Preparing for the Enhancing Oncology Model

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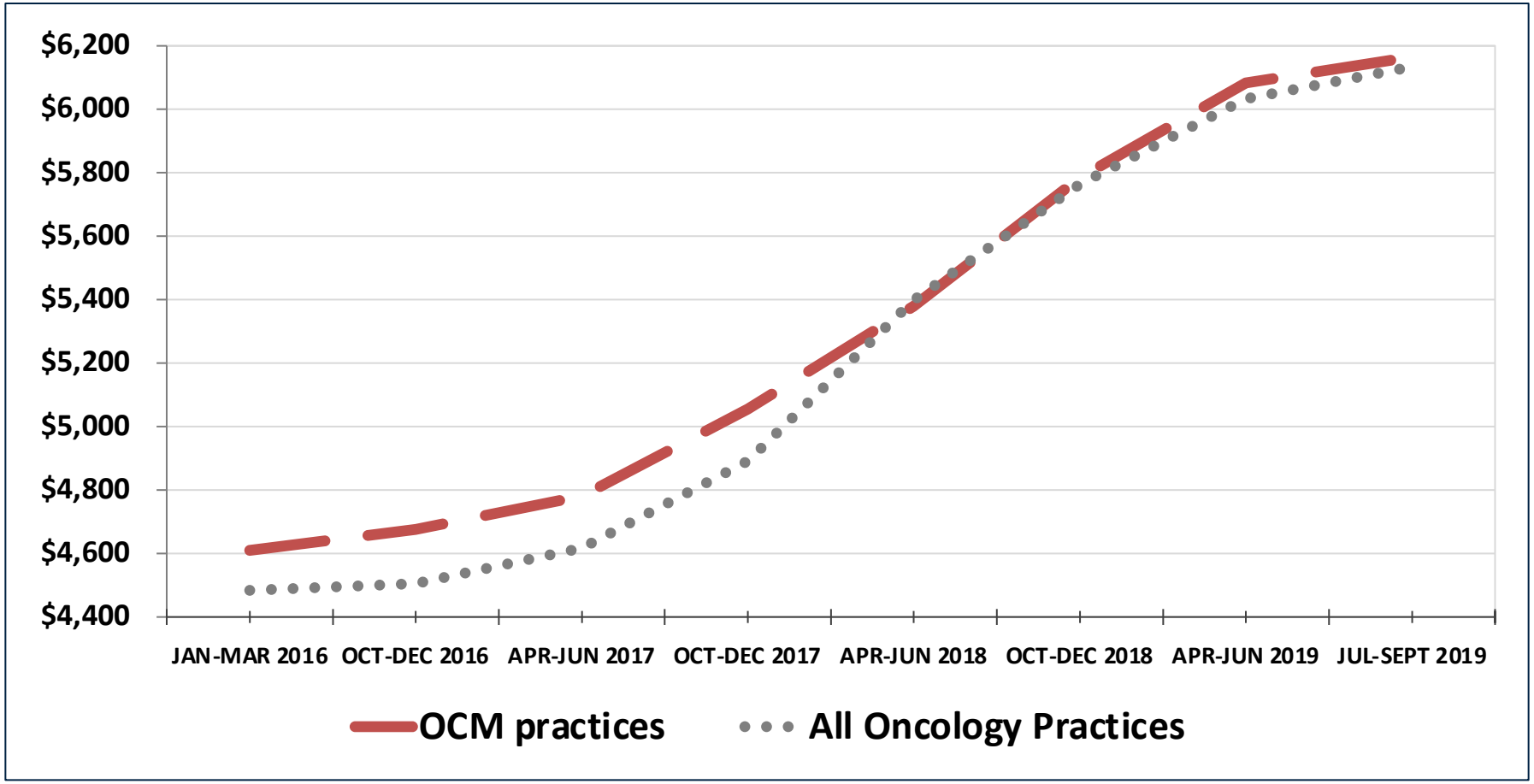
"We won't see bundled payments in cancer for at least another 5 to 10 years. It's just too complex"

me, 2014

The Oncology Care Model (OCM) was announced in 2015.[1]

Total Centers for Medicare & Medicaid Services (CMS) Spending per chemotherapy patient per month[2]



Cancer Costs Are About to Get Much Worse

- Labor and supply costs for all businesses are much higher, little room to absorb higher health benefits costs
- Insurance contracts are multi-year deals, and providers have not yet passed on higher labor and supply costs to payers
- More patients are surviving to 2nd/3rd line, and more treatment plans involve multi-modal therapy, vs. even 5 years ago
- Immunotherapy is taking off, survival and cost will continue to grow
- Cellular therapy is next, and manufacturers will eventually expand to community-based practices

Background on the OCM and Enhancing Oncology Model (EOM)

EOM Goals

- Practices take on financial and performance accountability for chemotherapy episodes of care
  - ✓ Starting July 1, 2023
- Identify best practices for simultaneously addressing multiple objectives:
  - ✓ Lower cost of care
  - ✓ Better health outcomes
  - ✓ Better patient experience
  - ✓ Better health equity
  - ✓ Better care coordination

EOM Goals

- Engage other payers, including commercial, Medicaid, and Medicare Advantage plans, in companion models to affect broader positive change across the industry

Minimum Requirements for Participation[3,4]

1. Patients must have 24/7 access to a clinician with real-time electronic health record (EHR) access
2. EHR must be certified by the Office of the National Coordinator and meet meaningful use Stage 2
3. Patients must have access to navigation support services*
4. Treatment plans must comply with evidence-based national guidelines

Minimum Requirements for Participation[3,4]

5. Practice must adopt the EOM oncology quality measures, report data on all EOM patients, and use data internally for quality improvement*
6. Each patient must have a documented Institute of Medicine (IOM; now the National Academy of Medicine) Cancer Care Management Plan
7. Identify health-related social needs using an appropriate patient screening tool
8. Use of electronic patient-reported outcomes (ePROs)

Quality Measures

Key:
Medicare RFP
My comments

Not yet finalized, but will include the following domains:

