

Redesigning the Oncology Care Model

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Redesigning the Oncology Care Model

At Remedy, we realign the healthcare system to help providers collaborate more successfully around episodes of care. Successful episode of care payment programs require technologies to link providers and patients, data analytics to measure and track performance, and systems to manage and report real-time financial and clinical information. Remedy focuses on each of these challenges and develops solutions that enable providers to deliver higher quality patient outcomes at lower costs for all.

Given our focus, we appreciate Medicare's interest in competition, patient empowerment, and specialist engagement. Payment models and insurance design that rely on these principles are essential for the Medicare and Medicaid programs to enlist those who are best positioned to improve care delivery. They're also essential to private sector payers and purchasers of health care. To this end, we encourage the Centers for Medicare and Medicaid Services (CMS) to support the continuation and expansion of voluntary episode-based payment models in Traditional Medicare, Medicare Advantage, and Medicaid. These models encourage integrated teams of clinicians and institutional and community providers to build business and care models that are driven by improvements in patient outcomes through:

Transparent Pricing: Straightforward pricing of clearly defined health care events,
Informed Patients: Improved visibility into provider quality and relative value, and
Smart Benefit Design: Complementary benefit design changes that support better shared decision-making.

They also create a platform from which the private sector can build its own programs, thus accelerating the move to value and away from fee-for-service medicine.

Purpose of the Work Group

In November 2018, Remedy convened this Work Group to create a recommendation for the future of Medicare's Oncology Care Model. This model tests whether additional funding for enhanced services and financial incentives to improve the quality and appropriateness of care provided to Medicare Fee-For-Service (FFS) beneficiaries can improve quality and reduce Medicare spending for patients undergoing chemotherapy for cancer.

For many payers, oncology care is a principal target of payment reform, given the high costs and variability inherent to these episodes of care. Payers have two objectives in mind for their oncology payment initiatives:

- (1) To provide clinicians with financial incentives for managing total cancer costs of care; and**
- (2) To reward groups for adherence to cost-effective and evidence-based clinical pathways.**

The high-value oncology care envisioned by payers includes the setting of and adherence to formal treatment plans, routine patient education, cost-effective drug administration, elimination of low-value care services, robust care coordination, and an unwavering focus on optimizing patient outcomes in accordance with patients' expressed needs.

To compensate and reward clinicians for undertaking these additional efforts, Medicare supplemented the Part B professional and drug reimbursement with monthly care coordination payments to fund quality improvement initiatives. For practices that significantly reduced spending for patients experiencing episodes of care, Medicare paid out performance-based bonuses.

The Oncology Care Model is a promising start to Medicare's payment reform for oncology care. As a Category 3 Model under the framework established by the Health Care Payment and Learning Action Network,¹ the Oncology Care Model includes measures of quality as well as utilization for episodes of oncology care. The model has correctly identified most of the elements of cancer care management.² And it has enabled practices to add additional functions to their group, supplementing their oncology care delivery with the capabilities for meeting the varied demands of their patients. Importantly it has moved practices away from a focus on fee-for-service medicine and toward improving cancer care quality.

¹Health Care Payment Learning and Action Network, Roadmap for Driving High Performance in Alternative Payment Models (April 2019). Retrieved on May 15, 2019, from <https://hcp-lan.org/workproducts/roadmap-final.pdf>.

²Abt Associates. Oncology Care Model: Evaluation of the Oncology Care Model: Performance Period One (December 2018). Retrieved on May 15, 2019, from <https://innovation.cms.gov/Files/reports/ocm-secondannualeval-pp1.pdf>.

But the model needs refinement, which is the focus of this Work Group. There are several important changes that would enhance the model and the knowledge obtained. The reporting requirements are burdensome.³ Moreover, the Clinical Episode categories are not intuitive to clinicians,⁴ who cannot easily apply and implement the concept as currently defined by Medicare. We stand ready to help Medicare define the triggers, categories, and substance of oncology Clinical Episodes. We recognize that this is not an inconsequential undertaking; and there are issues beyond the scope of this paper that will require the concerted attention of clinical and actuarial experts. But Medicare and patients will reap the rewards, if the definitions of the Episodes are clinically relevant to the way physicians think.

Moreover, while the CMS Innovation Center has good intentions for the model, the current episode definitions are highly constraining with regard to partnerships with local commercial plans. Very few commercial payers have chosen to participate in the OCM model of care, forcing practices to make difficult choices regarding transformation for all patients or just those in the OCM. Further, few, if any commercial payers have expanded the current OCM model to the rest of their book of business and, when they have, they focus on upside-only payment models, which fall short of the goals of shifting financial accountability to providers.

