ACCC 2019 Policy and Provider Insights Summit

Beyond the Oncology Care Model

What's Next for Value-Based Care?

Andrew Furlow, Counsel
andrew.furlow@hoganlovells.com
(212) 918-5843

Hogan Lovells

Beyond the Oncology Care Model (OCM): Trends in Value-Based Programs

End of an era: Shared losses join shared savings

- OCM: Impending shift to mandatory two-sided risk for some practices
- Medicare Accountable Care Organizations (ACOs):
  - Shared Savings Program ACOs – faster transition to two-sided risk
  - More recent Innovative Center ACOs have required two-sided risk and at higher levels
- Bundled Payments for Care Improvement (BPCI) Advanced: Two-sided risk required for all participants – regular fee-for-service (FFS) payment with retrospective adjustment up or down
- Proposed Radiation Oncology (RO) Model: Two-sided risk required for all participants – prospective payment, with potential retrospective adjustments
- Two-sided risk required to qualify as an Advanced Alternative Payment Model (APM) under the Quality Payment Program (QPP)

Increased involvement by private payers

- A few models (including OCM) provide for participation by private payers, but participation has been limited and with low volume
  - Interesting exception – BPCI Advanced "conveners"
- But many private payers are developing and expanding their own bundled payment or value-based payment initiatives
  - United Healthcare "Care Bundles Program" – bundled payments in Medicare Advantage (MA) business
  - Cigna claims 50% of Medicare and commercial payments made through alternative payment models
- The Centers for Medicare & Medicaid Services (CMS) continues to implement the "All Payer Advanced APM" option that allows eligible clinicians to qualify as an APM participant (avoid Merit-Based Payment Incentive Program (MIPS) adjustments, earn 5% Part B payment bonus) by combining participation in Medicare-sponsored APM and non-Medicare-sponsored APM

Continued exploration of value-based contracts

- More and more contracts between payers/providers and manufacturers/suppliers of health care items and services
  - Value-based or outcomes-based rebates or guarantees
  - Subscription models
  - Bundled sale arrangements
- More limited scope than payer-sponsored programs (i.e., one manufacturer, one product, or one provider) but helping to build momentum
- We are expecting a new proposal from HHS Office of Inspector General (OIG) that may extend anti-kickback safe harbor protection to certain value-based arrangements

Push toward “meaningful measures”

- Longstanding sense that quality measures used for value-based programs require providers simply to “check the box”
- Sense that low-hanging fruit has been picked and benefits are tapering off
  - Hospital readmissions penalty
  - Upside-only ACOs
- CMS launched “Meaningful Measures Initiative” in 2017 to cut the number and variety of “disparate” measures; “focus on critical areas that matter most”; “promote alignment” across continuum of care and payers; and promote innovation in new types of measures
- Recent proposals in MIPS bear out the initiative:
  - Removal of process measures and move toward MIPS Value Pathway (MVP)
  - Development of episode-based cost measures (including screening colonoscopy and lumpectomy partial mastectomy/simple mastectomy)

Mandatory value-based programs

- QPP/MIPS is most prominent
  - Slow implementation, with limited actual downside penalties imposed to date
  - Push to “meaningful measures” may make participation riskier
- CMS increasingly willing to move forward with mandatory value-based payment models, even when not required by Congress
  - Comprehensive Joint Replacement (CJR) Model – pre-dated Trump Administration
  - Former HHS Secretary Price opposed mandatory models; Secretary Azar reversed course
- RO Model is the latest proposed mandatory model
  - Like CJR, mandatory participation for specific geographic areas, provider types, and health care services
  - RO Model goes further – prospective payment, no drop-out option as proposed

Oncology Care Model Update

OCM Basics

- 5-year voluntary program (July 2016 through June 2021)
- Participants: 175 group or solo practices providing care for patients undergoing chemotherapy, plus 10 private payers
- Two major components intended to incentivize oncology practices to provide better, more efficient care:
  - $160 per-beneficiary-per-month (PBPM) payment for increased availability and care coordination
  - A performance-based payment - practices can earn up to 20% of savings or losses against a target cost
- Participants receive regular Medicare FFS payments
- Performance-based payments calculated retrospectively after each 6-month performance period