- ❑ Patient experience (Oncology CAHPS® Cancer Care Survey)
- ❑ Avoidable acute care utilization (all-cause emergency department [ED] admits)
- ❑ Symptom management (Pain assessment)
- ❑ Psychosocial health (Depression/distress screening)
- ❑ End of life care (Death with hospice length of stay>3 days)

Quality Measures

Key:
Medicare RFP
My comments

- Quality measures can change over time:
  - CMS dropped majority of the OCM measures during OCM
  - CMS is sensitive to reporting burden for practices (to a point)
  - CMS is willing to drop measures that don't correlate to success
  - OCM never added metrics that weren't revealed before model start
- Radiation Oncology Model quality metrics are very similar to OCM

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OCM Quality Measures (as of PP10)[5]

	Measure	Points
	Possible Quality Points	50.0
X	1. All-cause inpatient (IP) admits	10
	2. All-cause ED visit	10
	3. Death w/ hospice	10
	4. Pain management	10
	5. Depression screen/plan	10
	6. OCM CAHPS patient experience	10
X	7. Hormone w/ high risk prostate	n/a[1]
X	8. Chemotherapy with Stage 3 colon cancer	n/a[1]
X	9. Chemotherapy w/ HR- breast cancer	n/a[1]
X	10. Trastuzumab w/ HER2+	n/a[1]
X	11. Hormone w/ ERPR+ breast cancer	n/a[1]
X	12. Medication reconciliation	2.5[2]
X	24. Care plan documentation	2.5[2]
X	30. Closing the referral loop documented	2.5[2]

Score of 75% needed to keep 100% of savings bonus

1. Measure never collected
2. Pay for reporting only

X. Dropped

Health Equity Plan

Practices will share patient sociodemographic data with CMS

CMS will provide data and reports back to practice based on this data to help identify disparities

Practices develop, maintain, and implement a health equity plan to address disparities based on their local population with annual reporting

Health Equity Plan

Practices will screen patients for health-related social needs to inform health equity plans

- Allowable screening tools to be determined

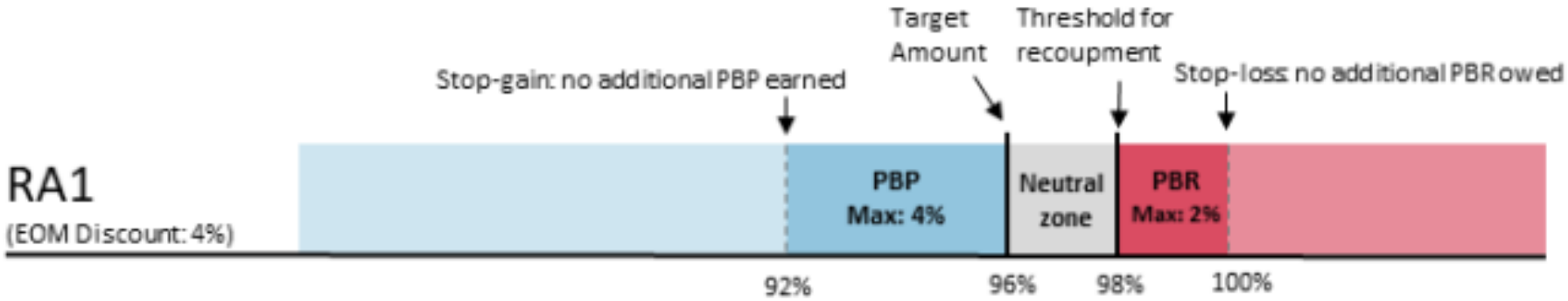
Higher per member, per month (PMPM) payment (+43%) for dual eligible patients reflecting higher patient complexity

Payment Model

- Two components on top of normal fee-for-service payments:
  - $70 PMPM revenue to practice in exchange for enhanced services
  - Performance-based payment based on total cost of care and quality

Payment Model[6]

- Compare actual vs. predicted total cost of care for 6-month chemotherapy episodes:
  - If your claims are lower than 98% of predicted, CMS shares savings
  - If your claims are higher than 98% of predicted, you pay a penalty



Key Differences from OCM

- Overall, very similar to final years of OCM
- Low volume cancers excluded (only breast, lung, colorectal, prostate, leukemia, lymphoma, multiple myeloma)
- Low-acuity, hormone-only treatments excluded
- Cancer-specific pricing model
- Two-sided risk only
- Improved attribution model to assign cancer episodes to practices

Key Differences from OCM

- New requirement on health equity and identifying health-related social needs
- Emphasis on developing patient-reported outcomes (PRO) monitoring
- Permission to use telehealth and home health for chemotherapy patients
- Reduced MEOS (Monthly Enhanced Oncology Service) payments
- Model now open to Maryland providers
- Experience adjustment model more sophisticated for regional/national peer differences

How worried should you be about being forced to do this in the future?

Next Steps for EOM if You Applied

- Applications were due **October 10, 2022** (late entry **not** possible in OCM)
- Practice applications are non-binding, so no reason to not proceed to next step
- Many questions will be answered after the initial application deadline

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Next Steps for EOM if You Applied

- What to expect after submitting application:
  - Formal notice from the Center for Medicare & Medicaid Innovation (the Innovation Center) that the application has been accepted (late 2022)
  - The Innovation Center is still formulating model details and will share with applicants over the next year
  - The Innovation Center may provide data/modeling on the new financial model and new baseline period

Next Steps for EOM if You Applied

- What to expect after submitting application:
  - Accepted practices will have opportunities to seek official clarification on participation requirements
  - Industry groups will convene EOM applicants to educate on requirements and relevant best practices under OCM
  - Accepted applicants will make a final decision on EOM participation later (spring 2022)
  - Accepted practices that sign final participation agreement will begin EOM on July 1, 2023

Does EOM Really Reflect the Future?

- Commercial payers did not rapidly adopt the OCM:
  - Not all national payers signed up
  - Those that participated often limited geographic eligibility
  - Some that participated ended up withdrawing
  - Medicare Advantage plans were excluded
  - Cost/complexity of implementation for payers that typically farm this work out to specialty groups

Does EOM Really Reflect the Future?

