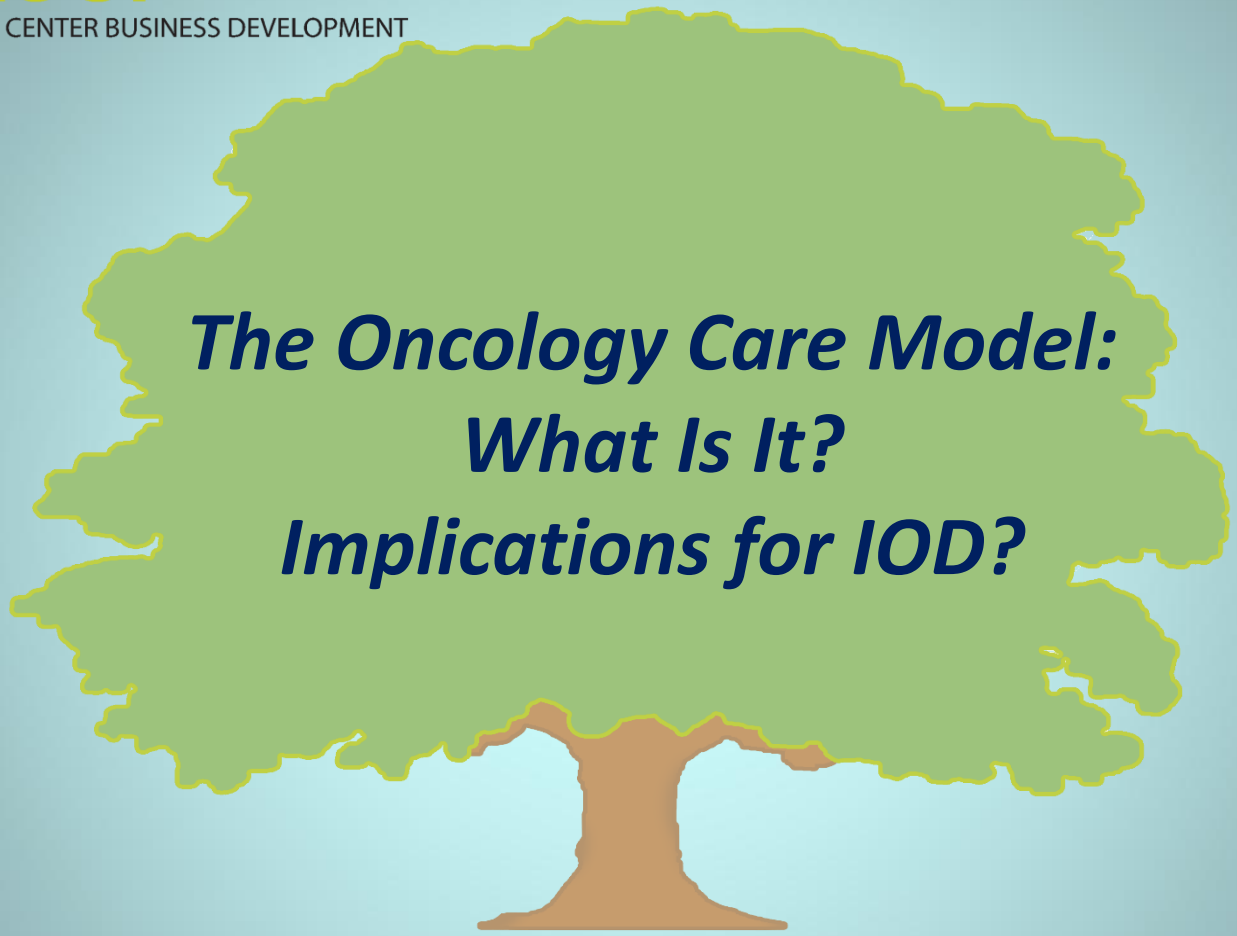
CCBD GROUP
CANCER CENTER BUSINESS DEVELOPMENT



The Oncology Care Model: What Is It? Implications for IOD?

