OCM TO OCF: IMPLICATIONS FOR TOTAL COST OF CARE

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INTRODUCTION

The oncology care model (OCM) was launched in July 2016 as the first innovative payment and service delivery model to promote value-based care specifically within cancer. The program introduced two new payments on top of standard fee-for-service payments – a Monthly Enhanced Oncology Services (MEOS) payment for each chemotherapy patient and a performance-based payment based on participants' adherence to quality measures and generation of savings against benchmark costs. However, despite being near the end of its 5-year pilot, the OCM has not yet achieved clear savings for CMS, nor has it driven consistent improvements along its quality metrics. As a direct follow-up to the OCM, CMS proposed at the end of 2019 a draft of the Oncology Care First (OCF) model, which would begin at the start of 2021. This new model is intended to improve upon the flaws of the OCM based on feedback collected from OCM participants while simultaneously pushing practices into a more advanced state of value-based payments.

OBJECTIVE

To map the limitations of the OCM to the proposed features of the 2021 OCF model in order to evaluate whether the OCF is more likely to successfully reduce total cost of care.

METHODOLOGY

The study employed a pragmatic literature and policy review and utilized the annual evaluation reports published by CMS to understand the current OCM and identify key shortcomings, particularly with respect to lowering total cost of care. These findings were mapped to specific features (e.g., two-sided risk, tumor-specific adjustments) proposed in the OCF's informal request for information published on November 1st, 2019 to identify differences between the current and proposed model. In addition to the literature review, primary research interviews were conducted with a CMS expert and an OCM participant to further understand how the OCF might affect participants.

RESULTS

OVERVIEW OF THE ONCOLOGY CARE MODEL (OCM) AND KEY DIFFERENCES IN THE ONCOLOGY CARE FIRST MODEL (OCF)

Although the OCM and OCF models overlap in certain aspects, the OCF brings about several major changes, including changes to patient attribution, an updated prospective payment structure, new therapy adjustment calculations, and a different set of risk tracks (See Table 1).

In place of the OCM's Monthly Enhanced Oncology Services (MEOS) payment, the OCF proposes a Monthly Prospective Payment (MPP) for every patient managed by the practice, even if not concurrently receiving chemotherapy. This would be a bundled payment that fully replaces fee-for-service billing for patient management and drug administration services. The MPP will be divided into separate management and administration payments, which may be split between participants (e.g., a hospital that administers the drug and outpatient practice provides follow-up care). Practices will be eligible for MPP payments if they carry out practice redesign activities, which will be the same as in the OCM except for the addition of a requirement to implement electronic Patient Reported Outcomes (ePROs).

TABLE 1: OVERVIEW OF THE ONCOLOGY CARE MODEL (OCM) AND KEY DIFFERENCES IN THE ONCOLOGY CARE FIRST MODEL (OCF)

ATTRIBUTE	OCM	OCF
PROGRAM DURATION	JUL 2016 - JUN 2021 (5 years)	JAN 2021 - DEC 2025 (5 years)
PROSPECTIVE PAYMENT	**Monthly Enhanced service (MEOS)** = $160 upfront payment for each beneficiary receiving chemotherapy	**Monthly Prospective Payment (MPP)** = Tiered and bundled upfront payment for each beneficiary that is managed by the practice, including those not receiving chemotherapy
PERFORMANCE-BASED PAYMENT	PBP dependent on the practice's ability to achieve quality measures and reduce Medicare expenditures below a calculated target / benchmark amount	Instead of only by practice, the updated PBP calculation will be adjusted by a trend factor based on tumor mix
RISK ARRANGEMENT	• **PP1-4:** One-sided risk or optional two-sided risk • *If PBP achieved in previous periods* **PP5+:** No change • *If no PBP in previous periods* **PP5+:** Mandatory switch to two-sided risk	• *If not part of OCM* **PP1-2:** One-sided risk **PP3+:** Two-sided risk • *If part of OCM* **PP1+:** Two-sided risk

