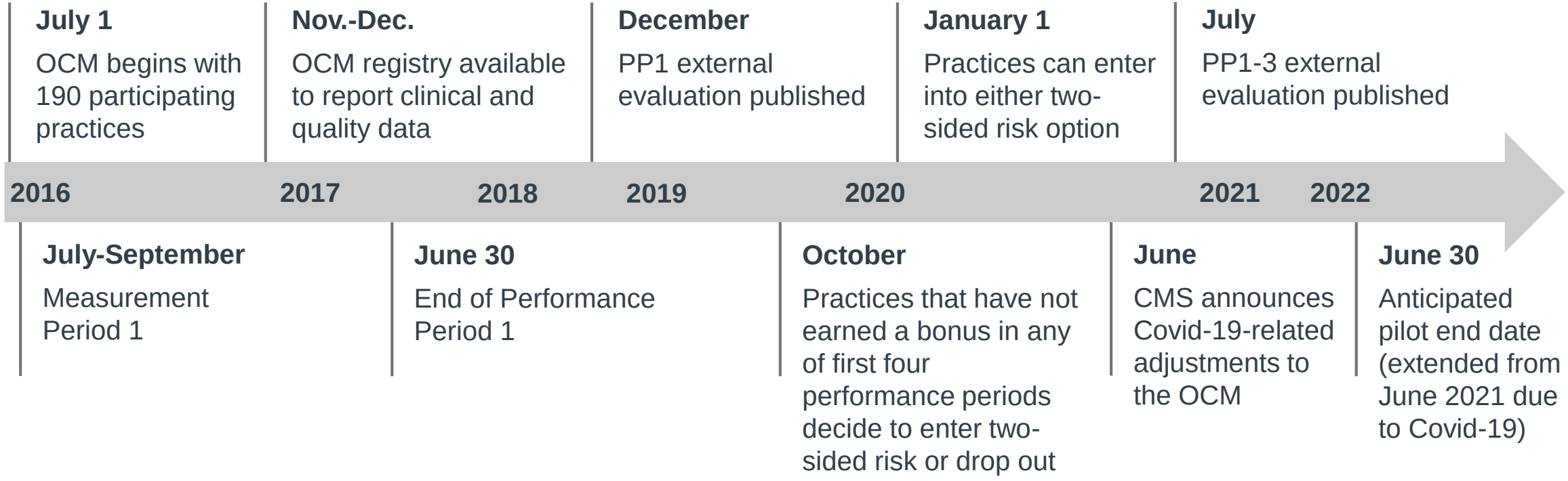
Oncology Care Model

A timeline of the Oncology Care Model (OCM)

CMS recently released results from the first three performance periods (PPs)

Timeline of key OCM events



Source: "CMS announces additional opportunities for clinicians to join innovative care approaches under the Quality Payment Program," Centers for Medicare & Medicaid Services, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-10-25.html; "Oncology Care Model Overview," Association of Community Cancer Centers, http://oi.accc-cancer.org/advocacy/OCM-Overview.asp; Strawbridge L, ACCC Oncology Care Model Collaborative Workshop at the ACCC 44th Annual Meeting and Cancer Business Summit, Washington, DC, March 16, 2018.

CMMI's efforts to drive value in medical oncology

Oncology Care Model has entered its fifth year

Overview of the OCM

Who is participating?

- 138 medical oncology practices
- 10 commercial payers
- CMS

How are practices paid?

- **Fee-for-service payments** for all services to enrolled beneficiaries
- **Monthly enhanced oncology services** (MEOS) payment of $160 for six months upon initiation of chemo
  - If the patient continues or resumes chemo, practice can trigger subsequent episodes
- **Performance-based payment** (PBP) provided if practice reduces beneficiaries' total Medicare billings and meets threshold for quality performance
  - Quality measured relative to other practices
  - Cost performance is evaluated against historic performance

What are the requirements for participating providers?

- Provide 24/7 access to appropriate clinician with real-time access to medical records
- Provide the core functions of patient navigation
- Document a care plan with the 13 components recommended by the IOM
- Treat patients on nationally recognized clinical guidelines
- Use certified electronic health record technology (CEHRT)
- Utilize data for continuous quality improvement

Source: CMS, Oncology Care Model, https://innovation.cms.gov/initiatives/oncology-care/.

Little change in practice characteristics from baseline to PP3

Some practices added staff or were acquired by hospitals

Characteristics of OCM practices over time

	Baseline Period (n=194)	3rd Performance Period (n=195)
Size	18 median **number of providers** (average is 36)	23 median **number of providers** (average is 42)
Ownership	44% of practices **owned by hospital** or affiliated with health-system	48% of practices **owned by hospital** or affiliated with health system
Specialties	64% proportion of **oncologists per practice**	61% proportion **of oncologists per practice**
	12% proportion of **APs per practice**	17% proportion of **APs per practice**

Source: "Oncology Care Model: Evaluations," CMS, https://innovation.cms.gov/innovation-models/oncology-care.

Oncology Roundtable interviews and analysis.

