

# Optimal Oncology Alternative Payment Models

April 2021

APMs

Summary of Themes

## Taking stock of lessons to date from oncology alternative payment models

As the Biden administration carves out its approach to healthcare policy, some healthcare thought leaders are reflecting on the successes and failures of recent experiments in payment reform.<sup>1</sup> Voluntary alternative payment models (APMs) in a range of specialties have proliferated in recent years with mixed outcomes to date, including limited success in generating net savings.<sup>2</sup> This has prompted some influential bodies, such as the Medicare Payment Advisory Commission, to consider recommending that the Center for Medicare and Medicaid Innovation (CMMI) streamline its portfolio of APMs.<sup>3</sup> In oncology specifically, CMMI's Oncology Care Model (OCM) has undoubtedly yielded some impact, but it too has resulted in net losses for the Medicare program, and detailed plans for a successor program have yet to be announced.<sup>4</sup>

As Medicare's near-term plans for oncology payment reform remain uncertain, some stakeholders are looking to the commercial sector for insights to inform oncology APM design and good practices. Yet early lessons from commercial ventures in this space echo conclusions drawn from the OCM: challenges in design and implementation abound, and meaningful cost savings may be elusive in the short term.

Against this backdrop, participants of the oncology APMs advisory council reconvened in March 2021 for a pulse check on stakeholders' outlook for APMs in this specialty. While some participants were cautiously optimistic that APMs remain a viable tool to improve healthcare quality and sustainability, others reiterated concerns that APMs have yielded limited impact and questioned whether they can be effectively scaled. The council also met to refine lessons learned from commercial APMs to incorporate into a planned article by a subgroup of council participants, one of the next steps that the council supported during its October 2020 meeting.

This *Summary of Themes* provides a brief overview of the meeting. *For a list of meeting participants, please see the appendix on page 8.*

### Oncology APMs are facing a reality check

In January 2021, CMMI published the OCM's evaluation report covering performance periods 1–5. The report described meaningful progress toward the OCM's aim to “provide higher quality, more highly coordinated oncology care at the same or lower cost to Medicare”<sup>5</sup>—for example, the report highlights evidence that OCM practices may be embracing value-based choices for some Part B supportive therapies and a reduction in total episode costs relative to

non-OCM counterparts.<sup>6</sup> However, cost savings achieved by OCM practices were not able to compensate for Medicare's \$65–\$100 million in losses per pay period that reflect the care coordination fee and performance bonus payouts Medicare made to participants.<sup>7</sup> Furthermore, although many OCM participants focused considerable effort on interventions to reduce unnecessary emergency department visits and prevent hospitalizations related to chemotherapy-related toxicity, the report concluded that the program observed no meaningful impact in those areas.<sup>8</sup>

Echoing some of the OCM report's conclusions, participants at the March meeting discussed the community's lessons to date from public- and private-sector oncology APMs, with some stakeholders asserting that such models *"have not lived up to their promise."* One clinician described observing waning interest from leadership in the community: *"I think there's a feeling, at least among some of us, that the emphasis on and the concern of the C-suite level about the seriousness of APMs has gone down. There tends to be more of a push for changing the price per widget and going back to just decreasing the cost per unit, and not so much on overall utilization of care and quality."*

In addressing lessons from the commercial space specifically, participants underscored the uncertain impact of programs to date and considerable design challenges. Specifically, they noted how commercial APMs in oncology struggle with a limited number of episodes and patients, at least relative to Medicare. This can make model participants more susceptible to random variation, which can in turn complicate potential transfers of risk.

## It is still too early to dismiss APMs in oncology

While some stakeholders no longer consider APMs *"a silver bullet,"* several still view them as *"tools in addressing cost of care and improving quality."* Many participants underscored that APMs remain valuable options for payers seeking to test ways in which they can improve efficiency and align with practices around quality, incentives, and accountability. *"The power of an alternative payment model is that if the provider is accountable for deciding between the MRI and that PET scan, then that will relieve both parties of the burden of having to fight over those marginal dollars,"* one payer said. APMs also remain attractive to practices that have already invested in practice transformation activities relating to value-based care and see the fee-for-service model as untenable in the long run. Clinicians also continue to underscore that from their perspective, APMs have value in not only reducing cost to the system but also in enabling and incentivizing enhanced quality, innovation, and freedom in physician decision-making.

