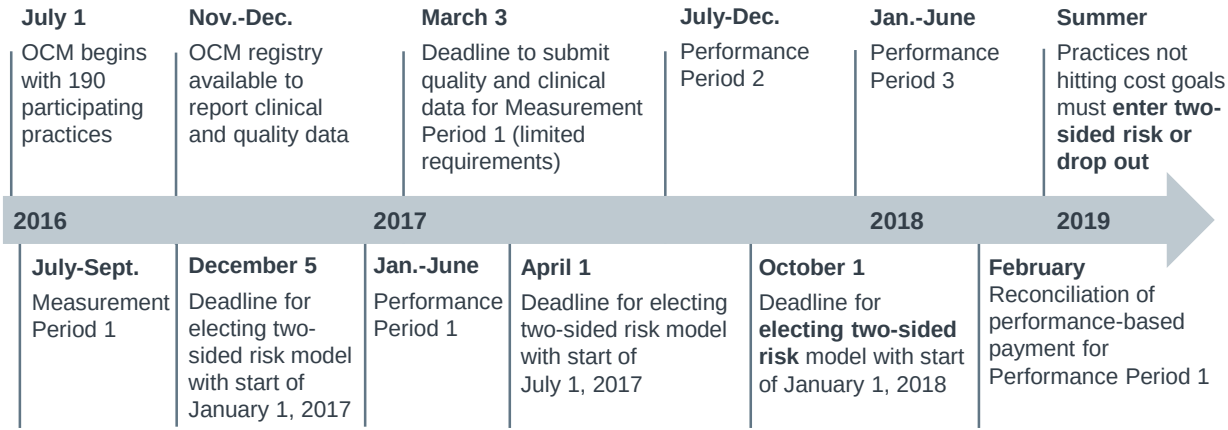
The Results Are In

Participants Approaching Critical Decision

Timeline of the Oncology Care Model (OCM)



25%

Of OCM participants received a performance bonus in Performance Period 1[1,2]

≈50%

Of OCM participants reduced costs below their historical benchmark in Performance Period 1 even if it was not enough to qualify for a bonus

1) To receive a bonus, participating practices must have spent less than their target price, which is equivalent to the episode of care benchmark with a 4% discount. This benchmark is adjusted for historical data, geographic variation, and performance period trends.
2) Close to 30% of participants received a performance bonus in Performance Period 2.

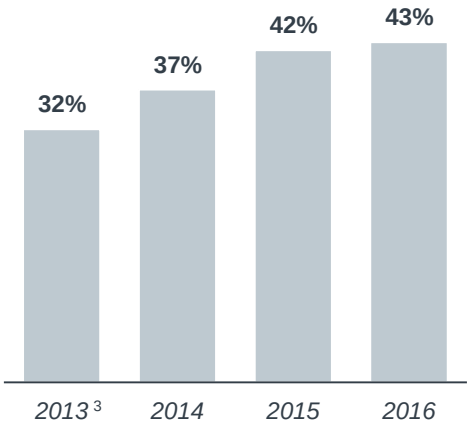
Source: "CMS announces additional opportunities for clinicians to join innovative care approaches under the Quality Payment Program," Centers for Medicare & Medicaid Services, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-10-25.html; "Oncology Care Model Overview," Association of Community Cancer Centers, http://oi.accc-cancer.org/advocacy/OCM-Overview.asp; Strawbridge L, ACCC Oncology Care Model Collaborative Workshop at the ACCC 44th Annual Meeting and Cancer Business Summit, Washington, DC, March 16, 2018; Joszt L, "Implications of OCM Reports and the Future of the Program", *AJMC*, October 29, 2018; Oncology Roundtable interviews and analysis.

