THE FUTURE OF ONCOLOGY ALTERNATIVE PAYMENT MODELS

Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform
www.CHQPR.org
3 Options for Future Payments: Which Will Oncologists Choose?

VALUE-BASED PAYMENT

OPTION #1

OPTION #2

OPTION #3
Option #1 (the Default): Pay for Performance (P4P)

Value-Based Payment
Premise of P4P is Physicians Need “Incentives” for Better Care

P4P

P4P Incentives Based on Quality and Cost Measures

FFS STANDARD PHYSICIAN FEES

Bonuses
Penalties
The Problem Isn’t “Incentives,”
It’s The Barriers in FFS Payment

- A small bonus may not be enough to pay for delivering a high-value service or for the added costs of improving quality
- A small bonus may not be enough to offset the costs of collecting and reporting the quality data
- A small penalty may be less than the loss of fee-for-service revenue from healthier patients or lower utilization

P4P Incentives Based on Quality and Cost Measures

Bonus
Penalty

FFS STANDARD PHYSICIAN FEES

Unpaid Services
Financial Losses

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P4P Has Been Studied to Death

Annals of Internal Medicine

The Effects of Pay-for-Performance Programs on Health, Health Care Use, and Processes of Care
A Systematic Review

Aaron Mendelson, BA; Karli Kondo, PhD; Cheryl Damberg, PhD; Allison Low, BA; Makalapua Motuapuaka, BA; Michele Freeman, MPH; Maya O’Neil, PhD; Rose Relevo, MLIS, MS; and Devan Kansagara, MD, MCR

Background: The benefits of pay-for-performance (P4P) programs are uncertain.

Purpose: To update and expand a prior review examining the effects of P4P programs targeted at the physician, group, managerial, or institutional level on process-of-care and patient outcomes in ambulatory and inpatient settings.

Data Sources: PubMed from June 2007 to October 2016; MEDLINE, PsyclINFO, CINAHL, Business Economics and Theory, Business Source Elite, Scopus, Faculty of 1000, and Gartner Research from June 2007 to February 2016.

Study Selection: Trials and observational studies in ambulatory and inpatient settings reporting process-of-care, health, or utilization outcomes.

Data Extraction: Two investigators extracted data, assessed study quality, and graded the strength of the evidence.

Data Synthesis: Among 69 studies, 58 were in ambulatory settings, 52 reported process-of-care outcomes, and 38 reported patient outcomes. Low-strength evidence suggested that P4P programs in ambulatory settings may improve process-of-care outcomes over the short term (2 to 3 years), whereas data on longer-term effects were limited. Many of the positive studies were conducted in the United Kingdom, where incentives were larger than in the United States. The largest improvements were seen in areas where baseline performance was poor. There was no consistent effect of P4P on intermediate health outcomes (low-strength evidence) and insufficient evidence to characterize any effect on patient health outcomes. In the hospital setting, there was low-strength evidence that P4P had little or no effect on patient health outcomes and a positive effect on reducing hospital readmissions.

Limitation: Few methodologically rigorous studies; heterogeneous population and program characteristics and incentive targets.

Conclusion: Pay-for-performance programs may be associated with improved processes of care in ambulatory settings, but consistently positive associations with improved health outcomes have not been demonstrated in any setting.

Primary Funding Source: U.S. Department of Veterans Affairs.


For author affiliations, see end of text.
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Conclusion: Pay-for-performance programs may be associated with improved processes of care in ambulatory settings, but consistently positive associations with improved health outcomes have not been demonstrated in any setting.

Background: Programs are widespread but evidence is scant and conflicting.

Purpose: To examine the effects of P4P, geriatric, or integrated care on outcomes in ambulatory settings.

Data Sources: MEDLINE, PsycINFO, CINAHL, Business Economics and Theory, Business Source Elite, Scopus, Faculty of 1000, and Gartner Research from June 2007 to February 2016.

