Presentation Overview

Proposed RO APM: What You Need to Know

• Model History and Overview
• How the Model Works
• RO APM Summary and Next Steps
Model History and Overview

Proposed RO APM
Role of Medicare in US Health Care

Medicare provides health insurance for most adults age 65 and older

Although Medicare only insures a fraction of the US population, Medicare payment and coverage policies set the standard for other insurers.


Focus where it matters.
Shift from Volume to Value
Evolving Medicare payment landscape

Opportunities for efficient and high value treatments, such as radiation therapy, exist within this payment landscape shift.
RO APM Is Implemented by the CMS Innovation Center

- The CMS Innovation Center was established by Section 115A of the Social Security Act under the Affordable Care Act.
- The CMS Innovation Center tests new payment models, including Advanced Alternative Payment Models.
RO APM Timeline

PAMPA initiated RO APM process

- Dec 2015: Patient Access and Medicare Protection Act (PAMPA) enacted
- Jan 2017: Start of 2 year PAMPA-mandated freestanding RT rate freeze
- Apr 2017: ASTRO releases RO APM design proposal
- Nov 2017: HHS issues PAMPA-mandated report on RO APM design
- Feb 2019: CMS issued transmittal on design features of RO APM
- Jan 2019: 1 year extension of freestanding RT rate freeze effective
- Jan 2020: End of freestanding RT rate freeze
- Jan 2020: Earliest potential implementation date of RO APM

ASTRO: American Society for Radiation Oncology; CMS: Centers for Medicare and Medicaid Services; HHS: Health and Human Services; RT: Radiation Therapy

Focus where it matters.
Medicare payment rules for fee for service radiation therapy services provided in outpatient hospitals and freestanding facilities will follow a similar timeline.
RO APM Will Be Implemented Under the CMS Innovation Center

RO APM will be run for up to five years, culminating on December 31, 2024

Target Medicare program savings of 3%

If program meets savings goals, potential for program-wide implementation

MACRA Quality Payment Program

MIPS

APM

RO APM

RO APM

APM

RO APM

APM

RO APM

APM

MACRA: Medicare Access and CHIP Reauthorization Act; MIPS: Merit Based Incentive Payments System

Focus where it matters.
## What Is and Is Not Included in the Bundle

### Technologies

<table>
<thead>
<tr>
<th>Included in Bundle</th>
<th>Not included in the Bundle, Paid FFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Included in Bundle</td>
<td>Certain Brachytherapy Surgical Procedures</td>
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<tr>
<td></td>
<td>Radiopharmaceuticals</td>
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<tr>
<td></td>
<td>Neutrons</td>
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<td></td>
<td>Hyperthermia</td>
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</table>

### Radiation Therapy Services

<table>
<thead>
<tr>
<th>Treatment Planning</th>
<th>Treatment Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical Preparation and Special Services</td>
<td>Treatment Delivery</td>
</tr>
<tr>
<td>Evaluation &amp; Management</td>
<td>Certain Imaging Procedures</td>
</tr>
</tbody>
</table>

*CMS is considering excluding Proton Beam Therapy from the bundle when the beneficiary is participating in a federally-funded, multi-institution randomized controlled clinical trial.

FFS: Fee for Service; HDR: High Dose Rate; IGRT: Image Guided Radiation Therapy; IORT: Intraoperative Radiation Therapy; LDR: Low Dose Rate; SBRT: Stereotactic Body Radiation Therapy; SRS: Stereotactic Radiosurgery

Focus where it matters.
How the Model Works

Model Mechanics
We Will Be Living Under Two Payment Systems
Fee for Service Medicare and RO APM will coexist from 2020-2025

Traditional Fee for Service
60% of Episodes
Sites are on one side of the wall or the other

Radiation Oncology Alternative Payment Model (RO APM)
40% of Episodes
Determination of Sites in Mandatory Model

CMS will use CBSAs to determine site inclusion

- CMS will identify randomly selected Core Based Statistical Areas (CBSAs) for participation in the model
  - 40% of radiation episodes will be included in participating CBSAs
- CBSAs included in the model will be released with the final rule, expected in early November 2019
- Certain sites are will be excluded from the model, including:
  - Sites in Maryland and Vermont (due to existing all payer models)
  - Critical access hospital or those with Pennsylvania rural health designation
  - PPS-exempt cancer hospitals
  - Ambulatory surgical centers (ASCs)

Source: Core Based Statistical Areas, US Census Bureau, Public Domain
# Site Neutral Payment

Both hospital outpatient and freestanding sites will receive same payment amount

## Current FFS Payment

**Payment Depends on Site of Service**

(60% of Episodes)

