Oncology Payment Reform: Ready or not, here it comes

Association of Northern California Oncologists
May 20, 2015

Elaine L. Towle, CMPE
Director, Analysis and Consulting Services
Clinical Affairs Department

Learning Objectives for today

• The imperative for payment reform: SGR repeal
• Innovation
  • The CMMI Oncology Care Model
  • COME HOME
• ASCO’s payment reform proposal
• What do I do tomorrow?
SGR is Repealed

...Creates two tracks for providers

Merit-Based Incentive Payment System (MIPS)

- Meaningful Use (MU)
- Physician Quality Reporting System (PQRS)
- Value Based Modifier (VBM)

2019
This is NOT in the distant future

- HHS required to publish final plan for MIPS and APM measure development by **May 1, 2016**

- Measure priorities:
  - Outcomes
  - Patient experience
  - Care coordination
  - Appropriate use
  - Observed quality gaps

- HHS may contract with physician organizations to develop measures

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**MIPS Performance Categories and Weights**

- **Meaningful Use**: 25%
- **Quality (PQRS)**: 30%
- **Resource Use (Cost)**: 15%
- **Clinical Improvement** (Patient satisfaction, care coordination, etc.): 30%
MIPS Potential Impact

Resource Use
Quality Reporting
EHR MU
Clinical Improvement Activities
Composite Score 1-100

High Performers +27%
Flat
Low Performers -9%

What is An Alternative Payment Model (APM)?

- Comprises “significant” share of provider revenue
  - 25% 2019-2020
  - 50% 2021-2022
  - 75% 2023 and on
- Carries two-sided risk
- Includes financial incentives (e.g., bonus, shared savings)
- Includes quality measurement

Stay Tuned...Implementing Rules Still to be Written
Bottom Line

- Strong incentives to participate in APMs
- Consolidated quality reporting incentivizes participation in qualified clinical data registries
- Will motivate practice transformation/infrastructure
- Implementing rules will be critical, e.g.,
  - Defining and assigning risk
  - Determining appropriate quality measures

Update on Innovation
CMMI

- More than $2B since 2011
- Focus on costly diseases (e.g., cancer, heart disease, diabetes, mental health)
- Emphasis on multi-payer experiments
- Mixed opinions about results/impact

Moving Away From Fee For Service

"...moving away from the old way of doing things, which amounted to 'the more you do, the more you get paid.'"

Sylvia M. Burwell
HHS Secretary
HHS Goal:

By 2018, 50% of all Medicare payments based on alternative models

Why Fee For Service Doesn’t Work

• **Low or no payment** for:
  - Patient education
  - Nursing evaluation & care coordination
  - Social work, financial counseling, nutrition
  - Survivorship & palliative care
  - Cost and use of innovative technology

• **Loss of revenue** if fewer or lower cost treatments are given or oral drugs used

• **No payment** for work outside of face to face encounters
In Oncology…

COME HOME

- Medical Home model, 7 practices nationwide
- Significant reductions in hospital/ED use

Oncology Care Model (OCM)

* CMMI Developed Pilot Targeting 100 Practices

- **Episode-based**
  - Payment model targets chemotherapy and related care during a 6-month period following the initiation of chemotherapy treatment

- **Emphasizes practice transformation**
  - Physician practices are required to engage in practice transformation to improve the quality of care they deliver

- **Multi-payer model**
  - Includes Medicare fee-for-service (FFS) and other payers working in tandem to leverage the opportunity to transform care for oncology patients
Oncology Care Model (OCM)

Types of cancer
• OCM-Fee For Service (FFS) includes nearly all cancer types

Episode initiation
• Episodes initiate when a beneficiary starts chemotherapy as evidenced by the use of any of 162 drugs, of which 56 are oral

Included services
• All Medicare A and B services that Medicare FFS beneficiaries receive during episode
• Certain Part D expenditures will also be included

Episode duration
• OCM-FFS episodes extend six months after a beneficiary’s chemotherapy initiation.
• Beneficiaries may initiate multiple episodes during the five-year model performance period

