Evolving the OCM: OCM 2.0 & Beyond

Webinar
Tuesday, January 9, 2018

Innovating and Advocating for Community Cancer Care

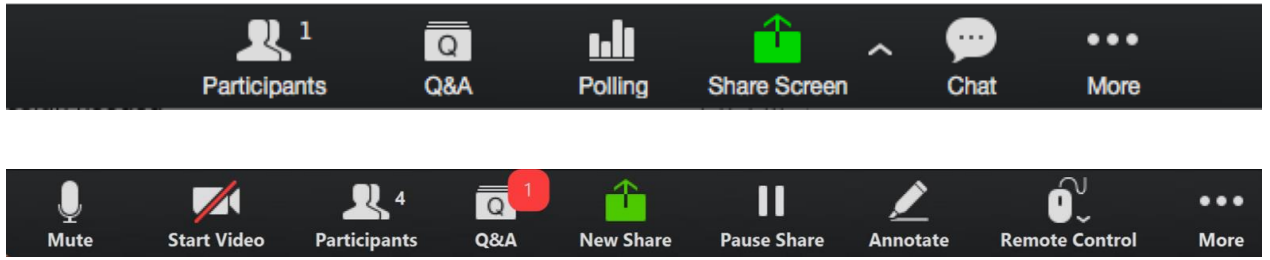
Speakers

- Kavita Patel, MD, MS, Tuple Health
- Basit Chaudhry, MD, PhD
- Ted Okon, Community Oncology Alliance
- Bo Gamble, Community Oncology Alliance

Housekeeping

1. This webinar is being recorded and will be posted on the COA website later this week.

2. Q&A will take place at the END of the webinar. Please submit questions via the Zoom platform – **look for the Q&A button of your screen.**



Innovating and Advocating for Community Cancer Care

"OCM 2.0"
The Journey Ahead

Kavita Patel, MD, MS
Tuple Health

Innovating and Advocating for Community Cancer Care

The Grand Vision

- Meaningful alignment to expand the vision of value-based oncology care
- Preservation of options for patients to experience high quality care in a variety of settings
- Better care coordination
- Enhanced quality for all patients
- Inclusion of innovation and clinical transformation-flexibility and rigorous standards

How We Developed OCM 2.0

- Interviews with:
  - Patient Groups
  - Providers
  - Payers/Employers
  - Federal/State/Local Officials
- 2016 COA Payer Summit
- 2016 COA Annual Meeting
- 2017 COA State of the Union
- 2017 COA Payer Summit
- Focus groups
- Thought Leader Input: Dr. Bruce Gould, Dr. Mark Fendrick
- Literature Review

	OCM 1.0	OCM 2.0	OCM 3.0	OCM 4.0
SCOPE	Episodic payment model for patients undergoing chemotherapy	Comprehensive oncology medical home for patients under active therapy and/or active surveillance	Upfront financial risk for care of patients undergoing active therapy and /or active surveillance	Population Based Capitated Payment for patients undergoing active therapy and/or active surveillance
TRIGGER	Administration of chemotherapy, oral or physician-administered	Administration of chemotherapy, oral or physician administered	Diagnosis of cancer with primary management by medical oncologists	Screening and diagnosis of cancer regardless of primary management
ATTRIBUTION	Patients attributed to the practice	Patients attributed to the practice	Patients attributed to the practice	Patients attributed to the practice
PAYMENT METHODOLOGY	Monthly enhanced fees with shared savings after a discount applied	Monthly care coordination fees with first dollar shared savings	Up front risk adjusted payment with potential for bonus if below cost targets	Capitated population based payment
FINANCIAL RISK	Initial upside with transition to downside financial risk	Initial upside with transition to downside risk	Initial downside risk	Capitated
QUALITY MEASURES	Claims based and practice reported	Reflective of population served-also drawn from combination of claims and practice reporting	Reflective of population served-drawn from claims, practice and patient reporting	Reflective of population served drawn from claims, practice and patient reporting
PHYSICIAN ADMINISTERED DRUGS	No change in reimbursement	No change	Some drugs in a value based arrangement	Drug payments included in capitated payment
ORAL DRUGS	Included	Included with provision for complete claims data along with VBID component	Included with a VBID component	Included with capitated payment
CARE NAVIGATION AND COORDINATON	Part of practice requirements	Part of practice requirements	Part of practice requirements	No specific requirements
EFFICIENCY MEASURES (time spent in direct clinical care)	None	Included	Included	Included
PATIENT ENGAGEMENT	Minimal awareness	Active shared decision-making	Shared decision-making and VBID for consumers	Beneficiary engagement included potentially component of savings
RISK ADJUSTMENT	HCC Based	HCC Based	HCC plus additional factors	

