

# From OCM 1.0 to 2.0: Two Paths to Payment Reform



The original hypothesis of OCM was to design a model that focused on **what providers could directly control in oncology. Specifically, hospital admissions, ER use and related facility utilization.**

Prior to OCM, whether or not hospitalization/facility use could be decreased in oncology was very unclear given the severity and intensity of cancer. First priority area was to address hospitalization/facility utilization costs.

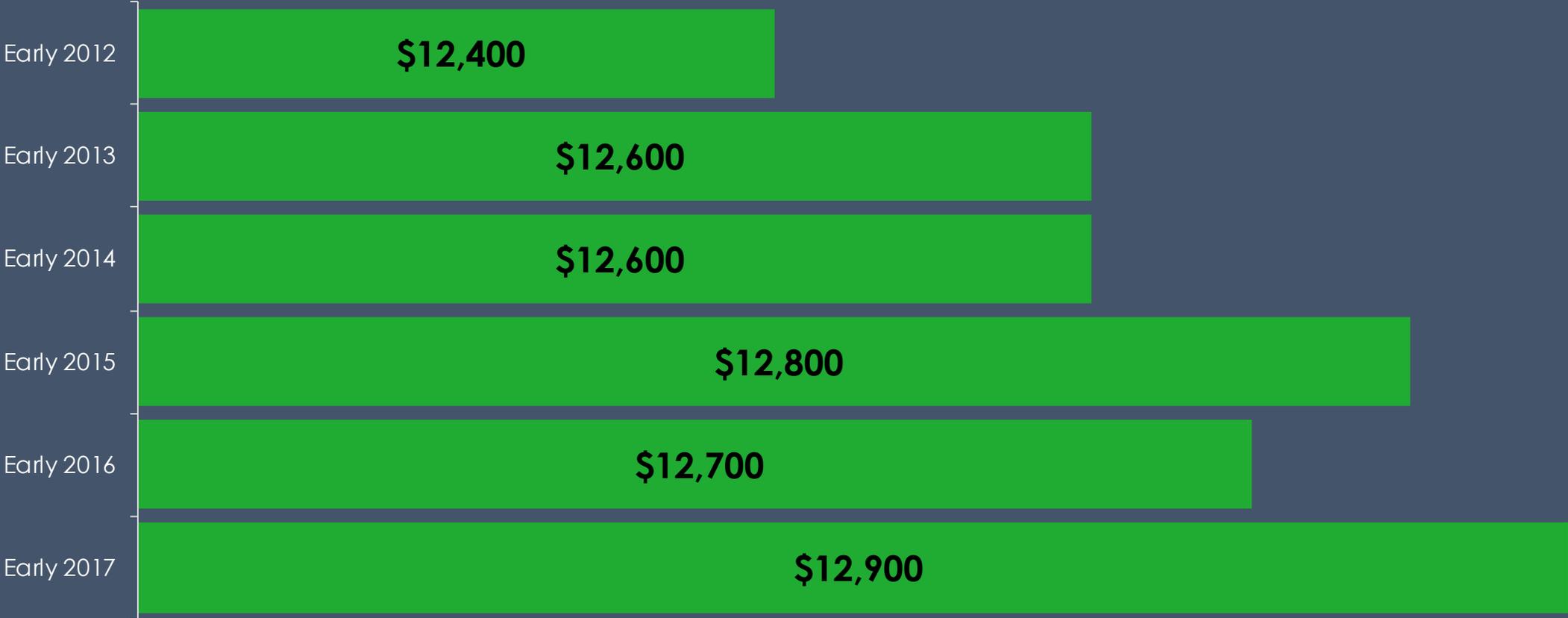


### ***What about drugs?***

OCM was not directly designed to be a drug pricing model.

Market/policy assumption, at the time, believed primary drivers of drug costs were related to inappropriate utilization.

Facility costs are largely stable and utilization is starting to trend downwards. The central hypothesis of OCM is proving true.

