Evolving the OCM: OCM 2.0 & Beyond

Webinar
Tuesday, January 9, 2018
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.
“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
<table>
<thead>
<tr>
<th>SCOPE</th>
<th>OCM 1.0</th>
<th>OCM 2.0</th>
<th>OCM 3.0</th>
<th>OCM 4.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episodic payment model for patients undergoing chemotherapy</td>
<td>Comprehensive oncology medical home for patients under active therapy and/or active surveillance</td>
<td>Upfront financial risk for care of patients undergoing active therapy and/or active surveillance</td>
<td>Population Based Capitated Payment for patients undergoing active therapy and/or active surveillance</td>
<td></td>
</tr>
<tr>
<td>TRIGGER</td>
<td>Administration of chemotherapy, oral or physician-administered</td>
<td>Administration of chemotherapy, oral or physician-administered</td>
<td>Diagnosis of cancer with primary management by medical oncologists</td>
<td>Screening and diagnosis of cancer regardless of primary management</td>
</tr>
<tr>
<td>ATTRIBUTION</td>
<td>Patients attributed to the practice</td>
<td>Patients attributed to the practice</td>
<td>Patients attributed to the practice</td>
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<tr>
<td>PAYMENT METHODOLOGY</td>
<td>Monthly enhanced fees with shared savings after a discount applied</td>
<td>Monthly care coordination fees with first dollar shared savings</td>
<td>Up front risk adjusted payment with potential for bonus if below cost targets</td>
<td>Capitated population based payment</td>
</tr>
<tr>
<td>FINANCIAL RISK</td>
<td>Initial upside with transition to downside financial risk</td>
<td>Initial upside with transition to downside risk</td>
<td>Initial downside risk</td>
<td>Capitated</td>
</tr>
<tr>
<td>QUALITY MEASURES</td>
<td>Claims based and practice reported</td>
<td>Reflective of population served-also drawn from combination of claims and practice reporting</td>
<td>Reflective of population served-drawn from claims, practice and patient reporting</td>
<td>Reflective of population served-drawn from claims, practice and patient reporting</td>
</tr>
<tr>
<td>PHYSICIAN ADMINISTERED DRUGS</td>
<td>No change in reimbursement</td>
<td>No change</td>
<td>Some drugs in a value based arrangement</td>
<td>Drug payments included in capitated payment</td>
</tr>
<tr>
<td>ORAL DRUGS</td>
<td>Included</td>
<td>Included with provision for complete claims data along with VBiD component</td>
<td>Included with a VBiD component</td>
<td>Included with capitated payment</td>
</tr>
<tr>
<td>CARE NAVIGATION AND COORDINATION</td>
<td>Part of practice requirements</td>
<td>Part of practice requirements</td>
<td>Part of practice requirements</td>
<td>No specific requirements</td>
</tr>
<tr>
<td>EFFICIENCY MEASURES (time spent in direct clinical care)</td>
<td>None</td>
<td>Included</td>
<td>Included</td>
<td>Included</td>
</tr>
<tr>
<td>PATIENT ENGAGEMENT</td>
<td>Minimal awareness</td>
<td>Active shared decision-making</td>
<td>Shared decision-making and VBiD for consumers</td>
<td>Beneficiary engagement included potentially component of savings</td>
</tr>
<tr>
<td>RISK ADJUSTMENT</td>
<td>HCC Based</td>
<td>HCC Based</td>
<td>HCC plus additional factors</td>
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## Focusing on OCM 2.0

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

**Episode/Trigger Definition**

- Inclusion once diagnosis is confirmed and management is primarily managed by a medical oncologist.
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 \textit{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
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
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
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**

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The Journey: Looking Back and Looking Forward

- OMH
- Private Payer Initiatives
- OCM
- OCM 2.0
- Global Payment for Cancer Care and Beyond
Questions?

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