



HHS Announces New Payment Initiative Designed to Encourage Better Oncology Care

On February 12, 2015, the U.S. Department of Health and Human Services (“HHS”) announced the Oncology Care Model (“OCM”), a new initiative sponsored by the Centers for Medicare & Medicaid Services (“CMS”) Innovation Center (the “Innovation Center”) aimed at supporting improved coordination in cancer care by incentivizing care quality and value rather than quantity and volume. The OCM is a five-year model scheduled to begin in spring 2016 that incorporates (i) performance-based payments to participating physician practices that deliver quality care on a per-episode basis at a cost that is less than targeted expenditures and (ii) monthly per-beneficiary care management and practice transformation payments.

Focus of the OCM

The OCM seeks to encourage participating physician practices to improve the quality and lower the cost of cancer care for Medicare beneficiaries undergoing chemotherapy by (i) providing opportunities for participating practices to share in savings achieved through participation in the OCM, (ii) linking payment to care quality, (iii) providing financial support for care delivery improvement and innovation, and (iv) furthering information sharing among providers, patients, and other relevant parties. The OCM’s Request for

Applications indicates that the Secretary of HHS may waive certain federal fraud and abuse laws as they pertain to the OCM, to encourage participation and innovation. The details of these waivers are not described in the OCM’s Request for Applications; rather, additional information on any such waivers will be provided to OCM participants in separately issued documentation. The scope of these waivers will guide the structuring of OCM arrangements involving participating physician practices, other providers, qualified Medicare beneficiaries, and non-Medicare payers. For instance, without applicable waivers, practices will be prohibited from or limited in sharing OCM performance-based payments with another provider or offering incentives to an OCM Medicare beneficiary to encourage the beneficiary’s adherence to a treatment or drug regime. Prospective participants should consider requesting further guidance from CMS on the waivers prior to the OCM application deadline to assist them in evaluating OCM participation.

Potential Participants

Physician Practices. Physician group practices and solo physicians that furnish chemotherapy to Medicare beneficiaries may participate in the OCM. Both specialty and multispecialty practices (which may include

practitioners that do not furnish cancer chemotherapies) may participate. Because OCM compensation is performance-based and does not include a “shared savings” component, practices participating in the OCM are not precluded from participating in the Medicare Shared Savings Program or the Pioneer ACO Program, but participation in such programs by OCM participating physician practices will be monitored for potential overlap in shared savings and performance-based payments for the same beneficiary. Practitioners who participate in the CMS Transforming Clinical Practices Initiative are not eligible to participate in the OCM.

Participating physician practices must meet certain requirements relating to the following:

- Providing 24/7 patient access to an appropriate clinician with real-time access to the practice's medical records;
- Using electronic health record technology and achieving meaningful use of the same;
- Utilizing metric analysis for continuous quality improvement;
- Providing certain patient navigation core functions;
- Documenting a comprehensive, 13-point cancer care plan; and
- Treating beneficiaries in accordance with nationally recognized clinical guidelines.

CMS will implement enhanced claims audits, complaint tracking, site visits, and other monitoring activities to ensure that access and quality of care are not compromised by participating practices.

If a physician practice participates in the OCM, all physicians and non-physician practitioners in the group who prescribe chemotherapy to treat cancer are included in the group's OCM participation for beneficiary attribution and other program purposes. The Innovation Center will select practices based on several factors, including, without limitation, the size and geographic dispersion of practice applicants.

CMS expects practices to commit to participate for the entire five-year model period; however, practices may continue to participate in the OCM only if they are able to qualify for performance-based compensation by the end of the third OCM performance year.

While physicians in provider-based departments of prospective payment system exempt cancer hospitals and other physicians who are not paid for physician services off of the Medicare Physician Fee Schedule (“PFS”) may not participate in the OCM, physicians may participate in the OCM if they bill for any services off of the PFS. For example, an oncologist employed by a hospital-owned physician practice who bills for evaluation and management services rendered to a qualified Medicare beneficiary off of the PFS may participate in the OCM even if all other services rendered to that beneficiary are not billed off of the PFS (for instance, the beneficiary receives chemotherapy in a hospital outpatient department setting). This creates planning opportunities for practices that may lead to appropriate restructuring of practice organization to realize maximum performance-based compensation under the OCM.

Non-Medicare Payers. Commercial payers (including Medicare Advantage plans), state Medicaid agencies, and other non-Medicare governmental payers may also participate in the OCM. Non-Medicare payers must incentivize the OCM practice requirements described above with financial incentives that are aligned with the OCM's episodic and performance-based payment models relating to cancer care for non-Medicare patients. Each participating non-Medicare payer is required to contract separately with at least one participating OCM physician practice but may also include non-OCM practices in its program. In selecting physician practices, the Innovation Center intends to favor those practices that propose to participate in the OCM together with non-Medicare payers.

CMS expects participating payers to commit to participate for the entire five-year model period. Participating payers need not incorporate the OCM's benchmarking, patient attribution, or specific payment methodologies, but they must share their methodologies with the Innovation Center. Participating payers must collect data relating to and report to practices on a core set of OCM quality measures, but they may incorporate additional quality measures into their programs, as long as such additional measures do not conflict with the OCM's practice requirements or substantially increase the reporting burden on participating practices.

CMS believes that participation in the OCM will give payers the opportunity to leverage the OCM's practice transformation achievements to deliver higher-quality and lower-cost cancer care to such payers' non-Medicare patients who receive cancer care through the payers' plans. Based on the guidance provided by CMS thus far, the extent of the benefits to other payers, in the form of access to CMS data or otherwise, is unclear. We expect CMS to issue further guidance on the benefits of participation for other payers.