- Independent evaluations of OCM showed that it lost money. However,
  - Initial evaluations are heavily skewed by the non-value-added implementation period
  - In more recent data, CMS is saving money on higher acuity cases
  - MEOS fees tip the scales to the negative

Does EOM Really Reflect the Future?

- Independent evaluations of OCM showed that it lost money. However,
  - With changes to MEOS payments ($160 → $70), exclusion of low acuity cases, and two-sided risk, the model will save money for CMS
- Assume there is a minimum participant count at CMS for the EOM to be worthwhile

Feedback from OCM Practices

- Widespread support for OCM among oncology practices.
  Little to no notable complaints regarding:
  - Overall model goals
  - Quality measures
  - Total cost of care
  - Involving commercial payers
  - Practices taking on some level of risk

Feedback from OCM Practices

- Some frustration from participants in several key areas:
  - Difficult to make substantial changes to drug choices
  - Difficult to save money in model without changes to drug choices
  - EHR vendors did not support practices with enhancements
  - Initial difficulty in data gathering and reporting (better)

Feedback from OCM Practices

- Some frustration from participants in several key areas:
  - Somewhat homogenous episode pricing model **(fixed)**
  - Attribution model of how patients are assigned to practices **(fixed)**
  - Financial model penalized practices that were already efficient

How is Penn Medicine Lancaster approaching the EOM?

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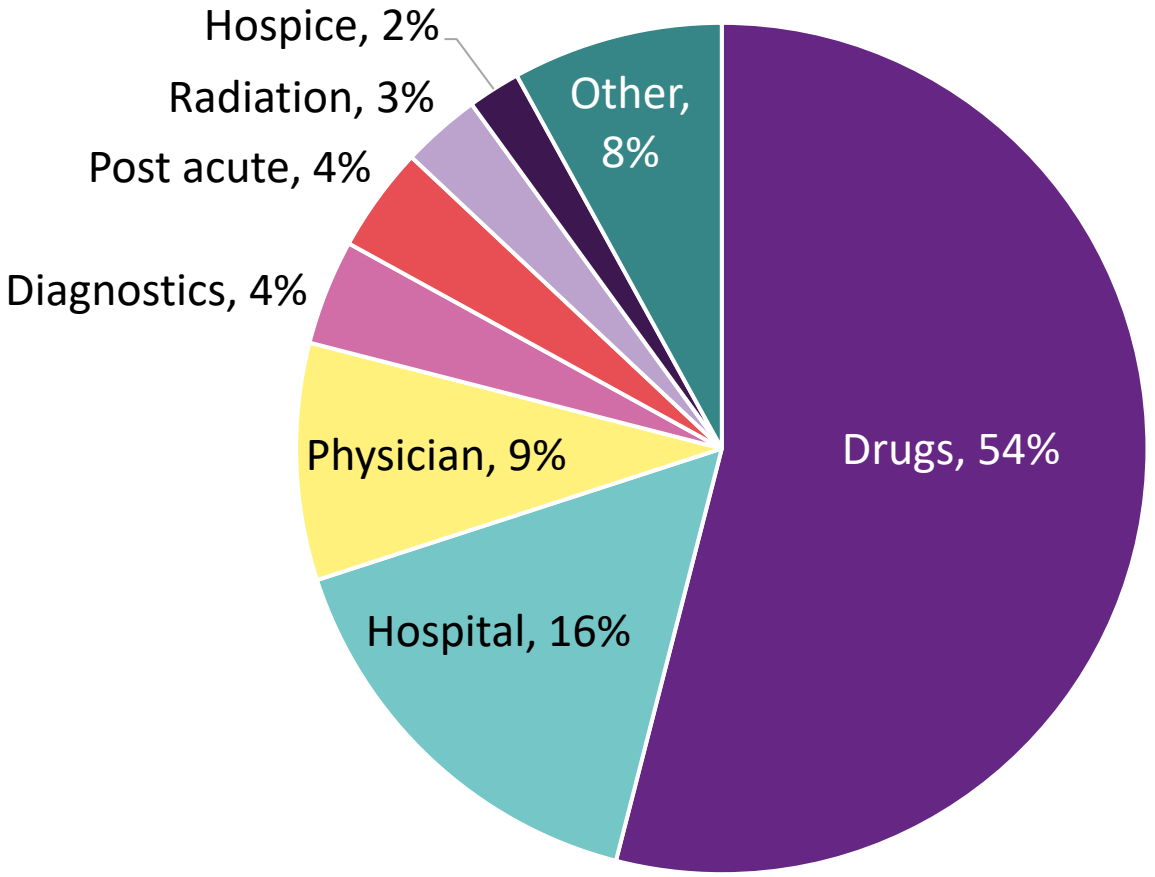
Lancaster OCM Spending by Category[2]



Lancaster EOM Project Timeline

	J	A	S	O	N	D	J	F	M	A	M	J	J
Investigate													
Education													
$ Modeling													
EMR build													
Exec Team													
Contract			LOI due 9/30						Final decision likely due Mar/Apr				
Go Live													7/1/23

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Lancaster EOM Project Timeline

- **Concerns:**
  - Building a financial model to understand expected financial outcome from participation
  - Getting Lancaster's executive team support for resources needed to succeed
  - Getting IT (information technology) team support for EHR enhancements
  - Successfully developing and implementing a plan to save additional $ on top of OCM savings

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Issues that Must be Resolved to Participate

- Education:
  - Social determinants of health (SDOH) requirements
  - Final quality measures
  - Financial model
- Alignment/engagement:
  - Hematology oncology
  - Clinic nurses and aides
  - Navigators and social workers
- Financial modeling:
  - Get CMS data
  - Assumptions for unknown variables
  - Determine acceptable loss
  - Estimate MIPS (merit-based incentive payment) alternative impact
- Quality measures:
  - Develop process maps
  - Investigate health equity measures
- Resource request:
  - IT staff
  - Clinical risk scoring artificial intelligent (AI)
  - People (coder, Spanish navigator)
  - Other
- EHR (Epic)
  - Update OCM workflows for patient rooming
  - Quality measures
  - Data reporting automation
  - Health Related Social Needs
- Find opportunities to cut cost/waste

