The current state of oncology value-based care

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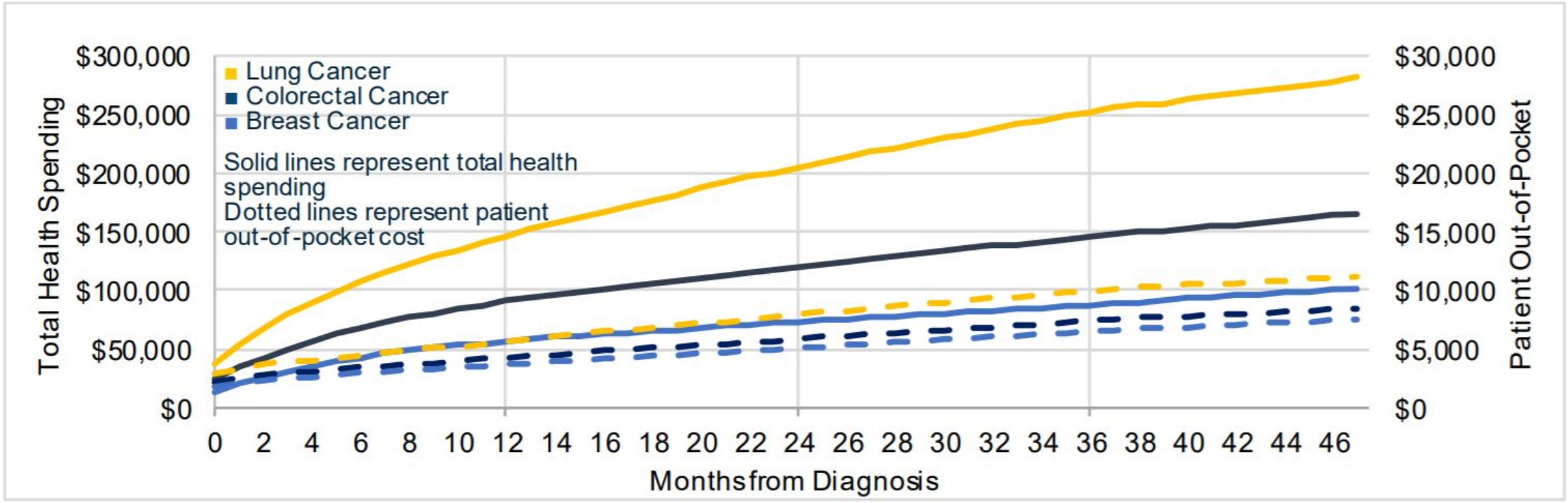
TENNESSEE ONCOLOGY

Caring for cancer patients is a privilege!

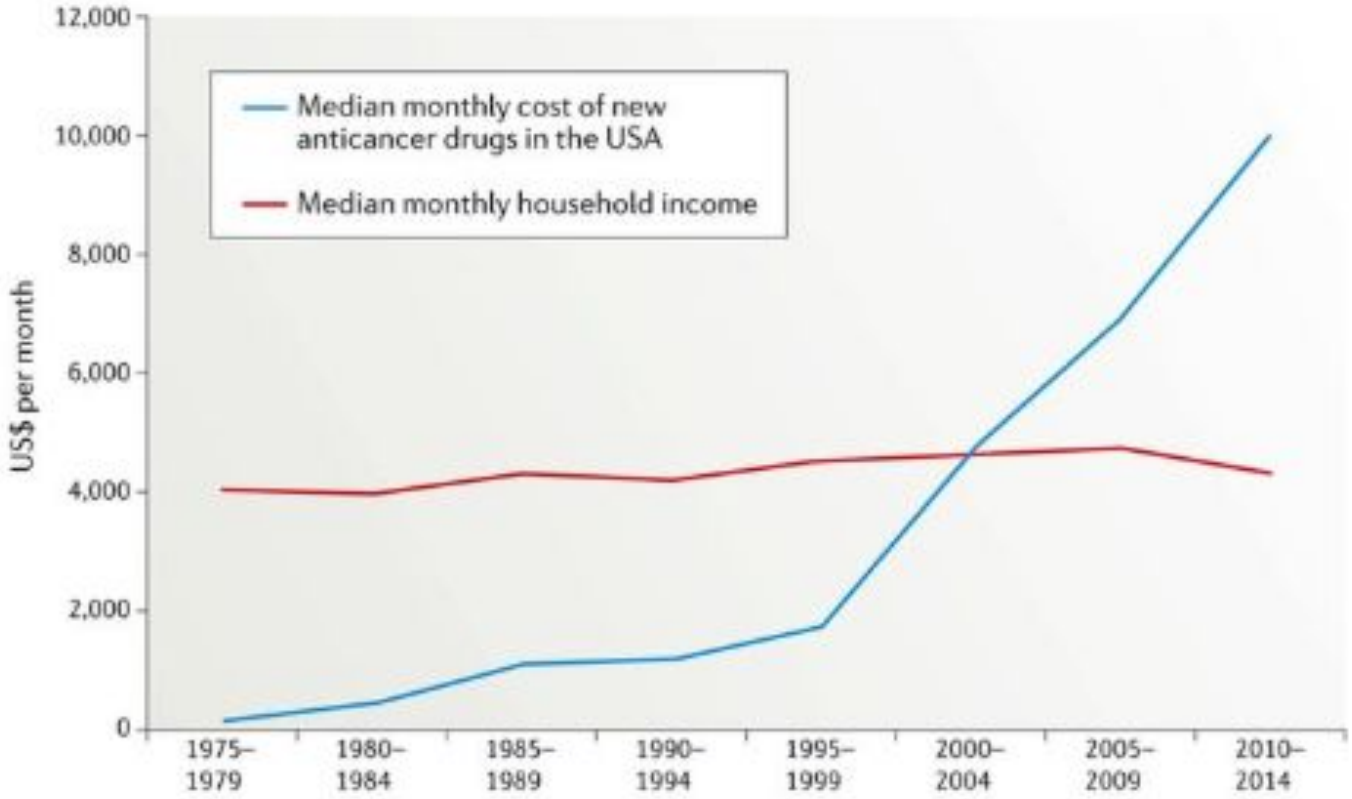
What's going on around us?

Annual cost of cancer care is particularly high and expected to approach $246B by 2030

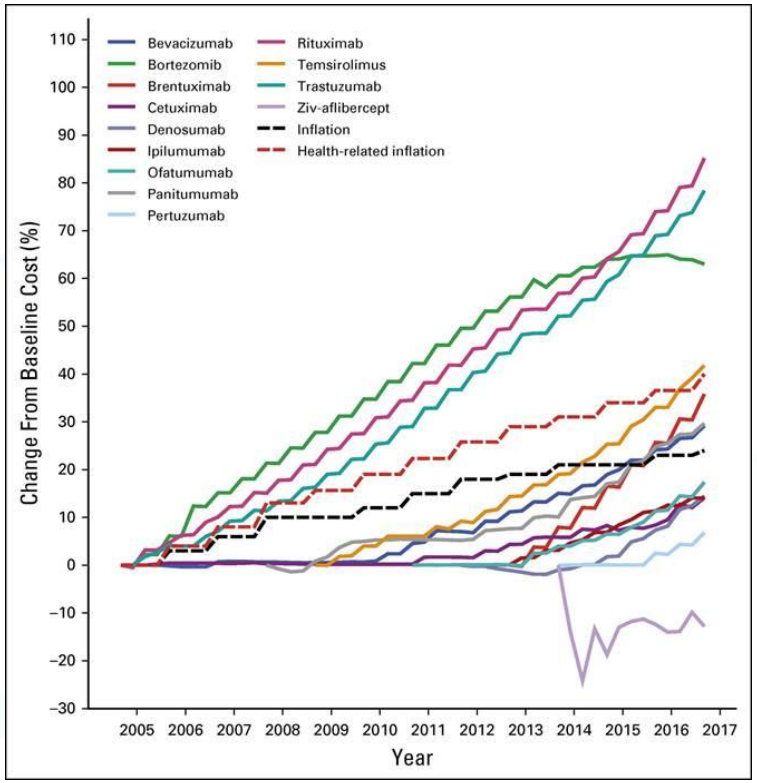


What's going on around us?

Both launch price AND post-launch price (i.e. drug inflation) have skyrocketed over last decade, increasing the cost of cancer tx over time



Anti-cancer drug median monthly launch price in US



Anti-cancer drug price increases AFTER launch

One result? Financial toxicity for patients (and an increasing concern by payers)

FIRST OPINION

Cancer patients shouldn't be responsible for out-of-pocket costs

By Ezekiel J. Emanuel May 23, 2023

Financial toxicity is the economic burden patients experience from the costs related to getting treatment for their cancer. Cancer care is expensive. By one 2020 estimate, the average cost of medical care and drugs is more than $42,000 in the year following a cancer diagnosis. To complicate matters, up to 85% of cancer patients leave the workforce during their initial treatment. Consequently, more than 40% of patients spend their entire life savings in the first two years of treatment, while roughly 30% of Americans with a cancer history report having had problems paying their medical bills, having to borrow money, or filing for bankruptcy protection because of their cancer. In addition, informal caregivers, often family members, also experience out-of-pocket and opportunity costs, estimated to be upwards of several thousand dollars per month.

Agenda

1. The Oncology Care Model: why, what is it, was it a success?
2. Lessons learned, would TO do it all over again?
3. OCM 2.0: the Enhancing Oncology Model
4. Is VBC worth pursuing for a long term strategy?

