The CMMI Oncology Care Model (OCM) Preliminary Design

BREAKING NEWS:
***Interest Surges in Medicare Bundled Payment Initiative*. Modern Healthcare. July 31, 2014.**

To date, enthusiasm for bundled pricing has been associated with the Medicare Bundled Payments for Care Improvement (BPCI) initiative, which has consisted principally of cardiac and orthopedic procedures with a hospital inpatient component. But what about modifying the payment methods for oncology/cancer care? Is oncology next in line for alternate/bundled payment?

It now appears that, in fact, oncology is next up. In August, the Center for Medicare & Medicaid Innovation (CMMI) released its preliminary design description for the Oncology Care Model (OCM), which is expected to be formalized later this fall in the form of a major new CMMI initiative in alternate payment for Medicare fee-for-service beneficiaries undergoing chemotherapy treatment services. This CMMI initiative can be expected to be a "call to action" in the transformation from fee-for-service to value-based/alternate payment methodologies in oncology.

Key features of the CMMI-OCM preliminary design include:

1. Program goal is to utilize appropriately aligned financial incentives to bring about improved health outcomes, higher quality of care, lower expenditures ("triple aim");

2. Financial incentives are associated with total medical cost of Medicare fee-for-service beneficiaries undergoing chemotherapy treatment over a six month episode;

3. Two-part financial incentives are monthly per-beneficiary per month (PBPM) care management payment plus retrospective performance-based payment ("shared savings"), both in addition to traditional FFS payments;

4. Participants will be "physician practices that furnish chemotherapy"

5. Will be a "multi-payer model" to include other (commercial) payers working in tandem;

6. Significant data and quality reporting requirements must be met ("Appendix A. Practice Requirements")

OCM Issues and Commentary

A. Who can participate in OCM? Is the definition of participant to be taken literally, that is, only private medical practices with a chemotherapy service can qualify for the OCM program? If so, what about the approximately 40% of community oncologists that are today "practicing" in relationship with a hospital, those that are employed by a hospital or a by a hospital affiliated/captive medical group? Or those practicing in a contractual relationship with a hospital, such as PSA, MSA, co-management?

   In preliminary discussion with representatives from CMMI, it has been clarified that CMMI did not intend to exclude physicians/practices other than traditional private medical practices and welcome OCM applications from other forms of practice (hospital employed or contracted). And further, practices that do not furnish chemotherapy directly on their

own account would not be precluded. The threshold determinant is only that the Medicare FFS patient can be "attributed" to the Tax ID/provider number of the physician/practice.

B. Will the PBPM payment be adequate? The amount of the PBPM payment to an OCM participant is to be based on the OCM participant's estimated practice costs to furnish the OCM enhanced services. So, it appears that the PBPM payment will not be consistent across all OCM participants, but will vary by the participant's cost structure. What might be the range of acceptable PBPM payment? Two recent (summer 2014) program announcements may be instructive. First, Wellpoint/Anthem announced its new "Cancer Care Quality Program" which pays a $350 PMPM amount for cancer care management and drug pathways compliance. And CMS has proposed a new payment for Chronic Care Management of $41.92 per month effective in 2015. These two programs might establish a theoretical floor and ceiling for the range of OCM PBPM payment: $42 to $350, documented by the OCM participants actual costs.

C. Shared Savings benchmarked to historic data. OCM proposes to establish benchmark expenditure targets for a participant based on the participant's historic data. Benchmarking based on a look-back to a participants historic cost performance will disadvantage those participants who have already been active in care management process re-design, such as oncology medical home and oncology ACO practices. But benchmarking based on historic claims data does advantage higher cost programs – there is theoretically a higher benchmark amount on which to achieve savings. In oncology, with the risk of the ever increasing costs of drug and new technologies, it would be preferable to benchmark against a regional or national norm for like services, not benchmark against oneself. There is some reference in the OCM that CMMI would "leverage regional or national data to increase precision for target prices for practices with a low number of episodes," so perhaps there is some room for further deliberation of benchmarking based on market norms rather than benchmarking against oneself.

D. What Is meant by a multi-payer model? The OCM program envisions that in addition to their arrangement with OCM, participants will also have a commitment for a similar alternate pay arrangement in effect with a commercial health plan. This "multi-payer" requirement is intended to bring about payment transformation across the broader population (Medicare plus commercial). Many health plans have in place some form of alternate payment program in oncology (for example, United Healthcare, Aetna, Humana, Wellpoint/Anthem, most Blue Cross Plans), so incorporating this multi-payer element into an OCM application should be achievable.

E. Significant data and quality reporting requirements. Appendix A to the OCM provides a rather comprehensive list of process and quality monitoring "Practice Requirements" that must be satisfied in order to participate in OCM. The Practice Requirements are similar to those of existing oncology accreditation/recognition programs, such as Commission on Cancer (CoC) accreditation (of hospital cancer programs), Quality Oncology Practice Initiative (QOPI) and the new NCQA Patient-Centered Specialty Practice recognition program. Adherence to the Appendix A requirements may prove to be too burdensome to implement and manage for many private practices. However, these types of process and quality monitoring activities are right in the wheelhouse of hospital programs. Is there a potential synergy between oncologist and hospital joint participation in OCM? For example, hospital assumes responsibility for the Appendix A Practice Requirements in exchange for a portion of the shared savings generated? What, if any, are the regulatory implications

(Stark, anti - fraud & abuse or otherwise) of hospital and physician participation in the OCM shared savings?

F. OCM "double dipping" with ACO shared savings program? Hmmm…what if a Medicare cancer patient attributed to an OCM program is already attributed by the patient's PCP to a Medicare Shared Savings Program (MSSP) ACO? Wouldn't that result in Medicare sharing the savings for the same patient twice? It would appear so and apparently CMMI has become aware of this dynamic and will be addressing it in the final form of the OCM initiative.

G. Industry Response. CMS/CMMI has received a number of responses to the OCM preliminary design from professional associations and individual stakeholders. On September 18, the American Society for Clinical Oncology (ASCO) issued a letter to CMS commenting that the CMMI-OCM was consistent with a number of important policy goals of ASCO's payment reform model, Consolidated Payments for Oncology Care (CPOC). In its letter, ASCO offered observations and recommendations with regard to an number of CMMI-OCM features concluding that "to be meaningful, the incentives embedded in the OCM must reflect decisions that are under the control of the oncology practice, performance measures must be robust and applicable to the patient population and the overall system must reflect the variability in labor and resources required to treat individuals with cancer." (www.asco.org/advocacy/asco-comments-cmmi-proposed-cancer-care-payment-reform-model).

OCM as a "Call to Action"

We can expect that the nuances of the OCM program will be reconciled and fine tuned in anticipation of the official launch of the OCM initiative later this fall. And regardless of the ultimate features of the OCM initiative design, we expect that it will receive significant response from oncology/cancer care stakeholders in a variety of practice settings and that it will represent a "call to action" in the transformation from fee-for-service to value-based/alternate payment methodologies in oncology.

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