO participants. However, historical experience and case mix adjustments are calculated from all your locations that furnish RT services under one TIN.

38. We are a hospital outpatient department (HOPD) located in a Core-Based Statistical Area (CBSA) selected for participation in the RO Model. The physician group practice (PGP) that furnishes the professional component is *not* located in a CBSA selected for participation in the RO Model. How are these two entities treated under the RO Model?

Participation is determined by where included RT services are furnished, not by the physical address or billing address of the RT provider or RT supplier. The claims systems will look at the ZIP Code associated with the service location.

In this scenario, the HOPD furnishing the technical component (TC) would be a Technical participant.

The PGP furnishing the professional component (PC) would be a Professional participant if it furnishes services in a participating ZIP Code. So, if the PGP furnished the PC at the HOPD in a participating ZIP Code, that PGP is furnishing services in a participating ZIP Code, and thus is an RO participant. The PGP would bill RO Model-specific HCPCS codes for the included professional services furnished during RO episodes in the HOPD. If the PGP does furnish services in a participating ZIP Code, they may be eligible for Advanced APM incentive payments if they meet the QP thresholds and are compliant with RO Model requirements.

If the PGP also furnished services at a location in an excluded ZIP Code, the PGP would bill fee-for-service for all RT services furnished in non-participating ZIP Codes.

39. Why is my ZIP Code included for participation in the RO Model when my practice furnishes RT services in a rural community?

The use of Core-Based Statistical Areas (CBSAs) and their corresponding ZIP Codes is intended to capture the diversity of RT providers and RT suppliers that may be affected by the RO Model. The RO Model was not designed to exclude rural RT providers and RT suppliers. Generally, CBSAs and their corresponding ZIP Codes do not include extreme rural regions, but they do contain rural RT providers and RT suppliers as designated by CMS and Health Resources and Services Administration and U.S. Department of Agriculture Rural-Urban Commuting Area Codes. In cases where RO participants are furnishing RT services in rural communities, the historical experience adjustment will account for those RO participants' historical care patterns and their relative cost, so long as they furnished at least 60 episodes during the baseline period. In addition, if an RO participant has furnished fewer than 20 episodes in the prior year among the CBSAs and their

corresponding ZIP Codes selected for participation in the RO Model, then they are eligible for the low volume opt-out in the subsequent performance year.

40. If there are multiple facilities under one Tax Identification Number (TIN) and only one facility is located in a participating ZIP Code, will the other facilities also be included in the RO Model due to a common TIN?

Only the facility that furnishes RT services in the participating ZIP Code will be required to participate in the RO Model. Other locations will not be responsible for following RO Model requirements. However, historical experience and case mix adjustments from all your locations that furnish RT services and bill under one TIN will be used to calculate your historical experience and case mix adjustments.

41. Are any RT providers or RT suppliers ineligible to participate in the RO Model?

Only RT providers and RT suppliers in the randomly selected Core-Based Statistical Areas (CBSAs) are eligible to participate in the RO Model. In addition to those entities that are not located in selected CBSAs, any physician group practice, freestanding radiation therapy center, or hospital outpatient department that meets the following criteria will also be excluded from the RO Model:

- Furnishes RT only in Maryland;
- Furnishes RT only in Vermont;
- Furnishes RT only in United States (U.S.) Territories;
- Is classified as an ambulatory surgery center (ASC), critical access hospital (CAH), or Prospective Payment System (PPS)-exempt cancer hospital (PCH);
- Participates in the Pennsylvania Rural Health Model (PARHM); or
- Participates in the community track of the Community Health Access and Rural Transformation (CHART) once the CHART Community Transformation track model performance period begins.

42. [REVISED] If an RO participant furnishes RT in a randomly selected Core-Based Statistical Area (CBSA) but delivers a low volume of RT episodes, can it opt out of the RO Model?

Any physician group practice (PGP), freestanding radiation therapy center, or hospital outpatient departments that is otherwise an eligible RO participant and furnishes fewer than 20 episodes or RO episodes within one or more CBSAs selected for participation in the most recent calendar year with available claims data, may elect to opt out of the RO Model under the model's low volume opt-out policy so long they attest to the intention of opting out of the Model prior to the start of the applicable performance year (PY). Prior to the start of each PY, CMS will identify which RO participants are eligible to opt out of the RO Model (including the RO Model payments and participation requirements) based on the most recently available claims data. We will notify RO participants at least 30 days prior to the upcoming PY if they are eligible to opt out. This process will be repeated prior to each PY of the RO Model. This could result in some RO participants being eligible for the low volume opt-out option in some PYs and not in others.

Any PGP or freestanding radiation therapy center that opts out of the RO Model will need to add the GB modifier to claim lines for included RT services when furnished to an RO beneficiary with an included cancer type to receive fee-for-service payments. See FAQ "How should I bill if my entity,

or the entity furnishing the technical or professional component of an episode, has opted out of the RO Model?" for more detailed information.

43. [REVISED] If a new entity did not furnish RT in a randomly selected Core-Based Statistical Area (CBSA) in the period used to assess low volume opt-out eligibility, can the entity opt out of the RO Model?

Any physician group practice (PGP), freestanding radiation therapy center, or hospital outpatient departments (HOPD) that is otherwise an eligible RO participant and furnishes fewer than 20 episodes within one or more CBSAs selected for participation in the most recent calendar year with available claims data may elect to opt out of the RO Model via the Model's low volume opt-out policy so long as they attest to the intention of opting out of the Model prior to the start of the applicable performance year (PY) (that is on or before December 31 of the prior PY). We will notify RO participants at least 30 days prior to the upcoming PY if they are eligible for the low volume opt-out. This process will be repeated prior to each PY of the RO Model. This could result in some RO participants being eligible for the opt-out option in some PYs and not others, that is, an RO participant could be able to opt out in one PY and then be required to participate in the subsequent PY.

The 'Adjustments and Low volume opt-out' option in the 'Administrative Data' tab on ROAP gives RO participants the option to attest to opting out of the Model, if they are eligible. The opt out text will only display if the participant is eligible to opt out for the upcoming PY. We encourage you to review your case mix and historical experience adjustments before making the decision to opt out. Only Legal Points of Contact can attest to opting out by selecting the low volume opt-out option.

During the model performance period, a new TIN or CCN that results from a merger, acquisition, or other business relationship is not eligible for the low volume opt-out if the entities involved in the merger or acquisition have furnished 20 or more episodes and/or RO episodes of RT services as a combined total between the entities across all CBSAs selected for participation in the most recent year with claims data available, which is two years prior to the applicable PY. In other words, CMS would include episodes and/or RO episodes, associated with the RO participant's current CCN or TIN and episodes and/or RO episodes, attributed to the RO participant's legacy CCN(s) or legacy TIN(s), as applicable. A legacy CCN means a CCN that an RO participant identified as a HOPD, or its predecessor(s), previously used for to bill Medicare for included RT services but no longer uses to bill Medicare for included RT services. A legacy TIN means a TIN that an RO participant that is identified as a PGP (including freestanding radiation therapy centers), or its predecessor(s), previously used to bill Medicare for included RT services but no longer uses to bill Medicare for included RT services.

Examples of a change in business or billing arrangements that must be reported to CMS include, but are not limited to, changes in business or billing arrangements via:

- Merger;
- Acquisition;
- Addition of a new physician identified by a NPI to a PGP by updating the individual practitioner list (IPL) in the Radiation Oncology Administrative Portal (ROAP);
- Addition of a new HOPD identified by a CCN;

- Addition of a new freestanding radiation therapy center identified by a TIN; and
- Any other new clinical or business relationship.

Any PGP or freestanding radiation therapy center that opts out of the RO Model will need to add the GB modifier to claim lines for included RT services when furnished to an RO beneficiary with an included cancer type to receive fee-for-service payments. See FAQ "How should I bill if my entity, or the entity furnishing the technical or professional component of an episode, has opted out of the RO Model?" for more detailed information.

44. [REVISED] Is the volume for the low volume opt-out determined at the TIN/CCN level or the diagnosis level?

The volume for the low volume opt-out is determined at the TIN or CCN level, not at the diagnosis level. We use the volume of episodes or RO episodes within the participating ZIP Codes two years prior to the applicable performance year (PY) to determine low volume opt-out eligibility. Please note that RO participants must attest on the Radiation Oncology Administrative Portal to opting out prior to the start of the applicable PY, that is on or before December 31.

45. Do RO participants need to notify CMS of changes in their business or billing arrangements during the model performance period?

RO participants must notify CMS of changes in business or billing arrangements at least 90 days before the effective date of the change. This notification should occur in the Radiation Oncology Administrative Portal (ROAP).

Examples of a change in business or billing arrangements that must be reported to CMS include, but are not limited to, changes in business or billing arrangements via:

- Merger that results in a new TIN or a new CCN;
- Acquisition that results in a new TIN or a new CCN;
- Addition of a new physician identified by a NPI to a physician group practice (PGP) by updating the Individual Practitioner List in ROAP (even if there is no change in TIN);
- Addition of a new hospital outpatient department (HOPD) identified by a CCN;
- Addition of a new freestanding radiation therapy center identified by a TIN; and
- Any other new clinical or business relationship that results in a new TIN or CCN.

RO Model requirements apply throughout the model performance period, so if a new TIN or CCN begins to furnish RT services within a selected Core-Based Statistical Area (CBSA) as identified by ZIP Code between the start date and end of the Model, then, absent qualifying for and attesting to the intention of opting out of the Model for that PY prior to its start (that is on or before December 31 of the prior PY in which the opt-out would occur), it must participate in the RO Model. All RO participants must keep CMS apprised of all relevant business and organizational changes.

Please note that during the model performance period, a new TIN or CCN that results from a merger, acquisition, or other business relationship is not eligible for the low volume opt-out if the entities involved in the merger or acquisition have furnished 20 or more episodes and/or RO episodes of RT services as a combined total between the entities across all CBSAs selected for participation in the most recent year with claims data available, which is two years prior to the

applicable PY. In other words, CMS would include episodes and/or RO episodes, as applicable, associated with the RO participant's current CCN or TIN and episodes and/or RO episodes, as applicable, attributed to the RO participant's legacy CCN(s) or legacy TIN(s). A legacy CCN means a CCN that an RO participant identified as a HOPD, or its predecessor(s), previously used for to bill Medicare for included RT services but no longer uses to bill Medicare for included RT services. A legacy TIN means a TIN that an RO participant that is identified as a PGP (including freestanding radiation therapy centers), or its predecessor(s), previously used to bill Medicare for included RT services but no longer uses to bill Medicare for included RT services. Similarly, for a new TIN or CCN that results from a merger, acquisition, or other business relationship, we will calculate the RO participant's historical experience adjustments based on all episodes attributed to the RO participant's legacy TIN(s) or legacy CCN(s) during the baseline period and all episodes attributed to the RO participant's current TIN or CCN during the baseline period. We will also calculate the RO participant's case mix adjustments based on all episodes including applicable RO episodes attributed to the RO participant's legacy TIN(s) or legacy CCN(s) during the 3-year period that determines the case mix adjustment for each PY and all episodes including applicable RO episodes attributed to the RO participant's current TIN or CCN during the 3-year period that determines the case mix adjustment for each PY.

46. What happens if a new physician group practice (PGP), hospital outpatient department (HOPD), or freestanding radiation therapy center is established and furnishes services in a ZIP Code included in a selected Core-Based Statistical Area (CBSA)?

If the new PGP, HOPD or freestanding radiation therapy center begins billing Medicare before the start of the RO Model and meets eligibility requirements under the RO Model, then the entity will be an RO participant. If there is not sufficient historical data for the entity (that is 60 episodes during the baseline period) the entity will not receive an historical experience adjustment. The entity will also not have a case mix adjustment for performance year (PY) 1. The RO participant may have a case mix adjustment in successive PYs if there is sufficient data in the applicable rolling three-year period.

New entities that furnish RT services in a participating ZIP Code and do not qualify for an exclusion, are required to participate in the RO Model, unless they qualify for the low volume opt-out for a given PY and attest to the intention of opting out of the Model for that PY prior to its start (that is on or before December 31 of the prior PY in which the opt-out would occur). A new entity that furnished less than 20 episodes and/or RO episodes across the randomly selected CBSA during the period used to assess low volume opt-out eligibility for a particular PY will qualify for the opt-out for that PY. Entities must attest to the intention of opting out of the Model prior to the start of the applicable PY.

If your entity begins furnishing RT services in one or more the Model's participating ZIP Codes during the model performance period, reach out to the Help Desk to acquire an RO Model ID. See FAQs "What do I do if I furnish RT services in a participating ZIP Code?" for instructions on obtaining your RO Model ID.

Entities that start billing Medicare during the model performance period must immediately start billing the RO Model-specific HCPCS codes when furnishing include RT services for included cancer types and must start complying with RO Model requirements. A list of RO Model

requirements can be found in FAQ "What must RO participants do to meet the RO Model participation requirements?"

RO participants are required to register for the Radiation Oncology Administrative Portal (ROAP). ROAP allows RO participants to comply with RO Model requirements such as submitting Data Request and Attestation forms, attesting to use of CEHRT and participation in a Patient Safety Organization, and revising and attesting to their Individual Practitioner List. A complete list of ROAP functionality can be found in "What is the Radiation Oncology Administrative Portal (ROAP)?" For instructions on accessing ROAP, see "How do RO participants access the Radiation Oncology Administrative Portal (ROAP)?"