Study Selection: Trials and observational studies in ambulatory and inpatient settings reporting process-of-care, health, or utilization outcomes.

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But Like a Zombie, P4P Keeps Coming Back - MIPS

How Does MIPS Work?
You earn a payment adjustment based on evidence-based and practice-specific quality data. You show you provided high quality, efficient care supported by technology by sending in information in the following categories.

- Quality
- Improvement Activities
- Advancing Care Information
- Cost
Option #2: Alternative Payment Models

#1 PAY FOR PERFORMANCE (MIPS)

#2 ALTERNATIVE PAYMENT MODELS (APMs)

VALUE-BASED PAYMENT
In MACRA, Congress *Encouraged* Use of APMs Instead of MIPS

- Physicians who participate in approved Alternative Payment Models (APMs) at more than a minimum level:
  - are exempt from MIPS
  - receive a 5% lump sum bonus
  - receive a higher annual update (increase) in their FFS revenues
  - receive the benefits of participating in the APM
CMS Has Implemented Only a Small Number of APMs

- **Accountable Care Organizations**
  - Medicare Shared Savings Program
  - NextGen ACO Program

- **Bundled Payments for Care Improvement**
  - Only for patients who have been hospitalized or receive outpatient cardiac and spinal procedures

- **Comprehensive Care for Joint Replacement**
  - Only large hospitals performing hip/knee surgery can participate

- **Comprehensive Primary Care Plus Initiative**
  - Only PCPs in 18 states/regions selected by CMS can participate

- **Comprehensive ESRD Care**
  - Only dialysis centers and nephrologists can participate

- **Oncology Care Model**
  - 179 oncology practices are participating
How Different Are CMS APMs From MIPS and P4P?

<table>
<thead>
<tr>
<th>MIPS</th>
<th>Upside-Only ACOs</th>
<th>2-Sided Risk ACOs</th>
<th>BPCI &amp; CJR</th>
<th>Oncology Care Model</th>
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</table>

- **Bonus**: FFS Standard Physician Fees
- **Penalty**: Unpaid Services Financial Losses
Track 1 MSSP ACOs: FFS + Shared Savings (P4P)

- Only ACOs
- FFS
- Standard Payments for all services patients receive
- SharedSvgs 2-sided Risk
- ACOs BPCI & CJR
- Oncology Care Model
- Comp. Primary Care + Unpaid Services Financial Losses
- Penalty
- Bonus

MIPS

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“Two-Sided Risk” ACOs: FFS + Shared Risk (P4P)

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- **Unpaid Services Financial Losses**
- **Bonus Penalty**
- **Penalty**
- **SharedSvgs**
- **RiskPenalty**

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Bundled Payment Programs: FFS + Shared Risk P4P

- **MIPS**
  - **Upside-Only ACOs**
  - **2-Sided Risk ACOs**
  - **BPCI & CJR**
  - **Oncology Care Model**
  - **Comp. Primary Care +**

- **FFS STANDARD PHYSICIAN FEES**
  - **FFS STANDARD PAYMENTS FOR ALL SERVICES PATIENTS RECEIVE**
  - **FFS STANDARD PAYMENTS FOR ALL SERVICES PATIENTS RECEIVE**
  - **FFS STANDARD PAYMENTS FOR ALL SERVICES IN A HOSPITAL EPISODE**

- **Unpaid Services Financial Losses**
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  - **Unpaid Services Financial Losses**

- **Bonus Penalty**
  - **Bonuses**
  - **Penalties**

- **Shared Svgs Risk Penalty**
  - **Risk**
  - **Penalty**

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Oncology Care Model:
FFS + PMPM + Shared Svgs/Risk

- **MIPS**
- **Upside-Only ACOs**
- **2-Sided Risk ACOs**
- **BPCI & CJR**
- **Oncology Care Model**
- **Comp. Primary Care +**

### FFS

- **STANDARD PHYSICIAN FEES**
  - **Unpaid Services Financial Losses**
  - **Bonus Penalty**