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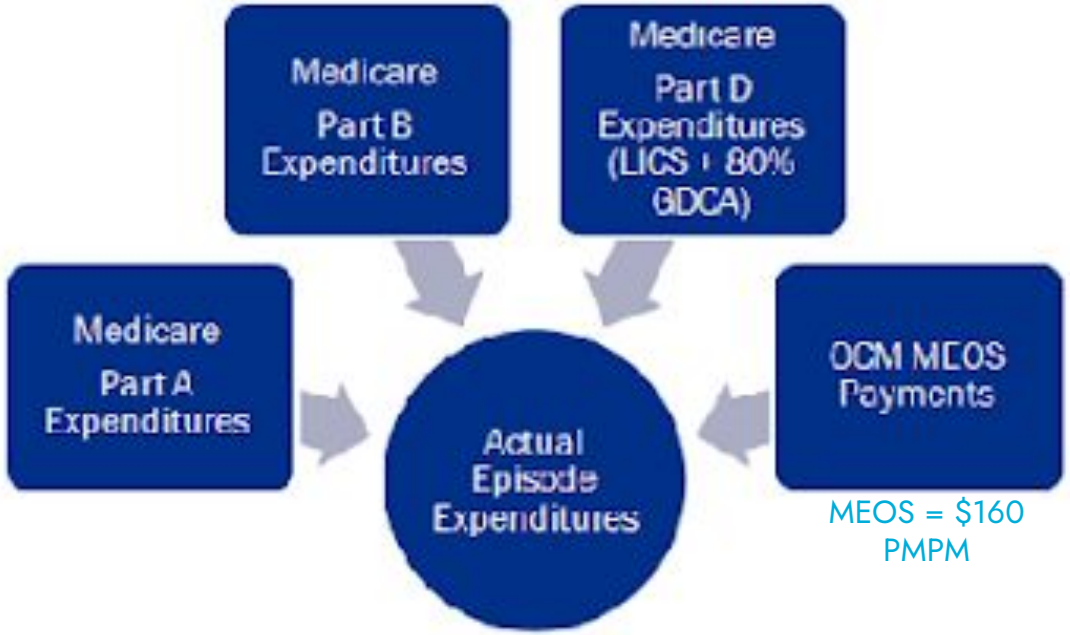
The largest VBC model in cancer: the OCM

In 2015, CMMI launched the first cancer-specific VBC model – the Oncology Care Model – in theory meant to maximize quality and reduce costs of care.

Figure 2: Components of Actual Episode Expenditures



MEOS = $160 PMPM

Trigger = systemic therapy
Episode length = 6 months (can repeat)

OCM Quality Measures

OCM Measure Number	Measure Name	Measure Source
OCM-2	Risk-adjusted proportion of patients with all-cause emergency department visits or observation stays that did not result in a hospital admission within the 6-month episode	Claims
OCM-3	Proportion of patients that died who were admitted to hospice for 3 days or more	Claims
OCM-4a	Oncology: Medical and Radiation – Pain Intensity Quantified (MIPS 143, NQF 0384)	Practice Reported
OCM-4b	Oncology: Medical and Radiation – Plan of Care for Pain (MIPS 144, NQF 0383)	Practice Reported
OCM-5	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (CMS 2v8.1, NQF 0418)	Practice Reported
OCM-6	Patient-Reported Experience of Care	CMS-Acquired Data

Source: https://innovation.cms.gov/innovation-models/oncology-care

Performance calculation in OCM is almost entirely based on spending

Table 11: Example Performance-Based Payment Calculation

		One-Sided Risk	Original Two-Sided Risk	Alternative Two-Sided Risk
A	Sum of Baseline Episode Prices	$2,500,000	$2,500,000	$2,500,000
B	Adjustment for Trend	1.02	1.02	1.02
C	Adjustment for Novel Therapies	1.01	1.01	1.01
D	Benchmark Amount (A * B * C)	$2,575,500	$2,575,500	$2,575,500
E	OCM Discount Rate	4.00%	2.75%	2.5%
F	OCM Discount Amount (D * E)	$103,020	$70,826	$64,388
G	Target Amount (D - F)	$2,472,480	$2,504,674	$2,511,113
H	Actual Episode Expenditures	$2,300,000	$2,300,000	$2,300,000
I	Difference (Target less Actual; G - H)	$172,480	$204,674	$211,113
J	Performance Multiplier	75%	75%	75%
K	Performance-Based Payment (I * J)	$129,360	$153,505	$158,334
L	Final Performance-Based Payment, after Geographic Adjustment and Sequestration (K * 1.03 * 0.98)	$130,576	$154,948	$159,823

Nothing unique to OCM; just accounts for 2$ Medicare sequester

- 2012-2015 costs
- Medical cost inflation
- Use of new FDA drugs relative to comparison
- Expected costs (owe money in 2-sided risk if above this)
- % savings needed to get PBP
- Target to beat to get PBP
- Based on quality metrics on prior slide

Source: https://innovation.cms.gov/innovation-models/oncology-care

Overall interpretation of OCM results (lost $500M) isn't as clear as it seems…

Association of Participation in the Oncology Care Model With Medicare Payments, Utilization, Care Delivery, and Quality Outcomes

Nancy L. Keating, MD, MPH[1,2]; Shalini Jhatakia, MA[3]; Gabriel A. Brooks, MD, MPH[4]; et al

Key Points

Question Was the Centers for Medicare & Medicaid Services Oncology Care Model (OCM), an alternative payment model for cancer patients undergoing chemotherapy, associated with differences in Medicare spending, utilization, quality, and patient experience over the model's first 3 years?

Findings In this exploratory difference-in-differences study of Medicare fee-for-service beneficiaries with cancer undergoing chemotherapy (483 310 beneficiaries with 987 332 episodes treated at 201 OCM participating practices and 557 354 beneficiaries with 1 122 597 episodes treated at 534 comparison practices), OCM was associated with a statistically significant relative decrease in total episode payments of $297 that was not sufficient to cover the costs of care coordination or performance-based payments. There were no statistically significant differences in most measures of utilization, quality, or patient experiences.

Meaning In its first 3 years, the OCM was significantly associated with modestly lower Medicare episode payments that did not offset model payments to participating practices, and there were no significant differences in most utilization, quality, or patient experience outcomes.

Tennessee Oncology Achieves High Quality Score and Save Millions During the Final Year of Medicare's OCM

November 25, 2021
Nichole Tucker

US Oncology Network, Tennessee Oncology Tout Medicare OCM Savings

November 20, 2021
Skylar Jeremias

The US Oncology Network

According to the report, all 14 of the participating practices within the Oncology Network improved patient care by achieving high quality measurement scores, resulting in a 100% Performance Multiplier for them. Combined, the practices saved Medicare about $54 million over the 6-month performance period to produce $197 million total savings since the OCM began in 2016, according to the organization.[1] These 14 practices represent approximately 1 fourth of all providers participating in the program.

Case Study: Florida Cancer Specialists and Research Institute Delivers High-Quality, Cost-Effective Care Through the Oncology Care Model

RESULTS

The OCM program has completed reporting for nine of its initial payment periods. Over these designated episodes, FCS has successfully improved care overall and reduced cost in all but the first payment period, resulting in a reduction of expenditures amounting to $168 million, more than $120 million in net CMS savings[2].

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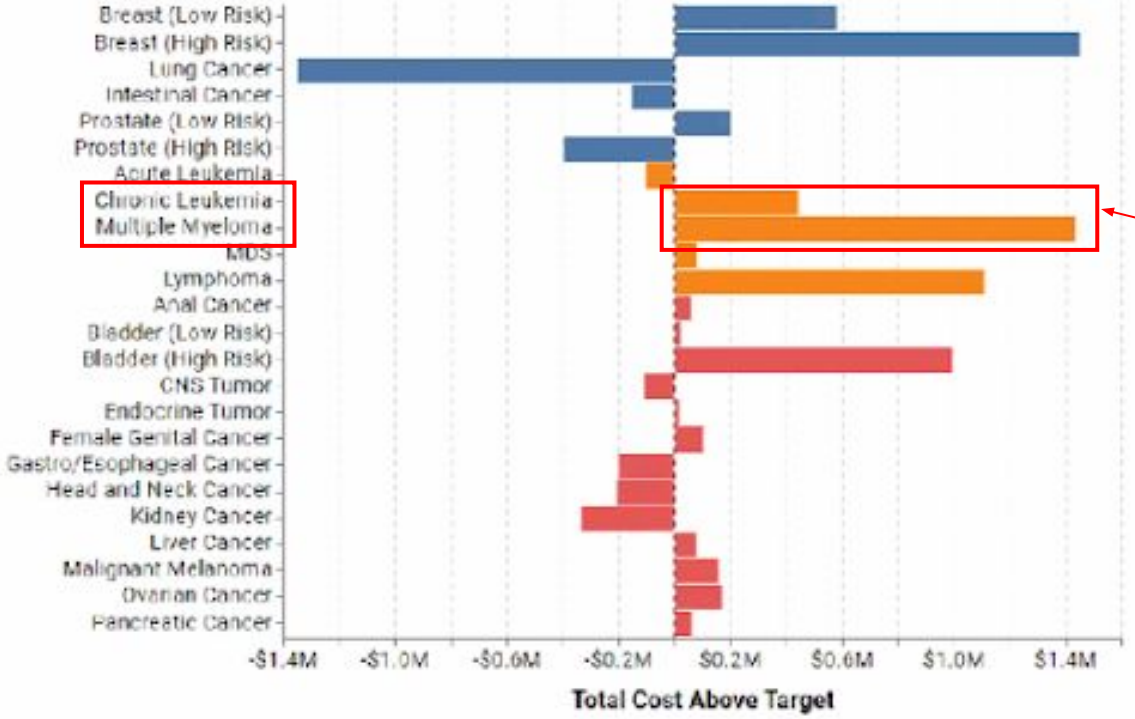
Lesson 1: cancer is heterogeneous

Performance by cancer type can vary drastically (i.e. heterogenous), thus inherent dependence on case mix, especially for smaller practices.



For a small practice, a random increase in patients with these diseases can completely alter performance.

Lesson 1: cancer is heterogeneous

Even within same disease category, the cost of care can vary widely based on phenotypes not captured at OCM disease-level.