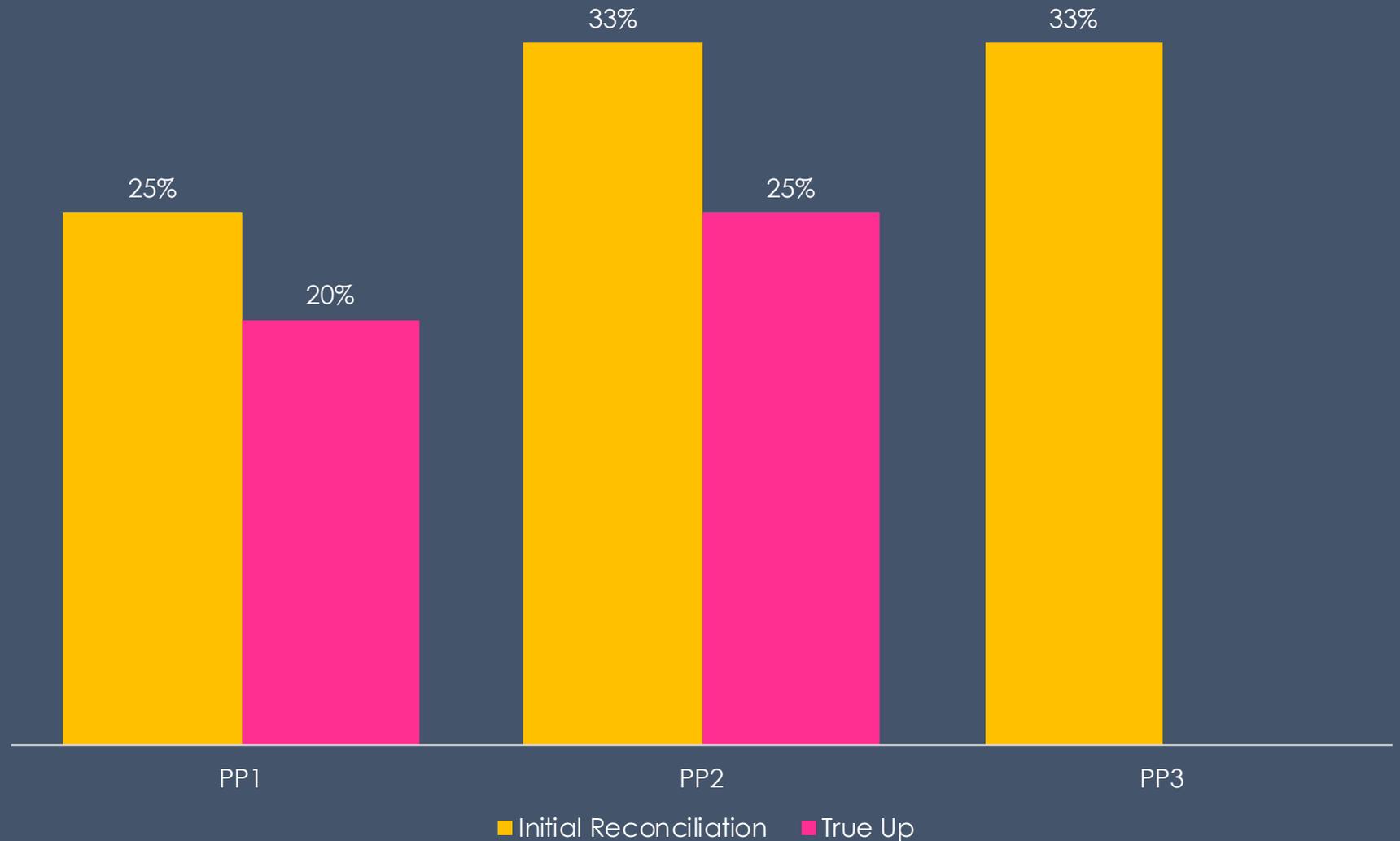


Cost Increases by Non Drug Costs  
(Largely Facility Utilization) 2012 - 2017

Despite the improvements in facility utilization and costs, many participants in OCM still aren't generating shared savings.

The percentage of practices that achieved shared savings from PP2 to PP3 did not increase. In addition, the number of practices from PP1 and PP2 that did achieve shared savings is decreasing through the true-up process.