- **STANDARD PAYMENTS FOR ALL SERVICES PATIENTS RECEIVE**
  - **Unpaid Services Financial Losses**

### Upside-Only ACOs

- **STANDARD PAYMENTS FOR ALL SERVICES PATIENTS RECEIVE**
  - **Unpaid Services Financial Losses**

### 2-Sided Risk ACOs

- **STANDARD PAYMENTS FOR ALL SERVICES PATIENTS RECEIVE**
  - **Unpaid Services Financial Losses**

### BPCI & CJR

- **STANDARD PAYMENTS FOR ALL SERVICES IN A HOSPITAL EPISODE**
  - **Unpaid Services Financial Losses**

### Oncology Care Model

- **STANDARD PAYMENTS FOR ALL SERVICES PATIENTS RECEIVE DURING CHEMO**
  - **Financial Losses**

### Shared Savings

- **Downside Risk**

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Only Comp. Primary Care Plus is Significantly Different from FFS

**MIPS**
- **Upside-Only ACOs**: FFS standard payments for all services patients receive
  - Unpaid services financial losses
  - Bonus penalties
- **2-Sided Risk ACOs**: FFS standard payments for all services patients receive
  - Unpaid services financial losses
  - Financial losses

**BPCI & CJR**
- **Shared Savings Risk Penalty**: FFS standard payments for all services in a hospital episode
  - Financial losses
- **Downside Risk**: FFS standard payments for all services patients receive during chemo
  - Financial losses
- **PMPM for Primary Care Services**: FFS standard payments for primary care physicians
  - Financial losses

**Comp. Primary Care +**
- **Bonus**: FFS standard physician fees for primary care
The “Shared Savings” Approach Isn’t Working Very Well

2013 Results for Medicare Shared Savings ACOs
- 46% of ACOs (102/220) increased Medicare spending
- After making shared savings payments, Medicare spent more than its goal
- Net loss to Medicare: $78 million

2014 Results for Medicare Shared Savings ACOs
- 45% of ACOs (152/333) increased Medicare spending
- After making shared savings payments, Medicare spent more than its goal
- Net loss to Medicare: $50 million

2015 Results for Medicare Shared Savings ACOs
- 48% of ACOs (189/392) increased Medicare spending
- After making shared savings payments, Medicare spent more than its goal
- Net loss to Medicare: $216 million

2016 Results for Medicare Shared Savings ACOs
- 44% of ACOs (191/432) increased Medicare spending
- After making shared savings payments, Medicare spent more than its goal
- Net loss to Medicare: $39 million

2017 Results for Medicare Shared Savings ACOs
- 40% of ACOs (188/472) increased Medicare spending
- After making shared savings payments, Medicare spent less than its goal
- Net gain to Medicare: $314 million

2013-2017 Results: Net Loss of $69 million
The “Shared Savings” Approach Isn’t Working Very Well

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2013-2017 Results: **Net Loss of $69 million**
Upside-Only ACOs Saved Very Little Money in 2017

MSSP Net Savings/Loss Per Beneficiary in 2017

$37 per Patient (0.34%)
Downside-Risk ACOs Saved Even Less

MSSP Net Savings/Loss Per Beneficiary in 2017

Upside-Only ACOs
- Track 1 (Upside Only Risk) (433 ACOs)
  - $37 per Patient (0.34%)

Downside Risk ACOs
- Track 2-3 (Two-Sided Risk) (39 ACOs)
  - $27 per Patient (0.24%)
How Exactly Did Any of the ACOs Reduce Spending???
Did They Reduce Spending on Undesirable/Unnecessary Svcs?

- Benchmark Spending
- Necessary Spending
- Avoidable Spending
- Actual Spending
- Savings
Or Did They Stint on Necessary Care to Produce Savings?

