



CMS Innovation Center Oncology Care Model



Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services

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August 22, 2014

Delivery system and payment transformation

Historical State –

Producer-Centered

Volume Driven

Unsustainable

Fragmented Care

FFS Payment Systems



PRIVATE
SECTOR

PUBLIC
SECTOR

Ideal Future State –

People-Centered

Outcomes Driven

Sustainable

Coordinated Care

New Payment Systems and Policies (and more)

- Value-based purchasing
- ACOs, Shared Savings
- Episode-based payments
- Medical Homes and care mgmt
- Data Transparency

Framework for Progression of Payment to Clinicians and Organizations in Payment Reform

	Category 1: Fee for Service – No Link to Quality	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models on Fee-for-Service Architecture	Category 4: Population-Based Payment
Description	Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments vary based on the quality or efficiency of health care delivery	<ul style="list-style-type: none"> Some payment is linked to the effective management of a population or an episode of care Payments still triggered by delivery of services, but, opportunities for shared savings or 2-sided risk 	<ul style="list-style-type: none"> Payment is not directly triggered by service delivery so volume is not linked to payment Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (eg, >1 yr)
Examples				
Medicare	<ul style="list-style-type: none"> Limited in Medicare fee-for-service Majority of Medicare payments now are linked to quality 	<ul style="list-style-type: none"> Hospital value-based purchasing Physician Value-Based Modifier Readmissions/Hospital Acquired Condition Reduction Program 	<ul style="list-style-type: none"> Accountable Care Organizations Medical Homes Bundled Payments 	<ul style="list-style-type: none"> Eligible Pioneer accountable care organizations in years 3 – 5 Some Medicare Advantage plan payments to clinicians and organizations Some Medicare-Medicaid (duals) plan payments to clinicians and organizations
Medicaid	Varies by state	<ul style="list-style-type: none"> Primary Care Case Management Some managed care models 	<ul style="list-style-type: none"> Integrated care models under fee for service Managed fee-for-service models for Medicare-Medicaid beneficiaries Medicaid Health Homes Medicaid shared savings models 	<ul style="list-style-type: none"> Some Medicaid managed care plan payments to clinicians and organizations Some Medicare-Medicaid (duals) plan payments to clinicians and organizations

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**
 - Testing new payment and service delivery models
 - Evaluating results and advancing best practices
 - Engaging a broad range of stakeholders to develop additional models for testing
- **Goals of Innovation Center models include better care for patients, better health for communities, and lower costs**

CMS Innovations Portfolio: Testing New Models to Improve Quality

Accountable Care Organizations (ACOs)

- Medicare Shared Savings Program (Center for Medicare)
- Pioneer ACO Model
- Advance Payment ACO Model
- Comprehensive ERSD Care Initiative

Primary Care Transformation

- Comprehensive Primary Care Initiative (CPC)
- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Independence at Home Demonstration
- Graduate Nurse Education Demonstration

Bundled Payment for Care Improvement

- Model 1: Retrospective Acute Care
- Model 2: Retrospective Acute Care Episode & Post Acute
- Model 3: Retrospective Post Acute Care
- Model 4: Prospective Acute Care

Capacity to Spread Innovation

- Partnership for Patients
- Community-Based Care Transitions
- Million Hearts

Health Care Innovation Awards

State Innovation Models Initiative

Initiatives Focused on the Medicaid Population

- Medicaid Emergency Psychiatric Demonstration
- Medicaid Incentives for Prevention of Chronic Diseases
- Strong Start Initiative

Medicare-Medicaid Enrollees

- Financial Alignment Initiative
- Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents

Bundled Payment Care Improvement Model

- **Testing different types of bundles: acute care, acute and post-acute, post acute alone**
- **Over 40 conditions**
- **Hundreds of participants and growing**
- **Bundles cost of services for an episode of care with quality measures related to episode**
- **Allows providers to innovate, remove waste from system, and improve quality**

Specialty Practitioner-Focused Models

- The Innovation Center is interested in testing new models of care that will focus on specific diseases, patient populations, and specialty practitioners.
- New models would focus on services furnished by specialty practitioners in ambulatory settings.
- These models would complement CMS' existing portfolio, which already includes models focusing on both primary care and inpatient hospitalizations as well as care in other settings.