Paths to Success for Lancaster

Managing avoidable hospital care:

- "Oncology Urgent Care," reserved clinic appointments for same-day symptomatic walk-ins
- Update symptom management algorithms and review patient education
- Office visit within 5 days scheduled at discharge
- Transition of care call from clinic nurse immediately after discharge
- All readmissions reviewed by medical director, nursing, and tumor-specific care teams

Paths to Success for Lancaster

Managing end of life care:

- Shared-decision making and mandatory advance care planning before treatment starts
- Early palliative care and automatic referral triggers
- Weekly palliative care “tumor board” case reviews
- Hospice length of stay > 3 days

Paths to Success for Lancaster

Managing drug spend:

- Clinical pathway development and maintenance
- Clinical pathway auditing and review
- Develop an outpatient formulary process for oncology with value/cost as a consideration
- Converting to biosimilars
- Creating a bias toward auto-substitution for pharmacy
- Know when the “cheaper” drug is not cheaper in the long run

Paths to Success for Lancaster

Managing drug spend:

- Move inpatient regimens to outpatient when safe to do so or develop hybrid inpatient/outpatient regimens

- Malignant hematology is the biggest cost overage opportunity for Lancaster

Paths to Success for Lancaster

- Early identification of high-risk patients
  - “Worry board” tracks patients at risk of ED use
  - Predictive analytics
  - Screening tools with automatic triggers (including ePROs)
  - Real time billing data to find costly patients we missed

Find outliers

- Increase clinical trial enrollment
- Accurately coding hepatocellular carcinoma co-morbidities
  - Lancaster in bottom half for acuity ☹

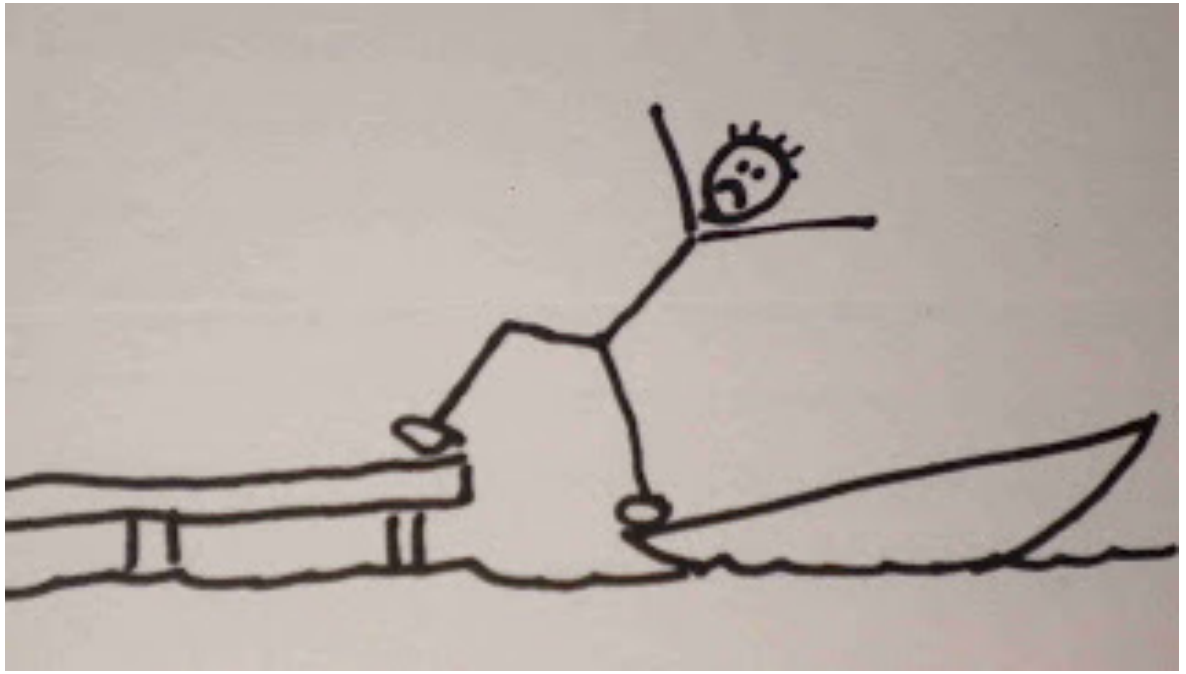
Reduce goal difficulty

- Improving quality scores in trouble areas
  - Pain screening and follow-up
  - Depression screening and follow-up

Keep any savings we earn

How should *your* practice approach the EOM?

Transitioning from Fee-For-Service to Value-Based Care



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Transitioning from Fee-For-Service to Value-Based Care *Without Going Broke*

- Understand the risk/reward and look for a glide-path to downside risk
- Although “cost” now means revenue, cutting your own costs is still a good idea
- Pursue thoughtful demand destruction to reduce care that is:
  - Avoidable (non-admitted ED visits)
  - Non-value-adding (duplicate tests)
  - Not reimbursed or lose money (readmissions, long length of stay, observation)
  - Services that are expensive but not profitable
  - Look at expensive but profitable services last
- Maximize quality scores to keep any shared savings you do earn
- Expand to as many other payers as possible once you have it figured out

How Payers Approach Risk

Risk assessment

Risk mitigation

Risk protection

Risk Assessment

- ✓ Determine maximum loss potential
- ✓ Analyze your cost structure and pricing
- ✓ What is your realistic ability to get needed resources?
  - IT
  - Staff
  - Space

Risk Assessment

- What is your realistic ability to influence the care model?
- Organizational readiness for clinical transformation
  - Leadership
  - EHR
  - Culture
  - Provider/staff engagement and workload

Risk Protection

If the size of maximum downside risk is relatively large:	Reinsurance for downside risk
If the size of maximum risk is relatively small:	Self-funded through general operating expenses

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Risk Mitigation

Our Challenge (2016)

- How do we meet OCM requirements?
- How do we save money? (for payers, patients, and us)
- How do we get our team on board?
- How do know what to do without CMS data?

