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The Oncology Care Model: Oncology's First Foray Away From Volume and Toward Value-Based Care.

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Value-based health care is positioned to become the de facto standard for delivery of care in the United States, replacing traditional fee for service with alternative payment models (APMs), focusing on value rather than volume. Over the years, the Centers for Medicare & Medicaid Services (CMS) has designed and piloted payment and delivery models that demonstrate a trend toward increased accountability, evolving from pay for reporting to pay for performance with bundled payments, which place providers and payers into shared financial risk arrangements. The Oncology Care Model (OCM) is a specialty-focused APM, with the goal of increasing coordination of oncology care while reducing associated costs, first launched on July 1, 2016, with a 5-year run through June 30, 2021.1 The model tracks total costs of care initiated by the administration of chemotherapy for Medicare beneficiaries and followed in 6-month episodes. Beneficiaries can have multiple episodes during the 5-year pilot unless they enter hospice or become deceased. There are currently 13 payers and 179 practices involved, with the expectation that care adheres to National Comprehensive Cancer Network (NCCN) guidelines and utilizes certified electronic health record technology.

For compensation, practices are financially accountable for performance. Participants receive standard Monthly Enhanced Oncology Services payments of $160 per beneficiary per episode, to a maximum of $960. This amount is intended to support adherence to higher quality care. The more experimental aspect is the Performance-Based Payment (PBP), whereby risk-adjusted target prices are retrospectively compared with actual expenditures. If total costs are below the target price, then the practice receives this difference as a PBP. Target prices and risk exposure depend on whether a practice agrees to a 1-sided or 2-sided risk arrangement.

The 1-sided risk arrangement entails zero downside risk for practices. Target prices are set at 4% below benchmark prices. The maximum benefit would be equivalent to the target price less actual costs, without being accountable for costs exceeding target prices. For example, a benchmark price of $10 000 would have a target price of $9600. If actual costs are $8000, the practice would receive a PBP of $1600. The 2-sided risk arrangement results in downside risk exposure. The target price ceiling is higher, with a 2.75% reduction from benchmark prices, giving practices the potential to recoup a higher PBP. However, practices will become responsible for costs exceeding the target price. Following the same example, the target price would be $9750 and the actual cost $9900, so instead of reaping a PBP, the practice would be responsible for the difference. All practices started with 1-sided risk arrangements and could have opted for the 2-sided risk model in 2017. However, none has voluntarily elected 2-sided risk at this time, leading to the development of a third option: an alternative 2-sided risk model that features reduced discounts as well as reduced stop-gain and stop-loss amounts based on practice revenue.

After reconciliation of the fourth performance period in mid-2019, practices that achieved a PBP can elect to stay in the 1-sided model or switch to the 2-sided risk model. Otherwise, practices will be forced to switch to the 2-sided risk model. This imposition creates a strong incentive to achieve the target price within the 1-sided risk model so that the option to stay in an upside risk arrangement is available.

A practice aiming to achieve a PBP requires leadership willing to reshape infrastructure to harness data and engage providers individually. In order to successfully implement OCM, a practice will need to transform itself on both macro and micro levels to achieve success and reduce exposure to downside risk. An essential first step is leadership committed to change because OCM is only part of the evolving reimbursement landscape.2

As more APMs roll out over the years, hospital systems that are better prepared to adapt to risk schema with potential downside risk will find themselves in a better financial position, and ultimately be able to deliver higher quality care at lower costs. This transition requires buy-in from leadership because of the scope of long-term goals for financial sustainability and also the extent of externalities that typically are handled by executive management, who have access to resources across the system and could make decisions to reach

allocative efficiency. As with any system-wide change, there will be initial capital costs and subsequent upkeep that may lead to short-term losses for anticipated long-term gains. Once leaders have consensus on goals through OCM, the next step is to effectively distill and disseminate data for providers to act on.

