



FROM 1.0 TO 2.0:

Charting a Path Forward for the Oncology Care Model

REFLECTIONS ON THE OCM AND DEFINING THE FUTURE OF VALUE-BASED CANCER CARE

The Oncology Care Model (OCM) is a Federal health reform program that aims to change the way cancer care in America is delivered. Its goal? To provide high quality, well-coordinated cancer care to patients while reducing costs for Medicare and beneficiaries.

Eager to be involved in the future of cancer care, nearly 200 practices, treating more than 150,000 Medicare beneficiaries, joined when the Center for Medicare and Medicaid Innovation (CMMI) launched the OCM in the spring of 2016.

As a longtime coordinator of oncology payment reform and recognizing the importance of the program, the Community Oncology Alliance (COA) has been helping practices succeed in the OCM since day one. Today, close to 80 percent of the OCM participants are in a peer-to-peer network that is hosted by COA. They have access to experts with deep knowledge of Federal and

private reform efforts, a private network of practices, regular calls to provide guidance on challenges, and numerous free tools and resources to help them thrive in the program.

At first, practices were enthusiastic about the OCM and its potential to improve quality while lowering costs. However, as it has moved forward, the complexity, challenges, efforts and resources have grown in intensity. This has left some oncologists questioning their involvement and even the overall future of the OCM program. From inefficiencies and technical challenges, to a lack of transparency and meaningful feedback, oncologists and practice administrators

interviewed for this report identified numerous concerns about the OCM – and had plenty of suggestions for its future.

COA has been listening and learning from the current OCM to understand and plan for the future. The result is a new framework of guidelines for evolving the program so that momentum is not lost and value-based care in oncology can succeed. Known as OCM 2.0, this universal model borrows and builds upon the OCM to provide a fundamental structure for the future of oncology payment reform.

“Community oncology practices have seen firsthand the problems that the increasing cost and complexity of cancer care the OCM is trying to address.”

From Fee-for-Service to Value-Based Payment: A Brief Recap of How and Why Oncology Got to the OCM

“Community oncology practices have seen firsthand the problems that the increasing cost and complexity of cancer care the OCM is trying to address,” explained Bruce Gould, MD, an oncologist and the medical director of Northwest Georgia Oncology Centers (NGOC), which has 21 physicians, 15 physician assistants and nurse practitioners, and eight infusion centers in Northwest Georgia. The practice has 1,500 patients in the OCM.

“As the frontline providers of care for the majority of Americans battling cancer,” explains Dr. Gould, who is also past president of COA and chair of the COA Oncology Payment Reform Committee. “Community oncology practices have been working with Medicare and private insurers to advance payment reform in cancer care for years.”

Indeed, NGOC is a payment reform pioneer, having participated in one of the first oncology payment reform pilot programs ever, the UnitedHealthcare’s Episode of Care Pilot in 2011. The three-year project tested an innovative approach to bundling payment for oncology services. This innovative spirit has been continued by community oncology practices in payment reform projects with Aetna, Anthem, Cigna, Horizon, Humana, and Priority, to name a few.

The OCM and many oncology payment reform projects can trace foundational elements to the patient-centered Oncology Medical Home (OMH) model that COA and community oncology practices created and continue to advance. The OMH model is a patient-focused system of delivering quality cancer care that is coordinated and efficient. It is designed to meet the needs of patients, payers, and providers.

In 2012, seven community oncology clinics participated in the first CMMI grant focused on specialty care, known as the Community Oncology Medical Home (COME HOME) project. This highly successful test of the medical home model of care delivery was for newly diagnosed or relapsed, Medicare insured patients with breast, lung, or colorectal cancer.

“As the saying goes, you need to either lead, follow, or get out of the way. Well, the extensive track record of community oncology in payment reform is a testament to the fact that we want to lead our practices and patients into the future,” says Dr. Gould. “This same spirit has stayed with us through the OCM, as we have learned from it, worked to overcome the challenges, and plan for the future.”

The OCM 1.0: A (Challenging) Foundation for Practice Transformation

Despite past experience with two value-based care contracts with other payers, Lalan Wilfong, MD, credits the OCM with making Texas Oncology, based in Dallas, Texas, take a step back and look at how they were delivering care. “We always say that we focus on patient care, and people always talk about it, but the OCM made us do it. Instead of just thinking we do it, we really did it,” he said.

