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SP316

MEASURING VALUE. A peer-reviewed article from authors at Florida Cancer Specialists & Research Institute addresses the need for an alternative to medication possession ratio as a performance/quality metric, and presents a multifaceted approach to evaluate specialty oncology pharmacy services. With a Call to Action. [SP316-SP324.](#)



POWELL



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IN FOR THE LONG HAUL.

In a groundbreaking partnership, Takeda will invest in Xavier University of

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BETTER PATIENT DATA. The president of Ontada discusses collaborations to incorporate social determinants of health into the electronic medical record, [SP312.](#)

TRILACICLIB RESULTS. This first-in-class therapy prevents myelosuppression by arresting bone marrow cells when they are at key point before DNA replication. It promises fewer hematological events and better quality of life. Already approved in extensive stage small cell lung cancer, trilaciclib is now being studied in other cancers and reports real-world data, [SP335.](#)

**CONTINUING EDUCATION.**

Updates and Evolving Treatment Strategies in Acute

Myeloid Leukemia, [SP358-SP392.](#)

POLICY

Addressing Cancer Health Disparities in a Multilateral Collaboration in an Independent Community Cancer Clinic: Translating Words Into Action

Kashyap Patel, MD; Hirangi Mukhi, BS; Anjana Patel, BSc; Niyati Nathwani, MD; Dhwani Mehta, MS; Jennifer Sherak, MBA; Natasha Clinton, MSN, APRN, AOCNP; Holly Pizarik, JD; Benjamin Brown, BS; Sara Rogers, PharmD; Mary Kruczynski; Nicolas Ferreyros, BA; and Ted Okon, MBA

NO ONE LEFT ALONE, a program to provide financial assistance and access to cancer care at Carolina Blood and Cancer Care Associates in South Carolina, was first presented during a session of the Community Oncology Alliance 2022 Community Oncology Conference, held March 17-18 in Kissimmee, Florida.

Take-Away Points

During 2021, No One Left Alone achieved the following:

- 319 patients received cancer treatment and 154 patients were covered. Nearly half (48%) of patients receiving cancer treatment at the practice were identified as needing financial support.
- Of the patients receiving cancer treatment, 29 did not report income data. Of the 290 who did report income data, 67% of households reported an annual income below \$75,000.
- The program generated \$1,769,520.58 in financial help relating to parenteral drugs for patients.
- No patient was turned away for treatment, regardless of ability to pay.
- The practice pharmacy found resources to cover \$253,218 in out-of-pocket costs for 61 patients, involving 374 prescriptions.
- Over 12 months, 53 patients received free drugs with a total value of more than \$1.63 million.

CONTINUED ON SP398 »

PAYMENT MODELS

OCM Successor Puts Focus on Equity in Cancer Care—With Fewer Dollars for Services

Mary Caffrey

DAYS BEFORE IT EXPIRED, CMS announced a replacement for the Oncology Care Model (OCM) that officials say will put more focus on health equity—but with less money to offer services that physicians say have improved patients' lives.

The OCM, launched in 2016, ended on June 30 amid calls for an extension and praise from oncologists who say they will never return to the old way of delivering care. Despite the OCM's flaws, practice leaders say they've learned a lot, which they see reflected in the successor, the Enhancing Oncology Model (EOM), announced on June 27.^{1,2}

CONTINUED ON SP403 »

New Enhancing Oncology Model Builds on Knowledge From the OCM

Stuart Staggs, MSIE

WHEN THE CENTER for Medicare & Medicaid Innovation (CMMI) announced the Oncology Care Model (OCM) in 2015,¹ The US Oncology Network (The Network) was excited to see an oncology-specific model that focused on all aspects of value-based care. Aimed at improving the patient experience and quality outcomes while also bending the cost curve, the OCM pilot program completed a 6-year run, and its replacement, a new program called the Enhancing Oncology Model (EOM), has just been announced.² Performance Period (PP) 9 results for the OCM have been reported, and The Network practices earned top quality metrics while delivering substantial cost savings. Steady progress resulted in significant achievements. A closer look at The Network PP9 results and how they were achieved, as well as an overview of the new EOM program, may provide some valuable insight to help practices and payers successfully transition to the new model.