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Backdrop

1. U.S. healthcare system is regularly criticized as being inefficient, inaccessible and way too costly
2. As a result, the healthcare system is undergoing a transformation from traditional "volume-based" to the notion of "value-based" care
3. Cancer care, with high variability in terms of outcomes and cost, is under particular scrutiny
4. This transformation is being catalyzed in large part by the Affordable Care Act ("ACA") and it's various alternative payment model (APM) initiatives
5. CMMI's new Oncology Care Model (OCM) is one such APM initiative designed to financially incentivize oncology providers to engage in the transformation [innovation.cms.gov/initiatives/oncology-care]
6. Reform is here to stay. Cost of healthcare is unsustainable. 17.5% of GDP in 2015 and climbing. Medicare to be insolvent by 2020. Regardless of new Administration in 2017, Congress has weighed in: volume → value = MACRA

Today's Focus

1. Chronology of Oncology Alternative Payment
2. Profile: Oncology Consultants, PA
3. OCM Basics
4. OCM Economics
5. Sources of OCM Cost Savings
6. OCM Operational Challenges
7. IOD as Solution to Part D Tracking
8. A Bit About MACRA, MIPS, AAPM

Chronology of Oncology Alternative Payment

2009	Drug Pathways Compliance	Health Plan waives pre-auth and pays higher % on generics for drug pathways compliance. CareFirst, Highmark, Michigan Blue Cross Plans
2009-2012	United H/C Episodes Model	Replaces % drug mark-up with pre-set drug margin payment. Findings published 2014: drug costs not reduced, but overall costs down by 11% annual
2010	Oncology Medical Home (OMH)	John Sprandio, MD, Drexel Hill, PA. Applies to NCQA for PCMH certification and originates the OPCMH model
2010 - 2012	US Oncology - Innovent Model	Aetna + Texas Oncology. Pro-active care management reduces ER and inpatient costs. 12% annual by year 2
2011	Priority Health OMH	Priority Health Plan and Michigan oncologists. $550 per patient reduction in ER and hospitalization costs
May 2012	Oncology ACO	Baptist Health + Advanced Med Specialties + Florida Blue. Add Hospital to OMH = Onc ACO. Shared savings
May 2014	Anthem Cancer Care Quality	$350 per treatment patient per month for pathway compliance + care coordination

Chronology of Oncology Alternative Payment

Aug 2014	OCM Design Paper	CMMI releases OCM design paper. Model intended to improve quality, reduce costs for Medicare FFS beneficiaries undergoing chemo
Oct 2014	Aetna Oncology Medical Home Program	Care coordination activities. Enhanced generic drug fees + shared savings
Oct 2014	Horizon BC NJ Episodes of Care	Horizon BC – RCCA retrospective bundled pricing for breast cancers
Dec 2014	United H/C - MD Anderson	Bundled prices for head & neck cancers. All care for one year. May add lung, prostate
Apr 2015	Medicare Access & CHIP Reauthorization Act	Congress weighs in: MACRA repeals SGR. Mandates merit-based pay (MIPS) or advanced APMs. OCM 2-sided risk qualifies as an APM
July 2015	Comprehensive Care for Joint Replacement (CJR)	MANDATORY hip & knee bundled pricing in 75 markets – mandatory as harbinger of future?
July 2016	OCM Launch Date	Enhanced services for Medicare Beneficiaries undergoing chemo. $160 MEOS PBPM for 6-mo Episode + performance-based pay (PBP)

Family Tree of Oncology Alternative Payment

*OMH Key Features: pathways compliance; pro-active care management; end-of-life planning

Profile: Oncology Consultants

- Overview
  - Located in Houston, TX
  - 14 Physicians, 4 Advanced Practitioners
  - 10 Locations
  - Service Lines, (Med Onc, Retail Pharmacy, Rad Onc, Imaging, research

ACR RADIOLOGY | CLIA Clinical Laboratory Improvement Amendments | ONCC | QOPI® The Quality Oncology Practice Initiative | CERTIFICATION PROGRAM