Like many oncology practices, Texas Oncology’s physicians have a lot of autonomy in how they take care of patients, and with 175 sites of service across the state,

each has its own way of managing things. To begin the OCM transformation process to value-based care, Texas Oncology homed in on best practices. “Some sites were doing great things with patient education; some sites were doing great things with financial counseling. It helped us to really start looking at the whole continuum of cancer care and instilling best practices in every one of our locations,” said Dr. Wilfong, a hematologist/oncologist and Texas Oncology’s medical director of quality programs.

OCM practices receive support and incentives to improve the quality of care

through two mechanisms. First, practices receive a monthly enhanced oncology services (MEOS) payment of \$160 for the duration of each six-month chemotherapy episode, a fee that is intended to assist practices in managing and coordinating care for these patients, 24 hours a day, seven days a week. The payments have given practices the ability to hire patient care coordinators, patient navigators and social workers, and to offer financial counseling and depression screening.

Second, practices receive a performance-based payment for associated episodes of cancer care, which is the OCM's major financial incentive for practices to improve quality and reduce costs. Practices are eligible for this payment if they can demonstrate costs savings, as well as meet various quality metrics and performance measures that represent a higher level of care coordination or care management.

Practices are required to report on those quality and performance measures for each patient enrolled in the OCM, and one of the biggest concerns practices have about the OCM is the process by which they are required to provide that data. While the process to provide some of the data has been automated, much of it must be input manually through a web portal provided by CMMI.

DATA AND REPORTING REQUIREMENTS

A near universal challenge for OCM participants has been the data and reporting requirements. "I understand the need for the reporting requirements that they have," explains Sarah Cevallos, chief revenue cycle officer at Florida Cancer Specialists & Research Institute, "but there are just too many reporting requirements that we have to meet and align—we have the clinical data submission, the quality metric reporting, the cost reporting, and all these different things we need to do take resources and time away from patient care."

As one of the largest practices in the OCM, with 26,000 Medicare patients enrolled, "we'd love to electronically report," Cevallos

said. "It's been a lot of work that has really bogged us down and been eye-opening. We had an incredibly fast ramp up period at the beginning to get the infrastructure in place, hire staff, get our EMR set up, and more. That was very difficult to do, even for a large practice like ours – and it is ongoing. I am having to spend a lot of resources right now on data collection and reporting requirements."

Like Florida Cancer Specialists and other OCM practices, Northwest Medical Specialties, in Tacoma, Washington, has found the amount of data required, along with the data collection method, to be "extremely cumbersome." The practice's other value-based projects with heavy data reporting requirements have online portals through which the practice uploads data in aggregate form using a spreadsheet with appropriately labeled columns, according to Jeff Hunnicutt, Northwest Medical Specialties' chief operations officer. This is not the case with the OCM.

Instead, CMMI requires practices to log in to a portal and enter the quality metric data line by line for each patient. "There is no way to automate the process," Hunnicutt said.



“At first we were all very excited. I find that oncologists – almost all physicians, but oncologists in particular – are really motivated to provide the best care possible.”

With 700 patients now enrolled in the OCM, the manual entry of 15 to 16 data points on a regular basis for each patient is a time-consuming process. Another example is incompatibilities between the OCM web portal and the practice’s EMR vendors. For example, the EMR utilizes parentheses, whereas the OCM does not – so that something as fundamental to oncology care as the way the TNM Classification of Malignant Tumors (a standard notation system for cancer) is reported is not standard. Because of that, each patient’s TNM score must be input by practices manually.

The OCM data collection issue is especially frustrating for Northwest Medical Specialties, which has been collecting and analyzing data for almost eight years. “It has been extremely important for us to make sure that as much as possible of the work that we are doing can be measured inside of a structured field inside a database. If it is done that way, you can create custom reporting to be able to pull any of that information back out,” Hunnicutt said.

“If they want to be able to get data back from us, they have to provide us an avenue to be able to get them the data that is feasible. If they are not getting the data back from us, then the project is useless. It’s a five-year experiment that’s going to just put a little money in the practice’s pocket and is not going to do anything beyond that. While in the short-term it’s great for the practice, I think that it would be a tremendous failure overall. The practices that are involved want this to be a stepping stone to transform health care for oncology,” said Hunnicutt.