$\text{BENCHMARK SPENDING}$

$\text{NECESSARY SPENDING}$

$\text{AVOIDABLE SPENDING}$

$\text{NECESSARY SPENDING}$

$\text{AVOIDABLE SPENDING}$

$\text{ACTUAL SPENDING}$

$\text{SAVINGS}$
ACOs Don’t Have to Tell Us and CMS Hasn’t Tried to Find Out

The ACO Black Box

BENCHMARK SPENDING

ACTUAL SPENDING

SAVINGS
How Much Could an ACO Save By Stinting on Care?
Wide Range of Costs for Lung Cancer Treatment

Average Cost: $52,000

11 Different Chemotherapy/Immunotherapy Regimens Ranging from $2,500 to $105,000 Depending on Patient Characteristics

A Small Number of Lung Cancer Cases Involve a Lot of Spending

Lung Cancer Incidence in 65+ Population:
300/100,000 = 30 Cases in a 10,000 Member ACO

> $1.5 Million for Chemo Alone

Episode Costs of Alternative Chemotherapy Treatments for Non-Small Cell Lung Cancer

Average Cost: $52,000

11 Different Chemotherapy/Immunotherapy Regimens
Ranging from $2,500 to $105,000
Depending on Patient Characteristics


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Using Cheaper Treatments for 15 Patients = 1.2% Savings

Lung Cancer Incidence in 65+ Population: 300/100,000 = 30 Cases in a 10,000 Member ACO

>$1.5 Million for Chemo Alone
ACO Financial Risk for Total *Cost*
But Not for Total *Quality* of Care

ACO Quality Measures

- Timely Care
- Provider Communication
- Rating of Provider
- Access to Specialists
- Health Promotion & Education
- Shared Decision-Making
- Health Status
- Readmissions
- COPD/Asthma Admissions
- Heart Failure Admissions
- Meaningful Use
- Fall Risk Screening
- Flu Vaccine
- Pneumonia Vaccine
- BMI Screening & Follow-Up
- Depression Screening
- Colon Cancer Screening
- Breast Cancer Screening
- Blood Pressure Screening
- HbA1c Poor Control
- Diabetic Eye Exam
- Blood Pressure Control
- Aspirin for Vascular Disease
- Beta Blockers for HF
- ACE/ARB Therapy
- SNF Readmissions
- Diabetes Admissions
- Multiple Condition Admissions
- Medication Documentation
- Depression Remission
- Statin Therapy

**NO Measures to Assure:**

- Evidence-based treatment for cancer
- Effective management of cancer treatment side effects
- Evidence-based treatment for rheumatoid arthritis
- Evidence-based treatment of inflammatory bowel disease
- Rapid treatment and rehabilitation for stroke
- Effective management for joint pain and mobility
- Effective management of back pain and mobility
OCM Financial Risk for Total Cost
But Not for Total Quality of Care

**OCM Quality Measures**

- All-cause hospital admission rate
- All-cause ED visits/observation stays
- % of deaths in hospice >3 days
- Pain assessment and management
- Screening for depression & follow-up
- Patient-reported experience
- Hormonal therapy for high-risk prostate cancer
- Adjuvant chemo for AJCC III colon cancer
- Combination chemo for AJCC T1cNOMO or Stage IB-III hormone receptor negative breast cancer
- Trastuzumab for AJCC T1b-IIIc ER/PR+ breast cancer
- Documentation of medications

**NO Measures to Assure:**

- Evidence-based treatment for lung cancer
- Evidence-based treatment for liver cancer
- Evidence-based treatment for melanoma
- Evidence-based treatment for leukemia
- Evidence-based treatment for lymphoma
- Evidence-based treatment for bladder cancer
- Evidence-based treatment for ovarian cancer
- Evidence-based treatment for pancreatic cancer
- Evidence-based treatment for other kinds of cancer and metastatic cancer
How Much Risk Does CMS Want Physician Practices To Take?
Only 16% of Medicare Spending Goes to **Physician Fees**
10-15% Downside Risk for ACOs = 60-90% of Physician Revenue
<5% of Spending During Chemo Goes to Oncology Practice Fees