Initial decision to participate in OCM dependent on financial and strategic considerations

Financial considerations

+ Model does not require practices to take on contracted risk
+ Practices guaranteed additional revenue from MEOS payments
- Real risk is overspending to achieve practice requirements
- Hospitals may lose revenues from decreased cancer patient ED visits and hospitalizations

Strategic considerations

+ Gain access to new cost and quality benchmarks
+ Gain experience with new type of payment model
+ Create structure and incentives for care transformation
+ Have opportunity to shape new oncology payment model

Accountability for total cost of care deters participation

Includes costs outside their span of influence

1

Practices' billings

- Evaluation and management
- Chemotherapy drugs
- Chemotherapy administration
- Supportive care

2

Billings related to cancer care

- Emergency department visits
- Hospitalizations
- Surgery
- Radiation therapy

3

Other billings

- Care for comorbidities
- Care for accidental injury

Oncologists' ability to influence costs

High | Medium | Low

Source: Center for Medicare and Medicaid Innovation, Oncology Care Model (OCM) Request for Applications (RFA), updated 3/20/2015," CMS.gov, http://innovation.cms.gov/Files/x/ocmrfa.pdf;

Oncology Roundtable interviews and analysis.

OCM offers three different risk arrangements

Third option was announced in fall 2018 to make two-sided risk more palatable

	Risk arrangement		
	One-sided risk	**Original two-sided risk**	**Alternative two-sided risk**
OCM discount	4% of benchmark	2.75% of benchmark	2.5% of benchmark
Performance-based payment based on…	Actual < target	Actual < target	Actual < target
Performance-based payment calculated on…	Target – actual	Target – actual	Target – actual
Stop-gain	20% of benchmark	20% of benchmark	16% of revenue + chemo
Recoupment is the following is true…	NA	Actual > target	Actual > benchmark
Recoupment based on this difference…	NA	Actual – target	Actual – benchmark
Stop-loss	NA	20% of benchmark	8% of revenue + chemo
Advanced APM status	No	Yes	Yes

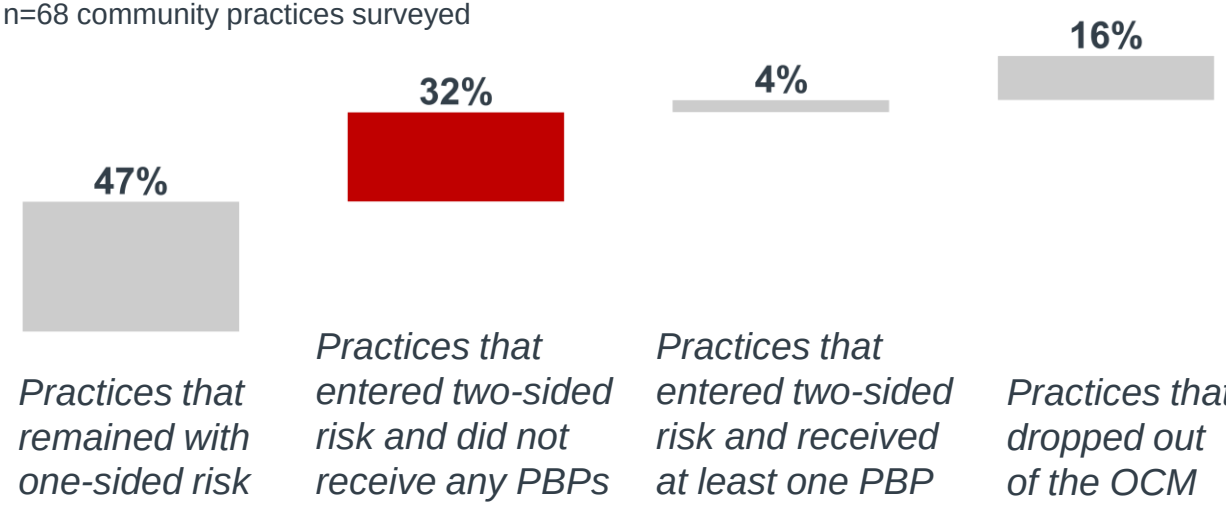
Source: CMMI, *OCM Performance Payment Methodology*, December 17, 2018: https://innovation.cms.gov/files/x/ocm-pp3beyond-pymmeth.pdf.

Most practices chose two-sided risk over leaving the OCM

Practices see value-based care as the future of oncology reimbursement

OCM practice risk arrangement decisions for PP8

n=68 community practices surveyed



DATA SPOTLIGHT

Percent of participants earning a bonus

25%	30%	33%
PP1	PP2	PP3

~65% of participants had earned a bonus in at least 1 PP by PP4

Reasons practices opted in to two-sided risk

- Continued receipt of MEOS payments
- Possibility of earning PBPs and shared savings
- Commitment to improving care quality, especially considering effort already invested and current momentum
- **Perceive risk-based payment models as the future of oncology reimbursement**

Source: "COA Survey Finds OCM Participants Willing to Take on Two-Sided Risk," *Community Oncology Alliance*, https://communityoncology.org/coa-survey-finds-ocm-participants-willing-to-take-on-two-sided-risk/.