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Suggested Approach

Create	Develop	Approach
Create a culture that will support value-based care • Teamwork • Putting patients first	Develop basic competencies • Performance improvement • Creating, collecting, and reporting data	Approach harder care model problems after this

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Focus on Building a Better Culture

Working better together

- Non-hierarchical teamwork
- Psychological safety to speak about problems
- Consensus-based decisions
- Teamwork across disciplines and specialties
- Use of daily huddles

"If you want to build a ship, don't drum up men to gather wood, divide the work, and give orders.

Instead, teach them to yearn for the vast and endless sea"

Antonie de Saint-Exupéry

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Focus on Building a Better Culture

Putting patients first:

- Encourage patients to bring a caregiver with them
- Widespread use of shared decision making (IOM Cancer Care Plan)
- Commitment to reducing cost of care for patients
- Safe to talk about hospice and why patients may not want to consider therapy
- Early use of palliative care
- We are responsible for the patient before and after the office visit
- Manage care locally and do not send to the emergency department

Focus on Building a Better Culture

Value-based care:

- Safe to talk about cost of care with patients, providers
- Expectation that patients receive personalized price estimates up front
- Safe to question repeat diagnostic studies or those that won't impact care plan
- Caring for patient in lowest cost of care setting
- Safe to question decision to treat
  - Deathbed chemotherapy doesn't work
  - No such thing as emergency chemotherapy
  - Death in the hospital isn't favorable

Develop Core Competencies

Performance improvement

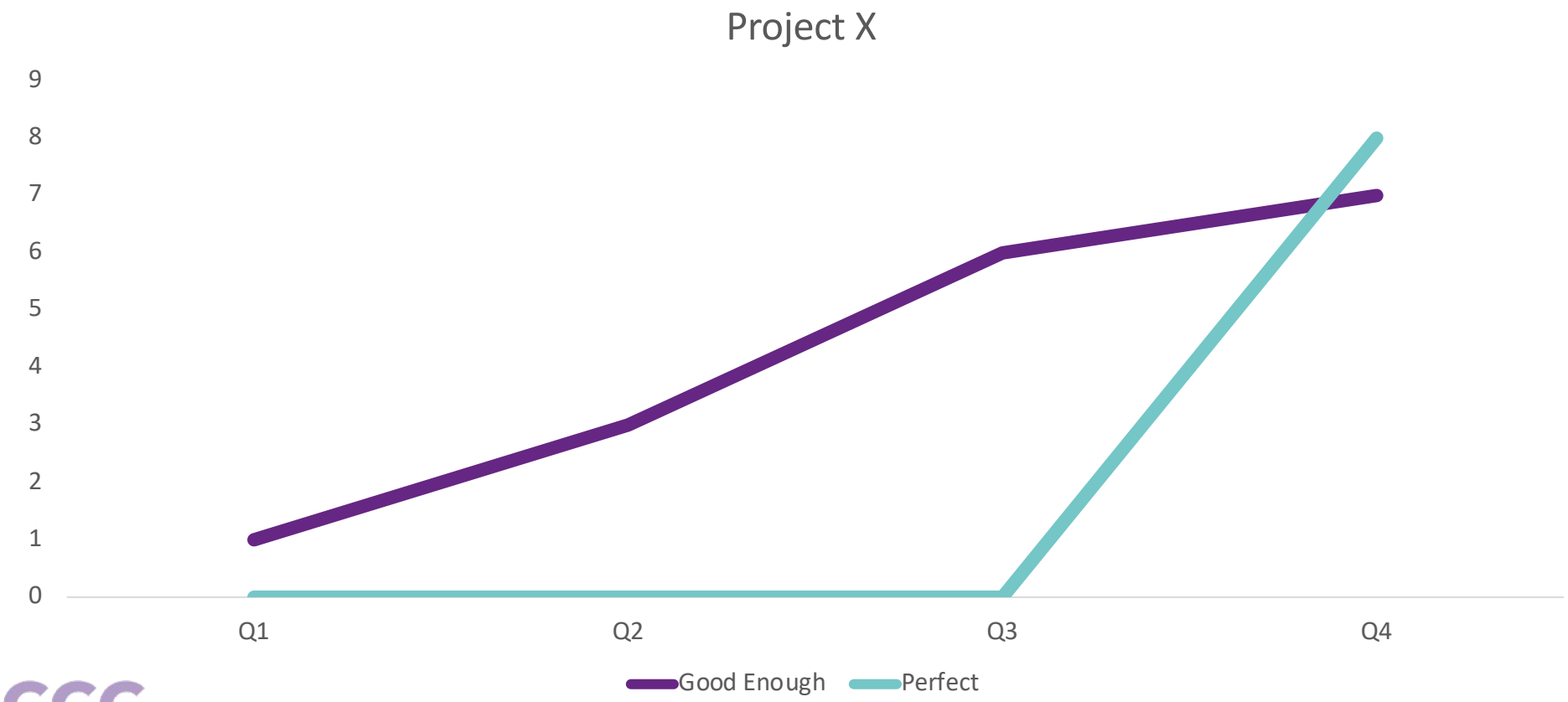
- Daily huddles and rapid performance improvement cycles
- Setting clear priorities each year; do a few things excellently
- Management through measurement and better use of EHR data
- However, also not waiting for perfect or complete data to act
- Leadership and staff training on performance improvement
- Establish team accountability for outcomes, not just action

Develop Core Competencies

Performance improvement:

- Listening to the process experts (front-line staff)
- Empowering teams to act (if no concerns for cost, safety, or impact on others)
- Provide daily/weekly performance feedback, not monthly, quarterly, or annually
- Completed projects periodically reviewed to monitor backsliding

