Requiem for the Oncology Care Model

Michael Kolodziej MD

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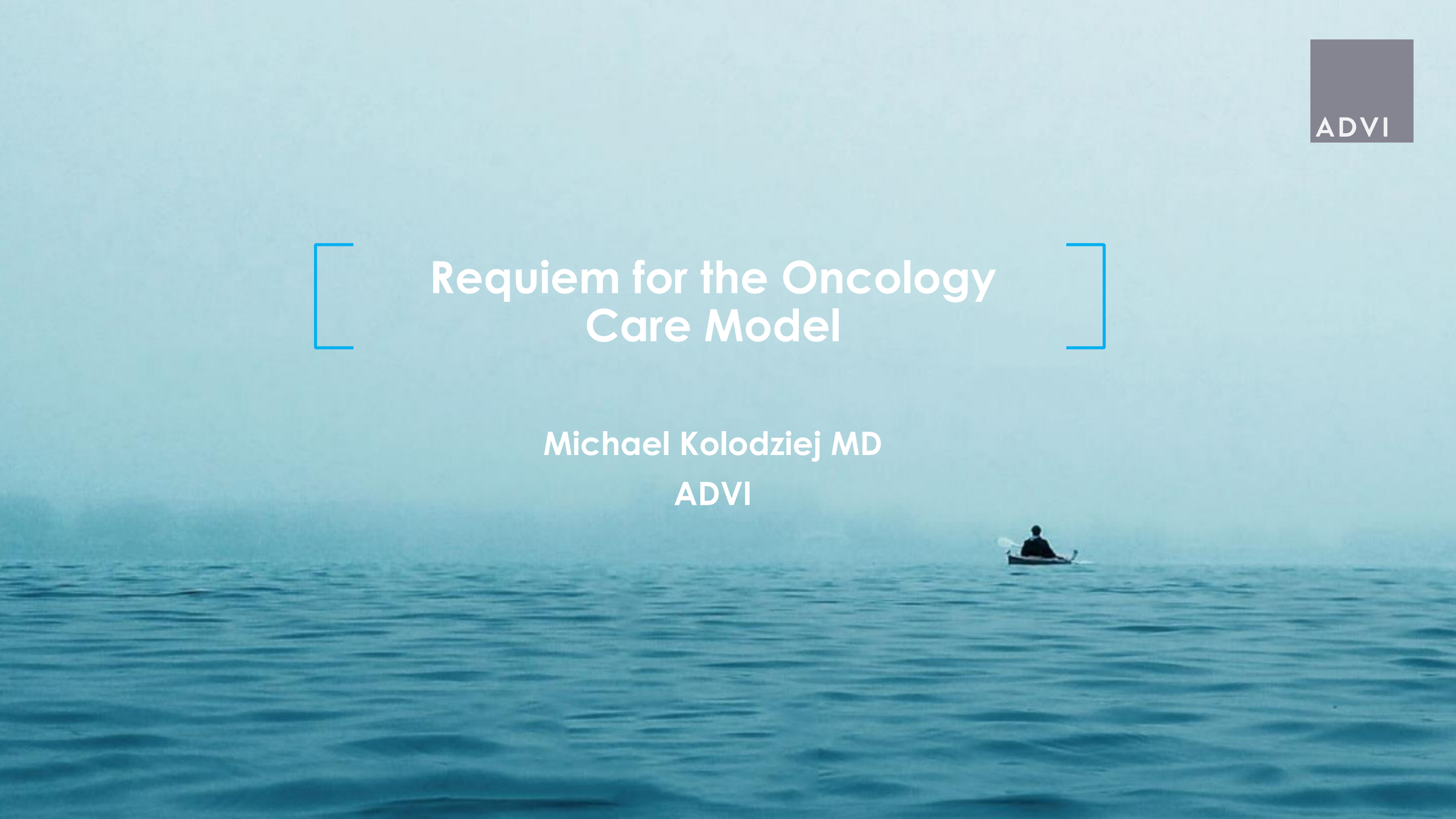

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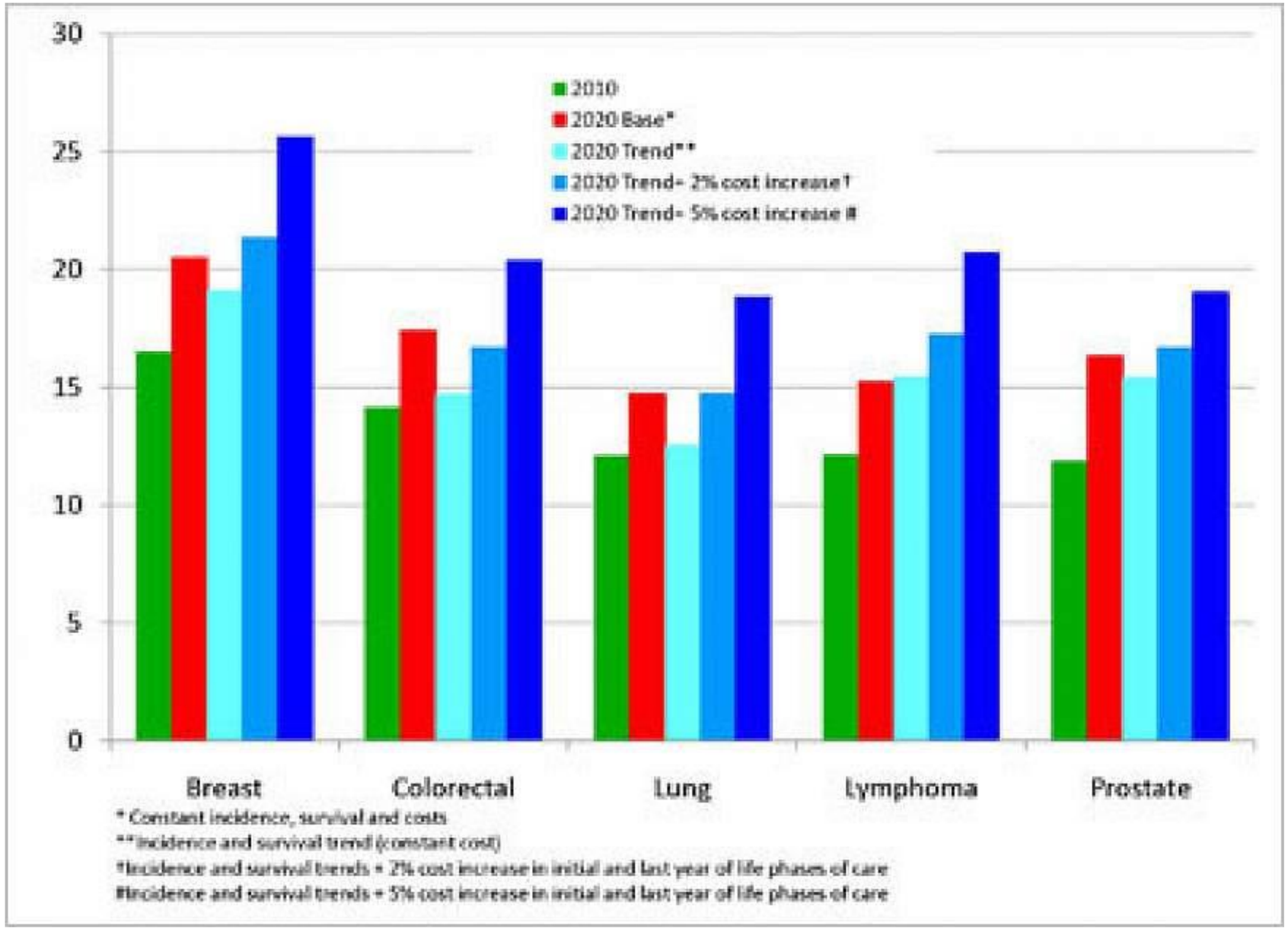
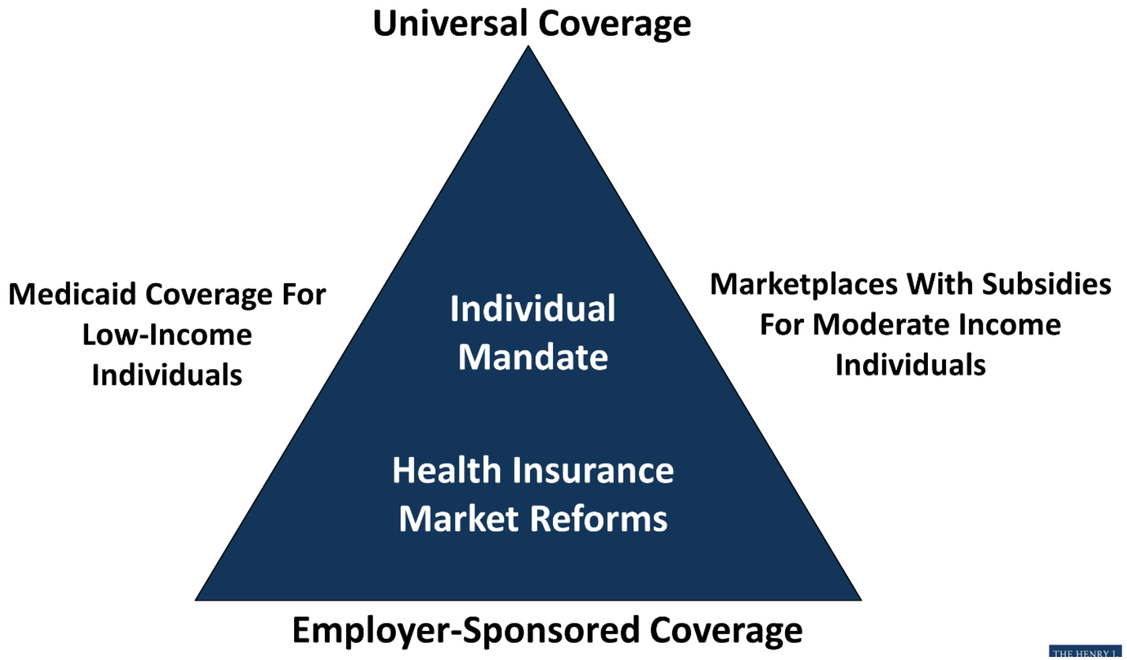
Cancer care costs are increasing