Oncology Roundtable interviews and analysis.

CMMI extended OCM through June 2022 due to Covid-19

CMS may make additional modifications as the pandemic continues to evolve

Adjustments to OCM in response to Covid-19

Financial methodology	Quality reporting	Model timeline
• Option for OCM practices to elect to forgo upside and downside risk for performance periods affected by the PHE[1] • For OCM practices that remain in one- or two-sided risk for the performance periods affected by the PHE, remove Covid-19 episodes from reconciliation for those performance periods	Make the following optional for the affected performance periods: • Aggregate-level reporting of quality measures • Beneficiary-level reporting of clinical and staging data Remove the requirements for cost and resource utilization reporting and practice transformation plan reporting in July/August 2020	• Extend model for 1 year through June 2022

1. Public health emergency.

Source: "CMS Innovation Center Models COVID-19 Related Adjustments," Centers for Medicare & Medicaid Services, https://www.cms.gov/files/document/covid-innovation-model-flexibilities.pdf.

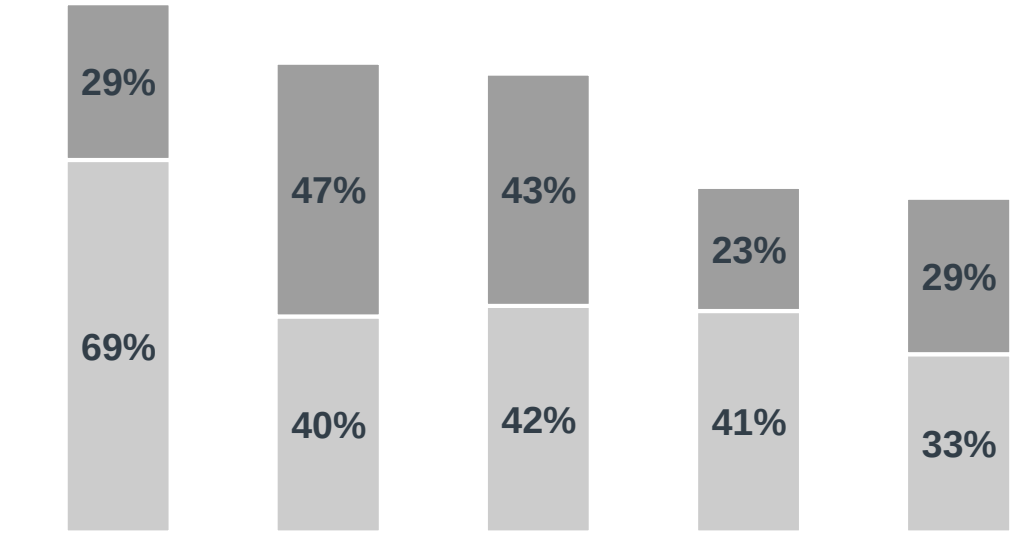
Oncology Roundtable interviews and analysis.

OCM practices used new strategies to improve care quality

Outreach to high-risk patients most common practice change during OCM

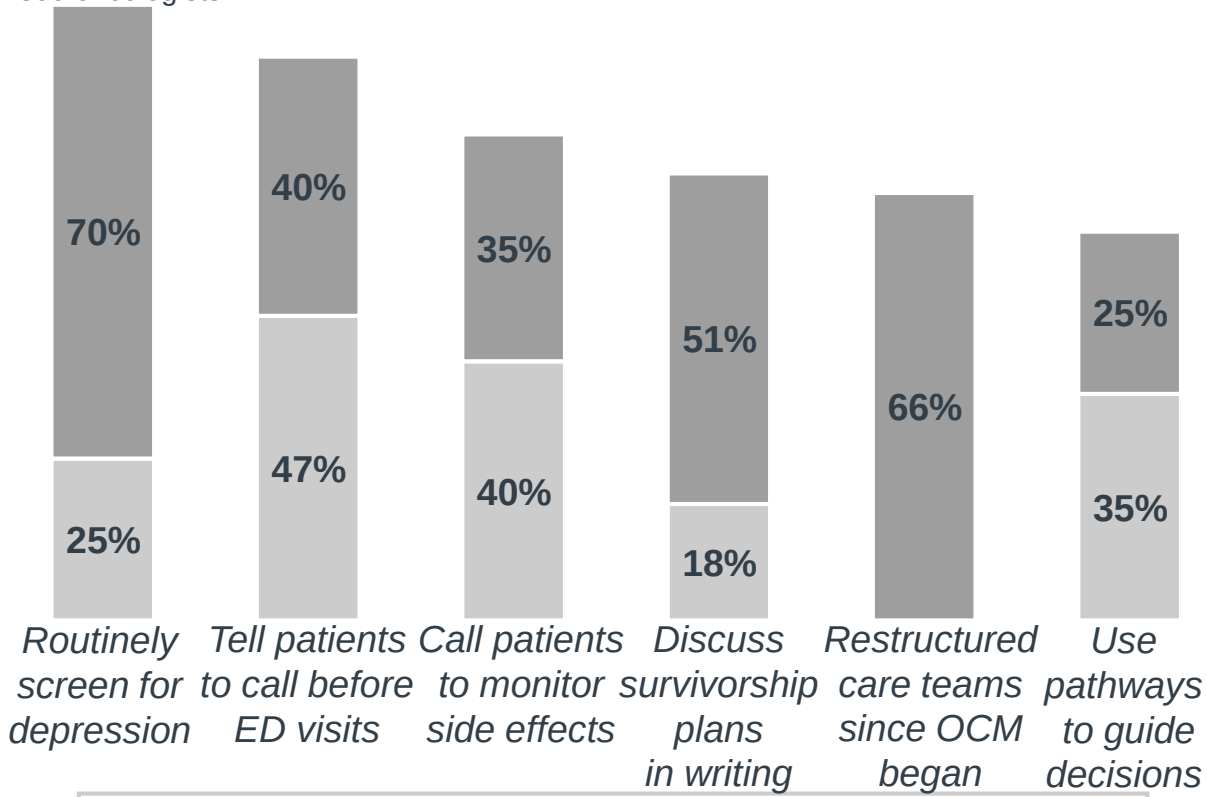
OCM practices implementing care transformation processes

