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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.[1] 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.[2]

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).[3] 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*."[4] The OCM is a fairly unique CMS payment model, as it includes not just Medicare fee-for-service (FFS), but also commercial payors.[5]

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*."[6]

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*."[7]

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*."[8]

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*").[9]

Only those practices participating in the *two-sided* risk arrangements are eligible for the PBP.[10]

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

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

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.[16] 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.[17]

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).[18] 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.[19] However, it is unclear whether these positive payment adjustments would be enough to convince current OCM practices to remain in the voluntary program.[20]

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.[21] 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.[22] 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.[23]

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.[24] 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*."[25] Unlike the OCM, this payment model is not episode based, but quality based.[26] 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.[27] 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),[28] 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.

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