

CMS Perspective:

Oncology Care Model (OCM) Second Annual Evaluation Report and next steps on Oncology Innovation

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For information on the model and to download the independent evaluation report discussed in this document, please visit

<https://innovation.cms.gov/initiatives/Oncology-Care/>



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Millions of Americans are diagnosed with cancer every year, and the majority are Medicare beneficiaries. Cancer care in the United States is fragmented and costly. CMS believes that improving care and reducing costs in oncology is of critical importance, and thus has implemented the Oncology Care Model (OCM).

OCM is a 6-year episode-based payment model, scheduled to run from July 1, 2016, to June 30, 2022, and is nationwide in scope. OCM attempts to improve care coordination and access to care for Medicare beneficiaries receiving chemotherapy for cancer within six month episodes. OCM is designed to drive improvements in cancer care and lower cancer care costs through a two-pronged payment incentive approach involving the following: 1) \$160 per-bene-per-month Monthly Enhanced Oncology Services (MEOS) payments, and 2) the potential to earn a Performance-Based-Payment (PBP). Practices that did not earn a PBP by the initial reconciliation of the fourth performance period were required to request to change to a two-sided risk arrangement or terminate from OCM.

The Evaluation of the Oncology Care Model: Performance Periods 1-3 report includes 379,219 episodes that ended by June 30, 2018. Thirty-four percent were “low-risk” episodes, and sixty-six percent were “high-risk episodes”¹. CMS anticipates continuing the evaluation throughout the eight remaining performance periods of the model.

Total Episode Payments for high-risk episodes declined in the first three performance periods, but increases in Total Episode Payments for low-risk episodes offset these impacts, leading to a small, non-statistically significant \$145/episode overall gross estimate of reduction in Medicare spending. When model payments to participants were included (MEOS payments and PBPs), OCM resulted in net losses for Medicare of nearly \$90M in PP1 and \$65M in PP2.²

In addition to Medicare payments, the report examines utilization and quality. Despite practices’ efforts to manage symptoms in the outpatient setting to help beneficiaries avoid emergency department (ED) visits and hospitalizations, there was no OCM impact on hospitalizations, and there were only small, non-significant relative reductions in ED visits and hospitalizations for chemotherapy-related toxicity. OCM practices adopted Care Plans to improve information sharing and support shared decision making. OCM practices also expanded patient navigation, phone triage, same-day urgent care, financial counseling, and advance care planning. Despite these transformation efforts by practices, to date, we have yet to identify substantive impacts of the model on quality or utilization.

The OCM evaluation report draws conclusions that help us to understand what is happening in OCM. Based on program data, the evaluation report, and input from stakeholders, we have

¹ Low-risk episodes include breast and prostate cancers treated with hormonal only therapies, and bladder cancers treated with Bacillus Calmette-Guérin [BCG] therapy and/or mitomycin. High-risk episodes include all other episodes with the most common being lung, colorectal, and high-risk breast cancers.

² Reconciliation data for PP3 was not available in sufficient time to include in the Second Annual Evaluation Report

made adjustments to the model mid-course such as restructuring the baseline beginning in PP3. We also use these results to help to plan for any potential future oncology models.

- **Low-risk episodes:** In OCM, about one-third of all included episodes are for low-risk episodes. The evaluation identified a statistically significant increase of \$130/episode (exclusive of MEOS and PBP). Since the average cost of a low-risk episode in the baseline was only \$7,200, there do not seem to be many opportunities for cost savings for low-risk episodes, and practice transformation may actually increase costs for these episodes.

In the design of OCM, episodes for patients with these cancer types were included to align incentives across as much of a practice's Medicare population as possible and encourage whole practice transformation. However, given that these episodes have been challenging for OCM practices to identify and that the costs in these types of episodes are generally low and tend to include a significant portion of non-cancer costs, CMS is considering excluding them from a total cost of care responsibility in any future oncology models.

- **Enhanced Payments:** While the evaluation report showed potentially promising (although not statistically significant) impacts on Medicare payments, to date, these reductions have not been sufficient to cover the MEOS and PBP paid out under the model, and the model has resulted in net losses to Medicare over the first two performance periods.

In the design of OCM, the amount of the MEOS payment was calculated based on expected investments that OCM practices would need to make to provide Enhanced Services to OCM beneficiaries. Given the evaluation's results to date, CMS is assessing whether there should be Enhanced Services in any potential future oncology model, and if so, the appropriate level of model payment for such services.

- **Quality and Utilization:** OCM was designed to improve quality of care, and OCM practices have reported improvements in management of OCM beneficiaries, although reductions in acute care utilization have not, to date, been identified in the evaluation. CMS must consider these results and other potential opportunities to impact utilization in any future oncology model design.

CMS acknowledges the dedication of OCM participants to continuously improve the quality and accessibility of cancer care for Medicare beneficiaries. Additionally, CMS appreciates the engagement of the broader oncology community throughout OCM. CMS announced an informal Request for Information (RFI) for the potential Oncology Care First (OCF) Model and held a public listening session. CMS is carefully reviewing many thoughtful comment letters submitted in response to the informal RFI, in combination with other information, such as the evaluation reports, to determine the best design for a potential future oncology model.