WHERE WE GO NEXT: OCM 2.0 & THE FUTURE OF ONCOLOGY PAYMENT REFORM

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GOAL

To provide a payment methodology template that could be used to initiate and frame a new payment system for cancer patients. This template would be available to Medicare, commercial plans, and self-insured employers of any size or type but who have a mission and vision to assure their beneficiaries or employees receive the highest quality and cost-effective cancer care.
• **Most important** – Open, timely, and frequent communications and reporting are critical to fine-tuning, implementing and monitoring this model. All of this should be done with a high degree of collaboration. Recommendation of no more infrequent then quarterly meetings to keep collaboration and communication open.

• **Other**
  – **Target population**  Cancer patients receiving cancer directed therapy with details depending on population size and reporting capabilities.
  – **Trigger**  – Submission of a G-code or similar
  – **Attribution**  – Patients with corresponding G-code and reconciled with the payer
  – **Plurality**  – Patients with the highest quantity of Evaluation and management billing codes of 99212-99215 (Established patients – levels 2 – 5) As a tiebreaker if needed.
  – **Episodes**  – Episodes are based on the calendar year and start any time after January 1. Patients will stay enrolled in the model until 90 days after last treatment or time of death.
  – **Care management**  – There will be a mutually agreed upon care management fee that would be paid monthly for every patient that is attributed to that participating care team
  – **Clinical trials**  – Clinical trial patients would be included
FEATURES

• Quality measures –
  – Base of 5 – 7 quality and value measures
  – Additional measures as agreed upon
  – Maximum of 12 -14 measures
  – Used as a multiplier for performance payments, threshold reporting or both

• Risk adjustments – Minimal set of required cohorts
  – Grouping by the principal, or primary ICD-10 diagnosis codes with the same first 3 digits. (Minimum of CXX)
  – Groupings by a minimum of 2 age groups.

• Other adjustments – If or when mutually agreed upon participants and as long as these adjustments could be emulated, duplicated and validated.

• Shared savings – This model would allocate savings achieved through this program to three entities:
  – Payer
  – Provider
  – Employer associated with the patient care team
OCM 1.0, WHAT WE LIKE:

• Open to all payers
• Episode start
• Patient engagement
• Risk Adjustment
• Monthly Enhanced Oncology Services (payment) i.e. MEOS
• Winsorization
Problem
• Too prescriptive and many requirements are not in keeping with oncology practice.

Solution
• OMH accreditation
ONCOLOGY MEDICAL HOME

• Elements
  – Patient engagement
  – Expanded access
  – Evidenced-based care
  – Comprehensive team based care
  – Quality improvement
  – Chemotherapy safety/Adverse Event Monitoring

• Standards for each Element

• Measures for each Standard

• Emphasis on outcomes measures
MONTHLY ENHANCED ONCOLOGY SERVICES (MEOS)

Problem
• Attribution
  – 20-40% misattribution rate
  – Main problem is orals

Solution
• Simplify
  – Remove adjuvant hormonal therapy for breast ca from MEOS and use the moneys for other cancers.
• Greater clarity i.e. Part D requirement.
REPORTING AND MEASURES

Solution
• Better coordination with CMS and their contracts to develop seamless, user friendly interfaces.
• Few measures until technology advances
• Harmonization of measures

Problem
• Poor technology interfaces
• Too much data entry
• Too many measures
PERFORMANCE BASED PAYMENT (PBP)

Problem
• Baseline price is based on claims data and not clinical data.
• Baseline prices do not reflex true drug costs.

Solution
• Baseline prices and risk adjustment based on clinical as well as claims data
• Shared savings vs Gains savings
• Time needs to be allowed for stakeholders to provide solutions

• Discussions
  – Drug value agenda item at 30+ ASCO meetings: May 31 – June 3
  – Individual discussions with 10+ pharmaceutical companies: July 18 – August 3
  – Group meeting with 9 pharmaceutical companies: September 19

• Discussion focus
  – Value based cancer care and arrangements
  – Value based insurance design in cancer care
  – Efforts towards value in foreign markets
  – Obstacles to emphasizing value in cancer care
  – Measures of drug value in cancer care

• More on the above during the session on Tuesday, 10:00 – 11:00
As % non-drug costs go down, % of drug costs will go up – unless value is emphasized more.

VBA is the most difficult for cancer care due to the complexity.

Providers, and care teams, are rarely included in structured value based arrangements.

- Pharmaceutical companies are the discussing and preparing proposals.
- Some payers are ready for VBA, most are not.
- Providers are the least prepared for VBA.

Payers usually do no want providers to be aware of a VBA with a drug company.

Foreign markets have not figured it out.

Outcomes measures for VBA are sometimes difficult to define, or obtain.

Obstacles are regulatory and cultural.
DRUGS AND DRUG VALUE AND OCM 2.0 - ACTION ITEMS

• Promote and facilitate
  – Continued understanding and growth of VBA for cancer care
  – Readiness of oncology care teams to enter VBA
  – VBA communications between drug companies, pharmaceutical companies and payers
  – Identification and accessible of meaningful VBA outcomes measures

• Continue to support and encourage pharmaceutical companies to develop VBA with cancer care teams

• Identify and address regulatory obstacles

• Identify and address cultural obstacles

• Integrate VBA within a Universal Payment Model for cancer care