A CALL FOR MORE PRACTICE INPUT AND GUIDANCE

Natalie Dickson, MD, a practicing hematologist/oncologist, is the chief medical officer of Tennessee Oncology, based in Nashville, Tennessee. The 90-physician practice has 33 clinics throughout Midland and East Tennessee, and they have more than 3,000 patients in the OCM. She and her colleagues believed that by participating in the OCM during the volunteer time period,

they would be able to help develop the program in a way that advances care for their patients.

“At first we were all very excited. I find that oncologists – almost all physicians, but oncologists in particular – are really motivated to provide the best care possible. This was an opportunity for us to have support, to produce these great programs, to really impact our patients one on one,” Dr. Dickson said.

Tennessee Oncology soon realized that the program’s requirements – in particular, its focus on data collection and reporting – were diverting resources that should have gone to patient care. “The petals are beginning to fall off the rose,” Dr. Dickson said.

She has also been disappointed in her practice’s ability to influence the evolution of the OCM. Although the practice has been able to participate in small group sessions on some specific issues, and there has been some dialogue with CMMI, it is not to the extent that they, as early participants in the program, were led to believe they would have.

“We need to focus primarily on improving the quality of medicine we provide to our patients. In particular,” Dr. Dickson said, “I would like us to be able to focus on the practice redesign requirement for patient navigation, which can start even before we see the patient for the first time. It moves through the whole treatment course, survivorship and end of life.”

ARE WE USING THE RIGHT QUALITY MEASURES?

Dr. Dickson also wonders why the OCM is using the Institute of Medicine’s quality measures instead of one of the numerous quality programs that are already in place in oncology practices, such as Merit-based Incentive Payment System (MIPS) or Physician Quality Reporting System (PQRS). CMMI’s additions to the quality measures have made them “burdensome,” as well.

For example, the OCM measures that address timeliness require a patient’s date of diagnosis. For almost all EMR vendors,

the date of diagnosis defaults to the date of entry, which in the oncology practice is not necessarily when the patient had a biopsy, or the cancer was diagnosed. “For us to report on quality measures based on timeliness on the date of diagnosis, is going to be inaccurate,” Dr. Dickson pointed out.

Another example cited by Dr. Dickson involves prostate cancer, which in the United States is typically treated by urologists until the cancer becomes advanced, which may be many years later, and there are few other treatment options available. “When patients with advanced prostate cancer come to our practice, we do not have all the information from the time of their initial diagnosis. There is a quality measure that asks for this information we do not have,” Dr. Dickson said.

She stressed the need for CMMI to tailor the quality measures to the population of physicians participating in the OCM and to focus on relevant quality measures. “Choose those that are relevant to patient care and for which we can actually have a meaningful outcome if we change them,” Dr. Dickson said. “Pain management, depression screening and management – these are really important because they affect patient outcome. Simplify the quality measures and use things that we can make changes to and there will be a meaningful outcome for the patient.”

Dr. Gould of NCOG, shares the concerns about quality measures and the OCM’s use of the documented care plan covering the 13 components within the Institute of Medicine (IOM)’s Care Management Plan. While he believes many parts of the IOM’s 13-point care plan are important for the patient, such as the diagnosis, the prognosis, and the treatment plan, Dr. Gould is concerned about the requirement that calls for the patient to be provided with an estimate on the total cost of their care.

“Estimating the total cost of care is essentially taking wild guesses because we don’t have access to most of those costs. Their total cost of care would include

surgeries, radiation therapy, hospitalization visits, radiologic services, etc.,” stated Dr. Gould. “Very few of the numbers we could come up with will have any basis in reality or practical meaning to patients.”

What would be more meaningful, Dr. Gould said, would be if they could report to CMMI on how the practice helps patients navigate their insurance benefits and understand their out-of-pocket expenses, and, when a patient is unable to meet those out-of-pocket expenses, how the practice helped them find additional resources. “There are other ways of addressing the cost issue that really mean more to the patient than just giving them some random number for the total costs,” he said.

Other issues that require correction include hospice and clinical trials. Although there is an OCM quality measure that promotes hospice care, the MEOS payment stops when a patient is enrolled in hospice. Additionally, for many cancer patients, clinical trials offer a life-saving opportunity – and one for which the cancer care system struggles to recruit. However, the CMMI excludes patients participating in most pharmaceutical trials from participating in the OCM. They can only participate if they are in a National Cancer Institute sponsored trial.

