BETTER CANCER CARE AT LOWER COST
Oncology Payment Reforms That Support Higher Quality, Lower Spending, and Financially Viable Oncology Practices

Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform
www.CHQPR.org
DISCLOSURE:

I Have No Financial Relationships With Any Commercial Interests
Healthcare Spending Is the Biggest Driver of Federal Deficits

Source: CBO Budget Projections April 2014

Biggest Share of Spending Growth is Healthcare
Cancer Care is a Logical Target Because of High Cost Growth
Oncology is #2 Cost Driver for Medicare & #3 for Private Payers

Percent of Total Spending on Health Conditions
By Payer, 2010

- Normal birth/live born
- Lupus/connective tissue disorders
- Gallbladder, pancreatic, and liver disease
- Back problems
- Urinary endocrine, nutritional & immune disorder
- Kidney Disease
- Cerebrovascular disease
- Hypertension
- Mental disorders
- Diabetes mellitus
- Osteoarthritis/joint disorders
- Trauma-related disorders
- COPD, asthma
- Cancer
- Heart conditions
Federal Cost Containment Policy Choices

MEDICARE SPENDING = SERVICES TO SENIORS \times PAYMENTS TO PROVIDERS

- Cut Services to Seniors?
- Cut Pay for Providers?
If The Choice is Rationing or Payment Cuts, Which is Likely?

MEDICARE SPENDING = SERVICES TO SENIORS × PAYMENTS TO PROVIDERS

Guess which one they’ll try to reduce?
Cuts in Payments to Providers Reduces Services Indirectly

MEDICARE SPENDING = SERVICES TO SENIORS \times PAYMENTS TO PROVIDERS

Cut Services to Seniors?  
Cut Pay for Providers?
Pressure on State Budgets From Medicaid Creates Similar Pressure

\[
\text{MEDICAID SPENDING} = \text{SERVICES TO PATIENTS} \times \text{PAYMENTS TO PROVIDERS}
\]
Public Funding Cuts Lead to Cost-Shifting to Private Payers

Hospital Payment-to-Cost Ratios for Private Payers, Medicare, and Medicaid, 1988 – 2008

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2008, for community hospitals.
Private Insurance Costs Are Increasing Unaffordably

Employer-Sponsored Family Insurance Premiums, 2002-2013

- U.S. Insurance Premiums
- Inflation

© Center for Healthcare Quality and Payment Reform CHQPR.org
Florida Family Premiums Are Higher Than Majority of States
Commercial Payers Pursue Even More Problematic Options

Higher Cost-Sharing for Patients?
Cut Services to Patients?
Cut Pay for Providers?

HEALTHCARE SPENDING = SERVICES TO PATIENTS \times PAYMENTS TO PROVIDERS
What Providers *Can* Do That Congress & Payers *Can’t*

- Higher Cost-Sharing for Patients?
- Cut Services to Patients?
- Cut Pay for Providers?

HEALTHCARE SPENDING = SERVICES TO PATIENTS × PAYMENTS TO PROVIDERS

Redesign CARE to Reduce Spending Without Harming Quality

Higher Cost-Sharing for Patients?
Providers Also Must Define How to Change the Payment System

HEALTHCARE SPENDING = SERVICES TO PATIENTS \times PAYMENTS TO PROVIDERS

- Higher Cost-Sharing for Patients?
- Cut Services to Patients?
- Cut Pay for Providers?

- Redesign CARE to Reduce Spending Without Harming Quality
- Redesign PAYMENT to Make Good Care Financially Viable for Providers
Physicians Are Understandably Skeptical About “Payment Reform”

WIN-LOSE APPROACHES
(THE DOMINANT MODE TODAY)

Medicare and Health Plans Define Payment to Benefit Payers

Physicians Forced To Change Care to Align With Payment Systems

Patients and Physicians Can Both Lose
Typical “Value-Based Payment” Is a Tweak to Fee for Service

QUALITY MEASURES
- Mammograms
- Colon Cancer Screening
- HbA1c Control
- LDL

P4P Bonus

FFS
More Measure Burden Each Year, With the Same Small Bonuses

QUALITY MEASURES
- Mammograms
- Colon Cancer Screening
- Flu Vaccine
- Tobacco Counseling
- Hypertension Control
- HbA1c Control
- LDL
- Eye Exams
- Aspirin Use

P4P Bonus
FFS

© Center for Healthcare Quality and Payment Reform  CHQPR.org
Bonuses Turn to Penalties With No Way to Support Better Care

QUALITY MEASURES
- Mammograms
- Colon Cancer Screening
- Flu Vaccine
- Tobacco Counseling
- Hypertension Control
- HbA1c Control
- LDL
- Eye Exams
- Aspirin Use

P4P Bonus
FFS

P4P Bonus
FFS

QUALITY MEASURES
- Mammograms
- Colon Cancer Screening
- Flu Vaccine
- BMI Screens
- Tobacco Counseling
- Fall Risk Assessment
- Hypertension Control
- HbA1c Control
- LDL
- Eye Exams
- Aspirin Use

P4P Penalty
FFS
We Need Win-Win-Win Approaches to Payment Reform

WIN-LOSE APPROACHES
(THE DOMINANT MODE TODAY)

Medicare and Health Plans Define Payment to Benefit Payers

Physicians Forced To Change Care to Align With Payment Systems

Patients and Physicians Can Both Lose

WIN-WIN-WIN APPROACHES

Physicians Design Better Ways to Deliver Care at Lower Cost

Payers Change Payment to Remove Barriers to Better Care

Better Care, Lower Spending, Financially Viable Physicians
## Many Specialties Working to Develop Good Payment Reforms

<table>
<thead>
<tr>
<th>Opportunities to Improve Care and Reduce Cost</th>
<th>Barriers in Current Payment System</th>
<th>Solutions via Accountable Payment Models</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiology</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Use less invasive and less expensive tests &amp; procedures when appropriate</td>
<td>• Payment is based on which test or procedure is used, not the outcome for the patient</td>
<td>• Condition-based payment covering CABG, PCI, or medication mgt</td>
</tr>
<tr>
<td>• Help patients with heart failure, atrial fibrillation, and other chronic conditions avoid hospitalization</td>
<td>• No payment for care management services or in-home supports</td>
<td>• Condition-based payment for management of chronic disease</td>
</tr>
<tr>
<td><strong>Orthopedics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reduce rate of readmissions &amp; cost of post-acute care</td>
<td>• No flexibility to offer coordinated services after surgery</td>
<td>• Episode payment for surgery with warranty</td>
</tr>
<tr>
<td>• Use non-surgical care to address pain and mobility</td>
<td>• Inadequate payment for non-surgical care alternatives</td>
<td>• Condition-based payment for management of osteoarthritis</td>
</tr>
<tr>
<td><strong>OB/GYN</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reduce use of elective C-sections</td>
<td>• Similar/lower payment for vaginal deliveries</td>
<td>• Condition-based payment for total cost of delivery in low-risk pregnancy</td>
</tr>
<tr>
<td>• Reduce early deliveries and use of NICU</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

© Center for Healthcare Quality and Payment Reform  CHQPR.org
ASCO’s Approach to Oncology Payment Reform

Oncologists Identify What’s Needed for High-Value Cancer Care

Design Changes In Payment to Support Patient-Centered Care

Better Care, Lower Spending, Practices Stay Financially Viable

www.asco.org/paymentreform
How Well Does the Current Payment System Support High-Value Cancer Care?

What Needs to Be Changed?
WHAT ONCOLOGY PRACTICES DO

Diagnosis and Treatment Planning

• Review tests & pathology reports
• Determine type and stage of cancer
• Identify and evaluate treatment options
• Identify clinical trial options
• Discuss treatment options with patient
• Develop plan of care
• Educate patient about treatment
• Provide genetic counseling
• Provide psychological counseling
• Provide nutrition counseling
• Provide financial counseling
• Determine insurance coverage and obtain pre-authorization
• Document information in records
• Etc.
Before Treatment Begins…
…Practices Are Underpaid

**WHAT ONCOLOGY PRACTICES DO**

**Diagnosis and Treatment Planning**
- Review tests & pathology reports
- Determine type and stage of cancer
- Identify and evaluate treatment options
- Identify clinical trial options
- Discuss treatment options with patient
- Develop plan of care
- Educate patient about treatment
- Provide genetic counseling
- Provide psychological counseling
- Provide nutrition counseling
- Provide financial counseling
- Determine insurance coverage and obtain pre-authorization
- Document information in records
- Etc.