Source: NIH

ACA: Main Components

The ACA intended to expand access to insurance, increase consumer protections, emphasize prevention/wellness, improve quality, expand the health workforce, and curb rising health care costs



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Source: KFF (link), (link)

The creation of CMMI may have been the most important consequence of the ACA from a provider perspective

- CMMI was charged with testing alternative payment models to preserve or improve quality while reducing cost.
- It was given near absolute power. It does not need Congressional approval for its pilots.
- Its focus has been on population based strategies.
- The mantra is transitioning from volume to value

What are the Medical Home principles?

Personal physician

- Each patient has an ongoing relationship with a personal physician
- Personal physician leads a team of individuals that take responsibility for the ongoing care of patients
- Personal physician is responsible for providing for all the patient's health care needs or arranging care with other qualified professionals

Care is coordinated across health care system

Quality and safety are hallmarks of the medical home

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication

Payment recognizes the added value provided to patients who have a patient-centered medical home

Come Home Modestly Reduced Medicare Spending by Implementing an Oncology Medical Home Model … but generated a lot of excitement

Key Findings from the IOBS Initiative:

- A significant decrease in the number of ED visits, acute care setting hospitalizations, and total cost of care was observed for the IOBS participants relative to the comparison group
- Neither significant decreases in hospitalizations nor 30-day readmissions were observed for participants in the IOBS program relative to the comparison group
- Total cost of care decreased significantly

Difference-in-Differences Estimates for Core Measures for IOBS

Average Quarterly Impact	
Outcome Measure	**Adjusted Estimate [90% Confidence Interval]**
Hospitalizations per 1,000 Patients	2 [-5, 9]
ED Visits per 1,000 Patients	**-13 [-21, -5]*** **
30-day Readmissions per 1,000 Patients Hospitalized	-16 [-41, 9]
ACS Hospitalizations per 1,000 Patients	**-3 [-6, 0]***
Total Cost of Care per Patient ($)	**-$612 [-$979, -$245]*** **
Aggregate Impact	
Outcome Measure	**Adjusted Estimate [90% Confidence Interval]**
Total Cost of Care ($)	**-$12,887,923 [-$20,612,821, -$5,163,025]*** **

NOTES: ***p<0.01, **p<0.05, *p<0.1. ACS, ambulatory care sensitive; ED, emergency department.

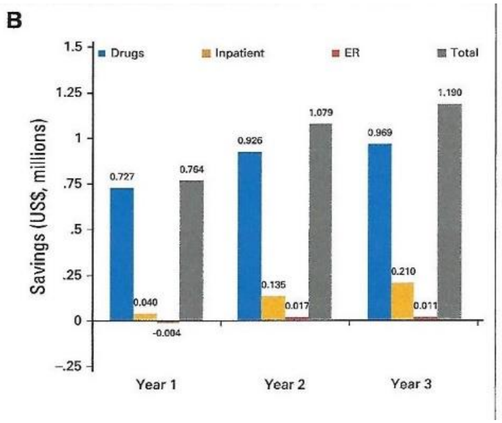
1. NORC at the University of Chicago. HCIA Disease-specific evaluation. Third annual report. February 2016 (link).
2. Dimick JB and Ryan AM. Methods for evaluating changes in health care policy. The difference-in-differences approach. *JAMA*. 2014;312(22):2401-2402.

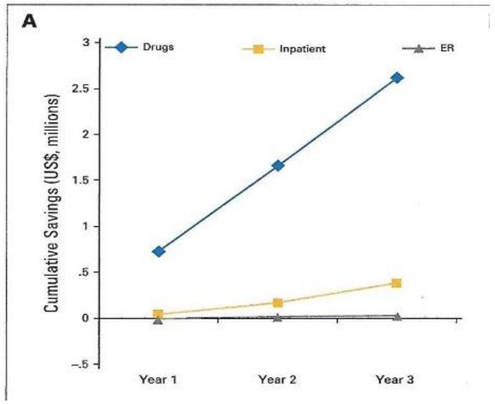
The Aetna Oncology Medical Home also generated savings

Three-Year Results of a Medicare Advantage Cancer Management Program

J. Russell Hoverman, Marcus A. Neubauer, Melissa Jameson, Jad E. Hayes, Kathryn J. Eagye, Mitra Abdullahpour, Wendy J. Haydon, Maria Sipala, Amy Supraner, Michael A. Kolodziej, and Diana K. Verrilli

- 390 Aetna Medicare Advantage (MA) patients were enrolled in a program at Texas Oncology (TOPA) that used the following to try to improve patient care and reduce total costs:
  - Evidence-based treatment pathways*
  - A disease management call center
  - Advance care planning program





	Chemo & Supportive Care	Inpatient	ER	Total
Benchmark Cost	$11,420,791	$3,925,662	$305,247	$15,651,701
Actual Cost	$9,081,351	$3,323,072	$281,140	$12,685,563
Savings Percent	20.48%	15.35%	7.90%	18.95%

- Savings were calculated by comparing TOPA performance with that of a matched concurrent control, different from the OCM. Found limited savings from ER and inpatient reductions.

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Key Takeaways

The Aetna OMH program combine the care delivery principles of the Oncology Medical Home with the U.S.ON pathways. The majority of the savings were generated by pathways adherence.

