

Optimal Oncology Alternative Payment Models

October 2020

APMs

Summary of Themes

Critical lessons from the OCM and beyond to shape the future of oncology payment reform

As details on the Center for Medicare & Medicaid Innovation's (CMMI) new Oncology Care First (OCF) model remain undecided, participants of the oncology alternative payment models (APMs) advisory council met in October 2020 to take stock of new data and recent analyses from oncology payment reform experiments. The overarching aim of the meeting was to assess whether meaningful, longer-term findings are emerging from early evaluations and explorations in this space.

To this end, council participants discussed recent lessons and anticipated trends from the Oncology Care Model (OCM); insights and lessons from models outside of the OCM; and the possibility of producing a council publication to share these insights. Throughout the course of the meeting, participants emphasized that defining the optimal cost components for which a practice should be held accountable remains a fundamental challenge across models.

This Summary of Themes provides a brief overview of the meeting. For a full list of meeting participants, please see the appendix on page 6.

Early evaluations indicate limited OCM impact; long-term data shows more promise, but with caveats

In July, CMMI posted an evaluation of the OCM's performance periods (PP) 1-3, which covered the second half of 2016 and 2017, and largely concluded that the program had not yielded significant impact on cost—it reported net losses for Medicare—nor meaningful reductions in utilization, such as reducing emergency department visits and acute care.¹ During the October council meeting, experts presented data that forecasted whether trends discussed in the evaluation report will be sustained in more recent performance periods. Early data suggests that over the long term, OCM participants may fare better than the control group used in CMMI's formal evaluation of the program, albeit with several caveats and complexities to consider:

- **Emerging data shows that OCM practice performance meaningfully diverges from the national control group in more recent performance periods; two-sided risk may be influencing this trend.** OCM participants started the program with a higher risk-adjusted four-quarter average spend than the control group. As experts discussed at the meeting,

this gap remains through PP3 but closes in PP4, *“indicating that the control group had more of an increase in spending than OCM participants.”* Furthermore, data suggest that in PP8, spending by non-OCM practices starts to meaningfully increase when compared with OCM practices, signaling that OCM practices may have better success in bending the cost curve over time. One expert underscored that this divergence coincides with the introduction of two-sided risk. To gain clarity on whether the introduction of two-sided risk is influencing the PP8 divergence, some emphasized that the impact of two-sided risk on the OCM needs to be a critical focus area of future evaluation reports by CMMI.

- **More-granular cancer diagnoses and classifications are critical for understanding the drivers and potential complications behind the OCM’s emerging trends.** Participants have previously discussed the need to appropriately capture the granularity of a patient’s diagnosis.² During the October meeting, some suggested that the lack of granularity in the OCM’s payment methodology may create challenges for evaluating the model and drawing high-level conclusions about its trends. This is illustrated by, in an example a participant described, increased spending for low-risk prostate cancer in OCM participants. A portion of this increase can be linked to immunotherapies delivered to patients with castrate-resistant prostate cancer, which was *“sometimes being categorized as high risk and sometimes being categorized as low risk,”* depending on whether chemotherapy was ordered for the patient. Some non-chemotherapy agents can still carry high costs, experts noted; therefore, as one said, *“this is something that needs to be accounted for when making summaries about a low-risk cancer type such as prostate cancer having an increase in spending.”* The expert noted that there may be a need to adjust this categorization. In a similar vein, a participant described the impact of a simplified trend factor and risk adjustment methodology on the model, noting that they were interested to see how OCM performance data might change once metastatic disease at diagnosis is introduced for risk adjustment in PP7.

“In OCM, a single trend factor is used across all cancer types, and that can really mask some of the — meaningful changes that might be going on at the cancer level.”

—Subject matter expert

Emerging data is clarifying drivers of cost and variation in models

Given the complexities noted above, payers and clinicians alike are focused on understanding the drivers behind spending trends and elements that may cause volatility and variation, particularly for APMs where providers are at risk for controlling costs. Within this focus, the cost of novel and supportive therapies is frequently top of mind, as illustrated in the October meeting. For participants, drugs continue to have an outsized impact on performance and outcomes in the OCM; however, to the surprise of some, their role in the commercial space may be less pronounced.