n=177 practices



OCM oncologists implementing care transformation processes

n=399 oncologists



Source: "Evaluation of the Oncology Care Model: Performance Period 1-3," Centers for Medicare & Medicaid Services, https://innovation.cms.gov/data-and-reports/2020/ocm-evaluation-annual-report-2.

Care process changes varied by ownership and affiliation

Independent and hospital-owned practices favored different strategies

Independent practices

Were more likely to:

- Restructure care teams (+20.8%[1,3])
- Share expected prognosis, treatment goals, expected response, and potential harms with patients (+10.9%-+18.2%[1,3])
- Receive performance feedback about adherence to guideline-recommended care (+25.4%[1,3])
- Want additional performance feedback (+18.4%[1,3])

Hospital- or health system-owned practices

Were more likely to:

- Screen for depression (both prior to and since the OCM began) (+11.5%[2,3])
- Regularly receive information (from patient surveys) about patient satisfaction and care experiences (+27.5%[2,3])

OTHER FACTORS

Academic affiliation

- Did not impact care processes, except for some elements of Care Plan enhancement
- Academic practice oncologists were less likely to receive performance feedback about guideline adherence, utilization patterns, or episode costs

Practice size

- Did not impact care processes
- Had no effect on oncologists' experiences with using data for continuous quality improvement

1. Percentage-point difference in independent practices reporting this care process change compared to hospital-owned practices.
2. Percentage-point difference in hospital-owned practices reporting this care process change compared to independent practices.
3. Statistically significant ($p<0.05$).

Source: "Evaluation of the Oncology Care Model: Performance Period 1-3," Centers for Medicare & Medicaid Services, https://innovation.cms.gov/data-and-reports/2020/ocm-evaluation-annual-report-2.

Oncology Roundtable interviews and analysis.

OCM had little impact on service utilization and total spending thus far

Impact of OCM on service utilization and spending during PP1-3

ED visits and hospitalizations

No reduction in ED visits or hospitalizations[1]

No improvements in symptom management or adherence to oral chemo[1]

0.184-day decline in length of stay during PP3

End-of-life care

1.1% decrease in EOL hospitalizations

No changes in ED or hospice utilization in last 30 days of life[1]

50% of practices enhanced advanced care planning after OCM began

93% of OCM oncologists provide access to outpatient palliative care, up from 57% before the OCM started

Spending

$119 decrease in Part A payments[2] and $160 increase in Part D payments[2]

No change in ACH[3] spending or higher-value treatment selection[1]

$124 decrease in payments[2] to OIPs[4]

$672 decrease in EOL payments[2]

$154.3M overall loss during first two PPs

1. No significant change.
2. Per beneficiary per episode.
3. Acute care hospital.
4. Other Inpatient Hospitals, such as PPS-exempt cancer hospitals.