Current participants agree that prostate cancer, breast cancer, and perhaps lung cancer were the only episodes that had sufficient volume to justify participation outside of the Medicare fee-for-service population. Outside of these, the volume in other oncology clinical episodes for the under-65 commercial populations averaged 10-12 per year per payer.

The Incidence and Importance of Cancer

Approximately 14 million individuals are currently living with cancer; nearly 2 million Americans are newly diagnosed with cancer each year.⁵ Medicare pays for the treatment of half of these newly-diagnosed.⁶ In the aggregate, annual costs for oncology care will reach nearly \$158 billion in two years, a 27 percent increase since 2010.⁷ Demographic factors contribute to this remarkable increase, but new technology and therapeutics are equally as important.

³Abt Associates. Oncology Care Model: Evaluation of the Oncology Care Model: Performance Period One (Section 3.5.6) (December 2018). Retrieved on May 15, 2019, from <https://innovation.cms.gov/Files/reports/ocm-secondannualeval-pp1.pdf>.

⁴Polite BN, The Road From Theory to Reality: Illuminating the Complexity of Prospective Cancer Bundles. *J. Oncol. Prac.* 2018;14(2):59-62.

⁵“SEER Cancer Statistics Review (CSR) 1975-2014,” National Cancer Institute, updated April 2, 2018.

⁶Statistical Brief #443: Trends in Use and Expenditures for Cancer Treatment among Adults 18 and Older, U.S. Civilian Noninstitutionalized Population, 2001 and 2011. Retrieved on November 13, 2019, from https://meps.ahrq.gov/data_files/publications/st443/stat443.shtml.

⁷Agency for Health Care Research and Quality. Total Expenses and Percent Distribution for Selected Conditions by Source of Payment: United States, 2014. Medical Expenditure Panel Survey Household Component Data.

New techniques in surgery and radiation, as well as developments in oncology medication, add to the treatment cost.⁸ Historically, many believed that the majority of cancer-care-services costs are for outpatient services, followed by inpatient admissions and drug spending. The consulting firm Milliman analyzed trends in the changes of these services, observing that the per-patient cost of drugs is increasing at a much higher rate than other cost components, driven largely by specialty drugs.⁹ Claims data from the OCM show that drug spending now makes up more than half of the total cost of care. Analyses of private sector payer data also show significant variation in the use of specialty drugs for treating cancer, caused by the lack of refined diagnoses, rapidly changing therapies, lack of adherence to pathways and perverse financial incentives.

Key Principles for Redesigning the Oncology Care Model

As this Work Group developed its recommendations, the members identified five key principles that they believed should guide the redesign of the Oncology Care Model. These principles, as articulated in detail in this paper, align with the broader set of principles described in the HCP LAN Roadmap:¹⁰

- (1) Focus on Episodes with the most opportunity for care redesign, quality improvement and cost reduction;**
- (2) Use existing, payer-agnostic sets of clinical pathways;**
- (3) Clinicians should be responsible for only the care patterns they can control, but should have full accountability within those pathways;**
- (4) Overlap policy should ensure appropriate opportunity within each model; and**
- (5) Model evaluation is paramount to enable informed payment policy decisions.**

1st Principle: Focus on Episodes with the most opportunity for care redesign

Payers should strive to create comprehensive oncology care models that hold providers accountable for appropriate symptom management, behavioral health needs, palliative and end-of-life care, and survivorship.¹¹ In 2016, breast, prostate, and lung cancer had the highest incidence rates. These cancers, as well as colorectal cancer, had the highest mortality rates.¹² More importantly, for the Medicare program, these types of cancers had the highest number of episodes, mitigating concerns about the nature of the risk associated with small sample sizes.¹³

⁸Prasad V, De Jesús K, Mailankody S, The high price of anticancer drugs: origins, implications, barriers, solutions. *Nat. Rev. Clin. Oncol.* 2017 Jun;14(6):381-390.

⁹Fitch, Kathryn, Pelizzari, Pamela M., and Pyenson, Bruce. "Cost Drivers of Cancer Care," Milliman, April 2016. <http://www.milliman.com/uploadedFiles/insight/2016/trends-in-cancer-care.pdf>, accessed May 15, 2019.

¹⁰Health Care Payment Learning and Action Network, Roadmap for Driving High Performance in Alternative Payment Models (April 2019). Retrieved on May 15, 2019, from <https://hcp-lan.org/workproducts/roadmap-final.pdf>.

¹¹CMS Alliance to Modernize Healthcare. Specialty Payment Model Opportunities Assessment and Design: Environment Scan for Oncology (July 23, 2013).