Medicare Spending on Colorectal Cancer Patients During 6 Months Following Initiation of Chemo, 2014

- Chemotherapy: 41%
- Hospital Inpatient Care: 27%
- Other: 12%
- Lab/Imaging: 5%
- SNF/HH: 7%
- Radiation: 4%

Physician FFS Payments
20% Total Spending Risk in OCM >4x Oncologists’ Fee Revenue

Medicare Spending on Colorectal Cancer Patients During 6 Months Following Initiation of Chemo, 2014

- Chemotherapy: 41%
- Hospital Inpatient Care: 27%
- Other: 12%
  - Lab/Imaging: 5%
  - SNF/HH: 7%
  - Radiation: 4%

Oncologist Fees: 3%

OCM Maximum Risk: 20% of Total Medicare Spending

400%+ of Physician Revenues
What’s Behind Door #3?

VALUE-BASED PAYMENT

#1 PAY FOR PERFORMANCE (MIPS)

#2 ALTERNATIVE PAYMENT MODELS (APMs)

OPTION #3
Value-Based Payment Is Being Designed the *Wrong* Way Today
Value-Based Payment Is Being Designed the *Wrong* Way Today

**TOP-DOWN PAYMENT REFORM**

Medicare and Health Plans Define Payment Systems
Value-Based Payment Is Being Designed the *Wrong* Way Today

**TOP-DOWN PAYMENT REFORM**

- Medicare and Health Plans Define Payment Systems
- Physicians and Hospitals Have To Change Care to Align With Payment Systems
Value-Based Payment Is Being Designed the *Wrong* Way Today

**TOP-DOWN PAYMENT REFORM**

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems

Patients Get Worse Care and Providers Close/Consolidate
Is There a Better Way?

TOP-DOWN PAYMENT REFORM

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems

Patients Get Worse Care and Providers Close/Consolidate
Start By Identifying Ways to Improve Care & Reduce Costs…

TOP-DOWN PAYMENT REFORM

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems

Patients Get Worse Care and Providers Close/Consolidate

BOTTOM-UP PAYMENT REFORM

Ask Physicians and Hospitals to Identify Ways to Improve Care for Patients and Eliminate Avoidable Costs
…Pay Adequately & Expect Accountability for Outcomes…

**TOP-DOWN PAYMENT REFORM**

- Medicare and Health Plans Define Payment Systems
- Physicians and Hospitals Have To Change Care to Align With Payment Systems
- Patients Get Worse Care and Providers Close/Consolidate

**BOTTOM-UP PAYMENT REFORM**

- Payers Provide Adequate Payment for Quality Care & Providers Take Accountability for Quality & Efficiency
- Ask Physicians and Hospitals to Identify Ways to Improve Care for Patients and Eliminate Avoidable Costs
...So the Result is Better, More Affordable Patient Care

TOP-DOWN PAYMENT REFORM

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems

Patients Get Worse Care and Providers Close/Consolidate

BOTTOM-UP PAYMENT REFORM

Patients Get Good Care at an Affordable Cost and Independent Providers Remain Financially Viable

Payers Provide Adequate Payment for Quality Care & Providers Take Accountability for Quality & Efficiency

Ask Physicians and Hospitals to Identify Ways to Improve Care for Patients and Eliminate Avoidable Costs

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The Third Option Under MACRA: Physician-Focused Payment

#1 PAY FOR PERFORMANCE (MIPS)

#2 ALTERNATIVE PAYMENT MODELS (APMs)

#3 PHYSICIAN-FOCUSED PAYMENT MODELS
How Do You Define a Physician-Focused Alternative Payment Model?
Step 1: Identify Ways to Reduce Spending Without Harming Patients

