Applying OCM Strategies to Boost Value-Based Contract Opportunities

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Objectives

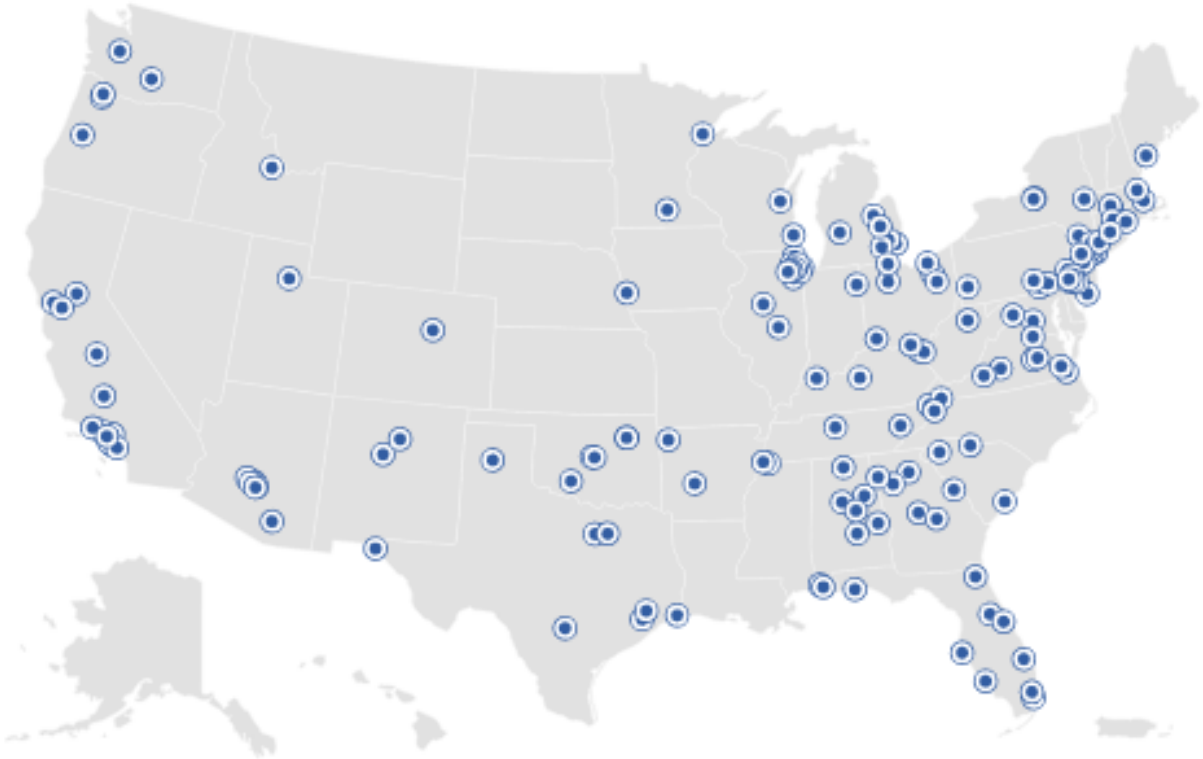
- Review the CMS Oncology Care Model structure
- Understand the unique opportunities and challenges of a tertiary care community oncology practice when operating in the setting of an Oncology Care Model (government and private payers)
- Share differences and similarities between CMS and Private Payor OCMs
  - Quality Dashboards
  - Drug cost management
- Leverage ACO team member integration and collaboration

Oncology Care Model Overview

Center for Medicare & Medicaid Innovation payment model

CMS Oncology Care Model Started July 1, 2016

Financially incentivizes high-quality, coordinated patient care



Source: Centers for Medicare & Medicaid Services

Overview of the CMS OCM

Six-month Episode

- Medicare fee-for service beneficiaries
- Services include Part A, Part B and some Part D expenditures
- All Cancer types included
- Initiated by Outpatient chemotherapy administration