High-Level Overview:

CMMI Launched OCM as the First Specialty Model

Provides enhanced care coordination payments and performance-based payments (PBP) to practices whose expenditures are below expected benchmarks

Participants

- Originally 175 practices (List) and 10 payers
- Since January 2020, 138 practices (list) and 10 commercial payers

Intended to runs July 1, 2016 – June 30, 2021 (extended to June 30, 2022 due to COVID-19 for voluntary participation)

- Originally a 5-year demo
- CMMI began RFI process in late 2019 for OCM follow-on program, now pushed back a year due to COVID
- In 2021, CMMI expected to re-initiate public feedback from OCM follow-on ("Oncology Care First" or otherwise named)

Practice Participants

OCM Includes 3 Payments and Encourages Practice Accountability: Providers Are Driven to Find Cost Savings

Payment Model Overview

1

Fee-for-Service Payment

- Participating practices continue to earn fee-for-service payments for services to Medicare beneficiaries
- Drugs continue to be reimbursed at ASP + 6% (sequestration reduction applied)

2

Monthly Enhanced Oncology Services (MEOS) Payment

- Upon initiation of chemotherapy, practice bills for per-beneficiary per member (PBPM) and receives $160 Monthly Enhanced Oncology Services (MEOS) payment for six months
- If the patient continues or resumes chemotherapy after the initial six-month episode, practice can trigger a second episode

3

Performance-Based Payment (PBP)

- Practice is eligible to receive performance-based payment (PBP) if it reduces beneficiaries' total Medicare billings and meets threshold for quality performance
- Quality measures yet to be finalized
- Cost performance is evaluated against the practice's historical performance

Source: Request for Applications (RFA). February 2015. Available at http://innovation.cms.gov/Files/x/ocmrfa.pdf.

CMMI OCM Basics: Key Features

Targets Almost All Cancers: Covers all cancer types at any stage that requires non topical chemotherapy. 95% is part of "reconciliation," the remaining 5% will still be eligible for the care management fee.

Payers: Medicare FFS and 10 private payers

- Aetna
- Blue Cross Blue Shield of Michigan/Blue Care Network
- BlueCross BlueShield of South Carolina
- Cigna Life & Health Insurance Company
- Health Care Services Corporation
- Highmark, Inc.
- Priority Health
- SummaCare
- The University of Arizona Health Plans
- UPMC Health Plan

Payment Approach: Two new payments 1) MEOS and 2) PBP based on savings to CMS, quality metrics, additional savings; OCM payments are in addition to standard FFS payment

Episode Period: Focused on total cost during a 6-month "episode" of care commencing with a chemotherapy trigger

Included Costs: Includes all Part A, Part B and some Part D expenditures during the 6-month chemotherapy episode

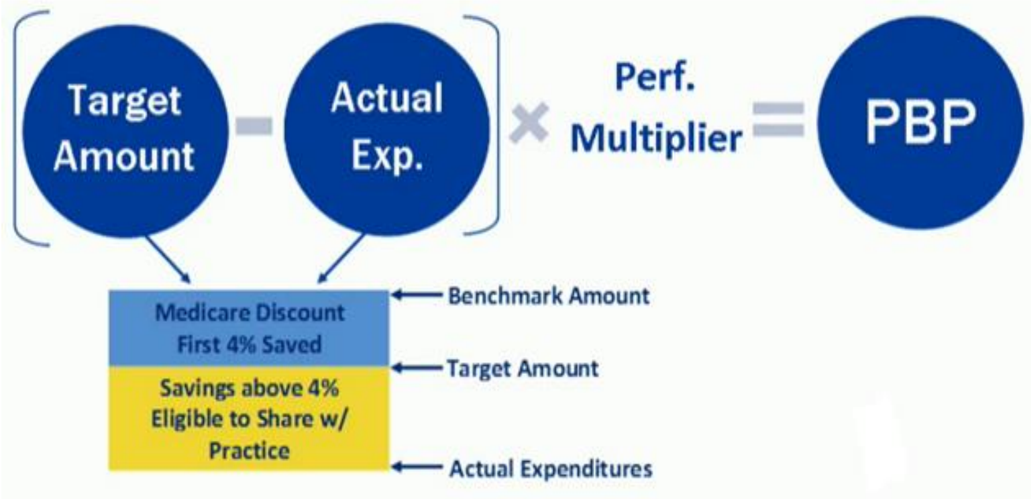
Requirements*: Participants must meet certain "practice requirements" and demonstrate quality and performance improvement

Risk Options: Originally, 1-sided risk with option to convert to 2-sided risk starting January 1, 2017 (up side and down side risk).
Per the OCM guidance, "Practices or pools that do not achieve a performance-based payment by the time of the initial reconciliation of the fourth performance period must exit the model or opt for the 2-sided risk arrangement thereafter until achieving a performance-based payment." There is no penalty for exiting.

OCM PBP Based on Target Price: Providers Are Driven Under OCM to Find Cost Savings

PBP is Based on Target Price

- Encouraging savings from baseline
- Trying to get under baseline to achieve shared savings



Target Amount = sum of all baseline episode prices, risk-adjusted for specific patient population, based on the specific practice's historic spending levels, trended forward, minus CMS savings

Actual Expenditures = total expenditures attributed to episodes eligible for reconciliation (includes Parts A, B, and some D costs & MEOS payments)

Performance Multiplier = determined by performance on quality score

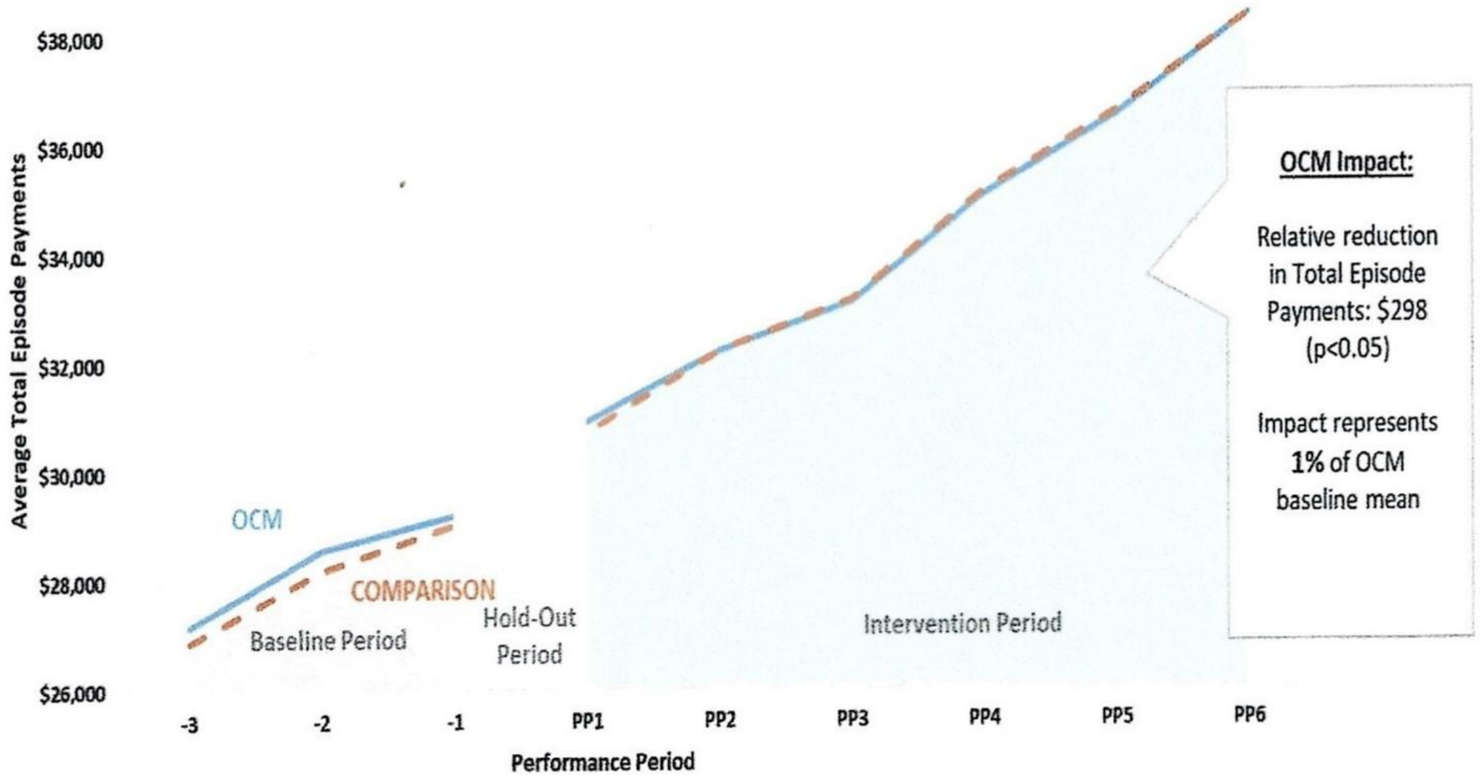
Key Takeaways

Practices are benchmarked against Medicare claims historic data; unnecessary hospitalizations and ER utilization, drug spending and improved end of life care all are important areas of focus.