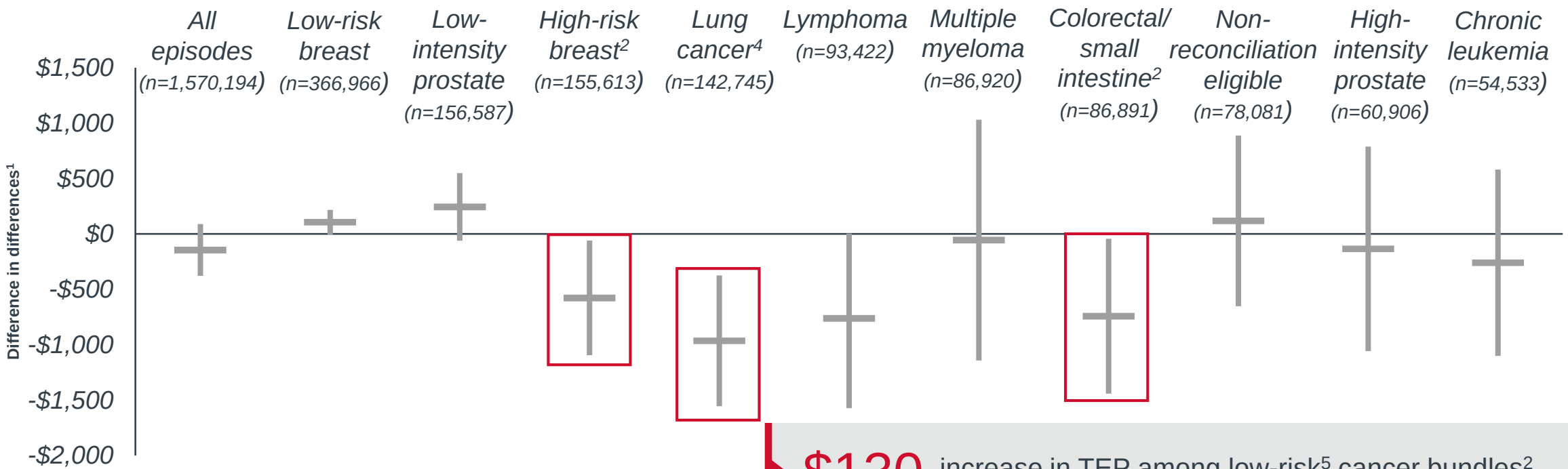
Source: "Evaluation of the Oncology Care Model: Performance Period 1-3," Centers for Medicare & Medicaid Services, https://innovation.cms.gov/data-and-reports/2020/ocm-evaluation-annual-report-2.

OCM reduced total episode payments among some cancers

Payments decreased for high-risk cancers and increased for low-risk cancers

Change in total episode payments (TEP) by cancer type between baseline and PP1-3

Bars represent 90% confidence interval



$130 increase in TEP among low-risk[5] cancer bundles[2]

-$430 decrease in TEP among high-risk[5] cancer bundles[3]

1. Compares TEP changes in OCM episodes to TEP changes in comparison episodes to describe the average effect of the OCM on TEP.
2. Statistically significant (p<0.1).
3. Statistically significant (p<0.05).
4. Statistically significant (p<0.01).
5. Low-risk cancer bundles includes low-risk breast cancer, low-intensity prostate cancer, and low-risk bladder cancer; All other episodes are considered high-risk.

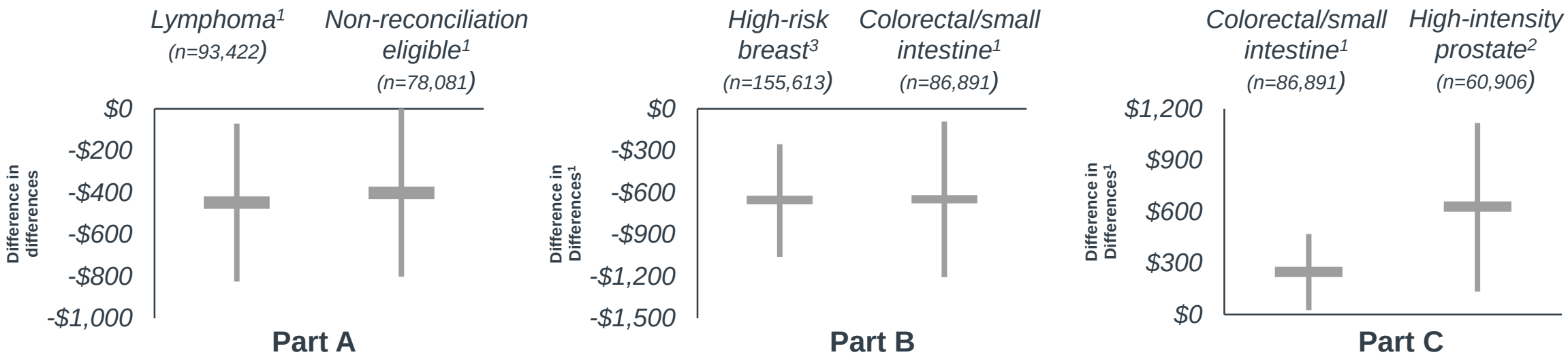
Source: "Evaluation of the Oncology Care Model: Performance Period 1-3 – appendices," CMS, https://innovation.cms.gov/data-and-reports/2020/ocm-evaluation-annual-report-2-appendices.

Oncology Roundtable interviews and analysis.

Part A and Part D spending changed in some tumor sites

Tumor site spending changes contributed to spending shifts in high-risk cancers

Changes in payments for cancers with statistically significant differences



Significant changes in Part A and Part D payments among high-risk cancers[4]

-$227 decrease in Part A payments among high-risk cancer bundles[3] (no Part A impact on low-risk bundles)

$229 increase in Part D payments among high-risk cancer bundles[2] (no Part D impact on low-risk bundles)

1. Statistically significant (p<0.1).
2. Statistically significant (p<0.05).
3. Statistically significant (p<0.01).
4. All cancers except low-risk breast cancer, low-intensity prostate cancer, and low-risk bladder cancer are considered high-risk.