OCM: The Early Results

- In first performance period, CMS announced:
  - No statistically significant impact on total cost of care, Part A or B costs, Part D costs
  - Savings not enough to cover monthly PMPM supplement or any performance-based payments
- We also heard that very few practices earned performance-based payments
- Some indications that OCM practices did implement or continue improvements in clinical flow that may bear fruit in the future
- Later today: Insights from OCM practices about results from later performance periods

OCM: Shift to Mandatory Two-Sided Risk

- Practices were allowed to begin with one-sided risk – if the practice generated savings for Medicare, the practice would share those savings. If the practice generated losses, it would not share the losses.
  - Practices also could volunteer to take on two-sided risk
- After the fourth performance period, if a practice has not earned a performance-based payment, it must either exit the model or shift to two-sided risk until it earns a performance-based payment.

QPP and MIPS: A whole new world?

Proposed “MVP” Approach (MIPS Value Pathways)

- New proposal in CY 2020 Physician Fee Schedule proposed rule
- Beginning in CY 2021, CMS would create various “MIPS Value Pathways” that MIPS eligible clinicians would be encouraged (required?) to follow
- Each MVP would include sets of measures across all four MIPS performance categories, oriented to a specific clinical area (e.g., diabetes prevention or major surgery)
- Measures would be standardized for all eligible clinicians who choose that MVP (i.e., all clinicians report the same measures)

Proposed “MVP” Approach (MIPS Value Pathways)

- CMS says intent of MVP is to:
  - Connect measures and activities across the four MIPS performance categories
  - Incorporate a new set of claims-based quality measures focusing on population health
  - Provide greater data and information to clinicians and patients
- Risk is that creating more uniformity in reporting reduces flexibility too much and penalizes clinicians through no fault of their own
- Potential concerns:
  - MVP approach too one size fits all even within clinical areas
  - Some clinical areas lack an appropriate MVP
  - Uneven level of difficulty between measures in different clinical areas
  - Measures outside of quality may not be well developed enough – especially cost measures

MIPS: In the meantime (CY 2020 proposals)

- CMS continues to increase the weight of the cost score (20% in CY 2020, 25% in CY 2021, 30% in CY 2022) and decrease weight of quality score (40%, 35%, 30%).
- CMS proposes to add 10 new episode-based cost measures, including a lumpectomy/mastectomy measure
- More stringent requirements for quality data completeness (70% in CY 2020), improvement activity participation (50% of groups, not just 1 clinician)
- "Refinement" of quality measures – CMS proposes to eliminate 55 existing measures
- Increase in performance threshold (minimum score to earn a bonus) to 80 points; maximum bonus/penalty in CY 2020 is +/- 9%

MIPS: In the meantime (CY 2020 proposals)

- Measures proposed for deletion include:
  - HER2 Negative or Undocumented Breast Cancer Patients Spared Treatment with HER2-Target Therapies (standard of care – no "meaningful gap" – 97.4% average performance)
  - Patients who Died from Cancer with More than One Emergency Department Visit in Last 30 Days of Life (duplicative of similar measure for admissions to ICU)
  - Patients who Died from Cancer Not Admitted to Hospice (duplicative of new measure of hospice admissions for cancer patients)
  - Optimizing Patient Exposure to Ionizing Radiation: (1) Reporting to Radiation Dose Index Registry and (2) CT Images Available for Patient Follow-Up and Comparison (simply reporting to a registry or setting up a database and no "meaningful impact" on quality improvement or radiation reduction)
  - Reminder System for Screening Mammograms ("structure measure" that does not support "direct patient care")

Proposed Radiation Oncology Model: A sign of things to come?