While for most practices, care delivery reform has focused on reducing ER and inpatient utilization, some have attempted to focus on the cost of pharmaceuticals. The OCM data has shown that drugs make up close to 60% of the total cost of care making them a prime opportunity for cost reduction.

How did OCM practices do?

TEP rose by nearly 20% from the baseline to intervention period, but by only 1 % less among OCM episodes



Source: Medicare claims 2014–2019

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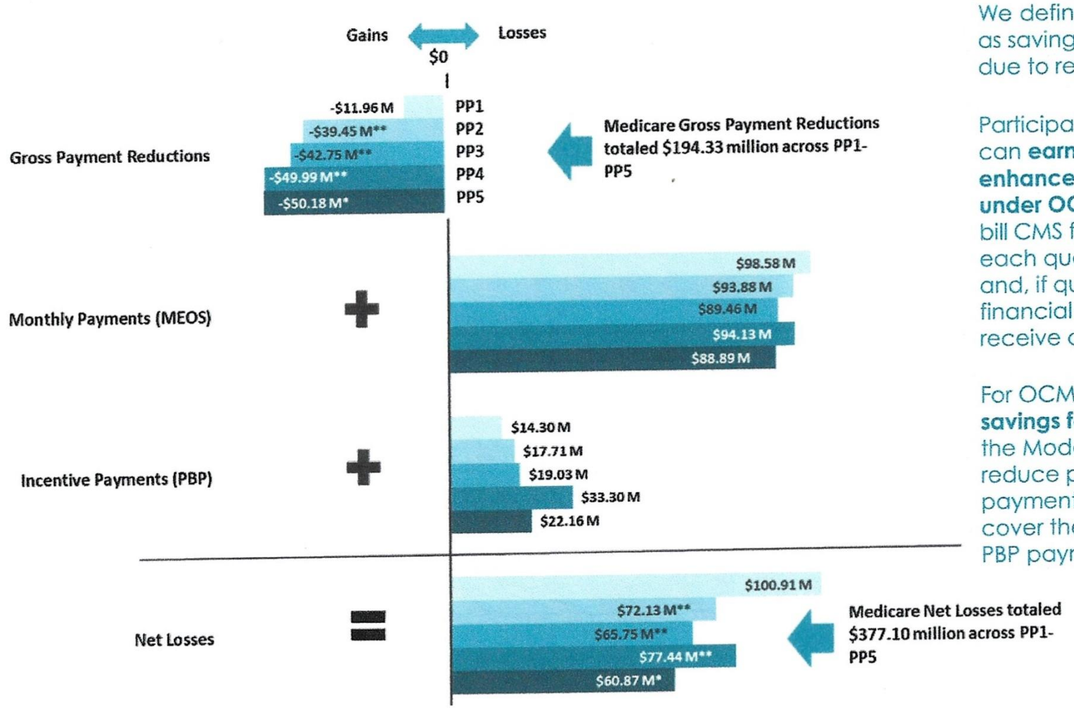
As a payment model, OCM failed

After including payments made to practices under the Model, OCM resulted in significant net losses for Medicare.

OCM resulted in Net Losses to Medicare totaling $377.1M over five Performance Periods.



We define **gross savings** as savings that accrue due to reductions in TEP.

Participating practices can **earn two types of enhanced payments under OCM**. They can bill CMS for MEOS for each qualifying patient, and, if quality and financial goals are met, receive a PBP.

For OCM to result in **net savings for Medicare**, the Model needs to reduce per-episode payments enough to cover the MEOS and PBP payments.

Asterisks denote statistically significant impact estimates at *p<0.10 and**p<0.05.
Source: Medicare claims 2014–2019. OCM first true-up reconciliation reports, PP1–PP5.
Notes: MEOS: Monthly Enhanced Oncology Services payment. PBP: performance-based payments. PP: performance period.
At the time this report was written, MEOS and PBP amounts were available for PP1 through PP5, but not for PP6.

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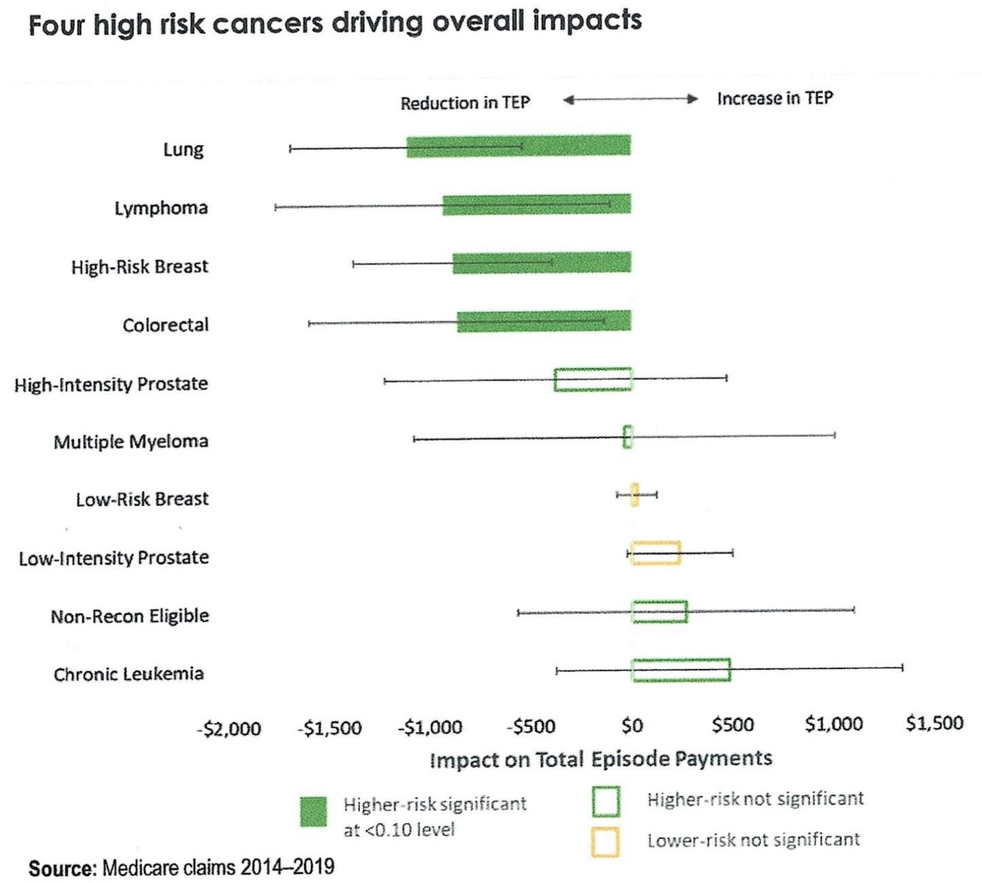
Some savings were realized….but they were small

The relative reduction in TEP was concentrated in higher-risk episodes.



Source: Medicare claims 2014–2019

TEP for higher-risk episodes, which made up about two-thirds of all episodes, averaged about $48,000 during PP1–PP6. For higher-risk episodes, OCM reduced TEP by $487 ($p<0.05$) relative to comparison episodes. This relative reduction in TEP was statistically significant and notable for four common higher-risk episodes: lung cancer (TEP relative reduction of $1,112), lymphoma ($934), colorectal cancer ($865), and high-risk breast cancer ($885). These same four types of episodes were also responsible for TEP reduction in the previous ***Evaluation Report for PP1-PP5***.