Practice Preparation and Implementation

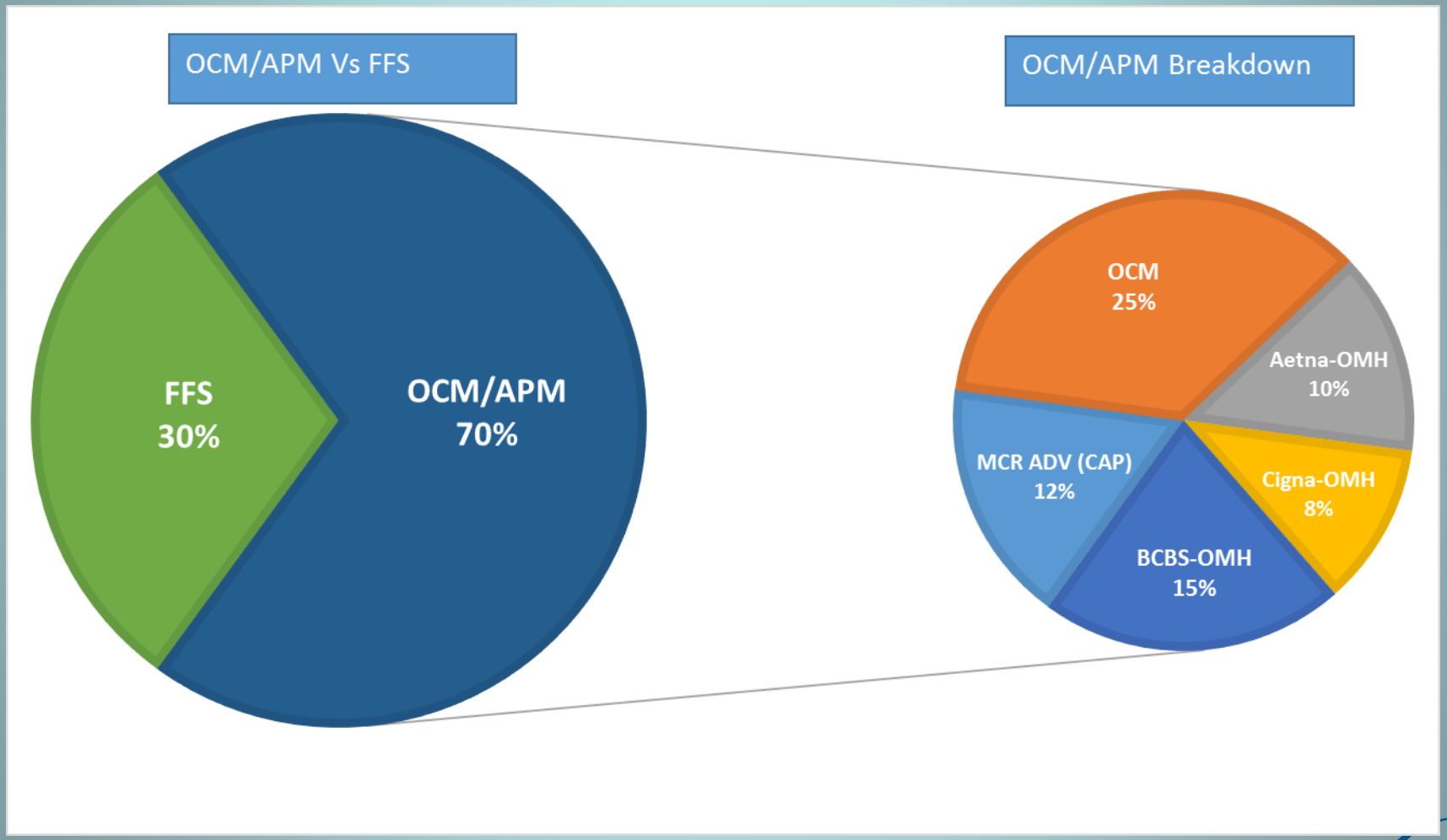
Oncology Consultants, PA

- Timeline: Transition to the OCM/APM World
- Identification of Common Denominators for all Initiatives
- Budgeting: Technology, Clinic, and Staffing Needs
- Preparing the Staff and Physicians: “Quality Care Initiatives”

