Oncology Care Model Launched by CMS: Implications for Radiation Oncology Centers

CMS has chosen nearly 200 physician group practices and 17 health insurance companies to participate in a new demonstration project, the Oncology Care Model (the OCM). This new model can be characterized as an oncology-specific Accountable Care Organization controlled by one or more medical oncology practice(s). The model, which covers nearly all cancer types, will run for 5 years, beginning July 1, 2016, and ending June 30, 2021, with a model closeout period after model completion.

Why is the OCM demonstration important?

The Medicare arm of the Oncology Care Model includes more than 3,200 oncologists and will cover approximately 155,000 Medicare beneficiaries nationwide. The 17 private payers that are participating include some of the bigger plans, such as Aetna and Cigna, and a number of Blue Cross/Blue Shield plans are also participating, including those in Michigan New Mexico; Oklahoma; Texas; South Carolina; and Capital BlueCross, Inc.

In addition, CMS is proposing that certain OCM participants—those medical oncology that take on financial risk—ultimately may qualify for substantial bonuses and increased annual adjustments under the new physician payment system authorized by MACRA, since risk-bearing OCMs would qualify as ,the as Advanced Alternative Payment Models (AAPMs) under the new system. Providing AAPM status to risk-bearing OCM has the potential to turbo charge movement of medical oncology practices into OCMs.

What is an OCM?

Under the OCM demo, the selected oncology practices will receive a $160 care coordination fee (a "Monthly Enhanced Oncology Services" ("MEOS") payment) to cover certain coordination services that are not ordinarily separately paid under the Physician Fee Schedule. Other than the MEOS, all services are paid on the basis of the regularly applicable Medicare payment methodology during demonstration, but each participating medical oncology practice has the opportunity to receive a performance-based payment, which is intended to incentive the practice to lower the total cost of care and improve quality.

Under the demonstration project, performance-based payment will be determined based on oncology care episodes, which will begin on the date of an initial Part B or Part D chemotherapy claim; include all Medicare Part A and Part B and certain Part D services that Medicare Fee For Service beneficiaries receive during the episode period; and terminate six months after a beneficiary's chemotherapy initiation. Beneficiaries who receive chemotherapy after the end of an episode will begin a new six-month episode.

Basically, all Part A, Part B and certain Part D expenditures for each episode (i.e. each six month period) will be compared to a risk-adjusted, practice-specific target amount. The target amounts will be based on historical expenditures trended forward to the performance period and subject to a discount (representing Medicare savings). Initially, participants in the OCM demonstration will not incur financial risk (i.e. they will not owe anything back to Medicare if costs exceed the target amounts) but will earn bonuses only if they save more than 4% as compared with the historic baseline. After this initial period, they may switch to a different payment model under which it will be easier to earn bonuses and the bonuses will be higher, but they will take on financial risk (i.e. they will owe money back to the Medicare program if they fail to reduce costs by at least 2.75%).

Performance-based payments will be made only for higher-volume cancer types. The cancer types most often treated by radiation oncology centers--breast and prostate cancer are on the list of cancer types that are eligible for shared savings distributions to participating medical oncology practices, as are a wide range of other cancer types.

While participants in the OCM are required to report on certain quality measures, and eligibility for shared savings will take into account their reporting of and performance on these measures, none of the measures relate to or otherwise track beneficiary access to radiation oncology or other non-chemotherapy treatment modalities (other than tracking the extent to which patients are referred to hospice care within 3 or more days of death). In fact, the quality measures that CMS selected do not even appear to track patient mortality or morbidity. Applicable quality measures do track patient satisfaction, provision of certain types of adjuvant medical oncology services, and care coordination, as well as hospital admissions and ER utilization. However, it appears clear that a participating practice could score well on the quality measures while skimping appreciably on care.

So what are the financial incentives for oncology practices that are participating in the OCM? For any "high volume" cancer that is on the list eligible for shared savings (including but not limited to prostate and breast cancer):

- Refrain from referring patients for radiation oncology if at all practicable, and to the extent that referrals are made, strongly encourage or require hyperfractionation.
- Refrain from referring patients for imaging, laboratory or other "ancillary" services to the extent possible.
- Cut medical oncology services and expenditures for Part D drugs last and least, since these continue to be paid on the basis of otherwise applicable Medicare reimbursement rules and, at least during the initial period, any amounts paid are not subject to recoupment.

In its comments, AFROC strongly objected to CMS' proposal to designate the OCM as an AAPM, and urged CMS to redesign the model to include a multi-specialty approach to cancer care that includes radiation oncology at the table.

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Want to know if any of the practices that refer to your center are included in the OCM demo? Click here: https://innovation.cms.gov/initiatives/map/index.html#model=oncology-care. And search for "Oncology Care Model" in your state.