**HOW PRACTICES ARE PAID**

- E&M payments for face-to-face visits with physicians

_No payments for services delivered by nurses, social workers, financial counselors, etc._
_No payments for time spent by physicians on phone calls with patients and other physicians, researching treatment options, etc._
When Oral Therapy is Used…
…Practices Are Underpaid

WHAT ONCOLOGY PRACTICES DO

Oral Therapy
• Prescribe drugs
• Order tests
• Evaluate patient progress
• Meet with patient to discuss progress
• Answer calls from patients
• Respond to complications
• Manage patients’ pain
• Document information in records
• Keep detailed records for clinical trials
• Discuss end-of-life planning with patient
• Etc.

HOW PRACTICES ARE PAID

• E&M payments for face-to-face visits with physicians

(No payments for services delivered by nurses, social workers, financial counselors, etc.)
(No payments for time spent by physicians on phone calls with patients and other physicians, etc.)
If Parenteral Therapy is Given…
More Payment, But Linked to Drugs

<table>
<thead>
<tr>
<th><strong>WHAT ONCOLOGY PRACTICES DO</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parenteral Therapy</strong></td>
</tr>
<tr>
<td>• Administer IV therapy</td>
</tr>
<tr>
<td>• Order tests</td>
</tr>
<tr>
<td>• Evaluate patient progress</td>
</tr>
<tr>
<td>• Meet with patient to discuss progress</td>
</tr>
<tr>
<td>• Answer calls from patients</td>
</tr>
<tr>
<td>• Respond to complications</td>
</tr>
<tr>
<td>• Manage patients’ pain</td>
</tr>
<tr>
<td>• Document information in records</td>
</tr>
<tr>
<td>• Keep detailed records for clinical trials</td>
</tr>
<tr>
<td>• Bill insurance companies</td>
</tr>
<tr>
<td>• Discuss end-of-life planning with patient</td>
</tr>
<tr>
<td>• Etc.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>HOW PRACTICES ARE PAID</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• E&amp;M payments for face-to-face visits with physicians</td>
</tr>
<tr>
<td>• Payment for in-office infusions</td>
</tr>
<tr>
<td>• ASP+x% - acquisition cost of drugs</td>
</tr>
</tbody>
</table>

(No payments for services delivered by nurses, social workers, financial counselors, etc.)
(No payments for time spent by physicians on phone calls with patients and other physicians, etc.)
No Payment to Support Oncology Medical Home Services

<table>
<thead>
<tr>
<th>WHAT ONCOLOGY PRACTICES DO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parenteral Therapy</strong></td>
</tr>
<tr>
<td>• Administer IV therapy</td>
</tr>
<tr>
<td>• Order tests</td>
</tr>
<tr>
<td>• Evaluate patient progress</td>
</tr>
<tr>
<td>• Meet with patient to discuss progress</td>
</tr>
<tr>
<td>• Answer calls from patients</td>
</tr>
<tr>
<td>• Respond to complications</td>
</tr>
<tr>
<td>• Manage patients’ pain</td>
</tr>
<tr>
<td>• Document information in records</td>
</tr>
<tr>
<td>• Keep detailed records for clinical trials</td>
</tr>
<tr>
<td>• Bill insurance companies</td>
</tr>
<tr>
<td>• Discuss end-of-life planning with patient</td>
</tr>
<tr>
<td>• Care management services</td>
</tr>
<tr>
<td>• 24/7 triage and response</td>
</tr>
<tr>
<td>• Etc.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOW PRACTICES ARE PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>• E&amp;M payments for face-to-face visits with physicians</td>
</tr>
<tr>
<td>• Payment for in-office infusions</td>
</tr>
<tr>
<td>• ASP+x% - acquisition cost of drugs</td>
</tr>
</tbody>
</table>

(No payments for services delivered by nurses, social workers, financial counselors, etc.)
(No payments for time spent by physicians on phone calls with patients and other physicians, etc.)
After Therapy Ends…
…Practices Are Underpaid

**WHAT ONCOLOGY PRACTICES DO**

**Post-Treatment**
- Develop a survivorship or end-of-life plan
- Order and review tests
- See patient to address needs
- Answer calls from patients
- Respond to post-treatment complications
- Manage patients’ pain
- Document information in records
- Keep detailed records for clinical trials
- Etc.

**HOW PRACTICES ARE PAID**

- E&M payments for face-to-face visits with physicians

(No payments for services delivered by nurses, social workers, financial counselors, etc.)
(No payments for time spent by physicians on phone calls with patients and other physicians, etc.)
When You Look at the Overall Picture of Practice Expenses…

SOURCE:
Current Service Payments Fall Far Short of Covering Expenses


Revenue from payments other than drugs only cover 2/3 of oncology practice costs
Without Drug Margins, Oncology Practices Couldn’t Stay Afloat

Revenue from payments other than drugs only cover 2/3 of oncology practice costs

SOURCE:
Payments Are Also Poorly Aligned to Phases of Cancer Care
Today: Many Hours in Diagnosis, Treatment Planning & Counseling

New Patient: Diagnosis, Choosing Therapy, Counseling

Costs:
- Diagnosis: $1000
- Therapy: $1500
- Counseling: $2000

0 Dx
Today: Costs to Deliver Treatment & Help Avoid Complications

- New Patient: Diagnosis, Choosing Therapy, Counseling
- Treatment: Therapy & Preventing Complications

<table>
<thead>
<tr>
<th>0 (Dx)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2000</td>
<td>$1500</td>
<td>$1000</td>
<td>$500</td>
<td>$0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TREATMENT MONTHS
Today: Many Months of Follow-Up Monitoring & Survivorship Care

New Patient: Diagnosis, Choosing Therapy, Counseling
Treatment: Therapy & Preventing Complications
Post-Treatment: Monitoring & Support
FFS: Large Payments for Infusions, Inadequate Payment Before & After

Physician/Staff Time for Cancer Care

How Oncology Practice is Paid

Drug Margin

Infusion

EM

E&M

TREATMENT MONTHS

POST-TREATMENT CARE

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

Dx

TREATMENT MONTHS

POST-TREATMENT CARE

© Center for Healthcare Quality and Payment Reform  CHQPR.org
Goal of ASCO’s PCOP Proposal is to Better Match Payment to Services

PHYSICIantan/STAFF TIME FOR CANCER CARE

PATIENT-CENTERED ONCOLOGY PAYMENT (PCOP)

© Center for Healthcare Quality and Payment Reform CHQPR.org
Start With Existing FFS Payments

PATIENT-CENTERED ONCOLOGY PAYMENT (PCOP)
+1. Significant New Payment During Crucial Planning Stage

Additional $750 One-Time Payment for Each New Patient

PATIENT-CENTERED ONCOLOGY PAYMENT (PCOP)

© Center for Healthcare Quality and Payment Reform CHQPR.org
## +2. Flexible Care Management Payments During Treatment

**Additional $750 One-Time Payment for Each New Patient**

<table>
<thead>
<tr>
<th>TREATMENT MONTHS</th>
<th>Care Mgt</th>
<th>Care Mgt</th>
<th>Care Mgt</th>
<th>Care Mgt</th>
<th>Care Mgt</th>
<th>Care Mgt</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>E&amp;M</td>
<td>E&amp;M</td>
<td>E&amp;M</td>
<td>E&amp;M</td>
<td>E&amp;M</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>1</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
</tr>
<tr>
<td>2</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
</tr>
<tr>
<td>3</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
</tr>
<tr>
<td>4</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
</tr>
<tr>
<td>5</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
</tr>
<tr>
<td>6</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
<td>Infusion</td>
</tr>
</tbody>
</table>