Oncology Care

- One of the specialty practice areas that the Innovation Center aims to improve the effectiveness and efficiency of specialist care is oncology care.
- More than 1.6 million people are diagnosed with cancer in the United States each year. Approximately half of those diagnosed are over 65 years old and Medicare beneficiaries. Cancer patients comprise a medically complex and high-cost population served by the Medicare program.
- About 50% of patients in oncology practices are Medicare FFS beneficiaries
- The Innovation Center has the opportunity to further its goals of better quality care, improved health, and lower costs through an oncology payment model.

Oncology Care Model

- Currently, the Innovation Center is developing the Oncology Care Model (OCM) that focuses on an episode of cancer care, specifically a chemotherapy episode of care
- The goal of an oncology payment model would be to utilize appropriately aligned financial incentives to improve
 - care coordination,
 - appropriateness of care, and
 - access for beneficiaries undergoing chemotherapy.
- Financial incentives would encourage participating practices to work collaboratively to comprehensively address the complex care needs of the beneficiaries receiving chemotherapy treatment, while decreasing the use of services that do not improve health outcomes.

OCM: Overview

- **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 and other payers working in tandem to leverage the opportunity to transform care for oncology patients across the population

Participants: Physician Practices

- Participants would be physician practices that furnish chemotherapy
- Practices would be expected to engage in practice transformation to improve the quality of care they deliver. This transformation would be driven by the requirements practices must fulfill in order to participate in OCM, including:
 - Treat patients with therapies compliant with nationally recognized clinical guidelines
 - Provide and attest to 24/7 patient access to an appropriate clinician with real-time access to practice's medical records
 - Use an ONC-certified EHR and attest to Stage 2 of meaningful use by the end of the fourth model performance year
 - Utilize data for continuous quality improvement
 - Employ one or more patient navigator/care coordinators
 - Document a care plan for every patient that contains the 13 components in the Institute of Medicine Care Management Plan

Participants: Payers

- CMS believes that working in tandem with other payers would leverage the opportunity to transform care for oncology patients across the population. Ideally, OCM would have a high level of collaboration between Medicare FFS and other payers, allowing OCM to drive comprehensive care redesign at the practice level.
- The OCM umbrella would cover both Medicare Fee-for-Service (OCM-FFS) and other participating payers (OCM-OP)
- Other payers would be expected to participate in alignment with Medicare in a number of ways, including but not limited to:
 - Provide payments for enhanced services and
 - Provide participating practices with payment and utilization data for their OCM patients to allow for continuous improvement
- Payer participation will drive the geographical scope of the model

Episode Definition

- **Types of cancer**
 - OCM includes all types of cancer.
- **Episode initiation**
 - Episodes initiate on the date of an initial chemotherapy administration or drug claim.
 - The Innovation Center has devised a list of chemotherapy drugs that would trigger OCM episodes, including endocrine therapies but excluding topical formulations of drugs.
- **Included services**
 - All Medicare A, B, and D services that Medicare FFS beneficiaries receive during the episode period would be included in OCM episodes.
- **Episode duration**
 - OCM episodes would extend six months after a beneficiary's chemotherapy initiation.
 - Beneficiaries continuing to receive chemotherapy at the end of an episode would initiate a new episode, with a maximum of two episodes per beneficiary.

Two-part payment approach

- Per-beneficiary-per-month (PBPM) payment
 - Creates a new payment for practices to furnish the required enhanced services
 - Monthly care management payment for every OCM-FFS beneficiary for 6 months
- Performance-based payments
 - Incentivize participating practices to lower the total cost of care and improve care for beneficiaries over the 6-month episode period
 - Calculated based on the practice's historical Medicare expenditure and achievement on selected quality measures (these selected measures are **bolded** on the following slides)
 - Providers will continue to receive regular Medicare FFS payments during the model performance period