CONTINUED ON SP405 »

OCM Successor Puts Focus on Equity in Cancer Care— With Fewer Dollars for Services

MARY CAFFREY

CONTINUED FROM COVER

However, the EOM will not start until July 2023, creating a yearlong gap for practices that took part in the OCM and relied on it to report quality measures to Medicare. Now, these practices will be required to report through the Merit-based Incentive Payment System (MIPS), which serves as a fallback option for any practice that receives Medicare payments but does not participate in an advanced alternative payment model (APM). A 2015 law overhauling Medicare reimbursement requires quality reporting under either MIPS or an APM.^{3,4}

Early reviews of the EOM are mixed. Physicians, including some who spoke with *Evidence-Based Oncology™ (EBO)* say the Center for Medicare & Medicaid Innovation (CMMI) made several improvements that will make the new model easier to administer than the OCM. But there's a downside: Monthly payments that OCM practices used to fund new services—such as patient navigation—will be cut 56% for each Medicare patient and 37% for those receiving both Medicare and Medicaid.²

“If you’re a practice that hasn’t already invested in the OCM, now you have a smaller population, lower MEOS [payments], and you have to do 2-sided risk....It’s going to be hard to get the practices that really need this to voluntarily participate.”

—Stephen Schleicher, MD, MBA,
chief medical officer, Tennessee Oncology

In its announcement, the Biden administration addressed complaints that the OCM fell short in addressing disparities in treatment and outcomes, and that it failed to reward practices that cared for the poorest patients. The EOM comes with significant new reporting requirements, which will track demographic information and how well practices deliver care when patients have “health-related social needs.”

“There are stark inequities in the ability of people with cancer across race, gender, region, and income to access cancer screening, diagnostics, and treatment,” said CMS Administrator Chiquita Brooks-LaSure. “CMS is working to advance President Biden’s Cancer Moonshot goals by helping Medicare cancer patients better navigate a challenging and often overwhelming journey. The Enhancing Oncology Model will incentivize participating oncology practices—including those in rural and underserved areas—to improve the provision of high quality, coordinated care that addresses patients’ social needs and improves patient and caregiver support.”¹

When the EOM was unveiled, Ted Okon, MBA, executive director of the Community Oncology Alliance (COA), said the group was “disappointed” with both the plan to cut monthly payments and with the yearlong gap between the 2 models. “During this time, practices will have to shoulder the extensive investments and operational changes put in place to benefit patients without reimbursement,” he said.⁵

In the weeks that followed, Okon reacted strongly to additional CMS proposals that will cut the Medicare conversion factor by 4.42%, along with “additional cuts to oncology, imaging, and radiation.”⁶ Finally, COA blasted a separate plan that would halt reforms to the 340B drug discount program, which community oncologists say have pushed too many independent practices into mergers or buyouts from hospitals.⁷

The net result, some community oncologists say, is that the EOM could be a tough sell to practices that lack experience in delivering value-based care. Larger community oncology networks that had mastered the OCM in its final years will still have to navigate the financial pieces with care. As Okon stated, COA fully supports screening for social needs and collecting patient-reported data; however, “it seems unfair to burden practices with more work but pay less for it.”

Stephen Schleicher, MD, MBA, the chief medical officer for Tennessee Oncology, praised CMMI for building a new model that clearly reflects lessons from the OCM and feedback from physicians. But Schleicher said that cuts to Monthly Enhanced Oncology Services (MEOS) payments, which are the more predictable of 2 Medicare reimbursement streams, could put practice transformation beyond the reach of those who most need to embrace it. Even practices that were not part of OCM must take on some downside risk right away. This is a change from OCM, which let practices learn the model before taking on 2-sided risk.

“Tennessee Oncology is excited for this next model. We want to understand more, but it will take a lot for us not to participate—to not want to keep innovating with a partner like Medicare,” Schleicher said. “But if you’re a practice that hasn’t already invested in OCM, now you have a smaller population, lower MEOS [payments], and you have to do 2-sided risk—and one option might not get you out of MIPS.

“It’s going to be hard to get the practices that really need this to want to voluntarily participate,” Schleicher stated. “I’m afraid we’re going to get some selection bias on who’s excited to participate.”