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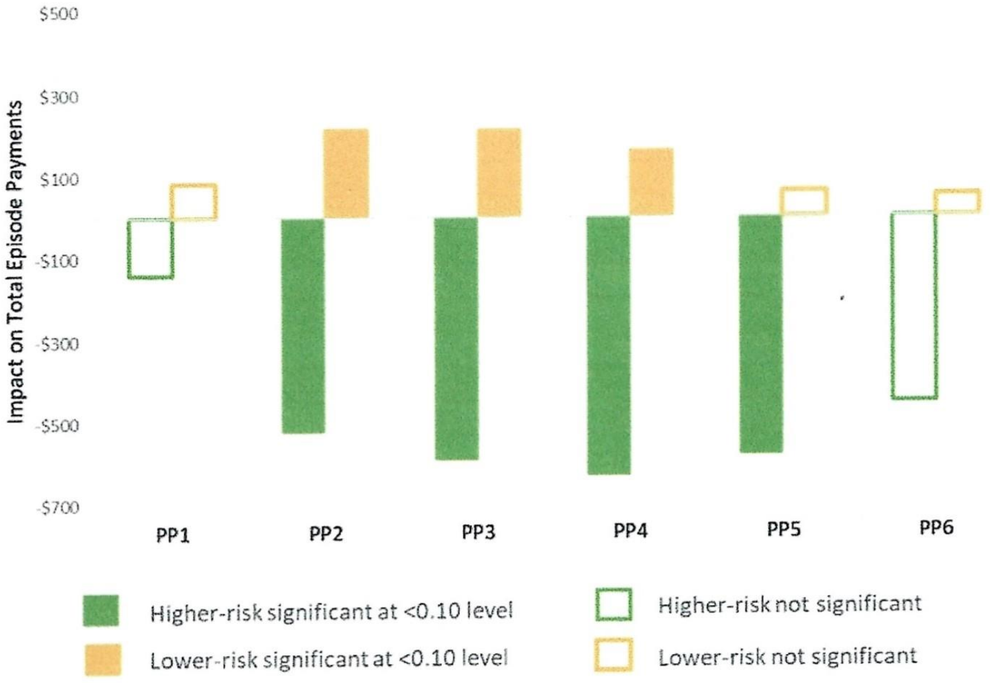
There was no learning curve in OCM

The TEP impact in performance period 6 departed from previous patterns.

Impact for higher-risk episodes no longer significant in PP6



Source: Medicare claims 2014–2019
Notes: PP: Performance period.

Among higher-risk episodes, the impact of OCM in PP6 was smaller in magnitude than in previous periods and was no longer significant. This is a departure from the larger, significant impacts in each individual period during PP2–PP5. The change in the pattern for PP6 was primarily due to a smaller OCM impact for lung cancer episodes. The smaller impact was likely due to emerging differences in trends for lung cancer immunotherapy payments in PP6, with immunotherapy payments continuing to increase for OCM episodes, but plateauing for comparison episodes. TEP increased slightly more in OCM lower-risk episodes than in comparison episodes (by $130, primarily driven by a relative increase in Part B payments.

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How you calculate savings matters

- Earning a PBP meant the practice outperformed the model…so if the model was lousy (or if there were extenuating circumstances), the results might NOT reflect how Medicare fared.
- The success of the program was judged based on a CONCURRENT MATCHED CONTROL GROUP NOT IN OCM….so these results DID reflect how Medicare fared.
- Interestingly, CMMI has been inconsistent on methodology for savings generated by the various models (see ACO's).

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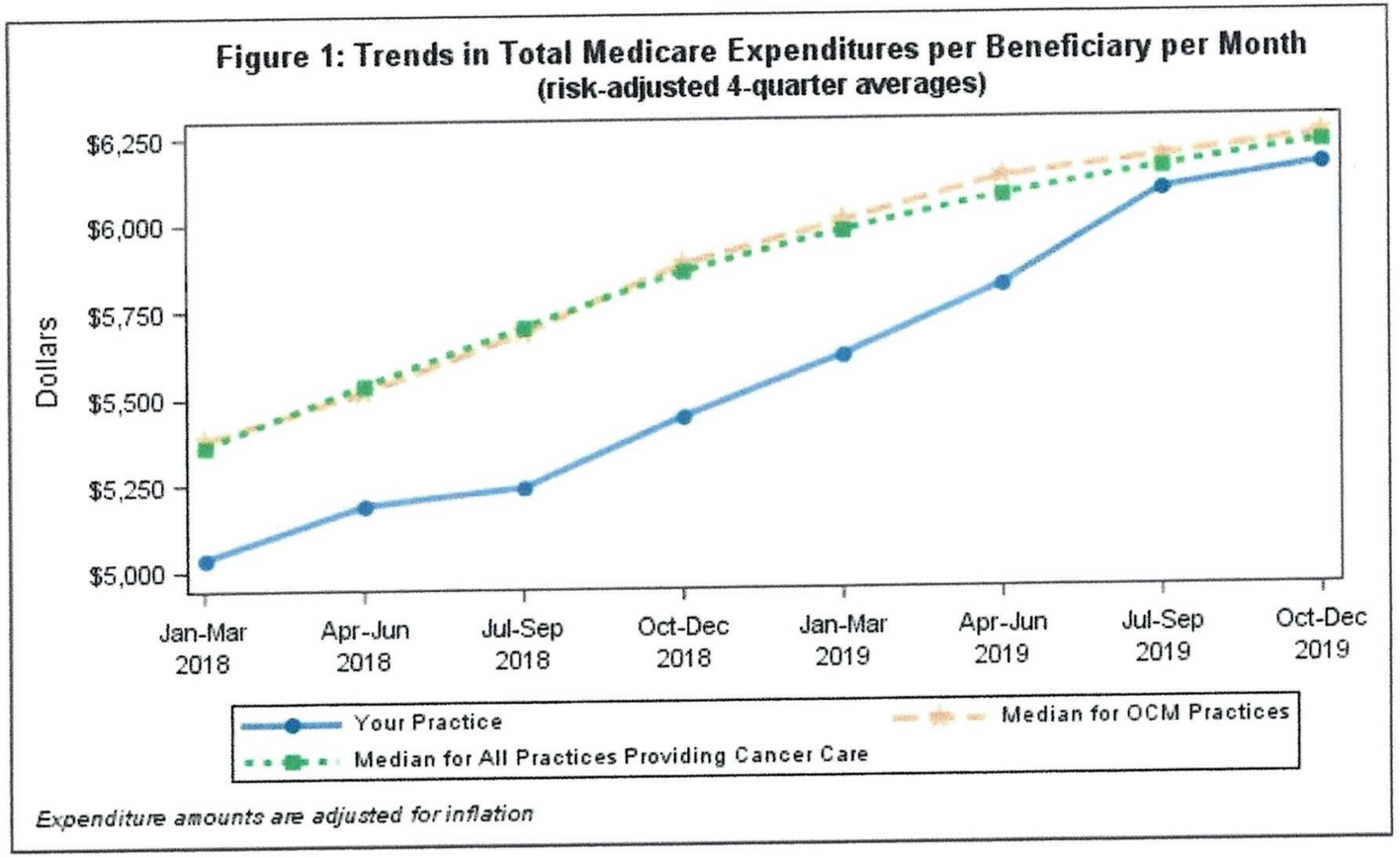
Earning a PBP does NOT mean you saved Medicare money