Proposed RO Model Basics

- 5-year model (Jan. 1, 2020 to Dec. 31, 2024)
- Mandatory for providers in geographic areas that are selected to participate (aim is to capture about 40% of eligible radiation therapy (RT) episodes)
- Medicare would pay RT providers a pre-determined, site-neutral bundled rate for most services provided during a 90-day episode of radiation therapy – replaces FFS billing for those services
  - Base rates calculated from current Hospital Outpatient Prospective Payment System (OPPS) payments, adjusted for payment trends
  - Automatic "discount" of 4% (professional services) or 5% (technical services)
  - Some opportunity to recoup additional payment later based on quality/patient experience measures)

Proposed RO Model Basics

- Applies only to payments for RT to treat 17 specific cancers, identified by diagnosis code (see next slide)
- Covers most RT modalities, including external beam radiation therapy (including intensity-modulated radiotherapy (IMRT), stereotactic radiosurgery (SRS), stereotactic body radiotherapy (SBRT), proton beam therapy (PBT)), intraoperative radiotherapy (IORT), image-guided radiation therapy (IGRT), and brachytherapy
- Includes treatment planning, dose planning, dosimetry, calibration of devices, RT delivery, and treatment management, but not related evaluation and management services
- Base rate would not incorporate any new technology add-on or update

Proposed RO Model Basics

Covered Cancers

Cancer Type	ICD-9 Codes	ICD-10 Codes
Anal Cancer	154.2x, 154.3x	C21.xx
Bladder Cancer	188.xx	C67.xx
Bone Metastases	198.5x	C79.5x
Brain Metastases	198.3x	C79.3x
Breast Cancer	174.xx, 175.xx, 233.0x	C50.xx, D05.xx
Cervical Cancer	180.xx	C53.xx
CNS Tumors	191.xx, 192.0x, 192.1x, 192.2x, 192.3x, 192.8x, 192.9x	C70.xx, C71.xx, C72.xx
Colorectal Cancer	153.xx, 154.0x, 154.1x, 154.8x	C18.xx, C19.xx, C20.xx
Head and Neck Cancer	140.xx, 141.0x, 141.1x, 141.2x, 141.3x, 141.4x, 141.5x, 141.6x, 141.8x, 141.9x, 142.0x, 142.1x, 142.2x, 142.8x, 142.9x, 143.xx, 144.xx, 145.0x, 145.1x, 145.2x, 145.3x, 145.4x, 145.5x, 145.6x, 145.8x, 145.9x, 146.0x, 146.1x, 146.2x, 146.3x, 146.4x, 146.5x, 146.6x, 146.7x, 146.8x, 146.9x 147.xx, 148.0x, 148.1x, 148.2x, 148.3x, 148.8x, 148.9x, 149.xx, 160.0x, 160.1x, 160.2x, 160.3x, 160.4x, 160.5x, 160.8x, 160.9x, 161.xx, 195.0x	C00.xx, C01.xx, C02.xx, C03.xx, C04.xx, C05.xx, C06.xx, C07.xx, C08.xx, C09.xx, C10.xx, C11.xx, C12.xx, C13.xx, C14.xx, C30.xx, C31.xx, C32.xx, C76.0x
Kidney Cancer	189.0x	C64.xx
Liver Cancer	155.xx, 156.0x, 156.1x, 156.2x, 156.8x, 156.9x	C22.xx, C23.xx, C24.xx
Lung Cancer	162.0x, 162.2x, 162.3x, 162.4x, 162.5x, 162.8x, 162.9x, 165.xx	C33.xx, C34.xx, C39.xx, C45.xx
Lymphoma	202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 203.80, 203.82, 200.0x, 200.1x, 200.2x, 200.3x, 200.4x, 200.5x, 200.6x, 200.7x, 200.8x, 201.xx, 202.0x, 202.1x, 202.2x, 202.4x, 202.7x, 273.3x	C81.xx, C82.xx, C83.xx, C84.xx, C85.xx, C86.xx, C88.xx, C91.4x
Pancreatic Cancer	157.xx	C25.xx
Prostate Cancer	185.xx	C61.xx
Upper GI Cancer	150.xx, 151.xx, 152.xx	C15.xx, C16.xx, C17.xx
Uterine Cancer	179.xx, 182.xx	C54.xx, C55.xx