<table>
<thead>
<tr>
<th>Medicare Physician Fee Schedule (MPFS)</th>
<th>Outpatient Prospective Payment System (OPPS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Office</td>
<td>Hospital Outpatient: Facility Component</td>
</tr>
<tr>
<td>Freestanding Centers</td>
<td>Hospital Outpatient: Physician Component</td>
</tr>
<tr>
<td>Payment rate includes: professional and technical components</td>
<td>Payment rate includes: technical component</td>
</tr>
</tbody>
</table>

## Proposed RO APM

**Site Neutral**

(40% of Episodes)

- **Freestanding**
  - Technical Component (TC) + Professional Component (PC)
  - Dual Participant

- **Hospital Outpatient**
  - Technical Component (TC) + Professional Component (PC)

*The RO APM is site neutral, meaning there is a common payment amount for services regardless of where they are furnished*
Cancer Types Included in the RO APM

Inclusive of commonly treated cancer types

- Brain Metastases
- Head and Neck Cancer
- Lung Cancer
- Kidney Cancer
- Upper GI Cancer
- Cervical Cancer
- Prostate Cancer
- Anal Cancer
- Bone Metastases

CMS proposes to include 17 cancer types in the model that will be identified with ICD-10-CM diagnosis codes

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>ICD-9 Codes</th>
<th>ICD-10-CM Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pancreatic Cancer</td>
<td></td>
<td></td>
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<tr>
<td>Bladder Cancer</td>
<td></td>
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<tr>
<td>Liver Cancer</td>
<td></td>
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<tr>
<td>Colorectal Cancer</td>
<td></td>
<td></td>
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<tr>
<td>Uterine Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brain Metastases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brain Metastases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head and Neck Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate Cancer</td>
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<td></td>
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<tr>
<td>Upper GI Cancer</td>
<td></td>
<td></td>
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<tr>
<td>Kidney Cancer</td>
<td></td>
<td></td>
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<tr>
<td>Lung Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head and Neck Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CNS Tumors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphoma</td>
<td></td>
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</tr>
</tbody>
</table>
| CNS: Central Nervous System; GI: Gastrointestinal; ICD-10-CM: International Classification of Diseases, Tenth Revision, Clinical Modification

Focus where it matters.
RO APM Participant National Base Rates

Rates per disease site will be adjusted

- CMS developed national base rates using HOPD cost data from 2015-2017
- These base rates will be adjusted based on:
  - Annual updates
  - Practice historical experience
  - Practice geography
  - Withholds
  - Discounts
  - Beneficiary Cost Sharing
  - Sequester

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Professional</th>
<th>Technical</th>
<th>Global/Dual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anal Cancer</td>
<td>$2,968</td>
<td>$16,006</td>
<td>$18,974</td>
</tr>
<tr>
<td>Bladder Cancer</td>
<td>$2,637</td>
<td>$12,556</td>
<td>$15,193</td>
</tr>
<tr>
<td>Bone Metastases</td>
<td>$1,372</td>
<td>$5,568</td>
<td>$6,940</td>
</tr>
<tr>
<td>Brain Metastases</td>
<td>$1,566</td>
<td>$9,217</td>
<td>$10,783</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>$2,074</td>
<td>$9,740</td>
<td>$11,814</td>
</tr>
<tr>
<td>Cervical Cancer</td>
<td>$3,779</td>
<td>$16,955</td>
<td>$20,734</td>
</tr>
<tr>
<td>CNS Tumors</td>
<td>$2,463</td>
<td>$14,193</td>
<td>$16,656</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>$2,369</td>
<td>$11,589</td>
<td>$13,958</td>
</tr>
<tr>
<td>Head and Neck Cancer</td>
<td>$2,947</td>
<td>$16,708</td>
<td>$19,655</td>
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<tr>
<td>Kidney Cancer</td>
<td>$1,550</td>
<td>$7,656</td>
<td>$9,206</td>
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<tr>
<td>Liver Cancer</td>
<td>$1,515</td>
<td>$14,650</td>
<td>$16,165</td>
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<tr>
<td>Lung Cancer</td>
<td>$2,155</td>
<td>$11,451</td>
<td>$13,606</td>
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<tr>
<td>Lymphoma</td>
<td>$1,662</td>
<td>$7,444</td>
<td>$9,106</td>
</tr>
<tr>
<td>Pancreatic Cancer</td>
<td>$2,380</td>
<td>$13,070</td>
<td>$15,450</td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td>$3,228</td>
<td>$19,852</td>
<td>$23,080</td>
</tr>
<tr>
<td>Upper GI Cancer</td>
<td>$2,500</td>
<td>$12,619</td>
<td>$15,119</td>
</tr>
<tr>
<td>Uterine Cancer</td>
<td>$2,376</td>
<td>$11,221</td>
<td>$13,597</td>
</tr>
</tbody>
</table>

