Alternative Payment Models: Here to Stay?

BY LEAH RALPH

The February decision by the Center for Medicare and Medicaid Innovation (CMMI) to build its first specialty care model around oncology is an important indication of the agency's focus on how to contain costs in cancer care. The Oncology Care Model (OCM) has been a focal point for many months, as practices consider whether or not to participate and the Centers for Medicare & Medicaid Services (CMS) works to provide continuous updates and assistance as practices make their way through the application process. The OCM will provide a monthly, per-beneficiary care coordination fee to administer chemotherapy, while requiring practices to meet certain infrastructure and quality requirements. In addition, and perhaps most attractive, it allows practices the opportunity to share in any savings that materialize based on a historical spending benchmark.

Of the 443 practices who completed the first step toward OCM participation (submitting a letter of intent in early May), 106—nearly one-quarter—are ACCC members. To help our members navigate this process, ACCC launched its OCM Resource Center: a one-stop-shop for tips, tools, and real-time information from CMS. We've held webinars, gathered testimonials, and created an OCM hotline to answer your questions.

How this model plays out over the next five years and beyond will have real implications for the future of oncology payment reform. It's likely the OCM will be an iterative process. As selected practices get started in the spring of 2016, we'll see CMS make adjustments—albeit small adjustments—and work with practices to implement their programs, as we have seen with other CMMI models.

CMMI's work is part of a broader effort by the Department of Health and Human Services (HHS) to move Medicare payments away from fee-for-service towards reimbursement for quality and value. In January, HHS announced explicit goals to tie 85 percent of Medicare payments to quality programs like CMS' PQRS (Physician Quality Reporting System) or EHR Meaningful Use requirements by 2016, and 90 percent of payments by 2018. Taking it one step further, HHS also announced a goal of tying 30 percent of Medicare payments to alternative payment models (APMs), like the OCM, by 2016 and 50 percent by 2018. For context, in 2011, Medicare made almost no payments to providers through APMs, but today those payments represent approximately 20 percent.

In many ways, the long-awaited passage of a permanent fix to the sustainable growth rate (SGR) formula solidifies the future of APMs in the Medicare program and likely across the healthcare system. In April, Congress finally repealed and replaced the flawed SGR—a huge win for ACCC members after 80 plus meetings on Capitol Hill and hundreds of letters sent to legislators just as Congress was negotiating the bill. The Medicare Access and CHIP Reauthorization Act (MACRA)—the legislation that repealed the SGR—creates important relief for providers by establishing much needed predictability in payment rates. Ultimately, however, MACRA will require a shift in the way physicians are paid in Medicare. Starting in 2020, the law creates a new dual-track reimbursement system, in which future payments will be contingent on participating either in a new quality program under fee-for-service, called the Merit-Based Incentive Program (MIPS), or opting to receive a certain percentage of Medicare payments through an APM, like the OCM. While physicians may choose either track, and will be familiar with the quality requirements under MIPS, the law calls for higher updates in the APM track, creating a stronger incentive to participate in an alternative payment model.

CMS recently reinforced its commitment to developing APMs with an announcement that the agency is expanding the Pioneer Accountable Care Model (ACO) program. The agency was able to demonstrate that this early ACO program produced cost savings (more than $384 million in its first two years) without decreasing quality of care. This move is notable because it is the first time CMS has used its authority to allow CMMI to expand a demonstration project. How CMMI does this will be watched carefully, as it will set precedent for future expansions and provide insight into their approach.

While we have a way to go in the development and evaluation of appropriate, successful APMs—and even longer before providers are required to participate—these models appear to be here to stay. We encourage our members to become familiar with what it might take for your program to engage in payment reform initiatives and look to ACCC as a resource in the coming months on the OCM and other models. OI

Leah Ralph is ACCC manager of provider economics & public policy.