Data thus far signals that drugs play a central role in practices' performance and outcomes in OCM

During a discussion of anticipated trends following PP3, some participants extrapolated that in more recent performance periods, Part D increases will continue to offset decreasing Part A payments as the model evolves, as was discussed in the 2020 evaluation report.³ Some participants presented data suggesting that the introduction of novel therapies at certain points of time can significantly influence payment trends for specific cancer types, which prompts questions for some participants on whether OCM's novel therapy adjustment is sufficient as currently designed. Some stressed that OCM cohorts that demonstrated strong performance employed cost-saving strategies such as greater use of biosimilars. One participant commented on these trends: *"My continued and growing concern is that the OCM model has really become and will increasingly become a drug model only, such that any real changes in inpatient, emergency-room, and end-of-life care will be dwarfed by drug spending—which leads to the question, Are drugs overweighted in the model?"*

Including drugs in a model for commercial populations may not significantly impact volatility and risk

As has been raised in past meetings, some health systems may be deterred from entering an oncology APM thinking that the cost of drugs would erode savings achieved from other interventions and potentially increase the actuarial risk associated with "unlucky" high-cost patients. Researchers have demonstrated, however, that while drug spending is harder to predict at the individual patient level, including drugs within an APM actually reduces overall spending variation at the practice level when costs are viewed on a percentage basis—that is, as a fraction of a pool of money.

The effect can depend on the size of the practice. As one participant noted, when considering the overall volatility of a model in a large practice, *"it doesn't really make a big difference whether we include or exclude drugs."* In small practices, researchers found that including drugs reduces relative risk, given that the pool of potential costs expands, although it will not reduce absolute risk for experiencing "unlucky" high-cost, outlier episodes. However, payers and providers may be able to mitigate the latter through various incentives and provisions in contracts, such as modifying the eligible amount of shared savings.

Payers and providers are focusing on building trust and finding mutual benefits in commercial APMs

In past meetings, participants have agreed that to advance APMs, *"more large-scale models need to exist to engage diverse practices and institutions,"* and that *"one big national model, no matter how brilliant, cannot work for everyone."* Commercial payers are working to fill that void and are partnering with practices to gradually gain comfort in the process of

implementing performance-oriented models. The following lessons emerged as payers and providers discussed early outcomes in this space:

- **Payers will benefit from being proactive and inclusive, though this may require considerable investment.** One participant said, *“Practices have demonstrated different levels of engagement with, and investments in, the people, processes, and technology to improve patient care”*; therefore, commercial payers must meet them where they are to pilot and scale APMs. One payer discussed a recent pivot within her institution to engage with smaller practices that did not meet their original criteria for eligibility but still wanted to pursue an APM. She discussed how the investment in these groups, via assistance with chart reviews, data transfers, and the like, succeeded and ultimately helped to improve care for their members: *“We offered these groups an opportunity to gain the experience within the value-based program that otherwise was not offered to them, and I can tell you, the engagement, the excitement, their willingness to meet with us on a regular basis far exceeds some of the larger groups in other programs.”* Furthermore, even larger practices appreciate payers’ support on factors ranging from reducing administrative burden to clarifying patient eligibility: *“You have to start somewhere; getting providers involved in a nonthreatening way is the way you to start to make a shift. Any way a payer can help augment our data, especially to better understand total costs of care, is important to us.”*
- **Commercial models do not shy away from incenting cost-saving, but many are focusing on cost measures that providers can control.** One payer shared an example of how her institution is approaching this principle. Although the model’s cost-saving metrics include inpatient and emergency-room utilization, only *“immunotherapy, biologics, chemotherapies, support agents, and any other drugs that the oncologist ordered”* were included as part of the model, a distinction from a total cost of care approach that holds practices accountable for all costs during an episode, including those that are unrelated to cancer treatment.⁴ Payer participants also advocated for the need for precise risk and novel therapy related adjustments to ensure practices are not penalized for factors that are out of their control.
- **Models aim to foster year-over-year cost and quality improvement by practices, but this will get more difficult over time.** Many payers’ efforts to establish APMs remain nascent, and they are iterating on their programs based on shared experiences with clinicians. Some programs have demonstrated early successes, with most participating practices showing improvements in cost of care and quality metrics. Some have cautioned, however, that because practices’ baseline measurements are reset each year, results *“in year one are probably more evident than if you continue on from there ... year over year, it gets more difficult to have improvement in cost of care.”* As has been discussed in earlier meetings, comparing practices’ performance to regional benchmarks rather than their historical performance may be an alternative to consider in the future.⁵