Percentage of OCM Practices at or Below Target



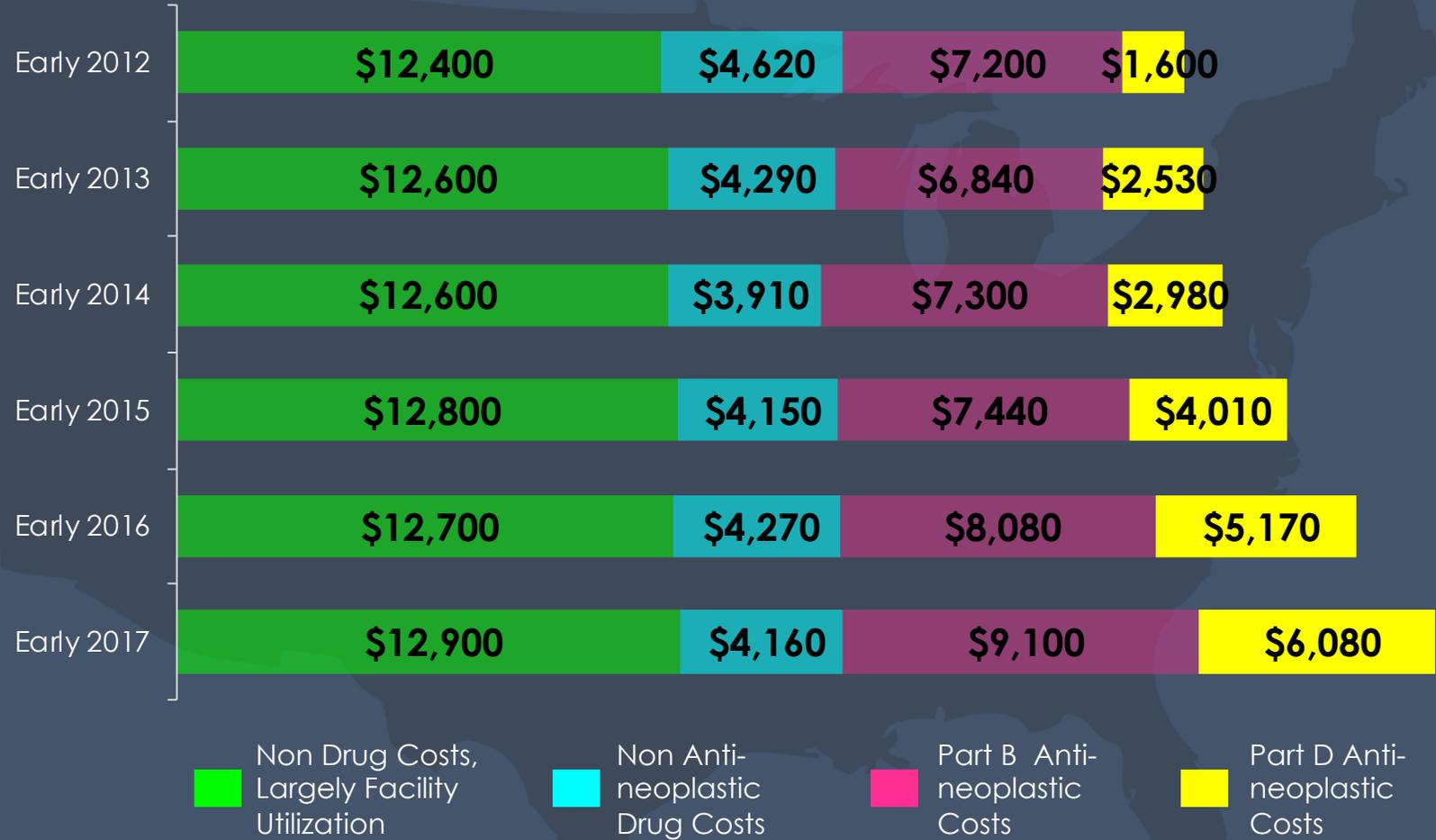
**280%** growth  
Part D

**26%** growth  
Part B

**4%** growth  
facility  
utilization

**-10%** growth  
Non anti-  
neoplastic drugs

*\*from 2012 - 2017*



Despite successful efforts to limit facility utilization and costs, oncologists have found themselves struggling to find success in OCM as a payment model due to rapidly rising drug costs.