RO participants must also register for the RO Model Secure Data Portal. RO participants will use the RO Model Secure Data Portal to submit Clinical Data Element (CDE) files and quality measure data. Guidance for submitting quality measure and CDE data, including the process for uploading files, submission deadlines, and data validation, can be found in the RO Model Quality Measure and Clinical Data Element Collection and Submission Guide (https://innovation.cms.gov/innovation-models/radiation-oncology-model). For specific questions on how to use the RO Model Secure Data Portal, see the RO Model Secure Data Portal User Manual on the RO Model website (https://innovation.cms.gov/innovation-models/radiation-oncology-model).

47. I am a radiation oncologist. Can I opt in to participate in the RO Model if I am not in a selected Core-Based Statistical Area (CBSA)?

No. An individual, physician group practice, or facility that is not furnishing RT services in one of the selected CBSAs may not opt into the RO Model.

48. What can RT providers and RT suppliers not in the RO Model expect?

If your ZIP Code is not included in the RO Model, you will not be responsible for following RO Model requirements. You may be randomly selected to be included in the comparison group for the evaluation of the Model. If your ZIP Code is randomly selected to be in the comparison group, all needed information will be pulled from existing Medicare fee-for-service claims you regularly submit, and results will be reported in aggregate to help better estimate the impact of the RO Model. We anticipate sending the voluntary Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Cancer Survey to a subset of patients treated by selected comparison group RT providers and RT suppliers to better measure the patient experience of care among RO participants. This process will likely be completed twice during the model performance period.

49. What if my organization furnishes both professional and technical RT services?

Freestanding radiation therapy centers, which commonly furnish both the professional component (PC) and technical component (TC) of RT services, are categorized as Dual participants, and are identified by a single TIN and have a single RO Model ID. A Dual participant is required to follow all RO Model requirements.

If the PC and TC are furnished by entities with separate TINs or a TIN and CCN, there will be a separate RO Model ID for each TIN and CCN. A Professional participant is a Medicare-enrolled physician group practice, identified by a single TIN that furnishes only the PC of RT services at either a freestanding radiation therapy center or a hospital outpatient department (HOPD). A Technical participant is a HOPD or freestanding radiation therapy center, identified by a CCN or

TIN, which furnishes only the TC of RT services. If the PC and TC are delivered by two separate TINs or a TIN and a CNN and thus have separate RO Model IDs, the PC would be required for the Professional requirements and the TC would be required to follow the Technical requirements.

50. An RO participant has multiple locations in participating ZIP Codes. How does this impact their involvement in the RO Model, such as the aggregate quality scores (AQS) or historical experience and case mix adjustments?

Under the RO Model, participation is determined by ZIP Code. RO participants are identified by their CCN if they are a hospital outpatient department that furnishes and bills technical RT services under the Outpatient Prospective Payment System or by their TIN if they bill professional, technical, or professional and technical RT services under the Medicare Physician Fee Schedule. If there are multiple service locations or multiple practices furnishing RT services in a participating ZIP Code under a single CCN or TIN, those locations are considered a single RO participant under the RO Model and will submit a combined set of quality measure data and a combined set of clinical data to calculate their aggregate quality scores (AQS). However, data from all service locations that furnish and bill RT services under that TIN or that CCN (regardless of where those service locations are located) are used to determine the historical experience and case mix adjustments for that RO participant. Of note, quality measure reporting is limited to the TIN/NPI combination of participating radiation oncologists. Additional information on quality measure reporting may be found in the RO Model Quality Measure and Clinical Data Element Collection and Submission Guide on the RO Model website (https://innovation.cms.gov/innovation-models/radiation-oncology-model).

51. Can an RO participant be in another CMS payment model and/or initiative and participate in the RO Model?

In some cases, you may participate in the RO Model concurrently with other CMS models and/or initiatives. Because the RO Model is an episode-based payment initiative, RT providers and RT suppliers participating in the RO Model will not be precluded from also participating in an Accountable Care Organization (ACO) initiative. Specifically, overlap is possible in two instances: (1) the same RT provider or RT supplier participates in both a Medicare ACO initiative and the RO Model; or (2) a beneficiary that is aligned to an ACO participating in a Medicare ACO initiative receives care from a RT provider or RT supplier outside the ACO that is participating in the RO Model. It is possible that certain shared savings payments made under ACO initiatives may overlap with discounts and withholds in the RO Model. CMS will continue to review the potential overlap between the RO Model and ACO initiatives. For more information on potentially duplicative billing, consult the CMS staff responsible for demonstration initiatives.

RO participants may also participate in the Oncology Care Model (OCM) while participating in the RO Model. Since prospective episode payments made under the RO Model will not be affected by OCM, OCM will account for RO Model overlap in its reconciliation calculations, and OCM participants will be notified and provided with further information through OCM's typical channels of communication. Finally, there may be overlap with the Bundled Payments for Care Improvement (BPCI) Advanced Model. While there are no cancer episodes included in the design of BPCI Advanced, a beneficiary in an RO episode could be treated by an RT provider or an RT supplier that is participating in BPCI Advanced. Since prospective episode payments made under the RO Model will not be affected by BPCI Advanced, BPCI Advanced will determine whether to account for

beneficiary overlap with the RO Model in its Reconciliation calculations, and BPCI Advanced participants will receive further information from CMS if the BPCI Advanced Model team determines to make changes to their overlap policy.

The RO Model does not include RT providers and RT suppliers that only furnish RT services in Maryland and Vermont to avoid overlap between the RO Model and participants in the Maryland Total Cost of Care Model and the Vermont All-Payer ACO Model, respectively. The RO Model excludes hospital outpatient departments that participate in the Pennsylvania Rural Health Model (PARHM). CMS also excludes those participating in the Community Track of the Community Health Access and Rural Transformation (CHART) Model.

52. How does the RO Model differ from the Oncology Care Model (OCM)?

OCM is a total cost of care model, which includes all the care a beneficiary receives, and includes a broader set of oncology services than the RO Model, such as chemotherapy. The RO Model is a prospective, episode-based payment model, which means that RT providers are paid a predetermined rate per cancer type for a 90-day episode of treatment, for included RT services. The RO Model complements the OCM evidence base in several ways, including its specific focus on radiation oncology, its innovative payment structure and alignment with private sector models, and its potential to greatly increase the information the Innovation Center has regarding RT pricing, care delivery, and overall treatment decisions. By focusing on prospective payment for RT, the RO Model will provide further insight into the effects of alternative payment on oncology care outcomes and experience for patients beyond what is currently underway in other models, such as the OCM. The additional insights into RT services are important as the incidence of cancer is expected to increase, along with the use of RT as a core method of treatment.

53. Do I still participate in the RO Model if I leave my current physician group practice (PGP) and join another one?

Yes, but only if your new PGP is an RO participant, i.e., is furnishing RT services in one of the Core-Based Statistical Areas randomly selected to participate in the RO Model. RO participants must supply and/or confirm the NPIs for the physicians who bill using the applicable TINs, and annually attest to the accuracy of an individual practitioner list provided by CMS, of all the eligible clinicians who furnish care under the RO participant's TIN. RO participants must notify the Innovation Center of changes in business or billing arrangements through the Radiation Oncology Administrative Portal.

54. What happens if my current physician group practice (PGP) changes the hospital outpatient department or freestanding radiation therapy center where it furnishes the professional component of RT services?

If the PGP changes the facility where they furnish professional RT services, it will continue to participate in the RO Model if the RO beneficiary continues to receive the technical component of RT services at a facility that is an RO participant. If each facility where the PGP will now furnish professional RT services is not a participant in the RO Model, then the PGP will no longer participate in the RO Model. Conversely, if a PGP furnishes professional RT services in more than one facility, and at least one of those facilities is a participant in the RO Model, then the PGP will continue to participate in the RO Model.

55. Are dermatologists included in the RO Model? I understood that skin cancer was excluded from the RO Model.

Given that skin cancer is excluded from the RO Model, we understand that there may be uncertainty about whether some dermatologists are RO participants. Claims for malignant neoplasm of external upper or lower lip are classified as a head and neck cancer, which is an included cancer type in the RO Model. Similarly, mycosis fungoides - though it presents on the skin - is classified as lymphoma, which is also an included cancer type in the RO Model. As such, dermatologists that have furnished and billed for included RT services for included cancer types are currently RO participants.

However, due to the volume of included RT services billed for included cancer types, some dermatologists may be eligible for the low volume opt-out. Any physician group practice (PGP), freestanding radiation therapy center, or hospital outpatient department that is otherwise an eligible RO participant and furnishes fewer than 20 episodes or RO episodes within one or more Core-Based Statistical Areas (CBSAs) selected for participation in the most recent calendar year with available claims data, may elect to opt out of the RO Model under the model's low volume opt-out policy so long as they attest to the intention of opting out of the Model prior to the start of the applicable performance year.

Any PGP or freestanding radiation therapy center that opts-out of the RO Model will need to add the GB modifier to claim lines for included RT services when furnished to an RO beneficiary with an included cancer type to receive fee-for-service payments.

For more information on the low volume opt-out, including how to opt out in the Radiation Oncology Administrative Portal, see FAQ "If an RO participant furnishes RT in a randomly selected CBSA but delivers a low volume of RT episodes, can it opt out of the RO Model?"

56. What is the Extreme and Uncontrollable Circumstances (EUC) policy?

In light of the current Public Health Emergency and several recent natural disasters, we have added an EUC policy similar to those in other Innovation Center models. This policy would be executed in the affected geographic areas and not for individual participants and gives us flexibility to reduce administrative burden of Model participation, particularly around reporting requirements, and/or adjust the payment methodology as a result of extreme and uncontrollable circumstances.

The key aspects of the policy are as follows:

- In instances where CMS believes the EUC may impact all RO participants' ability to implement the requirements of the RO Model as of the start date indicated in the CY 2022 OPPS/ASC Payment System final rule with comment period (CMS-1753-FC), CMS may change the start date to a future date.
- In instances where CMS believes the EUC may impact affected RO participants' ability to comply with the quality measure and/or clinical data element reporting requirements, CMS may unilaterally modify or remove the reporting requirements, make the requirements optional, and/or extend the time for affected RO participants to report data to CMS, as applicable. If CMS were to unilaterally remove the quality and clinical data submission requirements for affected RO participants, and not merely extend the deadline, CMS would remove the quality withhold for affected RO participants.

- CMS may remove or adjust other Model requirements such as, but not limited to, the requirement that affected RO participants actively engage with an Agency for Healthcare Research and Quality-listed patient safety organization and provide Peer Review (audit and feedback) on treatment plans.
- In situations where RT providers and RT suppliers experience significant, aggregate-level disruptions to their service utilization, reflected by changes either in volume and/or type of modalities furnished, CMS may unilaterally modify the pricing methodology to ensure utilization changes due to the extreme and uncontrollable circumstance do not significantly impact a future trend factor.

CMS will determine which elements of the EUC policy will be implemented based on the nature of the extreme and uncontrollable circumstance.

57. [REVISED] Has CMS invoked the Extreme and Uncontrollable Circumstances (EUC) policy due to the ongoing impact of the Public Health Emergency (PHE)? How does this impact Model requirements?

CMS previously announced that it intended to invoke the EUC based on the ongoing COVID-19 public health emergency. However, The Protecting Medicare and American Farmers from Sequester Cuts Act (P.L. 117-71) enacted on December 10, 2021, includes a provision that prohibits implementation of the RO Model prior to January 1, 2023. Thus, the RO Model did not begin on January 1, 2022.

Due to this delay, CMS did not invoke the EUC policy on January 1, 2022.

58. More information about the implications of the delay will be forthcoming. How do I inform CMS of a situation that may be subject to the Extreme and Uncontrollable Circumstances (EUC) policy?

If you believe that your organization faces a situation where the EUC policy applies, please inform CMS by emailing the Help Desk (RadiationTherapy@cms.hhs.gov). Your email should include:

- a detailed description of the situation
- how the situation meets one of the following requirements:
  - whether the RO participants are furnishing services within a geographic area considered to be within an ‘‘emergency area’’ during an ‘‘emergency period’’ as defined in section 1135(g) of the Social Security Act.
  - whether the geographic area within a county, parish, U.S. territory, or tribal government designated under the Stafford Act served as a condition precedent for the Secretary’s exercise of the 1135 waiver authority, or the National Emergencies Act.
  - whether a state of emergency has been declared in the relevant geographic area.
- how the situation has had a regional or local impact
- how long you expect the situation to continue.

RO Participant Requirements

59. [REVISED] What must Professional participants and Dual participants do to meet the RO Model participation requirements?

In addition to meeting Medicare eligibility requirements, all RO participants must meet additional requirements. Requirements for all RO participants include:

- Submit claims in accordance with the RO Model billing instructions.
- Meet applicable state and federal licensure and certification requirements.

Requirements that Professional participants and Dual participants must demonstrate to CMS annually, either through attesting or submitting data:

- Use CEHRT throughout the performance year (PY) in a manner sufficient to meet applicable requirements of the Advanced Alternative Payment Models (APM) criteria (§ 512.220(b)), and attest to this requirement in the Radiation Oncology Administrative Portal (ROAP) within 30 days of the start of each PY.
- Submit data on quality measures (QMs) through the RO Model Secure Data Portal by the following March of each PY, and clinical data elements (CDEs) in July and January of each PY (or forfeit the potential to earn back all or some of the quality withhold amount).
- Review, update, and certify the Individual Practitioner List (IPL) in ROAP before the last QP determination snapshot date each PY. This typically occurs in early fall.

For all other model requirements applicable to Professional participants and Dual participants, CMS will monitor compliance during site visits and possibly virtual chart reviews. For these requirements, Professional participants and Dual participants must show that they are occurring if they are selected for a random site visit or virtual chart audit during the course of the RO Model. Documenting these actions can be done in any manner and do not need to be submitted electronically to CMS. No changes to EHR systems are necessary for tracking these requirements unless a RO participant wishes to document these requirements in that manner.