Practice Operations

- Adhere to 6 practice requirements
  - 24/7 access
  - ONC-certified EHR
  - Data driven PI
  - Patient navigation
  - Care plan documentation
  - National guidelines
- Report on quality of care measures
- Report staging and clinical data

Financial Methodology

- Providers continue to receive payment per usual
- New payment for enhanced services
- Actual spend is compared to target
- Adjustments for novel therapies and quality metrics determine final performance-based payment
- Optional two-sided risk (for now)

Saint Francis Cancer Center

Greenville, South Carolina

Community Based Oncology Care at Saint Francis

- **Clinical Research** department offering over 100 clinical trials and enrolling more than 13% of all cancer patients (national average 1%)
  - OCM impact: New drug utilization rapid if not immediate
- **Quality** team responsible for all accreditations and tumor registry
  - OCM impact: Well-established team dedicated to quality benchmarking and data management
- **Cellular Therapy** programs including bone marrow transplant
  - OCM impact: High cost and aggressive care requirements

CMS Oncology Care Model Performance-to-Date

Overview: Success

- **To date 1.7 Million received in performance based payments and incentive dollars**
- Socialization of the “what and why” across frontline staff: physicians, nurses, schedulers, front desk
- Slow but steady improvement with physician engagement (most ☺)
- Integrated quality team goals
- Development of comprehensive dashboards with meaningful benchmark and action planning

Overview: Challenges and Opportunities

- Accounting for volatility and extreme fluctuations in care cost
- As always….the search for meaningful data
  - Basic operations
  - Advocating for resources
  - **And most importantly discussion with your frontline staff and providers**
- Drug cost, CMS and payor discussions
- Emergency Department Utilization
- Palliative Care and Hospice Utilization

Financial Results: Target Amount and Actual Expenditures

- Baseline data collected 2012-2015
- Baseline expenditure data for our institution significantly lower then national average and other regional institutions
- Target prices based on historical performance and adjusted for episode-specific factors and national trend
- Results from CMS
  - PP1 July 2016 – Dec 2016: ($660,808)
  - PP2 January 2017 – July 2017: ($72,496)
  - PP3 July 2017 – January 2018: $191,975

Yay!! But why?

OCM Methodology Changes Between Performance Periods

PP2 Changes	PP3 Changes	PP7 Changes
• Updating determination of cancer-related surgery, BMT, clinical trial risk adjustment flags • Baseline hospital referral region (HRR) relative cost values used for predicted prices versus performance period experience	• Target adjustments for low- and high-risk bladder and prostate cancer • Refinements to low- and high-risk breast cancer (using specific drug codes) • Beneficiary attribution must be made to TIN with at least one oncology provider	• Target adjustment for Breast, lung, and small intestine/colorectal cancers using metastatic status reported through OCM registry

Episode ID 91055 PP1

- Prior to Ibrance approval (2/3/15) for advanced ER+, HR- breast cancer only AIs were available
- **AI (Letrozole) paid by CMS** was $42 (6 refills with a 30 day supply)
- **Ibrance Drug paid by CMS** was $57,932
- CMS total **target price** for this patient was $5,041
- **Total spend was $59,910.**
- Subtracting Ibrance ($57,932) the case cost $1,978 **with a cost savings of $3,054.**

Fast Forward PP3…same patient

- PP2 Target Price $10,687
- PP3 Target Price $76,978
- Ibrance spend $99,028
- Accounting for drug cost alone (not any additional services)
  - PP2 ($88,341)
  - PP3 ($22,050)

Thank you CMS for recognizing and course correcting! HOWEVER:

(1)there are numerous drugs (new and expanding indications/combinations) that have the same effect of drastically impacting results.
(2) How can we create a nimble system that can recognize and account in a current Performance Period (vs. a year later)

Premier OCM Cohort Results for PP1, PP2, PP3

Practice	Actual Expenditure Comapred to Target Price prior to Adjustments	
	With Ibrance	Without Ibrance
A	$ (687,621)	$ 888,844
B	$ (837,782)	$ (107,603)
C	$ (121,880)	$ 419,223
D	$ (337,561)	$ 136,162
E	$ (568,568)	$ (204,474)
F	$ (2,566,501)	$ (354,881)
G	$ (332,558)	$ 265,352
H	$ (1,007,410)	$ (54,453)
I	$ (1,210,881)	$ 676,502
TOTAL	**$ (7,670,763)**	**$ 1,664,671**

Drug Cost Overshadowing Quality Improvements?