The performance-based payment (PBP) system in the OCF will continue to encourage adherence to same set of quality measures as the OCM while targeting lower spending than episode benchmark prices. However, the OCF intends to incorporate a tumor-specific trend factor that would enable more costly cancers to have higher target prices. The concept of tumor-specific trend factors would then also be applied to the OCF's new therapy adjustment (NTA). Finally, the risk arrangements of both programs are tied to the PBP calculations. The OCM began as an upside-only track, although participants would be forced into a two-sided risk track (or drop out of the program) if they did not achieve a PBP by the fourth performance period. Under the OCF, all prior OCM participants would be required to join the two-sided risk track at the start.

TABLE 2: KEY CHALLENGES WITH THE ONCOLOGY CARE MODEL (OCM)

	TOPIC	KEY OCM PROBLEMS	IMPACT ON OCM SUCCESS
MODEL EXECUTION	TIMELINESS OF REPORTING	Performance period publications delayed such that providers (as well as third-party payers) do not have timely insight into what they are doing well and what needs improvement	HIGH
MODEL EXECUTION	RECONCILIATION PAYBACKS	Providers learn that they must pay back to CMS a portion of their MEOS payment due to incorrect patient attribution, after having already spent the money	MEDIUM
MODEL EXECUTION	PATIENT ATTRIBUTION	Substantial difficulty for providers to understand patient eligibility criteria and payment calculations	MEDIUM
MODEL DESIGN	TWO-SIDED RISK	Lack of confidence in undertaking two-sided risk, given uncertainties in ability to control costs in availability of infrastructure to manage paybacks	HIGH
MODEL DESIGN	TARGET PRICE CALCULATIONS	Target price calculations are not linked to tumor types, which makes it difficult for providers that treat more expensive tumor types to stay under target price thresholds	HIGH
MODEL DESIGN	NOVEL THERAPY ADJUSTMENT	The novel therapy adjustment is calculated at the provider level, which penalizes practices treating a high-cost tumor set	MEDIUM
MODEL DESIGN	SELF-BENCHMARKING	The use of a participant's own historical data to calculate target price benchmarks makes it harder for practices who have already done well to show incremental improvement over time	MEDIUM
MODEL DESIGN	MOVEMENT AWAY FROM FFS	The continuation of FFS payments has been a problem for CMS in generating savings	LOW
MODEL DESIGN	QUALITY METRICS	Several of the quality metrics (e.g., hospice care) are not showing improvements across practices	LOW

KEY CHALLENGES WITH THE ONCOLOGY CARE MODEL (OCM)

Several problems with the OCM have emerged since its inception (See Table 2) that have limited the effectiveness of the program in achieving cost savings for CMS and improving quality of care. While some of these problems are inherent to the model's design, others have arisen from how the program has been executed by CMS. On the execution side, one of the primary issues associated with the OCM is the delayed timing for the reporting of performance period results. Participants do not have timely insight into where they are underperforming, making it difficult to pinpoint how to improve. Moreover, lack of clarity about how to properly attribute patients have caused many practices to face MEOS recoupment, which can be concerning if these practices have already spent their upfront payments.

In addition to procedural problems, many participants believe that CMS' calculations for target prices do not properly account for different cost exposure across practices. Firstly, current target price calculations make it more difficult for participants with strong baseline performance to make incremental improvements, as they are benchmarked to their own historical data. Furthermore, the calculations currently disadvantage practices who treat a higher proportion of high-complexity tumor types as compared to the average non-OCM participant. Another key problem is the lack of tumor-specificity with novel therapy adjustments. Practices which treat a higher proportion of expensive tumor types with more novel therapies are penalized, even if they are following clinical best practices.

Because of mistrust in CMS' calculations for PBP payments and the inability to receive real-time feedback on their performance, OCM participants are highly hesitant to take on two-sided risk. Many OCM participants lack the financial infrastructure to be able to handle downside risk, so those that have performed poorly to-date may consider dropping out of the program entirely. Overall, the OCM has not yet resulted in cost savings for CMS, even though a few quality metrics (i.e., end-of-life hospitalizations and ICU admissions) have improved over time.

