

## New Data Questions Viability of CMS Oncology Model

On May 21, 2019, Avalere Health released a report analyzing the viability of a compulsory two-sided risk arrangement within the *Oncology Care Model* (OCM), a Medicare payment model commenced in July 2016.<sup>1</sup> Significantly, the analysis found that should practices be forced to switch to a two-sided risk arrangement, more than half of them would be forced to pay recoupments back to the *Centers for Medicare and Medicaid Services* (CMS), meaning that participation in the OCM would no longer be justifiable for these practices.<sup>2</sup>

The OCM was established by the *Center for Medicare and Medicaid Innovation* (CMMI), a division of CMS. The 5-year (10-performance period), voluntary model runs through June 30, 2021, and includes almost 200 participants, comprised of 176 practices and 11 payors (including CMS).<sup>3</sup> The goal of the bundled payment program is “to examine the impact of the OCM on primary outcomes such as reduction in total cost of care as well as improvements in key utilization quality metrics (risk-adjusted hospital admissions, risk-adjusted emergency department visits and hospice visits) and achievement of performance-based payments.”<sup>4</sup> The OCM is a fairly unique CMS payment model, as it includes not just Medicare fee-for-service (FFS), but also commercial payors.<sup>5</sup>

As part of their participation requirements, practices enrolled in the OCM must furnish a number of “enhanced services,” including:

- (1) “The core functions of patient navigation;
- (2) A care plan that contains the 13 components in the Institute of Medicine Care Management Plan outlined in the Institute of Medicine report, “Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis”;
- (3) Patient access 24 hours a day, 7 days a week to an appropriate clinician who has real-time access to practice’s medical records; and
- (4) Treatment with therapies consistent with nationally recognized clinical guidelines.”<sup>6</sup>

The participants are reimbursed via regular payments throughout the six-month episode, which commences with chemotherapy. There are two forms of payment involved, including:

- (1) A *Monthly Enhanced Oncology Services* (MEOS) payment of \$160 per beneficiary per month (for a total of \$960 for the entire episode) for the delivery of the aforementioned “enhanced services”; and,
- (2) The potential for a *performance-based payment* (PBP) for each episode, which is meant to “incentivize[] practices to lower the total cost of care and improve care for beneficiaries during treatment episodes.”<sup>7</sup>

In order to obtain a PBP, a participant must meet the following requirements:

- (1) The OCM practice must expend less than their target amount;
- (2) The OCM practice must achieve an *Aggregate Quality Score* (AQS) of at least 30%;
- (3) The OCM practice must report all of the required quality data to the OCM Data Registry; and,
- (4) The OCM practice must implement all “*Practice Redesign Activities*,” which activities include the “enhanced services.”<sup>8</sup>

OCM currently offers three risk arrangement options for participating practices:

- (1) A one-sided risk arrangement with a 4% discount;
- (2) A two-sided risk arrangement with a 2.75% discount (termed “*original two-sided risk*”); and,
- (3) A two-sided risk arrangement with a 2.5% discount (termed “*alternative two-sided risk*”).<sup>9</sup>

Only those practices participating in the *two-sided* risk arrangements are eligible for the PBP.<sup>10</sup>

For the first performance period of the model, all practices participated in one-sided risk only.<sup>11</sup> Then, beginning in Performance Period 2 (i.e., January 12, 2017), practices could participate in either one-sided risk or *original two-sided risk*.<sup>12</sup> Starting in Performance Period 7 (i.e., July 2, 2019), practices may participate in one-sided risk, *original two-sided risk*, or *alternative two-sided risk*.<sup>13</sup> Of note, all OCM practices are currently participating in the *one-sided* risk arrangement.<sup>14</sup> However, effective January 1, 2020, CMS will require those practices that did not achieve a PBP in any of the

first four performance periods to switch to a *two-sided* risk arrangement (either the *original* or the *alterative*), or leave the payment program altogether.<sup>15</sup>

As noted above, Avalere’s report found that should OCM practices be forced to switch to a *two-sided* risk arrangement, most of them would owe money, through repayments, back to the government.<sup>16</sup> Specifically, Avalere’s analysis of “*Medicare Part A/B FFS claims and Part D prescription drug event data*” found that, under the *original* two-sided risk arrangement, 70% of those practices would owe recoupments (i.e., payments) to CMS, and under the *alternative* two-sided risk arrangement, approximately 50% would owe recoupments.<sup>17</sup>