The Cost of Perfection



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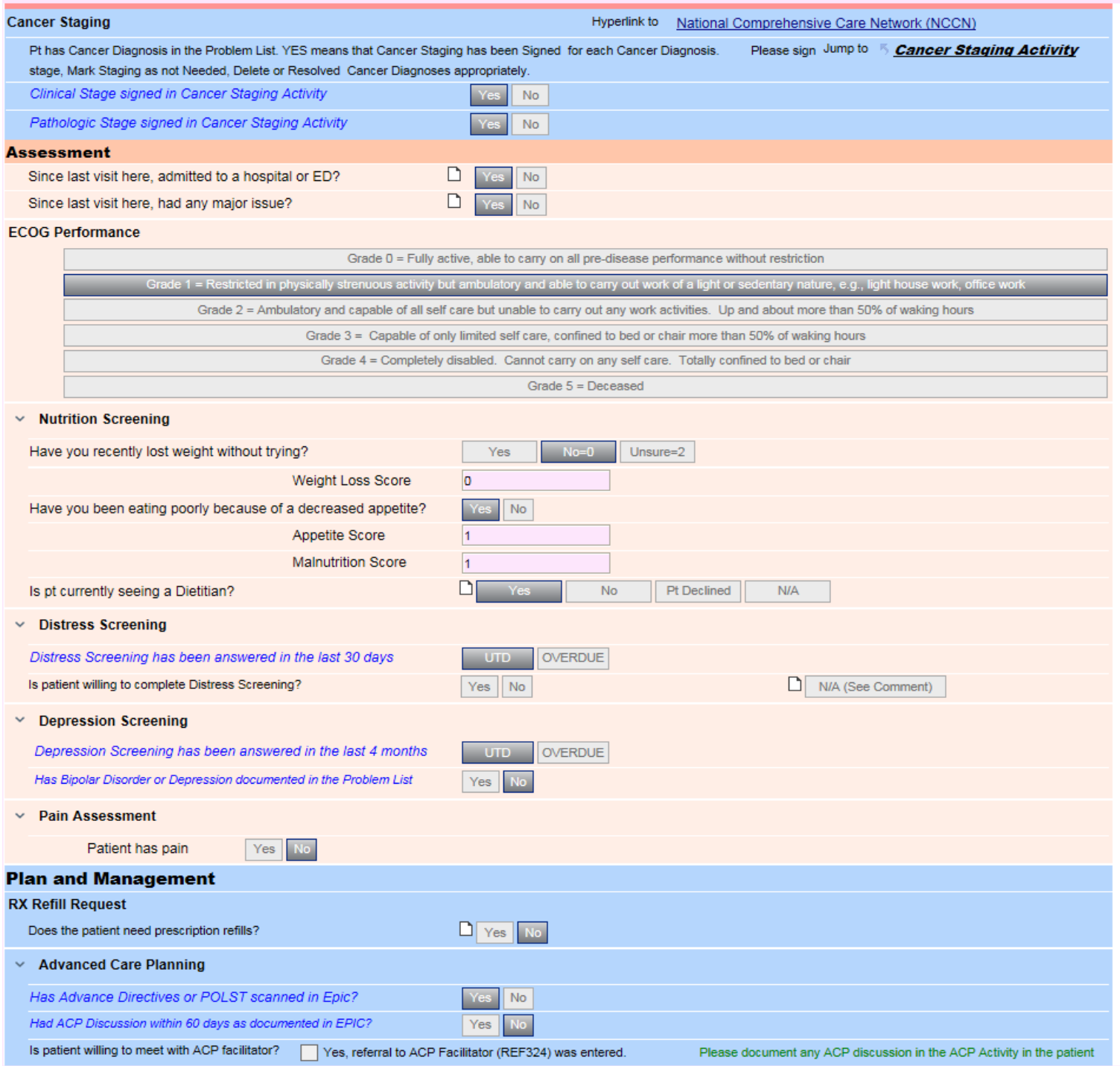
Develop Core Competencies

Establishing data:

- A home for staging data in EHR
- Assigning members of care team to patient
- Treatment intent
- Treatment summary
- Creating outcome measures
- Creating process measures
- Creating data gathering ability
- Creating data reporting ability

Orange elements are completed by clinic staff

Blue elements must be completed by the provider.



Cancer Staging Hyperlink to National Comprehensive Care Network (NCCN)

Pt has Cancer Diagnosis in the Problem List. YES means that Cancer Staging has been Signed for each Cancer Diagnosis. Please sign Jump to ***Cancer Staging Activity*** stage, Mark Staging as not Needed, Delete or Resolved Cancer Diagnoses appropriately.

Clinical Stage signed in Cancer Staging Activity Yes No

Pathologic Stage signed in Cancer Staging Activity Yes No

Assessment

Since last visit here, admitted to a hospital or ED? Yes No

Since last visit here, had any major issue? Yes No

ECOG Performance

Grade 0 = Fully active, able to carry on all pre-disease performance without restriction

Grade 1 = Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work

Grade 2 = Ambulatory and capable of all self care but unable to carry out any work activities. Up and about more than 50% of waking hours

Grade 3 = Capable of only limited self care, confined to bed or chair more than 50% of waking hours

Grade 4 = Completely disabled. Cannot carry on any self care. Totally confined to bed or chair

Grade 5 = Deceased

Nutrition Screening

Have you recently lost weight without trying? Yes No=0 Unsure=2

Weight Loss Score 0

Have you been eating poorly because of a decreased appetite? Yes No

Appetite Score 1

Malnutrition Score 1

Is pt currently seeing a Dietitian? Yes No Pt Declined N/A

Distress Screening

Distress Screening has been answered in the last 30 days UTD OVERDUE

Is patient willing to complete Distress Screening? Yes No N/A (See Comment)

Depression Screening

Depression Screening has been answered in the last 4 months UTD OVERDUE

Has Bipolar Disorder or Depression documented in the Problem List Yes No

Pain Assessment

Patient has pain Yes No

Plan and Management

RX Refill Request

Does the patient need prescription refills? Yes No

Advanced Care Planning

Has Advance Directives or POLST scanned in Epic? Yes No

Had ACP Discussion within 60 days as documented in EPIC? Yes No

Is patient willing to meet with ACP facilitator? Yes, referral to ACP Facilitator (REF324) was entered. Please document any ACP discussion in the ACP Activity in the patient