Proposed RO Model Basics

Proposed Base Rates

RO Model-Specific Placeholder Codes	Professional or Technical	Cancer Type	Base Rate
MXXXX	Professional	Anal Cancer	$2,968
MXXXX	Technical	Anal Cancer	$16,006
MXXXX	Professional	Bladder Cancer	$2,637
MXXXX	Technical	Bladder Cancer	$12,556
MXXXX	Professional	Bone Metastases	$1,372
MXXXX	Technical	Bone Metastases	$5,568
MXXXX	Professional	Brain Metastases	$1,566
MXXXX	Technical	Brain Metastases	$9,217
MXXXX	Professional	Breast Cancer	$2,074
MXXXX	Technical	Breast Cancer	$9,740
MXXXX	Professional	Cervical Cancer	$3,779
MXXXX	Technical	Cervical Cancer	$16,955
MXXXX	Professional	CNS Tumor	$2,463
MXXXX	Technical	CNS Tumor	$14,193
MXXXX	Professional	Colorectal Cancer	$2,369
MXXXX	Technical	Colorectal Cancer	$11,589
MXXXX	Professional	Head and Neck Cancer	$2,947
MXXXX	Technical	Head and Neck Cancer	$16,708
MXXXX	Professional	Kidney Cancer	$1,550
MXXXX	Technical	Kidney Cancer	$7,656
MXXXX	Professional	Liver Cancer	$1,515
MXXXX	Technical	Liver Cancer	$14,650
MXXXX	Professional	Lung Cancer	$2,155
MXXXX	Technical	Lung Cancer	$11,451
MXXXX	Professional	Lymphoma	$1,662
MXXXX	Technical	Lymphoma	$7,444
MXXXX	Professional	Pancreatic Cancer	$2,380
MXXXX	Technical	Pancreatic Cancer	$13,070
MXXXX	Professional	Prostate Cancer	$3,228
MXXXX	Technical	Prostate Cancer	$19,852
MXXXX	Professional	Upper GI Cancer	$2,500
MXXXX	Technical	Upper GI Cancer	$12,619
MXXXX	Professional	Uterine Cancer	$2,376
MXXXX	Technical	Uterine Cancer	$11,221

Proposed RO Model: Early Insights

- Prospective payment is most aggressive model yet, and in a *mandatory* model
- Automatic 4%-5% discount from current rates – significant incentive to actually cut costs and improve cost efficiency
- Policymaking by value-based model?
  - Base rate calculated from current OPPS rates, not Physician Fee Schedule (PFS)
  - CMS cites its previous statements that it trusts the OPPS rates more

Proposed RO Model: Early Insights

- Winners and losers – Base rates calculated as an average across all modalities; and disproportionate impact likely higher for freestanding treatment facilities that are currently reimbursed based on PFS rates
- RO Model may overlap with participation in ACO, OCM, or other value-based model
  - No automatic exclusion for OCM practices
  - And if RO Model episode occurs entirely within a 6-month OCM episode, CMS proposes the 4%/5% discount and withholding amounts from RO Model base payment would be included in the total cost of the OCM episode to avoid double counting

The larger picture

- Comments on the proposed RO Model due September 16, 2019
- Innovation Center has authority to adopt further mandatory models in other clinical areas
  - Ultimate implementation of proposed RO Model will be test of political will to move forward with mandatory models
  - We are expecting more details soon on a voluntary Primary Care First model (2020 start date); no other specific models on the horizon
  - Expecting new director of Innovation Center after departure of current director Adam Boehler
  - CMS leadership has indicated more mandatory models may be coming, but also have been careful to say they will use mandatory models only where CMS does not expect robust voluntary participation or to meet an urgent need for reform

Presenter

Andrew Furlow

Counsel, New York, NY

T +1 212.918.5843

andrew.furlow@hoganlovells.com

ACCC 2019 Policy and Provider Insights Summit

Beyond the Oncology Care Model

What's Next for Value-Based Care?

Andrew Furlow, Counsel
andrew.furlow@hoganlovells.com
(212) 918-5843

Hogan Lovells