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2018 COMMUNITY ONCOLOGY CONFERENCE

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Update & Challenges on the OCM: Oncology Payment Reform

Bruce Gould, MD
Northwest Georgia Oncology Centers
OCM Progress & Update

Originally, 196 practices; now 190

Source: Centers for Medicare & Medicaid Services
CMMI – Oncology Care Model

• 5 Year EOC Model of High Volume Cancers beginning July on 2016
• July 1, 2016 – June 30, 2021
• 9 episodes of 6 months each
• Includes Medicare FFS and 15 Commercial Payers (not MA)
• Aim to Improve:
  – Care Coordination
  – Appropriateness of Care
  – Access for Beneficiaries Receiving Chemotherapy
  – Overall Care
  – Lower Costs
OCM Components

• Practice redesign
• Monthly Enhanced Oncology Services Payments (MEOS)
• Performance Based Payment (PBP)
Practice Redesign

1. Provide and Attest to 24 Hours a Day, 7 Days a Week Patient Access to an Appropriate Clinician Who has Real-Time Access to Practice’s Medical Records

2. Attestation and Use of Certified EMR

3. Utilize Data for Continuous Quality Improvement

4. Provide Core Functions of Patient Navigation

5. Document a Care Plan that Contains the 13 Components in the Institute of Medicine Care Management Plan

6. Treat Patients with Therapies Consistent with Nationally Recognized Clinical Guidelines
Monthly Enhanced Oncology Services (MEOS) Payment

• $160/month/pt for 6 months
• 6 month episodes that start when pt receives IV anticancer therapy or when pt obtains oral script from pharmacy.
  – Includes adjuvant hormonal therapy for breast cancer
• The episodes end at 6 months if chemo terminates before then (ie if an adjuvant therapy ends at month 4, the MEOS continues two more months).
• MEOS payments end immediately if pt dies or goes on hospice.
• 6 month episode rolls over to a new one if the pt continues therapy (as in metastatic therapy).
• Pts on clinical trials included if trigger drug billed.
Performance-Based Payments (PBPs)

**PBP CALCULATION OVERVIEW**

The PBP calculation will occur for each of OCM’s nine performance periods.
Performance-Based Payments (PBPs)

Based on historical experience:
July 1, 2012 – June 30, 2015
Performance-Based Payments (PBPs)

**STEP 2: CALCULATE THE BENCHMARK AMOUNT**

- **Benchmark amount** = sum of benchmark prices for all episodes that are attributed to that practice and that have a cancer type that is reconciliation-eligible

```
Pt characteristics  
Disease pricing  
Practice experience  
Treatment factors
```

Baseline Price  ×  Trend  ×  Novel Therapies Adj.  =  Benchmark Price
Examples of Disease Pricing per Episode Before Risk Adjustment

- Lung w/ Surgery: $31,098
- Lung w/o Surgery: $22,825
- Lymphoma: $30,210
- MDS: $33,950
- Melanoma: $44,563
- Myeloma: $31,790
Factors That Go into Predicted Baseline Episode Expenditures

Impact of Other Factors on OCM Prices

- BMT, Allogeneic: 99.4%
- BMT, Autologous: 88.6%
- Episode Length ≥302+ Days: 2.0%
- Last Chemo 1-61 Days Before Epi Start: 11.4%
- Last Chemo 62-730 Days Before Epi Start: 21.5%
- Institutionalized Patient: 13.1%
- hr_relative_cost: 0.7%
- Full_Dual: 25.0%
- Part D with Low Inc. Subsidy: 17.9%
- Part D w/o Low Inc. Subsidy: 3.7%
- New Beneficiary, No HCC Data: 13.7%
- 1 HCC: 12.4%
- 2 HCCs: 24.5%
- 3 HCCs: 35.9%
- 4 or 5 HCCs: 49.4%
- 6 or more HCCs: 73.0%
- In Clinical Trial: 25.5%
- Radiation Therapy in Episode: 61.5%
Examples of baseline prices per episode *after* risk adjustment

1. HCC $25,655 (12.4%)
2. 2 HCCs $28,531 (25%)
3. 2 HCCs/Clinical Trial $34,237 (50%)
Performance-Based Payments (PBPs)

**STEP 2: CALCULATE THE BENCHMARK AMOUNT**

- **Benchmark amount** = sum of benchmark prices for all episodes that are attributed to that practice and that have a cancer type that is reconciliation-eligible