Dr. Gould, is also concerned about the prescriptive nature of the program. As an example, he cited the program’s requirement for a pain management plan to be determined at the beginning of treatment.

“No one will argue that addressing the pain in a cancer patient is important. That’s clearly important and part of what we do,” Dr. Gould said. “On the other hand, writing a pain plan into the medical record is not how we practice medicine. It’s not realistic because the management of pain is an iterative process. The patient’s pain will wax and wane depending on what’s happening with their cancer, whether it’s getting better or worse, and how they respond to other interventions, such as pain medicines that they are placed on. Having one pain plan in the medical record is not appropriate.”

“Estimating the total cost of care is essentially taking wild guesses because we don’t have access to most of those costs.”



Neither is it realistic for a practice to then report back to CMMI how the patient's pain is managed when it is "scattered on progress notes throughout the patient's medical record," Dr. Gould said. "It's certainly not in a structured data field and therefore not easily reportable, yet we're expected to report on that."

THE NEED FOR MORE TIMELY AND MEANINGFUL FEEDBACK

On top of the challenges of providing CMMI with OCM data, practices are finding the reports they receive back from the OCM to be deficient as well. The format is not easily translated into clinically meaningful or actionable information – some practices have had to hire consultants to interpret the reports – nor are they receiving the data in a timely fashion. Furthermore, while the OCM feedback reports include information about the team's performance, they fail to provide feedback on the performance of individual physicians.

"The whole purpose is for continued improvement. The only way we can improve is with data, but the data has to be timely, so I can act on it. We need to get beneficiary level data in a timely manner, weekly preferably, daily if possible," Dr. Dickson said, noting that her practice has previously participated in pilot projects that have run for four to eight weeks. "You make changes and you re-measure. If I can't get access to data quickly, I don't know if I have made an improvement. They need to give us information that is actionable. That's not happening."

"The data that we get in has been a year to a year and a half behind the current performance period," Dr. Gould said. "We're expected to save Medicare money by the end of the fourth performance period, but we don't get our first cost reconciliation until the middle of the third performance period. So, we have three months to make interventions to try to improve our performance and if we don't, we get kicked out of the program."

Looking to the Future: Developing OCM 2.0

The OCM has forced the cancer community to rethink how they are providing care and to make changes that enhance the patient experience and treatment, but the tremendous challenges of participating has

left practices very concerned about its future as currently designed.

Ultimately, Cevallos of Florida Cancer Specialists agrees, the numerous value based projects that oncology practices are part of

need to be refined and winnowed down. “There are way too many payment reform projects that we are a part of. Forty percent of our patient population is in a value-based care initiative of some sort, whether it is the OCM or with commercial payers. There is no way we can keep up with all of these projects and the tremendous investment of time, energy, and resources that they take! Eventually, we as a community, will have to draw the line and focus on what works best for our patients and health care system.”

In an effort to start charting a path forward for oncology payment reform, COA has convened oncology stakeholders to discuss what the future might look like. This has included a research project interviewing stakeholders from every part of the cancer care system, including oncology practices, clinical care providers, payers (including non-profit payers), pharmaceutical and diagnostic companies, patient advocates, and OCM consultants and vendors.

The result is a universal value-based care model under development – not just for Medicare or CMMI but for commercial payors and employers – which is being called OCM 2.0.

The vision for OCM 2.0 is for a value-based model that evolves naturally, that uses universally accepted measures of improved quality and value, with a new transparent performance-based payment system, coordinated navigation for the patient among major care points, aligned with all stakeholders to improve quality and lower costs, and in which all components are patient centric with effectiveness determined by appropriate feedback systems.

Robert “Bo” Gamble, COA’s director of strategic practice initiatives, outlined some of OCM 2.0’s major components, which will include:

- **A care coordination fee** – In OCM, participating practices received a monthly MEOS payment to help cover the costs of transforming the practice to value-based care. COA believes the fee is essential

if oncology practices are to be a true medical home for patients with cancer.