Sources:  
\* Abt Associates, [Evaluation of the Oncology Care Model: Performance Period One](#), Dec. 2018  
\* Abt Associates, [First Annual Report from the Evaluation of the Oncology Care Model: Baseline Period](#), Feb. 2018;  
\* Tuple Health Analysis

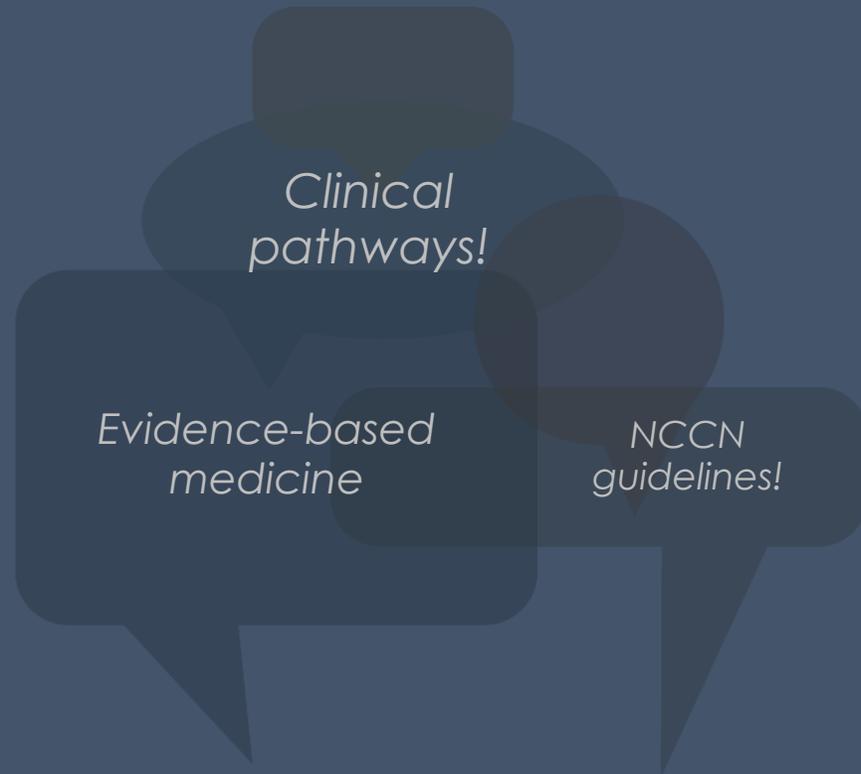
***What's the balance between utilization and cost? What can oncologists actually control?***

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Oncologists have adopted NCCN guidelines to inform treatment decisions on a large scale for the past several years.

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Physician decision making has become more standardized with the increase of guidelines such as NCCN.