![Diagram showing the calculation process with nodes for Pt characteristics, Disease pricing, Practice experience, Treatment factors, Baseline Price, Trend, Novel Therapies Adj., and an output of Benchmark Price with 1 patient/episode]
Performance-Based Payments (PBPs)

**STEP 3: CALCULATE THE TARGET PRICE**

- **Target price** = the benchmark price adjusted for the OCM discount

Typically 96% of Baseline price
Performance-Based Payments (PBPs)

STEP 4: CALCULATE THE RISK-ADJUSTED TARGET AMOUNT

- **Risk-adjusted target amount** = sum of the target prices for all episodes attributed to practice for the performance period

\[ \sum \text{Episode Target Prices} = \text{Target Amount} \]
Performance-Based Payments (PBPs)

PBP CALCULATION OVERVIEW

The PBP calculation will occur for each of OCM’s nine performance periods.
## OCM Quality Measures

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## Performance Multiplier

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<th>Aggregate Quality Score</th>
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<tr>
<td>75% - 100%</td>
<td>100%</td>
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<tr>
<td>50% - 74%</td>
<td>75%</td>
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<tr>
<td>30% - 49%</td>
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<tr>
<td>Below 30%</td>
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Performance-Based Payments (PBPs)

PBP CALCULATION OVERVIEW

The PBP calculation will occur for each of OCM’s nine performance periods.
OCM CHALLENGES

• Clinical
  • Changing MD behavior
  • ER avoidance
  • Same day appts/more midlevels
  • Understanding and influence the total cost of care
  • Influencing MD behavior outside the practice
  • Better end of life care

• Patient Navigation
  • 13 point IOM care plan
    – Not EMR compatible
    – Total cost of care
  • Providing expanded access
  • Structured triage
  • Data analysis
Clinical Challenges

13 point IOM care plan

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
8. Information on quality of life and a patient’s likely experience with treatment
9. Who will take responsibility for specific aspects of a patient’s care (e.g., the cancer care team, the primary care/geriatrics care team, or other care teams)
10. Advance care plans, including advanced directives and other legal documents
11. Estimated total and out-of-pocket costs of cancer treatment
12. A plan for addressing a patient’s psychosocial health needs, including psychological, vocational, disability, legal, or financial concerns and their management
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
OCM challenges

• Technologic
  – Data upload
  – Database Corruption
  – EMR limitations
ONE patient’s data upload detailing: practice, doctor, breast cancer, ER, PR, her2/neu

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25 25 10 9 10

13 lines of data
Technologic: Database Corruption

Receiving error messages in OCM portal when trying to enter clinical data for some patients following demographic upload:

• Must delete patient and re-enter demographics manually
OCM challenges

• Administrative
  – OCM attribution
  – Manual data extraction
  – Manual data entry
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Technologic: EMRs
Many Elements Required to be Manually Entered into Portal

Q. Can Staging and Clinical Data be uploaded to the OCM Data Registry? *Updated Content*
A. Staging and Clinical Data can be uploaded using the CSV "OCMR Encounter Upload File." except for a few elements that must be manually entered. These elements are:

OCM Frequently Asked Questions

- Current Clinical Status
- Disease Status
- ISS Stage
- Tumor Grade
- Resection
- Clinical Stage
- Remissions
- Relapses
- Prognostic Multi-Gene Assay Test

We are currently evaluating options for these elements to be uploaded in a future release.
• Four reportable data buckets
  1. Aggregate measures (5)
    ➢ Measures apply to all cancer pts (1/5)
  2. OCM patient clinical data (5-8)*
  3. Measures applied to individual OCM patients
    ➢ (7-8/12)**
  4. Cost data

• 17 measures that the practice has to report

1000 OCM pts

6500 data points

8000 data points

14,500 data points for data buckets ‘2’ and ‘3’ alone.
These are updated every 6 months
PBP Methodologic Challenges

- PBP Methodology
  - Practice experience multiplier
  - Gain sharing vs Shared savings
  - Novel therapy adjustment
  - Baseline Episode prices are not based on clinical parameters
  - Pricing adjustments not realistic ie BMT

![Diagram showing Myeloma costs: $31,790 and $61,000 with BMT]
Correlation of Predicted and Actual Costs
How do drugs figure in OCM?

• New incentives to use the most effective, least toxic and least expensive drugs
  – This must be done in the framework of total cost of care
  – Greater emphasizes of HEOR

• Greater pressure on manufactures in areas where there is competition:
  – Immunotherapy drugs
  – CDK4/CDK6 inhibitors (3)

• Rapid adoption of biosimilars

• Push for outcomes or indication based pricing
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