Episode Definition

Through the OCM, CMS will measure quality and determine cost savings achieved during a six-month episode of care. Episodes of care for nearly all types of cancers are covered by the OCM. An episode of care is initiated for a qualified Medicare beneficiary upon the date of an initial covered chemotherapy administration claim or Part D covered chemotherapy claim for cancer care. The calculation of costs associated with a covered episode includes costs for all Medicare Parts A and B services (cancer and non-cancer related) and certain Part D prescription drugs received by the covered Medicare beneficiary. Following conclusion of an initial, six-month episode of care, subsequent six-month covered episodes may occur.

All qualified Medicare beneficiaries receiving a covered chemotherapy treatment at a participating physician practice will be included in the OCM automatically. A Medicare beneficiary undergoing cancer care that does not involve a covered chemotherapy treatment, such as a beneficiary receiving radiation therapy only, would not be included in the OCM. Medicare beneficiaries who do not wish to be covered by the OCM must change providers to a non-OCM practice. Each participating physician practice is responsible for tracking beneficiary eligibility and billing the monthly care management and practice transformation payments, but CMS will perform a retrospective attribution of each beneficiary following completion of a covered episode.

Payments

Fee-for-Services Payments. Participating physician practices will continue to bill and receive Medicare fee-for-services payments for services provided throughout an OCM episode of care.

Monthly Care Management and Practice Transformation Payments. Participating physician practices will also receive a per-beneficiary-per-month ("PBPM") payment of \$160 for each of the six months in the episode, regardless of cancer type. These payments are intended to provide participating practices financial resources to assist in effectively managing and coordinating care provided to covered beneficiaries during the episode of care. A practice can continue to bill and receive the PBPM payments even if the beneficiary stops receiving chemotherapy prior to conclusion of the six-month period, unless the beneficiary enters hospice (although, as described below, such payments will be included in CMS's calculation of actual costs).

Performance-Based Payments. Upon successfully achieving targeted cost savings for covered episodes, participating physician practices will be eligible to receive a performance-based episode payment for certain high-volume cancers (covering approximately 90 percent of Medicare beneficiaries receiving chemotherapy). The maximum performance-based payment, if any, will equal an aggregate target price less the aggregate actual Medicare expenditures for covered episodes during an OCM performance year (including PBPM payments). At a high level, CMS determines the aggregate target price by calculating a participating practice's (or pool of participating practices') risk-adjusted performance-year benchmark expenditures (based on Medicare claims data from a historical baseline period trended to the then-current performance year) and reducing such amount by a set discount percentage (2.75 percent for two-sided risk arrangements and 4 percent for one-sided risk arrangements) retained as savings to Medicare. Performance-based payments are limited to a maximum expenditure reduction of 20 percent of the benchmark expenditures before the applicable discount percentage, in an effort to guard against unacceptable levels of care reduction.

Initially, all practices must participate in the OCM in a one-sided risk arrangement (i.e., upside only), but starting in the third performance year, practices may elect to switch to a two-sided (i.e., upside and downside) risk arrangement. Despite the lower discount rate for two-sided risk arrangements, industry experts predict that few practices will select that track because of the relatively small incentive for practices to take on the increased risk.

CMS will adjust performance-based payments based on each participating physician practice's achievement of or improvement in certain quality metrics relative to other participants or national benchmarks, which will be evidenced by a quality score assigned to the practice. A participating physician practice must meet minimum quality levels to receive any performance-based compensation.

The OCM presents a significant opportunity for physician practices to receive performance-based payments while bringing down the overall cost of cancer care. Cost improvements will be driven, primarily, by the ability of a practice participant to: (i) reduce emergency room use by its OCM beneficiaries, (ii) reduce their hospital admissions and readmissions, (iii) use lower-cost generic drugs, and (iv) use lower-cost sites of service for chemotherapy.

Participation Deadlines

To apply for the OCM, an interested practice must submit a nonbinding letter of intent to CMS by April 23, 2015, and an interested payer must submit a nonbinding letter of intent to CMS by March 19, 2015. For both practices and payers that timely submit letters of intent, applications for the OCM are due no later than June 18, 2015. CMS will notify applicants of acceptance into the OCM within six months of the application submission date. There are a number of applicant eligibility requirements and initiative restrictions for participation in the OCM. Jones Day will continue to monitor developments with the OCM and is available to assist interested parties in applying for the initiative.

Lawyer Contacts

For further information, please contact your principal Firm representative or one of the lawyers listed below. General email messages may be sent using our "Contact Us" form, which can be found at www.jonesday.com.

James R. Dutro

San Francisco
+1.415.875.5839
jdutro@jonesday.com

John M. Kirsner

Columbus
+1.614.281.3700
jkirsner@jonesday.com

Scott A. Edelstein

Washington / Los Angeles
+1.202.879.5572 /
+1.213.243.2160
sedelstein@jonesday.com

Catherine E. Livingston

Washington / Boston
+1.202.879.3756 /
+1.617.449.6877
clivingston@jonesday.com

David W. Grauer

Columbus
+1.614.281.3855
dgrauer@jonesday.com

David T. Morris

San Francisco
+1.415.875.5719
dmorris@jonesday.com

Gerald M. Griffith

Chicago
+1.312.269.1507
ggriffith@jonesday.com

Kevin A. McGill

Columbus
+1.614.281.3937
kmcgill@jonesday.com

Lisa G. Han

Columbus
+1.614.281.3641
lhsan@jonesday.com