Source: "Evaluation of the Oncology Care Model: Performance Period 1-3 – appendices," Centers for Medicare & Medicaid Services, https://innovation.cms.gov/data-and-reports/2020/ocm-evaluation-annual-report-2-appendices.

Oncology Roundtable interviews and analysis.

OCM has differential impacts for various beneficiary groups

Spending decreased among racial minority and high-risk beneficiaries

DATA SPOTLIGHT

-$576

Decrease in TEP among episodes for **minority beneficiaries** (1.9% change from baseline, $p<0.05$). No significant change in TEP was seen for non-minority beneficiaries.

-$344

Decrease in TEP among episodes **for beneficiaries with high HCC risk scores**.[1] No significant change in TEP was seen for low-risk beneficiaries.

No statistically significant differential impacts on TEP for beneficiary subgroups based on:

- Age
- Dual eligibility

No differences in patient-reported care experiences, or changes over time, based on:

- Beneficiary race
- Education
- Type of cancer

1. Assessment of patient risk based on demographics and diagnostic history.

Source: "Evaluation of the Oncology Care Model: Performance Period 1-3 – appendices," Centers for Medicare & Medicaid Services, https://innovation.cms.gov/data-and-reports/2020/ocm-evaluation-annual-report-2-appendices.

West Cancer Center used OCM data to find cost savings opportunities

OCM data also used to develop patient risk stratification system

Baseline OCM data

Identified that they had higher ED and inpatient utilization rates than other practices from baseline OCM data

1

Examined trends

- Found that higher ED and inpatient utilization was associated with:
  - High-acuity cancers (e.g., pancreatic, lung)
  - Increased number of comorbidities
  - Recent prior hospitalization

2

Developed algorithm

- Created predictive algorithm that assigns OCM patients a high-risk score (i.e., risk of ED or inpatient utilization) based on:
  - Cancer information
  - Comorbidities
  - Social factors
  - Past utilization

Source: West Cancer Center, Germantown, TN.

Oncology Roundtable interviews and analysis.

