And They're Off!

BY LEAH RALPH

Last month, practices participating in the Center for Medicare & Medicaid Innovation (CMMI) Oncology Care Model (OCM) finally made it to the finish line—or, more accurately, to the starting line. On June 10, nearly a year after the application deadline, practices signed contracts with CMS, officially signaling whether they were in or out of CMMI's flagship oncology-specific alternative payment model.

Getting there was no easy feat; OCM practices spent months producing implementation and financial plans, conducting extensive self-assessments, and hiring consultants and vendors to help them achieve infrastructure requirements, and—up until the final hour—negotiating with CMS on specific contracting arrangements and what these meant for OCM eligibility. Respite for these practices is brief: the program is scheduled to begin July 1, 2016, with any initial Part B administration claim or Part D chemotherapy claim and ICD-10 code for cancer diagnosis triggering a 6-month episode of care under the OCM.

As with any new payment model, several aspects of the OCM are proving to be operationally complex. CMS has specified a number of issues that were unclear in the original request for applications (RFA), including a methodology for patient attribution, the initial set of quality measures, additional detail on the performance-based payment methodology, and a "novel therapies" adjustment to account for newer therapies under an approach that benchmarks providers' performance against historical spend.

Practices are also facing requirements to provide their quality measure data through an OCM registry that is still being built, leaving big questions about compatibility with existing EHR systems. Bigger hurdles may prove to be CMS' ability to provide timely data to allow for improvements or course corrections within an episode, or achieving true cultural buy-in among providers and staff in OCM practices to work longer hours and transform the way they deliver care.

Over the past several months, ACCC has worked closely with OCM practices to troubleshoot barriers, clarify CMS requirements, and get answers from the agency on individual circumstances. We have built a network of support for practices that includes webinars, access to OCM experts, and education opportunities to share experiences among OCM peers.

In early June, ACCC launched an online forum, the Oncology Care Model (OCM) Collaborative, exclusively for providers to share tips, tools, and resources as they troubleshoot OCM onboarding and implementation challenges. The group also serves as a liaison to CMS, identifying trending issues and facilitating calls on critical topics. To receive updates and access the ACCC OCM Collaborative, visit ocmcollaborative.org and sign up today.

Most practices see the OCM as a strategic opportunity to work with new data sets, build infrastructure, and learn how to operate under a risk-based arrangement with Medicare. Even if your cancer program is not participating in this new model, the successes and failures of the OCM will permeate future oncology payment reform efforts, both public and private. Particularly with the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) and CMS's recently proposed Quality Payment Program, providers will be increasingly required to test the waters of alternative payment models. Look to the OCM quality measures and "practice transformation" requirements as a preview of what CMS believes cancer care providers should be able to do—and how you should be structured—in the coming years. OI

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