Timeline

- July-2013: MCR Advantage, Capitation
- Sept-2015: Aetna, Oncology Medical Home
- July-2016: Cigna, Oncology Medical Home
- July-2016: CMS, Oncology Care Model
- Q4-2016: BCBS, Oncology Medical Home

OCM/APM vs FFS 2016-2017



Data, Data, Data…

- Establishing common denominators across programs
- Physician and Staff training
- Campaign, “Quality Care Initiatives”

Oncology Consultants Clinical Quality Measures				
Measure	Quality Program			
	OCM	Aetna	Cigna	QOPI
Staging	X	X		X
Gene Mutation/Hormonal Status/Histopathology	X			X
Treatment Intent	X			X
Treatment Planning			X	X
Tobacco Cessation				X
Pain Assessed and Addressed	X	X	X	X
Clinical Depression Screening	X		X	X
ECOG Status Assessments		X	X	
Survivorship Care Orders				X

OCM Basics

- **Goal:** incentivize providers to improve care and reduce spending for Medicare beneficiaries with cancer who receive chemotherapy
- **Eligibility:** physician practices that provide care for oncology patients undergoing chemotherapy for cancer. Includes both independent medical practices and hospital-affiliated/owned practices
- **Term:** 5-year program commencing July 1, 2016 ("Start Date")
- **Participation:** 195 participating practices and 17 participating health plans. Represents over 3,200 oncologists (about 1/3 practicing oncologists). Avg. OCM practice size = 17 oncologists

OCM Basics

- **Objective:** reduce the total cost of care for OCM Beneficiary during a 6-month "Episode" to an amount below a "Target Price"
- **Episode:** an "Episode" commences with the initiation of chemotherapy, either via infusion/injection (Part B) or oral (Part D)
- **Compensation:** (i) Monthly Enhanced Oncology Services payment ("MEOS") of $160 plus (ii) performance-based payment ("PBP") based on total Medicare expenditure savings against aggregate Target Prices (OCM payments are in addition to regular Medicare fee-for-service reimbursement)
- **Enhanced Services:** see OCM Practice Redesign Activities, slide 11

OCM Basics

- **Risk Arrangement:** 1-sided risk to June 30, 2018; option to assume 2-sided risk thereafter; 2-sided risk model qualifies OCM as an APM under MACRA (Medicare Access and CHIP Reauthorization Act of 2015)
- **OCM Discount:** Deduction from "Benchmark Price" to determine Target Price: 4.0% 1-sided risk; 2.75% 2-sided risk
- **Practice Redesign Activities:** OCM Participants must implement and conduct the 6 Practice Redesign Activities
- **Clinical Data and Quality Measures:** 12 OCM measures. Reported quarterly through OCM Data Registry (Registry not yet operational)
- **Monitoring:** OCM Participants subject to lots of monitoring by CMS and its contractors, including on-site inspections

Practice Redesign Activities

1. Patient access 24/7 to clinician who has real time access to patient's medical record
2. Attestation and use of ONC-certified EMR
3. Utilize data for Continuous Quality Improvement (CQI)
4. Provide core functions of patient navigation
5. Document care plan in accordance with IOM 13-points
6. Chemotherapy treatment consistent with nationally recognized clinical guidelines

Activities 1, 4, 5, 6 above are the OCM "Enhanced Services."

