

# COA Survey Finds OCM Participants Willing to Take on Two-Sided Risk

*Practices in Oncology Care Model Confident They Can Succeed in Shift to Value-Based Cancer Care*

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*Bo Gamble, Director of Strategic Initiatives, COA*

Oncology practices participating in the Centers for Medicare & Medicaid Innovation's Oncology Care Model (OCM) are willing to take on two-sided risk, according to the results of a survey conducted by the [Community Oncology Alliance](#) (COA). The results suggest that oncology practices are confident they can succeed in delivering high-quality and cost-effective cancer care as the health care system undergoes a paradigm shift from fee-for-service to value-based care.

COA surveyed OCM participants following the Center for

Medicare & Medicaid Innovation (CMMI) December 3, 2019 deadline, by which practices had to decide whether to continue in the OCM program, as well as to commit to two-sided risk going forward. A total of 68 OCM practices responded to the 15-question survey which was available online between December 4-20, 2019. The survey results found:

- 47.1% (32 practices) opted to remain in the OCM with one-sided risk
- 36.8% (25 practices) chose to remain and enter into two-sided risk
- 32.4% (22 of the 25 practices) selected two-sided risk and had not received a single performance-based payment
- 16% (11 practices) said they were dropping out of the OCM
- Ten of the 11 practices leaving the OCM had not received a performance-based payment over the preceding four performance periods
- One practice indicated it had received at least one performance-based payment but opted to leave the OCM

Since the start of the OCM, COA has had more than 80 percent of OCM participants networked in an interactive "[OCM Support Network](#)" that includes regular calls and meetings, a dedicated listserv, access to subject matter experts, and more. The purpose is to support participants' involvement and success in the OCM.

Following the December 3 deadline, only OCM teams that had received at least one performance-based payment (out of a possible four performance-based payments) could remain in the OCM without accepting two-sided risk. If practices remained in the OCM, they had to decide between one-sided risk or taking on two-sided risk. With two-sided risk, practices would have to pay back Medicare if they did not achieve the required cost savings. Practices that have not received a performance-based payment but wished to remain in the OCM were required to enter a two-sided risk arrangement.

The COA survey included questions about the practice's prior OCM performance, its decision to continue or to withdraw from the program, its decision regarding two-sided risk, and whether the practice obtained reinsurance. Practices remaining in the OCM and taking on two-sided risk

represent 679 MDs. The average practice size that is assuming two-sided risk is 29.5 MDs. The largest practice taking on two-sided risk in the survey has 160 MDs, and the smallest practice has two MDs.

According to COA's Director of Strategic Initiatives, Bo Gamble, the survey results show that oncology teams have gained confidence with new models of cancer care. "The last three-and-a-half years have done much to educate and prepare teams for new models for cancer care," Mr. Gamble said. "No longer are incentives purely about utilization. Now there are numerous attempts to design a model with emphasis on quality, value, and meaningful quantifiable outcomes. The OCM, and the 20-plus other models, are consistent with that message."

### Taking on Risk Without Performance-Based Payments

Only three practices (4.4%) that had achieved a performance-based payment during the previous four performance periods reported they were entering the two-sided risk arrangement. Most surprising was the number of practices, 22 (32.4%) that had not received any performance-based payments but decided to continue in the OCM taking on two-sided risk.

"These teams must feel good about their progress or they were comfortable with the safe zone option," Mr. Gamble said. Seven (30%) of those practices were in the safe zone for all four performance periods; five (22%) were in the safe zone for three performance periods; nine (39%) were in the safe zone for two performance periods; and two (9%) practices were in the safe zone for one performance period.

The "safe zone," introduced by CMS with the performance period three reconciliation reports, is when a practice's actual costs fall between the OCM's targeted and benchmark costs. The practice does not earn a performance-based payment, but it is also not responsible for costs exceeding the target amount. In other words, the practice does not owe money to CMS. For many OCM practices, the safe zone option has made two-sided risk more acceptable.

COA also included questions in the survey about reinsurance, an insurance product that helps protect providers against catastrophic downside risk. Six (24%) of the 25 teams taking on two-sided risk indicated they would purchase reinsurance to cover their potential losses, with 17 (68%) practices indicating they would not obtain reinsurance. Two practices were undecided. One practice indicated it may withdraw from the OCM if it is unable to obtain reinsurance by the end of the year.

Of note, the average practice size that is purchasing reinsurance (17 MDs) is smaller than the average practice size opting for two-sided risk. "This suggests the smaller practices have more to lose if they do not do well and therefore need some financial security," Mr. Gamble said.

### What Does the Future Hold for Oncology Practice Transformation?

The OCM has had a transformative effect on community oncology practices but implementation has been challenging, even for practices with previous payment reform experience. COA's efforts to support and advocate for the OCM practices that have been struggling with implementation eventually led COA to begin developing its own payment model for cancer care based on quality and value. Known as the "[OCM 2.0](#)," it is a detailed alternative payment model (APM) that includes bold proposals for value-based drug contracts that, if implemented, would provide high-quality, coordinated oncology care at the same or lower cost.

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