CMS utilizes basic quality indicators that can be found within claims data

- Emergency Department visits
- Hospital admissions (all cause)
- Days until death from first hospice claim date

Can improvements in these areas compensate/counter rising drug costs ?

- All ED payments: $111,566
- Total Ibrance spend: $320,123

Private Payor Models and Narrow Networks

Comparison to CMS

- Each payor is taking different pieces of the CMS model and modifying on an ongoing basis
  - Looking for input and discussion
- Appears to be a more focused approach on quality metrics that impact daily operations
- Reduction in qualifying diagnosis
  - Easier and more efficient then all-comers
  - Allows for a deeper time closer to the actual time of the event

Plan Comparisons

Payor and Program	Data Source	Care Coordination Payments	Risk	Date Proposed Downside	Performance Based Payment Composition	Pathway Utilization	Pathway Software	Cancer Populations	Drug Cost Accounting
A	Claims	Yes	Upside Only	NA if PBP maintained	Total Spend times Quality Score	No	NA	All	3 yr baseline lag comparison
B	Claims/Medical Record Review	Yes	Upside Only	YTBD	Expense of IP, ER, Drugs, LAB/Path, Radiology times quality	No	NA	Most but selective	AWP with exclusion of new drugs
C	Data Entry Portal	No	Upside Only	YTBD	Pathway Adherence	Yes	x	Most but selective	Tier 1 vs. Tier 2 pathway
D	Claims	Yes	Upside Only	YTBD	Total Spend time Quality Score	No	NA	Currently Breast and Lung but expanding	3 yr baseline lag
E	Claims/Medical Record Review	No	Upside Only	YTBD	Expense of ER utilization, caner related drug costs and inpatient day cost times Quality Scores	Yes	x	Most but selective	Gross Savings on difference btwn cost per chemo treatment member month btwn non-control and control populations

Quality Metrics

- Patient and Care Giver Education
- Advanced Directive Planning
- Distress Screening
- Pain Intervention
- Access
- Pathway Adherence
- Days in Hospice
- All cause hospital admissions
- All cause emergency department visits

Some Smart Thinking: Improving Value Based Systems

- Triage Disposition
  - HIGH IMPACT
  - Puts resources in the right places
- ED utilization
  - Limited to oncology specific admissions
- Hospital Admissions
  - Non-chemotherapy admits vs. all cause admission
    - CMS argument that baseline data included higher all cause admissions therefore tertiary care centers like ours would not be affected by higher then average admission rates.
    - This does not account for any service line or market growth. Annual increase of 10% or greater since program inception 10 years ago.
- Alignment with other accreditations such as American Society of Clinical Oncology Quality Oncology Practice Initiative (QOPI©)
  - Decreases staff labor costs related to chart reviews and data collection

Drug Cost: No one has figured it out

- Pathways and pathway systems
  - VIA Oncology, payor specific portals, possible integration?
  - What is a reasonable goal?
  - Is the required input data enough to really make an accurate decision?
    - Simple enough for non-clinical staff yet accurate enough for appropriate categorization
- Comparing one practice to another
  - Chasing the drug cost trends: during same episode? During earlier episodes? How early is too early? Drug recovery programs?
- CMS modified
  - Can a private payor or narrow network relationship be nimble and develop meaningful trend factors and risk stratifications?

ACO team members

- Hospice and Palliative Care
- Hospital admission
- Care coordination teams throughout the system
- Cross-pollinating objectives
  - Diabetes management necessitated by steroid utilization
  - Discharge medication management
- Challenges
  - Duplication of services (post hospital discharge)