Professional participants and Dual participants must also ensure all individual practitioners:

- Discuss goals of care with each RO beneficiary before initiating treatment and communicate to the RO beneficiary whether the treatment intent is curative or palliative
- Adhere to nationally recognized, evidence-based clinical treatment guidelines when appropriate in treating RO beneficiaries or, alternatively, document in the medical record the extent of and rationale for any departure from these guidelines
- Assess each RO beneficiary's tumor, node, and metastasis cancer stage for CMS-specified cancer diagnoses
- Assess the RO beneficiary's performance status as a quantitative measure determined by the physician
- Send a treatment summary to each RO beneficiary's referring physician within 3 months of the end of treatment to coordinate care
- Perform and document Peer Review (audit and feedback on treatment plans) for 50 percent of new patients in PY1, for 55 percent of new patients in PY2, for 60 percent of new patients in

PY3, for 65 percent of new patients in PY4, and for 70 percent of new patients in PY5 preferably before starting treatment, but in all cases before 25 percent of the total prescribed dose has been delivered and within 2 weeks of the start of treatment.

Professional participants and Dual participants must also:

- Discuss with each RO beneficiary prior to treatment delivery their inclusion in the RO Model and their cost-sharing responsibilities.
- Notify RO beneficiaries of participation in the RO Model using the RO Beneficiary Notification Letter, which can be downloaded from the RO Model website (https://innovation.cms.gov/innovation-models/radiation-oncology-model).

60. [REVISED] What must Technical participants and Dual participants do to meet the RO Model participation requirements?

In addition to meeting Medicare eligibility requirements, all RO participants must meet the following requirements:

- Submit claims in accordance with the RO Model billing instructions.
- Meet applicable state and federal licensure and certification requirements.

Technical participants and Dual participants must meet the following requirements:

- Annually attest to whether it actively participates with an Agency for Healthcare Research and Quality-listed patient safety organization (for example, by maintaining a contractual or similar relationship with a PSO for the receipt and review of patient safety work product). This must be done on the Radiation Oncology Administrative Portal by the end of each performance year.

61. What must Dual RO participants do to meet the RO Model participation requirements?

Dual participants must meet the requirements of both Professional participants and Technical participants. Accordingly, Dual participants should consult the sections for both types of RO participant.

62. [REVISED] How do Professional participants and Dual participants demonstrate compliance with RO Model requirements that do not require an attestation in the Radiation Oncology Administrative Portal (ROAP)?

CMS requires Professional participants and Dual participants attest to the following in ROAP:

- Compliance with CEHRT use requirements for that performance year (PY) within 30 days of the start of the PY (i.e., between December 1 and January 31)
- The accuracy of their Individual Practitioner List (IPL) before the last QP determination snapshot date each PY (usually occurs in early fall).

CMS also requires Professional participants and Dual participants report on quality measures and clinical data elements through the RO Model Secure Data Portal.

For all other Model requirements applicable to Professional participants and Dual participants, CMS will be monitoring compliance during site visits and possibly through virtual chart reviews. For these requirements, Professional participants and Dual participants must show that they are

occurring if they are selected for a random site visit or virtual chart audit during the course of the RO Model. Documenting these actions can be done in any manner and do not need to be submitted electronically to CMS. No changes to EHR systems are necessary for tracking these requirements unless a RO participant wishes to document these requirements in that manner.

As a reminder, Professional participants and Dual participants must ensure all individual practitioners:

- Discuss goals of care with each RO beneficiary before initiating treatment and communicate to the RO beneficiary whether the treatment intent is curative or palliative
- Adhere to nationally recognized, evidence-based clinical treatment guidelines when appropriate in treating RO beneficiaries or, alternatively, document in the medical record the extent of and rationale for any departure from these guidelines
- Assess each RO beneficiary's tumor, node, and metastasis cancer stage for CMS-specified cancer diagnoses
- Assess the RO beneficiary's performance status as a quantitative measure determined by the physician
- Send a treatment summary to each RO beneficiary's referring physician within 3 months of the end of treatment to coordinate care
- Perform and document Peer Review (audit and feedback on treatment plans) for 50 percent of new patients in PY1, for 55 percent of new patients in PY2, for 60 percent of new patients in PY3, for 65 percent of new patients in PY4, and for 70 percent of new patients in PY5 preferably before starting treatment, but in all cases before 25 percent of the total prescribed dose has been delivered and within 2 weeks of the start of treatment.

Professional participants and Dual participants must also:

- Discuss with each RO beneficiary prior to treatment delivery their inclusion in the RO Model and their cost-sharing responsibilities.
- Notify RO beneficiaries of participation in the RO Model using the RO Beneficiary Notification Letter, which can be downloaded from the RO Model website (https://innovation.cms.gov/innovation-models/radiation-oncology-model).

63. What happens if I am not compliant with RO Model participation requirements?

If the RO Participant in non-compliant with the RO Model participation requirements, there are various options for dealing with this in accordance with the remedial action section, set forth in § 512.160. For example, RO participants that are found to be non-compliant will be notified they are not in compliance with RO Model requirements and will be given time to come into compliance. If non-compliance continues, CMS may use a Corrective Action Plan to help RO participants become compliant.

64. How should RO participants notify RO beneficiaries that they are included in the RO Model?

Professional participants and Dual participants are required to notify RO beneficiaries with the RO Beneficiary Notification Letter (available on the RO Model website, https://innovation.cms.gov/innovation-models/radiation-oncology-model) during the initial

treatment planning session which will detail, among other things, the RO beneficiary's cost-sharing responsibilities and right to refuse having their Medicare claims data shared with the RO participant for care coordination and quality improvement purposes. You can find more information about cost-sharing responsibilities in the FAQ "How will the RO Model impact beneficiary cost-sharing?"

The RO Beneficiary Notification Letter is a fillable PDF. RO participants will do the following to complete this letter:

- Input the organization's 'doing business as' name or whatever organization name the RO beneficiary would recognize in the first fillable line. This will auto-populate throughout the letter.
- Add the organization's phone number on the last page of the letter. RO participants should provide the best contact number for RO beneficiaries that have follow-up questions.
- RO participants may include their logo on the RO Beneficiary Notification Letter.

Technical participants are not required to provide RO beneficiaries with a RO Beneficiary Notification Letter.

65. [REVISED] How do I inform CMMI that an RO beneficiary does not want their Medicare claims data shared?

If an RO beneficiary does not want their Medicare claims data shared with the RO participant, the RO participant must notify CMS of this decision, in writing via the Radiation Oncology Administrative Portal (ROAP), within 30 days of the beneficiary informing the participant of their decision. RO participants will submit the beneficiary's name, Medicare ID Number, and the date of the first treatment planning session in ROAP. Participants should navigate to the "Attestations" tab and select the Beneficiary Data Sharing Opt-Out button. Only Legal Points of Contact can make this notification.

66. Does the RO Beneficiary Notification Letter have to be signed by the patient and saved in the patient's medical record?

No. CMS does not require a signature from the RO beneficiary. The RO participant shall document in a form and manner of their choice that they provided and discussed the contents of the RO Beneficiary Notification Letter with the RO beneficiary. CMS will monitor for compliance with this requirement during site visits.

67. [REVISED] Is the RO Beneficiary Notification Letter available in other languages? Can I translate it into other languages?

Currently, the RO Beneficiary Notification Letter is only available in English. RO participants may translate the RO Beneficiary Notification Letter into other languages, as long as the intent of the content of the letter remains identical to the English version. Please note that if an RO participant receives Federal financial assistance from the US Department of Health and Human Services, they are required to comply with Title VI of the Civil Rights Act of 1964, including its language access requirements, and may be required to comply with Section 1557 of the Affordable Care Act and its language access requirements as well.

68. [REVISED] What are the requirements for the peer review process and how do I implement this requirement?

Professional participants and Dual participants must perform and document Peer Review (audit and feedback on treatment plans) for:

- 50 percent of new patients in performance year (PY) 1;
- 55 percent of new patients in PY 2;
- 60 percent of new patients in PY 3;
- 65 percent of new patients in PY 4; and
- 70 percent of new patients in PY 5.

Peer review should occur preferably before starting treatment, but in all cases before 25 percent of the total prescribed dose has been delivered and within 2 weeks of the start of treatment. The RO Model does not specify how an RO participant shall implement Peer Review. The RO participant may choose how they document compliance with the Peer Review requirement. RO participants may seek advice from their professional organizations and their peers.

"New patients" refers to RO beneficiaries receiving RT services from an RO participant during the model performance period. RO participants must perform and document Peer Review for RO beneficiaries per the above thresholds; RO participants may include all patients in performing and documenting Peer Review, if they so wish.

69. Does accreditation count towards RO Model Requirements (e.g., peer review)?

Accreditation does not exempt an RO participant from RO Model requirements. RO participants shall attest to compliance with certain RO Model requirements in the Radiation Oncology Administrative Portal, and for other RO Model requirements document compliance in a manner of its choosing.

70. [REVISED] What are the requirements for having a patient safety organization and how do I implement this requirement?

All Technical participants and Dual participants will be required to attest annually that they actively participate in an Agency for Healthcare Research and Quality-listed patient safety organization (PSO). For example, active participation could include maintaining a contractual or similar relationship with a PSO for the receipt and review of a patient safety work product. The PSO does not need to be a radiation oncology-specific PSO.

Attestation is required to ensure compliance with the RO Model requirements. The PSO requirement will be effective beginning in performance year (PY) 1. RO participants that are not in a PSO will have until the attestation period near the end of PY1 to initiate participation with a PSO.

71. What are the requirements for CEHRT and how do I implement this requirement?

All Professional participants and Dual participants will be required to use CEHRT throughout the performance year in a manner sufficient to meet applicable requirements of the Advanced Alternative Payment Models (APM) criteria (§ 414.1415(a)(1)(i)).

We codified at § 512.220 that there are three tracks in the RO Model, as it relates to the Quality Payment Program.

Track One will include Professional participants or Dual participants who meet all RO Model requirements, including CEHRT use, and we expect Track One will qualify as an Advanced APM and a MIPS APM.

If Track One participants do not meet the QP threshold, they will be eligible for APM scoring in MIPS.

Track Two will include all Professional participants and Dual participants who meet all RO Model requirements, except for the CEHRT requirement, and we expect that Track Two will qualify as a MIPS APM only.

Track Three will include all other RO participants, specifically Professional participants and Dual participants who fail to meet the RO Model requirements, including CEHRT, and Technical participants. Track Three will not be an Advanced APM or MIPS APM.

72. [REVISED] What are the requirements for updating the Individual Practitioner List and how do I implement this requirement?

Professional participants, Dual participants, and Technical participants that are freestanding radiation therapy centers are required to maintain and certify an Individual Practitioner List (IPL). The IPL identifies, by NPI, practitioners who have assigned billing rights to an RO participant's TIN. Practitioners providing contracting or temporary services should only be included if they bill under the RO participant's TIN and furnish included RT services in participating ZIP Codes.

CMS will provide Professional participants, Dual participants, and Technical participants that are freestanding radiation therapy centers with an initial IPL that identifies, by NPI, each individual practitioner associated with the RO participant (NPIs who furnish included RT services and bill RO Model-specific HCPCS codes through the RO participant's TIN within the participating ZIP Code). Practitioners who are not radiation oncologists (e.g., medical oncologists) will not be on the IPL. For RO participants with multiple sites, only NPIs who are furnishing included RT services in included ZIP Codes should be included.

RO participants are required to maintain and update their IPL within the Radiation Oncology Administrative Portal. Primary and Legal Points of Contact (LPOCs) can review, add, or drop NPIs from the IPL at any time.

RO participants are also required to certify their IPL each performance year. Only LPOCs can certify the IPL. Certification should occur before the last QP determination snapshot date. This usually occurs in early fall.

Beneficiary Eligibility

73. Which Medicare beneficiaries are included in the RO Model?

A Medicare beneficiary who meets the following criteria will be included in the RO Model:

- Receives included RT services in a five-digit ZIP Code linked to a selected Core-Based Statistical Area from an RO participant that billed the start-of-episode modifier for the

professional component or technical component of an RO episode during the model performance period for one of the 15 included cancer types.

- At the time that initial treatment planning service of the episode is furnished by an RO participant, the individual:
  - Is eligible for Medicare Part A and enrolled in Medicare Part B.
  - Has traditional Medicare fee-for-service as their primary payer (i.e., is not enrolled in a Programs of All-Inclusive Care for the Elderly (PACE) plan, Medicare advantage or another managed care plan, or is not covered under United Mine Workers insurance).
  - Is not in a Medicare hospice benefit period.

In other words, beneficiaries with Medicaid or Medicare Advantage as their primary payer will not be included in the Model and should continue to be billed as usual.

Beneficiaries enrolled in a clinical trial for included RT services (except for proton beam therapy) for which Medicare pays routine costs will also be included in the RO Model if the above criteria apply.

74. Does an RO beneficiary need to be enrolled in *both* Medicare Part A and Part B?

RO beneficiaries must be eligible for Medicare Part A but enrolled in Medicare Part B.

Slide 18 of the Billing, Coding, and Pricing Methodology Webinar originally stated that a RO beneficiary must be enrolled in both Medicare Parts A and B. This is incorrect. This slide has been updated, and a corrected version of the slides has been posted on the RO Model website (https://innovation.cms.gov/innovation-models/radiation-oncology-model).

See FAQ "Which Medicare beneficiaries are included in the RO Model?" above for a full list of RO beneficiary criteria.

75. Is Medicare for Railroad Workers included in the RO Model?

Yes, Medicare beneficiaries covered under Railroad Medicare are included in the RO Model.

See FAQ "Which Medicare beneficiaries are included in the RO Model?" for more information about which beneficiaries are included in the RO Model.