**$200 Monthly Care Management Payments During Treatment Months**

- **TREATMENT MONTHS:** 0, 1, 2, 3, 4, 5, 6
- **ACTIVE MONITORING:** 7, 8, 9, 10, 11, 12, 13, 14, 15

**PATIENT-CENTERED ONCOLOGY PAYMENT (PCOP)**

- **One-Time Payment for Each New Patient:** $750
- **Monthly Care Management Payments During Treatment Months:** $200

© Center for Healthcare Quality and Payment Reform  CHQPR.org
+3. Continued Smaller Care Mgt Payments After Treatment Ends

**Additional $750 One-Time Payment for Each New Patient**

**$200 Monthly Care Management Payments During Treatment Months**

**$50 Care Management Payments During Active Monitoring Months Up to 6 Months After End of Treatment**

**PATIENT-CENTERED ONCOLOGY PAYMENT (PCOP)**
$100 Monthly Payments For Patients in (Unfunded) Clinical Trials
~$2,100/patient more from PCOP; 50% Increase from FFS Today

Additional $750 One-Time Payment for Each New Patient

$200 Monthly Care Management Payments During Treatment Months

$50 Care Management Payments During Active Monitoring Months Up to 6 Months After End of Treatment

PATIENT-CENTERED ONCOLOGY PAYMENT (PCOP)
Can We Afford to Pay 50% More With Cancer Costs Skyrocketing?

![Bar chart](chart.png)
Where Does Spending on Cancer Patients Go Today?
Most of the Money Does NOT Go to the Oncology Practice

E&M and infusion payments represent only 5% of total spending for Medicare patients during the 6 months after chemo begins.
Most Money Goes to Drugs, Hospitals, and Other Services

Distribution of Medicare Oncology Spending in 6 Months Following Initiation of Chemotherapy

- Practice
- Infusion
- E&M
- Other Prof. Svcs.
- Radiation & Other
- Hospital Inpatient & Outpatient
- Drugs
- Other: 95%
- 6% Drugs
So, Even A *Big* Increase in Payments to *Oncology Practices*…
...Represents a *Small* Increase in *Total* Spending

- 50% increase in payments to oncology practices
- More $\geq 2.5\%$ increase in total spending
A Mere 3% Reduction in Other Spending Would Pay for This

3% reduction in other spending offsets costs of better payments to practices

50% increase in payments to oncology practices
A 7% Reduction in Other Spending = 4% Net Savings

Distribution of Medicare Oncology Spending in 6 Months Following Initiation of Chemotherapy

- 7% reduction in other spending achieves net savings of 4%
- 50% increase in payments to oncology practices
How Do You Reduce Other Spending w/o Harming Patients?

Distribution of Medicare Oncology Spending in 6 Months Following Initiation of Chemotherapy

Other

Practice

Practice

Other

Practice

© Center for Healthcare Quality and Payment Reform CHQPR.org
Focus on Reducing the *Avoidable* Spending on Cancer Services

- ER visits & hospital admissions for complications of treatment
- Unnecessary use of supportive drugs
- Use of expensive chemotherapy where equivalent lower-priced drugs are available
- Unnecessary use of testing and imaging
- Treatment and hospital admission at end of life
Large Reductions in Avoidable Hospitalizations Are Possible

Source: Sprandio JD. “Oncology patient-centered medical home and accountable cancer care.” Community Oncology, December 2010

**FIGURE 3** Average emergency room (ER) evaluations at Delaware County Memorial Hospital of the Drexel Hill office population per chemotherapy patient per year, 2004–2010 (YTD).
ASCO Choosing Wisely List
Targets Areas of High Spending
20-50% Non-Adherence to Choosing Wisely Criteria

Rate of Non-Adherence to Choosing Wisely Guidelines

- Do not use routine biomarker tests and advanced imaging to screen for recurrence in asymptomatic breast cancer patients...
- Avoid anticancer therapy in patients with advanced solid tumors who are unlikely to benefit
- Do not use white-cell stimulating factors for patients undergoing chemotherapy with less than 20% risk of febrile neutropenia
- Do not use PET, CT and radionuclide bone scans in staging early prostate cancer at low risk of spreading
- Do not use PET, CT and radionuclide bone scans in staging early breast cancer at low risk of spreading

© Center for Healthcare Quality and Payment Reform  CHQPR.org
Most Cancer Drug Spending is Driven by a Few Drugs

2/3 of Total Spending on Cancer Drugs Goes to 6 Drugs
Multiple Studies Show Overuse of Neulasta

Improving Appropriate Use of Drugs

• A study of the use of Neulasta (pegfilgrastim) at an outpatient oncology clinic found that approximately half of all cases using pegfilgrastim for primary prophylaxis were not consistent with published guidelines, representing an avoidable cost of $8,093 per patient.


• A study of the use of myeloid colony-stimulating factors (CSF) such as pegfilgrastim in lung and cancer patients found that 96% of CSFs were administered in scenarios where CSF therapy is not recommended by evidence-based guidelines.


• Chemotherapy spending for Medicare patients ranged from $11,059 per patient for oncology practices in the lowest spending quartile to $18,044 per patient for practices in the highest-spending quartile, a range of $6,985. Over 1/3 of the variation ($3,600) stemmed from variation in the use of just two drugs – Neulasta (pegfilgrastim) and Avastin (bevacizumab).

(Clough JD et al. Wide Variation in Payments for Medicare Beneficiary Oncology Services Suggests Room for Practice-Level Improvement. Health Affairs 34(4): 601. April 2015.)
### Huge Variation in Cost of Regimens With Similar Efficacy

<table>
<thead>
<tr>
<th>Regimen</th>
<th>Survival (months)</th>
<th>Deaths During Treatment</th>
<th>Any Serious Adverse Event (Hospitalization)</th>
<th>Cost (4 Cycles)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carboplatin + Paclitaxel</td>
<td>13.0 (NR)</td>
<td>&lt;1%</td>
<td>53%</td>
<td>$ 452</td>
</tr>
<tr>
<td>Gemcitabine + Cisplatin</td>
<td>10.4 (9.6 – 11.2)</td>
<td>7%</td>
<td>35%</td>
<td>$ 886</td>
</tr>
<tr>
<td>Cisplatin + Pemetrexed</td>
<td>11.8 (10.4 – 13.2)</td>
<td>7%</td>
<td>37%</td>
<td>$ 25,619</td>
</tr>
<tr>
<td>Carboplatin + nab-Paclitaxel</td>
<td>13.1 (NR)</td>
<td>&lt;1%</td>
<td>NR</td>
<td>$ 24,740</td>
</tr>
<tr>
<td>Carboplatin + Paclitaxel + Bevacizumab</td>
<td>13.4 (11.9 – 14.9)</td>
<td>5%</td>
<td>75%</td>
<td>$ 39,770</td>
</tr>
<tr>
<td>Carboplatin + Pemetrexed + Bevacizumab</td>
<td>12.6 (11.3 – 14.0)</td>
<td>**</td>
<td>NR</td>
<td>$ 64,988</td>
</tr>
</tbody>
</table>


First line regimens for metastatic non-small cell lung cancer, non-squamous histology, no EGFR or ALK mutation present
Reductions in Overused Drugs Could Result in Large Savings

Cancer-Related Drug Spending

-8%

-25%

-25%

-25%
Spending on Drugs, Imaging, and Hospitals Varies by More Than 60%

Source: Clough, Patel, Riley, Rajkumar, Conway, Bach. “Wide Variation in Payments for Medicare Beneficiary Oncology Services Suggests Room for Practice-Level Improvement.” Health Affairs, April 2015
Reducing *Avoidable* Services Achieves Savings w/o Rationing

Distribution of Medicare Oncology Spending in 6 Months Following Initiation of Chemotherapy

- **Other**
- **Desirable Cancer Services**
- **Avoidable Services**

Savings

© Center for Healthcare Quality and Payment Reform  CHQPR.org
# Savings From Better Care

## Costs and Savings from Improved Payment for Oncology Care

Based on 2012 Average Part A & B Spending During Chemotherapy Treatment for Medicare Beneficiaries with Breast, Colon, or Lung Cancer