HOPD: Hospital Outpatient Department

Focus where it matters.
Participant Specific Payment Calculation

National Base Rate

- Trend Factor
- Case & Historic Factors
- Discount
- Withholds
- GPCI
- Co-insurance
- Sequester

Annual Payment Update
Based on Historic Billing
-5% TC
-4% PC
-3% TC*
-4% PC
Geographic Adjustment
Beneficiary Cost Sharing

Per Patient Rate

*-2% for PYs 1 and 2, -3% for PYs 3, 4, and 5

GPCI: Geographic Practice Cost Index; PC: Professional Component; PY: Performance Year; TC: Technical Component

Focus where it matters.
Payment Mechanism — Technical and Professional Components

Start of Episode

- Treatment Planning Code
- Treatment Delivery Code

\[ \text{Model Specific HCPCS Code} + \text{SOE Modifier} \rightarrow \text{50\% of Episode-Based PC Payment} \]

\[ \text{50\% of Episode-Based PC Payment} \]

A treatment delivery code must be billed within 28 days of the treatment planning code.

End of Episode

- Model Specific HCPCS Code
- EOE Modifier

\[ \text{EOE Modifier} \rightarrow \text{50\% of Episode-Based TC Payment} \]

\[ \text{50\% of Episode-Based TC Payment} \]

Sites will be required to bill for all services required, in addition to the codes that trigger payment under the bundle.

EOE: End of Episode; HCPCS: Healthcare Common Procedure Coding System; SOE: Start of Episode

Focus where it matters.
Bundled payment will cover all specified RO services provided in a 90-day episode.

Day 1: Treatment Planning Service Billed

Before Day 29:
First Treatment Delivery Billed

Day 90:
End of Episode Billed

A new treatment plan billed after the 28 day clean period will trigger a new bundle.

Time

90 Day Episode

28 Day Clean Period

New 90 Day Episode

$Bundled Payment

FFS

Bundled Payment
## Quality Measure, Patient Survey, and Clinical Data Reporting

Professional and dual participants will be required to report 4 quality measures:

<table>
<thead>
<tr>
<th>Preventative Care and Screening: Screening for Depression and Follow-Up Plan</th>
<th>Advance Care Plan</th>
<th>Oncology: Medical and Radiation - Plan of Care for Pain</th>
<th>Treatment Summary Communication – Radiation Oncology</th>
</tr>
</thead>
</table>

Technical and dual participants will be required to submit patient survey data in PYs 3-5:

- CAHPS Cancer Survey for Radiation

Professional and dual participants will be required to submit clinical data for 5 body sites:

- Prostate
- Breast
- Lung
- Bone Mets
- Brain Mets

CAHPS: Consumer Assessment of Healthcare Providers and Systems

*Focus where it matters.*
Summary and Next Steps
Proposed RO APM Summary

Key Takeaways

The RO APM model fundamentally changes the way CMS pays for radiation oncology services by replacing FFS payments with a 90 day episode of care bundled payment

• **APM Details**: The RO APM bundle payment is site neutral, technology agnostic, and unique for 17 different disease sites (skin cancer and benign neoplasms are notable exclusions)

• **Participation**: Participation will be mandatory for sites in selected CBSAs and total participation will represent 40% of RO episodes under FFS Medicare. A full list of participating sites will be released with the final rule in November 2019

• **Payment Mechanism**: The prospective national base rates are set using hospital outpatient data from 2015-2017; a multi-step process will adjust the payment levels per disease site and is site neutral, meaning the rate setting does not differentiate based on setting of care

• **Timing**: Earliest implementation is scheduled for January 1, 2020; CMS is also considering an April 1, 2020 start date

• **Changes**: All details of the RO APM are subject to change based on final rulemaking; CMS will make edits to the RO APM based on stakeholder input

• **Other Considerations**: While there are no specific provisions for new technology or advanced technology in the RO APM, CMS left the door open for model adaptations for future innovations
Next Steps

Education and Advocacy Efforts

• Elekta is fully engaged on this issue
  - Advocacy efforts are underway from Elekta and members of the RT community to promote fair and adequate reimbursement levels and policy considerations under this proposed RO APM

• Additional webinars and educational opportunities on impact of the RO APM are in the planning stage—*stay tuned for more details on dates and time*

• The RO APM will be addressed at the Elekta User Meeting at ASTRO

Save the Date!
Elekta User Meeting
September 14, 2019
Thank You

Please contact us:
Elekta.Reimbursement@Elekta.com

Questions?
Ask us, we may know

Focus where it matters.