



CLINICAL
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Clinical Pathways in the Oncology Care Model



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Medicaid Services
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Disclosures

Andrew York has nothing to disclose

Learning Objectives

- Define the goals and theory of action in the Oncology Care Model (OCM)
- Identify the key elements of OCM model design
- List the OCM Practice Redesign Activities
- Describe the role of Clinical Pathways in OCM

Agenda

- Overview of CMMI Oncology Care Model
 - Practice Redesign Activities
 - Payment Methodology
- Role of clinical pathways in OCM
 - Value of clinical pathways: reducing costs while improving care
 - Clinical pathways in OCM design
 - Challenges of using clinical pathways
- Application of clinical pathways in OCM
 - Practice redesign activity: use of national guidelines
 - Other payers

CMMI = Center for Medicare & Medicaid Services Innovation Center; OCM = Oncology Care Model

Innovation at CMS

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)
- 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

CHIP = Children's Health Insurance Program; CMS = Center for Medicare & Medicaid Services.



Innovation Center Models

- **Aim to “reduce program expenditures . . . while preserving or enhancing the quality of care”**
- **Range in focus, including:**
 - Accountable Care Organizations
 - Primary Care Transformation
 - Bundled Payments for Care Improvement
 - State-Based Innovation

Oncology Care Model Background

- The Innovation Center also focuses on specialty care, including improving the effectiveness and efficiency of oncology care
- In 2016, more than 1.6 million new cases of cancer will be diagnosed, and cancer will kill an estimated 600,000 Americans in 2016. A significant proportion of those diagnosed are over 65 years old and Medicare beneficiaries¹
- 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 2010²

NIH = National Institutes of Health

1. Institute of Medicine Report. Levit L, Balogh E, Nass S and Ganz P, ed. Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis. 2013.

2. Mariotto AB, Yabroff KR, Shao Y, et al. Projections of the cost of cancer care in the United States: 2010-2020. J Natl Cancer Inst 2011; 103:117-128.

Oncology Care Model (OCM)

- The Innovation Center's Oncology Care Model (OCM) focuses on episodes of cancer care that include chemotherapy
- The goals of OCM are to utilize appropriately aligned financial incentives to improve:
 - 1) Care coordination
 - 2) Appropriateness of care
 - 3) Access for beneficiaries undergoing chemotherapy
- Financial incentives encourage participating practices to work collaboratively with other providers to comprehensively address the complex care needs of beneficiaries receiving chemotherapy treatment, and encourage the use of services that improve health outcomes.

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

FFS = fee for service

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 Plan³
- **Treat OCM Beneficiaries with therapies that are consistent with nationally recognized clinical guidelines**

3. Institute of Medicine Report. Levit L, Balogh E, Nass S and Ganz P, ed. Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis. 2013

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.

MACRA = Medicare Access and CHIP Reauthorization Act of 2015

OCM Practices

- Nearly 200 oncology practices are participating in OCM.
- OCM Practices:
 - Medicare-enrolled physician groups identified by a single Taxpayer Identification Number (TIN)
 - Composed of one or more physicians who treat Medicare beneficiaries diagnosed with cancer
 - Cover urban, suburban and rural areas
 - Range in size from solo oncologists to large practices with hundreds of providers

OCM Payers

- 16 commercial insurers are supporting OCM practices in their practice transformation efforts; payers include regional and national organizations
- The goal of multi-payer participation is to provide aligned financial support and quality measurement across a practice's patient population, in order to facilitate whole practice change
- CMS and the OCM payers will convene regularly throughout the model to share lessons learned on engaging in alternative payment model work that supports oncology practice transformation

OCM Payer Alignment

- OCM payers are aligning their models with the Medicare FFS arm of OCM (OCM-FFS) in the following ways:
 - Provide payments for enhanced services and for performance
 - Include patients receiving chemotherapy as a focus of the model
 - Require similar practice requirements
 - Share data with participating practices
 - Align with CMS on a core quality measure set

FFS = fee for service

OCM-FFS Beneficiary Population

Medicare beneficiaries who meet each of the following criteria for the entire 6-month episode are included in OCM-FFS:

- Enrolled in Medicare Parts A and B;
- Does not receive the Medicare End Stage Renal Disease (ESRD) benefit;
- Medicare as his or her primary payer;
- Not covered under Medicare Advantage or any other group health program;
- Received an included chemotherapy treatment for cancer; and
- Has at least one Evaluation & Management (E&M) visit with an included cancer diagnosis during the 6 months of the episode.