76. Can beneficiaries enrolled in qualifying, federally funded clinical trials be included in the RO Model?

Beneficiaries that meet all the inclusion criteria at 42 CFR § 512.215(a) and are enrolled in a clinical trial for included RT services (except for proton beam therapy) for which Medicare pays routine costs will be included in the RO Model in accordance with 42 CFR § 512.215(b) and are considered RO beneficiaries.

77. What is the billing process for a beneficiary that is receiving proton beam therapy under a qualifying, federally funded clinical trial?

CMS will rely on RO participants to determine if the beneficiary is enrolled in a qualifying clinical trial. If so, they will use the existing claims process for billing CMS for clinical trials in addition to adding the appropriate modifier or condition code to allow the claim to be paid fee-for-service.

CMS will monitor this aspect of the RO Model closely to ensure these claims are valid and beneficiaries are protected.

78. If a center has patients participating in a qualifying, federally funded clinical trial, is the whole center exempt or just those patients?

Only patients receiving included RT services for one of the included cancer types that are in a qualifying clinical trial are exempt from the bundled payment. RO participants should add the existing modifiers for clinical trials to identify these patients. The RO Model team plans to monitor these claims. The current Medicare policy is described in Routine Costs in Clinical Trials 100–3 section 310.1.

79. Can beneficiaries continue to choose their RT providers and/or RT suppliers under the RO Model?

Beneficiaries continue to have the freedom to choose their providers and/or suppliers under the RO Model. The RO Model does not restrict beneficiaries' ability to choose to receive care from any provider or supplier. RO participants must not commit any act or omission, nor adopt any policy that inhibits beneficiaries from exercising their freedom to choose to receive care from any provider or supplier or from any health care provider who has opted out of Medicare. RO participants may communicate to RO beneficiaries the benefits of receiving care with the RO participant, if otherwise consistent with the requirements of the RO Model and applicable law.

80. [REVISED] Can beneficiaries opt out of the RO Model?

No, beneficiaries may not opt out of the RO Model if they receive RT services from an RO participant. However, beneficiaries may choose to see a RT provider and/or RT supplier who is not participating in the RO Model. Beneficiaries can also choose not to share their Medicare claims data with RO participants. Beneficiaries who choose not to share their Medicare claims data must inform their provider who must, in turn, provide Medicare with written notice of the beneficiary's decision within 30 days of receiving that decision. RO participants will submit the RO beneficiary's name, Medicare ID Number, and the date the RO beneficiary informed the RO participant of their decision in the Radiation Oncology Administrative Portal. RO participants should navigate to the "Attestations" tab and select the Beneficiary Data Sharing Opt-Out button. Only Legal Points of Contact can make this notification.

81. Will beneficiaries be notified of their RT providers' and/or RT suppliers' participation in the RO Model?

CMS recognizes the importance of informing beneficiaries that their RT providers and/or RT suppliers are participating in the RO Model. Therefore, Professional participants and Dual participants must provide an RO Beneficiary Notification Letter (https://innovation.cms.gov/innovation-models/radiation-oncology-model) to Medicare beneficiaries receiving treatment from them.

See FAQ "How should RO participants notify beneficiaries that they are included in the RO Model?" for more information about the RO Beneficiary Notification Letter.

82. Does the RO participant keep the episode payment amount for RT services furnished if an RO beneficiary switches RT providers?

If an RO beneficiary switches RT provider or RT supplier after the start-of-episode claim has been paid, CMS will subtract the first episode payment paid to the RO participant from the fee-for-service payments owed to the RO participant for services furnished to the beneficiary before the transition occurred and listed on the no-pay claims. This will occur during the annual reconciliation process.

83. How will the RO Model impact beneficiary cost-sharing?

All the standard rules and regulations under fee-for-service (FFS) pertaining to beneficiary coinsurance apply under the RO Model, including the Medicare bad debt provision. Beneficiaries will be responsible for 20 percent coinsurance of the prospective episode payments made under the RO Model (the exception is beneficiaries who experience an incomplete episode or duplicate services). Because CMS will apply a discount to episode components, we expect that beneficiary cost-sharing will be, on average, lower relative to what typically would be paid under Medicare's FFS system. As with all Innovation Center models, CMS will monitor the RO Model for any unintended consequences that might negatively impact RO beneficiaries.

84. Is there a way to determine how much the co-pay will be for RO beneficiaries receiving care for an included cancer type?

RO beneficiaries will pay 20 percent of each of the bundled professional component and technical component payments for their cancer type, regardless of what their total coinsurance payment amount would have been under the fee-for-service payment system. Hospital outpatient caps are also applied per standard Medicare rules. The coinsurance amount for an RO beneficiary is calculated on the payment amount that results after the case mix and historical experience adjustments, withholds, discount factors, and geographic adjustments have been applied to the trended national base rates for the included cancer type billed by the RO participant for the RO beneficiary's treatment.

The Payment Calculator Workbook on the RO Model website (https://innovation.cms.gov/innovation-models/radiation-oncology-model) shows how beneficiary coinsurance is determined. In addition to using this workbook to obtain estimates of payments you will receive for RO episodes, you can use this workbook to obtain estimates of beneficiary coinsurance for each cancer type.

85. How will an incomplete episode or a duplicate RT service affect beneficiary cost-sharing?

For duplicate RT services, a beneficiary will be responsible for 20 percent of the fee-for-service (FFS) amount for RT services furnished by the RT provider and/or RT supplier for one or more duplicate RT services. For incomplete episodes, a beneficiary will be 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 their primary payer any time after the initial treatment planning service is furnished and before the date of service on a claim with an RO Model-specific HCPCS code and end-of-episode (EOE) modifier, provided that an RT provider or RT supplier furnishes a technical component (TC) RT service to the RO beneficiary within 28 days of such initial treatment planning service. In this case, the beneficiary coinsurance payment equals 20 percent of the first installment of the episode payment amount to be paid to the RO participant(s). If

an RO participant bills the Model-specific HCPCS code and EOE modifier prior to the date that the RO beneficiary ceases to have traditional FFS Medicare, then the beneficiary coinsurance payment equals 20 percent of the full episode payment amount for the professional component or the TC.

86. Where can beneficiaries go with questions or concerns?

Beneficiaries with questions or who feel their care has been compromised can call 1-800-MEDICARE or contact their local Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIOs). Local BFCC-QIO contact information can be located here: https://www.qioprogram.org/locate-your-qio.

RO Episode Design Details

87. Which types of cancer diagnoses are included in the RO Model?

There are 15 cancer types included in the RO Model.

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

88. Why did CMS remove liver cancer from the list of included cancer types?

Given the changing evidence around the use of RT as a treatment for liver cancer, CMS believes it does not meet the requirements to be included in the RO Model. Any further additions to, or removal of, a cancer type from this list will be communicated via the RO Model website (https://innovation.cms.gov/initiatives/radiation-oncology-model/) and in written correspondence to RO participants. CMS will notify RO participants of any changes to the diagnosis codes for the included cancer types per the CMS standard process for announcing coding changes and update the list on the RO Model website no later than 30 days prior to each performance year.

89. What is the length and timing of an RO episode?

RO episodes are 90 days long. Day 1 is considered the date that a Professional participant or Dual participant furnishes the initial treatment planning service to an RO beneficiary (HCPCS codes 77261, 77262, or 77263 are the only codes that can be used to trigger an episode), provided that a Technical participant or Dual participant furnishes a treatment delivery service within 28 days of the treatment planning service.

90. When does an RO episode start?

An RO episode starts when a Professional participant or Dual participant furnishes the initial treatment planning service to an RO beneficiary (HCPCS codes 77261, 77262, or 77263 are the only codes that can be used to trigger an episode). The Professional participant or Dual participant also submits a claim with a professional RO Model-specific HCPCS code for an included cancer type with a start-of-episode modifier (V1), and a date of service that is the same as the initial treatment planning service. This signals to CMS the start date of an RO episode.

91. When does an RO episode end?

An RO episode ends when all RT services have been furnished and RO participants have submitted a claim with the same RO Model-specific HCPCS code that initiated the RO episode with the "End-of-episode" (EOE) V2 modifier. An RO episode cannot be longer than 90 days (i.e., 89 days after the "start" of the episode, which is the date of service that the initial treatment planning service was rendered, and a separate claim submitted with an RO Model-specific HCPCS code and the start-of-episode V1 modifier). While the RO episode can be as long as 90 days, an EOE claim can be submitted and paid as early as day 28 of the 90-day episode if the RO participant, to the best of their knowledge, is certain that the treatment plan is complete. Any RT services furnished after the EOE claim is submitted will not be paid separately during the remainder of the 90-day RO episode. CMS will monitor the Medicare claims system to identify potentially adverse changes in referral, practice, or treatment delivery patterns and subsequent billing patterns.

92. What RT services are included in the RO Model?

An RO episode covers most RT services furnished in hospital outpatient departments and freestanding radiation therapy centers, including treatment planning, certain technical preparation and special services, treatment delivery, and treatment management. For these services only, the RO Model payments will replace current Medicare fee-for-service (FFS) payments. A complete list of HCPCS codes that represent treatment planning, technical preparation and special services, treatment delivery, and treatment management for the included modalities are provided in the CY 2022 OPPS/ASC Payment System final rule with comment period (CMS-1753-FC), copied at the end of this document, and maintained on the RO Model website (https://innovation.cms.gov/initiatives/radiation-oncology-model/) and RO Connect. We will notify RO participants of any changes to the HCPCS codes per CMS annual Level 2 HCPCS code file. All RT services furnished by an RO participant during the model performance period, but not included in the list of included RT services, will be subject to Medicare FFS payment rules.

93. What RT modalities are included in the RO Model?

The following RT modalities are the finalized modalities in the RO Model: various types of external beam RT including 3-dimensional conformal radiotherapy (3DCRT), stereotactic radiosurgery

(SRS), stereotactic body radiotherapy (SBRT) and proton beam therapy (PBT), and image-guided radiation therapy (IGRT). These modalities are the most commonly used to treat the 15 included cancer types and including these modalities will provide CMS with greater visibility into the ability of an episode payment model to affect patients' care, experience, and overall system costs. Excluded modalities include brachytherapy, intraoperative radiation therapy (IORT), neutron beam therapy, hyperthermia treatment, and radiopharmaceuticals. We excluded most of these services from the RO Model because they are not offered in sufficient amounts for purposes of evaluation.

94. Why did CMS remove brachytherapy from the list of included modalities?

In the CY 2022 OPPS/ASC Payment System final rule with comment period (CMS-1753-FC), we finalized to remove brachytherapy from the list of included modalities so that it would still be paid fee-for-service. We believed that including brachytherapy in the Model would align with evidence that it is high value and support the Model goal of establishing a bundled approach to RT services. However, stakeholders have expressed concerns about potential reductions in access to brachytherapy for episodes with multiple modalities. Stakeholders were particularly concerned about cases where the RO participant furnishing the external beam radiation therapy is different from the RO participant providing brachytherapy. Stakeholders suggested creating a separate bundled payment for brachytherapy or removing it from the RO Model. Some stakeholders suggested that inclusion of brachytherapy in the bundled payments could lead to reduced utilization of brachytherapy in situations where a combination of brachytherapy and EBRT is clinically indicated (particularly for cervical and prostate cancers). Stakeholders expressed concern that in the case of multimodality treatment including brachytherapy, there may be a disincentive to refer patients to other radiation oncologists for treatment when the RO participant cannot deliver brachytherapy services themselves.

CMS seeks to neither incentivize nor discourage the use of one modality over another, but rather to encourage providers to choose RT services that are the most clinically appropriate for beneficiaries under their care. The exclusion of a modality from the RO Model is not meant to imply anything about the value of such modality. Published clinical evidence suggests brachytherapy is a high-value RT service, which could warrant its inclusion in the RO Model. However, we acknowledge the concerns stakeholders have about possible unintended consequences for beneficiaries' access to care.

95. Why is Proton Beam Therapy (PBT) included in the RO Model?

PBT is included in the RO Model because the Model is designed, in part, to evaluate the efficacy of site neutral payments and modality agnostic payments for external beam RT services. There has been debate regarding the benefits of PBT relative to other, less expensive modalities. In a June 2018 Report to Congress, Medicare Payment Advisory Commission (MedPAC) discussed Medicare coverage policy and use of low-value care and examined services, including PBT, which lack evidence of comparative clinical effectiveness and are therefore potentially low value.[1] Published, peer-reviewed studies suggest PBT has superior net health benefit for ocular tumors, head and neck cancers, and pediatric cancers, but PBT has been found to have equivalent outcomes to other forms of external beam RT for prostate, lung, and liver cancer. We finalized the inclusion of PBT in the RO Model with one exception. When PBT is furnished to an RO beneficiary participating in a

[1] https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-jun18_medpacreporttocongress_rev_nov2019_note_sec-pdf/

federally-funded, multi-institution, randomized control clinical trial for PBT, the Model pays fee-for-service to support gathering further clinical evidence on the health benefit of PBT compared to other modalities. Given the continued debate around the benefits of PBT and understanding that PBT is more costly than other modalities, we believe that it is appropriate to include in the RO Model's test.

96. What if the RO beneficiary needs additional RT services beyond the 90 days?

Another episode may not be triggered until at least 28 days after the previous episode has ended. This is because, while a missed week of treatment is not uncommon, a break from RT services for more four weeks (or 28 days) generally signals the start of a new course of treatment.[2] We refer to the 28-day period after an episode has ended, during which time an RO participant will bill for medically necessary RT services furnished to an RO beneficiary in accordance with traditional Medicare fee-for-service billing rules, as the "clean period." If clinically appropriate, an RO participant may initiate another episode for the same beneficiary after the 28-day clean period has ended. CMS will closely monitor utilization of RT services following the 90-day time period and the initiation of multiple episodes for a single beneficiary.