Table. Six-Month Costs for Guideline-Concordant Treatments Within the High-risk Breast Cancer and Lung Cancer Episode Groups[a]

Regimen	Cost per 6-mo period, $	Indication
High-risk breast cancer[b]		
Weekly paclitaxel	709	Metastatic breast cancer, *ERBB2* negative
Docetaxel plus cyclophosphamide (with growth factor support)	24 328	Early-stage breast cancer, (neo)adjuvant treatment, *ERBB2* negative
Docetaxel plus trastuzumab plus pertuzumab	109 580	Metastatic breast cancer, *ERBB2* positive
Protein-bound paclitaxel plus atezolizumab	142 529	Metastatic breast cancer, hormone receptor-negative, *ERBB2* negative, PD-L1 positive
Lung cancer[c]		
Cisplatin plus gemcitabine[2]	548	Early-stage NSCLC, adjuvant treatment, squamous histology
Durvalumab[2]	69 180	Stage 3 NSCLC, consolidation therapy after chemoradiation
Carboplatin plus etoposide plus atezolizumab[3]	75 350	Extensive-stage SCLC
Carboplatin plus pemetrexed plus pembrolizumab[5]	112 950	Metastatic NSCLC, nonsquamous histology with no targetable variations

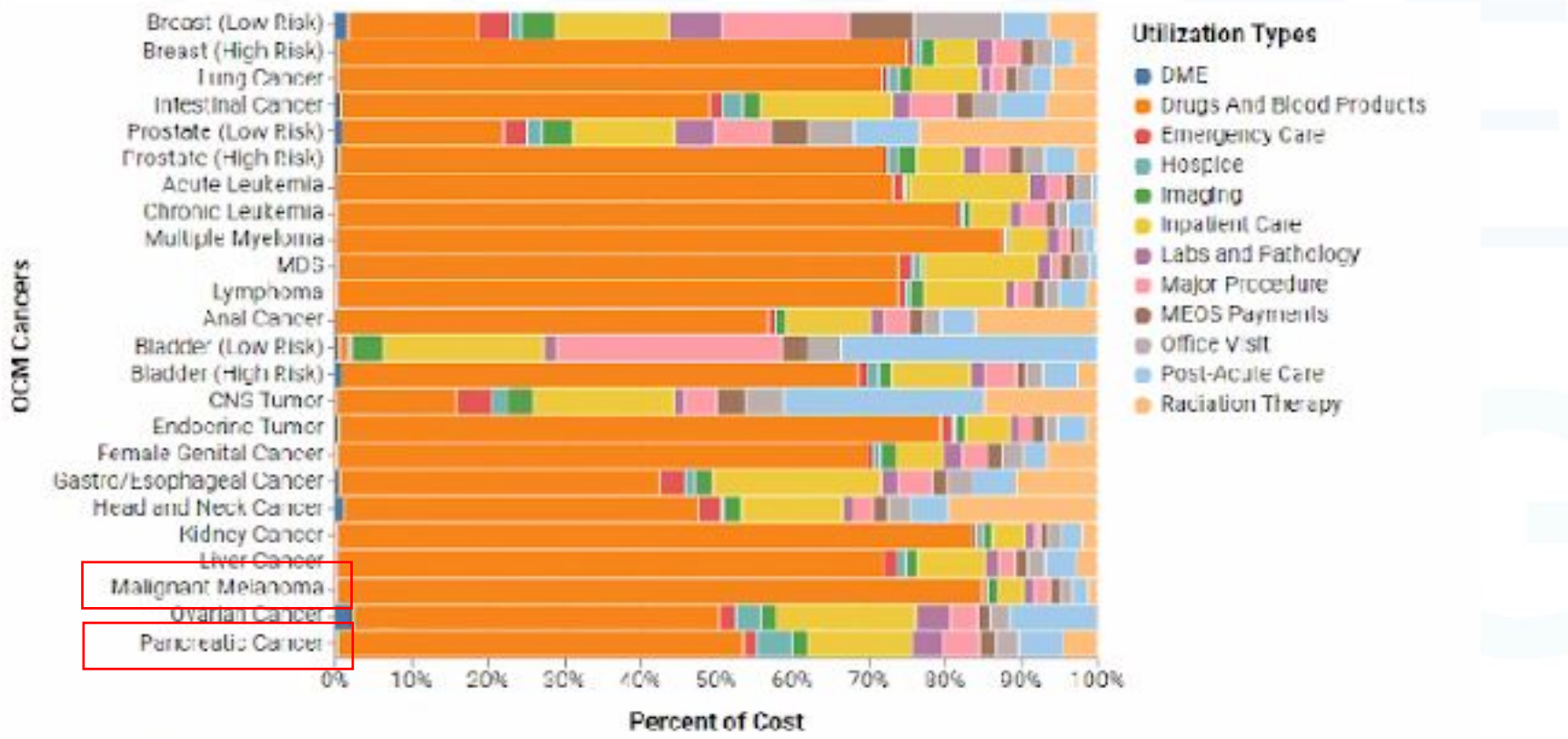
Appropriate drug costs can vary by 200x based on specific phenotype!

Note: atezolizumab indication has been withdrawn

Appropriate drug costs can vary by 205x based on specific phenotype!

Lesson 1: cancer is heterogeneous

Key contributors to total cost of care (including what is and what isn't within our control) also varies significantly by cancer type.

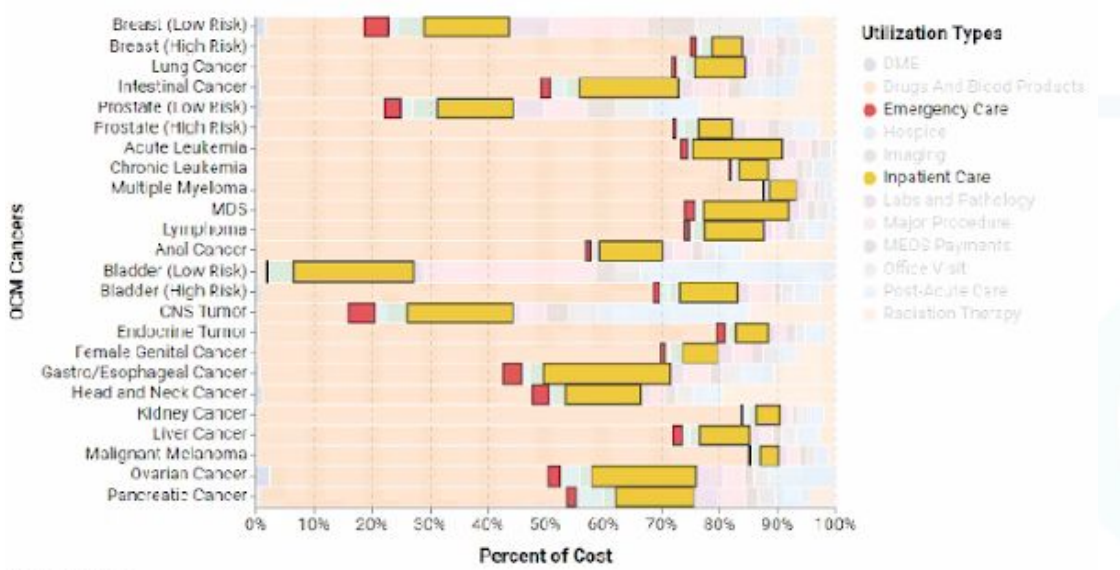


TUPLE HEALTH

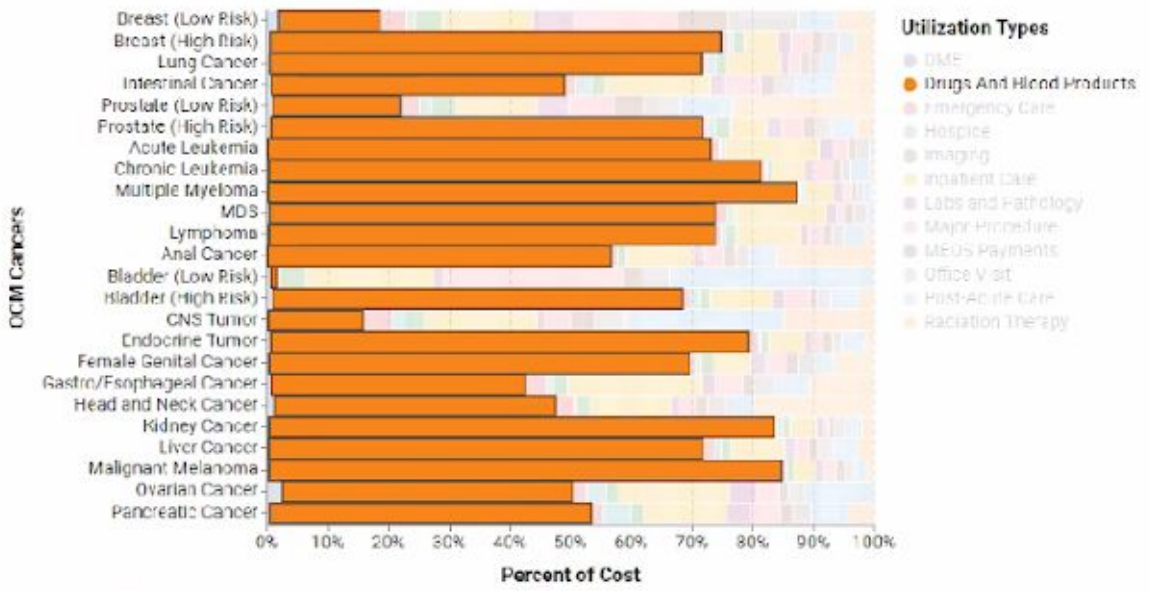
Lesson 1: cancer is heterogeneous

Key contributors to total cost of care (including what is and what isn't within our control) also varies significantly by cancer type.