Lessons From the OCM

The OCM, first proposed in 2015, created financial incentives for providers who offered a more complete set of cancer care services, with a focus on care coordination.⁸ The goal was to reward those who offered appropriate care—not necessarily the most expensive care. The model had several defining features:

- It required participating practices to offer several enhanced services, including 24/7 access to the patient’s medical records, use of a certified electronic health record, patient navigation, a documented care plan including survivorship care, and treatment that followed clinical guidelines.
- Practices had incentives to keep patients out of the hospital and the emergency department (ED). Using technology, many developed sophisticated triage systems to respond to patient calls. Practice schedules were revamped to accommodate same-day, evening, or weekend appointments. More attention was paid to services, such as nutrition, that help keep patients out of the ED.
- Practices had to develop systems for tracking and reporting patient quality data, which were needed for reimbursement. »



Ted Okon, MBA, executive director, Community Oncology Alliance.



Stephen Schleicher, MD, MBA, chief medical officer, Tennessee Oncology.



Kashyap Patel, MD, CEO, Carolina Blood and Cancer Care Associates; president, Community Oncology Alliance.



Edward J. Licitra, MD, PhD, chairman and CEO, Astera Health Partners.

Reimbursement through the OCM came through 2 streams:

1. Practices received monthly MEOS payments based on episodes of care.
2. Performance-based payments were made retroactively, based on measures of a practice's ability to deliver quality care and achieve savings. Over time, practices were encouraged to take on "downside" risk in this second stream—meaning they would owe Medicare money if they fell short of benchmarks.

Leading oncology practices have said that the OCM, while far from perfect, propelled them forward to make strides in practice transformation that would have been harder to achieve without Medicare's leadership. Many commercial payers have developed versions of the OCM, and few can envision returning to care without services such as patient navigation or care planning.

BOTH SIDES IMPROVED OVER TIME. A chief criticism of the OCM is that it failed to save enough money for Medicare.⁹ Large community oncology networks dispute this claim, arguing that the bad reviews were based upon outcomes during the model's early years, before practices developed efficiencies to administer it well.

During a recent webinar, leaders from The US Oncology Network said that the OCM had brought \$240 million in savings for Medicare going into 2020, and the network had seen a 24% drop in ED visits and a 37% decrease in hospitalizations (See **Cover** for related article).¹⁰

At the same time, CMMI tweaked the model to address complaints that payment structures were not keeping pace with drug development, shortchanging those practices that hewed to guideline-directed care.

What's New Under the EOM

Physicians have acknowledged that the next incarnation of the model should address health equity, and Kashyap Patel, MD, president of COA, supported this change when CMMI announced its "refresh" of APMs in 2021. "So far, models have focused on cost, quality, and patient experience. [Adding] equity as one of the factors is a welcome change," Patel said.¹¹

The EOM is proposed to run for 5 years through June 2028. It retains some key elements of the OCM; notably, it will be voluntary, not mandatory. It retains the basic structure, with 6-month care episodes and requirements for enhanced services, as well as the 2 reimbursement streams: monthly payments tied to episodes of care, and performance-based payments based on quality measures and demonstrated savings.

However, there are some important differences. Oncologists who spoke with *EBO* praised CMMI for narrowing the scope of the EOM to reward those practices that design systems for true practice transformation, without penalizing practices for events beyond the oncologists' control.

LIMITING NUMBER OF CANCER TYPES. In the biggest change, the EOM applies only to Medicare patients undergoing chemotherapy for common cancer

types: breast cancer, chronic leukemia, lung cancer, lymphoma, multiple myeloma, prostate cancer, and small intestine/colorectal cancer. In contrast, the OCM covered nearly all types of cancer. Oncologists who spoke with *EBO* praised this decision, because it's less likely that an outlier case—one with high costs and fewer similar cases for comparison—will throw off the practice's overall performance data.

"If you have patients with the 7 most common cancers, you're really focused on how you can take better care of those patients—and how you can transform the clinical care of those patients," Edward J. Licitra, MD, PhD, chairman and CEO of Astera Health Partners, said in an interview. "By choosing the 7 most common cancers, it actually creates a much larger pool of patients. So, this controls the outlier phenomenon."

If practices are evaluated on how they manage common cancer types, Licitra said, they can concentrate on selecting the right therapies, creating proper regimens, and enrolling patients in the right clinical trials. "You can really have a much more focused approach to taking care of patients, improving their experience, and controlling costs," he said.