- **Quality measures** – Measures need to exist, but oncologists want meaningful measures that can be collected electronically. COA wants the OCM 2.0 quality measures to be based on the categories of cancer care that are relevant, meaningful, and practical, such as the cancer patient is first priority; access to support from the practice is available 24 hours a day, seven days a week; all care is evidenced-based now and in the future; there is strong coordination with all of the teams that are supporting or treating the patient; and there is continuous and measurable quality improvement.
- **Risk adjustment** – Although there are limited types of cancer, each patient has their own set of comorbidities and complications, even when they have the same cancer and same stage for this cancer. The OCM 2.0 model will expand upon the existing OCM risk adjustment, consider the variations by patient, complications, new therapies and new indications for existing therapies. The original OCM allowed for the same variations but the methodology is very complex and not easily understood. The new model will simplify the approach to these differences to allow for the variations while also promoting high quality, efficient, appropriate care and minimizing unnecessary costs.
- **Shared savings, not gain sharing** – OCM practices begin by competing against themselves and then competing against each other for savings. OCM 2.0 would offer pure shared savings as practices would begin by competing against each other, and the calculations and necessary adjustments would be transparent to all. “Let’s level the playing field, let’s measure practices against all their peers and if you are doing better than your peers, you get the savings because you have set the bar for everyone else,” Gamble said.

The result is a universal value-based care model – not just for Medicare or CMMI but for commercial payors and employers, as well – under development, which is being called OCM 2.0.

COA believes CMMI needs to increase transparency regarding the performance-based payment methodology. Without clarity on how the payment is calculated, it is unlikely that practices will be willing to take on two-sided risk for shared savings, which, if the practice is successful, would potentially bring a higher percentage of shared savings to the practice. If practices had confidence in the risk methodology, they would be able to better assess their capacity to take on two-sided risk.

COA believes the problems with the OCM data reporting go beyond the volume and inefficiency of manual input. COA is concerned that CMMI's goal is to use the data for its clinical registry, which would then serve as the foundation for an oncology

bundle, an endeavor that COA says is beyond the mission of the OCM, and would merit an entirely different project. "While COA is not averse to bundling," said Ted Okon, executive director of COA, "the problem is that cancer is not singular – it's over 200 diseases. Even when you narrow it down to specific cancers like breast, there many iterations."

In OCM 2.0, the patient's enrollment would not be defined as a "six-month episode of chemotherapy," but rather would begin when the patient first sees an oncologist. "Treating cancer is a lot more than the drug. It's surgery, radiation, and then the drug – all working together. The OCM 2.0 will start when the oncologist takes over the patient's care instead of this narrow focus on building it around the drug experience," Okon said.

Iterative Progress Makes Perfect?

Okon described OCM 2.0 as simplifying the OCM, "making it about optimizing the treatment of the patient, and not just different mechanical changes that need to be made. We are not thinking that OCM 2.0 is the end point, there will be an OCM 3.0 and 4.0. We will evolve this logically," he added.

COA has created a standing Oncology Payment Reform Committee comprised of eight physician/administrator teams who will be charged with determining the quality measures that should be included, as well as the calculation behind the physician performance-based payments.

"We have spent a lot of time talking about how to provide practices with some flexibility and a sense of ownership, but we're holding fast to the principles of this model," Gamble said. "As we have seen

over the last five years, this is an evolving process and we all need to work together for continual improvements."

And if that doesn't sound ambitious enough, COA plans to begin discussing how to include pricing structures for drug therapies in the new model. "Everybody is scared to touch the issue. It's a big issue, no one knows how to handle it, we don't know how to handle it, but we know we have to talk about it, and we have to go after it aggressively," Gamble said. "We recognize that it's going to be a staged process. We can't come out of the gate with 'here's the answer to the drug pricing process', because that won't work. But, if we can begin talking about it, get people to implement ideas to help lower the pricing and increase the value, it will be far more productive."

"We are not thinking that OCM 2.0 is the end point, there will be an OCM 3.0 and 4.0. We will evolve this logically."

About the Community Oncology Alliance

The Community Oncology Alliance (COA) is a non-profit organization dedicated solely to preserving and protecting access to community cancer care, where the majority of Americans with cancer are treated. COA leads community cancer clinics in navigating an increasingly challenging environment to provide efficiencies, patient advocacy, and proactive solutions to Congress and policy makers. To learn more about COA visit www.CommunityOncology.org.

