BETTER WAYS TO PAY FOR CANCER CARE
Creating Win-Win-Win Approaches for Oncologists, Cancer Patients, and Payers

Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform
Physicians Are Understandably Skeptical About “Payment Reform”

HOW ALTERNATIVE PAYMENT MODELS ARE TYPICALLY DEVELOPED

1. Medicare and Health Plans Define Payment to Benefit Payers
2. Physicians Forced To Change Care To Align With Payment Systems
3. 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
- HbA1c Control
- LDL

P4P Bonus
FFS

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

P4P Bonus
FFS
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

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 Bonus -> FFS

P4P Penalty -> FFS
Win-Lose Approaches Are the Wrong Way To Change Payment

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
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
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?
Before Treatment Begins…

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…

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.
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…

WHAT ONCOLOGY PRACTICES DO

Parenteral Therapy
• Administer IV therapy
• 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
• Bill insurance companies
• Discuss end-of-life planning with patient
• Etc.
If Parenteral Therapy is Given…
More Payment, But Linked to Drugs

WHAT ONCOLOGY PRACTICES DO

Parenteral Therapy
• Administer IV therapy
• 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
• Bill insurance companies
• Discuss end-of-life planning with patient
• Etc.

HOW PRACTICES ARE PAID

• E&M payments for face-to-face visits with physicians
• Payment for in-office infusions
• ASP+x% - acquisition cost of drugs

(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

**WHAT ONCOLOGY PRACTICES DO**

**Parenteral Therapy**
- Administer IV therapy
- 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
- Bill insurance companies
- Discuss end-of-life planning with patient
- Care management services
- 24/7 triage and response
- Etc.

**HOW PRACTICES ARE PAID**

- E&M payments for face-to-face visits with physicians
- Payment for in-office infusions
- ASP+x% - acquisition cost of drugs

(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…

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.
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.)
Current Service Payments Fall Far Short of Practice Costs

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

$2000
$1500
$1000
$500
$0
0
Dx
Today: Costs to Deliver Treatment & Help Avoid Complications

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

Costs:
- $2000
- $1500
- $1000
- $500
- $0

TREATMENT MONTHS:
- 0
- 1
- 2
- 3
- 4
- 5
- 6

Dx
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

© 2009-2015 Center for Healthcare Quality and Payment Reform www.CHQPR.org
Goal of ASCO’s PCOP Proposal is to Better Match Payment to Services

PHYSICIAN/STAFF TIME FOR CANCER CARE

PATIENT-CENTERED ONCOLOGY PAYMENT (PCOP)
Start With Existing FFS Payments

PATIENT-CENTERED ONCOLOGY PAYMENT (PCOP)

<table>
<thead>
<tr>
<th>TREATMENT MONTHS</th>
<th>ACTIVE MONITORING</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>1</td>
<td>Infusion</td>
</tr>
<tr>
<td>2</td>
<td>Infusion</td>
</tr>
<tr>
<td>3</td>
<td>Infusion</td>
</tr>
<tr>
<td>4</td>
<td>Infusion</td>
</tr>
<tr>
<td>5</td>
<td>Infusion</td>
</tr>
<tr>
<td>6</td>
<td>Infusion</td>
</tr>
<tr>
<td>7</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>8</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>9</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>10</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>11</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>12</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>13</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>14</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>15</td>
<td>E&amp;M</td>
</tr>
</tbody>
</table>
+1. Significant New Payment During Crucial Planning Stage

Additional $750 One-Time Payment for Each New Patient

<table>
<thead>
<tr>
<th>TREATMENT MONTHS</th>
<th>ACTIVE MONITORING</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>New Patient</td>
</tr>
<tr>
<td>1</td>
<td>Infusion</td>
</tr>
<tr>
<td>2</td>
<td>Infusion</td>
</tr>
<tr>
<td>3</td>
<td>Infusion</td>
</tr>
<tr>
<td>4</td>
<td>Infusion</td>
</tr>
<tr>
<td>5</td>
<td>Infusion</td>
</tr>
<tr>
<td>6</td>
<td>Infusion</td>
</tr>
<tr>
<td>7</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>8</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>9</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>10</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>11</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>12</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>13</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>14</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>15</td>
<td>E&amp;M</td>
</tr>
</tbody>
</table>

PATIENT-CENTERED ONCOLOGY PAYMENT (PCOP)
+2. Flexible Care Management Payments During Treatment

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

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

- New Patient
- Care Management
- Infusion

- **TREATMENT MONTHS:**
  - 0: New Patient
  - 1-6: Care Management
  - 7-15: Active Monitoring
+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)
+4. Payment for Patients on Unfunded Clinical Trials

$100 Monthly Payments For Patients in (Unfunded) Clinical Trials

PATIENT-CENTERED ONCOLOGY PAYMENT (PCOP)
~$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?