Focusing on OCM 2.0

Elements For Consideration	OCM 1.0	OCM 2.0
Attribution	Practice/TIN	Practice/TIN
Network Design-whats in and whats out	Medical Oncology (primarily)	Community-based medical oncology
Episode Definition	Trigger based on Chemotherapy	Trigger based on therapy choice
Clinical Trials	Not included (without non trial trigger) but risk adjusted	Inclusion
Metrics/Accountability	Mix of Claims, Practice Reporting, Survey	Flexible
Level of Risk	Flexible- 1 or 2 sided	Flexible
Oral Drugs	Included with part of claims	Included with VBID Component
Financial Gains	MEOS + PBP	PMPM+ Shared Savings

Episode/Trigger Definition

- What we have learned: Cancer care is much more than active chemotherapy; payers, providers and patients want to have comprehensive cancer care that begins with prevention and runs all the way through diagnosis, treatment and survivorship
- Patients: want to know that their care is always coordinated and not interrupted because of arbitrary definitions
- Providers: want to deliver high quality care and ensure that savings generated are returned back to clinicians; want to also know that they are primarily responsible for care provided
- Payers: want to offer high quality, competitively priced cancer care
- OCM 2.0 elements:
  - Inclusion once diagnosis is confirmed and management is primarily managed by a medical oncologist

Attribution Elements

- Patients should be attributed to a physician who delivers the plurality of their care
- Patients: want to know that they have one physician coordinating their care
- Providers: want to be acknowledged for work and efforts to coordinate care during the difficult cancer journey
- Payers: Practice level attribution is much more practical
- OCM 2.0 Elements
  - Physician level attribution where plurality of services serve as definition of which physician in a calendar year is attributed to the patient **once treatment begins**; there will be cases where potentially a primary care physician or surgeon might then be attributed, but those cases can be excluded

Innovation

- What we have learned: Patients must be included in clinical trials where appropriate. Novel therapies must be offered in a balance with consideration for cost; OCM 1.0 adjusts for novel therapy inclusion partially; clinical trial patients are generally excluded
- Patients: want access to best information and innovative therapies
- Providers: do not want to be placed in between the cost of drugs and their patients
- Payers: want to find ways to mitigate growing costs of innovation while offering highest quality access to patients
- OCM 2.0 Elements:
  - Inclusion of clinical trial patients
  - **Ongoing work with providers to define how to include novel therapies and how best to determine opportunities for cost savings while not penalizing providers for appropriately prescribing medications**

Metrics/Accountability

- What we have learned: data must be two ways and as close to real time as possible; accountability must incorporate relevant cost and quality measures and the standard risk adjustment methods need to be modified to acknowledge the complexity of cancer care
- Patients: trust their providers but are definitely interested in having access to quality of care metrics that can help them make decisions around cancer care
- Providers: want metrics that are relevant to their population and do not place undue burdens on their practices, thus detracting from clinical care
- Payers: want to offer value-based contracts that balance financial rewards with measures of accountability, incorporating clinical and financial risk
- OCM 2.0 Elements
  - **Build on existing measures sets**
  - **Identify measures that are relevant to practices and have significant volume**
  - **Advance work with IT vendors to ensure data integrity, measurement capability, etc.**

Metrics/Accountability (Continued)

- OCM 2.0 Elements
  - Transparent claims data availability in real time
  - Risk adjustment that incorporates staging and relevant clinical information, socioeconomic status, etc.
  - Quality measures relevant to practitioners with clear inclusion and exclusion criteria with open source data extraction that is adopted by all EHR vendors
  - **Acknowledgment of practices that are QOPI, COC, NCQA certified**
  - **Acknowledgement of QCDR participation**
  - **Financial risk for quality/performance measures**

OCM 2.0 and OMH

- Collaborative effort for a ***NEW*** OMH:
  - American Society of Clinical Oncology (ASCO)
  - Community Oncology Alliance (COA)
  - Innovative Oncology Business Solutions (IOBS)
  - National Committee for Quality Assurance (NCQA)
- Committed to improving the following areas for oncology:
  - Care models
  - Quality measurement
  - Quality improvement
  - Payment models