<table>
<thead>
<tr>
<th></th>
<th>Current Average Spending Per Beneficiary</th>
<th>With Proposed New Payments and Estimated Savings</th>
<th>% Change</th>
<th>$ Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>During and 2 Months After Treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy/Drugs</td>
<td>$25,131</td>
<td>$23,372</td>
<td>-7%</td>
<td></td>
</tr>
<tr>
<td>Lab Tests</td>
<td>$583</td>
<td>$553</td>
<td>-5%</td>
<td></td>
</tr>
<tr>
<td>Imaging</td>
<td>$1,503</td>
<td>$1,428</td>
<td>-5%</td>
<td></td>
</tr>
<tr>
<td>ED/Ambulance</td>
<td>$421</td>
<td>$295</td>
<td>-30%</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>$7,100</td>
<td>$4,970</td>
<td>-30%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>$10,920</td>
<td>$10,920</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>$45,657</td>
<td>$41,538</td>
<td>-9%</td>
<td>$(4,120)</td>
</tr>
</tbody>
</table>
Cost of Higher Payments to Oncology Practice

<table>
<thead>
<tr>
<th>Month Prior to Treatment</th>
<th>Current Average Spending Per Beneficiary</th>
<th>With Proposed New Payments and Estimated Savings</th>
<th>% Change</th>
<th>$ Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>E&amp;M Services</td>
<td>$296</td>
<td>$296</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Patient Treatment Planning</td>
<td></td>
<td>$750</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td>$296</td>
<td>$1,046</td>
<td>253%</td>
<td>$750</td>
</tr>
<tr>
<td>During and 2 Months After Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M Services</td>
<td>$2,071</td>
<td>$2,071</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infusion Services</td>
<td>$1,904</td>
<td>$1,904</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Management (5 Mos. Treatment)</td>
<td></td>
<td>$1,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Management (3 Mo. Monitoring)</td>
<td></td>
<td>$150</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Trial Patients</td>
<td></td>
<td>$40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td>$3,975</td>
<td>$5,165</td>
<td>30%</td>
<td>$1,190</td>
</tr>
<tr>
<td>Months 3-6 After Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M Services</td>
<td>$120</td>
<td>$120</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Management (4 Mo. Monitoring)</td>
<td></td>
<td>$200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Trial Patients</td>
<td></td>
<td>$20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td>$120</td>
<td>$340</td>
<td>183%</td>
<td>$220</td>
</tr>
</tbody>
</table>

Subtotal Increased Payments $2,160

© Center for Healthcare Quality and Payment Reform CHQPR.org
Significant Net Savings for Payers

<table>
<thead>
<tr>
<th>Costs and Savings from Improved Payment for Oncology Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on 2012 Average Part A &amp; B Spending During Chemotherapy Treatment for Medicare Beneficiaries with Breast, Colon, or Lung Cancer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Current Average Spending Per Beneficiary</th>
<th>With Proposed New Payments and Estimated Savings</th>
<th>% Change</th>
<th>$ Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Month Prior to Treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payments to Practice</td>
<td>$296</td>
<td>$1,046</td>
<td>253%</td>
<td>$750</td>
</tr>
<tr>
<td><strong>During and 2 Months After Treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payments to Practice</td>
<td>$3,975</td>
<td>$5,165</td>
<td>30%</td>
<td>$1,190</td>
</tr>
<tr>
<td>Chemotherapy/Drugs</td>
<td>$25,131</td>
<td>$23,372</td>
<td>-7%</td>
<td></td>
</tr>
<tr>
<td>Lab Tests</td>
<td>$583</td>
<td>$553</td>
<td>-5%</td>
<td></td>
</tr>
<tr>
<td>Imaging</td>
<td>$1,503</td>
<td>$1,428</td>
<td>-5%</td>
<td></td>
</tr>
<tr>
<td>ED/Ambulance</td>
<td>$421</td>
<td>$295</td>
<td>-30%</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>$7,100</td>
<td>$4,970</td>
<td>-30%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>$10,920</td>
<td>$10,920</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>$45,657</strong></td>
<td><strong>$41,538</strong></td>
<td>-9%</td>
<td><strong>$4,120</strong></td>
</tr>
<tr>
<td><strong>Months 3-6 After Treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payments to Practice</td>
<td>$120</td>
<td>$340</td>
<td>183%</td>
<td>$220</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>$50,048</strong></td>
<td><strong>$48,089</strong></td>
<td>-3.9%</td>
<td><strong>($1,960)</strong></td>
</tr>
</tbody>
</table>

© Center for Healthcare Quality and Payment Reform CHQPR.org 66
PCOP Part 1: More Payment to Practices Where It’s Needed

Current FFS Payment

Patient-Centered Oncology Payment

Better Payment for Practices

Drug Margin
E&M Infusions
Non-E&M Care Mgt

Drug Margin
PCOP Pmts
E&M Infusions

Oncology Practice Receives Higher Payments Than Today
PCOP Part 2: Implement ASCO Guidelines & Control Hospital Use

Current FFS Payment

- ER/Hospital Admissions
- Other Services
- Testing
- Drugs
- Avoidable $

Drug Margin

E&M Infusions

Non-E&M Care Mgt

Patient-Centered Oncology Payment

- ER/Admissions
- Other Services
- Testing
- Drugs
- Drug Margin

PCOP Pmts

E&M Infusions

Better Payment for Practices

Lower Spending without Rationing

Oncology Practice Helps Patients Avoid Use of ED/Hospital for Complications of Treatment

Oncology Practice Follows ASCO Guidelines for Use of Chemotherapy, Supportive Drugs, Testing/Imaging, and End-of-Life Care

Oncology Practice Receives Higher Payments Than Today
PCOP Result: Better Care, Better Payment, Payer Savings

Current FFS Payment

- ER/Hospital Admissions
- Other Services
- Testing
- Avoidable $ (Drug Margin: E&M Infusions, Non-E&M Care Mgt)

Patient-Centered Oncology Payment

SAVINGS

- ER/Admissions
- Other Services
- Testing

Payer Spends Less in Total

- Oncology Practice Helps Patients Avoid Use of ED/Hospital for Complications of Treatment
- Oncology Practice Follows ASCO Guidelines for Use of Chemotherapy, Supportive Drugs, Testing/Imaging, and End-of-Life Care

Better Payment for Practices

- Drug Margin (PCOP Pmts)

Lower Spending without Rationing

© Center for Healthcare Quality and Payment Reform CHQPR.org
# ASCO PCOP Payments Similar in Magnitude to Anthem Program

<table>
<thead>
<tr>
<th>ASCO Patient-Centered Oncology Payment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patient</td>
<td>$750</td>
</tr>
<tr>
<td>Treatment Care Mgt (Mo 1)</td>
<td>$200</td>
</tr>
<tr>
<td>Treatment Care Mgt (Mo 2)</td>
<td>$200</td>
</tr>
<tr>
<td>Treatment Care Mgt (Mo 3)</td>
<td>$200</td>
</tr>
<tr>
<td>Treatment Care Mgt (Mo 4)</td>
<td>$200</td>
</tr>
<tr>
<td>Treatment Care Mgt (Mo 5)</td>
<td>$200</td>
</tr>
<tr>
<td>Post-Tx Care Mgt (Mo 1)</td>
<td>$50</td>
</tr>
<tr>
<td>Post-Tx Care Mgt (Mo 2)</td>
<td>$50</td>
</tr>
<tr>
<td>Post-Tx Care Mgt (Mo 3)</td>
<td>$50</td>
</tr>
<tr>
<td>Post-Tx Care Mgt (Mo 4)</td>
<td>$50</td>
</tr>
<tr>
<td>Post-Tx Care Mgt (Mo 5)</td>
<td>$50</td>
</tr>
<tr>
<td>Post-Tx Care Mgt (Mo 6)</td>
<td>$50</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$2050</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anthem Cancer Care Quality Program</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Planning (S0353)</td>
<td>$350</td>
</tr>
<tr>
<td>Treatment Month 1 (S0354)</td>
<td>$350</td>
</tr>
<tr>
<td>Treatment Month 2 (S0354)</td>
<td>$350</td>
</tr>
<tr>
<td>Treatment Month 3 (S0354)</td>
<td>$350</td>
</tr>
<tr>
<td>Treatment Month 4 (S0354)</td>
<td>$350</td>
</tr>
<tr>
<td>Treatment Month 5 (S0354)</td>
<td>$350</td>
</tr>
<tr>
<td>Post-Treatment</td>
<td>$0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$2100</strong></td>
</tr>
</tbody>
</table>
Low Adherence to Appropriate Use Criteria → Lower Payments

Rate of Adherence to Appropriate Use Criteria

HIGH

LOW

100%
80%
Min%

Choosing Wisely

American Society of Clinical Oncology

Five Things Physicians and Patients Should Question

Don’t use cancer-directed therapy for solid tumor patients with the following characteristics:

- low performance status (3 or 4)
- no benefit from prior evidence-based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anti-cancer treatment.