Spending on Cancer Care in U.S. 2004-2020

- 2004: $75,000,000,000
- 2010: $125,000,000,000
- 2020 Projected: $175,000,000,000
Where Does Spending on Cancer Patients Go Today?

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

$\$\$\$\$ for Services to Cancer Patients
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: 95%
- Hospital Inpatient & Outpatient
- Radiation & Other Prof. Svcs.
- Drugs
- 6% Drugs
So, Even A *Big* Increase in Payments to *Oncology Practices*...
…Represents a *Small* Increase in *Total* Spending
A Mere 3% Reduction in Other Spending Would Pay for This

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

- Other
- Practice
- Other
- Practice
- Other

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
- Other
- Other

Practice
Practice
Practice
Break Down Other Spending Into *Actionable* Categories
Desirable Cancer Services

Avoidable 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

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

Other

Practice

Non-Cancer Services

Practice

Practice

© 2009-2015 Center for Healthcare Quality and Payment Reform  www.CHQPR.org
PCOP Payments Enable Practices to Reduce Avoidable Services

- Triage and expanded practice access to avoid use of ER and hospital for complications
- Following ASCO Choosing Wisely guidelines and QOPI measures for chemotherapy, supportive drugs, testing, imaging, and end-of-life care
Large Reductions in Avoidable Hospitalizations Are Possible

![Graph showing ER evaluations per patient per year from 2004 to 2010.](image)

**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).

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

© 2009-2015 Center for Healthcare Quality and Payment Reform www.CHQPR.org
Reducing Spending Variation Would Save More Than PCOP $3,656

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
ASCO Choosing Wisely List
Targets Areas of High Spending

### Five Things Physicians and Patients Should Question

<table>
<thead>
<tr>
<th>No</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>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 anticancer treatment.</td>
</tr>
<tr>
<td>2</td>
<td>Don’t perform PET, CT, and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis.</td>
</tr>
<tr>
<td>3</td>
<td>Don’t perform PET, CT, and radionuclide bone scans in the staging of early breast cancer at low risk for metastasis.</td>
</tr>
<tr>
<td>4</td>
<td>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.</td>
</tr>
<tr>
<td>5</td>
<td>Don’t use white cell stimulating factors for primary prevention of febrile neutropenia for patients with less than 20 percent risk for this complication.</td>
</tr>
</tbody>
</table>
Analysis of PCOP Shows Large Net Savings from Better Payment

### 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>$750</td>
<td></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>$1,190</td>
<td></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>$220</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$50,048</td>
<td>$48,089</td>
<td>-3.9%</td>
</tr>
</tbody>
</table>
Reducing **Avoidable Services** Achieves Savings w/o Rationing

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

- **Other**
- **Desirable Cancer Services**
- **Non-Cancer Services**
- **Avoidable Services**
- **Savings**
PCOP Avoids Creating Incentives to Reduce Desirable Services…
...And Doesn’t Put Practices At Risk For Costs They Can’t Control
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
PCOP: More Payment to Practices Where It’s Needed

NOTE: Chart not drawn to scale

Oncology Practice Receives Higher Payments Than Today for Costs of Existing and New Services
PCOP: Implement ASCO Guidelines For Drugs & Tests

Oncology Practice Follows Appropriate Use Criteria for Drugs, Tests, and Imaging

Oncology Practice Receives Higher Payments Than Today for Costs of Existing and New Services

NOTE: Chart not drawn to scale
PCOP: Reduce Avoidable Hospital Admissions

**Current Practice**
- Hospital Admits
- ED Visits
- Testing
- Drug Costs

**PCOP**
- Hospital Admits
- ED Visits
- Testing
- Drug Costs

**Costs**
- Current Practice Services
- Other Revenue
- Infusion
- E&M

**Payment**
- Care Mgt

**Oncology Practice**
- Follows Appropriate Use Criteria for Drugs, Tests, and Imaging
- Receives Higher Payments Than Today for Costs of Existing and New Services

