

SPECIALTY PHARMACY NEWS

CMS's Oncology Care Model Has Issues, But Participants Say Care Has Improved

A little more than 14 months after CMS launched its Oncology Care Model (OCM) with 17 health insurers and 196 physician group practices, the experience seems to be mostly a positive one for participants. Although there have been a few challenges since the program's July 1, 2016, start (*SPN 7/16, p. 4*), participants agree that the model promotes high-quality care.

The five-year pilot, which was developed by the Center for Medicare & Medicaid Innovation (CMMI), is focused on providing better quality and more coordinated cancer care for Medicare fee-for-service (FFS) beneficiaries, as well as other payers, but at a lower cost. The OCM will reimburse providers for episodes of care in the administration of chemotherapy. "Nearly all cancers" are included in the initiative, which also allows beneficiaries to have 24-hour access to providers. Participants must "use therapies consistent with nationally recognized clinical guidelines," and CMS specifically mentions ones from the National Comprehensive Cancer Network (NCCN) and the American Society of Clinical Oncology (ASCO).

Payments to providers "include financial and performance accountability," says CMS, and OCM has a two-part payment system: (1) a per-beneficiary Monthly Enhanced Oncology Services (MEOS) payment of \$160 for an episode's duration for "effectively managing and coordinating care," and (2) a possible performance-based payment for episodes of care that "will incentivize practices to lower the total cost of care and improve care for beneficiaries during treatment episodes." The latter payment is available only for providers who care for people with "high-volume cancers for which it is possible to calculate reliable benchmarks." CMS estimates that these cancers cover about 90% of Medicare FFS beneficiaries who are undergoing chemotherapy.

Episodes of care are for six months starting with chemotherapy administration per a Part B claim or an initial chemotherapy claim under Part D and will include all Parts A and B services a beneficiary receives during that period of time, as well as some Part D costs. Subsequent episodes beyond the initial six months are possible as well when beneficiaries continue treatment beyond that period of time.

So how are participants assessing the OCM experience so far?

"Overall it's been very positive," says Roger Brito, D.O., national director for oncology at Aetna Inc. The insurer started an oncology medical home a couple of years ago

(*SPN 3/16, p. 1; 7/15, p. 1*), and that's the model on which it based its approach to the OCM. "When CMS saw our pilot program, it met all the criteria and more," he tells AIS Health. Aetna has 22 practices participating in its oncology medical home, and 21 of those are part of the OCM, says Brito. "The OCM is paralleling what we're doing with the oncology medical home."

According to Lalan Wilfong, M.D., medical director of quality programs for Texas Oncology and physician champion of value-based care for McKesson Specialty Health, "The experience with OCM has been mixed." On the plus side, he tells AIS Health, "The requirements of OCM have made our practice re-evaluate patient care, improve work flows and processes to enhance patient education and shared decision making, increase access to our clinics with urgent care visits and proactive nurse phone calls, evaluate patients' financial toxicity in a systematic fashion and overall focus our care more on the patient, all of which have served to enhance patient care." However, he maintains, "The reporting requirements have been a challenge" because they "take time away from patient-facing activities."

Karyn Dyehouse, M.D., chief medical officer of Oncology Hematology Care, a practice in The US Oncology Network, says the experience so far has been "very eye opening. This program looks at the delivery of care through a different lens. It is a care delivery system that is better quality and probably lower cost."

Working With CMMI Has Been 'Pretty Seamless'

And working with CMMI, says Brito, has "been pretty seamless." Similarly, says Wilfong, "I have enjoyed working with CMMI. I believe the goal of the CMMI team is truly to improve patient care." The team, he says, "has been responsive to our concerns and needs."

"The system they have developed for reporting is very cumbersome, but it sounds like they are willing to listen to feedback and make positive changes," Dyehouse tells AIS Health. She adds that there are "too many metrics to track given the current state of EHRs available."

Asked if the experience with the OCM has impacted how practices manage their non-Medicare patients, Marcus Neubauer, M.D., vice president and medical director of payer and clinical services for McKesson Specialty Health and The US Oncology Network, tells AIS Health that "some practices who have invested heavily in infrastructure for

the OCM (e.g., new staff, technology and work flows) are applying OCM principles to non-OCM patients. Others are still limiting transformative principles to the Medicare population."