ABILITY FOR OCF TO ADDRESS THE OCM'S CHALLENGES

Because the flaws of the OCM lie within both the program's design and CMS' execution, the OCF must improve on both domains to drive meaningful change in practice spending and quality of care. With respect to model execution challenges, the OCF is unlikely to be handled any differently and may lead to further delays due to the increased complexity of the MPP calculation and tumor-specific trend factors.

With regard to model design, there are also areas in which the OCF may cause more harm than good. OCM participants would need to begin immediately with two-sided risk, which could deter participation. Experienced OCM participants may also be hesitant to participate in the OCF if the self-benchmarking component is not changed, as they may perceive limited room for improvement. Additionally, the requirement for electronic patient-reported outcomes (ePROs) is expected to be a substantial hurdle, due to lack of clarity around optimal ePRO vendors and the logistical challenges of collecting data consistently across patients.

On the other hand, the biggest positive changes within the OCF are around reshaping calculations to be fairer to participants who treat high-complexity patients with the introduction of tumor-specific adjustments to both the MPP and the NTA. While these changes may make payment calculations more equitable, calculations may be inaccurate for tumors with high variance in treatment and management costs; as such, providers would prefer to see the OCF limit its scope to a select few tumor types with well-established treatment paradigms (e.g., lung, breast, colon). Ultimately, the positive and negative changes within the OCF balance each other out and will likely lead to a similar trajectory in practice performance outcomes as seen with the OCM (See Table 3).

TABLE 3: ABILITY FOR OCF TO ADDRESS THE OCM'S CHALLENGES

	TOPIC	ABILITY FOR THE OCF TO ADDRESS THESE CHALLENGES	OVERALL IMPACT
MODEL EXECUTION	TIMELINESS OF REPORTING	Uncertainty that CMS will be able to perform the new, more complex calculations in a timely fashion	NEUTRAL
MODEL EXECUTION	RECONCILIATION PAYBACKS	Reconciliation paybacks will be even larger than before	NEGATIVE
MODEL EXECUTION	PATIENT ATTRIBUTION	While expanding eligibility to non-chemotherapy patients who received E&M services, the MPP introduces several new, complex formulas around risk-stratified upfront payments	NEUTRAL
MODEL DESIGN	TWO-SIDED RISK	Any practices that participated in OCM may have to begin OCF with two-sided risk, though there is the option for a less aggressive two-sided risk track	NEGATIVE
MODEL DESIGN	TARGET PRICE CALCULATIONS	Tumor-specific target price benchmarks would ensure greater fairness for the target prices of providers treating mostly high-cost tumor types	POSITIVE
MODEL DESIGN	NOVEL THERAPY ADJUSTMENT	Tumor-specific novel therapy adjustments would also create greater fairness for providers who treat mostly high-cost tumor types	POSITIVE
MODEL DESIGN	SELF-BENCHMARKING	Historical benchmarking may become a challenge for some OCM participants entering the OCF who are already reaching the limits on cost reduction	NEUTRAL
MODEL DESIGN	MOVEMENT AWAY FROM FFS	Including E&M services into the MPP is progress towards bundled payments, though it could cause problems given different costs for managing different tumor types	POSITIVE
MODEL DESIGN	QUALITY METRICS	Adding ePROs as one of the default "practice redesign" requirements may pose logistical challenges for providers without the infrastructure for tracking and reporting, impacting the MPP	NEGATIVE

CONCLUSION

While the OCF model shows signs that CMS is listening to practices, there are still many weaknesses from the OCM that remain unaddressed, especially those around how CMS executes the program. Given past OCM experiences, the OCF may ultimately follow a similar trajectory and have limited impact on total cost of care unless CMS can address the issues in how it designs and manages the program.