For either of the two-sided risk arrangements, Avalere found that more participants would likely earn PBPs than they currently are in the one-sided risk arrangement (because they would have smaller discounts for their spending targets).<sup>18</sup> Additionally, because the OCM is an *alternative payment model* (APM), as established by the *Medicare and CHIP Reauthorization Act* (MACRA), those practices would potentially obtain the 5% bonus payment due to their participation in an APM.<sup>19</sup> However, it is unclear whether these positive payment adjustments would be enough to convince current OCM practices to remain in the voluntary program.<sup>20</sup>

These issues with the OCM are similar to those with the *Medicare Shared Savings Program* (MSSP), wherein CMS is similarly forcing *accountable care organizations* (ACOs) to transition to two-sided risk models, effective July 1, 2019.<sup>21</sup> A subsequent survey conducted by the *National Association of ACOs* (NAACOS) found that 71% of those survey respondents are likely to leave the MSSP (a voluntary program) as a result of being forced

to assume two-sided risk.<sup>22</sup> This may indicate that either CMS is forcing participants into two-sided risk arrangements too quickly, or that participants do not wish to voluntarily participate in a program wherein the rules are changed mid-program. However, this latter issue may become a moot point, as HHS Secretary Alex Azar has previously stated that CMS would be launching a mandatory payment model for Medicare cancer patients.<sup>23</sup>

Despite these program drawbacks, private payors are modeling value-based payment programs after CMS, indicating that CMS may be on the right path to value-based reimbursement, despite their programs’ various issues. For example, in January 2019, Humana launched a new payment model for both Medicare Advantage and commercial beneficiaries undergoing cancer treatment.<sup>24</sup> The similarly-named *Oncology Model of Care* will seek to coordinate cancer care by offering “*additional payment to [the 16] participating cancer practices for improved performance on certain metrics over a one-year period.*”<sup>25</sup> Unlike the OCM, this payment model is not episode based, but quality based.<sup>26</sup> Humana pays each practice a *care coordination fee*, which is used to help participating practices “*implement the reporting requirements and infrastructure for the model;*” those practices that improve performance from one year to the next will see that fee increased.<sup>27</sup> Such payment plans seek to control the costs of one of the most expensive service lines in healthcare (due in part to the cost of chemotherapy drugs),<sup>28</sup> and it appears that more tweaks will need to be made in order to determine a payment plan that is mutually beneficial for providers, payors, and patients, and then scale it to the rest of the oncology providers in the U.S. healthcare system.

1 “More than Half of All OCM Providers Could Owe CMS Money if Required to Join in 2-Sided Risk Model” By Richard Kane, et al., Avalere, May 1, 2019, <https://avalere.com/press-releases/more-than-half-of-all-ocm-providers-could-owe-cms-money-if-required-to-join-in-2-sided-risk-model> (Accessed 6/13/19).  
2 *Ibid.*  
3 “Oncology Care Model” Centers for Medicare & Medicaid Services, June 3, 2019, <https://innovation.cms.gov/initiatives/oncology-care/> (Accessed 6/13/19).  
4 “What Is The Oncology Care Model, And Why Is The Evaluation Important?” By Amy J. Davidoff, et al, Health Affairs Blog, February 14, 2019, <https://www.healthaffairs.org/doi/10.1377/hblog20190212.101448/full/> (Accessed 6/13/19).  
5 CMS, June 29, 2019.  
6 *Ibid.*  
7 *Ibid.*  
8 “OCM Performance-Based Payment Methodology” Prepared by RTI International and Actuarial Research Corporation, Version 3.2, December 17, 2018, available at: <https://innovation.cms.gov/Files/x/ocm-cancercodelist.pdf> (Accessed 6/13/19), p. 26.  
9 *Ibid.*, p. 9.  
10 *Ibid.*  
11 *Ibid.*, p. 10.  
12 *Ibid.*  
13 *Ibid.*  
14 Kane, May 1, 2019.  
15 *Ibid.*

