

What is the OCM 2.0

An Ambitious Reform Model to Improve Cancer Care and Reduce Costs

Presented by the Community Oncology Alliance

www.CommunityOncology.org

Innovating and Advocating for Community Cancer Care





Housekeeping

- Phone lines are muted
- Recording and slides will be shared with all registered attendees after the call
- A full copy of the OCM 2.0 application can be found on the COA website
- Email info@coacancer.org if you have any questions or problems



Introductions & Why OCM 2.0

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Innovating and Advocating for Community Cancer Care



What is the OCM 2.0

An Ambitious Reform Model to Improve Cancer Care and Reduce Costs

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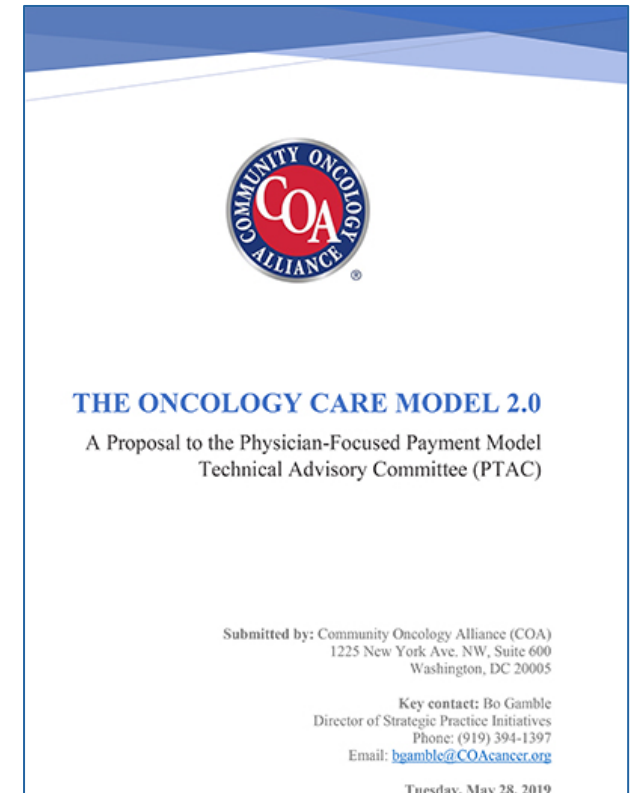
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OCM 2.0 is: One slide with all you need to know

- A blueprint for the next wave of reform for cancer care
 - Medicare
 - Commercial insurance companies
 - Employers
- Components
 - Clinician standards with accreditation
 - Measures
 - Payment model based on quality and value
 - Specific focus on drugs
- With emphasis on:
 - Transparency
 - Collaboration
 - Flexibility
 - Efficiency
 - Open lines of communications





Background: The CMMI OCM (aka OCM 1.0)

- Center for Medicare and Medicaid innovation (CMMI) launched the Oncology Care Model (OCM) on 7/1/16
 - 10 x 6 month episode periods
 - Practice transformation
 - Clinical registry
 - Incentive payment and shared savings
- 195 cancer care teams originally participating
 - Now 176
- 17 commercial insurance companies, each with unique models
 - Now 11
- Approximately 30% of Medicare beneficiaries being treated for cancer



Background: Other Oncology Reform Models

- COA knows of 20+ other oncology reform models out there
- All different, few similarities (shared savings common in commercial models).

Some examples:

- Priority Health – first commercial insurance reform model
- National models
 - Aetna
 - Cigna
 - Humana
- Many variations of regional BCBS models
- 2 major employer based models



Background: COA Deeply Involved in OCM 1.0

- Followed and supported OCM, from before launch to present
 - Host OCM support network for participants – apx. 80% participate
 - Monthly webinars and spotlights on best practices
 - Many comment letters to, meetings and calls with CMMI with feedback, suggestions
- 5 Annual Payer Exchange Summits on Oncology Payment Reform
 - Payers, employers, practices in attendance, sharing and learning
 - Invitation only to encourage frank discussion and sharing
 - Spotlight Medicare and other reform models, sharing of innovative concepts to improve cancer care
 - OCM team have regularly attended and participated
 - What is working AND what is not working

(A lot of observing, asking questions, taking notes)