CERTAIN LOW-RISK PATIENTS EXCLUDED. The EOM will not cover patients with low-risk breast and low-risk prostate cancer. Schleicher explained that these conditions are typically treated with hormonal therapy, and that the oncologist can do little from a care management standpoint to affect overall care costs. Under the OCM, a low-risk cancer patient who had a heart attack or joint replacement—and received that care elsewhere—could hurt the oncology practice's performance.

"I think this is an appropriate interpretation of OCM feedback reports," Schleicher said.

ATTRIBUTION. The EOM attempts to resolve a top physician complaint: When a patient sees many specialists, which practice includes that person in their roster of care episodes? Under the new program, if no practice provides 25% of all cancer-related evaluation and management (E/M) services for a patient during a 6-month episode, then the practice receiving attribution for that patient will have provided the plurality of E/M episodes.^{2,12}

PATIENT-REPORTED OUTCOMES. As expected, the EOM will add requirements for practices to collect electronic patient-reported outcomes. And in a consumer-friendly move, no co-payments will be required for patients to receive enhanced services.

TAKING ON 2-SIDED RISK. Risk arrangements will start with a benchmark, which is an estimated amount of cost for all episodes in a 6-month period. All practices enrolled in the EOM will be required to take on some "downside" risk; however, the program offers 2 different options:

1. Risk Arrangement 1, a lower-risk tier, will offer a limited level of performance-based reimbursement while limiting losses. According to information from CMMI, the stop loss will be capped at 2% of the benchmark, while the stop gain will be capped at 4%.

2. Risk Arrangement 2, a higher-risk tier, offers greater reimbursement potential with more risk of repaying Medicare if benchmarks are not met; stop loss can reach 6% of benchmark, while the stop gain can reach 12%.

The first tier may appear to be the best option for practices that are less experienced in value-based care, but there's a catch: The lower-risk tier will not qualify as an APM, and these practices will still have to report under MIPS.¹²

Addressing Health Equity in Cancer Care

As expected, a major focus of the EOM is addressing health equity: The model will include additional payments to oncology practices for patients who qualify for both Medicare and Medicaid. Practices must report demographic data and outline plans to address health equity.

Oncologists and practice leaders were surprised that the base MEOS payments will drop from \$160 to \$70. For dually eligible patients, MEOS payments will be \$100 per month.^{2,12} And, Schleicher said, the extra \$30 for Medicaid patients does not apply to the patient's total cost of care, which will aid practices when they measure savings.

Milena Sullivan, managing director for Avalere Health, explained in an email how the EOM will address patients who are "dually eligible." These beneficiaries are enrolled in both Medicare and Medicaid, "with Medicare serving as the primary payer, while Medicaid wraps around by providing assistance with premiums and cost sharing." As Sullivan explained, the EOM would recognize that these patients are often sicker and require more complex care; they represent 19% of enrollees, but 34% of spending.

Schleicher said the MEOS payments are "crucial" for practices' ability to deliver holistic care, so any cut presents a challenge. Already, many OCM practices have worked with commercial payers to extend enhanced services to every patient. Losing MEOS revenue will mean cost shifts for some practices; for others, services may be cut.

Practices have until September 30 to apply for the EOM, and it remains to be seen if the proposed reimbursement scheme will attract new participants. Already, CMS has seen the faltering of one highly touted evidence-based model—the Medicare Diabetes Prevention Program—when too few providers enrolled. Diabetes education advocates warned that this would happen because the reimbursement schedule was inadequate, given administrative costs.¹³

"Community oncology practices are fully committed to positive, patient-centered improvement of cancer care and look forward to supporting CMMI and practices to make the EOM a success," Okon said. "The goals of the EOM are ones we wholeheartedly support, especially related to improving cancer health equity, electronic patient-reported outcomes, enhanced access to cancer screenings." ♦

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New Enhancing Oncology Model Builds on Knowledge From the OCM

STUART STAGGS, MSIE



CONTINUED FROM COVER

Patient Care Improved, and Savings Were Seen

The Network eagerly embraced the OCM, viewing it as a way to reduce costs while improving the quality of care, the patient experience, and patient outcomes. Since OCM's start in July 2016 through May 2022, the 14 practices in The Network participating in the OCM enrolled more than 125,000 unique patients into the program.