97. What is an incomplete episode?

An incomplete episode may occur for different reasons:

- A Technical participant or a Dual participant does not furnish a technical component (TC) to an RO beneficiary within 28 days following a Professional participant or the Dual participant furnishing the initial RT treatment planning service to that RO beneficiary;
- Traditional Medicare stops being the primary payer for the RO beneficiary at any point during the relevant 90-day period, provided that an RT provider or RT supplier furnishes a TC RT service to the RO beneficiary within 28 days of such initial treatment planning service; or
- An RO beneficiary switches RT provider or RT supplier before all RT services in the episode have been furnished.

Incomplete episodes are reconciled to fee-for-service (FFS) during the annual reconciliation process or true-up process except when an RO beneficiary ceases to have traditional FFS Medicare as their primary payer at any time after the initial treatment planning service is furnished and before the date of service on a claim with an RO Model-specific HCPCS code and end-of-episode modifier, provided an RO participant furnishes a TC RT service to the RO beneficiary within 28 days of such initial treatment planning service. In this case, the RO participant is owed only the first installment of the episode payment amount.

98. [REVISED] What is an example of an incomplete episode?

There are four types of incomplete episodes.

First, an RO episode is considered incomplete if a Technical participant or Dual participant does not furnish a technical component (TC) to a beneficiary within 28 days following a Professional participant or Dual participant furnishing the initial RT treatment planning service to that beneficiary. If all RT services are furnished to a beneficiary in a non-participating ZIP Code, even if

[2] CMS was advised by radiation oncologists consulting on the design of the Model that four weeks signals the start of a new course of treatment.

the initial RT treatment planning service was furnished in a participating ZIP Code, the episode would be incomplete.

Second, an RO episode is considered incomplete if the RO beneficiary stops meeting any of the eligibility criteria or triggers any of the exclusion criteria before the TC of an episode initiates.

Third, an RO episode is considered incomplete if the beneficiary ceases to have traditional fee-for-service Medicare as their primary payer at any time after the initial treatment planning service is furnished and before the date of service on a claim with an RO Model-specific HCPCS code and an end-of-episode modifier. For example, this could occur if a beneficiary switches to Medicare Advantage or a private payer during the RO episode.

Fourth, an RO episode is considered incomplete if a beneficiary switches RT provider or RT supplier during the RO episode and is no longer under the care of the RO participant that initiated the professional component and/or the TC of the RO episode.

99. What is a duplicate RT service?

A duplicate RT service is defined as any included RT service that is furnished to an RO beneficiary by an RT provider or RT supplier that is not excluded from participation in the RO Model, and that did not initiate the professional component (PC) or the technical component (TC) of the RO beneficiary's RO episode.

An RT service furnished to a single RO beneficiary by a RT provider or RT supplier not operating in an included Core-Based Statistical Area but not otherwise excluded from participation in the Model, is considered a duplicate RT service.

An RT service furnished to a single RO beneficiary by a RT provider or RT supplier operating in an included CBSA but excluded from participation in the Model is not considered a duplicate RT service. The RO beneficiary would remain under the care of the RO participant that initiated the PC and/or TC, and in many circumstances, the duplicate RT service would be a different modality than what is furnished by the RO participant. The RO participant(s) that bills the start-of-episode and end-of-episode claims would receive the bundled payment and the RT provider and/or RT supplier furnishing one or more duplicate RT services would bill claims using the designated modifier or condition code to indicate that they should be paid fee-for-service. Thus, cash flow would not be affected by this.

100. What is an example of a duplicate RT service?

A duplicate RT service is any included RT service that is furnished to an RO beneficiary by an RT provider or RT supplier that did not initiate the professional component or technical component of that beneficiary's RO episode. The RT service is a duplicate RT service even if the RT provider or RT supplier did not furnish the included RT service in a participating ZIP Code. The RT service is not a duplicate RT service if it is furnished in Maryland, Vermont, or in a United States (U.S.) Territory. The RT service is also not a duplicate RT service if it is furnished by an ambulatory surgery center (ASC), critical access hospital (CAH), or Prospective Payment System (PPS)-exempt cancer hospital or an HOPD identified by CMS as participating in the Pennsylvania Rural Health Model (PARHM).

Duplicate RT services could occur when separate RT providers and RT suppliers deliver a combination of modalities to an RO beneficiary. Any included RT service that is covered by the bundled payment provided by an additional RT provider or RT supplier is a duplicate RT service.

101. Who can start an RO episode? Can only radiation oncologists start an RO episode?

There are no requirements on the type of clinician who can initiate an RO episode. However, treatment planning services, which trigger the start of an episode, are typically performed by a radiation oncologist.

See FAQ "When does an RO episode start?"

102. Why is CMS recommending the use of hypofractionation?

It is not CMS' intent to encourage hypofractionation specifically. It is our intent to use hypofractionation as an example of a treatment option often cited in nationally recognized, evidence-based guidelines. We rely on Medicare providers and suppliers to furnish appropriate care to RO beneficiaries. As finalized in sections III.C.14 (85 FR 61252) and III.C.16 (85 FR 61257), we will monitor for unintended consequences of the RO Model, and such monitoring could include utilization patterns regarding fractions.

103. Is CMS punishing historically efficient RO participants?

Some RO participants expressed concern that efficient practices will be punished under the RO Model. We do not believe that is the case. We calculate episode-based payments under the RO Model based on the average spend for each episode in all hospital outpatient departments (HOPDs) nationally. If RO participants spent less historically (on average) than the average spending of all HOPDs nationally, then their payment amount is 90 percent of what they would have been paid historically for the professional component and/or technical component of the respective cancer type furnished and 10 percent of the corresponding trended national base rate. This will result in a historically efficient RO participant seeing an increase in payment compared to historical amounts prior to the discount and withholds being applied; for some of these RO participants, the payment amounts will be an increase under the Model even with the discount and withholds being applied.

104. How will the RO Model account for new technology?

To the extent that new technologies and new equipment are billed under new HCPCS codes, CMS will go through rulemaking to propose adding those new codes to the list of RO Model Bundled HCPCS list. We believe that any increased utilization of established codes that are included RT services over time will be accounted for with the trend factor described in section III.C.6.d. (85 FR 61186). Until new technologies with corresponding HCPCS codes are added the list of included services for the RO Model, they will be paid fee-for-service.

Participant Billing and Reimbursement

Frequently asked questions about participant billing and reimbursement can be found in the RO Model Billing Guide on the RO Model website (https://innovation.cms.gov/innovation-models/radiation-oncology-model).

Episode Payment Amount

105. [REVISED] When will my historical experience and case mix adjustments be available and where can I find them?

Participant-specific professional and technical case mix adjustments, and participant-specific professional and technical historical experience adjustments for the previous 2022 RO Model start date are available on the 'Administrative Data' page in the Radiation Oncology Administrative Portal (ROAP).

RO participants can access their participant-specific adjustments based on the previous 2021 Model start date in the 'Archived' section of the 'Administrative Data' page in the ROAP.

106. Are historical experience and case mix adjustments calculated by cancer site?

No. The participant-specific historical experience and case mix adjustments do not vary by cancer type. There is one professional and/or one technical case mix adjustment per RO participant depending on the type of component the RO participant furnished during the baseline period, just as there is one professional and/or one technical historical experience adjustment per RO participant, depending on the type of component the RO participant furnished during the baseline period.

107. How does opting out impact my historical experience adjustments in later performance years?

Opting out does not impact an RO participant's historical experience adjustment. Whether an RO participant opts-out or not, an historical experience adjustment will still be calculated based on baseline episodes and used if an RO participant does not opt-out in later performance years.

108. [REVISED] How are the 60 episodes for the historical experience adjustment calculated?

If you have fewer than 60 episodes in the three-year baseline period, then you will not have an historical experience adjustment. The 60 episodes are calculated by summing the total over the three-year period. For example, if an RO participant has one episode in the first year of the baseline period, 20 in the second year, and 20 in the third year, then that RO participant will not have an historical experience adjustment.

109. Will I be able to find out how much I will be paid before participating in the RO Model?

In the CY 2022 OPPS/ASC Payment System final rule with comment period (CMS-1753-FC) you will find the national base rates by cancer type. You can also find a copy of that table at the end of this document. No later than thirty (30) days prior to the start of each performance year, CMS will provide each RO participant with its case mix and historical experience adjustments for both the professional component and technical component in the Radiation Oncology Administrative Portal (ROAP), and the trended national base rates on the RO Model website (https://innovation.cms.gov/initiatives/radiation-oncology-model/). The geographic adjustments will be applied in the same manner under the RO Model as they are under Medicare fee-for-service in the current Physician Fee Schedule and Outpatient Prospective Payment System claims systems.

The RO Model Pricing Workbook available on the RO Model website (https://innovation.cms.gov/innovation-models/radiation-oncology-model) is designed to help RO participants understand the RO Model pricing methodology by providing participant-specific

payment rate estimates based on cancer type, geographic location, and case mix and historical experience adjustments. Choose a cancer type and geographic location from the drop-down menus, input adjustment values (available on ROAP) and the appropriate trend factor (available on the RO Model website), and then the workbook will compute an estimate for your entity's participant-specific professional or technical (depending on the component chosen) episode payment amount for that cancer type. For the reasons listed in the workbook, this estimate will not be exact.

110. Are historical payments adjusted for inflation prior to calculation for a performance year amount? 2017 is five years ago when the RO Model begins.

The RO Model's pricing methodology describes how episode payment amounts under the RO Model are appropriately set for each performance year. For instance, the pricing methodology describes how episodes in the baseline period of 2017-2019 are converted to 2019 dollars and how the trend factor adjusts episode payment amounts for each performance year according to the payment rates set for the upcoming year under the Physician Fee Schedule and Outpatient Prospective Payment System.

111. How do I interpret my Case Mix and Historical Experience Adjustments?

The historical experience and case mix adjustments account for differences in RO participants' historical care patterns and the demographic characteristics of their patient populations. Every RO participant receives one professional and/or one technical historical experience adjustment and one professional and/or one technical case mix adjustment depending on the type of component the RO participant furnished during the baseline period.

An historical experience adjustment with a negative value indicates that the RO participant was historically efficient compared to the national base rates. Conversely, an historical experience adjustment with a positive value indicates that the RO participant was historically inefficient compared to the national base rates. Similarly, for the case mix adjustment, we look at the presence of beneficiary-level variables (cancer type; age; sex; presence of a major procedure; death during the first 30 days, second 30 days, or last 30 days of the episode; and presence of chemotherapy) among the beneficiaries that the RO participant treated historically compared to the presence of those variables among the national population. A negative case mix adjustment indicates that the RO participant treated complex or costlier beneficiaries less often when compared to the national average. A positive case mix adjustment indicates they treated complex or costlier beneficiaries more often when compared to the national average.

Participant-specific professional and technical case mix adjustments, and participant-specific professional and technical historical experience adjustments for the previous 2022 RO Model start date are available on the 'Administrative Data' page in the Radiation Oncology Administrative Portal (ROAP).

RO participants can access their participant-specific adjustments based on the previous 2021 Model start date in the 'Archived' section of the 'Administrative Data' page in the ROAP.

112. What if I have questions about my case mix and historical experience adjustments?

If an RO participant has questions about the values of their case mix adjustments and/or their historical experience adjustments, they may reach out to the RO Model Help Desk. Please also note that RO participants may download and submit a Data Request and Attestation form via the

Radiation Oncology Administration Portal to receive different types of files from CMS, including certain beneficiary line-level claims data, episode-level data, and participant-level data so long as the RO participant uses such data for care coordination and quality improvement purposes.

113. Does the RO Model have a stop-loss policy?

RO participants that have fewer than 60 episodes in the baseline period do not have sufficient historical volume to calculate a reliable adjustment. Since these RO participants do not qualify to receive an historical experience adjustment and may see greater increases or reductions as compared to what they were historically paid under fee-for-service (FFS) as a result of not receiving the adjustment, we are proposing a stop-loss limit of 20 percent for these RO participants that have fewer than 60 episodes in the baseline period and that were furnishing included RT services any time before the start of the model performance period in the Core-Based Statistical Areas selected for participation. Using no-pay claims to determine what these RO participants would have been paid under FFS as compared to the payments they received under the Model, CMS will pay these RO participants retrospectively for losses in excess of 20 percent of what they would have been paid under FFS. Payments under the stop-loss policy are determined at the time of the initial reconciliation.

114. Is the stop-loss amount based on what the RO participant would have been paid under fee-for-service, taking into consideration the site of service?

Yes. The stop-loss limit is based on what the RO participant would have been paid under fee-for-service, taking site of service into consideration.

Reconciliation Process

115. What is the purpose of the annual reconciliation process?

An annual reconciliation will be conducted for each RO participant after each performance year (PY) to calculate payments due to the RO participant and payments owed to CMS under the withhold policies. The annual reconciliation will occur in August following each PY to allow time for claims run-out, data collection, reporting, and calculating results. The reconciliation process includes a review of incomplete episodes and duplicate RT services and any stop-loss reconciliation amount due. Under the reconciliation process, CMS will calculate the amount of the quality and patient experience withholds RO participants earn back based on clinical data reporting, and reporting and performance on quality measures, and the beneficiary-reported Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Cancer Care Radiation Therapy Survey. Any portion of the withholds that is earned back will be distributed in an annual lump sum after the reconciliation process.

When an RO participant owes CMS money (reconciliation repayment) or CMS owes the RO participant money (reconciliation payment), the RO participant shall not collect coinsurance on these amounts. We will provide RO participants with additional instructions for billing, particularly as it pertains to how beneficiary coinsurance will be accounted for in reconciliation.