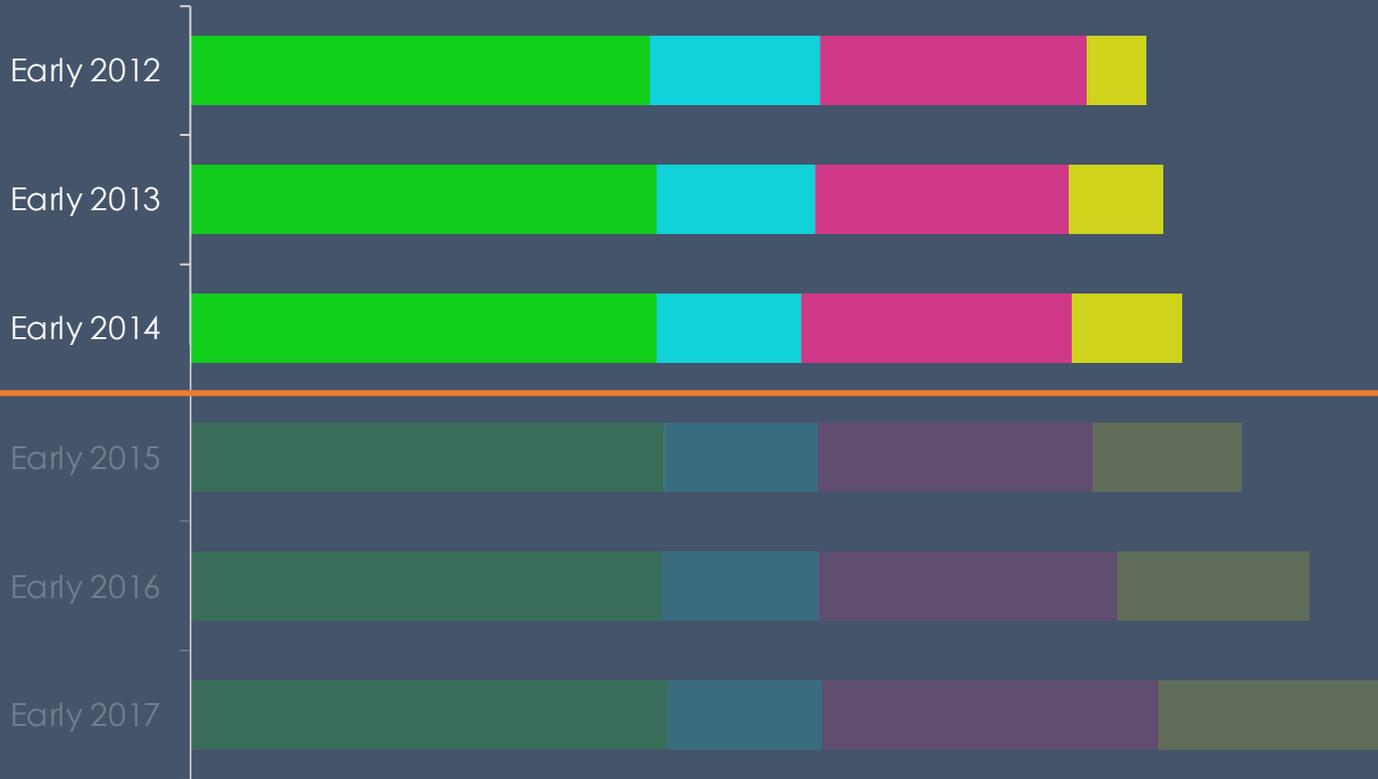
**Stuck between a rock and a hard place: OCM practices are controlling what they can control.**

Choice of drug is largely becoming standardized, but new indications and therapies continue to emerge. Practices feel they're being held accountable for something that they can't control – drug prices.



**How did we get here?**

Financial modeling for OCM 1.0 occurred in 2012 – 2014, before a rise in cancer treatment innovation (ex. Immunotherapies)



Cost Increases by Utilization Type, 2012 - 2017

■ Non Drug Costs, Largely Facility Utilization    
 ■ Non Anti-neoplastic Costs    
 ■ Part B Anti-neoplastic Costs    
 ■ Part D Anti-neoplastic Costs



Market dynamics and the introduction of new drug treatments creates significant barriers in accurately predicting the cost of drugs.



Unpredictable price increases for existing drugs



Patients are on expensive therapies longer and more lines of therapy



New drugs and treatments that have never been priced or financially modeled before



Existing drugs getting new FDA indications

CMMI tried to address drug prices by two main mechanisms in OCM:

## Novel Therapy Adjustment

- Accounts for above average use of novel drugs
- The policy is intended to reduce the risk of penalizing doctors who are prescribing a new drug