ED/Hospital costs: opportunity for improvement with culture/care coordination



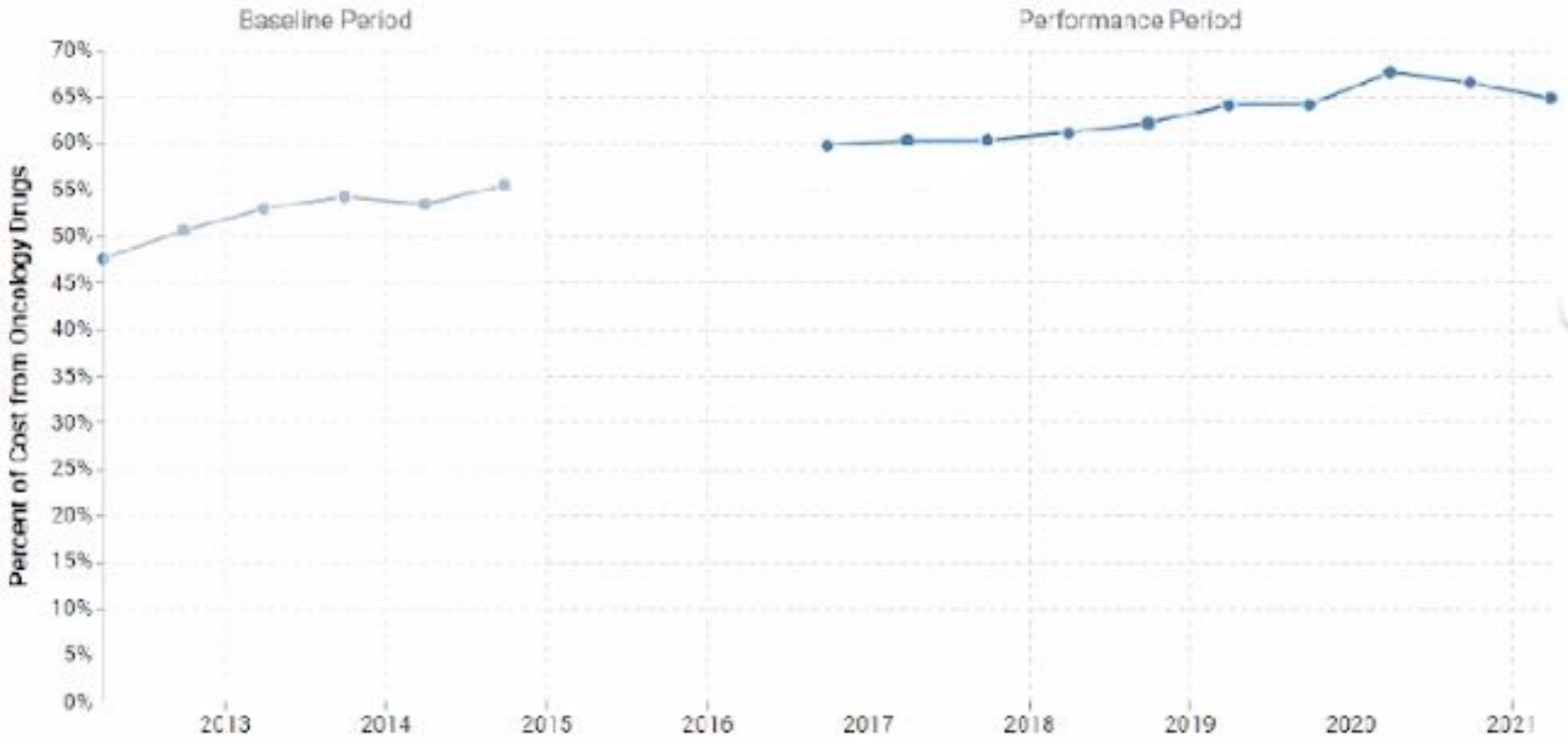
Drug costs: may not be as controllable?



TUPLE HEALTH

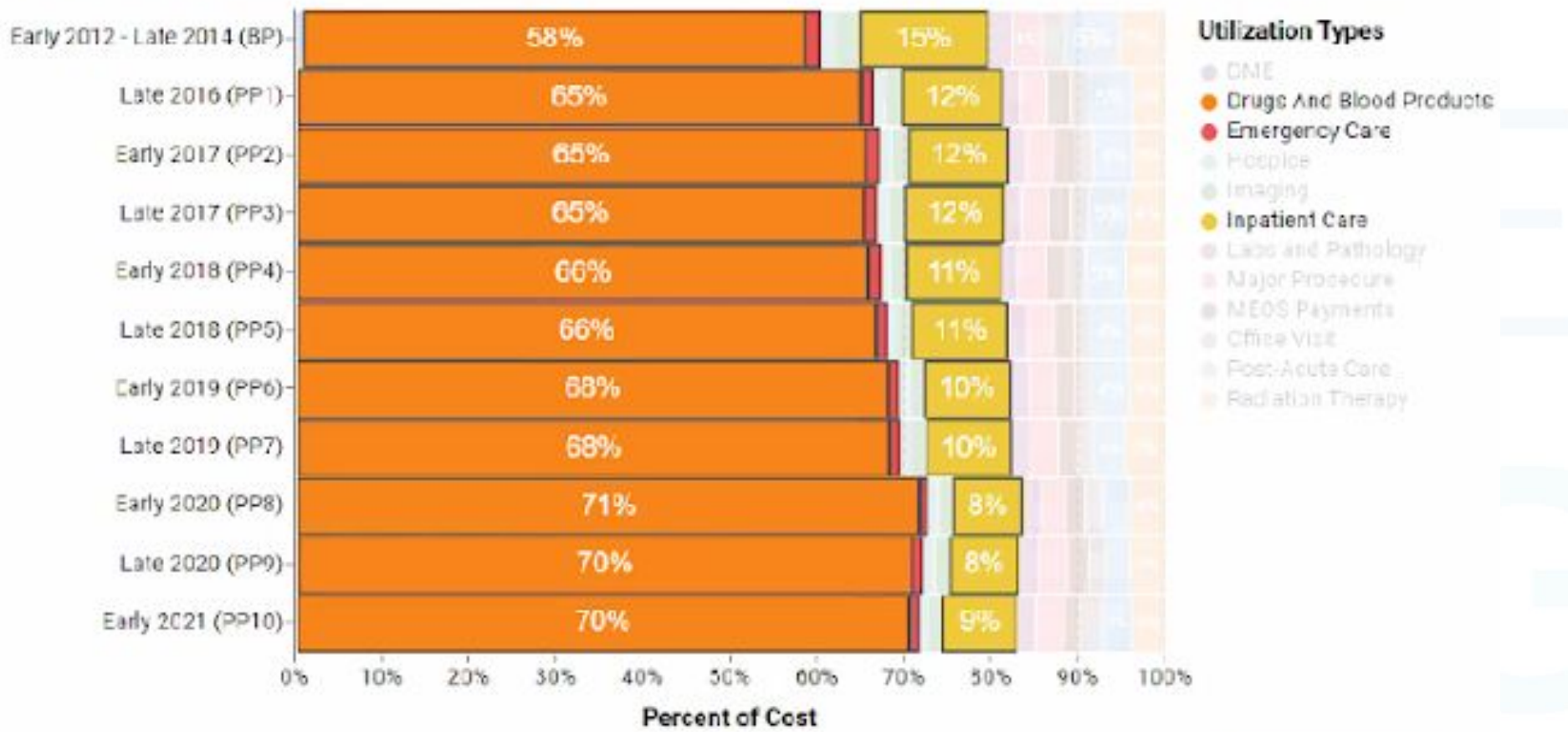
Lesson 2: over time, drugs have increasingly contributed to total cost of care, diluting impact of care coordination

% of total costs due to oncology drugs



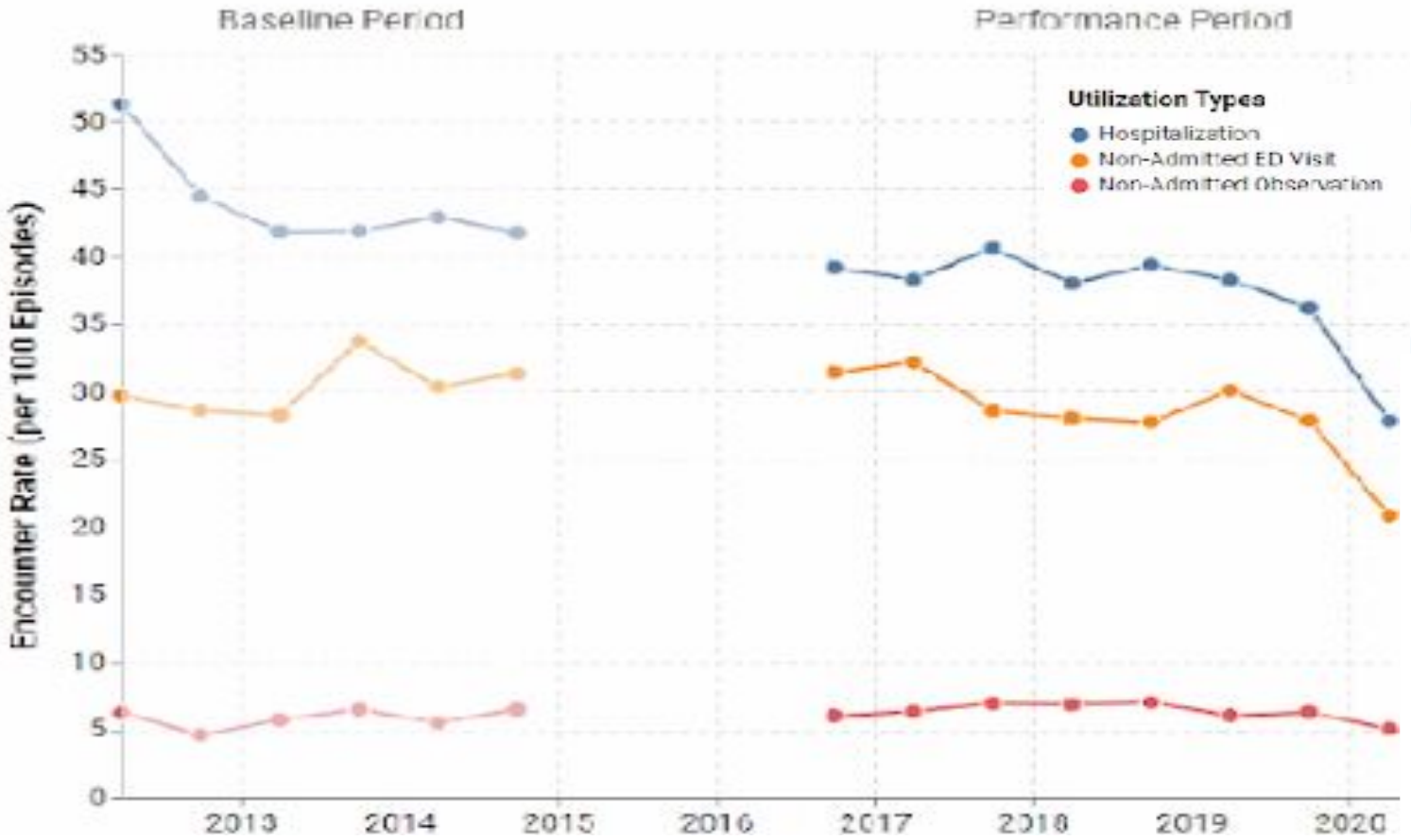
How much is new approvals that are appropriate?