**NOTE:** Chart not drawn to scale

© 2009-2015 Center for Healthcare Quality and Payment Reform www.CHQPR.org
Better Care, Better Payment, Savings for Payers = Win-Win-Win

**Current Practice**
- Hospital Admits
- ED Visits
- Testing
- Drug Costs

**PCOP**
- Savings
- Payer Receives Net Savings
- Hospital Admits
- ED Visits
- Testing
- Drug Costs

**Care Mgt**
- Current Practice Services
  - Other Revenue
  - Infusion
  - E&M

**Oncology Practice**
- Other Revenue
- Care Mgt
- New Patient
- Infusion
- E&M

**Oncology Practice Receives Higher Payments Than Today for Costs of Existing and New Services**
- Avoidable Hospital Admissions
- Follows Appropriate Use Criteria for Drugs, Tests, and Imaging

**NOTE:** Chart not drawn to scale

© 2009-2015 Center for Healthcare Quality and Payment Reform www.CHQPR.org
How Does PCOP Compare to the CMMI Oncology Care Model?
More Money During Treatment

**PHYSICIAN/STAFF TIME FOR CANCER CARE**

**HOW ONCOLOGY PRACTICE IS PAID IN CMMI OCM PROGRAM**

$960 in New Payment (6 x $160)

© 2009-2015 Center for Healthcare Quality and Payment Reform www.CHQPR.org
More Money During Treatment + Shared Savings on Total Spending

PHYSICIAN/STAFF TIME FOR CANCER CARE

HOW ONCOLOGY PRACTICE IS PAID IN CMMI OCM PROGRAM

$960 in New Payment (6 x $160)

Shared Savings on Total Cost
Where Will the Savings Come From?

Avoiding Unnecessary and Undesirable Spending

- Avoidable Spending
- Necessary and Appropriate Spending

SAVINGS

- Avoidable Spending
- Necessary and Appropriate Spending
What if Your Practice Is Already Delivering High-Value Care?

Avoiding Unnecessary and Undesirable Spending

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

SAVINGS

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

OR

Withholding Expensive But Necessary Care

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

SAVINGS

<table>
<thead>
<tr>
<th>$</th>
<th>Avoidable Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Necessary and Appropriate Spending</td>
</tr>
</tbody>
</table>
A Long List of Quality Measures Can’t Adequately Protect Patients

Avoiding Unnecessary and Undesirable Spending

\[\text{Avoidable Spending} \quad \text{SAVINGS}\]

\[\text{Necessary and Appropriate Spending}\]

OR

Withholding Expensive But Necessary Care

\[\text{Avoidable Spending}\]

\[\text{Necessary and Appropriate Spending}\]

\[\text{Avoidable Spending}\]

\[\text{Necessary and Appropriate Spending}\]

\[\text{SAVINGS}\]

\[\text{Necessary and Appropriate Spending}\]

\[\text{Available Quality Measures}\]

\[\text{No Measures or Appropriate Use Criteria}\]
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?
Problems with CMMI “Oncology Care Model”

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

- What’s Bad:
  - 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

| Significant and Predictable Resources for High-Value Oncology Care | Payments Match Costs By Phase and Type of Care | Payment Tied to Appropriate Use, Not Savings *Per Se* |
## How Proposed Oncology Payment Models Meet Needs for Reform

|                          | Significant and Predictable Resources for High-Value Oncology Care | Payments Match Costs By Phase and Type of Care | Payment Tied to Appropriate Use, Not Savings *Per Se*
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality P4P</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
## How Proposed Oncology Payment Models Meet Needs for 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>
</tbody>
</table>
# How Proposed Oncology Payment Models Meet 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>
</tbody>
</table>
How Proposed Oncology Payment Models Meet Needs for 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 <em>Per Se</em></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>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
How Proposed Oncology Payment Models Meet 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>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Anthem Cancer Care Quality</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
## How Proposed Oncology Payment Models Meet 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>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Anthem Cancer Care Quality</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>PCOP</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

PATIENT-CENTERED ONCOLOGY PAYMENT (PCOP)
PCOP Option A: Consolidate Existing and New Payments

