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Specialty-Based Global Payment—A New Phase in Payment Reform

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To control health care spending and improve quality, public and private payers are increasingly moving away from fee-for-service towards global payment contracts with pay-for-performance. To date, global payment has been centered on the role of primary care physicians coordinating all care, including specialty care. In 2016, Medicare plans to enter a new contracting model with physician practices for cancer care that may serve as a model for specialty-based global payment.

The Oncology Care Model (OCM)

The OCM combines key features of global payment, medical homes, and pay-for-performance, while aligning incentives across multiple payers (Figure). The OCM creates a spending target that covers all Medicare Part A and Part B services, as well as certain Part D expenditures, incurred during a 6-month episode starting at the initiation of chemotherapy.¹ Historically, 52–71% of total spending occurred during this period, depending on the type of cancer.² Similar to Medicare's bundled payment initiatives, the OCM spending target is based on an episode of care (6 months in the OCM). Yet similar to the Medicare Accountable Care Organization (ACO) programs, it covers spending across the care continuum, and is built atop continued fee-for-service payments to providers.³ To date, over 450 practices have submitted letters of intent to apply to participate in the OCM.⁴

Physicians enter the OCM under a one-sided payment model that offers performance-based payment (or shared savings) for spending under the target, without risk for spending above the target that exists in a two-sided model. The target is 96% of benchmark spending, estimated by trending forward historical spending adjusted for beneficiary risk and geography. In year 3, however, physicians may choose to enter a two-sided model with a target of 97.25% of benchmark, offering greater shared savings in exchange for bearing risk

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for spending above the target. Performance based payments are adjusted to reflect quality scores in physician communication, care coordination, and patient experience. Quality measures are derived from claims data, patient surveys, and from statistics collected at the practice level. Physicians earn full savings for maximal quality performance. Additionally, physicians may bill for a \$160 per beneficiary per month fee (\$960 per 6-month episode) for delivering enhanced services.

Innovation

While the Centers for Medicare and Medicaid Innovation is not the first to introduce payment reform for cancer care, the OCM is the most comprehensive initiative to date. A key element of the model is the inclusion of multiple payers in partnership with providers. Private insurers, Medicare Advantage plans, state Medicaid agencies, employee health plans, and other government payers are encouraged to participate. Participating payers are required to have a basic level of consistency in incentives and expectations for physicians, rendering the OCM a serious attempt to galvanize multi-payer reform.

The OCM also represents an initial effort at delivery system reform for the greater than 50% of patients with cancer who have Medicare as their primary payer.⁵ Even though the OCM only affects eligible fee-for-service Medicare beneficiaries receiving chemotherapy, Medicare's dominant footprint in oncology care renders the OCM a larger scale endeavor than individual programs from private payers. Recent efforts by private payers have included bundled payments for chemotherapy for a limited set of cancers. Physician-led efforts have focused on applying the medical home or ACO concept to oncology or oncologists not choosing certain chemotherapies. By and large, these reforms have not sparked broad participation across payers and physicians. Leadership by the Medicare program is vital for influencing broad trends in cancer care.

The OCM includes unique incentives for quality and physician coordination. Its quality measures pertaining to chemotherapy, adjuvant hormonal therapy, and performance status are specific to oncology care, helping to mitigate concerns for under-provision of necessary care. Moreover, the model allows large and small oncology practices to enter the contract together and receive a collective benchmark and quality performance over the five-year model. These shared incentives could help practices coordinate their delivery of oncology care, supported by evidence that patients with cancer who receive care in an integrated delivery system have increased rates of evidence-based treatment, fewer racial disparities, and improved outcomes.⁶

Potential pitfalls

Patients with different types of cancers are all eligible for the OCM, yet opportunities for savings will likely vary. Malignancies differ in natural history and treatment based on tissue of origin, grade, and stage. In designing benchmark payments for such a context, averages are useful when the variance is small and sample sizes large, but that may not be the case for many oncology therapies. Evidence shows that average spending per episode varies considerably across malignancies, with lymphomas averaging \$45,558, breast cancer

\$17,720, and prostate cancer \$12,968.² Within cancer types, variation in spending across patients is large, with the top quartile incurring substantially higher costs. Furthermore, the method for including new therapies or technologies into the spending benchmark remains unknown.

The OCM may engender concerns regarding patient selection. Academic medical centers, which tend to attract the patients with cancer who have the highest morbidity or those seeking aggressive treatment, may find that a spending cap at, for example, the 99th percentile is not adequate financial protection. Taking on high cost patients may benefit practices if they are able to deliver care more efficiently, but it could also make practices more likely to spend above the benchmark and thus become ineligible for performance payments.

Perhaps the biggest obstacle that the OCM faces is convincing physicians and private payers to take a leap of faith into uncharted waters.⁷ For physicians, risk bearing in the third year may not be feasible, as oncologists may find it difficult to control utilization unrelated to chemotherapy. Whether the OCM can cover enough patients across payers to catalyze practice pattern changes also remains unclear. The Pioneer ACO program similarly sought to align incentives across payers by requiring risk in private contracts, although it has proven challenging for ACOs to change private contracts quickly. For private payers who have to set their own benchmarking methodology and prices, price variations due to hospital or physician market power would be preserved, portending challenges to cross-payer collaboration when they face varying prices.

Implications for other specialties

Despite its challenges, the OCM provides an example of payment reform for other specialties.⁸ It allows oncologists to serve as the coordinator of the patient's care, similar to primary care physicians in ACOs. Oncologists may be particularly well-suited to assuming this role, given their longitudinal relationships with patients, continuity of oncologic treatments, and that costly episodes of care are relatively short and well-defined.

The OCM may pave the way for a new phase in payment reform centered on specialty-based global budgets. A burgeoning example is the Medicare Comprehensive End-Stage Renal Disease (ESRD) Care Model, in which physicians and dialysis organizations assume responsibility for a budget for beneficiaries with ESRD. While there are potential pitfalls of using smaller budgets, carefully designed incentives appropriately targeted to a specialty may offer a compromise between fee-for-service and wholesale risk contracts.

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	Traditional Medicare	Bundled Payments for Care Improvement Initiative	Oncology Care Model	Medicare Accountable Care Organizations
Payment model	Fee for service	4 types of bundled payments	Specialty-based budget	Global budget
Services covered	Single service	Episode of care for 48 targeted conditions	All services after initiation of chemotherapy	All services
Duration of care	Single encounter	3 months or variable	6 months	Annual within multiyear budget
Physician participation	All physicians	1574 participants in phase 2*	450 interested physician groups	447 physician organizations
No. of beneficiaries	25 million	Final estimates not available	To be determined	7.7 million
Financial risk for physicians	No risk; future payments subject to adjustments in the Merit-Based Incentive Payment System**	Risk in phase 2 of the model	No risk in years 1-2; option to bear risk in year 3	Largely no risk in Shared Savings program; greater risk in Pioneer and Next Generation models

Figure.

Payment Models in the Traditional Medicare Program*

* As of January 1, 2016, participants included 337 awardees and 1237 episode initiators (including 409 acute care hospitals, 700 skilled nursing facilities, 288 physician group practices, 100 home health agencies, 9 inpatient rehabilitation facilities, and 1 long-term care hospital) according to the CMS.

** The Merit-Based Incentive Payment System (MIPS) will adjust physician fees up or down based on quality, electronic health record adoption, and other factors as part of the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015 (MACRA).