

CMS Perspective: Oncology Care Model (OCM) Third Annual Evaluation Report and Next Steps for Oncology Innovation

January 2021

The Perspective associated with this report is an update to and replaces a previous one published with the Second Annual report for this model. 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 (extended by one year from original end date), and is nationwide in scope. OCM is designed 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 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 (PP) 1-5 report includes 641,451 episodes that ended by June 30, 2019. Thirty-four percent were “low-risk” episodes, and sixty-six percent were “high-risk episodes.”¹ CMS anticipates continuing the evaluation throughout the remainder of the model.

Total Episode Payments, defined as Medicare part A, B and D payments that occurred during a six-month window of time, increased for both the OCM and comparison groups in the first five PPs. However, in the OCM group, the total episode payments for high-risk episodes was on average \$503 less than the comparison group. During this same period relative increases in total episode payments for low-risk episodes somewhat offset the impact from the high-risk episodes. Across all cancer types there was an overall small but statistically significant decrease of \$297 per episode gross estimate of reduction in Medicare spending. When model payments to participants were included (MEOS payments and PBPs), OCM resulted in significant net losses for Medicare of nearly \$316M across the first four PPs.²

OCM practices adopted Care Plans to improve information sharing and support shared decision-making. OCM practices also broadened their use of patient navigation, phone triage, same-day urgent care, financial counseling, and advance care planning. Despite these efforts, OCM had no observable impact on utilization of outpatient emergency department visits or hospitalizations overall. OCM also had no impact on the rate of hospitalizations due to chemotherapy toxicity, and the impact on the number of emergency department visits for chemotherapy toxicity was so slight as to not be clinically meaningful. Hospitalizations in the last month of life declined by 1.1 percentage points for OCM patients who died, which led to a relative reduction in total episode payments of \$539, for deceased beneficiaries. Avoiding hospitalizations is considered positive and a sign of possible improved quality, because it may indicate better quality of life for the patient near the end of life.

While there was little change overall in quality and utilization, there was a shift toward higher-value use of supportive care drugs. For example, OCM episodes had higher-value

¹Low-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.

²Information on MEOS and PBP for PP five were not available in sufficient time for inclusion in this report, therefore net savings calculations are based on four PP.

patterns of drugs used to prevent neutropenia and cancer-related bone fractures. In patient surveys, patients continued to rate care experience highly in both the OCM and comparison groups. The OCM evaluation report draws conclusions that help us to understand overall cost and utilization patterns in OCM. Based on model data, the evaluation report, and input from stakeholders, methodological refinements were implemented mid-course such as restructuring the baseline beginning in PP3. The results are also helpful in planning 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 \$151/episode (exclusive of MEOS and PBP). Since the average cost of a low-risk episode in the baseline was only \$7,200, there are fewer 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 low-risk 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 total cost of care responsibility in any future oncology models.

- **Enhanced Payments:** While the evaluation report showed promising impacts on Medicare payments, to date, these reductions have not been sufficient to cover the MEOS payments and PBPs paid out under the model, and the model has resulted in net losses to Medicare over the first four 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 service payments in any potential future oncology model, and if so, the appropriate level of model payment for such services.

- **Quality and Utilization:** OCM practices have reported improvements in management of care for OCM beneficiaries. While the majority of quality and utilization measures remain unchanged, we see positive shifts toward higher value supportive care drug use and slight improvements in avoiding hospitalizations near the end of life. 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 in November 2019. 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, and lessons learned from the COVID-19 pandemic to determine the best design for a potential future oncology model.