Put another way, reducing hospitalizations just doesn't reduce total cost of care as much any more!



TUPLE HEALTH

Thus, despite large reductions in ED/inpatient spend, it's hard to significantly reduce cost of care

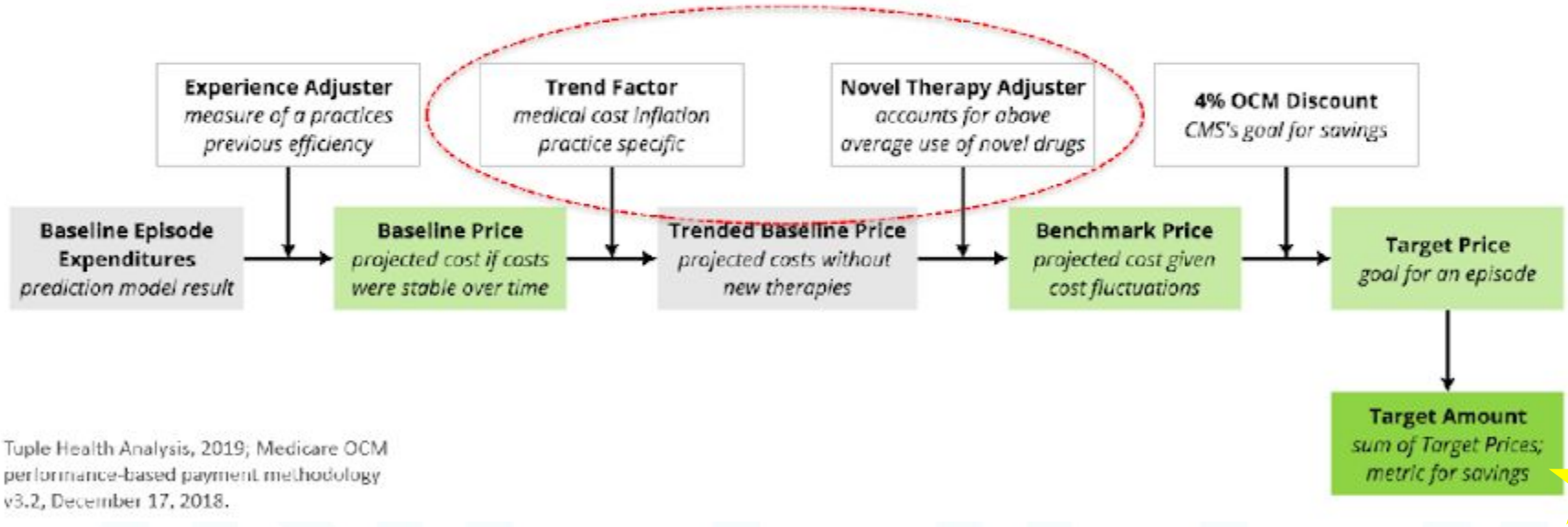


Thus, while it is great for patients that at TO that we have significantly reduced ED visits and hospitalizations over time…

…unfortunately, these improvements in ED visits and hospitalizations now account for only ~10% of the total cost of care!

Lesson 3: OCM (and other VBC models) cost predictions have trouble accounting for new FDA approvals

In addition, it is hard to accurately account for new drug approvals in total cost of care predictions.



Tuple Health Analysis, 2019; Medicare OCM performance-based payment methodology v3.2, December 17, 2018.

This determines performance

When I least gave this talk, there had been 6 new FDA approvals in last 2 weeks alone!

And current methodologies to account for new drugs (and their influence on cost of care) are not adequate

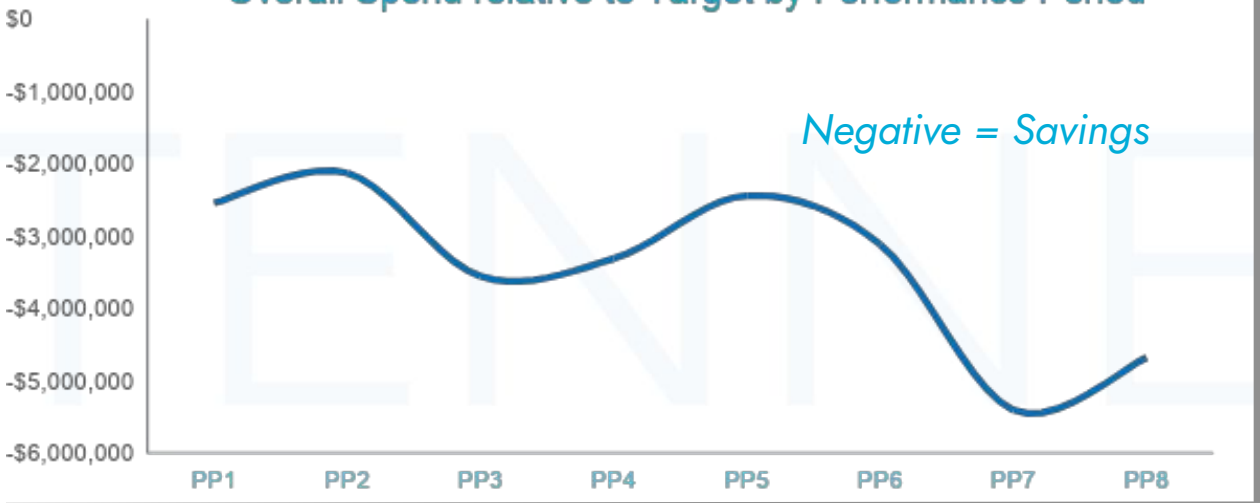
The Oncology Care Model Why It Works and Why It Could Work Better
Accounting for Novel Therapies in Value-Based Payment

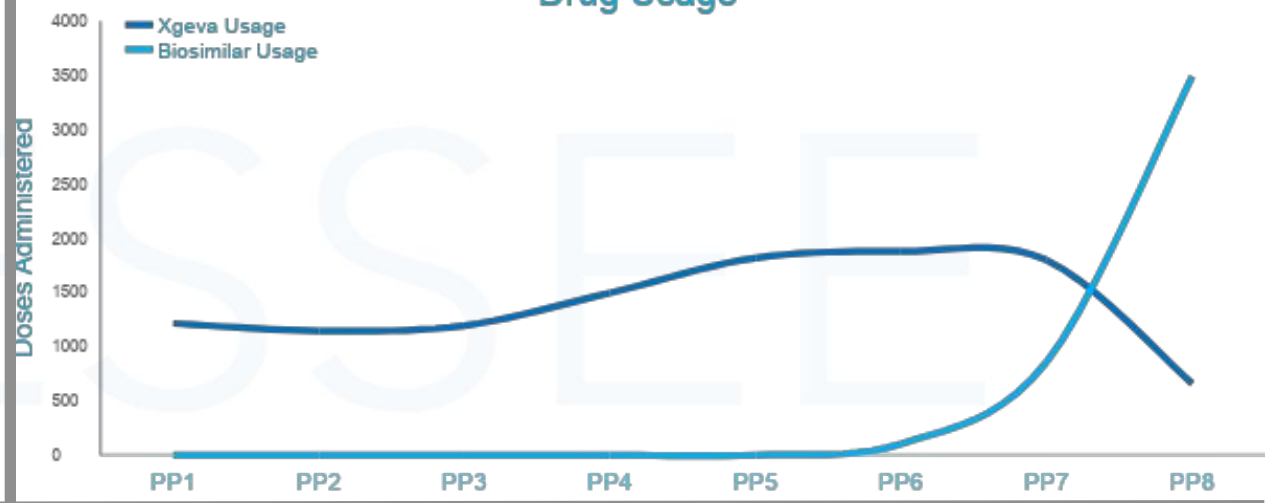
- Tennessee Oncology looked at 118 lung cancer patients triggering into OCM in 2017 with expenditures above target costs.
- In over half of these, there were NO ED, hospitalization, or post-acute care stays.
- In 2/3 of these cases, we were above target only because of standard of care 2nd line nivolumab or pembrolizumab that had become SOC between baseline period and January 2017.

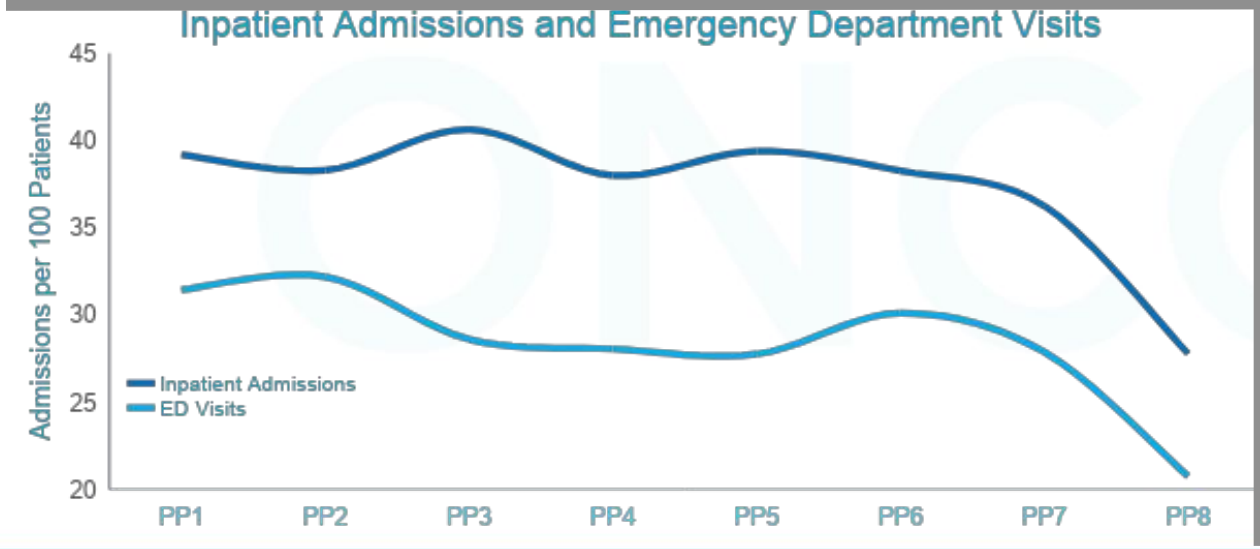
More recent examples: KN522, adjuvant atezo/pembro in NSCLC, etc