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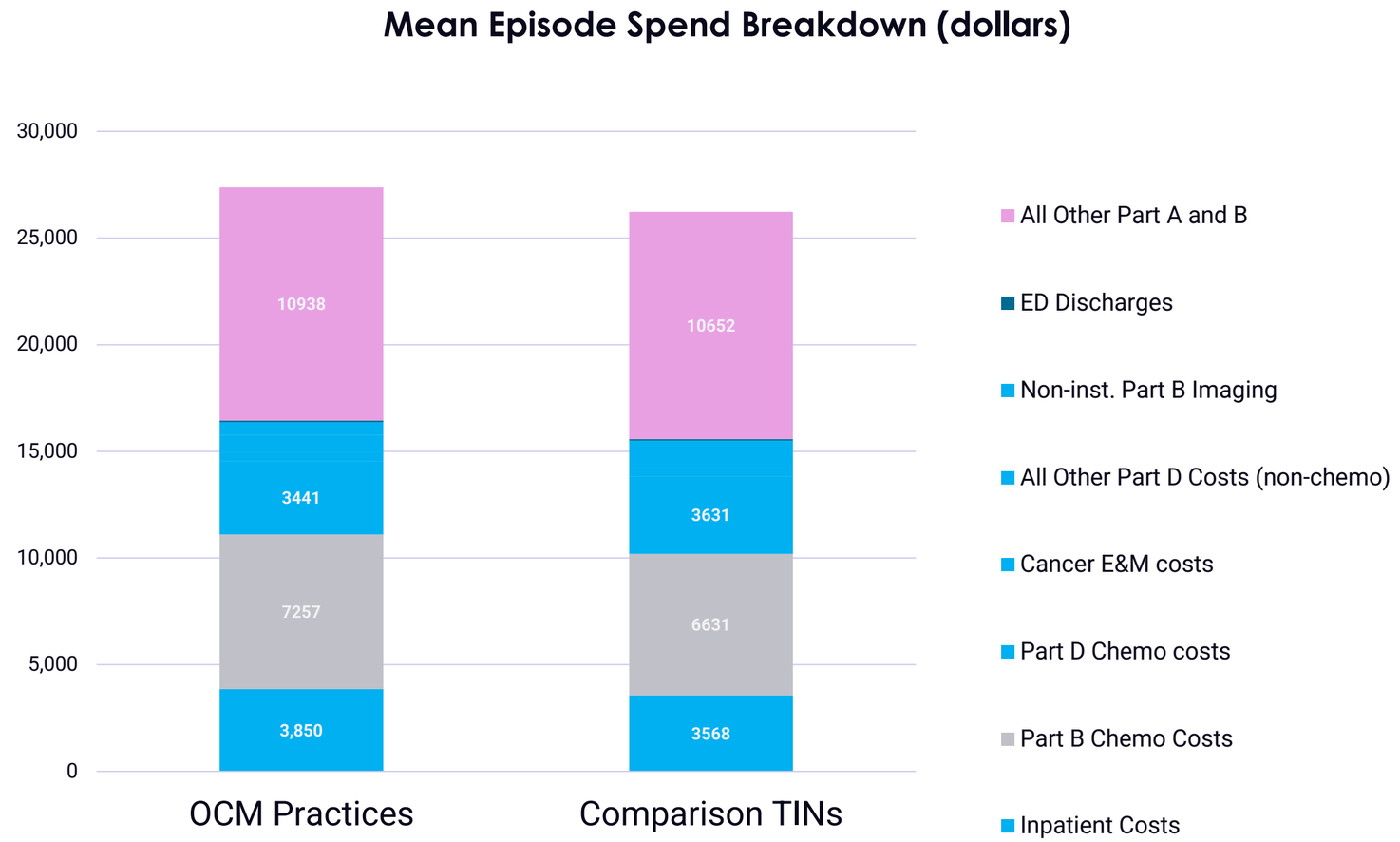
The problem with the OCM was that it failed to address the cost of chemotherapy



Key Takeaways

In the baseline period (the three years leading up to the OCM), 40% of costs were associated with systemic therapy (2/3 Part B; 1/3 Part D).

In the claims files from subsequent reconciliation periods, up to 60-70% of costs were associated with oral or infused drugs.

To succeed in an oncology APM, a strategy to manage cost of drugs is mandatory.

Source: Abt Associates. First annual report from the evaluation of the oncology care model: baseline period (link).

Oncology Care First Model Overview: a pre-COVID proposal from CMMI

- New and distinct model from current 5-year OCM, building on lessons learned to date in that model
- Test whether holding model participants accountable for total cost of care and offering them predictable revenue streams through an alternative payment mechanism improves care coordination and management while reducing expenditures
- Payment mechanisms would include:
  - A prospective, monthly population payment for an OCF participant's assigned population of Medicare fee-for-service beneficiaries
  - Total cost of care accountability for Medicare costs, including drug costs, incurred during a six-month episode of care
  - Opportunity to achieve a performance-based payment (PBP) or owe a repayment to CMS (PBP recoupment), depending on quality performance and costs

References: Centers for Medicare & Medicaid Services. Oncology Care First Model: Informal Request for Information. https://innovation.cms.gov/Files/x/ocf-informalrfi.pdf. Accessed 03-06-2020.

Oncology Care First – Key Differences from OCM[1,2]

OCM	OCF
July 1, 2016-June 30, 2021	January 2021-December 2025
Accountability for quality and total costs of care	Increased accountability for quality and total costs of care
Upside financial risk with a transition to upside-downside risk	Upside only or upside and downside risk
Episode-based chemotherapy payment model	Episode-based chemotherapy payment model
Financial incentives for high-quality, coordinated care	Higher reward payments for meeting value-based care targets
Commercial payer participation	More private payer participation
Monthly payments to support enhanced services	Payments would cover evaluation and management services, a separate category of enhanced services, and drug administration services

Reference: 1. Centers for Medicare & Medicaid Services, https://innovation.cms.gov/files/x/ocf-informalrfi.pdf 2. https://www.cms.gov/newsroom/fact-sheets/oncology-care-model

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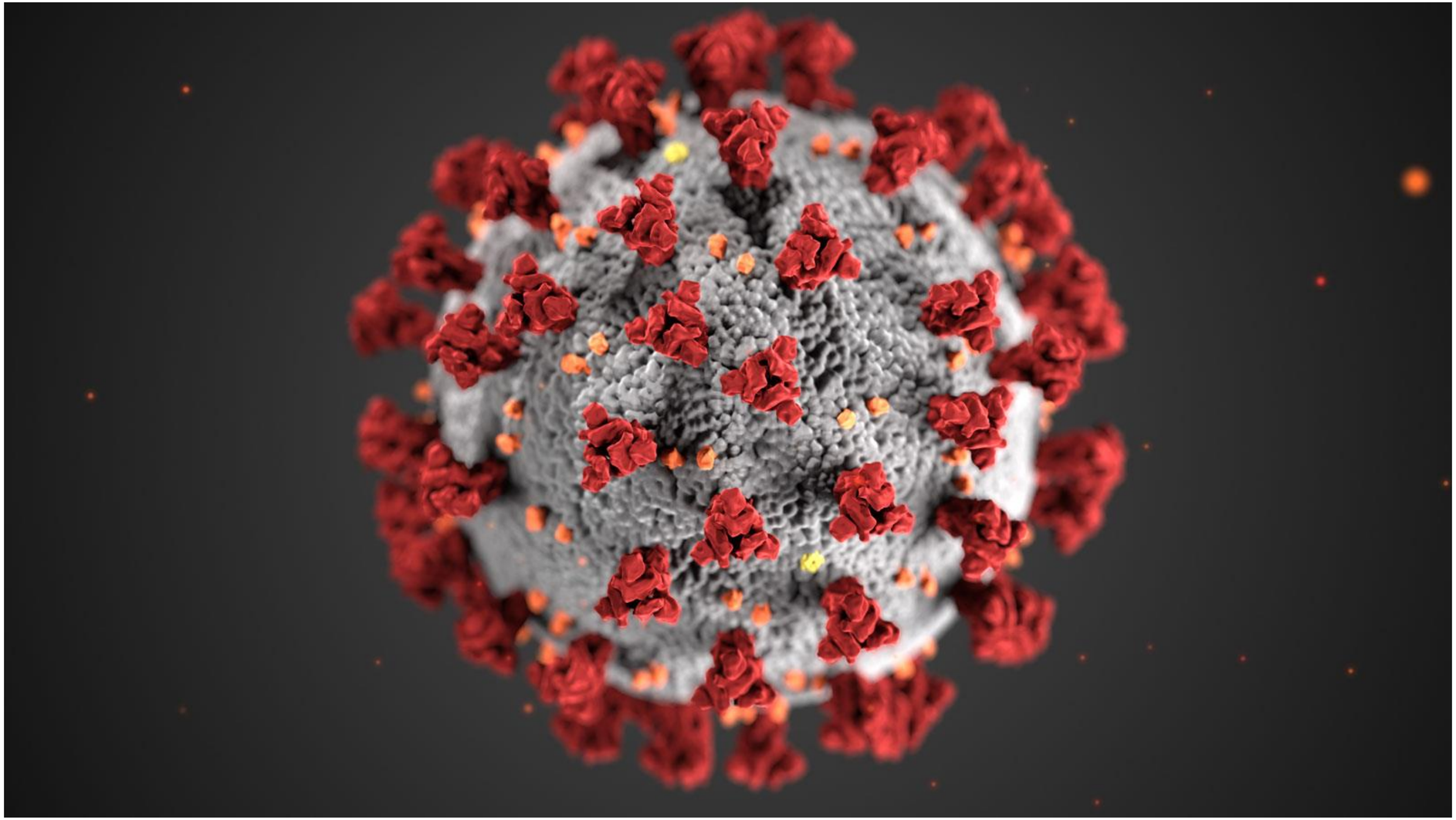


EOM and OCM are very similar

Payment Model Overview

Fee-for-Service Payment

- Participating practices continue to earn fee-for-service payments for services to Medicare beneficiaries
- Drugs continue to be reimbursed at ASP + 6% (sequestration reduction applied)

Monthly Enhanced Oncology Services (MEOS) Payment

- Upon initiation of chemotherapy, practice bills for per-beneficiary per member (PBPM) and receives:
  - OCM: $160 MEOS payment for six months
  - EOM: $70 MEOS payment for six months or $100 MEOS (for duals)

Performance-Based Payment (PBP)

- Practice is eligible to receive PBP if it reduces beneficiaries' total Medicare billings and meets threshold for quality performance
- Quality measures yet to be finalized
- Cost performance is evaluated against the practice's historical performance
- Two-sided risk is required from EOM onset

Practices encouraged to be more efficient, reduce unnecessary ER and hospitalization along with efficient drug management.