Council enthusiastically supports developing a publication evaluating lessons learned outside of the OCM

As plans for an OCM successor model remain in flux, many participants see value in leveraging the council's insights to develop a publication focusing on major lessons from models not driven by CMMI in order to progress discussions of oncology APMs and assess possible levers for innovation. The following themes emerged around the rationale and scope for such a publication:

- **The performance of oncology payment reform approaches outside of the OCM is an untapped white space.** Historically, commercial payers were less apt to share information on conceptual programs or programs in progress given the potentially proprietary nature of the information. As such, it is difficult for stakeholders in the space *“to get real information about how common these models are and what people are doing.”* Participants, including payers, believe it would now be worthwhile to pause and take stock of what payers outside of CMMI are doing and understand at a high level how they are tackling challenges. Many recognized that in addition to understanding what is working well, there is also inherent value in learning about approaches that did not work, because of the large information gap.
- **There is agreement that such a publication should be qualitative, focusing on relevant comparison factors.** A collective publication could be developed more seamlessly if it focused on qualitative lessons rather than quantitative analyses, participants agreed. They suggested proposing clear frameworks with which to assess and compare experiments to date. For example, one proposed anchoring the publication around a core five or six clearly defined elements of APMs (e.g., level of risk, pathway-driven care, risk stratification, predictive modeling) and comparing commercial APM case studies with one another based on these elements. Other framework suggestions included analysis of participation by practice type (e.g., hospital vs. independent, large practice vs. small practice) or identifying “success” factors from both a provider and payer perspective.
- **Potential value in reassessing what commercial APMs are designed to accomplish.** One question that was posed throughout the meeting was whether the “optimal APM” is designed around incenting behavior changes or enhancing predictability and narrowed variances. As such, one participant challenged the group to use the potential publication to first tackle *“the question of what we are trying to achieve”* and then evaluate commercial APM performance through that lens, noting that both behavior change and predictability are important and *“can change uptake and enthusiasm for the models from a payer and provider standpoint.”*

“There are so few of these publications. Right now we have Barbara McAneny’s Come Home effort and Lee Newcomer’s publication and that’s it. Having more lessons would be key.”

—Subject matter expert

Conclusion

The events of 2020 have illustrated that, now more than ever, stakeholders need to work more constructively together to improve the US healthcare system, including in specialty areas like oncology. As one participant said, *“we’re reaching a point in our healthcare system where we need to figure out sustainable solutions, and the only way of accomplishing that is for us all to work across the entire ecosystem ... [all stakeholders need to] figure out how we can find that right balance of sustainability in terms of new innovation coming to market while also ensuring that we’re not creating barriers to patients receiving life-changing therapies.”*

In this spirit, the council will reconvene later in 2020 to advance next steps on the proposed publication and explore how diverse payers and providers can contribute meaningfully to advancing continuous learning on these topics.

About this document

This *Summary of Themes* reflects the use of a modified version of the Chatham House Rule whereby comments are not attributed to individuals, corporations, or institutions. Italicized quotations reflect comments made by participants before and during the meeting.

Tapestry Networks is a privately held professional-services firm. Its mission is to advance society's ability to govern and lead across the borders of sector, geography, and constituency. To do this, Tapestry forms multistakeholder collaborations that embrace the public and private sector, as well as civil society. The participants in these initiatives are leaders drawn from key stakeholder organizations who realize the status quo is neither desirable nor sustainable and are seeking a goal that transcends their own interests and benefits everyone. Tapestry has used this approach to address critical and complex challenges in corporate governance, financial services, and healthcare.

