Oncology Care Model 2.0
The Universal Payment Model in Oncology

Kavita Patel, MD
Ted Okon, MBA
Review of the Oncology Care Model 1.0

• Medicare-centric model but involves private payers
  – Created by the Center for Medicare & Medicaid Innovation

• Currently being implemented by 191 cancer care facilities
  – Community oncology practices, hospitals, and academic systems
  – Involves 16 private payers

• Good first start but concerns with the design and implementation
  – Starts with an “artificial” 6-month chemotherapy bundle
  – Focus is just on Medicare fee-for-service cancer patients
  – Biased against patients in pharmaceutical-funded clinical trials
  – Burdensome quality measure reporting requirements
  – Overall too focused on process and not on patient care
Why an OCM Version 2.0?

• Create a truly universal model for the payment of both oncology services and drugs
  – Flexible and adaptable for modification by providers and payers
  – Provide a conduit for value-based services and drug reimbursement

• Focus on the patient and from the point of diagnosis
  – Regardless of what treatment is prescribed
  – Make the model truly about enhancing patient outcomes and not data collection and cost savings

• Provide a "safety-net" should the OCM 1.0 stumble
  – Concerns about the year 2+ viability of the OCM
OCM 2.0: Conceptual Framework

- Attribution
- Episode/Condition Definitions
- Cost-of-Cancer Based Care
- Novel therapies
- Patient-Centered Outcomes
- Quality Measures
- Risk Adjustment

OCM 2.0

Cost of Cancer Based Care

Quality Measures

Risk Adjustment

Patient-Centered Outcomes

Novel therapies

Episode/Condition Definitions

Attribution
OCM 2.0: Important Elements

• Flexibility for providers and payers
  – Allow both to modify the base model to meet their needs

• Ability to work across settings and providers
  – Community-based settings working where appropriate with larger facilities
    ➢ Community-based oncologists working closely with hospitalists, primary care, etc.

• Everybody needs to find a way to “win”
  – Patients want to trust that their physicians are practicing with the latest evidence and that they are getting the best “value”
  – Providers want to deliver the highest quality care
  – Payers want to decrease cost and inappropriate utilization while ensure the highest quality care is delivered
OCM 2.0: Major Points of Emphasis

• **Transparency**
  – Openness of the model, the measures, and the “math”

• **Consensus**
  – Among all the stakeholders, including patients, providers, and payers

• **Clarity**
  – Of what is expected of providers in terms of implementation and processes

• **Simplicity**
  – So that the emphasis is on enhancing patient care, not data collection and other tasks

• **Value**
  – Of services and drugs
OCM 2.0: Model Building on OCM 1.0

- Cancer begins with accurate screening and diagnosis
  - Major point of differentiation from the OCM 1.0

- Quality in cancer care involves:
  - Patient reported outcomes measures
  - Measures which push practices to the next level but also acknowledge their accomplishments
    - QOPI certification
    - NCQA designation
    - COC certification
  - Ability to select measures appropriate to practice setting

- Opportunity to include drugs tied to “value”

- Basic payment model following the OCM 1.0
  - Care management/coordination fee
  - Shared savings

- Two variations: single and double-sided risk
OCM 2.0: Payment Model

- Opportunity for Capitation
- Care Management Fee
- Shared Savings
OCM 2.0: Important Feedback Needed

• Risk Adjustment
  – Claims-based is limited
  – Possibilities
    ➢ Manual/EMR entry
    ➢ Mapping claims to additional datasets if possible – state based registries, etc.
  – HCC scores?
  – Numbers of conditions?
  – Participation in trials?
OCM 2.0: Important Issues

• Cost Target Issues & Questions
  – Cancer Related Costs
    ➢ All cancers?
    ➢ Predominant cancers?

• Unintended Consequence Issues
  – How will cherry picking be dealt with?
  – How long should the agreements be?
    ➢ Is a year adequate?
    ➢ 3 years?
OCM 2.0: Drugs, Drugs & Drugs

• What kind of guidance will be expected?
  – Pathways
  – NCCN guidelines
  – Others?

• How will the payment model account for inappropriate prescribing?
  – Both over/under prescribing
  – Removing barriers to prescribing appropriate state-of-the-art therapies

• Who will be held responsible for the increasing costs?
  – Patients?
  – Providers?
  – Payers?

• Real opportunity to introduce “value-based” drug payments
  – Protect innovation by rewarding it
OCM 2.0: Patients Matter & Come First

• Really understand “value” as perceived/measured by patients and incorporate it into the model

• Patient satisfaction and some important questions:
  – Measured by COA patient survey or other comparable tools
  – How much will satisfaction matter on financial distribution of shared savings, or fees, etc.
  – Will patients be able to opt in or opt out?
  – How can patients be educated, engaged, and excited to be part of OCM 2.0?
OCM 2.0: Provider Perspectives

• Don’t make the model prescriptive on how to practice medicine
  – Allow providers to practice but provide them with the best tools available
    ➢ Oncology Medical Home tool box and accreditation processes
    ➢ Help in transforming practice operations, both clinical and process
    ➢ Provide feedback on results – the more, and more frequently, the better

• Don’t make data entry and processing more important than actual patient care

• Make the quality measures meaningful to enhancing patient care

• Make the measurements relevant to what the oncologist actually “controls”
COA Perspective & Game Plan

• Trying to make the OCM 1.0 work
  – ”Cooperative” involving 80% of the participants
    ➢ Closed information-sharing listserv
    ➢ Regular calls and webinars
    ➢ In-person meetings and workshops
  – Continue building Oncology Medical Home resources for practices to use in the OCM 1.0

• Developing the OCM 2.0
  – Team conducting interviews, with a cultural anthropologist, to better understand the needs of all stakeholders
    ➢ Patients
    ➢ Providers
    ➢ Payers
    ➢ Pharma
COA Perspective & Game Plan (continued)

• Developing the 2.0 (continued)
  – Identifying what’s not working in the OCM 1.0 and devising solutions
  – Start working with providers and payers, including employers, to implement pilots and actual projects on the OCM 2.0

• Working with Congress on variations of the model
  – Senate and House oncology payment reform bills built on the Oncology Medical Home model
    - Cornyn/Carper S. 463
    - CMR/Sewell H.R. 1834

• Submitting 2-sided risk version to PTAC
  – Advanced alternative payment model (AAPM) under MACRA