EOM Draws from OCM Foundation with "Tweaks"

Narrower than OCM	Same as OCM	Broader than OCM

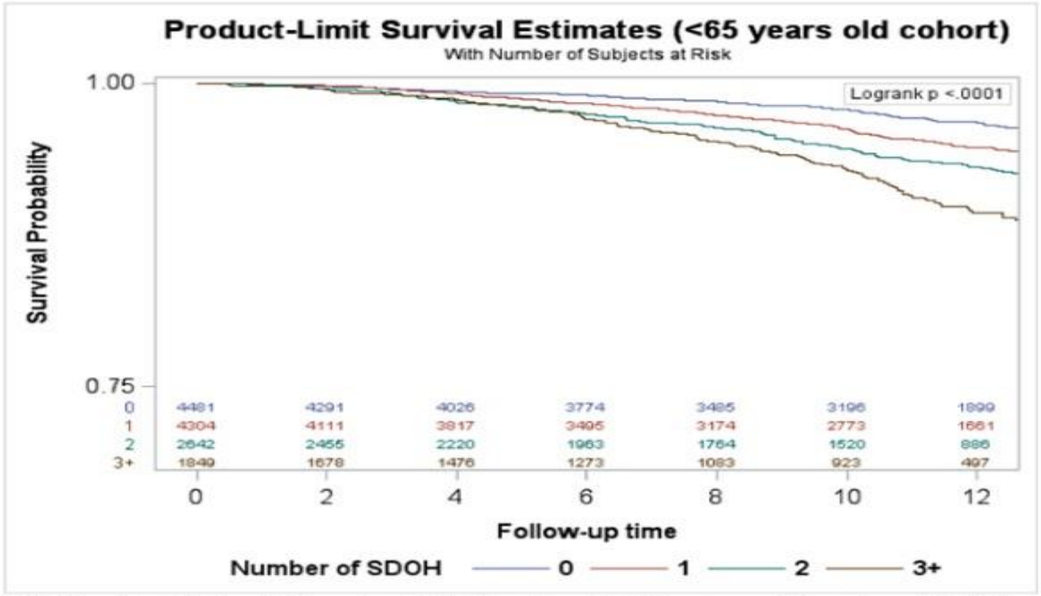
• Fewer eligible patients
  • Limited to 7 tumor types (breast cancer, chronic leukemia, small intestine/colorectal cancer, lung cancer, lymphoma, multiple myeloma, and prostate cancer)
  • Hormonal therapy (exclusively) excluded
• MEOS lowered from $160 to:
  • $70 (non-duals)
  • $100 (duals)
• Downside risk required at start
	• Voluntary
	• Chemotherapy trigger to 6-month episode measuring total cost of care
	  • MEOS plus PBP structure
	• Patient navigators remain
	• Multi-payer model
	• CAR-T excluded
	• Part B/D drug reimbursement remains according to current policy (e.g., ASP+6% or via Part D)
	• Evidence-based Guidelines play an integral role
		• Adopts OCM's 6 redesign activities and adds 2 more:
		  • ePROs (gradual phase-in)
		  • screening beneficiary social needs using HRSN* tool
		• Fixes OCM's attribution issues
		  • ADVI Advisors view EOM as more logical approach, as the initial treating practice is attributed so long as they have 25% of cancer claims
		• Novel Therapy Adjustment will be calculated separately for each of the 7 cancer types
		  • OCM NTA calculated in aggregate across all cancer types

*HRSN: health-related social needs

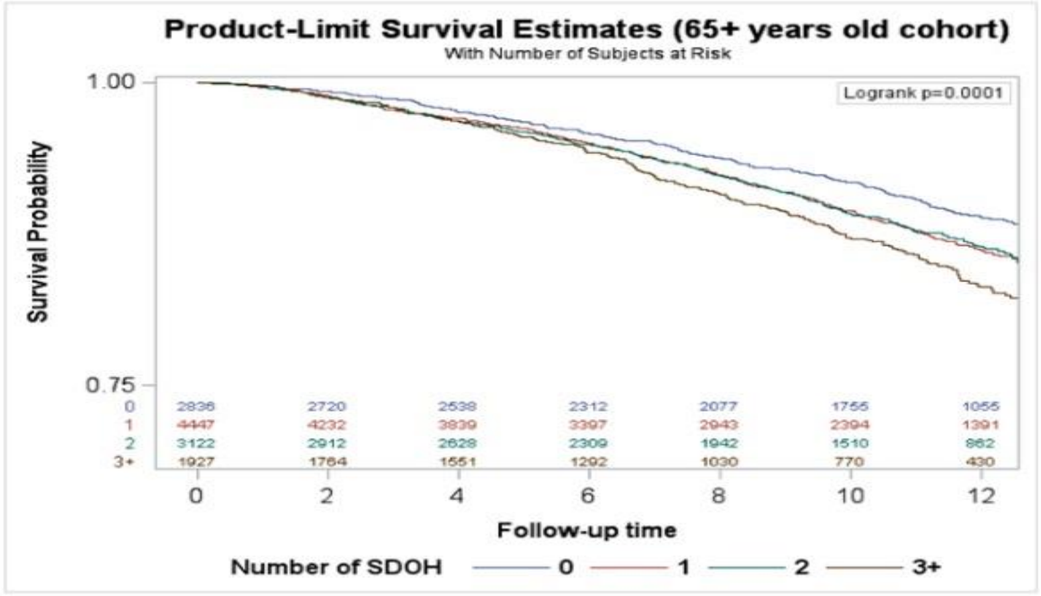
Social determinants of health and cancer mortality adjusted for age and gender

SDOH[a]	HR	95 % CI		p-value
Low education	1.56	1.39	1.74	<.0001
Low income	1.66	1.50	1.82	<.0001
Zip poverty	1.23	1.11	1.36	<.0001
HPSA[b] status	1.06	0.97	1.15	0.22
Lack of insurance	1.58	1.31	1.90	<.0001
Social isolation (sickness)	1.09	0.96	1.24	0.18
Social isolation (friends)	1.20	0.99	1.44	0.06
Public health infrastructure	1.09	0.99	1.18	0.07

Social determinants of health and cancer mortality adjusted for age and gender
[a]SDOH (Social determinants of health)
[b]HPSA (health professional shortage area)



(a) Product-Limit Survival Estimates (<65 years old cohort) With Number of Subjects at Risk



(b) Product-Limit Survival Estimates (65+ years old cohort) With Number of Subjects at Risk

JOURNAL OF CLINICAL ONCOLOGY ORIGINAL REPORT

Symptom Monitoring With Patient-Reported Outcomes During Routine Cancer Treatment: A Randomized Controlled Trial

Ethan Basch, Allison M. Deal, Mark G. Kris, Howard I. Scher, Clifford A. Hudis, Paul Sabbatini, Lauren Rogak, Antonia V. Bennett, Amylou C. Dueck, Thomas M. Atkinson, Joanne F. Chou, Dorothy Dulko, Laura Sit, Allison Barz, Paul Novotny, Michael Fruscione, Jeff A. Sloan, and Deborah Schrag

- RCT done at MSKCC from 2007-2011 comparing enhanced patient reporting compared to standard of care.
- Solid tumors only receiving outpatient chemotherapy.
- 766 patients randomized
- Web-based tool with weekly e mail prompts to report.
- 12 symptom questionnaire.
- Primary endpoint HRQOL. Secondary endpoints ER visits, hospitalizations, time on treatment and survival.