Care Mgt Payment

New Patient Payment

Infusion

E&M

Care Mgt

New Patient

Infusion

E&M

Don’t perform PET, CT, and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis.

1. Imaging with PET, CT, or radionuclide bone scans can be useful in the staging of specific cancer types. However, these tests are often used in the staging evaluation of low-risk cancer, despite a lack of evidence suggesting they improve detection of metastatic disease or survival.

2. Evidence does not support the use of these scans for staging of newly diagnosed low-grade tumors of the prostate (Gleason 6) or localized prostate-specific antigen (PSA) 4-10 ng/mL. Decreased cost has been equated with low risk of disease progression.

3. Unnecessary imaging can lead to treatment through unnecessary imaging procedures, overtreatment, unnecessary radiation exposure, and expedite payments.

Don’t perform PET, CT, and radionuclide bone scans in the staging of early breast cancer at low risk for metastasis.

4. Imaging with PET, CT, or radionuclide bone scans can be useful in the staging of specific cancer types. However, these tests are often used in the staging evaluation of low-risk cancers, despite a lack of evidence suggesting they improve detection of metastatic disease or survival.

5. In breast cancer, for example, there is a lack of evidence demonstrating a benefit for the use of PET, CT, or radionuclide bone scans in asymptomatic women with no history of breast cancer.

Don’t perform surveillance testing (biomarkers) or imaging (PET, CT, and radionuclide bone scans) for asymptomatic individuals who have been treated for breast cancer with curative intent.

- Surveillance testing with serum tumor markers or imaging has been shown to be cost-effective in certain cancers (e.g., colorectal).

- Imaging of early breast cancer has not been shown to be cost-effective.

- PET and CT scans of the brain and bone are not necessary for the management of metastatic breast cancer.

- Radionuclide bone scans are not necessary for the management of metastatic breast cancer.

Don’t use white cell stimulating factors for primary prevention of febrile neutropenia for patients with less than 20 percent risk for this complication.

- ASCO guidelines recommend using white cell stimulating factors when the risk of febrile neutropenia is greater than 25 percent.

- ASCO guidelines recommend using white cell stimulating factors when the risk of febrile neutropenia is greater than 25 percent.

- ASCO guidelines recommend using white cell stimulating factors when the risk of febrile neutropenia is greater than 25 percent.

- ASCO guidelines recommend using white cell stimulating factors when the risk of febrile neutropenia is greater than 25 percent.

- ASCO guidelines recommend using white cell stimulating factors when the risk of febrile neutropenia is greater than 25 percent.

- ASCO guidelines recommend using white cell stimulating factors when the risk of febrile neutropenia is greater than 25 percent.

© Center for Healthcare Quality and Payment Reform CHQPR.org
Eliminating Payer Need for Pathways & Prior Authorization

TODAY

Payer-Specific Proprietary Pathway
Payer-Specific Proprietary Pathway
Payer-Specific Prior Authorization Requirements
Payer-Specific Prior Authorization Requirements

PAYMENT PILOTS

ASCO Choosing Wisely Guidelines and QOPI End of Life and Overuse Measures

FUTURE

ASCO-Developed or Endorsed Pathways
Goal/Target Rate Also Established for ED Visits and Hospital Admits
Decreases in Payments If Admits Are Higher Than Target

Target Rate

Achieve Target Rate for ED Visits and Hospital Admits

High Rate of ED Visits and Hospital Admissions

GOOD

HIGH

$ Care Mgt Payment $ Care Mgt Payment

New Patient Payment New Patient Payment

Infusion Infusion

E&M E&M
Bonus Payment If ED/Hospital Use Is Better Than Goal/Target

Target Rate

GOOD
Achieve Target Rate for ED Visits and Hospital Admits

HIGH
High Rate of ED Visits and Hospital Admissions

LOW
Low Rate of ED Visits and Admits

$ Care Mgt Payment
New Patient Payment
Infusion
E&M

BONUS
Care Mgt Payment
New Patient Payment
Infusion
E&M

© Center for Healthcare Quality and Payment Reform CHQPR.org
Key Differences Between
Shared Savings and PCOP

“Shared Savings” Payment Models

Patient-Centered Oncology Payment (PCOP)
Key Differences Between Shared Savings and PCOP

“Shared Savings” Payment Models

• Oncology practices only receive higher payment for improved care management if they can reduce spending

Patient-Centered Oncology Payment (PCOP)

• Oncology practices receive adequate payment to cover costs of high-value patient services regardless of total spending
Key Differences Between Shared Savings and PCOP

“Shared Savings” Payment Models
- Oncology practices only receive higher payment for improved care management if they can reduce spending.
- Already efficient practices receive little or no additional revenue and may be forced out of business.

Patient-Centered Oncology Payment (PCOP)
- Oncology practices receive adequate payment to cover costs of high-value patient services regardless of total spending.
- Already efficient practices are able to continue operating and showing what is possible from high performance.
Key Differences Between Shared Savings and PCOP

“Shared Savings” Payment Models
- Oncology practices only receive higher payment for improved care management if they can reduce spending
- Already efficient practices receive little or no additional revenue and may be forced out of business
- Practices that have been practicing inefficiently or inappropriately may receive more revenue than they need

Patient-Centered Oncology Payment (PCOP)
- Oncology practices receive adequate payment to cover costs of high-value patient services regardless of total spending
- Already efficient practices are able to continue operating and showing what is possible from high performance
- Practices that have been practicing inefficiently or inappropriately generate significant savings for payers
Key Differences Between Shared Savings and PCOP

“Shared Savings” Payment Models

- Oncology practices only receive higher payment for improved care management if they can reduce spending
- Already efficient practices receive little or no additional revenue and may be forced out of business
- Practices that have been practicing inefficiently or inappropriately may receive more revenue than they need
- Practices could achieve savings by stinting on care as well as by reducing overuse

Patient-Centered Oncology Payment (PCOP)

- Oncology practices receive adequate payment to cover costs of high-value patient services regardless of total spending
- Already efficient practices are able to continue operating and showing what is possible from high performance
- Practices that have been practicing inefficiently or inappropriately generate significant savings for payers
- Patients are protected because savings are generated by delivery of appropriate care
Key Differences Between Shared Savings and PCOP

“Shared Savings” Payment Models

- Oncology practices only receive higher payment for improved care management if they can reduce spending
- Already efficient practices receive little or no additional revenue and may be forced out of business
- Practices that have been practicing inefficiently or inappropriately may receive more revenue than they need
- Practices could achieve savings by stinting on care as well as by reducing overuse
- Practices are placed at risk for costs they cannot control and random variation in spending

Patient-Centered Oncology Payment (PCOP)

- Oncology practices receive adequate payment to cover costs of high-value patient services regardless of total spending
- Already efficient practices are able to continue operating and showing what is possible from high performance
- Practices that have been practicing inefficiently or inappropriately generate significant savings for payers
- Patients are protected because savings are generated by delivery of appropriate care
- Practices are only accountable for services/costs they can control
How Does PCOP Compare to the CMMI Oncology Care Model?