116. What if I disagree with my RO Model Reconciliation Report?

Participants may submit a request to RadiationTherapy@cms.hhs.gov if they detect a calculation error(s) on an RO Model reconciliation report that has not been deemed final. There is a two-level process for RO participants to request reconsideration of determinations related to calculation of their reconciliation payment, recoupment amount, or Aggregate Quality Score (AQS) under the RO Model. First, participants must use the *timely error notice process* and if a second review is required, they may use the *reconsideration review process*. The RO Model pricing methodology and AQS methodology are not subject to review.

Quality Measures

117. [REVISED] How is quality measure and clinical data element (CDE) reporting impacted by the implementation of the Extreme and Uncontrollable Circumstances (EUC) policy?

CMS previously announced that it intended to invoke the EUC based on the ongoing COVID-19 public health emergency. This would have made CDE and quality measure reporting optional for performance year 1.

However, The Protecting Medicare and American Farmers from Sequester Cuts Act (P.L. 117-71) enacted on December 10, 2021, includes a provision that prohibits implementation of the Radiation Oncology Model prior to January 1, 2023. Thus, the RO Model did not begin on January 1, 2022.

Due to this delay, CMS did not invoke the EUC policy on January 1, 2022.

118. [REVISED] Will the RO Model collect quality measure data?

Yes. The RO Model will collect quality measure data for two reasons. First, the RO Model is designed to preserve or enhance quality of care, and quality measures are necessary to quantify the impact of the RO Model on quality of care, RT services and processes, outcomes, patient experience, and organizational structures and systems. Second, the RO Model qualifies as an Advanced Alternative Payment Models (APM) and will also meet the Merit-based Incentive Payment System (MIPS) APM criteria. We selected the RO Model's quality measures to satisfy concurrently the quality measure-related requirements for both an Advanced APM and a MIPS APM.

RO participants will report quality measure data (e.g., numerator, denominator) to CMS at the RO Model ID level, not the beneficiary level.

119. [REVISED] What quality measures are included in the RO Model?

The following four quality measures are included in the RO Model:

- Oncology: Medical and Radiation - Plan of Care for Pain - *NQF #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

CMS finalized in the CY 2022 OPPS/ASC Payment System final rule with comment period (CMS-1753-FC) that Oncology: Medical and Radiation – Plan of Care for Pain; Preventive Care and Screening: Screening for Depression and Follow-Up Plan; and Advance Care Plan will be implemented as pay-for-performance measures beginning in performance year (PY) 1. CMS also finalized that the Treatment Summary Communication will be implemented as pay-for-reporting in PY1 and PY2, and as pay-for-performance in PY3 (subject to change depending on availability of a historical benchmark).

Starting in PY3, the RO Model will also include patient experience measures based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Cancer Care Radiation Therapy Survey. The specific measures will be proposed through future rulemaking.

120. Do RO participants have to report on quality measures for cancer types that are not in the Model and are billed fee-for-service?

Yes. Professional participants and Dual participants should report on all patients seen by a participating radiation oncologist that meet the published inclusion criteria for the measure.

121. Do RO participants have to report on quality measures for patients that do not have traditional Medicare as their primary insurance?

Yes. Professional participants and Dual participants should report quality measure data for all patients seen by a participating radiation oncologist as described in the measure's specification.

122. Is the RO Model collecting outcome measures?

No. At the present time CMS is not collecting data on any outcome measures for the RO Model. QPP does require that model participants in Advanced Alternative Payment Models (APMs) that furnish professional services submit data for at least one outcome-based quality measure, unless CMS determines that there are no available or applicable outcome measures included in the Merit-based Incentive Payment System (MIPS) final quality measures list for the Advanced APM's first Qualifying APM Participant (QP) Performance Period. CMS determined there are currently no outcome measures available or applicable for the RO Model; as such, this outcome measure requirement does not apply to the RO Model. However, if a potentially relevant outcome measure becomes available in the future, CMS will review it to determine if it is appropriate for the RO Model, and if so, propose to apply it to the RO Model through rulemaking.

123. How will quality measure data be submitted?

Professional participants and Dual participants will use the RO Model Secure Data Portal to input quality measure data. The RO Model Quality Measure and Clinical Data Element Collection and Submission Guide and the RO Model Secure Data Portal User Manual, both available on the RO Model website (https://innovation.cms.gov/initiatives/radiation-oncology-model/), include references to the measure specifications for each quality measure, and instructions for how to use the RO Model Secure Data Portal for data submission. These resources also include relevant education and outreach information on the use of these mechanisms for data collection and where to submit the data prior to the first data submission period.

124. [REVISED] Is the RO Model collecting clinical data?

Yes. Starting in performance year 1, the RO Model will collect clinical data elements (CDEs) for five of the included cancer types (prostate, breast, lung, bone metastases, and brain metastases) to support: 1) clinical monitoring; 2) evaluation of the RO Model; 3) informing possible future refinements to the RO Model; and 4) possible development and testing of new radiation oncology-specific quality measures.

For details, see the RO Model Quality Measure and Clinical Data Element Collection and Submission Guide, available on the RO Model website (https://innovation.cms.gov/innovation-models/radiation-oncology-model).

125. [REVISED] What clinical data elements are participants required to submit?

All Professional participants and Dual participants are required to report clinical data elements (CDEs) for RO beneficiaries (Medicare beneficiaries who meet all the beneficiary inclusion criteria and whose RO episodes meet all the criteria) treated for five included cancer types – prostate, breast, lung, bone metastases, and brain metastases. The list of clinical data elements for each cancer type are available in the RO Model Quality Measure and Clinical Data Element Collection and Submission Guide, available on the RO Model website (https://innovation.cms.gov/innovation-models/radiation-oncology-model). In general, CDEs provide information not available in claims or captured in the quality measures, such as cancer stage, histology, treatment intent, and specific treatment plan information.

126. Will clinical data element submission be supported by electronic health records (EHR)?

To facilitate data collection, we have released an RO Model Quality Measure and Clinical Data Element Collection and Submission Guide, which is available on the RO Model website (https://innovation.cms.gov/innovation-models/radiation-oncology-model). Our goal is to structure data reporting standards to the extent possible so that existing electronic health records (EHRs) could be adjusted in anticipation of the first submission period. The first submission period will be due July 2022 for clinical data elements collected January 1, 2022 through June 30, 2022. Such EHR changes may facilitate easier data extraction and reduce the additional reporting burden on providers and may increase the quality and volume of reporting. Providers may also opt to extract the necessary data elements manually. The CDE templates provide a structured way to report CDEs via the RO Model Secure Data Portal. RO participants can manually enter the CDEs into the CDE templates or export CDEs from their EHRs. Included in the CDE templates is a tab containing information that may be useful for you and your EHR vendor, if setting up a query to output CDEs from your EHR.

The following CDE templates are available on the RO Model website (https://innovation.cms.gov/innovation-models/radiation-oncology-model):

- Bone Mets CDE Template (XLS)
- Brain Mets CDE Template (XLS)
- Breast CDE Template (XLS)
- Lung CDE Template (XLS)
- Prostate CDE Template (XLS)

127. Should I submit clinical data elements (CDEs) for the same cancer type on the same template? Should I submit all CDEs together, or separately by physician?

CDEs are submitted on cancer-specific tabs within the RO participant's Microsoft Excel CDE workbook, available in the RO Model Secure Data Portal. For example, all RO beneficiaries treated for breast cancer would appear on the breast cancer tab.

CDEs are submitted for the Professional participant or Dual participant as a whole. Included are all RO beneficiaries receiving RT services from providers included on the Individual Practitioner List certified in the Radiation Oncology Administrative Portal.

See FAQ "Will clinical data element submission be supported by electronic health records (EHR)?" for links to CDE templates, which replicate what each cancer-specific table will look like in the Microsoft Excel CDE workbook.

128. What level are quality measures and clinical data elements reported at? How do I report these for multiple locations?

Professional participants and Dual participants will report aggregate quality measure data at the TIN-NPI level.

Quality measure reporting will include all patients at the RO participant site who received RT services from providers included on the Individual Practitioner List. Unlike clinical data elements (CDEs), quality measure reporting is NOT limited to RO beneficiaries.

Clinical data element (CDEs) are reported at the RO beneficiary level, with one record for each RO episode completed during the reporting period.

129. How will performance on quality measures be connected to payment?

The RO Model includes an Aggregate Quality Score (AQS). The AQS is calculated based on each Professional participant's and Dual participant's 1) performance on a set of quality measures compared to quality performance benchmarks; 2) reporting of data for the pay-for-reporting measures; and 3) reporting of clinical data elements on applicable RO beneficiaries, with 50 percent of the score based on quality measures components and the other 50 percent on successful reporting of clinical data element. The Professional participant's and Dual participant's performance on both portions of the AQS is then used to calculate points, which are then converted into a percentage. This resulting AQS percentage is applied during the reconciliation process to allow a Professional participant or a Dual participant to earn back a percentage of the quality withhold that was included in the calculation of the episode payment amount.

Starting in performance year 3, RO participants will be accountable for patient experience via the patient reported CAHPS® Cancer Care Radiation Therapy survey administered by a CMS contractor. Professional participants and Dual participants will have their CAHPS® Cancer Care Radiation Therapy results incorporated into their AQS and applied to their quality withhold reconciliation amount. Technical participants will have their CAHPS results applied to their patient experience withhold reconciliation amount.

130. My practice has a variety of clinicians, many that are not radiation oncology practitioners. How does this impact our Alternative Payment Models (APM)/ Merit-based Incentive Payment System (MIPS) status? How does this impact our quality scores?

Quality measures will be reported at the TIN-NPI level and will include all patients receiving RT services from Professional participants and Dual participants included on the individual practitioner list (IPL) certified in the Radiation Oncology Administrative Portal (ROAP). Practitioners that are NOT radiation oncologists will not be on IPL certified in ROAP. Therefore, all visits to these practitioners are excluded from the quality measure calculations. Only eligible clinicians included on the IPL for the RO Model will be considered as Qualifying Alternative Payment Model (APM) Participants (QPs) or as Merit-based Incentive Payment System (MIPS) eligible clinicians. Any other practitioners in a practice not on the IPL for the RO Model would participate in the QPP separately.

131. Do we need to submit both question #143 and #144 for the Pain Intensity Quantified quality measure?

No. CMS Quality ID #143 – Pain Intensity Quantified and CMS Quality ID #144 – Plan of Care for Moderate to Severe Pain are separate quality measures. RO participants do not need to submit information on CMS Quality ID #143 – Pain Intensity Quantified. RO participants should submit data specifically on CMS Quality ID #144 – Plan of Care for Moderate to Severe Pain to ensure that patients with moderate to severe pain have a plan of care in place. As part of CMS #144, RO participants will need to have a process in place to quantify pain to determine which patients are included in the quality measure's denominator.

132. Is the NCCN Distress Thermometer an appropriate screening tool to satisfy the requirements of the "Preventive Care and Screening: Screening for Depression and Follow-Up Plan" quality measure?

The "Preventive Care and Screening: Screening for Depression and Follow-Up Plan" quality measure requires that an age-appropriate, standardized, and validated depression screening tool be used for numerator compliance, however, the measure is not prescriptive as to what screening tool may be used. While the measure specification includes examples of standardized depression screening tools for a range of patient populations, this list is not meant to be exhaustive. Clinicians may select one of the example tools or another standardized depression screening tool to apply in practice.

Upon reviewing the literature, the NCCN Distress Thermometer is a standardized and validated tool used for depression screening that meets numerator requirements. We encourage clinicians to review instructions on how to use the screening tool of their choice and interpret scores, keeping in mind that this measure looks at the most recent completed depression screening to determine if positive, and if appropriate, follow up was documented.

133. [NEW] Can depression screening be self-reported through the issuance and completion of a patient questionnaire that is completed prior to consult?

RO participants should refer to the measure specification to ensure they are complying with the quality action(s), given the intent of the measure. With that said, the Preventive Care and Screening: Screening for Depression and Follow-Up Plan measure (CQM #134) does not dictate where the depression screening occurs, just that it occurs on the date of the eligible encounter or up to 14 days

prior to the date of the eligible encounter. Since the location of the depression screening is not dictated within the measure specification, it is acceptable for the RO practitioner to have the patient complete the screening via a patient portal or some other mechanism on the date of the eligible encounter or up to 14 days prior to the date of the eligible encounter. The completed depression screening must be reviewed at the RO practitioner's office on the date of the eligible encounter and, if positive, a follow-up plan of care documented on the date of the eligible encounter.

134. [NEW] If a multidisciplinary setting includes Advance Care Planning as part of its own internal process, can the collection of an Advance Care Plan as part of the initial oncology visit satisfy requirements?

RO participants should refer to the measure specification to ensure they are complying with the quality action(s), given the intent of the measure. The Advance Care Plan measure (CQM #047) requires that patients have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan. The measure specifications do not dictate who must complete the discussion and documentation (the 'quality action'); however, the quality action does need to be documented in the patient's medical record during the measurement period.

135. [NEW] When must RO participants provide the treatment summary?

There are two requirements related to the treatment summary.

The RO Model requirements include that the treatment summary be sent to each RO beneficiary's referring physician within three months of the end of treatment to coordinate care.

The Treatment Summary Communication quality measure requires that the treatment summary report be communicated to the physician(s) providing continuing care and to the patient within one month of completing treatment. The measure specification does not define 'physician providing continuing care.' The type of physician will likely vary across patients but should be the one who is offering continuing care to the patient following the completion of treatment.