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OCM Requirements - Dr. Abbey Bartlet care team

MRN	Patient	Diagnosis	Episode Start	Next Appointment	Complete Stage in Epic	IOM Care Plan Complete	Depression Screening in past 4 months	ACP Conversation	ACP Documents Received
					Provider	Provider	Care team		
0123456	Fitzwallace, Percy	Colon	September	2/13/2017	YES	10/27/2016	11/28/2016	YES	NO
1234567	Cregg, CJ	Endometrial	September	2/14/2017	NO	11/29/2016	NO	YES	NO
2345678	Bartlet, Josiah	Lung	September	2/15/2017	YES	10/27/2016	11/28/2016	YES	YES
3456789	McGarry, Leo	Prostate	December	2/15/2017	NO	NO	12/15/2016	NO	NO
4567900	Ziegler, Toby	Rectal	August	2/16/2017	YES	12/15/2016	NA	YES	NO
5679011	Seaborn, Sam	Brain	September	2/17/2017	YES	11/29/2016	NO	YES	YES
6790122	Fitzpatrick, Carol	Breast	October	None Scheduled	NA	10/25/2016	11/30/2016	YES	YES
7901233	Landingham, Dolores	Breast	August	None Scheduled	YES	NO	NA	YES	YES
9012344	Concannon, Danny	Thyroid	January	None Scheduled	NO	NO	1/26/2017	YES	YES

ACP = Advance Care Planning

OCM Updates

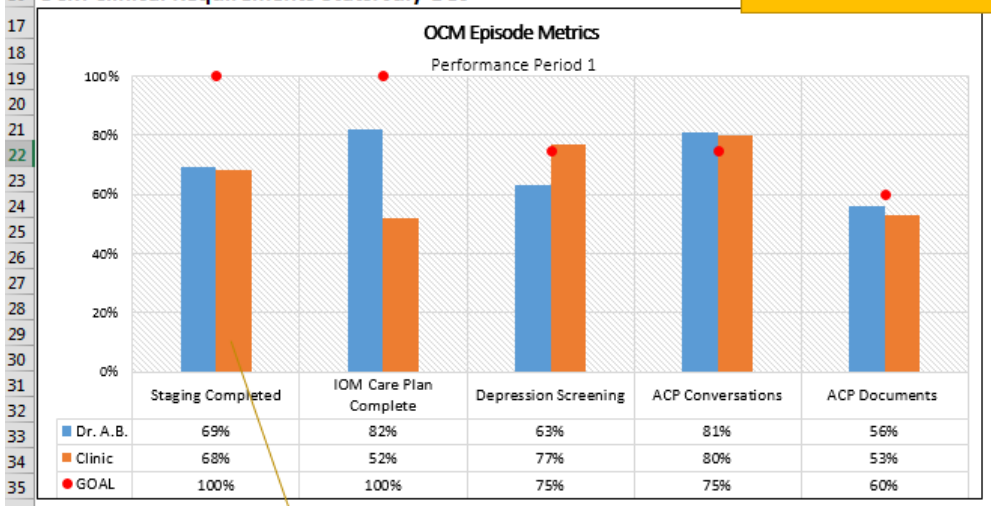
Week of 2/13/17:
- Individualized price estimates going live
- New rooming tool going live
- Palliative clinic adding days
- Lung cancer pathway updated
- Care plan will pre-populate survivorship
- PCP depression screening doesn't count must do our own at onc visit

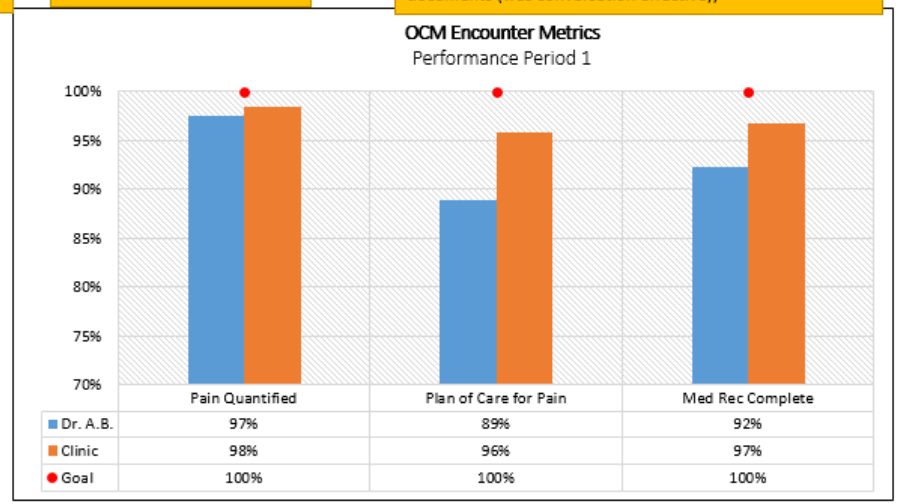
Patients with no next visit are flagged for follow-up

upcoming uncompleted tasks are RED. Patients with all

Distinguish between process measure (did we talk to patient about ACP) vs outcome measure (did patient return ACP documents (was conversation effective))

OCM Clinical Requirements Stats: July-Dec





Physician (blue) is compared to peers (orange)