Oncology Care Model
Overview and Application Process

Centers for Medicare & Medicaid Services Innovation Center (CMMI)
February 19, 2015
OCM: More $$ During Treatment

Physician/staff time for cancer care

How oncology practice is paid in CMMI OCM program

$960 in New Payment (6 x $160)
OCM: More $$ During Treatment + Shared Savings on Total Spending

HOW ONCOLOGY PRACTICE IS PAID IN CMMI OCM PROGRAM

$960 in New Payment (6 x $160)

© Center for Healthcare Quality and Payment Reform CHQPR.org
OCM Shared Savings: Upside Only…Then Big Downside

- **Two tracks under CMMI Oncology Care Model:**
  - “Upside only”: Oncology practice receives up to 100% of any additional savings achieved after spending is reduced by 4% below projected level.
  - “Two-sided risk”: Oncology practice receives up to 100% of any additional savings after spending is reduced by 2.75% below projected level, but practice must repay CMS if spending increases by more than 2.75%.

- **Savings must be achieved in order to continue in the program**
  - Oncology practice must receive a “performance-based payment” (i.e., shared savings) within 3 years in order to continue in the program in subsequent years.

- **“Savings” is determined by comparing current spending to what CMS projects spending “should be” by trending forward the spending per episode on the practice’s patients prior to joining the program**
  - Practices already following appropriate use criteria and avoiding hospitalizations will start with a lower baseline.
  - The methodology for trending and risk adjustment has not yet been developed.

- **Savings is based on total spending on the patients on all of their health conditions, not just oncology-related services.**

- **OCM is a 5-year demonstration program, with no guarantee of continuation beyond 5 years for any participant.**
**Shared Savings Reduced Based on 39 Quality/Utilization Measures**

1. Percentage of beneficiaries who are treated with therapies consistent with nationally recognized clinical guidelines
2. Provide and attest to 24 hour, 7 days a week patient access to appropriate clinician who has real-time access to practice’s medical record
3. Attestation and Use of ONC certified EHRs
4. Submission of all quality measures required by the program team
5. Provide core functions of patient navigation
6. Electronically document a care plan that contains the 13 components in the IOM Care Management Plan
7. Number of emergency department visits per attributed OCM-FFS beneficiary per OCM-FFS episode (Risk adjusted)
8. Number of hospital admissions per attributed OCM-FFS beneficiary per OCM-FFS episode for (Risk adjusted)
9. Percentage of all Medicare FFS beneficiaries managed by a practice who are admitted to hospice for less than 3 days in the last 30 days of life
10. % of all Medicare FFS beneficiaries managed by a practice who experience more than one emergency department visit in the last 30 days of life
11. % of face-to-face visits to the participating practice in which there is a documented plan of care for pain AND pain intensity is quantified
12. Score on patient experience survey (CAHPS as modified by the evaluation contractor)
13. Percentage of OCM-FFS beneficiary face-to-face visits 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
14. Percentage of OCM-FFS beneficiaries that receive psychosocial screening and intervention at least once per OCM-FFS episode
15. Percentage of OCM-FFS beneficiaries with least one palliative care consultation per OCM-FFS episode
16. Mortality rates of OCM-FFS beneficiaries, risk adjusted
17. Number of emergency department visits per OCM-FFS beneficiary in the 6 months following the OCM-FFS episode
18. Number of hospital admissions per OCM-FFS beneficiary in the 6 months following the OCM-FFS episode
19. Number of hospital readmissions per OCM-FFS beneficiary during the OCM-FFS episode and the following 6 months
20. Number of ICU admissions per OCM-FFS beneficiary during the OCM-FFS episode and the following 6 months
21. Proportion of all Medicare FFS beneficiaries managed by a practice not admitted to hospice
22. Proportion of all Medicare FFS beneficiaries managed by a practice receiving chemotherapy in the last 14 days of life
23. % of attributed beneficiaries that receive a follow-up visit from the participating practice within 7 days after discharge from any inpatient hospitalization
24. Percentage of face-to-face encounters between an attributed OCM-FFS beneficiary and a participating practice which include medication reconciliation
26. 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
27. Colon Cancer: Chemotherapy for Stage IIIC through Stage IIIC OCM-FFS beneficiaries with colon cancer
28. 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
29. Prostate Cancer: Adjuvant hormonal therapy for high-risk OCM-FFS beneficiaries
30. Percentage of OCM-FFS beneficiaries with documented ECOG, Karnofsky, or WHO performance status assessment prior to OCM-FFS episode initiation and at episode conclusion
31. Percentage of OCM-FFS beneficiaries that receive tobacco screening and cessation intervention at least once per OCM-FFS episode
32. Percentage of OCM-FFS beneficiaries that have an Influenza Immunization
33. Number of OCM-FFS beneficiaries enrolled in clinical trials at any point during an OCM-FFS episode
34. Prescription drug utilization under Medicare Part B and Part D
35. Radiation utilization by OCM-FFS beneficiaries
36. Imaging utilization by OCM-FFS beneficiaries
37. Post-acute provider utilization by OCM-FFS beneficiaries
38. Therapy service utilization by OCM-FFS beneficiaries
39. Home health services utilization by OCM-FFS beneficiaries
Will Savings Come Only From Avoidable Spending?

Avoiding Unnecessary and Undesirable Spending

Avoidable Spending

Necessary and Appropriate Spending

SAVINGS

Avoidable Spending

Necessary and Appropriate Spending
Fewer Savings Opportunities for Already High-Performing Practices

Avoiding Unnecessary and Undesirable Spending

<table>
<thead>
<tr>
<th>Necessary and Appropriate Spending</th>
<th>Avoidable Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAVINGS</td>
<td></td>
</tr>
</tbody>
</table>

High-Performing Practices

<table>
<thead>
<tr>
<th>Necessary and Appropriate Spending</th>
<th>Avoidable Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAVINGS</td>
<td></td>
</tr>
</tbody>
</table>
Quality Measures Can’t Offset OCM Incentives to Stint on Care

Avoiding Unnecessary and Undesirable Spending

Withholding Expensive But Necessary Care

Avoidable Spending

Necessary and Appropriate Spending

SAVINGS

Avoidable Spending

Necessary and Appropriate Spending

Avoidable Spending

Necessary and Appropriate Spending

SAVINGS

Avoidable Spending

Necessary and Appropriate Spending

Available Quality Measures

No Measures or Appropriate Use Criteria

© Center for Healthcare Quality and Payment Reform CHQPR.org
Extra Payments Are Made for **Fixed 6 Month Episodes**

An “episode” starts when chemotherapy starts and lasts 6 months even if chemotherapy ends sooner.
What Happens If One of the Patient’s Treatments is Delayed?

Many Patients Have to Delay a Treatment Because of Side Effects
Logic Would Say That It’s Now a Longer (7 Month) Episode
But CMMI Says It’s a New Episode With $960 More in Payments

A new “episode” starts if chemotherapy continues more than 6 months after it starts, even for a very short time.
And Shared Savings Is More Likely With Same Spending in 2 Episodes

Penalty for Helping Patients Avoid Side Effects?

Incentive to Stretch Out Treatment?
Bottom Line on the CMMI “Oncology Care Model”

• What’s Good: $160/month extra payment for practices
Bottom Line on the CMMI “Oncology Care Model”

• What’s Good: $160/month extra payment for practices

• What’s Bad:
  – Burdensome requirements for service delivery and quality measures
  – Could encourage delaying treatments in order to receive more PMPM payments & shared savings
  – Could encourage stinting on care to achieve shared savings
  – Oncology practice is accountable for all spending on their patients, even for health problems unrelated to cancer
  – Target spending level is based on historical spending for the practice’s own patients, so it rewards practices that are currently overusing and managing patient care poorly
  – Methodology for adjusting spending targets to deal with new drugs, new evidence about effectiveness of treatments, etc. has not been defined.
## Criteria for Evaluating Oncology Payment Reforms

<table>
<thead>
<tr>
<th>Significant and Predictable Resources for High-Value Oncology Care</th>
<th>Payments Match Costs By Phase and Type of Care</th>
<th>Payment Tied to Appropriate Use, Not Savings <em>Per Se</em></th>
</tr>
</thead>
</table>

© Center for Healthcare Quality and Payment Reform  CHQPR.org
Most Oncology Payment Models Don’t Meet All Needs for Reform