Payment & Savings
• $160/month care management fee
  – May be multiple episodes per beneficiary
  – Additional payment adjustment based on savings
• Must produce 4% savings over historical spend
  – Savings expected from ER and hospital admission reduction, judicious use of imaging and drug selection (ASCO Top 5)
  – Incentive is designed to limit services that will add cost
• Benchmarking savings will be based on historical Medicare expenditure data for the practice
  – Based on both practice data and regional/national data as necessary to increase precision
  – Risk adjusted, adjusted for geographic variation
  – Trended to applicable performance period
  – 4% discount for one-sided risk; 2.75% in two-sided risk
6 OCM Practice Requirements

1. 24/7 patient access to clinician with real-time access to patient’s medical records
2. Use ONC-certified HER and attest to Stage 2 of meaningful use (MU) by end of year 3
3. Utilize data for continuous quality improvement
4. Provide core functions of patient navigation
5. Document care plan that contains the 13 components in the IOM Care Management Plan
6. Treat patients with therapies consistent with nationally recognized clinical guidelines

OCM Application Process

- The OCM application consists of 4 selection criteria. Each selection criteria is associated with a weighted score that will be used by CMMI in evaluating OCM applications

<table>
<thead>
<tr>
<th>Selection Criteria</th>
<th>Description</th>
<th>Points</th>
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<tbody>
<tr>
<td>1 Implementation Plan</td>
<td>Present realistic &amp; comprehensive plan based on current capabilities and addressing necessary changes to meet OCM objectives</td>
<td>40</td>
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<tr>
<td>2 Financial Plan</td>
<td>Demonstrate participant stability and present realistic &amp; comprehensive plan based on expected financial resources to support the OCM implementation plan (1st 2 years)</td>
<td>25</td>
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<td>3 Participation with Other Payers</td>
<td>Demonstrate significant, realistic expected multipayer participation. Include Letters of Support from each payer.</td>
<td>30</td>
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<td>4 Diverse Populations</td>
<td>Demonstrate that participant manages care for diverse populations and has a realistic, sound plan for engaging these populations</td>
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OCM Application Process & Timeline

A. Highly recommended: prospective applicants assess organizational readiness and financial impact of OCM participation

B. **May 7, 2015:** Letter of Intent (LOI) Deadline

C. OCM LOI is mandatory (no LOI, no application)

D. **June 18, 2015:** Application Deadline

E. Application to include electronic application, participant profile, implementation plan, financial plan, letters of support from other payers

F. Participants notified of acceptance by December 2015. OCM “go live” in spring 2016

Implications for Oncology Care

- Accountability for **ALL** Medicare spending (Parts A, B, D)
- Must produce 4% savings over historical spend
- Performance based payment depends on overall savings
- Incentive to limit services or referrals that will affect savings
OCM Resources

• ASCO
  – [www.asco.org/medicaremodel](http://www.asco.org/medicaremodel)
  – Includes access to staff and industry experts for your specific questions through the application process

• CMMI
  – [OncologyCareModel@cms.hhs.gov](mailto:OncologyCareModel@cms.hhs.gov)
ASCO Model

Patient-Centered Oncology Payment
Payment Reform to Support Higher Quality, More Affordable Cancer Care

• 3 options with transition away from fee-for-service
  – Add new codes to existing E&M codes to cover cost of services
  – Replace E&M codes with monthly payment codes that provide flexibility in how care is delivered
  – Bundled monthly payments that include both oncology practice costs and other costs such as tests, hospitalizations and/or drugs

• Accountability in all three options… but for things oncologists can control

A Continuum for Practice Transformation

Allows any practice—regardless of starting point—to participate in some alternative payment model
**ASCO Payment Reform Leadership**