Episode metrics are done once each six months, Encounter metrics @ every visit

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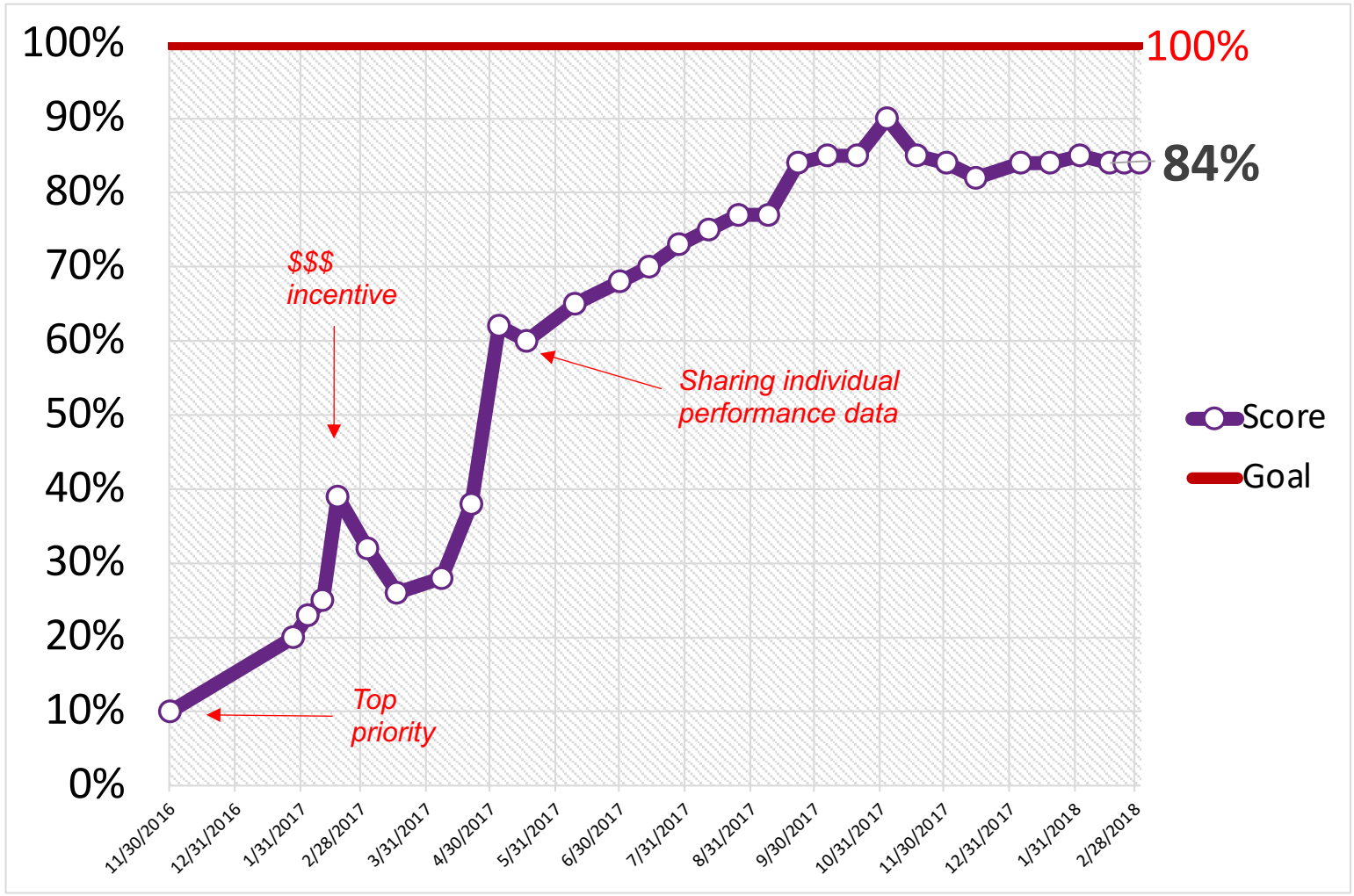
IOM Care Plan Completion



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Summary

Is It Worth It?

- Not about the money, it's about doing the right thing
- Take time to make the changes meaningful, not just "checking a box"
- Managing cost and full risk are better in the long run than managing authorizations
- You need to start now to be ready for what happens in 5 years
- You are **NEVER** "done"
- In our view, survival ten years from now depends on seeing value-based care *not* as one more thing to do but as *the **ONE** thing to do*

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But Remember, it Starts with You…

1. How are you presenting yourself?
2. Are you excited about value-based care?
3. Have you recovered from the COVID-19 pandemic burnout?
4. What will your legacy be?

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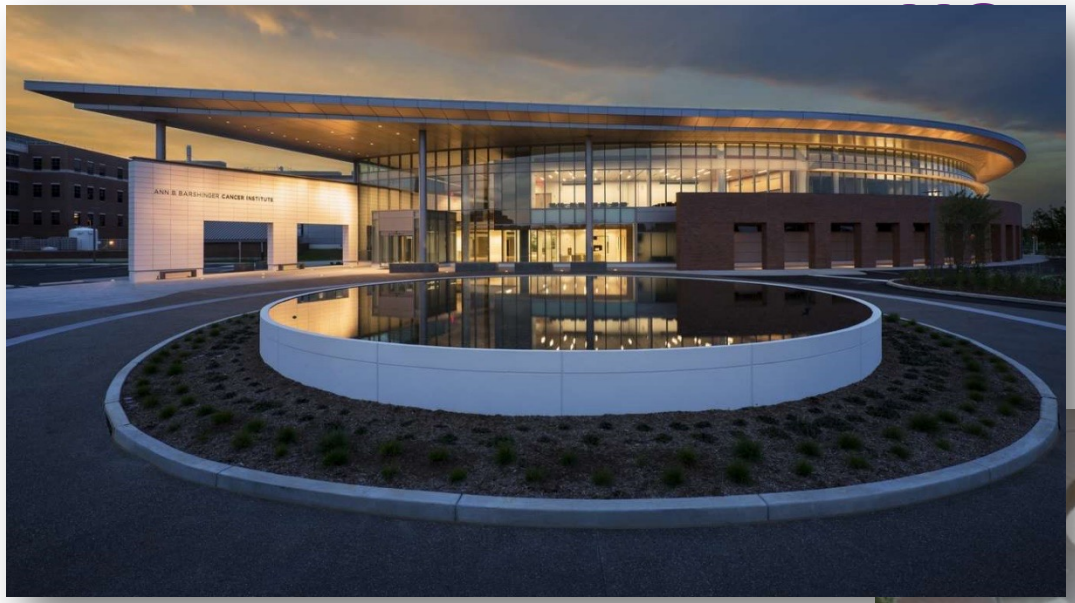
Want to Learn More? You're Invited to Visit



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