<table>
<thead>
<tr>
<th>Model</th>
<th>Significant and Predictable Resources for High-Value Oncology Care</th>
<th>Payments Match Costs By Phase and Type of Care</th>
<th>Payment Tied to Appropriate Use, Not Savings Per Se</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality P4P</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Shared Savings</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>CMMI OCM</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>United “Episodes”</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Anthem Cancer Care Quality</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Only PCOP Addresses All Three Criteria for Payment Reform

<table>
<thead>
<tr>
<th></th>
<th>Significant and Predictable Resources for High-Value Oncology Care</th>
<th>Payments Match Costs By Phase and Type of Care</th>
<th>Payment Tied to Appropriate Use, Not Savings Per Se</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality P4P</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Shared Savings</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>CMMI OCM</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>United “Episodes”</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Anthem Cancer Care Quality</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>PCOP</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Basic PCOP Model Improves But Does Not Replace Current FFS

Additional $750 One-Time Payment for Each New Patient

$200 Monthly Care Management Payments During Treatment Months

$50 Care Management Payments During Active Monitoring Months Up to 6 Months After End of Treatment

© Center for Healthcare Quality and Payment Reform  CHQPR.org
New Billing Codes Will Be Easy for Payers & Practices to Implement

• **New Billing Code for New Patient Treatment Planning**
The oncology practice would bill the payer for a $750 payment for each new oncology patient who begins treatment or active management with the practice.

• **New Billing Code for Care Management During Treatment**
The oncology practice would bill the payer for a $200 payment for each month in which an oncology patient is receiving parenteral or oral anti-cancer treatment prescribed by the practice. This payment would also be made for patients who are in hospice if the oncologist is the hospice physician.

• **New Billing Code for Care Management During Active Monitoring**
The oncology practice would bill the payer for a $50 per month payment when an oncology patient was not receiving anti-cancer treatment but was being actively monitored by the practice. This would include any months in which treatment was not received before a treatment regimen was completed and up to six months after the completion of treatment.

• **New Billing Code for Participation in Clinical Trials**
The oncology practice would bill the payer for a $100 payment for each month in which a patient was participating in a clinical trial (for treatment or follow-up) if the trial sponsors do not provide support for practice expenses related to participation in the trial. This would be in addition to the New Patient Treatment Planning and Care Management Payments.

• **Continuation of Current Billing Codes for Services**
The practice would continue to bill the payer for all existing CPT and HCPCS codes (e.g., E&M services, infusions, drugs administered in the practice, etc.)
New Fee Codes Preserve/Expand A Very Complex System

### 50+ Current Billing Codes

- 99211 Established Patient Office Visit – Level 1
- 99212 Established Patient Office Visit – Level 2
- 99213 Established Patient Office Visit – Level 3
- 99214 Established Patient Office Visit – Level 4
- 99215 Established Patient Office Visit – Level 5
- 99231 Subsequent Hospital Care – Level 1
- 99232 Subsequent Hospital Care – Level 2
- 99233 Subsequent Hospital Care – Level 3
- 96401 Subcutaneous chemotherapy administration
- 96402 Subcutaneous chemotherapy administration
- 96403 Subcutaneous chemotherapy administration
- 96404 Subcutaneous chemotherapy administration
- 96405 Intralesional chemotherapy administration
- 96406 Intralesional chemotherapy administration
- 96407 Intralesional chemotherapy administration
- 96408 Intralesional chemotherapy administration
- 96409 Push chemotherapy administration
- 96410 Push chemotherapy administration
- 96411 Push chemotherapy administration
- 96412 Push chemotherapy administration
- 96413 Infusion chemotherapy administration
- 96414 Infusion chemotherapy administration
- 96415 Infusion chemotherapy administration
- 96416 Infusion chemotherapy administration
- 96417 Infusion chemotherapy administration
- 96418 Infusion chemotherapy administration
- 96419 Infusion chemotherapy administration
- 96420 Intra-arterial push chemotherapy
- 96421 Intra-arterial infusion chemotherapy
- 96422 Intra-arterial infusion chemotherapy
- 96423 Intra-arterial infusion chemotherapy
- 96424 Intra-arterial infusion chemotherapy
- 96425 Intra-arterial infusion chemotherapy
- 96426 Pleural cavity chemotherapy
- 96427 Peritoneal cavity chemotherapy
- 96428 CNS chemotherapy

### + 4 New Codes

1. New Patient Treatment Planning
2. Care Management During Treatment
3. Care Management During Active Monitoring
4. Participation in Clinical Trials

- 96521 Refilling and maintenance of portable pump
- 96522 Refilling and maintenance of implantable pump
- 96523 Irrigation of implanted venous access device
- 96542 Chemotherapy injection via subcutaneous reservoir
- 96549 Unlisted chemotherapy procedure
- 79005 Oral radiopharmaceutical therapy
- 79101 Radiopharmaceutical infusion
- 79200 Radiopharmaceutical intracavitary administration
- 79300 Radiopharmaceutical therapy
- 79403 Radiopharmaceutical therapy infusion
- 96365 Intravenous infusion, non-chemotherapy
- 96366 Intravenous infusion, non-chemotherapy
- 96367 Intravenous infusion, non-chemotherapy
- 96368 Intravenous infusion, non-chemotherapy
- 96369 Subcutaneous infusion, non-chemotherapy
- 96370 Subcutaneous infusion, non-chemotherapy
- 96371 Subcutaneous infusion, non-chemotherapy
- 96372 Injection, non-chemotherapy
- 96373 Intra-arterial injection, non-chemotherapy
- 96374 Intravenous push, non-chemotherapy
- 96375 Intravenous push, non-chemotherapy
- 96376 Intravenous push, non-chemotherapy
- 96377 Unlisted injection or infusion, non-chemotherapy
- 96360 Intravenous infusion, hydration
- 96361 Intravenous infusion, hydration
### Dramatic Simplification of Coding and Billing

#### 50+ Current Billing Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>Established Patient Office Visit – Level 1</td>
</tr>
<tr>
<td>99212</td>
<td>Established Patient Office Visit – Level 2</td>
</tr>
<tr>
<td>99213</td>
<td>Established Patient Office Visit – Level 3</td>
</tr>
<tr>
<td>99214</td>
<td>Established Patient Office Visit – Level 4</td>
</tr>
<tr>
<td>99215</td>
<td>Established Patient Office Visit – Level 5</td>
</tr>
<tr>
<td>99231</td>
<td>Subsequent Hospital Care – Level 1</td>
</tr>
<tr>
<td>99232</td>
<td>Subsequent Hospital Care – Level 2</td>
</tr>
<tr>
<td>99233</td>
<td>Subsequent Hospital Care – Level 3</td>
</tr>
<tr>
<td>96401</td>
<td>Subcutaneous chemotherapy administration</td>
</tr>
<tr>
<td>96402</td>
<td>Subcutaneous chemotherapy administration</td>
</tr>
<tr>
<td>96405</td>
<td>Intralesional chemotherapy administration</td>
</tr>
<tr>
<td>96406</td>
<td>Intralesional chemotherapy administration</td>
</tr>
<tr>
<td>96409</td>
<td>Push chemotherapy administration</td>
</tr>
<tr>
<td>96411</td>
<td>Push chemotherapy administration</td>
</tr>
<tr>
<td>96413</td>
<td>Infusion chemotherapy administration</td>
</tr>
<tr>
<td>96415</td>
<td>Infusion chemotherapy administration</td>
</tr>
<tr>
<td>96416</td>
<td>Infusion chemotherapy administration</td>
</tr>
<tr>
<td>96417</td>
<td>Infusion chemotherapy administration</td>
</tr>
<tr>
<td>96420</td>
<td>Intravenous push chemotherapy</td>
</tr>
<tr>
<td>96422</td>
<td>Intravenous infusion chemotherapy</td>
</tr>
<tr>
<td>96423</td>
<td>Intravenous infusion chemotherapy</td>
</tr>
<tr>
<td>96425</td>
<td>Intravenous infusion chemotherapy</td>
</tr>
<tr>
<td>96440</td>
<td>Pleural cavity chemotherapy</td>
</tr>
<tr>
<td>96446</td>
<td>Peritoneal cavity chemotherapy</td>
</tr>
<tr>
<td>96450</td>
<td>CNS chemotherapy</td>
</tr>
</tbody>
</table>