Taking a Lesson from the MSSP

MSSP[1] Bonus Trends Promising for OCM Participants

Percentage of Initial MSSP Participants That Earned Shared Savings

n=105 ACOs that joined MSSP in 2012[2]



Strategies MSSP ACOs Implemented to Reduce Costs

- Redesigned clinical care model by investing $1.6M annually in initiatives related to:
  - Care coordination
  - Care improvement
  - Health information technology
  - Population health management
- Reduced network leakage
  - Educated providers and staff
  - Leveraged Medicare claims data
  - Reached out to PCPs and specialists with highest of percentage non-ACO referrals

1) Medicare Shared Savings Program.
2) ACOs that joined MSSP in 2012 with data available.
3) 24% of ACOs that joined the MSSP across 2012-2013 earned shared savings in 2013.

Source: Cinque M, "The strategy many ACOs call the secret to MSSP success," *Advisory Board's Daily Briefing*, November 21, 2013; Lazerow R, "Four takeaways on the recent ACO results," *Advisory Board's Daily Briefing*, October 2, 2014; Rappleye E, "CMS release 2014 Medicare ACO quality, financial results: 10 things to know," *Becker's Hospital Review*, August 25, 2015; "Medicare Accountable Care Organizations 2015 Performance Year Quality and Financial Results," *CMS Fact Sheet*, August 25, 2016; Sinclair H, "Last year's MSSP results are out. Here are our 5 key takeaways," *Advisory Board's Daily Briefing*, October 31, 2017; Oncology Roundtable interviews and analysis.

CMMI Also Has Skin in the Game

Both Parties Must Show Cost and Quality Improvements to Continue

Changes to MSSP from 2012 to 2014

Enhanced Flexibility

Allowed Track 1 ACOs to remain in Track 1 for an additional three-year period if no significant losses were incurred in the first two years

Tailored Risk

Modified level of risk faced by ACOs to vary by number of beneficiaries rather than setting a fixed level

Expanded Options

Added a new two-sided shared savings and loss model (Track 3) that gave Track 2 participants the ability to earn more revenue in exchange for accepting more risk

Source: McClellan M, et al., "Early Evidence on Medicare ACOs and Next Steps for the Medicare ACO Program (Updated)," *Health Affairs Blog,* January 22, 2015, https://www.healthaffairs.org/do/10.1377/hblog20150122.043904/full/; Oncology Roundtable interviews and analysis.

Still Work to Be Done

Methodological Concerns Raised by Providers

1 Correctly **attributing** OCM patients

Retrospective attribution model requires practices to try to predict which patients will be attributed to them.

2 Identifying **novel therapies**

Some novel therapies were not being correctly identified as novel therapies by CMMI. Not getting credit for all of the novel therapies provided alters the risk adjustment CMMI performs for the practice, decreasing the practice's chance of receiving a bonus.

Managing Total Cost of Care

OCM participants struggle to manage costs for patients who also receive care from non-OCM providers outside of their practice, which may negatively impact their ability to achieve a bonus.

To address care coordination issues, OCM practices should:

- Identify providers with whom they share patients
- Engage these providers in reducing patient costs
- Increase patient loyalty to prevent patients from going to providers outside of the system, who can be the hardest with whom to coordinate

Source: Oncology Roundtable interviews and analysis.

Dive into the Data

West Cancer Center Uses OCM Data to Find Cost Savings Opportunities

West Cancer Center's Development of Patient Risk Stratification System

Baseline OCM Data

Identified that they had higher ED and inpatient utilization rates than other practices from baseline OCM data

Examined Trends

Found that higher ED and inpatient utilization was associated with:

- High-acuity cancers (e.g., pancreatic, lung)
- Increased number of comorbidities
- Recent prior hospitalization

Developed Algorithm

Created a predictive algorithm that assigns OCM patients a high-risk score (i.e., risk of ED or inpatient utilization) based on:

- Cancer information
- Comorbidities
- Social factors
- Past utilization

Source: West Cancer Center, Germantown, TN; Oncology Roundtable interviews and analysis.

Dive into the Data (cont.)