OCM Participants submitted Practice Transformation Plans and attestation to implementation by Sept 30, 2016

OCM Economics for 10-Oncologist Practice

Description	Year 1	Year 2	Year 3
Avg. overall cost/Episode (CMMI "Snapshot")	$27,634	$27,634	$27,634
Estimated M/Care FFS chemo/year (10 MDs)	650	650	650
MEOS payments ($160 x 6 = $960 x 650)	$624,000	$624,000	$624,000
Benchmark expenditures ($27,634 x 650)	$17,962,100	$17,962,100	$17,962,100
Less: OCM discount (4% off Benchmark)	$718,484	$718,484	$718,484
Practice Target Price (Benchmark-Discount)	$17,243,616	$17,243,616	$17,243,616
Expenditure savings target (off Benchmark)	6%	8%	10%
Estimated actual expenditures + MEOS)	$17,508,374	$17,149,132	$16,789,890
Gain (Target Price less actual expenditures)	($264,758)	$94,484	$453,726

OCM Economics for 10 Oncologist Practice

Description	Year 1	Year 2	Year 3
Gain (target price less actual expenditures)	($264,758)	$94,484	$453,726
Times "Performance Multiplier"	75%	100%	100%
Performance based payment	$0	$94,484	$453,726
Add back care management fees paid	$624,000	$624,000	$624,000
Estimated total OCM revenue to practice	$624,000	$718,484	$1,077,726
Less: OCM-specific incremental costs	$300,000	$300,000	$300,000
Net margin to OCM Participant	**$324,000**	**$418,484**	**$777,726**
Possible payments from commercial payer APM initiatives (Anthem, Aetna, etc.)	**$120,000**	**$120,000**	**$120,000**

Sources of OCM Cost Savings

Source	% Cost Reduction
Drug pathways compliance	1.0% to 3.0%
Avoidable ER utilization	0.6% to 1.1%
Avoidable hospital admissions	4.0% to 7.0%
Diagnostics (imaging, lab)	0.2% to 0.5%
End-of-life care management	0.9% to 1.9%
Total potential savings	6.7% to 13.5%

About 2/3 of the savings comes from avoidable hospital events.

(1) John D. Sprandio, MD, Consultants in Medical Oncology & Hematology. Oncology Patient Centered Medical Home ® Analysis of OPCMH savings conducted by third party actuary 2010.
(2) *How Oncologists are Bending the Cost Curve*. *Oncology Times*. January 10, 2013.
(3) *Changing Physician Incentives for Affordable, Quality Cancer Care: Results of an Episode Payment Mode*l. Newcomer et. Al. Journal Oncology Practice. July 8, 2014.

Oncology Consultants: Budgeting

Technology Infrastructure	Unit	Cost	Year 1	Subsequent Years
Pathways (Treatment, Nurse triage, Hardware)	1	$ 14,880	$ 14,880	$ 47,880
		Total Cost	$ 14,880	$ 47,880
Clinic Infrastructure (After Hours+Weekend)	**Unit**	**Cost**	**Year 1**	**Subsequent Years**
Utilities/Security	110	$ 25		$ 2,750
Space	1	$ 6,000	$ 6,000	Sunk Cost
ID Card Printer Hardware	7	$ 1,999	$ 13,993	Sunk Cost
ID Card Printer Toner	2	$ 134	$ 268	$ 268
TelePhone/Fax	1			
ID Card Printer Supplies	20	$ 62	$ 1,230	$ 1,230
		Total Cost	$ 21,491	$ 4,248
Staffing Infrastructure (After Hours+Weekend)	**Unit**	**Cost**	**Year 1**	**Subsequent Years**
Front Office	0	$ 31,200	$ -	$ -
Midlevels	1	$ 92,500	$ 95,275	$ 95,275
RN	1	$ 67,600	$ 67,600	$ 69,628
LVN/RN	1	$ 55,000	$ 55,000	$ 56,650
Lab MA	0	$ 33,280	Sunk Cost	Sunk Cost
PhT	0	$ 38,480	Sunk Cost	Sunk Cost
Nurse Navigator	0	$ 75,000	Sunk Cost	Sunk Cost
Benefits and Cost of Living	20%		$ 43,575	$ 44,311
		Total Staffing Costs	$ 261,450	$ 265,864
		Technology+Clinic+Staffing Costs	$ 297,821	$ 317,992

