Evaluation of the Oncology Care Model
Performance Periods 1–6

Executive Summary

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

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Model Background and Evaluation

In February 2015, the Centers for Medicare & Medicaid Services (CMS) invited oncology physician group practices to participate in the Oncology Care Model (OCM), an alternative payment model based on six-month episodes for cancer care. OCM tests whether financial incentives can improve quality and reduce Medicare spending. OCM applies to Medicare fee-for-service (FFS) beneficiaries with any type of cancer who are undergoing chemotherapy treatment. The Model, launched on July 1, 2016, combines attributes of medical homes (patient-centeredness, care coordination, accessibility, evidence-based guidelines, and continuous quality improvement) with financial incentives for providing services efficiently and with high quality.

OCM features a two-pronged financial incentive strategy. Practices can bill for additional money on a monthly basis to support care improvements. Specifically, participating practices may bill Medicare a $160 Monthly Enhanced Oncology Service (MEOS) fee for FFS Medicare beneficiaries, which is intended to support the practice in providing enhanced oncology services such as increased access to timely ambulatory care, and patient navigation.

Practices can also earn money in the form of retrospective performance-based payments (PBP) if they are able to meet Model cost and quality goals. Participating OCM practices are paid under Medicare's FFS billing rules, then CMS combines all Medicare-covered services that their chemotherapy patients receive into six-month episodes. If practices meet performance quality goals, they can receive a PBP that CMS calculates by comparing all expenditures during an episode (including MEOS payments) to risk-adjusted historical benchmarks, minus a discount that CMS retains.

Some Key Acronyms in This Report

PP: Performance Period. Episodes that start during a six-month window. This report discusses impacts in the first six PPs (episodes starting 7/1/16 through 7/1/19).

TEP: Total Episode Payments. Per-episode calculation that does not include MEOS, performance incentives, or beneficiary copays.

MEOS: Monthly Enhanced Oncology Services payment. The additional $160 per-beneficiary monthly fee that participating practices may bill for to help support their transformation efforts.

PBP: Performance-based payments. Incentive payments that participants are able to earn based on their success in reducing expenditures.

The OCM evaluation uses mixed methods, integrating comprehensive quantitative and qualitative data analyses based on Medicare administrative data and claims, patient surveys, case study interviews, and other inputs.

The First Annual Report from the Evaluation of the Oncology Care Model: Baseline Period explained the construction of the evaluation comparison group, and described the trends during a multi-year baseline period for both the OCM and comparison groups. The Evaluation of the Oncology Care Model: Performance Periods 1–5 assessed care delivery changes and model impacts through Performance Period 5 (PP5), covering episodes that began between July 1, 2016 and January 1, 2019 and had ended by June 30, 2019.

Performance Period 6 (PP6) is the last full performance period of episodes that ended prior to the start of the COVID-19 public health emergency in early 2020. As such, it is the last period before the COVID public health emergency for which we can assess the cumulative impact of the OCM model. This Evaluation of the Oncology Care Model: PP1–6 report adds one additional PP to those in our prior report, and addresses model impacts through the sixth PP (including episodes that began between July 1, 2016 and July 1, 2019, all of which had ended by December 31, 2019). This report focuses only on episode payments and net savings/losses for Medicare, and is essentially an addendum to our PP1–PP5 report to update payment-related model impacts for the pre-COVID Model years. This report does not address utilization of services or impacts of the Model on quality or delivery of care, end-of-life care, or patient care experiences. At the end of PP6, 173 practices were actively participating in the Model.