West Cancer Center

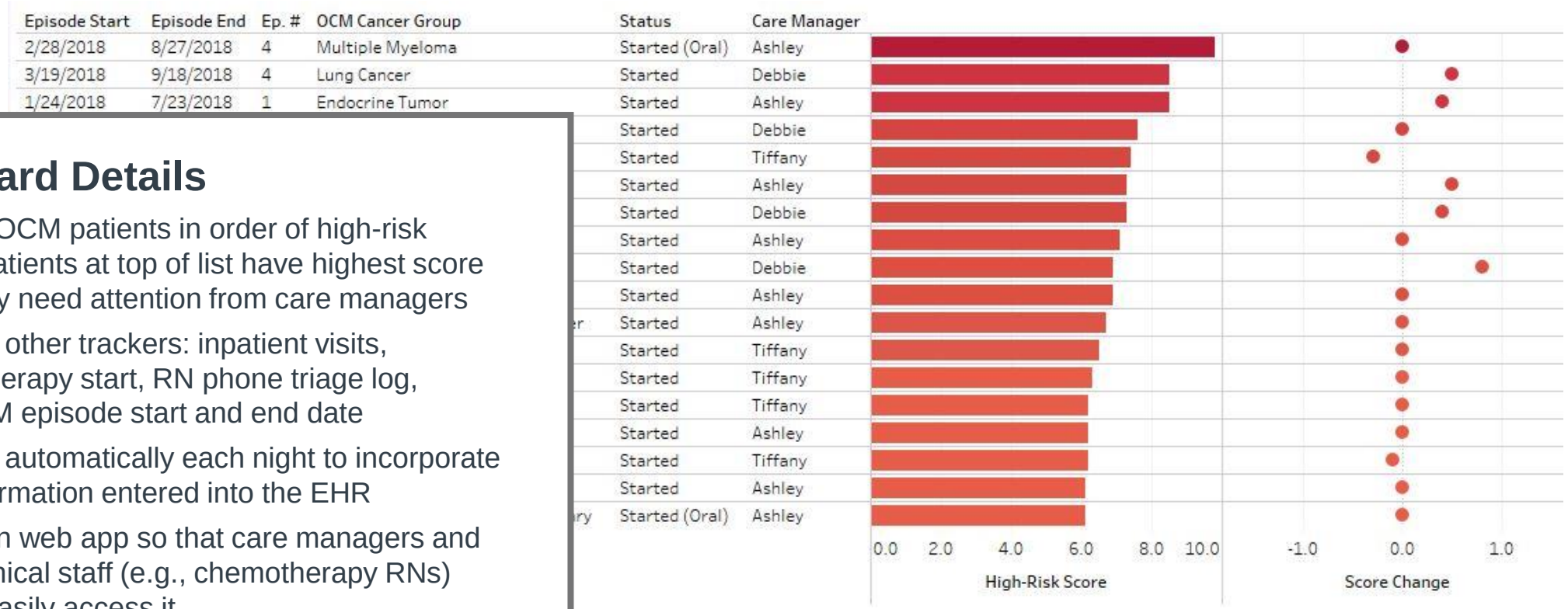
Dive into the data

- 2,100-analytic case academic medical center based in Germantown, Tennessee; includes 17 cancer center sites
- All physicians are employed; uses Mosaiq as EHR vendor
- Identified that they had higher inpatient admissions and ED utilization rates than other practices from baseline OCM data
- Examined trends in ED and inpatient utilization; found that risk of ED and inpatient utilization was associated with cancer acuity, number of comorbidities, and prior hospitalizations
- Used OCM data, along with data from their EHR and partner health system, to create a predictive algorithm that assigns each OCM patient a high-risk score (i.e., risk of ED or inpatient utilization)
- Created dashboard ranking OCM patients by high-risk score to help OCM care managers prioritize outreach efforts to highest risk patients
- Plan to measure dashboard impact on ED and inpatient utilization, episode costs, supportive care utilization, and care manager contact

Source: West Cancer Center, Germantown, TN.

Dashboard helps OCM care manager prioritize outreach

West Cancer Center's Patient Identification Dashboard



Dashboard Details

- Lists all OCM patients in order of high-risk score; patients at top of list have highest score and likely need attention from care managers
- Includes other trackers: inpatient visits, chemotherapy start, RN phone triage log, and OCM episode start and end date
- Updates automatically each night to incorporate new information entered into the EHR
- Hosted in web app so that care managers and other clinical staff (e.g., chemotherapy RNs) can all easily access it

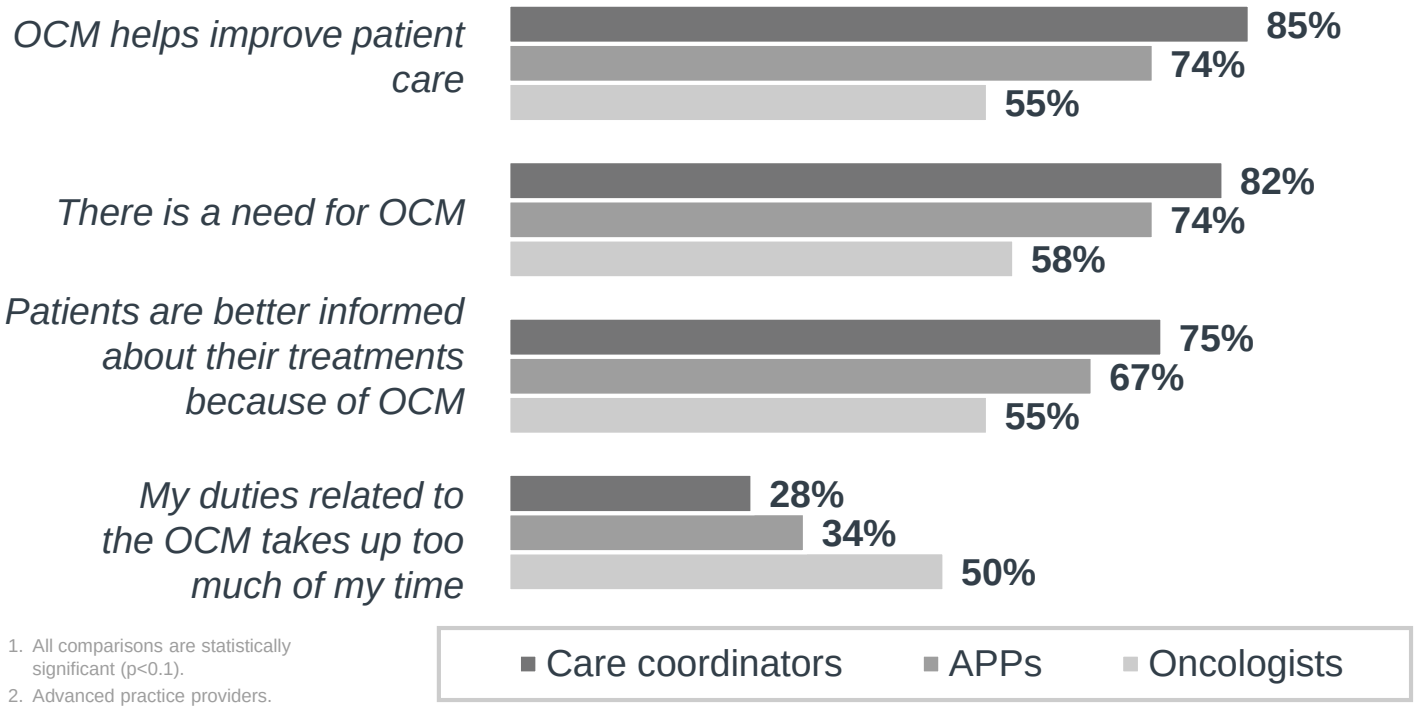
Clinicians believe OCM improves patient care

Care coordinators were most likely to report positive experiences

Surveyed clinicians' experience with OCM during PP1-3[1]

By percent of clinicians who agree or strongly agree

n=480 clinical coordinators, n=373 APPs[2], n=399 oncologists



1. All comparisons are statistically significant (p<0.1).
2. Advanced practice providers.

Independent vs. hospital-owned practices

Independent practice oncologists were more likely to:

- **Report positive experiences** with the OCM
- Feel that OCM takes up **too much of their time**

than oncologists in hospital- or health-system owned practices.