OMH – Standards and Measures

- Standards
  - 7 main competencies
  - Minimal and optional requirements for each
  - Minimal total score is required
  - Relevant and practical
  - Describes what is required – NOT how to achieve
- Measures
  - Limited set
  - Relevant and practical
  - Gather AND report
  - Automatic reporting
  - Evidence of completed requirements
- More details should be available early Spring 2018

Financial Design

- What we have learned: keeping it simple is best when it comes to the financial elements; ensure financial stability while offering greater potential for upside savings and a limited downside risk
- Patients: do not want OCM 2.0 to increase their copays or out of pocket costs; would, in fact, want the opposite
- Providers: interested in taking downside financial risk with limits on the maximum or some form of stop loss insurance/reinsurance
- Payers: Want to develop value based contracts that include incentives for better care while also incorporating some element of financial risk around cost of care
- **OCM 2.0 Elements:**
  - **PMPM + shared savings…but with straightforward methodology that is easy to reproduce**
  - **Limited financial downside risk**

Drugs

- Inclusion of oral meds
- Inclusion of claims data in a timely manner (particularly 3rd party plans, PBMs, etc)
- Incorporation of concepts related to VBID
  - Goal would be to identify discrete treatment regimens that do not offer any additional value or could even pose potential risks to patients
  - Goal: consensus, evidence-driven benefit design with element of clinical nuance
  - E.g. Tarciva in EGFR+ in patients with no response after 3 months

Additional VBID Ideas

- Potential VBID idea for Drugs:
  - Eliminate copays for oral chemotherapeutics
  - Emerging data illustrating lack of adherence at higher copay rates:
    - Overall 18% abandonment rate, with higher rates in greater OOP categories:
    - 10.0% for ≤ $10 group
    - 13.5% for $50.01 to $100 group
    - 31.7% for $100.01 to $500 group, 41.0% for $500.01 to $2,000 group
    - 49.4% for > $2,000 group

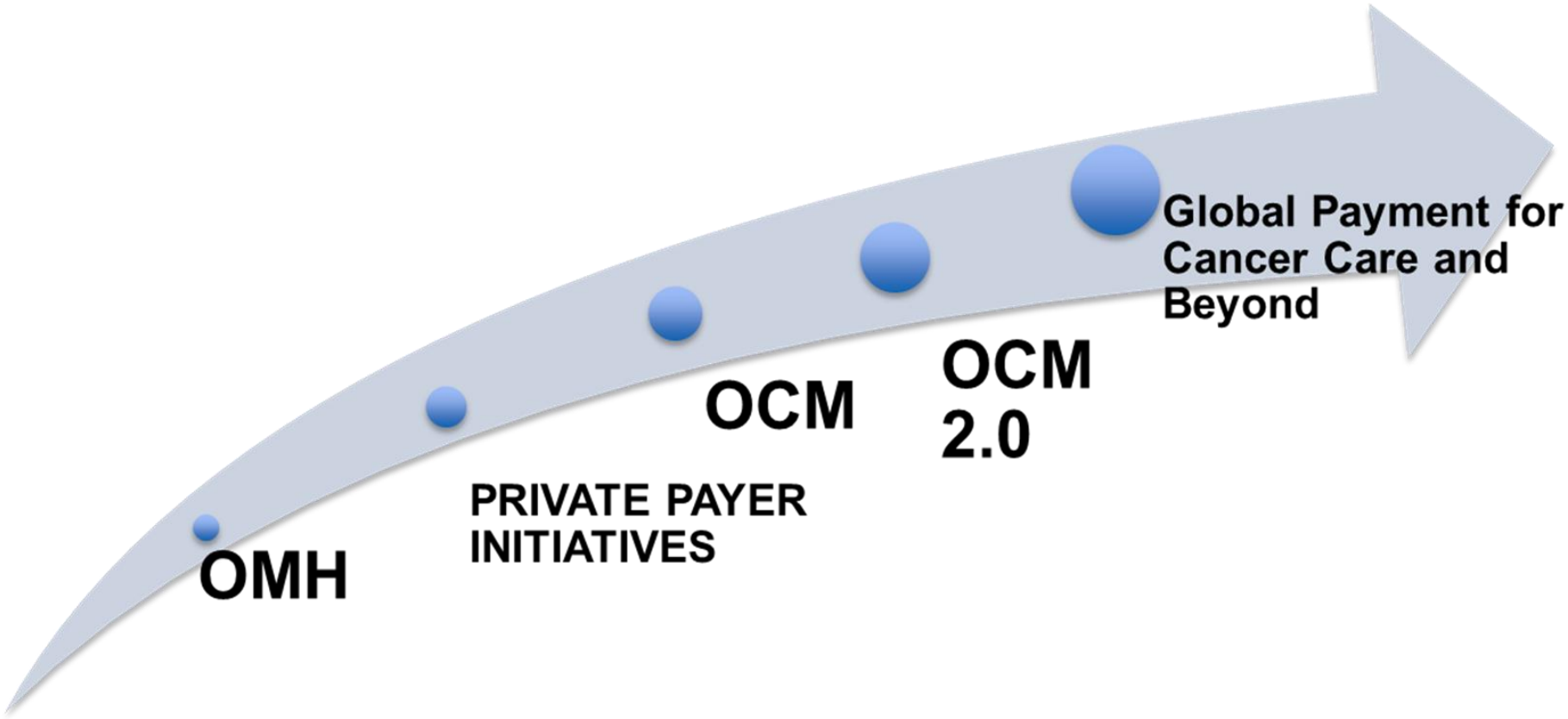
- Armstrong et al. *Journal of Clinical Oncology* - published online before print December 20, 2017