¹²American Cancer Society, Cancer Facts & Figures 2019. Retrieved on November 13, 2019, from <https://www.cancer.org/research/cancer-facts-statistics/all-cancer-facts-figures/cancer-facts-figures-2019.html>

The next Oncology Care Model should require that practices participate in these four Clinical Episode types, ensuring that the model covers the most prevalent treatable, and costly cancers.

Requiring participation in these four Clinical Episode types will not disadvantage oncology practices, which rarely focus on only one type of cancer. Payers need to be bold in their attempt to influence the practice's approach to care delivery. The global approach of an oncology practice to the care of a patient should not differ based on the type of cancer that the patient is afflicted with. Although the model should encourage customization of strategies based on differences in that cancer cohort, this standardized but personalized approach should prevent the perverse incentives to target care redesign to a subset of the practice's patients. Moreover, Medicare should proffer a model that is adaptable and attractive to the needs of commercial payers. Focusing on these four Clinical Episode types would support a multi-payer model; practices will typically contract with a commercial payer for lung, prostate, colorectal and breast cancers.

Payers, including Medicare, need to ensure that clinicians can apply and implement the Episode definitions in a tumor-specific way. To achieve this, however, requires a sophisticated and detailed financial methodology. The clinical pathways and metrics for each cancer will be different, with concomitant financial implications. Translating oncology clinical pathways into reporting metrics and episode budgets is particularly difficult due to the staging issues associated with each type of cancer. But these issues are necessary to confront so that participating physicians do not have to; simplicity in the care model requires sophistication in the financial model.

2nd Principle: Use existing, payer-agnostic sets of clinical pathways

Clinical pathways are decision-support tools used by either clinicians or health plans to ensure that care delivery is in accordance with evidence-based medicine. These tools set forth decision algorithms that are derived from the scholarly-evidence for care in that practice area. For oncology, clinical pathways intend to direct oncologists as to the course of treatment that is cost-effective, most efficacious, and least toxic. Pathways are tailored to individual patients based on diagnostic tests, the stage of cancer, and any comorbidities. Importantly, these tools allow for refinement to the treatment in the event that the patient is not responding to a set of physician- or patient-administered drugs.

Building on previous oncology initiatives by national payers, the next Oncology Care Model should reward practices for (and hold them responsible for) following known evidence-based pathways.¹⁴ Medicare should first, however, identify—with the advice of commercial payers, practices, and patients—the pathways that will underpin the model, regardless of the payer.

¹³Abt Associates. Oncology Care Model: Evaluation of the Oncology Care Model: Performance Period One (December 2018). Retrieved on November 13, 2019, from <https://innovation.cms.gov/Files/reports/ocm-secondannualeval-pp1.pdf>

¹⁴Feinberg BA, Lang J, Grzegorzcyk, et al. Implementation of cancer clinical care pathways. *J. Oncol. Prac.* 2012;8(3 Suppl):e38s-43s.

Those developing oncology-specific clinical pathways differ in their approach to defining, implementing, and enforcing them.

This Work Group believes that the clinical pathways should define the financial accountability of the participating practices. It is therefore imperative that Medicare and other payers agree on the clinical pathways that will underlie the model. Given the amount of work and credibility that Medicare has afforded to the National Comprehensive Care Network, we believe that the clinical pathways should derive from the work already completed with the NCCN. In fact, OCM incorporates NCCN guidelines. Our recommendation would be to make the NCCN guidelines—or pathways constructs based on the NCCN guidelines—more explicit as a component of quality and payment in Medicare’s next oncology payment model.

The foundation of the next oncology payment model should rest on these widely-accepted guidelines. Using NCCN guidelines is the surest way to support the difficult process of translating clinical practice into metrics and budgets.¹⁵ This is important to consumers, to employers, and to payers. Consumers want to receive appropriate care and survive.¹⁶ And employers reinforce these needs; they are concerned principally with whether their employees are receiving evidence-based-guideline-driven care.¹⁷ Clinical guidelines support employers’ aspirations for evolved versions of a “Center of Excellence,” emphasizing diagnosis as well as treatment of a given condition.

Above all, this requires measures derived from guidelines that allow employers, clinicians, and patients to meaningfully compare providers.¹⁸ And it requires data generated by the physicians or observed in Medicare claims. In an ideal model, the information would be available in the claims process, but the next oncology payment model may not be able to evaluate clinicians properly without direct access to medical records. Nevertheless, consistent measurement based principally on Medicare claims or existing registries could reduce the regulatory burden on the participating clinicians. Medicare and other payers should aspire to set forth metrics that—if a clinician demonstrates conformity with the relevant guideline—eliminate duplicative or unnecessary documentation and reporting.