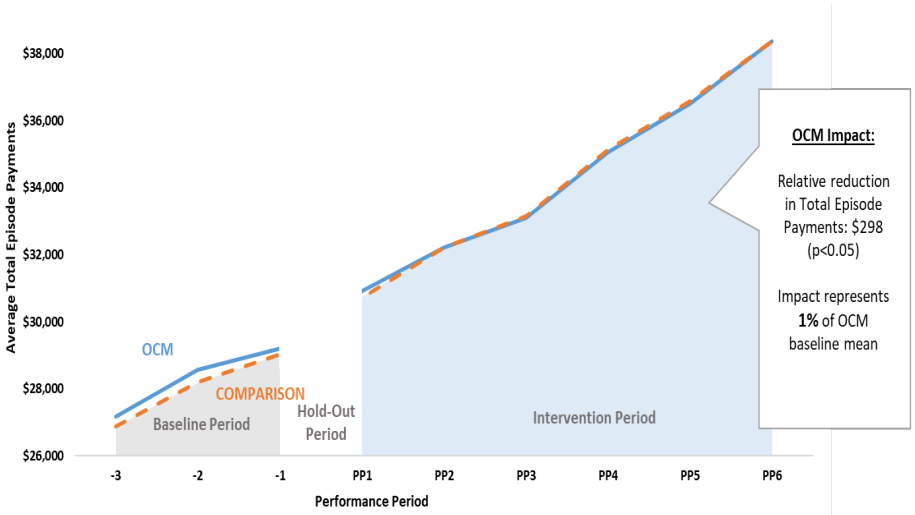
Using six-month episodes attributed to practices, the OCM evaluation measures the impact of OCM by comparing OCM episodes with episodes from a matched comparison group of oncology physician practices that are not participating in the Model. Medicare payments are referred to as Total Episode Payments, or TEP, in this report. In both OCM and comparison episodes, TEP rose from about $28,500 at baseline (before OCM began) to an average of $34,00 over PP1–PP6. This report addresses whether that increase differed among OCM and comparison episodes; whether OCM had differential impacts on payments for certain types of cancer episodes; and how the impact of OCM varied by Medicare Coverage Part and payment component. This report quantifies the savings or losses to Medicare when adding MEOS payments and PBP to the estimated impact on episode payments.

Key Evaluation Findings

The OCM impact was small relative to the rapid increase in payments.

OCM reduced Total Episode Payment (TEP) by $298 (p<0.05) relative to comparison episodes. This finding is nearly identical with results in the Evaluation Report for PP1–PP5 . TEP increased substantially in both OCM and comparison episodes, but slightly less in OCM episodes. While this difference was statistically significant, it was small, representing approximately 1 percent of baseline episode payments.

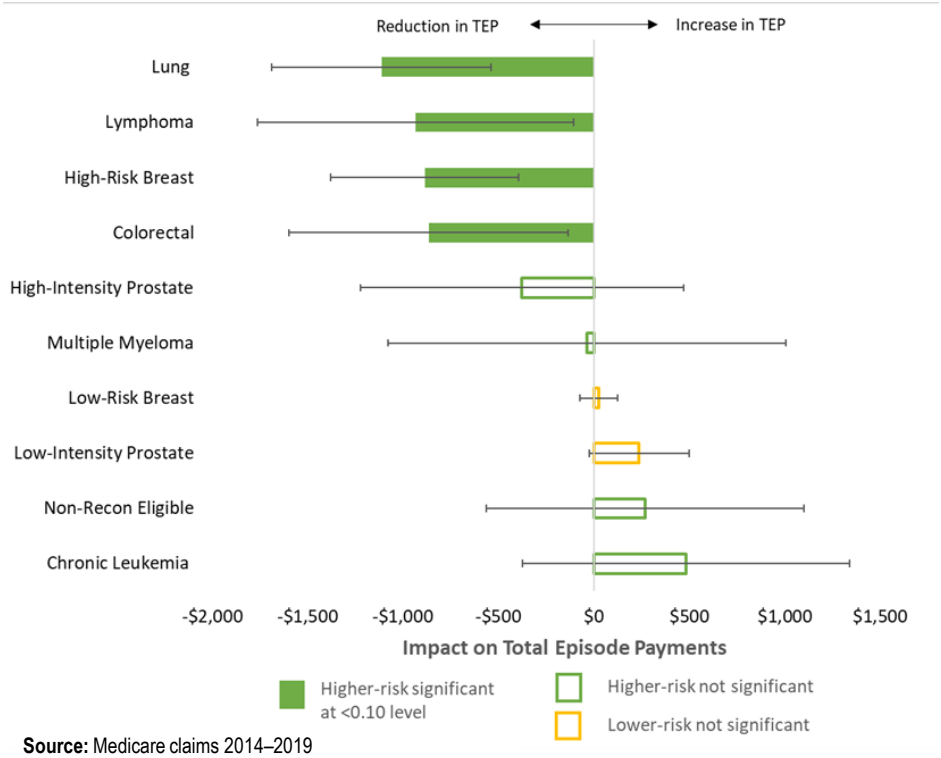
TEP rose by nearly 20% from the baseline to intervention period, but by only 1 % less among OCM episodes