*"Is the only value of APMs saving money? If that is the case, throw them all out, they don't work. However, if it is about freeing clinicians from fee-for-service limits and allowing innovation, then they have unrealized promise."*

— Clinician

Therefore, even if some stakeholders have a more measured view of APMs today versus three or four years ago, most agreed on the value of sharing and disseminating lessons from recent

programs. In this vein, participants supported a plan for a small working group of council participants to write an op-ed style article describing emerging insights from APMs supporting commercial, Medicare Advantage, and/or Medicaid populations; the article will, among other topics, emphasize the small-number challenges cited above.

One participant underscored that such a piece could be a valuable complement to the extensive publications on the OCM: *“A lot of the publications around OCM that have come out recently are going to naturally serve as a jumping-off point for this publication. In terms of a differentiator for this, we should get to the commercial space as quickly as possible.”* A participant involved in the article’s development also underscored that in addition to addressing small numbers, the piece will highlight the distinct motivations of payers and practices for pursuing an APM: *“The payers in the room say, ‘Look, if I’m going to bring this to the C-suite, I have to present that this is a way to save money.’ If you ask the providers in the room, [they say,] ‘What we view as the value of the APM and what we love about APMs is this ability to divorce our ability to provide services from a fee-for-service model and actually be able to figure out, How do you deliver care the best way to patients?’ Those are the two very philosophically different ways to approach the question, Why are we doing APMs?”*

Participants also noted that if oncology APMs are to continue, more work can be done to enhance their design and implementation. Some considerations for future action include:

- **Leveraging multistakeholder collaboration to address specific unmet gaps in this space.** Participants cited several needs the community should address, including focusing on potential solutions to the small-numbers problem, agreeing on minimum/most important quality measures that models could prioritize, developing good practices for risk adjustment and calculating savings, and assessing solutions for model scalability and standardization.

- **Further assessing the role that delegated risk entities could play.** Such entities contract directly with payers to bear risk on behalf of a pool of practices and work with those practices on quality enhancement and value-based care initiatives. Some participants, especially payers, noted these firms may help extend evidence-based pathways to a broader pool of practices than exists today and, from a cost-savings perspective, possibly tackle *“low-hanging fruit.”* One payer said, *“I want to test whether these groups do have the ability to bring in added volume and allow new ways to measure. And do they bring in any value in having the ability to do analytics that practices can’t invest in and the payers aren’t doing well?”* However, some stakeholders remain skeptical about these firms, especially clinicians who perceive that they may extract more value from the system than they provide.

*“I think in terms of what are the elephants in the room that we have to solve; as we’ve talked about here, it’s the small-numbers problem. Until you can get past the small-numbers problem, it’s going to be very, very difficult to create an APM in the private insurance market that’s going to mean anything. And so we’ve got to work to come up with a solution to that.”*

— Clinician

- **Tempering expectations around impact.** Some participants also recommended that the community reset its expectations around the potential cost savings and other outcomes APMs might yield, at least in the short term. Communicating to C-suite executives that APMs are a long-term investment will be important in this regard, as is delaying any consideration of risk transfer until the program has been operational for some time. One payer said, *“We do get questions and pressures from the C-Suite, but if you’re not looking for a huge output or dollars to get started, then that really shouldn’t be an issue.”*

Finally, some noted that enthusiasm for oncology APMs may soon be reignited as the acute nature of the COVID-19 pandemic subsides and CMMI announces its final direction on an OCM successor model. As noted above, CMMI’s proposed successor to the OCM, the Oncology Care First (OCF) model, remains delayed and details for its design and implementation are unconfirmed. In light of this, one practice leader opined, *“More specificity around what Medicare’s going to do in OCF is going to be a big topic of conversation. It’s going to be important; we know it’s going to move the field.”* Some clinicians, in contrast, attributed less importance to the finalization of the OCF model. Based on the model’s proposed design, which some describe as *“very vague,”* some participants are concerned that they will not experience the same success with the OCF model as they did with the OCM and thus are less likely to participate. One clinician said, *“I’ll just stand on the sidelines and watch. I think [the OCF model] will be taking inadequate data, rolling it up into a big bundle, and handing it to me. And I don’t think I want to be on the receiving end of that.”*

## Several broader challenges remain top of mind

Participants also emphasized that there are enduring barriers to enhancing oncology care and cost sustainability that need to be addressed. Some of these are directly related to oncology APMs; others are adjacent topics that, if progressed, would create a more enabling environment for value-based oncology care.