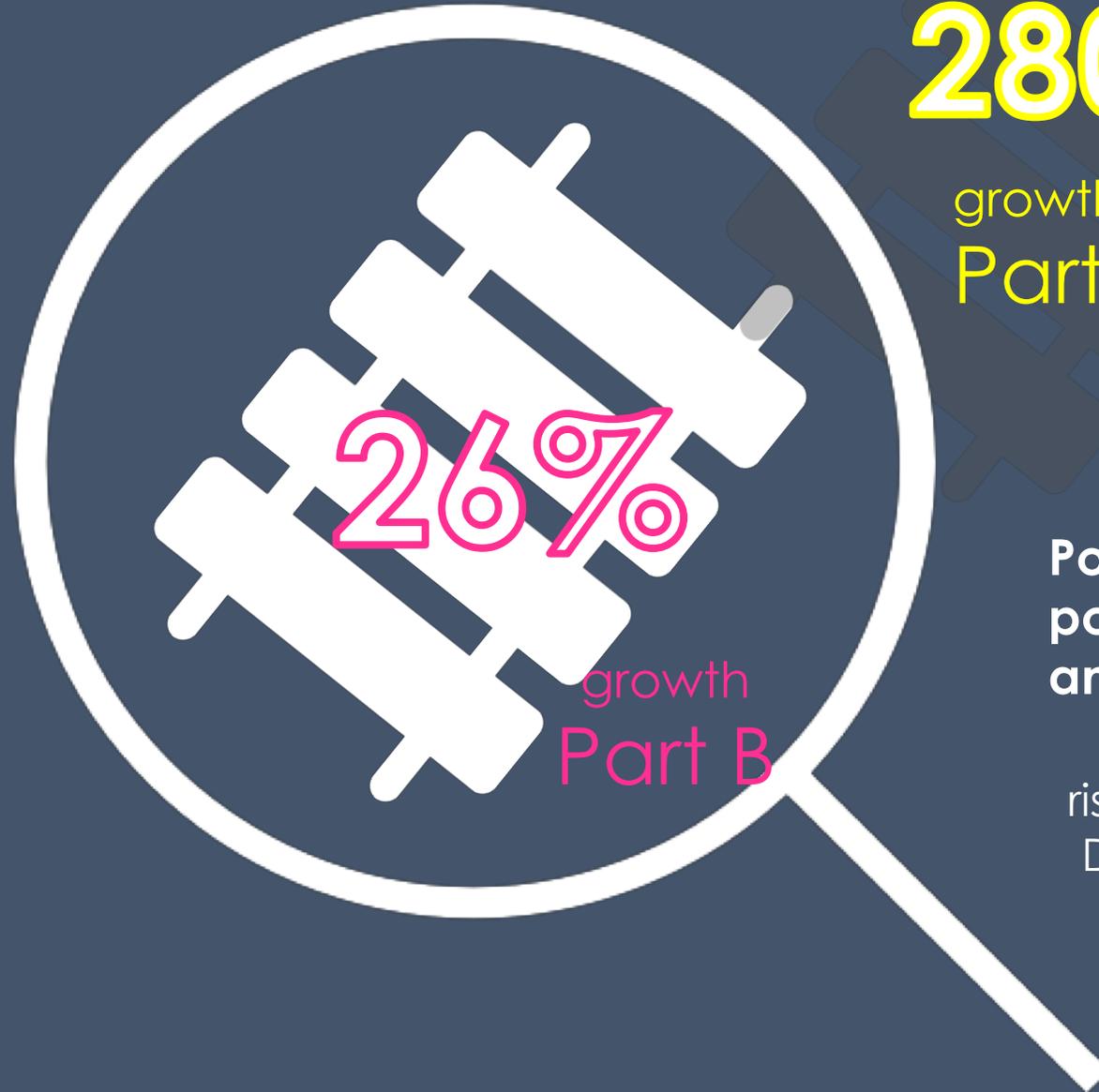


## Trend Factor

Medical cost inflation multiplier that is practice-specific



In an attempt to address some of these challenges and make physicians feel more accountable for the things that they can in principle control, CMS refined the methodology and calculations for two-sided risk, **putting more focus on Part B drugs.**



**280%**

growth  
Part D

**Potential misalignment of policy efforts inside OCM and outside OCM:**

Changing the exposure to risk between Part B and Part D drugs, particularly as cost growth in Part D is a key dynamic.

# Preparing for OCM 2.0

01

Evaluated key methodology components from OCM 1.0 to determine which should be adopted, improved, or discontinued in OCM 2.0.



02

Convened a meeting with practices to develop an outline for a universal oncology payment model that could be embraced by multiple payers.



03

Convened meetings with manufacturers to understand their role in value-based arrangements in oncology.



04

Continued development of the Oncology Medical Home program (with ASCO).



05

Developed OCM 2.0 model to continue the progress of OCM but with increased transparency & stakeholder engagement.