136. Will my practice administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Cancer Care Radiation Therapy Survey?

No. A CMS contractor will be administering the survey. The contractor will be responsible for all aspects of fielding the CAHPS® Cancer Care Radiation Therapy survey.

Administration of the CAHPS® Cancer Care Survey will begin in the seventh month of performance year (PY) 1 and include all RO beneficiaries completing their RO episode during the first six months of the RO Model. Thereafter, RO beneficiaries completing their RO episode will be added to the survey sample quarterly. CAHPS® results will be included in the AQS beginning in PY3.

Quality Payment Program

137. What changes were made in the CY 2022 OPPS/ASC Payment System final rule with comment period (CMS-1753-FC) regarding the RO Model's participation in the Quality Payment Program?

CMS codified at § 512.220 that there are three tracks in the RO Model, as it relates to the Quality Payment Program.

Track One will include Professional participants or Dual participants who meet all RO Model requirements, including CEHRT use, and we expect Track One will qualify as an Advanced APM and a MIPS APM.

If Track One participants do not meet the QP threshold, they will be eligible for APM scoring in MIPS.

Track Two will include all Professional participants and Dual participants who meet all RO Model requirements, except for the CEHRT requirement, and we expect that Track Two will qualify as a MIPS APM only.

Track Three will include all other RO participants, specifically Professional participants and Dual participants who fail to meet the RO Model requirements, including CEHRT, and Technical participants. Track Three will not be an Advanced APM or MIPS APM.

138. Can RO Participants be Qualifying Alternative Payment Model (APM) Participants?

The RO Model is an Advanced Alternative Payment Model (APM) and a Merit-based Incentive Payment System (MIPS) APM. As such, eligible clinicians who are Professional participants and Dual participants may potentially become Qualifying APM Participants (QPs) who earn an APM Incentive Payment and are excluded from the MIPS reporting requirements and payment adjustment. Those who are not excluded from MIPS as QPs or Partial QPs will receive a final score and payment adjustment under MIPS, unless otherwise excepted. We believe these aspects of the RO Model as an Advanced APM and a MIPS APM will provide eligible participants with an example of the upside opportunity for high-performing participants under the Model.

139. If a practice is already a participant in an Advanced Alternative Payment Model (APM), are they required to drop that participation and report for the RO Model?

No, we encourage continued participation in multiple Alternative Payment Models (APMs).

140. How does the Qualifying Alternative Payment Model (APM) Participant (QP) threshold apply to the RO Model?

In 2021, the Qualifying Alternative Payment Model (APM) Participant (QP) threshold is such that eligible clinicians must receive at least 50 percent of their Medicare Part B payments or see at least 35 percent of Medicare patients through an Advanced APM at one of the determination dates during the QP Performance Period. Further information may be found on CMS' Advanced APMs website (https://qpp.cms.gov/apms/advanced-apms).

141. How does the Alternative Payment Model (APM) Incentive Payment apply to RO participants?

CMS has finalized in the CY 2022 OPPS/ASC Payment System final rule with comment period (CMS-1753-FC) that Dual participants or Professional participants who meet the RO Model requirements, including CEHRT use, will fall into a category called "Track One." Track One participants who achieve Qualifying Alternative Payment Model (APM) Participant (QP) status through the RO Model in a QP Performance Period earn an APM Incentive Payment in the corresponding payment year. The APM Incentive Payment is equal to 5 percent of the aggregate payments for the professional component of the episode payment in the calendar year preceding the payment year. The technical component of the episode payment is not included when calculating the APM Incentive Payment under the RO Model.

142. How does the RO Model interact with the Merit-based Incentive Payment System (MIPS)?

Merit-based Incentive Payment System (MIPS) eligible clinicians (identified by a combination of their TIN and NPI)) will receive positive, neutral, or negative adjustments to their Medicare Part B payments for covered professional services based on their performance on a range of measures and activities during the applicable MIPS performance period. MIPS eligible clinicians that participate in the RO Model, will see the MIPS payment adjustment factors applied to the professional component only of their RO Model claims.

CMS codified at § 512.220 that there are three tracks in the RO Model, as it relates to the Quality Payment Program.

Track One will include Professional participants or Dual participants who meet all RO Model requirements, including CEHRT use, and we expect Track One will qualify as an Advanced APM and a MIPS APM.

If Track One participants do not meet the QP threshold, they will be eligible for APM scoring in MIPS.

Track Two will include all Professional participants and Dual participants who meet all RO Model requirements, except for the CEHRT requirement, and we expect that Track Two will qualify as a MIPS APM only.

Track Three will include all other RO participants, specifically Professional participants and Dual participants who fail to meet the RO Model requirements, including CEHRT, and Technical participants. Track Three will not be an Advanced APM or MIPS APM.

143. If an RO participant is not compliant with the Advanced Alternative Payment Model (APM) requirement to use CEHRT, does it impact their standing in the RO Model, or the Quality Payment Program?

RO participants will be monitored for compliance with the RO Model requirements, including CEHRT. To be in Track One of the RO Model, which we expect will qualify as an Advanced APM and a Merit-based Incentive Payment System (MIPS) APM, Professional participants and Dual participants must meet all RO Model requirements specified at § 512.220, including CEHRT. Professional participants and Dual participants who meet all RO Model requirements specified at § 512.220, except for the CEHRT requirement, will be in Track Two of the RO Model, which we expect will qualify as a MIPS APM only. If an RO participant meets the CEHRT use requirements pursuant to § 414.1415(a)(1)(i) by the last QP determination snapshot date specified at § 414.1325,

they would be moved to Track One of the RO Model and would be considered at that point to be participating in an Advanced APM, provided the RO participant meets all other RO Model requirements set forth at § 512.220.

144. How do I attest to CEHRT use?

RO participants will attest to CEHRT use in the Radiation Oncology Administrative Portal in the "Attestations" tab.

- Professional participants and Dual participants that are using CEHRT for the current performance year can check the box "I attest that we are in compliance with the CEHRT statement to the best of my knowledge." Assuming all other requirements are met, this makes you eligible for Track One. Track One means a track for Professional participants and Dual participants that meet all RO Model requirements as specified in § 512.220, including use of CEHRT. QPP would make Qualifying Advanced Payment Model (APM) Participation (QP) determinations for the eligible clinicians on your individual practitioner list, as provided in as provided in 42 CFR § 414.1425.
- Professional participants and Dual participants that do not have CEHRT for the current performance year can check "I attest that we are not in compliance with the CEHRT statement to the best of my knowledge." Assuming all other requirements are met, this makes you eligible for Track Two. Track Two means a track for Professional participants and Dual participants that meet all RO Model requirements as specified in § 512.220, except for use of CEHRT. You can report to the Merit-based Incentive Payment System (MIPS) using reporting options applicable to MIPS APM participants as specified at 42 CFR § 414.1367.
- Technical participants should check "N/A. We are a Technical participant." This will put you in Track Three.

145. Can an RO participant use one system for CEHRT and a different software system to capture quality measures and clinical data elements?

For the CEHRT requirement under the QPP, RO participants must use an electronic health record software system that is certified by the Office of the National Coordinator for Health Information Technology. For the quality measures and clinical data elements, RO participants may use the software system of their choice.

146. Do both the Professional participants and Technical participants both need to meet Certified Electronic Health Record Technology (CEHRT) requirements?

Professional participants and Dual participants are required to meet CEHRT requirements.

Technical participants are <u>not</u> required to meet CEHRT requirements.

147. When will the QPP system recognize RO participants?

Participation in the RO Model will be reflected on the QPP website starting in performance year 1.

Monitoring and Evaluation

148. What will RO participants be monitored for to ensure RO Model compliance?

Pursuant to 512.150(b), CMS will conduct monitoring activities to ensure that each RO participant and their individual practitioners are in compliance with the RO Model requirements as outlined in III.C.14 (85 FR 61252). In addition, CMS may conduct monitoring activities to understand RO participants' use of model-specific payments, to promote the safety of beneficiaries, and to ensure the integrity of the RO Model. These activities could include analysis of participant claims, quality, clinical and other data, as well as desk audits, chart reviews, and onsite visits.

149. What data are RO Participants required to provide for monitoring purposes?

CMS has broad authority to obtain information for monitoring and oversight. Under § 512.150(b)(2), CMS may use "any relevant data or information, including without limitation all Medicare claims submitted for items or services furnished to model beneficiaries." In conducting monitoring activities, CMS may require the submission of any information determined necessary to monitor the RO Model (see 42 CFR § 403.1110(b)). Such information may include medical records and other protected health information required to support audits of claims data and quality and clinical data. CMS may use these data to track utilization of certain types of treatments, beneficiary hospitalization and emergency department use, and fractionation (numbers of treatments) against historical treatment patterns for each participant. Site visits may be used to better understand how RO participants manage services, use evidence-based care, and practice patient-centered care. Site visit activities may include, but are not limited to, interviewing RO participant(s) and staff, reviewing records, and observing treatments.

150. What is the purpose of the RO Model evaluation?

Under section 1115A(b)(4) of the Social Security Act, the RO Model evaluation must include an analysis of at least the following information: (i) the quality of care furnished under the RO Model, including measurement of patient-level outcomes and appropriate patient-centeredness criteria; and (ii) the changes in Medicare spending under the RO Model.

All RO participants are required to cooperate with efforts to conduct an independent, federally funded evaluation of the Model, which may include participation in surveys, interviews, site visits, and other activities that CMS determines necessary to conduct a comprehensive formative and summative evaluation. The evaluation will assess the impact of the RO Model in meeting its intended goals and serves to inform policy makers about the effect of the RO Model on health care quality and Medicare spending. The evaluation will consider how the RO Model results may have been affected by any relevant changes in Medicare payment policy that became effective during the model performance period.

An Evaluation Report will be publicly released for each performance year of the RO Model. Detailed methodologies and data sources used to create these estimates will be included in each Evaluation Report.

151. What is the process for CMS to take remedial action against an individual practitioner?

CMS will monitor for compliance with Model terms as well as other Medicare program rules. Under § 512.160, CMS may take remedial action against an RO participant or a downstream

participant, including an individual practitioner, if any of the grounds for remedial action exist (see 42 CFR. § 512.160(a)). In the case of remedial action based on the act or omission of an individual practitioner, we would typically notify the RO participant and the individual practitioner of the grounds for remedial action and require the submission of additional information or a corrective action plan. Depending on the circumstances, CMS may also initiate action against RO participants or individual service providers under other existing authority, including 42 CFR. § 424.535(a).

Resources

152. What resources are available to participants to guide them through the RO Model?

A variety of resources are available on the RO Model website (https://innovation.cms.gov/initiatives/radiation-oncology-model/) and RO Connect, including the following:

General Information

- RO Model Fact Sheet
- Participating ZIP Code List (XLS)
- RO Beneficiary Notification Letter (PDF)
- PA Rural Health Model Participating Hospitals

Regulations and Notices

- Medicare Program: Specialty Care Models to Improve Quality of Care and Reduce Expenditures Final Rule (2020) (https://www.federalregister.gov/documents/2020/09/29/2020-20907/medicare-program-specialty-care-models-to-improve-quality-of-care-and-reduce-expenditures)
- Medicare Program: Specialty Care Models to Improve Quality of Care and Reduce Expenditures Technical Correction (2020) (https://www.federalregister.gov/documents/2020/12/02/2020-26512/medicare-program-specialty-care-models-to-improve-quality-of-care-and-reduce-expenditures-correction)
- CY 2021 OPPS/ASC Final Rule (CMS-1736-FC) (2021) (https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1736-fc)
- CY 2022 OPPS/ASC Payment System Notice of Proposed Rulemaking (2022) (https://public-inspection.federalregister.gov/2021-15496.pdf)
- CY 2022 OPPS/ASC Payment System Final Rule (CMS-1753-FC) (2022) (https://www.federalregister.gov/documents/2021/11/16/2021-24011/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment)

Technical Documents

- Data Dictionary for Participant-Specific Data – Data Request and Attestation (DRA) (ZIP)
- Data Dictionary for 2017 – 2019 Baseline Episode File (PDF)
- Bone Mets CDE Template (XLS)

- Brain Mets CDE Template (XLS)
- Breast CDE Template (XLS)
- Lung CDE Template (XLS)
- Prostate CDE Template (XLS)
- 2017 – 2019 Baseline Episode File (2017-2019) (XLS)
- HCPCS_CD Chemotherapy Codes File - July 2021 (CSV)
- NDC Chemotherapy Codes File - July 2021 (CSV)
- Major Procedures File - July 2021 (CSV)
- Case Mix Regression Model – July 2021 (XLS)
- Cancer Diagnoses Used for Assigning Cancer Type to Episodes in the Baseline Period (XLS)
- RO Model Payment Calculator Workbook – July 2021 (XLS)
- RO Model-Specific HCPCS Codes with Trended National Base Rates for PY1 - November 2021 (XLS)
- Included Cancer ICD-10 Codes – August 2021 (XLS)
- Included RT Services (HCPCS Codes) – August 2021 (XLS)

Guides

- Implementation Guide
- RO Model Quality Measure and Clinical Data Elements Guide Version 3.0 (PDF)
- RO Billing Guide

User Manuals

- ROAP User Manual
- RO Model Secure Data Portal User Manual
- RO Model Portal Overview

Additional Resources in RO Connect

- Videos regarding access and use of the RO Model portals (RO Connect, ROAP, and RO Model Secure Data Portal)
- RO Connect Quick Guide

Educational Materials

- RO Model 101 Refresher and Portal Overview Webinar—July 2021
  - Slides (PDF) (https://innovation.cms.gov/media/document/ro-model-101-refresher-slides)
  - Recording (MP4) (https://innovation.cms.gov/media/audio-file/ro-model-101-refresher-webinar-recording)
- Coding, Billing, and Payment Methodology Webinar and Office Hours —August 2021

  - Slides (PDF) (https://innovation.cms.gov/media/document/ro-model-coding-billing-pricing-webinar-aug21)
  - Recording (MP4) (https://innovation.cms.gov/media/audio-file/ro-model-webinar-recording-8-24-21)
- RO Model Requirements Webinar – September 2021
  - Slides (PDF) (https://innovation.cms.gov/media/document/ro-model-requirements-webinar-slides-2021)
  - Recording (MP4) (https://innovation.cms.gov/media/audio-file/ro-model-req-webinar-recording)
- RO Model Clinical Data Elements and Quality Reporting Requirements Webinar – November 2021
  - Slides (PDF) (https://innovation.cms.gov/media/document/ro-model-cde-qm-webinar-slides)
  - Recording (MP4) (https://innovation.cms.gov/media/audio-file/ro-model-data-qual-meas-report-req-webinar-recording)

153. How can I contact CMS if I have additional questions about the RO Model?

The RO Model team can be reached at RadiationTherapy@cms.hhs.gov or by calling the RO Model Help Desk at 1-844-711-2664, option 5. Please include your RO Model ID when making inquiries.