What are sensitive touchpoints?

- Start with certain cancers only? Dealing with issues of volume
- How to incorporate novel therapies
- Lessons from OCM that serve as important caveats:
  - Transformation is hard and costly (not just infrastructure dollars, but labor)
  - Inclusion of almost all cancers may not be best initial approach
  - Novel therapy adjustment and robust risk adjustment key...but how?
- Multi-payer participation

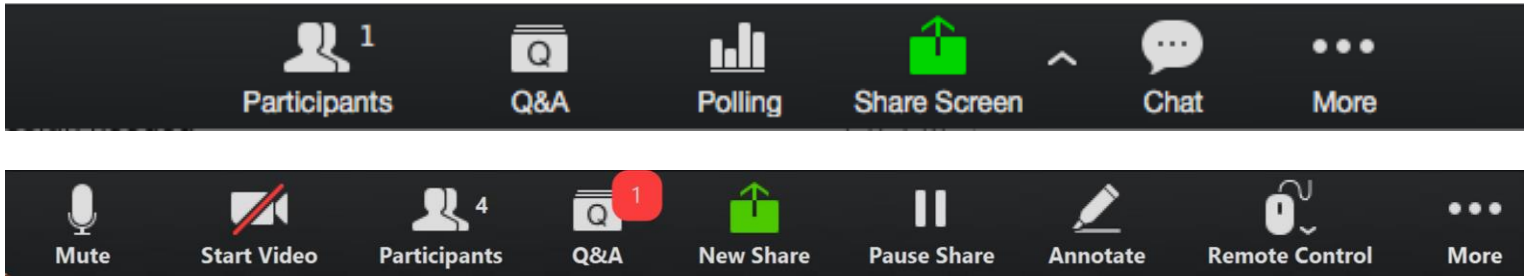
	Potential OCM 2.0 Model
SCOPE	Comprehensive oncology medical home for patients under active therapy and/or active surveillance
TRIGGER	Administration of chemotherapy, oral or physician administered
ATTRIBUTION	Patients attributed to the practice
PAYMENT METHODOLOGY	Monthly care coordination fees with first dollar shared savings
FINANCIAL RISK	Initial upside with transition to downside risk
QUALITY MEASURES	Reflective of population served- also drawn from combination of claims and practice reporting
PHYSICIAN ADMINISTERED DRUGS	No change
ORAL DRUGS	Included with provision for complete claims data along with reduction/elimination of copays for oral chemotherapeutics
CARE NAVIGATION AND COORDINATON	Part of practice requirements
EFFICIENCY MEASURES (time spent in direct clinical care)	Included
PATIENT ENGAGEMENT	Active shared decision-making
RISK ADJUSTMENT	HCC Based

The Journey: Looking Back and Looking Forward



Questions?

Use the Questions & Answer (Q&A) button in Zoom to ask a question!
(Look at the top or bottom of your screen.)



Innovating and Advocating for Community Cancer Care

Thank you!

Learn more about COA, the OCM 2.0, and more at www.CommunityOncology.org

- Be sure to sign up for our emails and newsletters for the latest updates!

Continue the conversation at the 2018 *Community Oncology Conference* taking place April 12-13 outside of Washington, DC.

- Featuring OCM panels and the eighth Payer Exchange Summit.
- Register at www.COAConference.org

Innovating and Advocating for Community Cancer Care