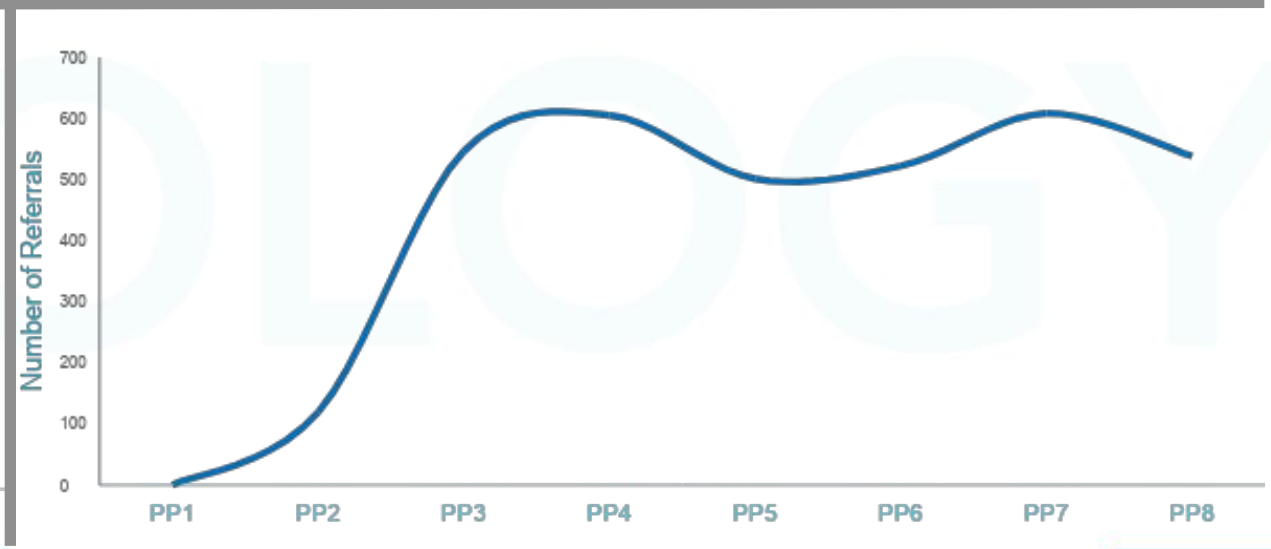
Lyss, Supalla, Schleicher, JAMA Onc, 2020.

Despite these challenges, TO was overall successful achieving FFS spend reduction of >$40 Million with top quartile quality performance throughout the entire program









OCM participation also created the learnings and infrastructure to create other partnerships and participate in other value initiatives

Tennessee Oncology Achieves High Quality Score and Save Millions During the Final Year of Medicare's OCM

November 25, 2021
Nichole Tucker

Tennessee Oncology and Blue Cross Blue Shield of Tennessee Launch New Value-Based Care Initiative

Posted on October 20, 2021

Program Serves as Model for Future Oncology Medical Home Programs

Tennessee Oncology Named One of Nine Oncology Practices Certified Through ASCO Patient-Centered Cancer Care Certification Pilot

Posted on July 26, 2022

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ASCO QOPI Certification Program

Tennessee Oncology Re-Certified With Perfect Score for High-Quality Cancer Care from the Largest Oncology Association in United States

Posted on December 21, 2021

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Blue Distinction Center

1 results for All Designations, Cancer Care, TN

FACILITY NAME & LOCATION (CLICK FOR MAP)	BLUE DISTINCTION CENTER (BDC) DESIGNATION
Tennessee Oncology Nashville, TN	Cancer Care

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The Enhancing Oncology Model


CMS.gov | Centers for Medicare & Medicaid Services

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Fact sheet

Enhancing Oncology Model

Jun 27, 2022 | Innovation models

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Overview

The Centers for Medicare & Medicaid Services (CMS) Innovation Center's new, voluntary Enhancing Oncology Model (EOM) is intended to transform care for cancer patients, reduce spending, and improve quality of care. It is designed to test how best to place cancer patients at the center of the care team that provides high-value, equitable, evidence-based care. EOM aims to improve care coordination, quality, and health outcomes for patients while also holding oncology practices accountable for total costs of care to make cancer care more affordable and accessible for beneficiaries and Medicare, which are key priorities described in the CMS Innovation Center's strategy refresh.

EOM aligns with President Biden's Cancer Moonshot pillars and priorities of supporting patients, caregivers, and survivors, and addressing inequities. On February 2, 2022, the Biden-Harris Administration reignited the Cancer Moonshot effort by setting a goal of reducing the cancer death rate by at least 50% over the next 25 years and improving the experience of people and their families living with and surviving cancer.

4 Key differences between OCM and EOM

1. ½ the patients, ½ the MEOS
2. Narrower (and less favorable) "safe zone" + mandatory risk
3. Improved drug adjustments (theoretically) – trend factor/NTA at disease, not practice, level; HER2+ influences target cost, etc.
4. Increased reporting (ePROs, SDOH) – important in theory, but more documentation required

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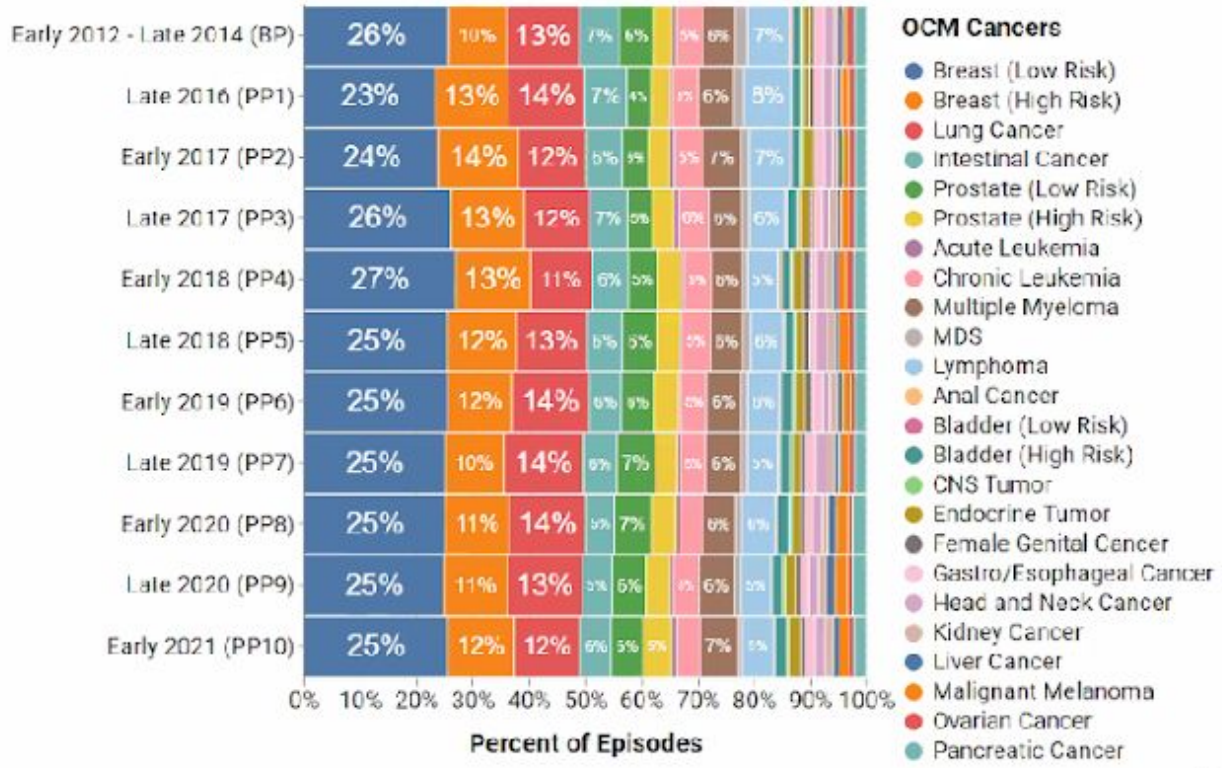
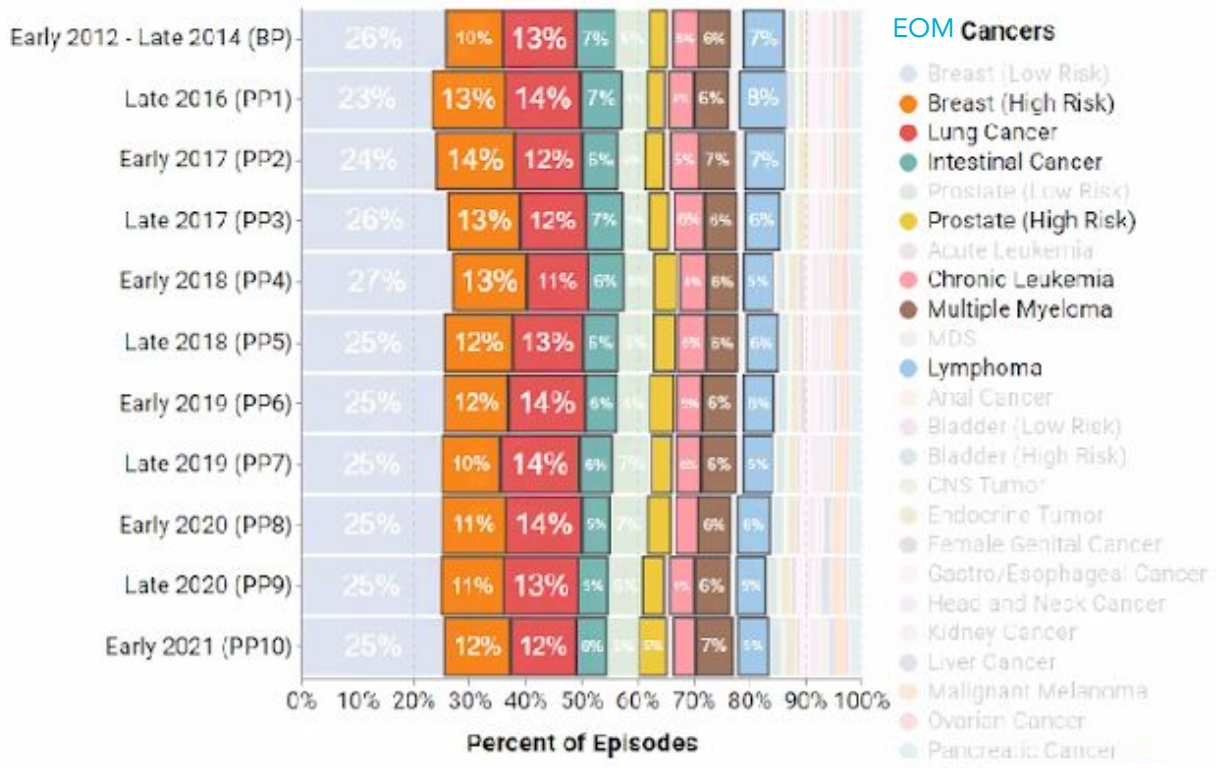
EOM will apply to approximately 50% of the eligible OCM population