"Texas Oncology made a decision at the beginning of the program to treat all of our patients the same," says Wilfong. "So all patients benefit from the enhanced services we provide." At Oncology Hematology Care, "We like the principles of the model so well, we have adopted the OCM approach for all of our patients," says Dyehouse.

Both Aetna's Medicare and commercial patients already were participating in its oncology medical home, says Brito. "Practices need to meet certain criteria" to be part of the oncology medical home — "providers must qualify" to participate, and then "providers choose members who are eligible" to be treated. Rather than providers considering only certain cancer types, they "look at all cancer patients."

All of the participants who spoke with AIS Health say they have made changes to their approach to the OCM since starting the pilot. At Aetna, "we've added more metrics than what was required," Brito says. Dyehouse reports that Oncology Hematology Care has made "a lot of changes. We have increased our care coordination activities. We have weekend care and same-day sick appointments. We launched a 'Call Us Early – Call Us First' campaign, as well as a five-nurse triage unit for ER avoidance. We have hired a number of mid-level providers and deployed financial counselors in all our offices. We have a long-standing tradition of patient navigation at OHC."

At Texas Oncology, "We initially focused on meeting the requirements of OCM," Wilfong says. "Although we still have work to do, we are now able to turn our focus more on actually improving patient care."

Data Reporting Has Been Challenging

Participants have encountered some speed bumps along the way, they tell AIS Health. "The reporting of data has been challenging," Dyehouse says. "Abstracting the data from the chart and sending to CMMI is very burdensome."

"One of our biggest challenges has been the workload created by OCM requirements," says Wilfong. "We have hired additional staffing, but need more. We have to ensure that funds are available to pay for all the additional staff we need. The other main challenge is buy-in from our physicians and staff. OCM significantly changes the way we care for patients. Change is difficult to accept. Many are still not sure that these changes improve patient care."

"Having the advantage of having the oncology medical home model in place" for a couple of years means that Aetna already had its feet wet before the OCM launched. A challenge has been to broaden the scope of the pilot so it's "involving more providers," says Brito — "getting the word out" that such an approach "makes sense. If I'm a patient,

I want to be treated" by a provider who is participating in such a model.

Asked about main takeaways so far, Wilfong responds that "Having access to the claims data from CMS has been extremely beneficial. Prior to this we only knew the care that happened in our clinic. Now, we have access to the continuum of care for our patients. This has helped us see where we can improve patient services to better align our care with patient needs."

According to Dyehouse, the OCM is "a great model that focuses on high-quality and low-cost delivery in the appropriate setting." However, it "has been a costly endeavor for the practice for which the MEOS payments does not cover. Hopefully we will achieve shared savings."

"The OCM is a difficult program for practices to implement and run while continuing with their core mission of providing quality patient care," says Neubauer. "Up-to-date technology is essential. Patients who are solely on oral medications are difficult to identify and track (when hundreds of patients have to be reviewed for program eligibility)." In addition, he tells AIS Health, "Practices that make a genuine effort to transform, learn from program data and document elements of the quality metrics in the EMR [i.e., electronic medical record] have the best chance of succeeding in the OCM."

"Measuring metrics and adhering to clinical pathways provide better cancer care," maintains Brito. "It's exciting that CMS and CMMI are finally working on metrics and clinical pathways and requiring adherence to the pathways."

With HHS's recent proposal to cancel the episode payment models and cardiac rehabilitation incentive payment model, could this potentially have any impact on the OCM?

"Yes, that worries me a lot," Wilfong says. "The increased revenue from MEOS payments helps pay for the practice transformation activities we have undertaken. If that money is lost, we would have to cut back the additional services we provide." Brito agrees that if such an approach is imposed on the OCM, and CMS takes away incentives for providers, that loss generally makes it hard to get people to participate.

"We know nothing is certain in the current administration," Neubauer says. "Even though there are efforts to change how health care is covered, I predict the OCM will survive the five-year term because it is designed to manage costs, and oncology care is very expensive, and costs are otherwise hard to control."

Ultimately, says Wilfong, "OCM has helped us refocus our efforts directly on patient care. The program is not perfect, and I hope moving forward we can continue to align payment models with improved patient care activities."

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