Patient monitoring during treatment using **electronic patient-reported outcomes (ePRO)** significantly improves outcomes

HRQL Improved among more patients (34% v 18%)

17% Reduction in ER visits and 8% reduction in Hospitalizations

30% Increase in time on chemotherapy.

20% Higher Overall Survival

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What did we learn from OCM

- Navigation is good.
- Same day visits are now standard practice.
- Data can be very helpful to practices.
- Drug costs (and especially medical cost inflation due to drugs) make generating cost savings in a TCOC model very difficult.
- ER and inpatient reductions can be achieved but they are uncommon events and have little impact on TCOC.
- Only a small number of practices chose to participate; voluntary models may not yield generalizable results.
- Bigger is better.
- Commercial payers aren’t ready.

CMMI needs a win

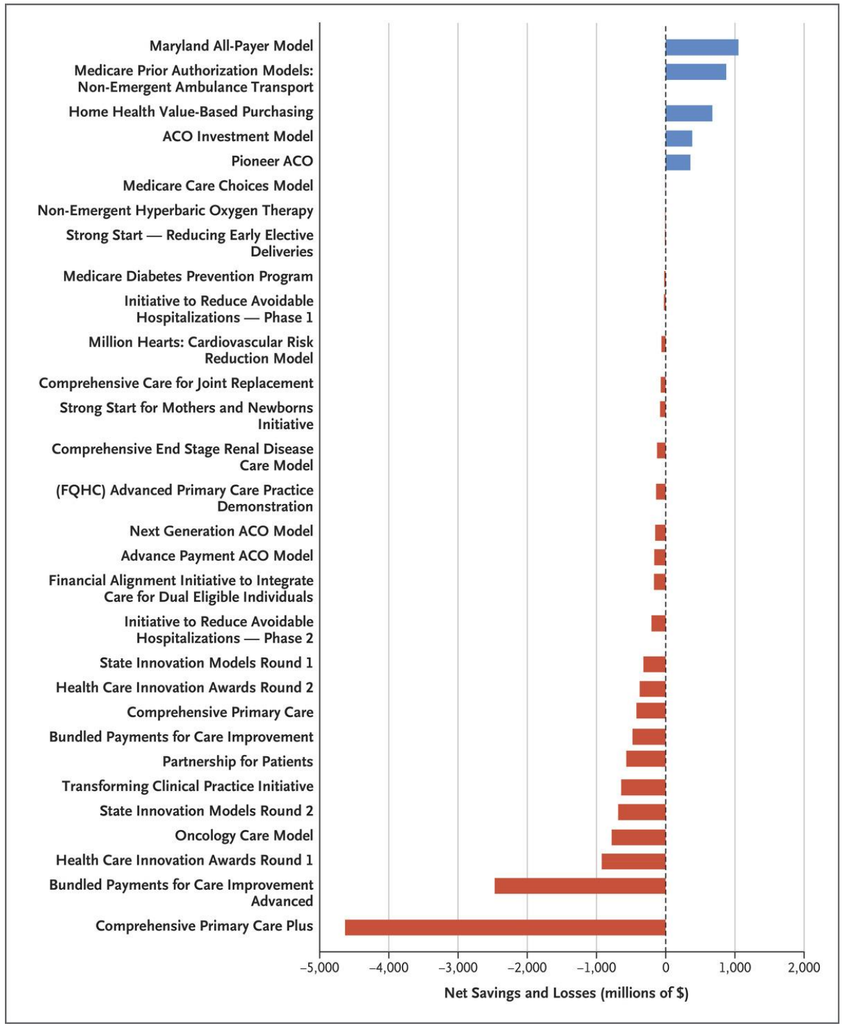
The NEW ENGLAND JOURNAL of MEDICINE

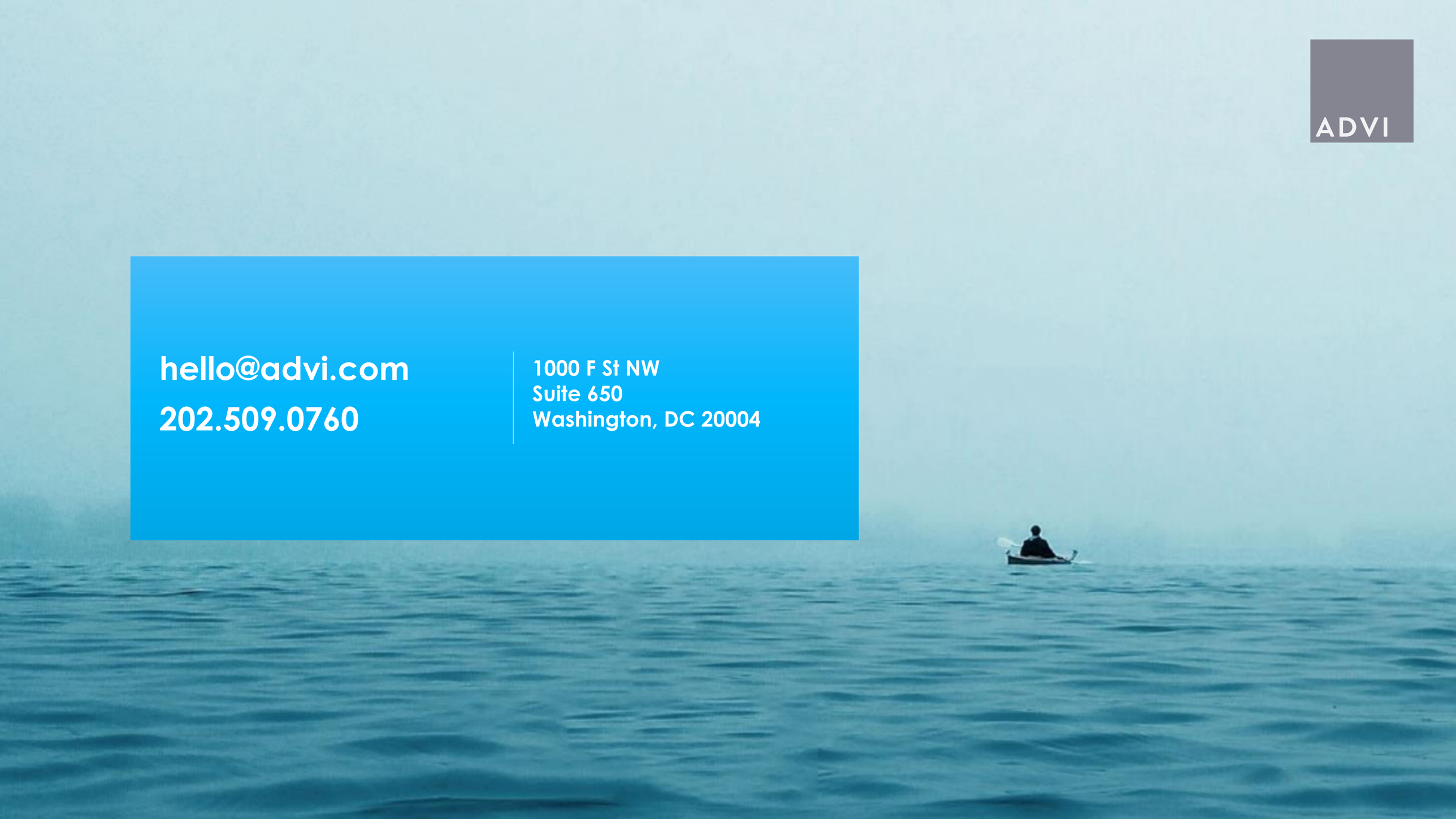
SOUNDING BOARD

CMS Innovation Center at 10 Years — Progress and Lessons Learned

Brad Smith, M.Phil.

In general, CMMI has not done very well….
BUT that does not mean accountable care is dead.





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