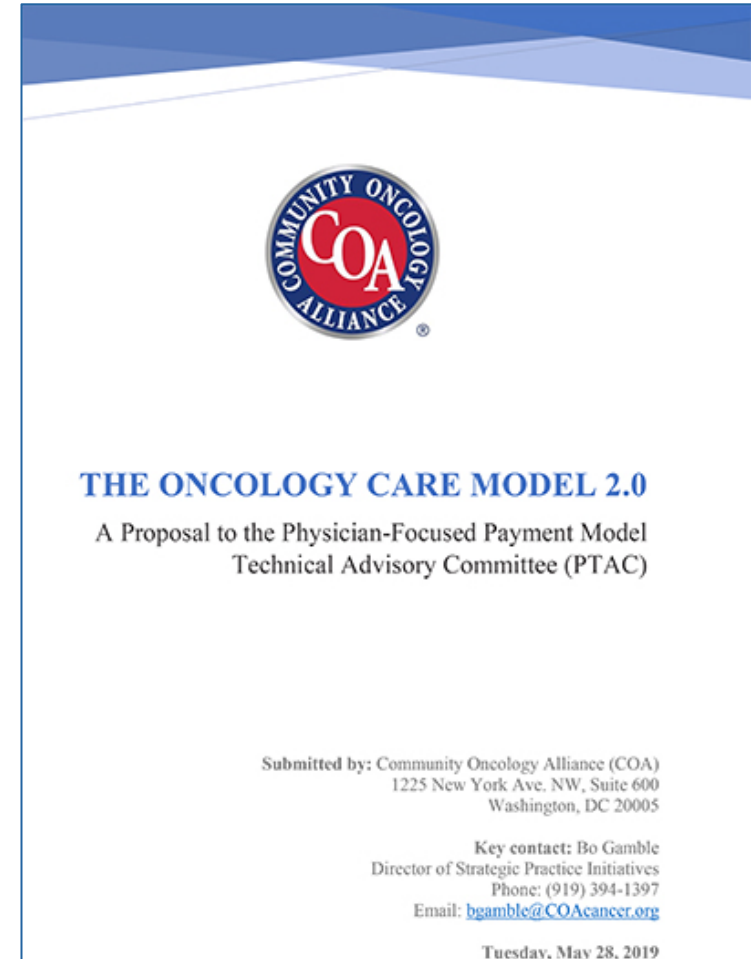
What is the PTAC? And why does it matter?

- The Physician-Focused Payment Model Technical Advisory Committee (PTAC)
 - Reviews physician-focused payment models and makes recommendations to HHS Secretary
- Created in 2015 as part of Medicare Access and CHIP Reauthorization Act (MACRA), along with MIPS, APMs, AAPMs.
 - 11 member committee, incl. physicians and non-physicians
- 34 proposals have been submitted to date
 - 3 for oncology
 - CMS has yet to implement any PTAC-recommended models.



The COA OCM 2.0 Model

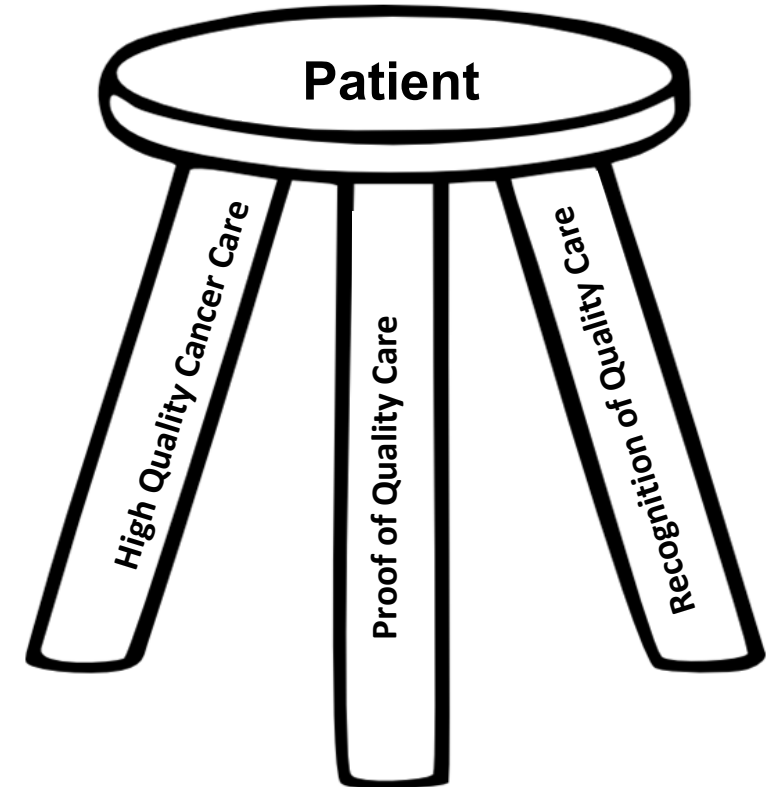
Not your typical PTAC application





What should a reform model achieve?

