



Oncology Care Model Overview



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CMMI Background

Center for Medicare & Medicaid Innovation (Innovation Center)

- Established by section 1115A of the Social Security Act (as added by Section 3021 of the Affordable Care Act in 2010)
- Created for purpose of developing and testing innovative health care payment and service delivery models within Medicare, Medicaid, and CHIP programs nationwide

Innovation Center priorities:

- Test new payment and service delivery models
- Evaluate results and advance best practices
- Engage a broad range of stakeholders to develop additional models for testing

Oncology Care Model Background

- The Innovation Center also focuses on specialty care, including improving the quality of oncology care.
- In 2016, more than 1.6 million new cases of cancer were diagnosed, and cancer was responsible for the death of an estimated 600,000 Americans. A significant proportion of those diagnosed are over 65 years old and Medicare beneficiaries.
- According to the NIH, based on growth and the aging of the U.S. population, medical expenditures for cancer in the year 2020 are projected to reach at least \$158 billion (in 2010 dollars) – an increase of 27 percent over 2010.
- The Innovation Center is pursuing the opportunity to further its goals of improved quality of care at the same or lower cost-through an oncology payment model.

OCM Overview

- Five-year model (2016-2021) to test innovative payment strategies that promote high-quality and high-value cancer care
- Real-time monthly payments (MEOS) that pay for enhanced services for beneficiaries combined with usual Medicare FFS payments and the potential for a retrospective performance-based payment based on quality and savings

OCM Overview

Episode-based

Payment model targets chemotherapy and related care during a 6-month period that begins with receipt of chemotherapy treatment

Emphasizes practice transformation

Physician practices are required to implement “practice redesign activities” to improve the quality of care they deliver

Multi-payer model

Includes Medicare fee-for-service and other payers working in tandem to leverage the opportunity to transform care for oncology patients across the practice’s population

Timeline: July 1, 2016-June 30, 2021

OCM Scope

- ~25% of Medicare FFS chemotherapy-related cancer care
 - 176 practices
 - >6,500 practitioners
 - >150,000 unique beneficiaries per year
 - >200,000 episodes of care per year
- 11 commercial payers participating

Geographic Diversity



Source: Centers for Medicare & Medicaid Services

Transforming Cancer Care: Practice Redesign Activities

1) Provide Enhanced Services

- Provide OCM Beneficiaries with 24/7 access to an appropriate clinician who has real-time access to the Practice's medical records
- Provide the core functions of patient navigation to OCM Beneficiaries
- Document a care plan for each OCM Beneficiary that contains the 13 components in the Institute of Medicine Care Management Plan
- Treat OCM Beneficiaries with therapies that are consistent with nationally recognized clinical guidelines

Practice Redesign Activities (cont.)

2) Use certified electronic health record technology (CEHRT)

OCM Practices must use CEHRT in a manner sufficient to meet the requirements of an “eligible alternative payment entity” under the MACRA rule implementing the Quality Payment Program.

3) Utilize data for continuous quality improvement

Practices must collect and report clinical and quality data to the Innovation Center. In addition, the Innovation Center will provide participating practices with feedback reports for practices to use to continuously improve OCM patient care management.