The communication strategy should have a direct impact on the provider's level of engagement. Key points to cover are the individual provider's performance and that of the department as a whole, with comparisons with other OCM participants, including at the national level. Performance should be measured by episodic costs summarily, which will ease the effects of any expected outliers. Although one could argue for comparing episodic costs per provider across each department, this methodology could lead to singling out providers and shifting blame purely on cost measures. Certain disease sites may be more resource intensive than others, which may not be represented accurately by the benchmark and target prices. A more palatable approach would be comparing the specialty as a whole with similar departments in the same region or even at the national level. One question that naturally arises is the comparative advantage of an academic center versus community practices. Academic centers tend to have larger systems that tend to manage more complicated patients and thus can have higher costs not represented appropriately by OCM. In the first annual report from CMS, larger practices, higher volume, and academic centers were associated with higher costs per episode.3 Smaller practices might have a more streamlined approach that removes inefficiencies that are not compensated by economy of scale. Providers also may consider the insurance coverage of patients when making treatment decisions. Medicare patients without supplemental insurance are at higher risk for incurring out-of-pocket expenses.4 Further subgroup analysis that may elucidate differences based on practice characteristics and patient populations may be released in future annual reports.

Lastly, improvement of patient care relies on provider engagement and enthusiasm to best align delivery of care with evidence-based guidelines in a changing environment. Because this stratum has the most tangible outcomes, there also are several challenges unique to this aspect of OCM. Providers who lag in PBP may feel stigmatized and pressured to change their practice of medicine outside of their comfort zone. Counter to that, some providers who have practiced differently from national guidelines for an extended period of time, either through training or through personal experience, may feel that patients are best served with different treatment options that are not entirely in the realm of NCCN guidelines. In addition, some providers may see more complex patients who do not conform to the guidelines. Ultimately, the hope is that providers will work in a multidisciplinary approach whenever possible to minimize costs while maximizing clinical outcomes.

At our institution, senior leadership chose to participate in OCM to gain a deeper understanding and prepare for the future of oncology reimbursement. As a National Committee for Quality Assurance Patient-Centered Specialty Practice and Patient-Centered Oncology Medical Home, our leadership recognized the chance to improve on the framework of OCM. Investments totaling ~$230 000 were made to build an infrastructure that supported the operational components of the program, including technology platforms for visual analytics (Qlik; Radnor, Pennsylvania) and clinical pathway navigation (Via Oncology; Pittsburgh, Pennsylvania). As one of the 23 academic medical centers participating in OCM, the data received from CMS presents an excellent opportunity to improve our practice. We established a plan to consistently communicate data to our providers through Qlik. This communication is generated monthly and delivered automatically via email, with a performance scorecard specific to each provider, and also is available to view within a Qlik dashboard. We examine the data to determine initiatives that have the potential to drive down our costs, engage providers and staff, and increase accountability. We then implement proven strategies to achieve program goals, such as tracking compliance with national guidelines through Via Oncology and enhancing the palliative care experience with the recently founded Neu Center for Supportive Medicine & Cancer Survivorship. Because of these efforts, we are on track to receive a PBP for the second performance period, which will allow our institution the choice to elect to either continue with the 1-sided risk model or

switch to the 2-sided risk model. Our institution has successfully adapted and learned that active participation in OCM requires iterative development of strategies and refining our platform through each episode.

In conclusion, OCM presents unique challenges that accompany the goals of a value-based model in a specialty care setting, especially one that requires a relatively high allocation of resources. CMS will soon judge whether participating practices have established themselves as a practice capable of achieving a PBP. If not, these remaining practices will be forced into an environment that will expose them to downside risk. Our institution has adapted strategies to improve on the framework of OCM and engage our providers at the front line, so that quality care is delivered while identifying cost-saving opportunities in the process. This endeavor requires vigilant analysis of cost data while ensuring compliance with evidence-based medicine. That being said, OCM is a work in progress, so we anticipate that there will be similar adjustments to methodology and adaptations created from this initial experience. If practices are not prepared for such changes, it could lead to significant financial consequences affecting the delivery of quality oncology care.

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