FFS = fee for service

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

FFS = fee for service

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

FFS = fee for service

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**

FFS = fee for service

OCM-FFS Risk Adjustment

Benchmark prices are risk-adjusted for factors that affect episodic expenditures:

- 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 proportion of each practice's average episode expenditures for novel therapies compared to the same proportion for episodes that are not part of OCM
 - Includes oncology drugs that received FDA approval after December 31, 2014
 - 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-FFS Risk Arrangement Options

One-Sided

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

MIPS APM = Merit-based Incentive Payment System Alternative Payment Models

QP Threshold = QP Threshold

Two-Sided

- OCM practices are responsible for Medicare expenditures that exceed target price
- Option to take two-sided risk begins in 2017
- Medicare discount = 2.75%
- OCM practices in two-sided risk that meet the QP threshold are in an Advanced APM

OCM-FFS Quality Measures that Affect Performance-Based Payment

OCM #	Measure Description	Source
OCM-1	Risk-adjusted proportion of patients with all-cause hospital admissions within the 6-month episode	Claims
OCM-2	Risk-adjusted proportion of patients with all-cause ED visits that did not result in a hospital admission within the 6-month episode	Claims
OCM-3	Proportion of patients who died who were admitted to hospice for 3 days or more	Claims
OCM-4a	Oncology: Medical and Radiation – Pain Intensity Quantified (NQF 0384/PQRS 143)	Practice
OCM-4b	Oncology: Medical and Radiation – Plan of Care for Pain (NQF 0383/PQRS 144)	Practice
OCM-5	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (NQF 0418/ eCQM CMS2.6.3)	Practice
OCM-6	Patient-Reported Experience	Survey
OCM-7	Prostate Cancer: Adjuvant Hormonal Therapy for High or Very High Risk Prostate Cancer (NQF 0390/PQRS 104)	Practice
OCM-8	Adjuvant chemotherapy is recommended or administered within 4 months (120 days) of diagnosis to patients under the age of 80 with AJCC III (lymph node positive) colon cancer	Practice
OCM-9	Combination chemotherapy is recommended or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cN0M0, or Stage IB - III hormone receptor negative breast cancer (NQF 0559)	Practice
OCM-10	Trastuzumab administered to patients with AJCC stage 1 (T1c) – III and human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy (NQF 1858)	Practice
OCM-11	Breast Cancer: Hormonal Therapy for Stage I (T1b)-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer (NQF 0387/eCQM CMS140v5.0)	Practice
OCM-12	Documentation of Current Medications in the Medical Record (NQF 0419/eCQM CMS68v6.1)	Practice

OCM FFS Program and Payment Overlap

Program Overlap:

- Overlap with OCM is allowable for the following programs:
 - Shared savings programs (e.g., Pioneer Accountable Care Organizations [ACOs], Medicare Shared Savings Program [MSSP])
 - Comprehensive Primary Care Initiative (CPC)
 - Bundled Payments for Care Improvement Initiative (BPCI)
 - Comprehensive Care for Joint Replacement Model (CJR)
 - Medicare Care Choices Model (MCCM)
- OCM practitioners may not participate concurrently in OCM and the Transforming Clinical Practice Initiative (TCPI)

Care Management Services

- Chronic Care Management (CCM), Transitional Care Management (TCM), Home Health Care Supervision, Hospice Care Supervision, and End Stage Renal Disease management services: Practices that bill the MEOS payment cannot also bill for these services in the same month for the same beneficiary.

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

Contact Information

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