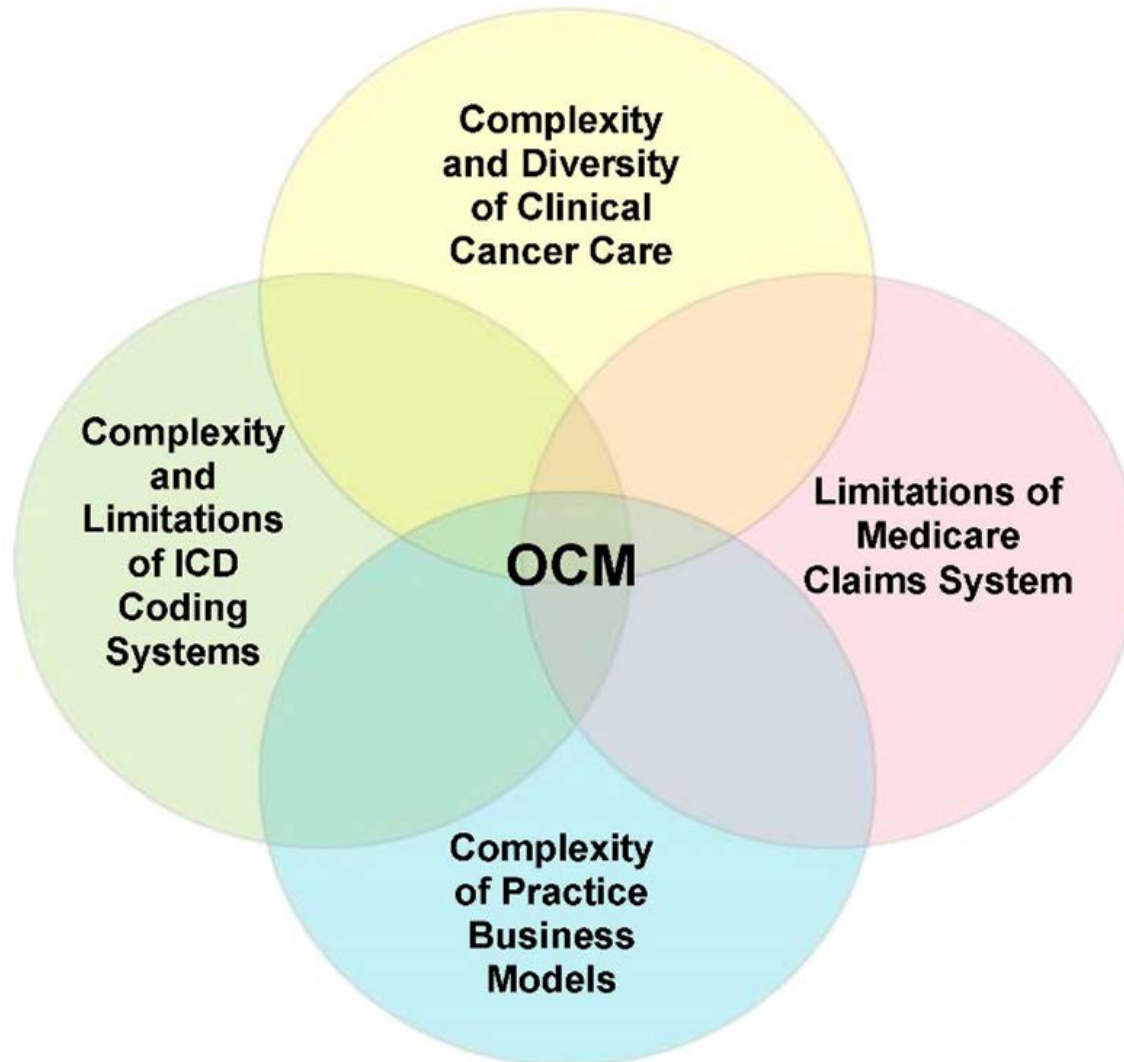
IOM Care Plan

- Patient name, DOB, medication list, allergies
- Diagnosis (stage, biomarkers, histology)
- Prognosis
- Treatment goals
- Treatment plan and duration
- Expected response to treatment
- Treatment benefits and harms

IOM Care Plan (2)

- Patient's anticipated experience with treatment
- Who takes responsibility for aspects of patient's care
- Advanced care plans
- Estimated total and out of pocket costs
- Plan for addressing psychosocial needs
- Survivorship plan

Challenges in Developing a Medicare APM in Oncology



OCM-FFS Episode Definition

Types of cancer

- OCM-FFS includes nearly all cancer types (see Cancer Code List on website)

Episode initiation

- Episodes initiate when a beneficiary receives a qualifying chemotherapy drug
- The list of qualifying chemotherapy drugs that trigger OCM-FFS episodes includes endocrine therapies but excludes topical formulations of drugs

Included services

- All Medicare A and B services that Medicare FFS beneficiaries receive during the episode
- Certain Part D expenditures are also included: the Low Income Cost Sharing Subsidy (LICS) amount and 80 percent of the Gross Drug Cost above the Catastrophic (GDCA) threshold

Episode duration

- OCM-FFS episodes extend six months after a beneficiary's triggering chemotherapy claim
- Beneficiaries may initiate multiple episodes during the five-year model

OCM-FFS Two-Part Payment Approach

During OCM, participating practices continue to be paid Medicare FFS payments

Additionally, OCM has a two-part payment approach:

(1) Monthly Enhanced Oncology Services (MEOS) Payment

- Provides OCM practices with financial resources to aid in effectively managing and coordinating care for Medicare FFS beneficiaries
- The \$160 payment for OCM enhanced services can be billed for OCM FFS beneficiaries for each month of their 6-month episodes, unless they enter hospice or die

(2) Performance-Based Payment (PBP)

- The potential for a PBP encourages OCM practices to improve care for beneficiaries and lower the total cost of care during the 6-month episodes
- The PBP is calculated retrospectively on a semi-annual basis based on the practice's achievement on quality measures and reductions in Medicare expenditures below a target price

OCM-FFS Performance-Based Payment

- 1) CMS calculates **benchmark** episode expenditures for OCM practices
 - Based on historical data
 - Risk-adjusted and adjusted for geographic variation
 - Trended to the applicable performance period
 - Includes a novel therapies adjustment
- 2) A discount is applied to the benchmark to determine a **target price** for OCM-FFS episodes
 - Example: Benchmark = \$30,000 → Discount = 4% → Target Price = \$28,800
- 3) If **actual** OCM-FFS episode Medicare expenditures are **below target price**, the practice could receive a performance-based payment
 - Example: Actual = \$25,000 → Performance-based payment up to \$3,800
- 4) The amount of the performance-based payment is adjusted based on the participant's achievement on a range of **quality measures**