#### < 10 New Codes

- **New Patient Payment**
- **Treatment Month (4-6 Levels)**
  - Patient characteristics
  - Treatment characteristics
  - Transitions
  - Clinical Trials
- **Active Monitoring Month (2 Levels)**

---

© Center for Healthcare Quality and Payment Reform  CHQPR.org  103
PCOP Option A: Consolidate Existing and New Payments

One-Time
New Patient Payment

Acuity-Adjusted
Treatment Month Payments

Active Monitoring Month Payments

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
TREATMENT MONTHS
ACTIVE MONITORING

PCOP: Option A

New Patient

$
Simpler, More Flexible Payment

Current FFS Payment

- ER/Hospital Admissions
- Other Services
- Testing
- Avoidable $
- Drugs
- Drug Margin
- Non-E&M Care Mgt
- E&M Infusions
- Non-E&M Care Mgt

Patient-Centered Oncology Payment (Basic Model)

- PCOP Pmts
- E&M Infusions
- Monitoring Mo.
- Treatment Mo.
- New Patient

PCOP Consolidated Payments for Oncology Practice Services
**Simpler, More Flexible Payment, Same Accountability Components**

<table>
<thead>
<tr>
<th>Current FFS Payment</th>
<th>Patient-Centered Oncology Payment (Basic Model)</th>
<th>PCOP Consolidated Payments for Oncology Practice Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER/Hospital Admissions</td>
<td>SAVINGS ER/Admissions</td>
<td>SAVINGS ER/Admissions</td>
</tr>
<tr>
<td>Other Services</td>
<td>Improved Care Management</td>
<td>Other Services</td>
</tr>
<tr>
<td>Testing</td>
<td></td>
<td>Testing</td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidable $</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug Margin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M Infusions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-E&amp;M Care Mgt</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **ER/Admissions**: Savings are realized in ER/Admissions costs through improved care management.
- **Testing**: Savings are achieved by using appropriate use criteria for tests, EOL.
- **Drugs**: Savings are realized by monitoring and reducing avoidable costs.
- **Drug Margin**: Savings are realized by consolidating payments for oncology practice services.
- **PCOP Pmts**: Additional payments to oncology practice are made.
- **Monitoring Mo., Treatment Mo., New Patient**: Monitoring and treatment months, new patient payments.
PCOP Option B: Bundled Monthly Budgets

Current FFS Payment

- ER/Hospital Admissions
- Other Services
- Testing
- Avoidable $ (Drug Margin)
- E&M Infusions
- Non-E&M Care Mgt

Patient-Centered Oncology Payment (Basic Model)

- SAVINGS
- Improved Care Management
- Appropriate Use Criteria for Drugs, Tests, EOL
- Additional Payments to Oncology Practice
- Drug Margin
- PCOP Pmts
- E&M Infusions

PCOP Consolidated Payments for Oncology Practice Services

- SAVINGS
- ER/Admissions
- Other Services
- Testing
- Drugs
- Drug Margin
- Monitoring Mo.
- Treatment Mo.
- New Patient

PCOP Virtual Budgets for Oncology Care

- SAVINGS
- Stop Loss/Risk Corridor
- Monitoring Month Payments (Bundled Pmts)
- Treatment Month Payments (Bundled Payments)
- New Patient (Bundled Payment)
Quality Measures in All Options
Focused On Avoiding Underuse

QUALITY MEASURES

• Quality of Treatment Planning for a New Patient
  – QOPI Measures
  – Patient ratings of their experience of care

• Quality of Care During Treatment
  – QOPI Measures for All Patients and Cancer-Specific
  – Patient ratings of their experience of care

• Quality of Care Following Completion of Treatment
  – Patient ratings of their experience of care

PAYMENT ADJUSTMENT

• Range of Acceptable Performance Defined in Advance Based on
  Levels Achieved by Other Practices

• Reductions in Payments if Performance Fell Below Minimum of
  Acceptable Range
A Transition Path to the Future: Step 1

<table>
<thead>
<tr>
<th>Current FFS Payment</th>
<th>Patient-Centered Oncology Payment (Basic Model)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER/Hospital Admissions</td>
<td><strong>SAVINGS</strong></td>
</tr>
<tr>
<td>Other Services</td>
<td>ER/Admissions</td>
</tr>
<tr>
<td>Testing</td>
<td>Other Services</td>
</tr>
<tr>
<td><strong>Avoidable $</strong></td>
<td>Testing</td>
</tr>
<tr>
<td>Drugs</td>
<td>Drugs</td>
</tr>
<tr>
<td>Drug Margin</td>
<td><strong>Drug Margin</strong></td>
</tr>
<tr>
<td>E&amp;M Infusions</td>
<td>PCOP Pmts</td>
</tr>
<tr>
<td>Non-E&amp;M Care Mgt</td>
<td>E&amp;M Infusions</td>
</tr>
</tbody>
</table>

- **Accountability for ER/IP**
- **Appropriate Use Criteria**
- **Additional Billing Codes**
A Transition Path to the Future: Step 2

Current FFS Payment

- ER/Hospital Admissions
- Other Services
- Testing
- Drugs
- Drug Margin
  - Non-E&M Care Mgt
  - E&M Infusions

Patient-Centered Oncology Payment (Basic Model)

- SAVINGS ER/Admissions
- Improved Care Management
- Additional Payments to Oncology Practice
- Drug Margin
  - PCOP Pmts
  - E&M Infusions

PCOP Consolidated Payments for Oncology Practice Services

- SAVINGS ER/Admissions
- Testing
- Drugs
- Drug Margin
  - Monitoring Mo.
  - Treatment Mo.
  - New Patient

Arrows indicate:
- Accountability for ER/IP
- Appropriate Use Criteria
- Bundled Billing Codes

© Center for Healthcare Quality and Payment Reform CHQPR.org
A Transition Path to the Future: Step 3

Current FFS Payment

<table>
<thead>
<tr>
<th>ER/Hospital Admissions</th>
<th>Other Services</th>
<th>Testing</th>
<th>Avoidable $</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Drug Margin

E&M Infusions

Non-E&M Care Mgt

Patient-Centered Oncology Payment (Basic Model)

<table>
<thead>
<tr>
<th>SAVINGS</th>
<th>ER/Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Improved Care Management

Appropriate Use Criteria for Drugs, Tests, EOL

Additional Payments to Oncology Practice

Drug Margin

PCOP Payments for Oncology Practice Services

<table>
<thead>
<tr>
<th>SAVINGS</th>
<th>ER/Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PCOP Virtual Budgets for Oncology Care

<table>
<thead>
<tr>
<th>SAVINGS</th>
<th>Stop Loss/Risk Corridor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Monitoring Month Payments (Bundled Pmts)

Treatment Month Payments (Bundled Payments)

New Patient (Bundled Payment)
Input and Help Needed

• **INPUT: Improving the PCOP Proposal**
  – Are there components that you think are problematic? How would you change them?
  – Are there elements of other payment models that you think should be incorporated? Are there other payment models that you think are better?
Input and Help Needed

• INPUT: Improving the PCOP Proposal
  – Are there components that you think are problematic? How would you change them?
  – Are there elements of other payment models that you think should be incorporated? Are there other payment models that you think are better?

• HELP: Implementing the PCOP Payment Model
  – Educate patients, employers, and elected officials about the problems with the current payment system that create barriers to good cancer care and financially viable oncology practices
  – Advocate for implementation of payment reforms that solve the problems with the current payment system, rather than simply adding “incentives”
  – Volunteer to serve as a pilot site for PCOP implementation; ASCO will provide help in the implementation process
FOR MORE INFORMATION

www.CancerPayment.org

www.asco.org/paymentreform

Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform
Miller.Harold@CHQPR.org
Harold D. Miller  
President and CEO  
Center for Healthcare Quality and Payment Reform

Miller.Harold@GMail.com  
(412) 803-3650

www.CHQPR.org  
www.PaymentReform.org