Analysis of total spending in 2012 for commercially insured patients during an “episode” of chemotherapy treatment (treatment months through the second month after treatment ends)
Opportunity 1: Reducing Avoidable ED Visits and Hospitalizations

- 40%+ of ED visits and hospital admissions are for chemotherapy-related complications.
Large Reductions in Avoidable ED Visits & Admissions Possible

Oncology patient-centered medical home and accountable cancer care

John D. Sprandel, MD
Consultant in Medical Oncology and Hematology, PC, Drexel Hill, PA

With the passage of healthcare reform and the call for improved quality, value, and demonstration of results, the primary care patient-centered medical home (PCMH) concept has garnered considerable traction across the United States. In 2004, we began transforming our processes of cancer care delivery in our medical oncology practice concurrently with the implementation of an oncology-specific electronic medical record and the development of customized software to better meet patient needs and to facilitate data collection. These custom software applications were designed to support comprehensive processes of care that were also required for level III medical home recognition by the National Committee for Quality Assurance (NCQA). We have been tracking our data for the past 5 years, documenting improvements in disease management—notably the reduction in emergency room utilization and hospital admissions. We have engaged local and national payers with the goal of developing collaborative pilot programs. Furthermore, we are establishing formalized relationships with other like-minded medical oncology and primary care PCMH practices, as we continue to refine our delivery of cancer care within an oncology PCMH model.

A backward glance at the PCMH model
A combination of factors led to the rapid acceptance of the PCMH model in the delivery of primary care: (1) physicians and patient recognition of the PCMH model as a partial solution to the unacceptable fragmentation of healthcare delivery; (2) the availability of electronic medical records (EMRs) and the accountable information that can be mined from clinical databases; (3) the alignment of incentives among stakeholders, including the largest employers in the United States, medical professional societies, consumers, insurance companies, academic institutions, patient advocacy groups, state Medical agencies, and the Centers for Medicare & Medicaid Services; and (4) early results from medical home demonstration projects, suggesting that elements of the model may have a positive effect on quality, cost, and satisfaction of the patient and clinical teams.

Unacceptable fragmentation of care
In order to address the fragmentation of care, there are a number of actions that physicians should take care for patients across the continuum, improve the coordination of care, establish a standardized comprehensive process of care, adhere to established practice guidelines, utilize a computerized approach, engage and educate patients to enhance involvement in their care, and create innovative ways of communicating with all parties involved.

EMR systems
While fully implemented and embraced, EMR systems have the potential to promote a culture of continuous improvement that creates practice efficiencies. Furthermore, EMR systems potentially allow physicians to concentrate on their primary responsibilities of making complex medical decisions based on real-time, evidence-based data while establishing and maintaining personal relationships with their patients.

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).
Opportunity 2: Reducing Avoidable Use of Drugs, Tests, & Imaging

- Unnecessarily expensive tests
- Unnecessary testing
- Unnecessarily expensive drugs
- Unnecessary drugs
- Unnecessary end-of-life treatment
ASCO Choosing Wisely List
Targets Areas of High Spending
22%-47% 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...

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
27%-40% Non-Adherence to Choosing Wisely Criteria

Rate of Non-Adherence to Choosing Wisely Guidelines

- Do not use combination chemotherapy when treating metastatic breast cancer unless the patient needs rapid response...
- Do not routinely use extended fractionation schemes for palliation of bone metastases
- Do not use white-cell stimulating factors for patients undergoing chemotherapy with less than 20% risk of febrile...
- Do not perform surveillance testing or imaging for asymptomatic individuals treated for breast cancer with curative...
- Do not give patients starting a chemotherapy regimen with low or moderate risk of nausea an antiemetic...
Many Opportunities to Reduce Spending Without Harming Patients

- ED visits and hospital admissions for chemotherapy-related complications
- Unnecessarily expensive tests
- Unnecessary testing
- Unnecessarily expensive drugs
- Unnecessary drugs
- Unnecessary end-of-life treatment
Step 2: Identify the Barriers in the Current Payment System