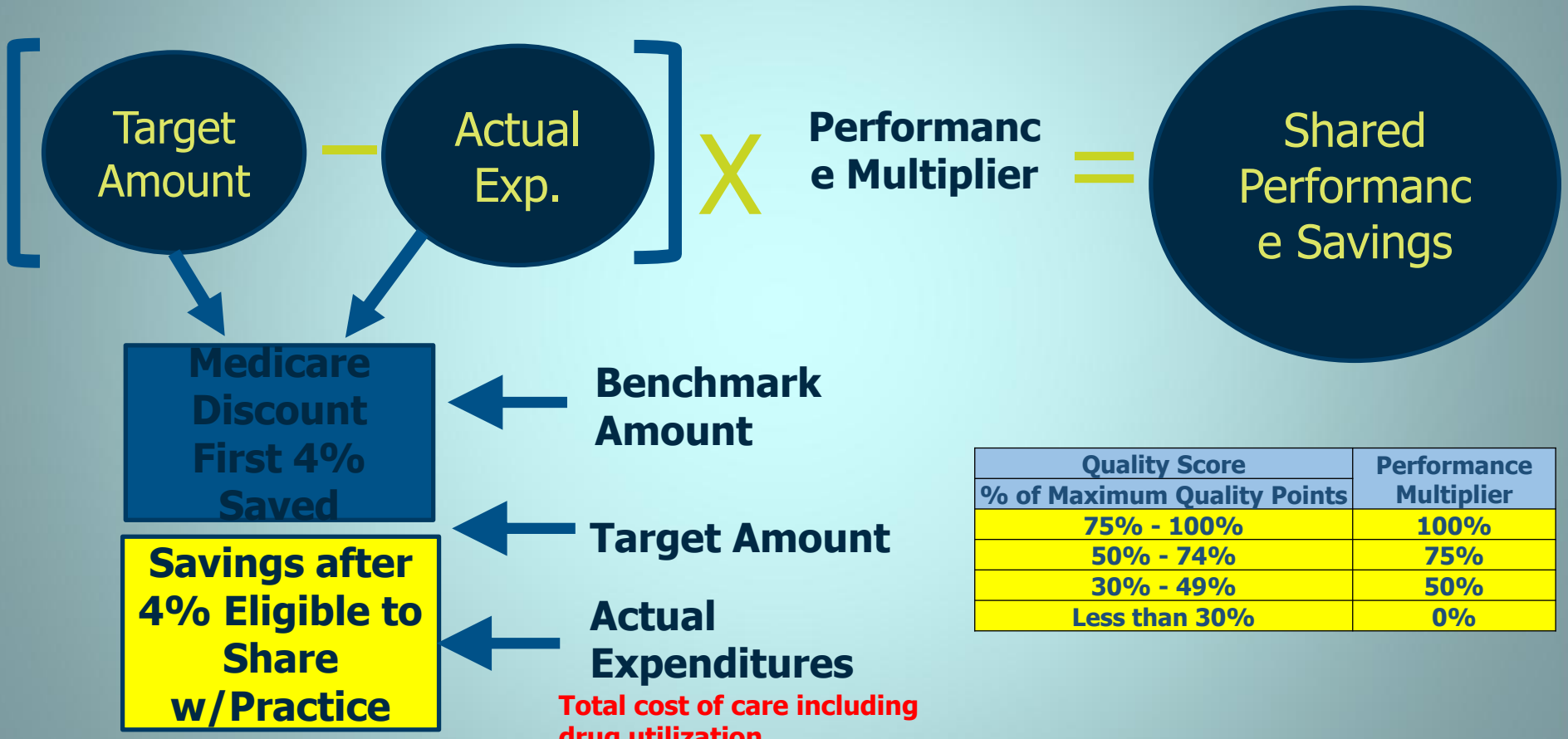
OCM Operational Challenges

- **Change Management:** managing the operational and cultural change required of practice redesign. What are "best practices?"
- **Clinical Data:** collecting and reporting OCM Clinical Data & Quality Measures. No single-solution automated system/platform
- **Claims Data:** accessing, analyzing, interpreting claims data. How are actual costs trending against Target Prices? Managing nuances of the OCM Prediction Model – risk stratification
- **Tracking Part D Oral prescription fills:** when has a Part D script been filled that commences a new Episode?
- **Next Milestones:** converting to 2-sided risk (2018) and transitioning from shared savings models to prospective bundled pricing (commercial health plans and self-insured employers)