Source: Medicare claims 2014–2019

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

Four high risk cancers driving overall impacts

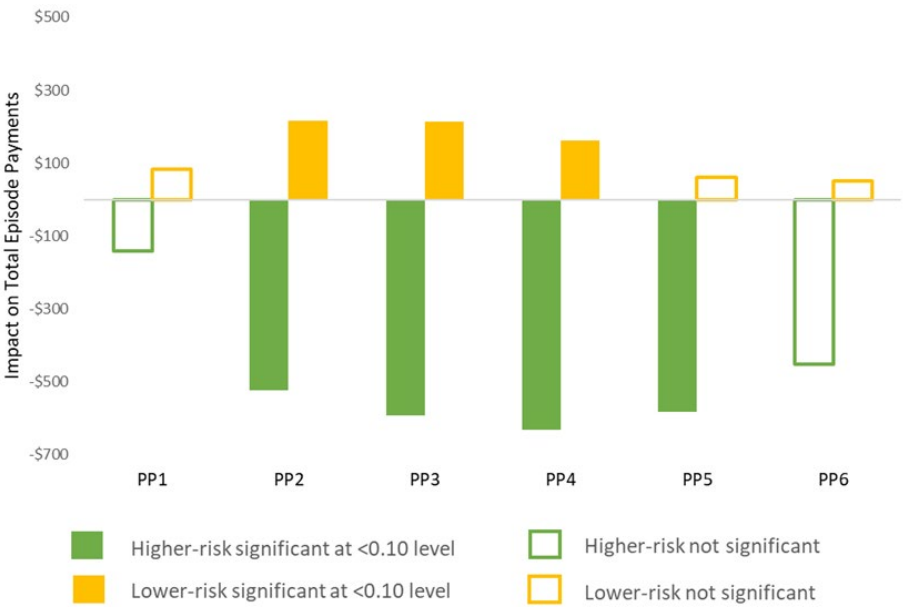


Source: Medicare claims 2014–2019

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***.

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

Impact for higher-risk episodes no longer significant in PP6

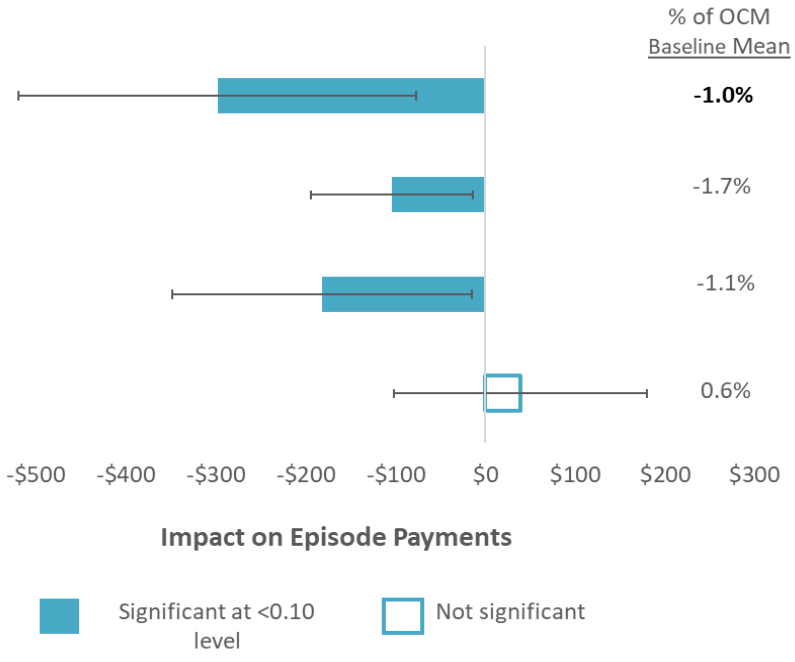


Source: Medicare claims 2014–2019
Notes: PP: Performance period.

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.

There were OCM Impacts in Part A and B payments but not in Part D.