- ED visits and hospital admissions for chemotherapy-related complications
- Unnecessarily expensive tests
- Unnecessary testing
- Unnecessarily expensive drugs
- Unnecessary drugs
- Unnecessary end-of-life treatment
- No payment for physician time outside of face-to-face visits with patients
- No payment for time spent with patients by non-physician staff (nurses, social workers, financial counselors, etc.)
- No payment for 24/7 hotline and triage services needed by patients experiencing complications
- No payment for extended hours or open schedule slots for urgent care
Step 3: Pay Practices for High-Value Services

Current FFS Payment

$45,000
$40,000
$35,000
$30,000
$25,000
$20,000
$15,000
$10,000
$5,000
$0

Oncology Alternative Payment Model

Drug Margin

Practice Fees

Non-E&M Care Mgt

Better Payment for Practices

APM Payments

Oncology Practice Receives Higher, More Flexible Payments Than Today
Step 4: Hold Practices Accountable for Utilization *They Can Control*

- **Current FFS Payment**
  - ER/Hospital Admissions
  - Other Services
  - Testing
  - Avoidable $
  - Drugs
  - Drug Margin
  - Practice Fees
  - Non-E&M Care Mgt

- **Oncology Alternative Payment Model**
  - ER/Admissions
  - Other Services
  - Testing
  - Drugs
  - APM Payments

**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, More Flexible Payments Than Today**
Win-Win-Win: Better Care, Better Payment, Payer Savings

Current FFS Payment
- ER/Hospital Admissions
- Other Services
- Testing
- Avoidable $
- Drugs
- Drug Margin
- Practice Fees
- Non-E&M Care Mgt

Oncology Alternative Payment Model
- SAVINGS
- ER/Admissions
- Other Services
- Testing
- Drugs
- APM Payments
- Oncology Practice Receives Higher, More Flexible Payments Than Today

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
- Lower Spending without Rationing

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ASCO PCOP APM Developed by Oncologists & Practice Managers

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- Tammy Chambers, Center for Cancer and Blood Disorders
- James Frame, MD, CAMC Cancer Center
- Bruce Gould, MD, Northwest Georgia Oncology Center
- Ann Kaley, Mountain States Tumor Institute
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- Lauren Lawrence, Karmanos Cancer Institute
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- Roscoe Morton, MD, Cancer Center of Iowa
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- Gabrielle Rocque, MD, University of Alabama at Birmingham
- Barry Russo, Center for Cancer and Blood Disorders
- Joel Saltzman, MD, Seidman Cancer Center
- Laura Stevens, Innovative Oncology Business Solutions
- Jeffery Ward, MD, Swedish Cancer Institute
- Kim Woofter, Michiana Hematology Oncology
- Robin Zon, MD, Michiana Hematology Oncology

www.asco.org/paymentreform
### Costs and Savings from Patient-Centered Oncology Payment

<table>
<thead>
<tr>
<th></th>
<th>Current Average Spending Per Beneficiary</th>
<th>With Proposed New Payments and Estimated Savings</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Month Prior to Treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M Services</td>
<td>$296</td>
<td>$296</td>
<td></td>
</tr>
<tr>
<td>PCOP</td>
<td></td>
<td>$750</td>
<td></td>
</tr>
<tr>
<td><strong>During and 2 Months After Treatment</strong></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>
</tr>
<tr>
<td>Infusion Services</td>
<td>$1,904</td>
<td>$1,904</td>
<td></td>
</tr>
<tr>
<td>PCOP</td>
<td></td>
<td>$1,190</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy/Drugs</td>
<td>$25,131</td>
<td>$23,372</td>
<td>-7%</td>
</tr>
<tr>
<td>Lab Tests</td>
<td>$583</td>
<td>$553</td>
<td>-5%</td>
</tr>
<tr>
<td>Imaging</td>
<td>$1,503</td>
<td>$1,428</td>
<td>-5%</td>
</tr>
<tr>
<td>ED/Ambulance</td>
<td>$421</td>
<td>$295</td>
<td>-30%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$7,100</td>
<td>$4,970</td>
<td>-30%</td>
</tr>
<tr>
<td>Other</td>
<td>$10,920</td>
<td>$10,920</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Months 3-6 After Treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M Services</td>
<td>$120</td>
<td>$120</td>
<td></td>
</tr>
<tr>
<td>PCOP</td>
<td></td>
<td>$220</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>$50,048</td>
<td>$48,089</td>
</tr>
</tbody>
</table>