Case in Brief: West Cancer Center

- 2,100-analytic case academic medical center based in Germantown, Tennessee; includes 17 cancer center sites
- All physicians are employed; uses Mosaiq as EHR[1] vendor
- Identified that they had higher inpatient admissions and ED utilization rates than other practices from baseline OCM data
- Examined trends in ED and inpatient utilization; found that risk of ED and inpatient utilization was associated with cancer acuity, number of comorbidities, and prior hospitalizations
- Used OCM data, along with data from their EHR and partner health system, to create a predictive algorithm that assigns each OCM patient a high-risk score (i.e., risk of ED or inpatient utilization)
- Created dashboard ranking OCM patients by high-risk score to help OCM care managers prioritize outreach efforts to highest risk patients
- Plan to measure dashboard impact on ED and inpatient utilization, episode costs, supportive care utilization, and care manager contact

1) Electronic health record.

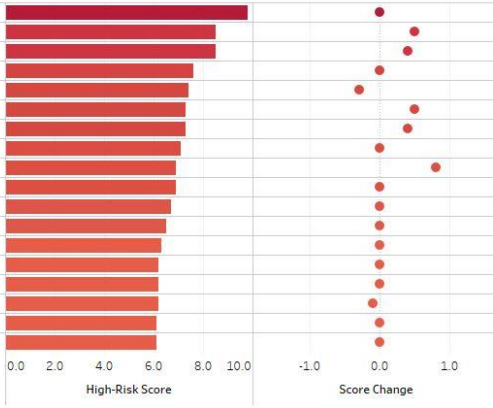
Source: West Cancer Center, Germantown, TN; Oncology Roundtable interviews and analysis.

Putting Data into Action

Created Dashboard to Help OCM Care Manager Prioritize Outreach

West Cancer Center's Patient Identification Dashboard

Episode Start	Episode End	Ep. #	OCM Cancer Group	Status	Care Manager
2/28/2018	8/27/2018	4	Multiple Myeloma	Started (Oral)	Ashley
3/19/2018	9/18/2018	4	Lung Cancer	Started	Debbie
1/24/2018	7/23/2018	1	Endocrine Tumor	Started	Ashley
11/6/2017	5/5/2018	1	Lymphoma	Started	Debbie
12/27/2017	6/26/2018	2	Pancreatic Cancer	Started	Tiffany
11/27/2017	5/26/2018	3	Lymphoma	Started	Ashley
1/2/2018	7/1/2018	2	Lung Cancer	Started	Debbie
1/22/2018	7/21/2018	4	Breast Cancer	Started	Ashley
1/26/2018	7/25/2018	1	Kidney Cancer	Started	Debbie
1/30/2018	7/29/2018	2	Breast Cancer	Started	Ashley
					Ashley
					Tiffany
					Tiffany
					Tiffany
					Ashley
					Tiffany
					Ashley
				(Oral)	Ashley



Dashboard Details

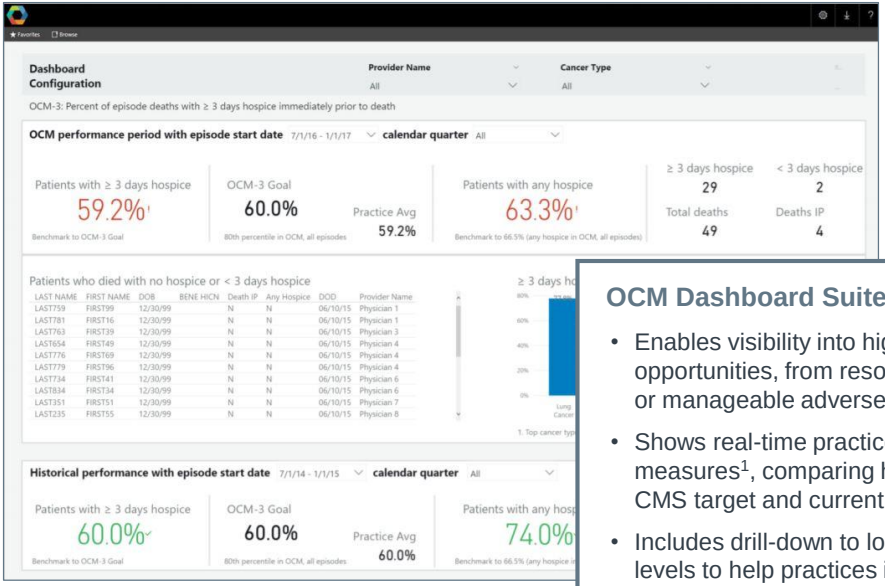
- Lists all OCM patients in order of high-risk score; patients at top of list have highest score and likely need attention from care managers
- Includes other trackers: inpatient visits, chemotherapy start, RN phone triage log, and OCM episode start and end date
- Updates automatically each night to incorporate new information entered into the EHR
- Hosted in web app so care managers and other clinical staff (e.g., chemotherapy RNs) can all easily access it