The OCM was structured as an episode-based payment model, with each episode triggered when a patient received a qualifying chemotherapy treatment. Starting on July 1, 2016, practices were evaluated for each 6-month interval of participation, known as a Performance Period. Practices were evaluated based on total care provided for the patient, including nononcology care.³

“For oncology practices, the OCM was a journey into unknown territory: It required a whole new way of doing business, as practices had to transition from volume-based reimbursement models to a new model focused on delivery more value.”

—Stuart Staggs, MSIE,
director of strategic programs,
The US Oncology Network

Program metrics across The Network steadily improved over time, culminating in impressive results for PP9. Of note:

All 14 participating practices achieved a 100% performance multiplier for the last 2 Performance Periods, demonstrating a continued improvement in quality even during the challenges brought about by COVID-19 that began in 2020. (The performance multiplier is a calculation based on a practice's quality scores.)

Comparing late 2020 with late 2016, The Network saw (1) emergency department (ED) visits reduced by 24% across the 14 participating practices; (2) hospice utilization beginning more than 3 days before death increased by 11%; and (3) hospitalizations, a performance measure eliminated by CMS but still tracked by The Network, fell by 37%.

- Patient-focused quality measures improved for pain, depression, and patient experience from measure inception through PP9. Thirteen of the 14 practices achieved 10 of 10 points for pain, while nine practices earned 10 of 10 points for depression. Steady improvement was also noted for patient experience from PP3, when the measure was first introduced, through PP9.
- Within The Network, 86% of OCM practices beat their benchmark amount for total cost, compared with 75% for all OCM practices nationwide.
- Over the first 4.5 years of the OCM—through PP9—practices in The Network saved Medicare \$240 million compared with the benchmark amount. These high-performing organizations received some of those dollars back in shared savings.

Resources to Drive and Support Success

For oncology practices, the OCM was a journey into unknown territory: It required a whole new way of doing business, as practices had to transition from volume-based reimbursement models to a new model focused on delivering more value. Given its periodic rule changes, frequent updates, and complex reporting requirements, it was challenging for practices to try to implement this complex program on their own. However, comprehensive, proven resources provided by The Network and McKesson were utilized by all OCM practices across The Network. These included industry-leading technologies to support decision-making at the point of care, advanced analytics to provide actionable data and optimal data management, innovative pharmacy solutions to drive and support efficient drug management, and many other useful resources. Practices also had access to thought leaders and key staff with deep expertise in value-based care. »



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Each of the 14 practices participating in the OCM was assigned a Network Value-Based Care Transformation Lead, an expert to guide the practice not only on program requirements, but also performance improvement. The Transformation Team was formed to develop and utilize many innovative tools and consistent activities to drive deep model adoption and improve OCM outcomes. Toolkits for pain, depression, ED and hospital utilization, hierarchical condition category documentation, geriatric risk, and advance care planning were developed in collaboration with practices' Quality Leadership to guide practices in these critical areas. Regular meetings were held for several reasons: to keep practices informed about program changes, to ensure they were making progress on key action plans, to coach them through any difficulties, and especially to share success stories. Practice workshops were also conducted to focus on solutions to reduce costs and improve care. All of these components worked together, creating a synergy that drove success in this complex program.

Pivoting to the Enhanced Oncology Model

The Network is encouraged by what is known so far about the new program, as its foundation is the assemblage of OCM's many successes. Six practice-redesign activities in the OCM are carrying forward to the EOM, building on what practices have already done around shared decision-making, care and treatment plans, advance care planning, navigation, survivorship, and enhanced services.

Two new redesign activities have been added to the requirements. Practices must now have technology in place for electronic Patient Reported Outcomes (ePROs) by year 3 to proactively receive reported outcomes from patients. The second additional redesign activity addresses health-related social needs, requiring practices to assess patients to identify those at risk in areas like transportation, housing, and food insecurity.

Although CMMI has not defined the quality measures yet, it is likely there will be substantial carryover in quality improvement based on the go forward themes; a deeper focus on health equity is likely as well. Much like the OCM, the model will aim to reduce the need for care at higher acuity levels, such as ED visits and hospitalization.