¹⁵ The NCCN guidelines are the most widely accepted clinical practice guidelines in use, though they are not without controversy.

¹⁶ Berry LL & Mate KS. Essentials for improving service quality in cancer care. *Healthcare* 2016;4:312-316.

¹⁷ National Business Group on Health. *An Employer’s Guide to Cancer Treatment & Prevention* (2013). Retrieved on May 15, 2019, from <https://www.businessgrouphealth.org/pub/?id=f314ce36-2354-d714-5167-94d96ac431fc>.

¹⁸ Clough JD and Kamal AH. Oncology Care Model. *J. Oncol. Prac.* 2015;11(4):319-321.

3rd Principle: Clinicians should only be responsible for the care patterns they control

Many oncology payment initiatives focus on achieving savings through the following and so should the next version of OCM:

**(1) Implementation of cost-effective drug regimens, advanced by clinical pathways; and
(2) Reduction in the utilization of health care services due to treatment toxicity, progressive symptoms of malignancy, or exacerbations of chronic underlying comorbid medical conditions, in an effort to improve patient outcomes.**

Setting financial targets is an integral part of payment reform, which should transfer to the provider the right technical risk but not the insurance risk associated with the patient population. Practices in the next Oncology Care Model should be responsible for risk-adjusted costs of care, but not exposed to exogenous risk.

Oncology practices need reliable, transparent benchmarks in order to make upfront capital investments in care redesign. Payers in the next Oncology Care Model should therefore establish realistic benchmarks that accommodate variability based on clinical characteristics and patient needs.¹⁹ This Work Group recommends that payers set Clinical Episode pricing derived from the evidence-based pathways defined under the 2nd Principle (Establish “payer-agnostic clinical pathways”). This will remove risks associated with an undesirable case mix associated with higher intrinsic cost. This is essential in order to articulate a program design that adapts to changes in oncology practice and can be understood by clinicians. That said, the choice of pathways should be informed by advanced diagnostics that help refine the disease state of the patient.

This Work Group recommends that payers under the next Oncology Care Model hold providers accountable to clinical pathways but not set benchmarks that include drug pricing, either for physician- or patient-administered oncology drugs. Oncology practices don’t control the price of drugs, which varies between payers, even within a given type of cancer.²⁰ However, practices are

¹⁹Kline RM, et al., Design Challenges of an Episode-based Payment Model in Oncology. *J. Oncol. Prac.* 2017; 13(7):e632-e645.

²⁰See Abt Associates. First Annual Report from the Evaluation of the Oncology Care Model: Baseline Period (February 2018). Retrieved on May 15, 2019, from <https://downloads.cms.gov/files/cmmi/ocm-baselinerreport.pdf>. Physicians should be compensated for managing the care they deliver in all its complexity while containing the costs they can effectively control. But this is not the oncology health care delivery system that exists today. By statute, Medicare pays physicians the average sales price, plus 6 percent, for most drugs and biologics covered by Part B. Physician offices capture nearly 60% of the over \$20 billion in Medicare (and patient) spending on this segment of Part B. Some analysts have credible evidence suggesting that this physician office business model for Part B drugs can affect selection of therapies. Jacobson M, et al., How Medicare’s payment cuts for cancer chemotherapy drugs changed patterns of treatment. *Health Affairs* 2010;29(7):1391-1399. See also Medicare Payment Advisory Commission, Report to the Congress: Medicare and the Health Care Delivery System (June 2015) (“Since 6 percent of a higher priced drug generates more revenue for the provider than 6 percent of a lower priced drug, selection of the higher priced drug has the potential to generate more profit, depending on the provider’s acquisition costs for the two drugs”).

and should be responsible for choosing the lower cost therapy within the choice set imposed by a payer. Practices are beholden to the attributes of their patient panel, including the incidence and type of cancer afflicting them, and can control the utilization of drugs and, in particular, the utilization of the right drug for the right patient. As such, payers should consider segmenting the financial responsibilities for the total costs of cancer care. Instead of a binary option of risk/no-risk for oncology drugs, payers could allow practices to accept downside risk for some components and upside risk for others (i.e. Part A and Part B services for downside risk; Part B drugs and Part D for upside only).

Further, the inability of many practices to manage downside risk has reduced the willingness to participate in many double-sided risk models, and that fear has even led larger medical groups and health systems to bow out of the Medicare ACO program. Organizations that can facilitate clinical data integration, information sharing and financial risk mitigation, such as the convener-awardees in the Medicare Bundled Payment for Care Improvement program, have proven to be effective at helping practices overcome the fear of downside risk, and we recommend that Medicare allow convener-awardees in the next OCM.