Source: West Cancer Center, Germantown, TN; Oncology Roundtable interviews and analysis.

Leveraging External IT Solutions

Integra Connect Helps Practices Proactively Assess OCM Performance

Integra Connect Intelligence's OCM-3 Dashboard



OCM Dashboard Suite Features

- Enables visibility into high-impact cost improvement opportunities, from resource utilization to avoidable or manageable adverse events
- Shows real-time practice performance on all OCM measures[1], comparing historical baselines and/or CMS target and current OCM performance periods
- Includes drill-down to location, provider, and patient levels to help practices identify outliers
- Facilitates identification of OCM participants, including those prescribed oral chemotherapies

1) OCM measures 1, 2, 3, 4a, 4b, 5, 8, 9, 10, 11, 12, 24, 30.

Source: Integra Connect, West Palm Beach, FL; Oncology Roundtable interviews and analysis.

Leveraging External IT Solutions (cont.)

Technology in Brief: Integra Connect Intelligence

- Advanced analytics suite for oncology practices created by Integra Connect, a cloud-based health care information technology company based in West Palm Beach, Florida
- Includes clinical, financial, and value-based care program modules; value-based care program module can be tailored to specific programs such as the OCM
- Unifies patient data from a wide variety of sources (e.g., EHRs, practice management systems, claims data)
- Applies proprietary algorithms to stratify and segment patients on population and individual levels
- Runs predictive models to anticipate cost and quality outliers requiring personalized treatment plans
- Enables OCM practices to assess how they are performing and develop strategies to meet performance targets; includes dashboards for all OCM measures[1]

1) OCM measures 1, 2, 3, 4a, 4b, 5, 8, 9, 10, 11, 12, 24, 30.

Source: Integra Connect, West Palm Beach, FL; Oncology Roundtable interviews and analysis.

Lessons Learned: Model 5

There are still methodology issues that need to be worked out with the OCM

- ❑ The methodology for attributing patients and identifying novel therapies are major points of contention for OCM participants

Being accountable for total cost of care is a challenge for OCM practices

- ❑ Improving care coordination and increasing patient loyalty will be critical in overcoming this challenge

The MSSP can provide insight into potential OCM program trajectory and success factors

- ❑ Redesigning clinical care models and reducing network leakage can drive cost reduction
- ❑ Success takes time; more practices may earn bonuses as the pilot progresses
- ❑ CMS is willing to iterate on elements of the payment pilot to help participants succeed

OCM data can be leveraged to proactively identify and support patients at high risk for avoidable costs

Model in Brief: CMMI Oncology Care Model

- Started in July 2016; requires participants to meet certain practice requirements in exchange for MEOS payments[1] and eligibility for performance-based bonuses in addition to FFS payments
- Practices received Performance Period 1 results in February 2018; 25% of the 187 practices received a performance bonus, and 50% of practices beat their historical benchmark
- Performance Period 3 started in January 2018; practices that do not achieve a performance bonus by the end of Performance Period 4 must exit the OCM or opt for two-sided risk until they achieve a bonus

1) Practices a receive monthly enhanced oncology services (MEOS) payment of $160 per enrolled beneficiary for six months upon initiation of chemotherapy.

Source: Cafardi S, et al., "First Annual Report from the Evaluation of the Oncology Care Model: Baseline Period," *Centers for Medicare & Medicaid Innovation*, February 1, 2018; Oncology Roundtable interviews and analysis.