Cancer makeup of OCM population per Performance Period



What OCM would have looked like if only EOM cancer types were included



So about 50% of patients and 50% MEOS/patient

Is the small number of cancer types included surprising?

Medicare (0.3 percent of TEP, or $131 per episode). The opposite was true in lower-risk episodes, where the relative increase in gross payments, combined with MEOS payments, generated substantial losses for Medicare (11.6 percent of TEP, or $838 per episode). The patterns were similar in PP4, with Medicare losses being much greater for lower-risk episodes.

Exhibit 17: Including Gross Payment Reductions and MEOS (But Not PBP), OCM Resulted in Greater Medicare Net Losses for Lower-Risk Episodes than for Higher-Risk Episodes

Cancer Episode Risk Group	Number of Episodes	Gross Impact on TEP	MEOS Payments	Impact on TEP + MEOS (Losses)	Losses as Percentage of TEP	Losses per Episode
PP3						
Lower-risk episodes	41,344	$3,085,210	$26,644,224	$34,630,434	11.6%	$838
Higher-risk episodes	87,382	-$52,347,892	$63,820,574	$11,472,682	0.3%	$131
PP4						
Lower-risk episodes	43,454	$7,233,649	$27,636,536	$34,869,187	10.7%	$803
Higher-risk episodes	80,748	$58,134,601	$66,476,986	$8,341,385	0.2%	$93

Source: Medicare claims 2014–2018. OCM final true-up episode-level data. MEOS: Monthly Enhanced Oncology Services payment. PP: Performance Period. TEP: total episode payments.

Low risk breast and low risk prostate episodes (i.e. endocrine/anti-androgen therapy only) led to significant money loss for CMS even before MEOS.

Evaluation of the Oncology Care Model:
Performance Periods 1–5

Final
January 2021 Contract #HHSM-500-2014-000261

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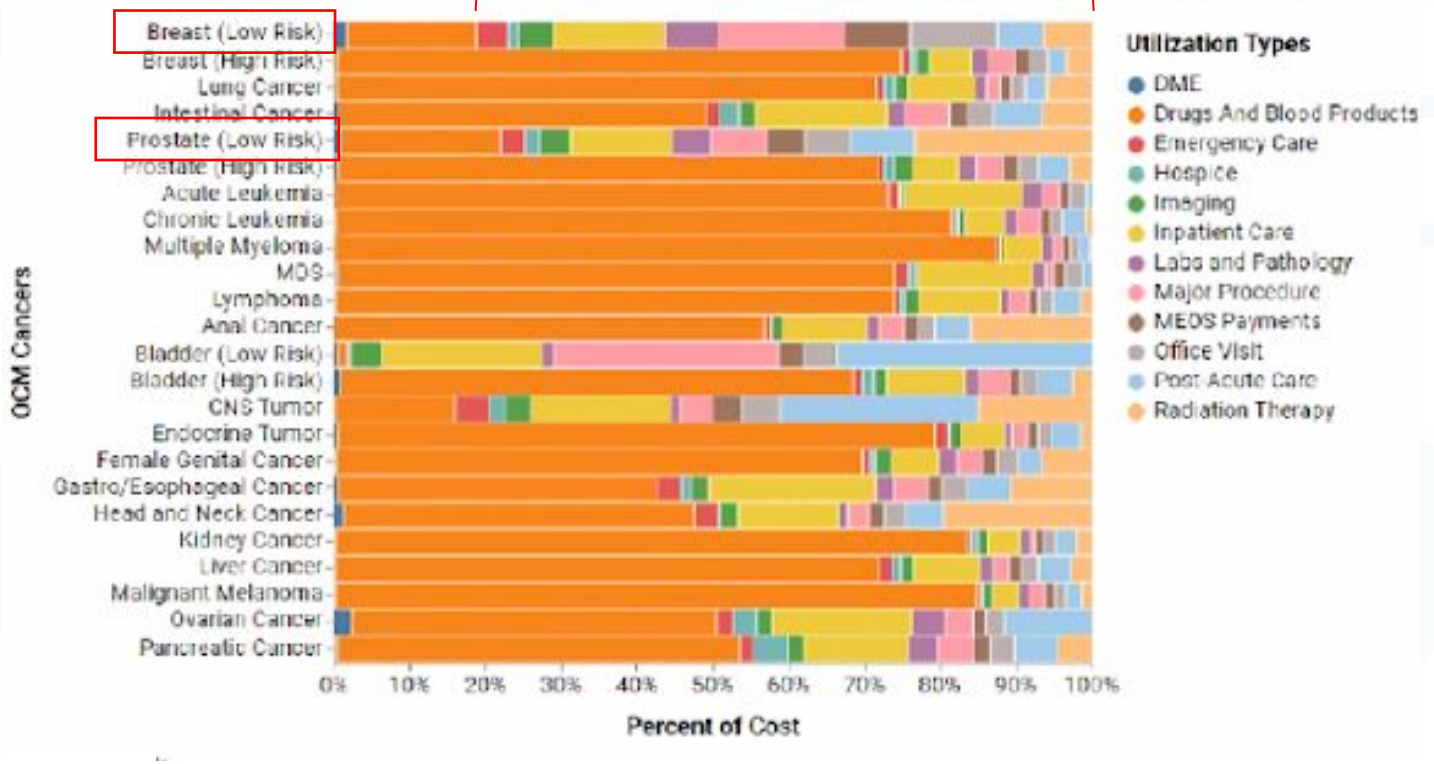
IN PARTNERSHIP WITH
The Lewin Group
Harvard Medical School
GDIT
Geisel School of Medicine at Dartmouth

The plus? Excludes diseases with costs of care almost completely beyond an oncologist's control

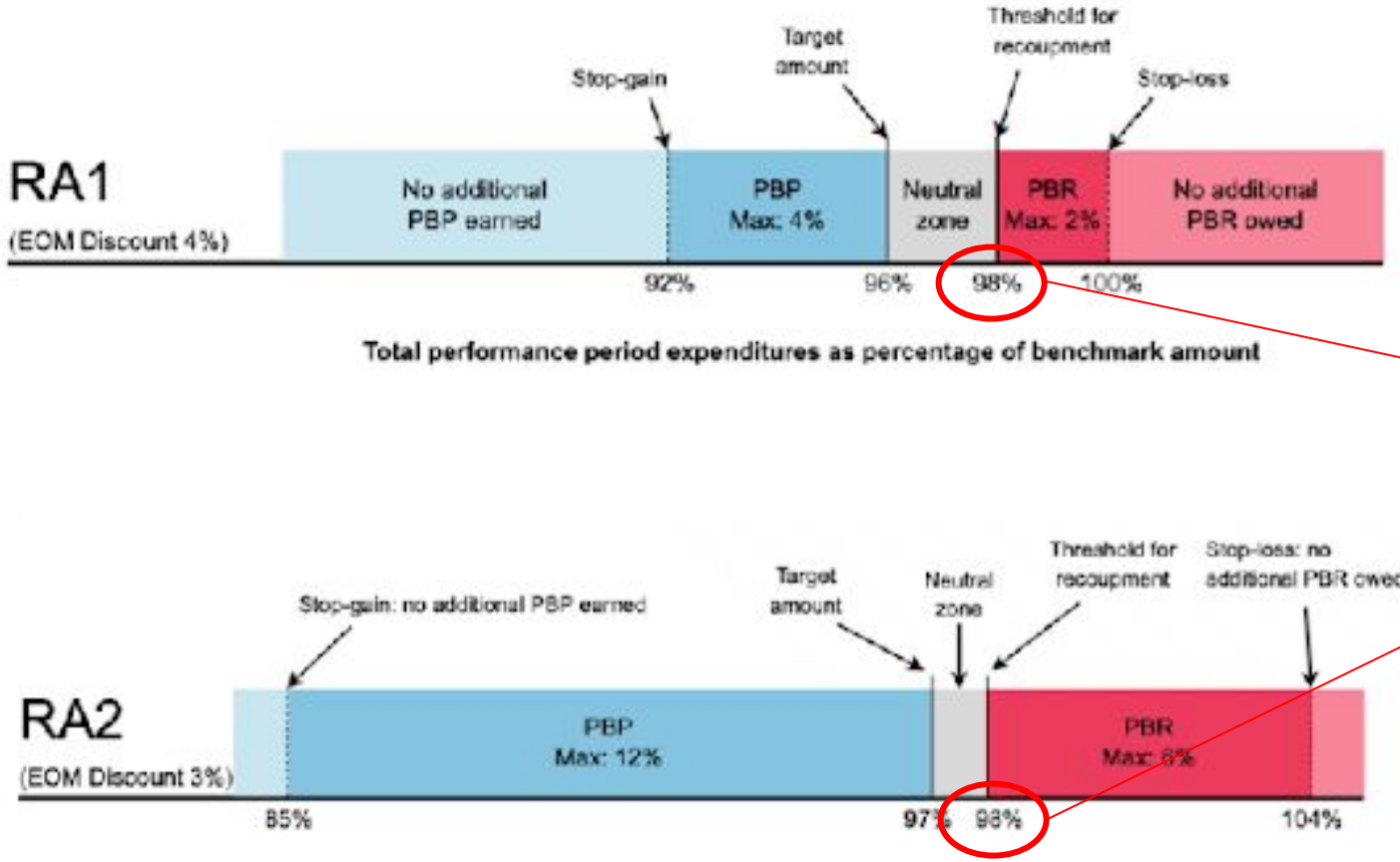
For low-risk breast/prostate (i.e. a stage 1 breast cancer patient AFTER we start letrozole only), ~80% of cost of care due to inpatient stay, major procedure, post acute care, or radiation therapy