### Addressing persistent data availability and analytics gaps

Throughout the council’s conversations, participants have emphasized the lack of robust, readily available data to meet the paradigm shift to value-based care and reimbursement. Several data gaps have endured and remain especially concerning to the council:

- **Meaningful information on cancer cost and variation.** Participants underscored their inability to obtain meaningful total cost information on diverse cancer types across patient populations and regions and put any notable variation into context. Such data is especially valuable in helping stakeholders understand drivers of care and cost variability—which can persist even within a given state or region,

*“It is one thing to be able to look at cost retrospectively; it’s difficult to tell if the cost was appropriate or not. CMS struggles with this, and for us it is harder because of smaller numbers. Commercial payers or Medicare Advantage don’t have programs that mimic OCM because it is hard to have a sound measure of cost.”*

— Payer

as was recently demonstrated in an analysis by healthcare data firm COTA<sup>9</sup>—and is essential for establishing clinically relevant financial benchmarks that underlie an APM’s payment methodology.

- **Lack of access to large-scale oncology data sets.** Inextricably linked to the lack of robust cost data is the fact that existing data sets—namely clinical data and cost information derived from claims—are siloed within individual practices and payers. Recognizing that oncology data siloes are a persistent challenge with no easy solution, some participants questioned whether the community could instead more effectively leverage the few large-scale data sets that do exist, namely data from Medicare. Specifically, one clinician wondered if researchers could extrapolate Medicare data for better analyzing trends in commercial populations. While commercial and Medicare populations are distinct, analytical methods could potentially generate insights that could enhance the community’s understanding of cancer’s cost drivers, variance, and so forth, on a national basis.
- **Lack of clinically oriented cost forecasting and stratification tools.** Participants also lamented their inability to accurately predict potential costs based on a patient’s disease characteristics. A practice representative said, *“We struggle with really understanding how you would predict the cost of an [individual] patient when they walk in the door, so that we know that expected cost.”* Some participants discussed whether artificial intelligence or advanced analytics could be potential solutions to this challenge. Some tentatively favored further exploration of these tools, but several expressed concern that they are not yet sufficiently robust and reliable.

## Understanding oncology APMs within the broader APM landscape

As noted above, the Medicare Payment Advisory Commission is considering a recommendation that CMMI streamline the number of APMs, given the challenges in navigating and coordinating across models that practices and CMMI face.<sup>10</sup> In a similar vein, for some participants, better understanding the role of oncology in accountable care organizations and how oncology APMs intersect with other APMs remains a priority.

Broadly, assessing how oncology care can appropriately overlap with primary care is an enduring question and has been addressed in earlier council meetings.<sup>11</sup> Some noted that in 2022, Medicare will start attributing cancer patients to Medicare accountable care organizations in instances where cancer centers are integrated within larger health systems. One clinician explained the importance of this change: *“This change provides health systems with a big incentive for figuring out how to get better quality care within their specialty programs at each individual center.”*

Additionally, while the council has been primarily focused on medical oncology models or those that focus on chemotherapy episodes, select payers and practices noted the need for continuous learning on value-based approaches in other areas of oncology, namely radiation oncology. Some stakeholders noted that currently they are thinking more about potential

radiation oncology APMs in light of CMMI's intention to implement a mandatory Radiation Oncology Model, the launch of which is delayed until January 2022.<sup>12</sup> Some participants indicated that they would be willing to share analytics conducted to date in this area to foster enhanced multistakeholder understanding of value-based models in this sub-specialty.