**For 500 New Patients:**

- Additional Practice Revenues: $1,080,000
- Net Payer Savings: $979,802

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**THE AMERICAN SOCIETY OF CLINICAL ONCOLOGY**

**PATIENT-CENTERED ONCOLOGY PAYMENT**

Payment Reform to Support Higher Quality, More Affordable Cancer Care

May 2015

www.asco.org/paymentreform
Not Just Medical Oncology…

Patient-Centered Oncology Payment for Medical Oncology

**Improvements in Value**
- Reduce ED visits and hospital admissions for toxicity-related complications of treatment
- Reduce unnecessary use of expensive tests and treatments
- Provide better support to patients in transition to survivorship or end-of-life care
Opportunities to Improve Value in Surgical Oncology

**PATIENT**

**Patient-Centered Oncology Payment for Medical Oncology**

**Bundled/Warrantied Payment for Surgical Oncology**

**Improvements in Value**
- Reduce repeat surgeries to assure successful resections of tumors
- Use most efficient imaging, localization, and pathology approaches for successful resection
- Minimize need for reconstructive surgery and perform resection and reconstruction at same time when possible
- Reduce infections/complications from surgery
Opportunities to Improve Value in Radiation Oncology

PATIENT

Patient-Centered Oncology Payment for Medical Oncology

Bundled/Warrantied Payment for Surgical Oncology

Bundled/Warrantied Payment for Radiation Oncology

Improvements in Value
- Reduce overuse of expensive treatments
- More predictable payments for payers/patients
- Predictable revenues to cover practice cost
Supporting Coordinated Care from All Oncology Specialties

Condition-Based Payment for Patient’s Cancer

- Patient-Centered Oncology Payment for Medical Oncology
- Bundled/Warrantied Payment for Surgical Oncology
- Bundled/Warrantied Payment for Radiation Oncology
Three Paths to the Future: Which Will Oncology Practices Choose?

VALUE-BASED PAYMENT

#1 PAY FOR PERFORMANCE (MIPS)

#2 ALTERNATIVE PAYMENT MODELS (APMs)

#3 PHYSICIAN-FOCUSED PATIENT-CENTERED PAYMENT MODELS
If You Don’t Like Options 1 & 2, What Should You Do?
If You Don’t Like Options 1 & 2, What Should You Do?

1. Listen to PowerPoint presentations at today’s conference, go back home, continue business as usual, and hope somebody else figures this out
If You Don’t Like Options 1 & 2, What Should You Do?

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If You Don’t Like Options 1 & 2, What Should You Do?

1. Listen to PowerPoint presentations at today’s conference, go back home, continue business as usual, and hope somebody else figures this out.


3. Take charge of value-based payment in oncology:
   - Measure and report on the quality of your care so patients and payers know you’re a high-value practice.
   - Look at your own patient population, identify opportunities to reduce spending, and plan for care changes that would achieve them if you can be paid the right way.
   - Design good APMs and demand that health plans and Medicare implement them so you can deliver affordable, high-quality care to your patients.
   - Refuse to participate in bad payer-designed APMs.
Learn More About Win-Win-Win Payment and Delivery Reform

www.PaymentReform.org
For More Information:

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President and CEO  
Center for Healthcare Quality and Payment Reform

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