TUPLE HEALTH

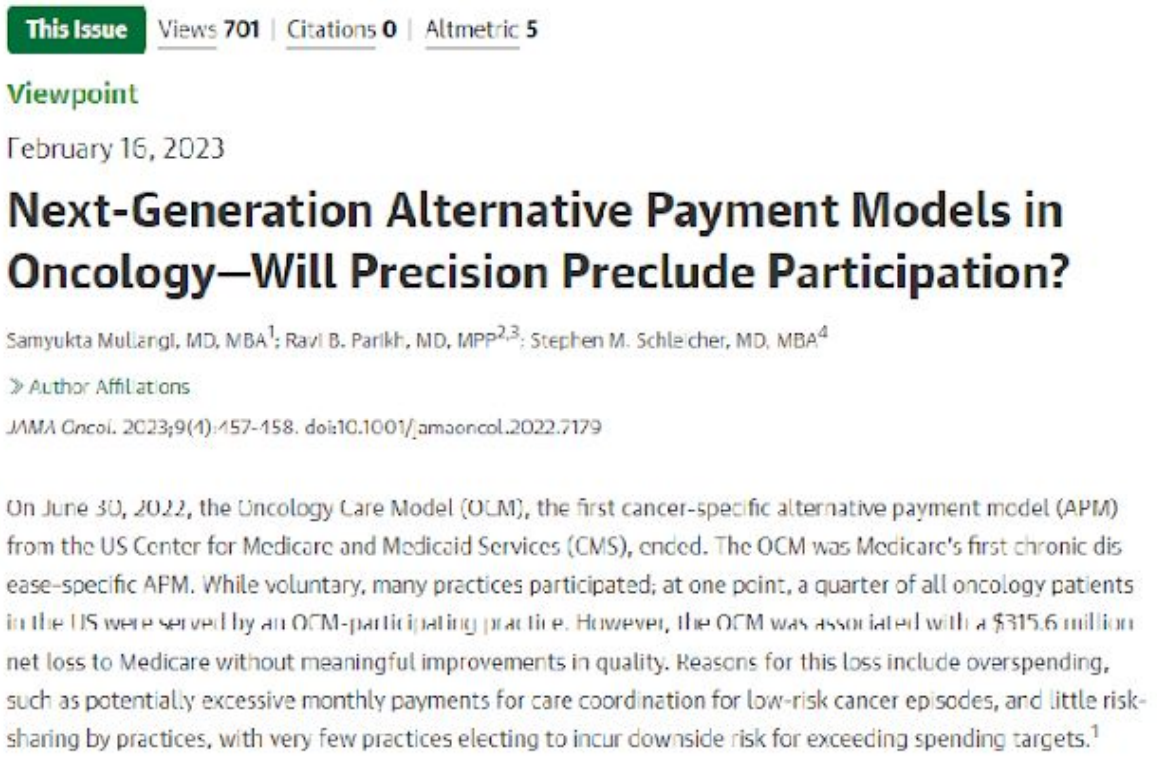
Narrower safe zone + mandatory risk halted created problems with participation

100% = we spend what CMMI predicts we should



For both, owe money back if you don't save 2%

In the end, less than 1/3 of the number of OCM practices signed up for EOM which launched 7/1/23.



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Viewpoint

February 16, 2023

Next-Generation Alternative Payment Models in Oncology—Will Precision Preclude Participation?

Samyukta Mullangi, MD, MBA[1]; Ravi B. Parikh, MD, MPP[2,3]; Stephen M. Schleicher, MD, MBA[4]

» Author Affiliations

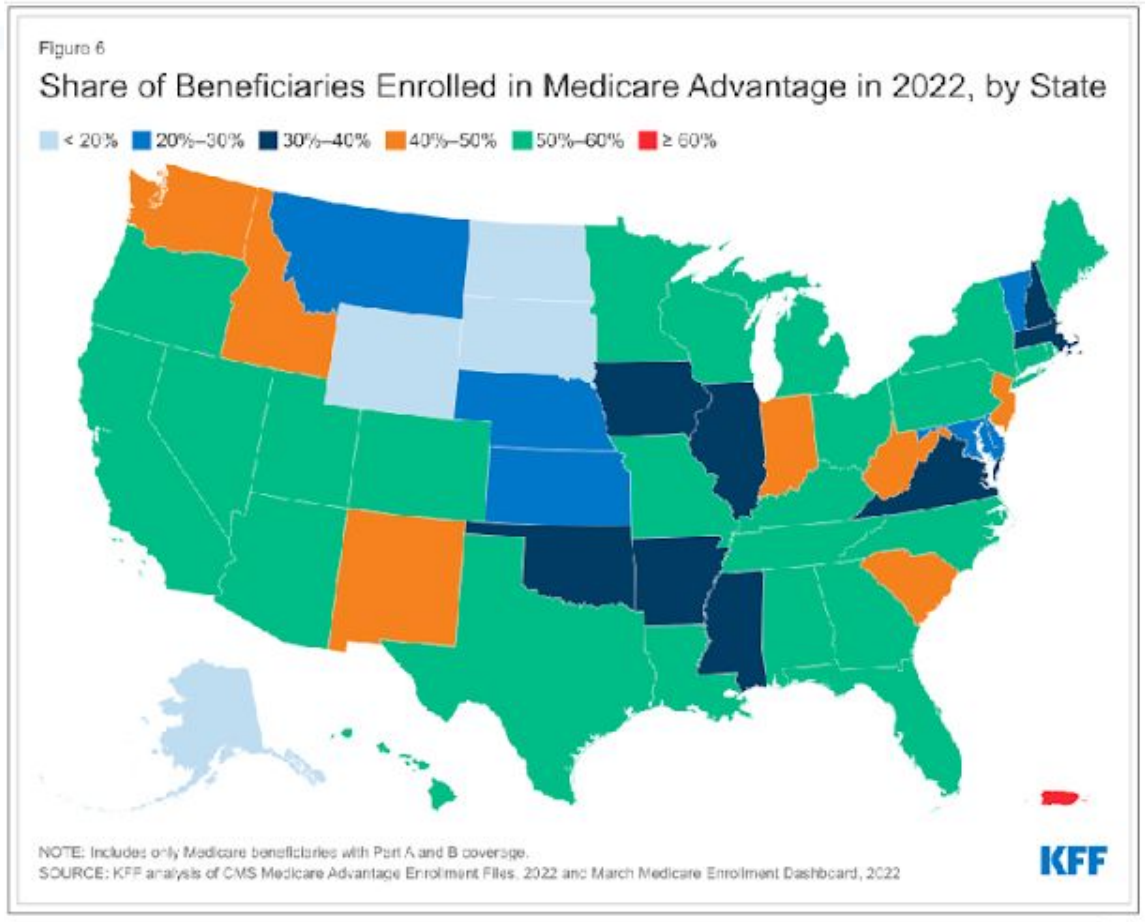
JAMA Oncol. 2023;9(4):457-458. doi:10.1001/jamaoncol.2022.7179

On June 30, 2022, the Oncology Care Model (OCM), the first cancer-specific alternative payment model (APM) from the US Center for Medicare and Medicaid Services (CMS), ended. The OCM was Medicare's first chronic disease-specific APM. While voluntary, many practices participated; at one point, a quarter of all oncology patients in the US were served by an OCM-participating practice. However, the OCM was associated with a $315.6 million net loss to Medicare without meaningful improvements in quality. Reasons for this loss include overspending, such as potentially excessive monthly payments for care coordination for low-risk cancer episodes, and little risk-sharing by practices, with very few practices electing to incur downside risk for exceeding spending targets.[1]

	# Participants
OCM launched 6/2016:	190
OCM ended 6/30/2022:	122
EOM list 3 days before launch:	67
Final EOM list as of 7/1/23:	44

However, in my personal opinion, it would be short sighted for any practice to ignore VBC given all the changes around us…

Medicare MA (capitated model) is outpacing FFS



Risk bearing entities are forming around us (and none yet know how to solve cancer care)

AGILON HEALTH

Transforming Primary Care.

agilon health is transforming health care for seniors by empowering primary-care physicians to focus on the entire health of their patients. Through our partnerships and our platform, agilon is leading the nation in creating the system we need – one built on the value of care, not the volume of fees. We honor the independence of local physicians and serve as their partners

Oak St. Health

MEDCITY INFLUENCERS

Value-Based Primary Care Must Also Integrate Specialty Care

The intentional use of specialty care coordination inside value-based, accountable primary care structures are necessary tools in the march to reward value and positive health outcomes over the volume of services rendered.

Aledade

Success in value-based care starts with physicians: How Aledade's Clinical Engagement Team is delivering change through real-world expertise

wellvana

IT'S MORE THAN VALUE-BASED CARE. IT'S CARE YOU VALUE.

MAIN STREET HEALTH

Reinventing rural health.

Main Street Health is leading the way in creating value-based healthcare solutions for rural America.

RUBICON FOUNDERS

We partner with exceptional teams that create value by transforming lives. Our investment focus includes large companies and spin-outs.

Questions?