## Addressing total cost of care

Participants engaged in broad discussion about why some payers still support the advancement of APMs, despite their modest impact and caveats. Several emphasized that for payers' C-suites, total cost of care trends are still the 800-pound gorilla in the room. Many payers expect to continue to develop strategies to contain healthcare costs, such as utilization management, implementation of clinical pathways, and other measures. APMs will likely remain on the list of potential cost-containment approaches. A payer said, *"I'll speak from my company's perspective. There's still a significant commitment to value. The focus is on value as a driver of medical expense savings, and value-based payment models are still seen as a mechanism to help with that. So our challenge is to actually make that a reality."*

Some also underscored that because of the rising costs of oncology care as a specialty, it is often a specific target of cost-containment initiatives. One payer described the pressures her organization faces from employer clients in this regard: *"Oncology is usually the top one or two [cost] drivers, and most clients have at least two or three patients in their catastrophic client list. And so it becomes a major issue for most commercial payers to be able to respond to questions on, How are you managing oncology cost?"*

## Conclusions

In the launch meeting of the council in 2018, one practice representative pondered when APMs would demonstrate that *"the juice is worth the squeeze"*—that is, worth considerable design and implementation effort and investment.<sup>13</sup> From a 2021 vantage point, the answer is not a definitive "yes," but many believe that APMs may continue to show benefits—at the very least, as an approach to better align payers and practices around accountability and quality of care. A payer said, *"I don't think value-based care is going to decrease costs, but I think the partnership with physicians that these models have brought has certainly helped get to some consensus goals and manage things better."*

Participants discussed pausing near-term council meetings to focus on the planned article and to assess the best way forward for the group, given the uncertain environment for APMs in the short term. Participants reiterated the value of the multistakeholder council and the need to continue to address critical topics in enhancing cancer-care quality and cost sustainability. One said, *"I believe everyone does ultimately have the care for the patient in mind. Having all of us here, with our different perspectives and incentives and challenges, this is the only way you get consensus at the conclusion, not just operating in our siloes."* Another commented on the progression of the group's conversations over time: *"It has been a journey, and I can tell you, we've covered an awful lot of topics over the time here, and certainly I've learned from it."*

## About this document

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## Endnotes

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- <sup>1</sup> Peter Wehrwein, “Oncology Care Model Is a ‘Debacle,’ Says Healthcare Policy Expert,” *Managed Healthcare Executive*, March 1, 2021.
- <sup>2</sup> Joyce Frieden, “MedPAC May Tell Medicare to Slim Down Its Alternative Payment Offerings,” *MedPage Today*, March 8, 2021.
- <sup>3</sup> Joyce Frieden, “MedPAC May Tell Medicare to Slim Down Its Alternative Payment Offerings.”
- <sup>4</sup> Andrea Hassol et al., *Evaluation of the Oncology Care Model: Performance Periods 1–5* (Rockville, MD: Abt Associates, January 2021), 3.
- <sup>5</sup> “Oncology Care Model,” Center for Medicare & Medicaid Services, last updated February 18, 2021.
- <sup>6</sup> Hassol, *Evaluation of the Oncology Care Model: Performance Periods 1–5*, 3–4.
- <sup>7</sup> Hassol, *Evaluation of the Oncology Care Model: Performance Periods 1–5*, 3.
- <sup>8</sup> Hassol, *Evaluation of the Oncology Care Model: Performance Periods 1–5*, 4.
- <sup>9</sup> Andrew L. Pecora et al., “The COTA Nodal Address Model: A Novel Digital Classification System Identifies Variances in Cancer Care Cost to Support Value Based Care Delivery,” *Journal of Precision Medicine* 6, no. 4 (2020); Mary Caffrey, “Use of COTA Nodal Address Highlights Variance in Cancer Care Cost: An Interview With Donald M. Berwick, MD, MPP,” *American Journal of Managed Care*, February 18, 2021.
- <sup>10</sup> Joyce Frieden, “MedPAC May Tell Medicare to Slim Down Its Alternative Payment Offerings.”
- <sup>11</sup> Oncology APMs Advisory Council, *Shaping the Future of Alternative Payment Models in Oncology*, ViewPoints (Waltham, MA: Tapestry Networks, 2019), 5–8.
- <sup>12</sup> “Radiation Oncology Model,” Center for Medicare & Medicaid Services, last updated March 8, 2021.
- <sup>13</sup> Tapestry Networks, *The Way Forward for Alternative Payment Models in Oncology*, ViewPoints (Waltham, MA: Tapestry Networks, 2018), 20.