154. Where can RO beneficiaries go with questions about the RO Model?

Beneficiaries can call 1-800-MEDICARE or contact their local Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIOs). Local BFCC-QIO contact information can be located here: https://www.qioprogram.org/locate-your-qio

A.1. List of RO Model Bundled/Packaged HCPCS

HCPCS	HCPCS Description	Category
77014	Computed tomography guidance for placement of	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77021	Magnetic resonance guidance for needle placem	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77261	Radiation therapy planning	Treatment Planning
77262	Radiation therapy planning	Treatment Planning
77263	Radiation therapy planning	Treatment Planning
77280	Set radiation therapy field	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77285	Set radiation therapy field	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77290	Set radiation therapy field	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77293	Respirator motion mgmt simul	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77295	3-d radiotherapy plan	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77299	Radiation therapy planning	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77300	Radiation therapy dose plan	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77301	Radiotherapy dose plan imrt	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77306	Telethx isodose plan simple	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77307	Telethx isodose plan cplx	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77321	Special teletx port plan	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77331	Special radiation dosimetry	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77332	Radiation treatment aid(s)	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77333	Radiation treatment aid(s)	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77334	Radiation treatment aid(s)	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77336	Radiation physics consult	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77338	Design mlc device for imrt	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77370	Radiation physics consult	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77371	Srs multisource	Radiation Treatment Delivery
77372	Srs linear based	Radiation Treatment Delivery

HCPCS	HCPCS Description	Category
77373	Sbrt delivery	Radiation Treatment Delivery
77385	Ntsty modul rad tx dlvr smpl	Radiation Treatment Delivery
77386	Ntsty modul rad tx dlvr cplx	Radiation Treatment Delivery
77399	External radiation dosimetry	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77402	Radiation treatment delivery	Radiation Treatment Delivery
77407	Radiation treatment delivery	Radiation Treatment Delivery
77412	Radiation treatment delivery	Radiation Treatment Delivery
77417	Radiology port images(s)	Radiation Treatment Delivery (Guidance)
77427	Radiation tx management x5	Treatment Management
77431	Radiation therapy management	Treatment Management
77432	Stereotactic radiation trmt	Treatment Management
77435	Sbrt management	Treatment Management
77470	Special radiation treatment	Treatment Management
77499	Radiation therapy management	Treatment Management
77520	Proton trmt simple w/o comp	Radiation Treatment Delivery
77522	Proton trmt simple w/comp	Radiation Treatment Delivery
77523	Proton trmt intermediate	Radiation Treatment Delivery
77525	Proton treatment complex	Radiation Treatment Delivery
G0339	Robot lin-radsurg com, first	Radiation Treatment Delivery
G0340	Robt lin-radsurg fractx 2-5	Radiation Treatment Delivery
G6001	Echo guidance radiotherapy	Radiation Treatment Delivery (Guidance)
G6002	Stereoscopic x-ray guidance	Radiation Treatment Delivery (Guidance)
G6003	Radiation treatment delivery	Radiation Treatment Delivery
G6004	Radiation treatment delivery	Radiation Treatment Delivery
G6005	Radiation treatment delivery	Radiation Treatment Delivery
G6006	Radiation treatment delivery	Radiation Treatment Delivery
G6007	Radiation treatment delivery	Radiation Treatment Delivery
G6008	Radiation treatment delivery	Radiation Treatment Delivery
G6009	Radiation treatment delivery	Radiation Treatment Delivery
G6010	Radiation treatment delivery	Radiation Treatment Delivery
G6011	Radiation treatment delivery	Radiation Treatment Delivery
G6012	Radiation treatment delivery	Radiation Treatment Delivery
G6013	Radiation treatment delivery	Radiation Treatment Delivery
G6014	Radiation treatment delivery	Radiation Treatment Delivery
G6015	Radiation tx delivery imrt	Radiation Treatment Delivery
G6016	Delivery comp imrt	Radiation Treatment Delivery
G6017	Intrafraction track motion	Radiation Treatment Delivery (Guidance)

A.2. Identified Cancer Types and Corresponding ICD-10 Codes

Cancer Type	ICD-10 Codes
Anal Cancer	C21.xx
Bladder Cancer	C67.xx
Bone Metastases	C79.51
Brain Metastases	C79.3x
Breast Cancer	C50.xx, D05.xx
Cervical Cancer	C53.xx
CNS Tumors	C70.xx, C71.xx, C72.xx
Colorectal Cancer	C18.xx, C19.xx, C20.xx
Head and Neck Cancer	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
Lung Cancer	C33.xx, C34.xx, C39.xx, C45.xx
Lymphoma	C81.xx, C82.xx, C83.xx, C84.xx, C85.xx, C86.xx, C88.xx, C91.4x
Pancreatic Cancer	C25.xx
Prostate Cancer	C61.xx
Upper GI Cancer	C15.xx, C16.xx, C17.xx
Uterine Cancer	C54.xx, C55.xx

A.3. RO Model-Specific HCPCS Codes with Trended National Base Rates for PY1

Assigned HCPCS Code	Professional or Technical	Short Descriptor	Long Descriptor	Type of Service	Effective Date	Paid by PFS	Paid by OPPS	Trended National Base Rate	Trended National Base Rate Divided by 2
M1072	Professional	ROM Rad Therapy Anal, PC	Radiation therapy for anal cancer under the Radiation Oncology Model, 90 day episode, professional component	6	1-Jan-22	Yes	No	$2,980.42	$1,490.21
M1073	Technical	ROM Rad Therapy Anal, TC	Radiation therapy for anal cancer under the Radiation Oncology Model, 90 day episode, technical component	6	1-Jan-22	Yes	Yes	$17,517.57	$8,758.79
M1074	Professional	ROM Rad Therapy Bladder, PC	Radiation therapy for bladder cancer under the Radiation Oncology Model, 90 day episode, professional component	6	1-Jan-22	Yes	No	$2,677.14	$1,338.57
M1075	Technical	ROM Rad Therapy Bladder, TC	Radiation therapy for bladder cancer under the Radiation Oncology Model, 90 day episode, technical component	6	1-Jan-22	Yes	Yes	$14,069.06	$7,034.53
M1076	Professional	ROM Rad Ther Bone Mets, PC	Radiation therapy for bone metastases under the Radiation Oncology Model, 90 day episode, professional component	6	1-Jan-22	Yes	No	$1,387.57	$693.79
M1077	Technical	ROM Rad Ther Bone Mets, TC	Radiation therapy for bone metastases under the Radiation Oncology Model, 90 day episode, technical component	6	1-Jan-22	Yes	Yes	$6,299.37	$3,149.69
M1078	Professional	ROM Rad Ther Brain Mets, PC	Radiation therapy for brain metastases under the Radiation Oncology Model, 90 day episode, professional component	6	1-Jan-22	Yes	No	$1,583.75	$791.88
M1079	Technical	ROM Rad Ther Brain Mets, TC	Radiation therapy for brain metastases under the Radiation Oncology Model, 90 day episode, technical component	6	1-Jan-22	Yes	Yes	$10,127.96	$5,063.98
M1080	Professional	ROM Rad Therapy Breast, PC	Radiation therapy for breast cancer under the Radiation Oncology Model, 90 day episode, professional component	6	1-Jan-22	Yes	No	$1,977.98	$988.99
M1081	Technical	ROM Rad Therapy Breast, TC	Radiation therapy for breast cancer under the Radiation Oncology Model, 90 day episode, technical component	6	1-Jan-22	Yes	Yes	$10,316.98	$5,158.49
M1082	Professional	ROM Rad Therapy Cervical, PC	Radiation therapy for cervical cancer under the Radiation Oncology Model, 90 day episode, professional component	6	1-Jan-22	Yes	No	$2,916.15	$1,458.08
M1083	Technical	ROM Rad Therapy Cervical, TC	Radiation therapy for cervical cancer under the Radiation Oncology Model, 90 day episode, technical component	6	1-Jan-22	Yes	Yes	$14,094.75	$7,047.38

Assigned HCPCS Code	Professional or Technical	Short Descriptor	Long Descriptor	Type of Service	Effective Date	Paid by PFS	Paid by OPPS	Trended National Base Rate	Trended National Base Rate Divided by 2
M1084	Professional	ROM Rad Therapy CNS, PC	Radiation therapy for CNS tumors under the Radiation Oncology Model, 90 day episode, professional component	6	1-Jan-22	Yes	No	$2,455.26	$1,227.63
M1085	Technical	ROM Rad Therapy CNS, TC	Radiation therapy for CNS tumors under the Radiation Oncology Model, 90 day episode, technical component	6	1-Jan-22	Yes	Yes	$15,434.87	$7,717.44
M1086	Professional	ROM Rad Ther Colorectal, PC	Radiation therapy for colorectal cancer under the Radiation Oncology Model, 90 day episode, professional component	6	1-Jan-22	Yes	No	$2,408.14	$1,204.07
M1087	Technical	ROM Rad Ther Colorectal, TC	Radiation therapy for colorectal cancer under the Radiation Oncology Model, 90 day episode, technical component	6	1-Jan-22	Yes	Yes	$12,646.72	$6,323.36
M1088	Professional	ROM Rad Ther Head/Neck, PC	Radiation therapy for head and neck cancer under the Radiation Oncology Model, 90 day episode, professional component	6	1-Jan-22	Yes	No	$2,984.45	$1,492.23
M1089	Technical	ROM Rad Ther Head/Neck, TC	Radiation therapy for head and neck cancer under the Radiation Oncology Model, 90 day episode, technical component	6	1-Jan-22	Yes	Yes	$18,223.47	$9,111.74
M1094	Professional	ROM Rad Therapy Lung, PC	Radiation therapy for lung cancer under the Radiation Oncology Model, 90 day episode, professional component	6	1-Jan-22	Yes	No	$2,142.03	$1,071.02
M1095	Technical	ROM Rad Therapy Lung, TC	Radiation therapy for lung cancer under the Radiation Oncology Model, 90 day episode, technical component	6	1-Jan-22	Yes	Yes	$12,477.92	$6,238.96
M1096	Professional	ROM Rad Therapy Lymphoma, PC	Radiation therapy for lymphoma under the Radiation Oncology Model, 90 day episode, professional component	6	1-Jan-22	Yes	No	$1,655.34	$827.67
M1097	Technical	ROM Rad Therapy Lymphoma, TC	Radiation therapy for lymphoma under the Radiation Oncology Model, 90 day episode, technical component	6	1-Jan-22	Yes	Yes	$8,239.84	$4,119.92
M1098	Professional	ROM Rad Therapy Pancreas, PC	Radiation therapy for pancreatic cancer under the Radiation Oncology Model, 90 day episode, professional component	6	1-Jan-22	Yes	No	$2,381.51	$1,190.76
M1099	Technical	ROM Rad Therapy Pancreas, TC	Radiation therapy for pancreatic cancer under the Radiation Oncology Model, 90 day episode, technical component	6	1-Jan-22	Yes	Yes	$14,129.15	$7,064.58

Assigned HCPCS Code	Professional or Technical	Short Descriptor	Long Descriptor	Type of Service	Effective Date	Paid by PFS	Paid by OPPS	Trended National Base Rate	Trended National Base Rate Divided by 2
M1100	Professional	ROM Rad Therapy Prostate, PC	Radiation therapy for prostate cancer under the Radiation Oncology Model, 90 day episode, professional component	6	1-Jan-22	Yes	No	$3,245.53	$1,622.77
M1101	Technical	ROM Rad Therapy Prostate, TC	Radiation therapy for prostate cancer under the Radiation Oncology Model, 90 day episode, technical component	6	1-Jan-22	Yes	Yes	$21,101.22	$10,550.61
M1102	Professional	ROM Rad Therapy GI, PC	Radiation therapy for upper GI cancer under the Radiation Oncology Model, 90 day episode, professional component	6	1-Jan-22	Yes	No	$2,560.84	$1,280.42
M1103	Technical	ROM Rad Therapy GI, TC	Radiation therapy for upper GI cancer under the Radiation Oncology Model, 90 day episode, technical component	6	1-Jan-22	Yes	Yes	$15,233.16	$7,616.58
M1104	Professional	ROM Rad Therapy Uterus, PC	Radiation therapy for uterine cancer under the Radiation Oncology Model, 90 day episode, professional component	6	1-Jan-22	Yes	No	$2,628.76	$1,314.38
M1105	Technical	ROM Rad Therapy Uterus, TC	Radiation therapy for uterine cancer under the Radiation Oncology Model, 90 day episode, technical component	6	1-Jan-22	Yes	Yes	$14,777.08	$7,388.54