Strategic Approach to OCM: Patient Care and Economics Optimizations

- Overview of the OCM Performance Based Payment Formula (PBP)
- Identification and tracking of OCM Performance Multiplier (PM) Objectives
- Alignment of PM + PBP = Provider Compensation Model

CMS Oncology Care Model



Quality Score % of Maximum Quality Points	Performance Multiplier
75% - 100%	100%
50% - 74%	75%
30% - 49%	50%
Less than 30%	0%

Performance Multiplier is based on the "Aggregated Quality Score" from each practice on quality measures

Identification and tracking of OCM Performance Multiplier (PM) Objectives

- Alignment of Performance Multiplier with Provider workflow

Score Card

Measures	Score
Staging	80%
Gene Mutation/Hormonal Status	90%
Treatment Intent	88%
Treatment Planning	95%
Pain Assessed and Addressed	85%
Mental Health	90%
ECOG Status Assessments	95%
Tobacco Cessation	65%
Composite Score	86%

Breakdown of Measures

Measures		
Measure	**Numerator**	**Denominator**
Staging	Patients' applicable cancer diagnosis are staged based on defined staging fields including appropriate staging system (i.e. TNM, Ann Arbor, etc.)	Unique patient counts for those with following diagnosis codes. C21, C65-C68, C50, C70-C72, C73-C75, C7A, C51-C55, C15-C16, C00-C14, C30-C33, C17-C20, C64, C22-C24, C34, C39, C45, C81-C86, C88, C43, C56, C25, C61, C90
Gene Mutation/Hormonal Status/Histopathology	Applicable mutations fields completed: ER, PR, HER2/neu, EGFR, ALK, KRAS, BRAF, NRAS, ROS1	Lung Cancer Group (EGFR, ALK, ROS1); Intestinal Cancer Group (KRAS, NRAS, BRAF); Anal Cancer (KRAS, NRAS, BRAF); Malignant Melanoma (BRAF); Gastro/Esophageal Cancer (HER2); Breast Cancer (ER/PR/HER2); Carcinoma In Situ of Breast (ER/PR); PDL 1 testing - Lung and Melanoma; MSI - Colon & Rectal Cancer
Treatment Intent	Treatment intent (Curative/Palliative) is chosen from pick list from the "Generate a Flowsheet" screen after creating a regimen order.	Patients that have an initiated regimen therapy
Treatment Planning	Treatment Planning Note template is approved prior to initiation of chemotherapy	Patients with qualifying ICD-10 cancer diagnosis codes who have initiated chemotherapy based on the regimen list. Exclude support regimens (non-chemotherapy) denoted by (SYM) in the regimen name.
Tobacco Cessation	Under social history tab in patient office visit note, smoking cessation intervention radio button is chosen	Patient is assessed as current smoker, chews tobacco, or snuff user. This needs to be counted as a one time unique patient assessment on an annual basis(not based on number of visits)
Pain Addressed	Under review of systems tab, patients that have a pain level of 2 and above are addressed with an appropriate radio button chosen.	Patient office visits based on Scheduled MD
Mental Health	Under review of systems tab, patient's mental health is assessed through appropriate radio button chosen	Patient office visits based on Scheduled MD
ECOG Status Assessments	Under physical examination tab, ECOG status assessed through appropriate radio button chosen	Patient office visits based on Scheduled MD