1. High quality cancer care (Standards)
2. Proof of high quality & value in cancer care
3. Recognition for high quality & value cancer care (Payment methodology)





And... a reform model should also contain

- **Collaboration** - between stakeholders
- **Communication** – effective and efficient
- **Timeliness** – of information to manage the model
- **Transparency** – a complete understanding of all aspects
- **Incentives** – that are appropriate and are manageable



OCM 2.0: Goals and Vision

- Emphasis on the patient
- Universally accepted for high quality cancer care
- Universally accepted measures to prove quality
- Direct focus on drugs/therapies and their active role to promote quality and value
- Collaborative partnerships for appropriate payment methodology
 - Federal, regional, and employers



OCM 2.0: Quality Cancer Care

- Building on COA's Oncology Medical Home program and standards
 - (Just like OCM originally built on the OMH...)
 - Learn more at www.MedicalHomeOncology.org
- New partnership between COA and ASCO to re-invigorate OMH
 - Multi-stakeholder team being formed
- Six standards
 1. Patient engagement
 2. Expanded access
 3. Evidenced based medicine
 4. Comprehensive team based care
 5. Quality improvement
 6. Chemotherapy safety
- Measures reported through QOPI/QCDR processes
 - QOPI will not be required to be an OMH



OCM 2.0: Quality Cancer Care

- Compliance to OMH standards through on-site accreditation and reporting
- Initial measures
 - Care plan QPP 47
 - Screening for clinical depression and follow-up QPP 134
 - Survivorship care plan
 - Proportion receiving chemotherapy in last 14 days of life MIPS 453
 - Proportion not admitted to hospice MIPS 456
 - Others TBD
- EMR and PM systems assisting – already
- Measure benchmarking results for all models
- Measures used for Threshold or Qualifying calculations



OCM 2.0: Drugs/Therapies

- Proposes CMMI waivers to overcome Federal regulatory obstacles
 - Best price calculations, etc.
- Numerous pilots of VBA with Providers – possibly Patients
 - Providers will need to be ready to participate
 - Numerous pilots will assist with determining best practices
- Drugs included in total cost of care
- Also addresses
 - Biosimilars
 - Targeted therapy



OCM 2.0: Payment Methodology

- Universal payment model for all payers
- Patient registration in the model replaces pre-certs
- All clinical trial patients included!
- Transparent regional benchmarks for savings targets
- Shared savings on the total cost of care for ALL – Provider, payer, and employer
- Total cost of care – until death or 30 days post last treatment
- Winsorization of 10% highest and lowest cost cases
- Basic risk methodology
- Timely reports to participants
- Open lines of communications



OCM 2.0: Payment Methodology

Additional details for payment methodology and recognition of success to be developed collaboratively



OCM 2.0: How It Was Developed

Many THANKs to the people that assisted with the OCM 2.0 project!

- Nearly 300 page proposal
- Two years of work
- 50+ discussions with stakeholders at all levels of cancer care
- 65 versions to the application...

Where do we go from here?