OCM-FFS Risk Adjustment

Benchmark prices are risk-adjusted for factors that affect episodic expenditures and that are available in Medicare claims data

- Age
- Sex
- Dual eligibility for Medicaid and Medicare
- Selected non-cancer comorbidities
- Receipt of selected cancer-directed surgeries
- Receipt of bone marrow transplant
- Receipt of radiation therapy
- Type of chemotherapy drugs used during episode (for breast, prostate, and bladder cancers only)
- Institutional status
- Participation in a clinical trial
- History of prior chemotherapy use
- Episode length
- Hospital referral region

Over time, the risk adjustment methodology may incorporate additional factors not captured in claims data, such as cancer staging.

OCM-FFS Novel Therapies Adjustment

- Potential adjustment based on the percentage of each practice's average episode expenditures for novel therapies compared to the percentage for practices that are not part of OCM
 - Includes oncology drugs that received FDA approval after 12/31/14
 - Use of the novel therapy must be consistent with the FDA-approved indications for inclusion in the adjustment
 - Oncology drugs are considered “new” for 2 years from FDA approval for that specific indication
- The novel therapies adjustment may lead to a higher benchmark only (i.e., it will never lower a benchmark)
- In the future, CMS may modify this adjustment to incorporate value of the novel therapies

OCM Quality Measures

| OCM Measure Number | Measure Name | Measure Source |
|--------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| OCM-2 | Risk-adjusted proportion of patients with all-cause emergency department visits or observation stays that did not result in a hospital admission within the 6-month episode | Claims |
| OCM-3 | Proportion of patients that died who were admitted to hospice for 3 days or more | Claims |
| OCM-4a | Oncology: Medical and Radiation – Pain Intensity Quantified (MIPS 143, NQF 0384) | Practice Reported |
| OCM-4b | Oncology: Medical and Radiation – Plan of Care for Pain (MIPS 144, NQF 0383) | Practice Reported |
| OCM-5 | Preventive Care and Screening: Screening for Depression and Follow-Up Plan (CMS 2v8.1, NQF 0418) | Practice Reported |
| OCM-6 | Patient-Reported Experience of Care | CMS-Acquired Data |

OCM-FFS Risk Arrangement Options

One-Sided

- OCM practices are NOT responsible for Medicare expenditures that exceed the target price
- Medicare discount = 4%
- *Must qualify for performance-based payment by mid-2019 to remain in one-sided risk*

Two-Sided

- OCM practices are responsible for Medicare expenditures that exceed target price
- Option to take two-sided risk began in 2017
- Two options:
 - Original: 20% of benchmark for stop-gain/stop-loss and 2.75% Medicare discount
 - Alternative: 16%/8% of practice revenue (including additional chemo if applicable), minimum threshold for recoupment of 2.5%, and 2.5% Medicare discount

OCM-FFS Monitoring and Evaluation

Monitoring aims to assess participants' compliance, understand use of model funding, and promote the safety of the beneficiaries and the integrity of model. Monitoring data sources may include:

- Claims data;
- Practice-reported quality measure and clinical data;
- Medical records;
- Patient surveys and patient feedback;
- Interviews with OCM Beneficiaries and their caregivers;
- Site visits;
- Documentation requests, including responses to surveys and questionnaires.

Evaluation: CMS's independent evaluation contractor is employing a non-randomized research design using matched comparison groups to detect changes in utilization, costs, and quality that can be attributed to the model

OCM Learning Community

The OCM Learning Community includes:

- Topic-specific webinars that allow OCM participants to learn from each other
- An online collaboration platform to support learning through shared resources, tools, ideas, discussions, and data-driven approaches to care
- Action groups in which practices work together virtually to explore critical topic areas and build capability to deliver comprehensive oncology care
- Site visits to better understand how practices manage services, use evidence-based care, and practice patient-centered care
- Technical support to help practices overcome barriers to improvement

Early Experiences/Lessons Learned

- Practice eligibility criteria
- Identifying OCM beneficiaries and episodes
- Estimating out-of-pocket costs
- Technology
 - OCM Data Registry/Reporting Requirements
 - Practices' EMRs
- Quality measures

Experiences/Lessons (2)

- Methodology
 - Low- vs. high-risk cancers
 - Coding practices: Z51
- Quality improvement
 - OCM Learning System
 - Practices' Use of Data

Improving Care for Cancer Patients

- Care transformation
 - “Enables us to do what we’ve always wanted to”
- Improving care coordination, symptom management, palliative care, and end of life care
- Recognizing depression and distress in cancer patients
- Addressing financial toxicity
- Improving communication with patients and other providers

Contact Information

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<http://innovation.cms.gov/initiatives/Oncology-Care/>