The views expressed in this document represent consolidated views of those who participated in discussions for the Optimal Oncology APMs initiative and are integrated with broader landscape analysis. This document is not intended to represent the particular policies or positions of the network's individual participants or their affiliated organizations. This material is prepared and copyrighted by Tapestry Networks with all rights reserved. It may be reproduced and redistributed, but only in its entirety, including all copyright and trademark legends. Tapestry Networks and the associated logo are trademarks of Tapestry Networks, Inc.

Appendix: Contributors

- **American Cancer Society:** William Cance, Chief Medical and Scientific Officer
- **American Society of Clinical Oncology:** Stephen S. Grubbs, Vice President, Clinical Affairs
- **Amgen:** Jennifer Norton, Vice President, Oncology Value & Access; Kathryn Phelps, Director, Strategic Planning & Operations, US Oncology Value & Access; Jennie Floyd, New Product Development Lead, Oncology Director, US Oncology Value & Access
- **Anthem:** Erin Smith, Director II, Payment Innovation
- **Archway Health:** Mah-Jabeen Soobader, Chief Analytics Officer; Keely Macmillan, SVP of Policy & Solutions Management
- **Blue Cross and Blue Shield of North Carolina:** David Johnson, Medical Director, Healthcare Strategy and Payment Transformation
- **Cigna:** Bhuvana Sagar, National Medical Executive
- **Community Oncology Alliance:** Bo Gamble, Director of Strategic Practice Initiatives
- **Dana-Farber Cancer Institute:** Anamika Chaudhuri, Director, Population Health Management & Finance
- **Humana:** Julie Royalty, National Director, Oncology and Laboratory Strategies
- **Milliman:** Pamela M. Pelizzari, Principal and Senior Healthcare Consultant
- **Moffitt Cancer Center:** Karen Fields, Medical Director, Clinical Pathways and Value-Based Cancer Care; Cindy Terrano, VP, Payer Strategies
- **New Mexico Oncology Hematology Consultants and New Mexico Cancer Center:** Barbara McAneny, Founding Partner/CEO (CEO/CMO, Innovative Oncology Business Solutions Inc.)
- **OneOncology:** Aaron Lyss, Director, Strategic Payor Relations
- **Pacific Business Group on Health:** Emma Hoo, Director, Pay for Value
- **Tapestry Networks:** Lindee Goh, Partner; Liz Shaughnessy, Senior Associate; Elena Brandano Birnbaum, Associate
- **University of Chicago Medicine:** Blase Polite, Associate Professor of Medicine, Deputy Section Chief for Clinical Operations, and Executive Medical Director for Cancer Accountable Care

Contributors contd.

- **UNC North Carolina Cancer Hospital Clinics:** Hanna K. Sanoff, Medical Director, also Associate Professor, Department of Medicine and Section Chief of GI Medical Oncology, UNC-Chapel Hill
- **University of North Carolina-Chapel Hill:** Luca Maini, Assistant Professor of Economics
- **University of Pennsylvania:** Ravi B. Parikh, Instructor in Medical Ethics and Health Policy and Staff Physician, Corporal Michael J. Crescenz VA Medical Center

Endnotes

¹ Andrea Hassol et al. *Evaluation of the Oncology Care Model: Performance Periods 1–3* (Rockville, MD: Abt Associates, May 2020), vii–viii.

² Oncology APMs Advisory Council, *Advancing Next-Generation Oncology Alternative Payment Models in the COVID-19 Era*, ViewPoints (Waltham, MA: Tapestry Networks, 2020), 6–9.

³ Hassol, *Evaluation of the Oncology Care Model: Performance Periods 1–3*, vi.

⁴ In contrast, in the OCM, practices are accountable for all Part A, B, and some Part D costs during an episode, even if they are unrelated to a patient’s cancer treatment. For discussion on this issue, see François de Brantes et al., “[Redesigning Oncology Care: A Look at CMS’ Proposed Oncology First Model](#),” *Health Affairs* (blog), December 19, 2019 and Christian A. Thomas et al., “[The Oncology Care Model: A Critique](#),” *American Society of Clinical Oncology Educational Book* 36 (May 19, 2016), e109–e114.

⁵ *The Way Forward for Alternative Payment Models in Oncology*, ViewPoints (Waltham, MA: Tapestry Networks, 2018), 18.