Engaging employers & coalitions

Fred M. Schnell, MD
Chief Medical Officer
Community Oncology Alliance

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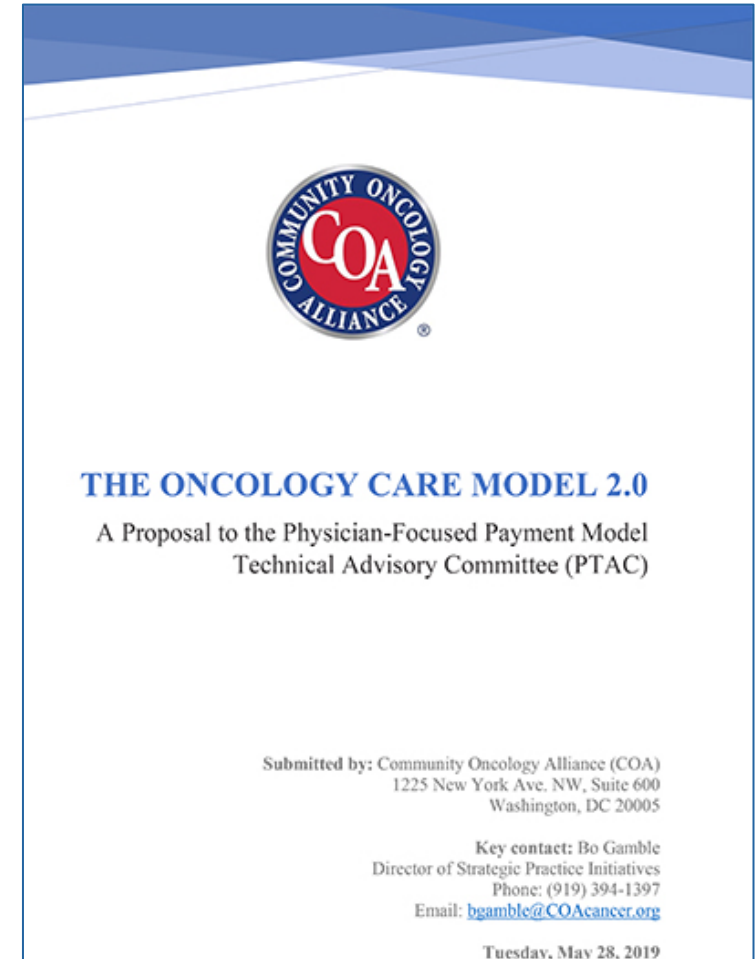
Recap: The OCM 2.0 Is...

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Access the full OCM 2.0 model & application on the COA website

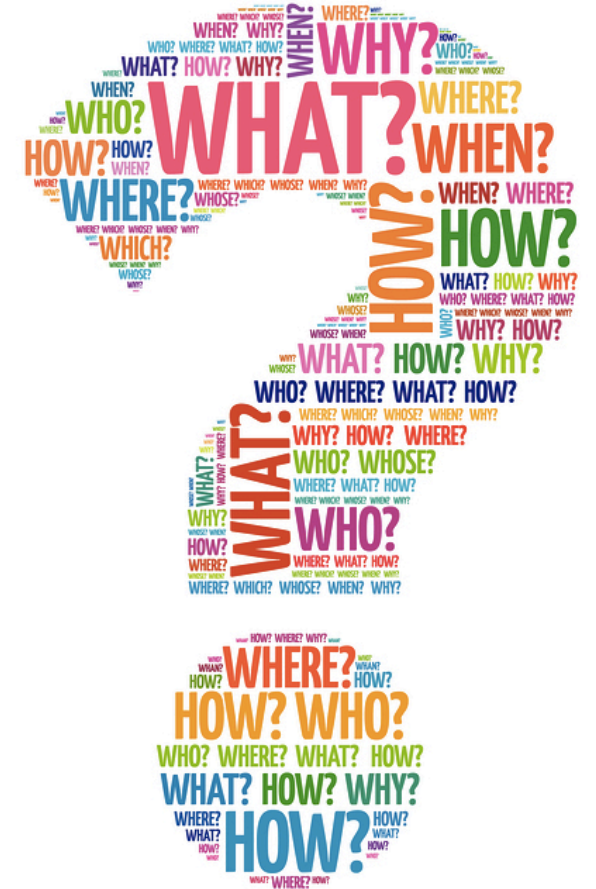
<https://www.communityoncology.org/wp-content/uploads/sites/20/2019/06/COA-PTAC.pdf>





Questions/Discussion?

If you are shy, COA is available for one-on-one calls to discuss





The OCM 1.0 and OCM 2.0: *Compare and Contrast*



OCM 2.0 Quality Cancer Care

OCM	OCM 2.0
IOM 13 Point Care Plan and Other	6 OMH Standards
IOM 1. Patient information	Usual and customary cancer care
IOM 2. Diagnosis, including specific tissue information, relevant biomarkers and stage	Usual and customary cancer care
IOM 3. Prognosis	Usual and customary cancer care
IOM 4. Treatment goals	Usual and customary cancer care
IOM 5. Initial plan for treatment and proposed duration, including specific chemotherapy drug names, doses and schedule as well as surgery and radiation therapy (if applicable).	OMH Standard 1.3: All patients are provided with education on their cancer diagnosis and an individualized treatment plan
IOM 6. Expected response to treatment	Usual and customary cancer care
IOM 7. Treatment benefits and harms, including common and rare toxicities and how to manage these toxicities, as well as short-term and late effects of treatment.	Usual and customary cancer care
IOM 8. Information on quality of life and patient's likely experience with treatment	OMH Standard 5.2: The OMH practice administers a patient satisfaction survey to cancer patients at least twice each calendar year or on an ongoing basis. The results of the survey are analyzed and used to guide quality improvement activities.
IOM 9. Who will take responsibility for specific aspects of a patient's care	Usual and customary cancer care
IOM 10. Advance care plans, including advanced directives and other legal documents	Usual and customary cancer care
IOM 11. Estimated total and out- of-pocket costs of cancer treatment	OMH Standard 1.2: Patient financial counseling services are available within the OMH practice