4th Principle: Overlap policy should ensure appropriate opportunity within each model

The Innovation Center recently proposed the Radiation Oncology (RO) model to test the value of a prospective episode-based payment model.²¹ This model will overlap with the Oncology Care Model; the extent of that overlap depends on the type of OCM Clinical Episode.²² According to the RO proposed rule, if an RO episode overlaps with an OCM episode, each will be initiated and reconciled.²³ The current overlap policy allows both models to co-exist, which CMMI has noted in other contexts is “likely to result in compounded efficiencies and clinical integration.”²⁴ We encourage CMS to maintain this overlap policy in the next version of the Oncology Care Model. Concurrent OCM and RO episodes will encourage different oncologists—furnishing different modalities of cancer treatment—to improve the quality of care and retain financial accountability for the cancer therapy services that each oncologist controls. And it would create an incentive for participants in the next OCM to work closely with providers of radiation therapy services to best manage the care of patients.

CMS correctly notes in the RO proposed rule that the overlap policy should avoid double counting savings and losses.²⁵ OCM participants will not receive the benefit of the withhold or the RO discount;

²¹84 Fed. Reg. 34478 (July 18, 2019).

²²Abt Associates. First Annual Report from the Evaluation of the Oncology Care Model: Baseline Period (February 2018). Retrieved on May 15, 2019, from <https://downloads.cms.gov/files/cmmi/ocm-baselinerreport.pdf>. 84 Fed. Reg. 34534-34535.

²³84 Fed. Reg. 34534-34535 (July 18, 2019) (“If an entire RO Model episode (90-days of RT services) occurs completely during a 6-month OCM episode, then the associated RO payments for RT services would be included in the OCM episode”).

²⁴80 Fed. Reg. 73393 (Nov. 24, 2015) (Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services; Final Rule).

²⁵84 Fed. Reg. 34535 (July 18, 2019).

those are inherent to the finances of the RO model. But CMS should apply this policy equally to the OCM Target Price calculation to avoid skewing oncologists' financial incentives. Instead of counting the radiation therapy services in the OCM baseline period, CMS should impute the RO baseline price to the OCM Target Price calculation. This will remove an arbitrage opportunity created by the difference between the sum of radiation therapy services in the OCM baseline period and the RO baseline price imputed in the OCM Performance Period. This policy will focus OCM participants on the clinical rather than financial justification for a particular radiation therapy provider or modality.

5th Principle: Rigorous model evaluation is paramount

The Innovation Center within the Medicare program, established by the Patient Protection and Affordable Care Act of 2010, was intended by Congress to test the merits of new approaches to paying for health care. To date, most of the payment reforms sponsored by the Innovation Center have been voluntary, including the Oncology Care Model. That's an important principle because it allows practices that are willing to take financial accountability for their patients to do so willingly.

However, models inviting—as opposed to compelling—participation can introduce biases into the evaluation, muddying the conclusions about the effectiveness of the model. In health policy, an “observational study”—or voluntary model—would draw in a cohort of physicians that is fundamentally different than those declining such an opportunity.²⁶ This creates issues for the evaluators of payment reform, and, as a result, can create an ongoing barrier to the adoption of APMs by failing to more definitively draw conclusions about their effect.

The Innovation Center should therefore use a geographically-defined mandatory model, run concurrently with a voluntary pilot, as that will allow rigorous evaluation of the next Oncology Care Model. The Medicare program has a strong interest in creating sufficient, unbiased scale in the next model to observe model impact and draw conclusions about payment policy.²⁷ And the ability for convener-awardees to participate in the next OCM could overcome the potential resistance of oncologists that are included in the randomized trial.

²⁶Newhouse JP & Normand SLT, Health Policy Trials. N. Engl. J. Med. 2017; 376:2160-2167.

²⁷Duke-Margolis Center for Health Policy. Exploring approaches for value-based reimbursement of oncology therapies (October 3, 2017).

Conclusion

The Oncology Care Model is a bold experiment from the Innovation Center. But many have found it not to be generalizable, whether to non-participating practices or payers. Those who have succeeded in the model do not understand the source of their success, and recent analyses suggest that the large majority of current participants would experience financial losses if the current model had downside risk. This Work Group recommends that the Innovation Center, in order to ensure proper refinement of the model, adopt the five Principles outlined in this report as it designs the next Oncology Care Model.

Payers and oncology practices are continuing to use financial incentives to deliver cost-effective oncology care. To achieve the desired ends—reduced toxicity, improved outcomes, and moderated cost—it is important for these principles to inform the design of payment reform for oncology practices to ensure widespread adoption and spread beyond traditional Medicare.