Quality Measures: Clinical Quality of Care

- Breast Cancer: Hormonal therapy for Stage IC-IIIC (ER/PR) Positive Cancer in OCM-FFS beneficiaries (NQF #0387)*
- Breast Cancer: Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or Stage III hormone receptor negative breast cancer in OCM-FFS beneficiaries (NQF #0559)*
- Colon Cancer: Chemotherapy for Stage IIIA through Stage IIIC OCM-FFS beneficiaries with colon cancer (NQF #0385)*
- Colon Cancer: Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to OCM-FFS beneficiaries under the age of 80 with AJCC III (lymph node positive) colon cancer (NQF #0223)*
- Prostate Cancer: Adjuvant hormonal therapy for high-risk OCM-FFS beneficiaries (NQF #0390)*
- Percentage of OCM-FFS beneficiaries with documented ECOG, Karnofsky, or WHO performance status assessment prior to OCM-FFS episode initiation and at episode conclusion*
- Breast Cancer: Hormonal therapy for Stage IC-IIIC (ER/PR) Positive Cancer in OCM-FFS beneficiaries (NQF #0387)*

Quality Measures: Communication and Care Coordination

- **Number of emergency department visits per attributed OCM-FFS beneficiary per OCM-FFS episode**
- **Number of hospital admissions per attributed OCM-FFS beneficiaries per OCM-FFS episode**
- **Percentage of all Medicare FFS beneficiaries managed by a practice who are admitted to hospice for less than 3 days (NQF #0216)**
- **Percentage of all Medicare FFS beneficiaries managed by a practice who experience more than one emergency department visit in the last 30 days of life (NQF #0211)**
- Proportion of all Medicare FFS beneficiaries managed by a practice not admitted to hospice (NQF #0215)
- Proportion of all Medicare FFS beneficiaries managed by a practice receiving chemotherapy in the last 14 days of life (NQF #0210)
- Percentage of attributed OCM-FFS beneficiaries that receive a follow-up visit from the participating practice within 7 days after discharge from any inpatient hospitalization

Quality Measures: Communication and Care Coordination

- Percentage of face-to-face encounters between an attributed OCM-FFS beneficiary and a participating practice which include medication reconciliation*
- Number of hospital readmissions per attributed OCM-FFS beneficiary during the OCM-FFS episode and the following 6 months
- Number of ICU admissions per attributed OCM-FFS beneficiary during the OCM-FFS episode and the following 6 months
- Percentage of attributed OCM-FFS beneficiaries with at least one palliative care consultation per OCM-FFS episode*
- Mortality rates of attributed OCM-FFS beneficiaries, risk-adjusted
- Number of emergency department visits per attributed OCM-FFS beneficiary in the 6 months following the OCM-FFS episode
- Number of hospital admissions per attributed OCM-FFS beneficiary in the 6 months following the OCM-FFS episode (NQF #1789)

**Reported by practice*

Quality Measures:

Person- and Caregiver-Centered Experience and Outcome

- **Percentage of attributed OCM-FFS beneficiary face-to-face encounters with the participating practice in which there is a documented plan of care for pain AND pain intensity is quantified (NQF #2100)***
- **Score on patient experience survey (CAHPS as modified by the evaluation contractor)**
- **Percentage of attributed OCM-FFS beneficiary face-to-face encounters in which the patient is assessed by an approved patient-reported outcomes tool. This would include a minimum of the PROMIS tool short forms for anxiety, depression, fatigue, pain interference, and physical function ***
- **Percentage of attributed OCM-FFS beneficiaries that receive psychosocial screening and intervention at least once per OCM-FFS episode***

**Reported by practice*

Quality Measures: Population Health

- Percentage of attributed OCM-FFS beneficiaries that receive tobacco screening and cessation intervention at least once per OCM-FFS episode (#0028)*
- Percentage of attributed OCM-FFS beneficiaries that have an Influenza Immunization (#0041)
- Number of attributed OCM-FFS beneficiaries enrolled in clinical trials at any point during an OCM-FFS episode

**Reported by practice*

Quality Measures: Efficiency and Cost Reduction

- Prescription drug utilization by attributed OCM-FFS beneficiaries under Medicare Part B and Part D
- Radiation utilization by attributed OCM-FFS beneficiaries
- Imaging utilization by attributed OCM-FFS beneficiaries
- Post-acute provider utilization by attributed OCM-FFS beneficiaries
- Outpatient therapy service utilization by attributed OCM-FFS beneficiaries

Discussion Questions

- Are there additional quality measures that we should consider including in the model?
- When setting prices for the chemotherapy episodes, what factors should we incorporate for price setting (cancer type, comorbidities, age, etc.)?
- What are the opportunities and challenges for payers in aligning requirements for practice transformation and the structure of financial incentives with those of CMS?

For further information

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