16 The payment recoupment is due to patient attrition (e.g., switching from Medicare to a Medicare Advantage plan) or attribution (the cancer diagnosis was incorrect, or not correctly attribution within the episode timeframe). “COA Letter to CMMI Regarding Challenges That Need to Be Addressed in the OCM and Future Payment Reform Models” Community Oncology Alliance, May 31, 2019, <https://www.communityoncology.org/coa-letter-to-cmmi-regarding-challenges-that-need-to-be-addressed-in-the-ocm-and-future-payment-reform-models/> (Accessed 6/17/19); Kane, May 1, 2019.  
17 Kane, May 1, 2019.  
18 *Ibid.*  
19 *Ibid.*  
20 *Ibid.*  
21 “Final Rule Creates Pathways to Success for the Medicare Shared Savings Program” Centers for Medicare & Medicaid Services, December 21, 2018, <https://www.cms.gov/newsroom/fact-sheets/final-rule-creates-pathways-success-medicare-shared-savings-program> (Accessed 6/17/19).  
22 “Press Release” National Association of ACOs, May 2, 2018, <https://www.naacos.com/press-release-may-2-2018> (Accessed 6/17/19).  
23 While no details were given, Secretary Azar noted that the model would focus on radiation oncology. “Azar says new mandatory oncology pay model is coming” By Virgil Dickson, Modern Healthcare, November 8, 2018, <https://www.modernhealthcare.com/article/20181108/NEWS/181109925/azar-says-new-mandatory-oncology-pay-model-is-coming> (Accessed 6/17/19).

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- 24 “Humana launches oncology payment model” By Maria Castellucci, Modern Healthcare, April 16, 2019, <https://www.modernhealthcare.com/insurance/humana-launches-oncology-payment-model> (Accessed 6/17/19).
- 25 *Ibid.*
- 26 *Ibid.*

- 27 *Ibid.*
- 28 “The 2018 Genentech Oncology Trend Report” Genentech, 10th Edition, 2018, available at: [https://www.genentech-forum.com/content/dam/gene/managedcare/forum/pdfs/Oncology-Trends/2018\\_Genentech\\_Oncology\\_Trend\\_Report.pdf](https://www.genentech-forum.com/content/dam/gene/managedcare/forum/pdfs/Oncology-Trends/2018_Genentech_Oncology_Trend_Report.pdf) (Accessed 6/17/19).



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**[Todd A. Zigrang](#)**, MBA, MHA, CVA, ASA, FACHE, is the President of **HEALTH CAPITAL CONSULTANTS (HCC)**, where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 20 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 1,000 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of "[The Adviser's Guide to Healthcare – 2nd Edition](#)" [2015 – AICPA], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Accountant's Business Manual* (AICPA); *Valuing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies*; *Business Appraisal Practice*; and, *NACVA QuickRead*. In addition to his contributions as an author, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); American Health Lawyers Associate (AHLA); the American Bar Association (ABA); the National Association of Certified Valuators and Analysts (NACVA); Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter, and is current Chair of the ASA Healthcare Special Interest Group (HSIG).



**[John R. Chwarzinski](#)**, MSF, MAE, is Senior Vice President of **HEALTH CAPITAL CONSULTANTS (HCC)**. Mr. Chwarzinski's areas of expertise include advanced statistical analysis, econometric modeling, as well as, economic and financial analysis. Mr. Chwarzinski is the co-author of peer-reviewed and industry articles published in *Business Valuation Review* and *NACVA QuickRead*, and he has spoken before the Virginia Medical Group

Management Association (VMGMA) and the Midwest Accountable Care Organization Expo. Mr. Chwarzinski holds a Master's Degree in Economics from the University of Missouri – St. Louis, as well as, a Master's Degree in Finance from the John M. Olin School of Business at Washington University in St. Louis. He is a member of the St. Louis Chapter of the American Society of Appraisers, as well as a candidate for the Accredited Senior Appraiser designation from the American Society of Appraisers.



**[Jessica L. Bailey-Wheaton](#)**, Esq., is Vice President and General Counsel of **HEALTH CAPITAL CONSULTANTS (HCC)**, where she conducts project management and consulting services related to the impact of both federal and state regulations on healthcare exempt organization transactions and provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of

transactions related to healthcare enterprises, assets, and services. Ms. Bailey-Wheaton is a member of the Missouri and Illinois Bars and holds a J.D., with a concentration in Health Law, from Saint Louis University School of Law, where she served as Fall Managing Editor for the *Journal of Health Law & Policy*.



**[Daniel J. Chen](#)**, MSF, CVA, is a Senior Financial Analyst at **HEALTH CAPITAL CONSULTANTS (HCC)**, where he develops fair market value and commercial reasonableness opinions related to healthcare enterprises, assets, and services. In addition, Mr. Chen prepares, reviews and analyzes forecasted and pro forma financial statements to determine the most probable future net economic benefit related to healthcare enterprises,

assets, and services, and applies utilization demand and reimbursement trends to project professional medical revenue streams, as well as ancillary services and technical component (ASTC) revenue streams. Mr. Chen has a Master of Science in Finance from Washington University St. Louis.