OCM 2.0 Quality Cancer Care

OCM	OCM 2.0
IOM 12. A plan for addressing a patient's psychosocial health needs, including psychological, vocational, disability, legal or financial concerns and their management	OMH Standard 4.3: All patients are provided on-site psychosocial distress screening and referral for the provision of psychosocial care, as needed
IOM 13. Survivorship plan, including a summary of treatment and information on recommended follow-up activities and surveillance as well as risk reduction and health promotion activities	OMH Standard 4.4: The OMH practice develops and implements a process to disseminate a treatment summary and survivorship care plan to patients within 90 days of the completion of treatment
24/7 access to appropriate clinician who has real-time access to patients' records	OMH Standard 2.1: The OMH practice institutes expanded access and a triage system to ensure that patients can easily access the practice and their providers
Core functions of patient navigation	OMH Standard 4.1: A medical oncologist directs the patient's care team within the OMH practice and manages or co-manages the inpatient team-based care
Core functions of patient navigation	OMH Standard 4.2: The OMH practice establishes relationships for effective communication with outside providers for the appropriate management of patient care
NA	OMH Standard 1.1: All patients are provided education on the OMH practice and concept
The use of therapies consistent with the nationally recognized clinical guidelines	OMH Standard 3.1: Evidence-based treatment guidelines and/or pathways are used for treatment planning
The use of data for continuous quality improvement	OMH Standard 5.1: The OMH practice records, reviews, and monitor completeness of clinical data for initiating quality improvement activities
The use of data for continuous quality improvement	OMH Standard 5.3: Each calendar year, the OMH practice develops, analyzes, and documents at least one quality improvement study associated with improving clinical outcomes and implements at least one quality improvement based on study results



OCM 2.0 Quality Cancer Care

OCM	OCM 2.0
Practice is required to use CEHRT	Practice is required to use CEHRT
NA	OMH Standard 6: Practice meets QCP Chemotherapy Safety Standards
NA	The above would be validated by a site visit of experienced leaders in cancer care. This entity would be responsible for assuring all general practice quality improvement activity is completed in a timely manner through the 3-year accreditation period



OCM 2.0 Drugs, treatments, and testing

OCM	OCM 2.0
Drugs	
<p>Novel therapy adjustment in attempt to predict rising drug costs based on historical trends for that cancer team and as compared to national trends.</p>	<p>CMMI is requested to remove regulatory obstacles so that numerous value-based arrangement pilots can be established between manufacturers and cancer care teams. To date, 6 drug companies have volunteered to present their different proposals once these regulations have been addressed.</p> <p>This PFPM would also focus on the value of biosimilars and targeted cancer therapy and their impact on the total cost of cancer care.</p>
Diagnostic testing	
<p>Considered only in the total cost of care</p>	<p>The following will be reviewed in the analysis of value and the total cost of care: advanced imaging and laboratory with special emphasis on molecular diagnostic tests.</p>
Clinical trials	
<p>Patients participating in clinical trials sponsored by the NCI are included in the benchmarking calculations. Patients participating in industry clinical trials are excluded</p>	<p>OMH Standard 3.2: Patients are provided clinical research study information by the OMH practice as appropriate for the patient's clinical condition</p> <p>Patients that participate in NCI or industry-sponsored clinical trials will be included in shared savings benchmarking calculations.</p>