Relative reductions in TEP were driven by Part A and B payments

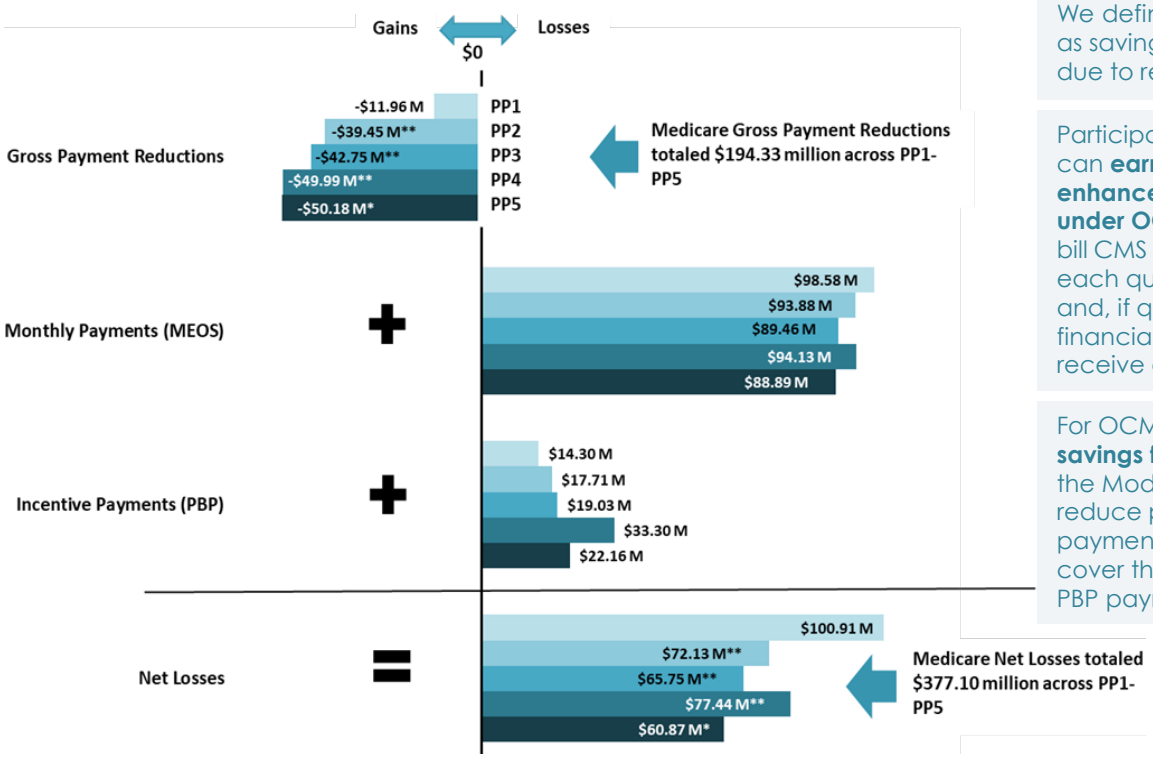


Source: Medicare claims 2014–2019

For higher-risk episodes, OCM was responsible for a relative reduction in both Medicare Part A and Part B payments but had no impact on Part D payments (similar to findings from previous PPs). The relative reduction in per-episode payments due to OCM was $185 for Medicare Part A services (e.g., hospitalizations, institutional post-acute care), and $294 for Part B payments (e.g., physician's services, drugs administered to patients in outpatient settings). The relative reduction in Part B payments for higher-risk episodes was mainly due to non-chemotherapy drugs, many of which are supportive care drugs used to prevent toxic side effects of chemotherapy such as infection, nausea, and bone damage. OCM had no statistically significant impact on Part D episode payments.

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.

The combined MEOS and PBP payments for the first five PPs were greater than the small gross reduction in TEP, resulting in significant net losses to Medicare ranging from $61M to $101M in each PP. 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. If per-episode payments do not decline enough to cover these Model payments (i.e., if OCM does not constrain TEP increases), OCM will result in net losses for Medicare.

Reductions in TEP consistently increased in absolute magnitude from PP1 through PP5. Net losses correspondingly decreased over time, with the exception of PP4. In PP4, more practices qualified for a PBP, and average payments were larger than in any of the other PPs.

Conclusion

Total episode payments rose steeply in both OCM and comparison episodes, from about $28,500 before OCM began, to an average of $34,000 during PP1–PP6. Against that backdrop of rapidly rising average payments, OCM reduced TEP by $298 relative to TEP in comparison episodes (1 percent).

The findings in this report are consistent with those in the prior evaluation reports: OCM created small relative reductions in TEP. However, payments for MEOS and PBP far exceeded these relative reductions, resulting in significant net losses for Medicare. The relative reduction in TEP was $300-$400 per episode across PP2-6 and the impact on TEP was statistically significant in PP 2-5 but no longer statistically significant in PP6.

The impact of OCM on TEP varied considerably across the different cancer episode types. As in prior periods, TEP increased for lower-risk cancer episodes and decreased for higher-risk cancer episodes. Four cancer episode types – lung cancer, lymphoma, high-risk breast cancer, and colorectal cancer – were chiefly responsible for OCM's reduction in TEP. With the exception of lymphoma, reductions in TEP for these cancers were driven by reductions in Part B payments, particularly payments for non-chemotherapy drugs, many which consist of supportive care medications used to manage side effects of chemotherapy treatment. OCM had no impact on payments for Part B chemotherapy drugs or Part D drugs, which collectively represented about 50 percent of TEP.

With the inclusion of one additional PP of data, the cumulative impact of OCM estimated in this report is very similar to that reported in the previous Evaluation Report for PP1–PP5. Through PP6, OCM led to a small reduction in TEP, but the reduction was more than offset by spending on MEOS and PBP, resulting in significant net losses for Medicare.

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