A big difference between the OCM and the new model is that the EOM will enroll only those patients who are receiving systemic chemotherapy for 1 of 7 prevalent, high-risk cancers: multiple myeloma, chronic leukemia, lymphoma, small intestine/colorectal cancer, and breast, lung, and prostate cancers. Patients receiving only hormonal therapy, such as those with low-risk breast and prostate cancer, are excluded. Model outcomes are focused around the needs of patients who have a higher risk because of the complexity of their diagnoses and cancer therapies. This allows practices to focus on the patients who have heightened needs, but the enhanced services funding will be lower in accordance with the smaller patient population.⁴

Overall, the program is a good progression from the OCM, carrying over benefits on the quality

and redesign fronts, and building on activities The Network has already started to support and expand around equity and social determinants of health. EOM is voluntary, more patient-centric than the last model, and has an even greater focus on patient health equity, while it also expands into broader areas of practice redesign such as ePROs.

A Closer Look at the Challenges

Practices in the OCM had the opportunity to remain in 1-sided risk the first few years to see whether they received a performance-based payment. That is not the case with the EOM: Practices are immediately jumping into 2-sided risk, increasing financial risk prior to fully understanding how to succeed.

On the positive side, CMMI is providing 2 different 2-sided risk plans: lower-risk and higher-risk models. In the higher-risk program, practices have more earning potential, but in turn they face higher penalties if they fail to achieve quality and savings benchmarks. There is a bit more fairness with the EOM around quality performance and payback, compared with the OCM, because CMMI will apply the quality score to the practice's downside payback if one is due, reducing the amount owed to CMS in return for delivering measurable high quality care.

The upfront payment received under the EOM to fund enhanced services will be reduced from the OCM's \$160 a month, down to \$70 a month for Medicare patients and to \$100 a month for patients dually eligible for Medicare and Medicaid.

Practices must carefully examine their options when considering participation. We will work with Network practices to analyze care management funding in tandem with the risks they could face to determine the upside vs potential downside of having to perform at 98% of benchmark to be neutral or better.

PAYERS CAN PARTICIPATE. Payers are being encouraged to partner with the EOM program through a multipayer model geared for private payers, Medicare Advantage plans, and Medicaid agencies at the state level. To participate, payers must be closely aligned with the tenets of the model, especially around equity, data sharing, and payments. They must also partner with an EOM participant for the duration of the model, so practice engagement is required.

Lessons Learned for Payers and Practices

The OCM offered 2 important lessons that can help managed care executives make good decisions as they transition to the EOM. First, from a managed care standpoint, the more value-based programs are aligned across the oncology landscape, the easier it is for practices to implement a program and make the necessary changes required for patient, program, and practice success. Consequently, payers should strive to find ways to achieve more similarities across models. The EOM is a good opportunity for payers to create more harmonization by getting all programs more aligned, creating strong momentum to drive the overall transformation of oncology to value-based care.

Second, in some of the commercial arenas, such as managed care, models tend to change fairly often. Payers frequently try a program for a year and then switch to something else, rather than leaving it in place long enough for results to take hold. This quick turnaround inhibits the ability to analyze what is working and what is not, depriving practices of vital information they needed to improve a program.

From a practice perspective, for those trying to partner with payers, it is imperative to know where your practice stands from a quality and cost standpoint. Practices need to address key issues, such as where improvement is needed, how the practice can partner with payers around areas of change, and how to keep patients at the center of initiatives while ensuring that they receive all needed services. The payer/practice partnership is critical, as the payer and the practice together enable value-based care.

Careful Evaluation Is the First Step to the EOM

With value-based care, practices have to perform a balancing act, trying to provide high-quality, cost-efficient care, optimal patient experiences, and sustainable outcomes while also taking on a tolerable amount of risk. Only time will tell whether the EOM can deliver all of these critical elements.

The Network will be helping its practices determine the viability of the EOM for their organizations, doing a deep dive and collaborating with each practice to determine the benefits and risks of jumping into this new model. Our initial go-forward approach will be to encourage all practices to consider applying by September 30, 2022, then continue to evaluate the model as they make the decision whether to sign the agreement, which could happen this winter or spring. ♦

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The statements contained in this document are solely those of the author and do not necessarily reflect the views or policies of CMS. The author assumes responsibility for the accuracy and completeness of the information contained in this document.

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