OCM 2.0 Measures

OCM	OCM 2.0
<p>In addition to the below, 33 additional data points related to staging and other clinical data, should be submitted to CMMI</p> <p>Data must be gathered and reported as a specific upload/manually.</p> <p>Some of the below is captured through billing data. Other must be manually gathered and submitted</p>	<p>No additional data will be required for OCM 2.0</p> <p>The numerators and denominators for the below would be captured and reported electronically</p>
Risk-adjusted proportion of patients with all-cause ED visits that did not result in a hospital admission within the 6-month episode	Not measured in OCM 2.0
Proportion of patients who died who were admitted to hospice for 3 days or more	Proportion not admitted to hospice
Patient-reported experience of care	Not a specific measure in OCM 2.0. Experience is reported through the OMH patient survey
Oncology: medical and radiation — pain intensity quantified	A plan for managing the pain is more important, if or when it occurs, than a single assessment of quantifying the pain. The specific measure to not quantify pain is not included.
Oncology: medical and radiation — plan of care for pain	Usual and customary cancer care
Preventive care and screening: screening for depression and follow-up plan	Preventive care and screening: screening for clinical depression and follow-up plan
Care plan	Care plan
NA	Pathway adherence and compliance rate
NA	Cancer patients — survivorship care plan
NA	Pneumococcal vaccination status for older adults
NA	Hepatitis studies before Rituxan administration
NA	Proportion receiving chemotherapy in the last 14 days of life



OCM 2.0 Payment methodology

OCM	OCM 2.0
Complicated with several "adjustments" and 17 different calculations to determine PBP per team. Excel example includes 7 worksheets as background calculations to some of the 17 calculations.	Simplified with many of the "adjustments" eliminated. Calculations for the differences by case and geography have been simplified. Other aspects to be modified in payer/care team(s) individual discussions. The goal for all payment methodology initiatives developed under this PFPM is for participant project leaders to be able to understand, recreate, educate others, and explain how their team performs in the PBP calculations. The goal would be for every team to be able to state, with confidence why they performed the way they did in on PBP reconciliations.
\$160 for the first episode.	Not measured in Suggested amount is \$150 which would register the patient for the model. This would also replace the pre-certification process for commercial payers that adopted the model
6 months in length for 5 years. January through June and July through December.	Follows the same primarily since CMMI and other payers have adapted a 6- month episode.
\$160 per patient per month for subsequent until the patient expires, is admitted to hospice or 90 days post treatment.	Suggested amount is \$160 but to be adjusted and finalized in discussions between care team(s) and payers.
Standardizes prices by removing GPCI and the HWI and then multiplying actual to standardized prices. These calculations are applied to all participating team and all teams are compared against all other teams	Participating cancer care teams would participate against all other cancer care teams within that state whether they are participating or not. Comparisons would be at the state level
12 covariates are used to determine target base amounts.	Base risk methodology would be the patient's main ICD-10 cancer code. Other layers would be mutually designed in order to assure effective educational material before model launch.
All charges are included in settlement. Charge capture stops at time of death or admission to hospice	Total costs will be through the date of death or 30 days following the last date of W chemotherapy or the dispensing of an oral chemotherapy agent



OCM 2.0 Payment methodology

OCM	OCM 2.0
Benchmarking is against other OCM teams and national	Against other COA PFPM participants and non-participants in their state.
Cost outliers for cases in excess of 5% and 95% are excluded from the PBP calculations.	Cost outliers for cases in excess of 10% and 90% are excluded from PBP calculations.
Attribution reports are not available for at least 1 year following the initial treatment. The average variance between CMMI and the OCM participants is approximately 40% for attributed patients. Teams have 30 days to contest attribution differences	Patients would register with and an assigned HCPCS code to minimize variance. Preliminary attribution reports would be produced 90 days after the trigger
Settlement reports are similar to attribution reports. A full year elapses before settlement reports are available for participants.	Preliminary settlement reports would be produced 90 days following the close of each episode. Teams would have 30 days to contest discrepancies. Final settlement reports would be produced 1 year following the preliminary report
Participants retain 100% of savings after the numerous PBP adjustments have been applied.	<p>Participating would share a percentage of shared savings depending on their benchmarked quality scores and after PMPM and target amounts have been added.</p> <p>Participants and insurance companies would share savings 50/50 and given the above criteria.</p> <p>In the event an insurance company is participating in the PFPM with an employer, the savings would be shared 1/3:1/3:1/3</p>
81 question patient survey. Feedback is available to the participating team after a 1-year delay in a paper report	40 question patient survey, electronic 5, languages and detail and summary benchmarking are available real-time.
Requires a single or multiple; informatic, IT or other consulting resources, to interpret reports and to guide the appropriate next steps to manage the OCM or to achieve a PBP	Goal is to remove most of the need to recruit and retain additional support for model interpretation and management