“OCM 2.0”
THE JOURNEY AHEAD

Panel Moderator: Kavita Patel, MD, MS
Tuple Health
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
- Focus groups
- Thought Leader Input: Dr. Bruce Gould, Dr. Mark Fendrick
- Literature Review
<table>
<thead>
<tr>
<th></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><strong>SCOPE</strong></td>
<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>
</tr>
<tr>
<td><strong>TRIGGER</strong></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><strong>ATTRIBUTION</strong></td>
<td>Patients attributed to the practice</td>
<td>Patients attributed to the practice</td>
<td>Patients attributed to the practice</td>
<td>Patients attributed to the practice</td>
</tr>
<tr>
<td><strong>PAYMENT METHODOLOGY</strong></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><strong>FINANCIAL RISK</strong></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><strong>QUALITY MEASURES</strong></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><strong>PHYSICIAN ADMINISTERED DRUGS</strong></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><strong>ORAL DRUGS</strong></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><strong>CARE NAVIGATION AND COORDINATION</strong></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><strong>EFFICIENCY MEASURES</strong> (time spent in direct clinical care)</td>
<td>None</td>
<td>Included</td>
<td>Included</td>
<td>Included</td>
</tr>
<tr>
<td><strong>PATIENT ENGAGEMENT</strong></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><strong>RISK ADJUSTMENT</strong></td>
<td>HCC Based</td>
<td>HCC Based</td>
<td>HCC plus additional factors</td>
<td></td>
</tr>
</tbody>
</table>
# Focusing on OCM 2.0

<table>
<thead>
<tr>
<th>Elements For Consideration</th>
<th>OCM 1.0</th>
<th>OCM 2.0</th>
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</thead>
<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>
</tr>
</tbody>
</table>
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

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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**
  - **Financial risk for quality/performance measures**
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
- 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
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
The Journey: Looking Back and Looking Ahead
QUESTIONS?
Manufacturers’ Perspectives on Value

Panel Moderator: Ted Okon
Community Oncology Alliance
Manufacturers’ Perspectives on Value
Moderator: Ted Okon

• Amgen
  – Cindy McDonald-Everett

• Bristol-Myers Squibb
  – Tamar Thompson

• Johnson & Johnson
  – Ira Klein, MD, MBA, FACP

• Pfizer
  – Gergana Zlateva, PhD