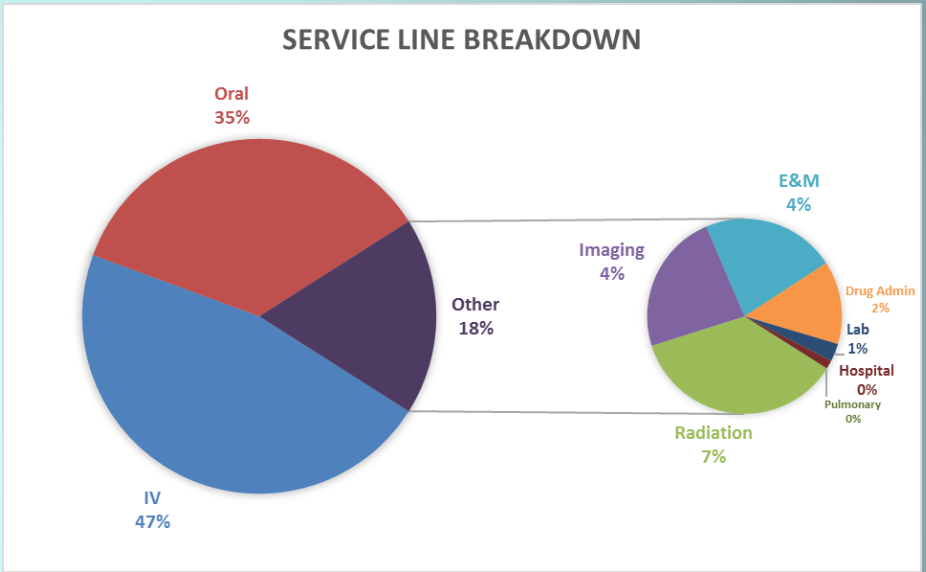
Alignment of PM + PBP = Provider Compensation Model

- Provider Compensation Model of CMS Performance Based Payments

Performance Based Pay (CMS)	$ 10,000			
	Dr A	Dr B	Dr C	Total
wRVU	1000	700	200	1900
wRVU %	*53%*	*37%*	*11%*	*100%*
Performance Multiplier (PM)	50%	75%	90%	215%
Composite Score	*23%*	*35%*	*42%*	*100%*
wRVU+PM	76%	72%	52%	200%
Composite Score	*38%*	*36%*	*26%*	*100%*
	Outcome			
Composite	$ 3,794	$ 3,586	$ 2,619	$ 10,000

IOD as Solution to OCM Challenges

- Cost/Risk Attribution
  - Part A (Hospital Services),
  - Part B (IV Drugs, DME, Hosp OP, Lab, Mental health)
  - Part D (Outpatient Prescription Drug)
- IOD as source for confirming Part D oral prescription fill date and tracking of patient compliance
- **<u>Chemotherapy committee</u>** comparing IV Vs Oral Chemotherapy treatments assessing Clinical efficacy, Toxicities, IP/ER, and Cost



A Bit About MACRA

- Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") replaces the flawed Sustainable Growth Rate ("SGR") formula for annually adjusting the Medicare Physician Fee Schedule with a new Quality Payment Program ("QPP")
- This is Congressional validation of the volume → value notion
- MACRA has two paths: (1) Merit-Based Incentive Payment System ("MIPS") or (2) Advanced Alternative Payment Models ("APMs")
- MIPS is a consolidation of the existing EHR Meaningful Use, PQRS and Value Modifier programs into a single program
- MIPS "allows physicians to be paid for providing high quality, efficient care." MIPS scores used to compute a positive, negative or neutral adjustment to the physician's Medicare reimbursement

A Bit More About MACRA

- CMS to begin measuring MIPS performance in 2017 with payments adjusted commencing in 2019. MIPS plus or minus adjustments in physician's Medicare reimbursement: 2019 = 4%; 2020 = 5%; 2021 = 7%; 2022 and thereafter = 9%
- MIPS is budget neutral: there will be winners and losers. Increased pay to some offset by decreased pay to others. What does a 9% "haircut" in pay do to practice financial sustainability? One theory: will drive more physicians to hospital affiliation
- APMs must have "not insubstantial risk." Physicians participating in APMs are exempted from MIPS and would qualify for 5% Medicare bonus
- **OCM 2-sided risk model qualifies as an APM (available 2018)**

Discussion

Questions - Comments?

Thank you for your Interest

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