Practice size and academic affiliation did not impact oncologists' experiences or satisfaction.

Source: "Evaluation of the Oncology Care Model: Performance Period 1-3 – appendices," Centers for Medicare & Medicaid Services, https://innovation.cms.gov/data-and-reports/2020/ocm-evaluation-annual-report-2-appendices.

Oncology Roundtable interviews and analysis.

OCM patients did not perceive changes in care during PP1-3

However, quality of care measures were high to begin with

Composite measures from patient and caregiver surveys	Baseline[1] (scale 0-10)	Most recent survey results[2,3]
Overall rating of cancer care team	9.27	9.24
Shared decision making	7.45	7.37
Access to care	8.88	8.80
Affective communication	9.01	8.89
Exchange of information	8.50	8.40
Self-management	5.93	5.93
Symptom management	7.28	7.13[4]

Other quality measures from patient and caregiver surveys	Baseline[1] (%)	Most recent survey results[2,3]
Caregivers saying hospice started at the right time	78%	80%

"OCM does not appear to be jeopardizing positive care experiences of cancer patients, despite financial incentives to reduce costs of care."

Evaluation of the Oncology Care Model: Performance Periods 1-3

1. Includes responses from 4/16-9/16.
2. Includes responses from 1/18-6/18, the most recent of 7 survey waves.
3. Not statistically significant unless noted.
4. Statistically significant but not clinically significant.

Source: "Evaluation of the Oncology Care Model: Performance Period 1-3," Centers for Medicare & Medicaid Services, https://innovation.cms.gov/data-and-reports/2020/ocm-evaluation-annual-report-2.

Recap: OCM participation and areas of success

Participation

Practices covered a wide range of sizes. Health system affiliation (especially among larger practices) increased over time. Larger practices were more likely to be affiliated with AMCs, representing about 16% of practices. Practices grew over time through the addition of APPs.

Differential outcomes by practice type

Independent practices reported more positive experiences with OCM, restructured care teams, enhanced care plan information, and want additional performance feedback. Practices associated with health systems gathered more patient experience data, screened for psychosocial needs, and coordinated better with hospitals. Larger practices were more likely to take on two-sided risk without reinsurance protection.

Areas of success

1. TEP decreased for high-risk cancers and among minority and high-risk beneficiaries
2. EOL hospitalizations and spending decreased
3. Patients and providers report high satisfaction

Oncology Roundtable interviews and analysis.

Participating in the OCM is resource intensive

Many of the OCM requirements have a high cost of implementation

Challenges that OCM practices have faced

- **Fulfilling reporting requirements**
  - EHRs are not always structured to readily extract necessary information
  - Some OCM practices did not have adequate staff to complete required reporting
- **Taking advantage of available data to assess value and improve performance**
  - Many OCM practices used consultants to analyze CMS's Medicare claims data, and others did not have the resources to analyze the data at all
  - Practices had trouble using data to identify actionable opportunities for improvement
- **Care Plan elements**
  - Providing out-of-pocket cost estimates was seen as one of the most challenging elements of the Care Plan—several practices hired additional financial counselors
  - Inability to deliver all of the elements was an important reason that practices terminated their participation in the OCM
- **Following evidence-based guidelines with treatment pathway software**
  - Encouraged as a form of clinical decision support, but expensive
  - Programs don't always interoperate with EHRs, and data extraction can be difficult

DATA SPOTLIGHT

30.4%

Clinical care coordinators surveyed who were hired specifically for the OCM

3

APPs hired, on average, by OCM practices (compared to 2 in comparison practices)[1]

Source: "Evaluation of the Oncology Care Model: Performance Period 1-3," Centers for Medicare & Medicaid Services, https://innovation.cms.gov/data-and-reports/2020/ocm-evaluation-annual-report-2.

1. Statistically significant.

Lessons learned

Being accountable for total cost of care is a challenge for OCM practices

- Improving care coordination and increasing patient loyalty will be critical in overcoming this challenge

Success takes time

- The relationship between care transformation practices and cost reduction is not clear-cut
- CMS is willing to iterate on elements of the payment pilot to help participants succeed

Providers are willing to participate in alternative payment models, even if participation requires assuming risk

- Despite substantial investment and unexceptional preliminary results, providers rate their experiences positively
- Many see value-based care as the future of oncology reimbursement

OCM data can be leveraged to proactively identify and support patients at high risk for avoidable costs

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