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<tr>
<td>Jeff Ward, MD</td>
<td>Roscoe Morton, MD</td>
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<tr>
<td>Anupama Acheson, MD</td>
<td>Charles Penley, MD</td>
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<tr>
<td>Andrew Hertler, MD</td>
<td>Barbara McAneny, MD</td>
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<tr>
<td>Blase Polite, MD</td>
<td>Ann Kaley</td>
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<td>Christian Thomas, MD</td>
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<td>Dan Zuckerman, MD</td>
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<td>Denis Hammond, MD</td>
<td>Barry Russo</td>
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<tr>
<td>Edward Balaban, MD</td>
<td>Bruce Gould, MD</td>
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<td>James Frame, MD</td>
<td>Scott Parker</td>
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<tr>
<td>John Cox, MD</td>
<td>Joel Saltzman, MD</td>
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<tr>
<td>Michael Diaz, MD</td>
<td>Julie Moran, RN, BSN, MBA</td>
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<tr>
<td>Omar Eton, MD</td>
<td>Justin Klamerus, MD</td>
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<tr>
<td>Ray Page, DO</td>
<td>John Hennessey</td>
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<td>Rena Conti, PhD</td>
<td>Kim Woofter, RN</td>
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<td>Laura Stevens</td>
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<td>Lauren Lawrence</td>
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<td>Robin Zon, MD</td>
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<td>Tammy Chambers</td>
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<td>Harold Miller</td>
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**Current Status**

- New model just released – we want to hear from you!
- Collecting/analyzing clinical/administrative data to better define payment amounts, risk corridors, unpaid services
- Pursuing pilots
  - With multiple practices, diverse settings
  - Outreach to payers (CMS and commercial)
- Pursuing standard performance measures/programs
  - Clinical performance (overuse, underuse)
  - Care processes/management (hospitalizations, ER visits)
  - Outreach to AHIP, NBGH, employers, payers, CMS
- Want to get involved? Elaine.towle@asco.org or Thomas.barr@asco.org
In Summary

• Virtually every alternative payment model—in and out of oncology—includes a medical home framework

• Performance will be measured in terms of clinical quality, patient satisfaction and cost

• All of the models—including payment adjustments—incentivize care coordination across specialties and providers

What do I do tomorrow?

6 universal payment reform basic requirements

1. 24/7 patient access to clinician with real-time access to patient’s medical records
2. Robust clinical measurement and management
3. Continuous quality improvement based on clinical and financial information
4. Patient navigation
5. Documented care plan containing the 13 IOM components
6. Treatments consistent with nationally recognized clinical guidelines
What do I do tomorrow?

• Fee for service is going away
• Electronic medical record automated clinical measurement and reporting is essential and required
• All payment reforms require the same basics.
• Today – drive data density in your EMR

• There is no time to lose

New!

ASCO’s Clinical Affairs Department
Helping practices survive and thrive...today AND in the future

• Led by a practicing oncologist—priorities and programs to be driven by you
• Hands on help for practices
  – Practice efficiency; staffing models, workflow; quality reporting/QI projects; learning networks
• Information and analysis
  – Practice trends; economic analysis; performance measurement; payment reform
Dr. Stephen Grubbs
Senior Director, Clinical Affairs

The new clinical affairs department of the American Society of Clinical Oncology is dedicated to providing services, education and other resources to support oncology practices in all settings. Dr. Grubbs will begin his new role in June.

Grubbs, 62, is a community oncologist and managing partner at Medical Oncology Hematology Consultants in Newark, Del. He is also a principal investigator with the Delaware/Christiana Care National Cancer Institute Community Oncology Research Program.

• A collaborative learning network for oncology practice knowledge
  – Focus on administrative, operational, financial and quality improvement activities
  – Valuable tool for practice improvement
• Enrollment is open now!
• Contact PracticeNet@asco.org for more information
The State of Cancer Care in America: 2015

- Be counted in the next ASCO Census!
- This year only **FIVE** questions!
  1) Type of Practice
  2) Number of Physicians by specialty
  3) Number of APPs (NPs, PAs)
  4) Current Payer Mix
  5) Number of new patients in the last 12 months

Questions?

Elaine L. Towle, CMPE
Director, Analysis and Consulting Services
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Elaine.towle@asco.org