One-Time New Patient Payment

Acuity-Adjusted Treatment Month Payments

Active Monitoring Month Payments

PCOP: Option A
## 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>Intra-arterial push chemotherapy</td>
</tr>
<tr>
<td>96422</td>
<td>Intra-arterial infusion chemotherapy</td>
</tr>
<tr>
<td>96423</td>
<td>Intra-arterial infusion chemotherapy</td>
</tr>
<tr>
<td>96425</td>
<td>Intra-arterial 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>
<tr>
<td>96521</td>
<td>Refilling and maintenance of portable pump</td>
</tr>
<tr>
<td>96522</td>
<td>Refilling and maintenance of implantable pump</td>
</tr>
<tr>
<td>96523</td>
<td>Irrigation of implanted venous access device</td>
</tr>
<tr>
<td>96542</td>
<td>Chemotherapy injection via subcutaneous reservoir</td>
</tr>
<tr>
<td>96549</td>
<td>Unlisted chemotherapy procedure</td>
</tr>
<tr>
<td>79005</td>
<td>Oral radiopharmaceutical therapy</td>
</tr>
<tr>
<td>79101</td>
<td>Radiopharmaceutical infusion</td>
</tr>
<tr>
<td>79200</td>
<td>Radiopharmaceutical intracavitary administration</td>
</tr>
<tr>
<td>79203</td>
<td>Radiopharmaceutical therapy</td>
</tr>
<tr>
<td>79403</td>
<td>Radiopharmaceutical therapy infusion</td>
</tr>
<tr>
<td>96365</td>
<td>Intravenous infusion, non-chemotherapy</td>
</tr>
<tr>
<td>96366</td>
<td>Intravenous infusion, non-chemotherapy</td>
</tr>
<tr>
<td>96367</td>
<td>Intravenous infusion, non-chemotherapy</td>
</tr>
<tr>
<td>96368</td>
<td>Intravenous infusion, non-chemotherapy</td>
</tr>
<tr>
<td>96369</td>
<td>Subcutaneous infusion, non-chemotherapy</td>
</tr>
<tr>
<td>96370</td>
<td>Subcutaneous infusion, non-chemotherapy</td>
</tr>
<tr>
<td>96371</td>
<td>Subcutaneous infusion, non-chemotherapy</td>
</tr>
<tr>
<td>96372</td>
<td>Injection, non-chemotherapy</td>
</tr>
<tr>
<td>96373</td>
<td>Intra-arterial injection, non-chemotherapy</td>
</tr>
<tr>
<td>96374</td>
<td>Intravenous push, non-chemotherapy</td>
</tr>
<tr>
<td>96375</td>
<td>Intravenous push, non-chemotherapy</td>
</tr>
<tr>
<td>96376</td>
<td>Intravenous push, non-chemotherapy</td>
</tr>
<tr>
<td>96379</td>
<td>Unlisted injection or infusion, non-chemotherapy</td>
</tr>
<tr>
<td>96360</td>
<td>Intravenous infusion, hydration</td>
</tr>
<tr>
<td>96361</td>
<td>Intravenous infusion, hydration</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)
Same Accountability Components But Simpler, More Flexible Pmt

Current Practice

<table>
<thead>
<tr>
<th>COSTS</th>
<th>PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admits</td>
<td>Drug Costs</td>
</tr>
<tr>
<td>ED Visits</td>
<td></td>
</tr>
<tr>
<td>Testing</td>
<td></td>
</tr>
<tr>
<td>Drug Costs</td>
<td></td>
</tr>
<tr>
<td>Care Mgt</td>
<td>Current Practice Services</td>
</tr>
<tr>
<td>Infusion</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>Other Revenue</td>
<td></td>
</tr>
</tbody>
</table>

PCOP

<table>
<thead>
<tr>
<th>COSTS</th>
<th>PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Revenue</td>
<td>Care Mgt</td>
</tr>
<tr>
<td>Care Mgt</td>
<td>New Patient</td>
</tr>
<tr>
<td>Infusion</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>Drug Costs</td>
<td></td>
</tr>
<tr>
<td>Savings</td>
<td>Hospital Admits</td>
</tr>
<tr>
<td></td>
<td>ED Visits</td>
</tr>
<tr>
<td></td>
<td>Testing</td>
</tr>
</tbody>
</table>

Option A

<table>
<thead>
<tr>
<th>COSTS</th>
<th>PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Revenue</td>
<td>Monitoring</td>
</tr>
<tr>
<td></td>
<td>Treatment Months</td>
</tr>
<tr>
<td></td>
<td>New Patient</td>
</tr>
<tr>
<td>Drug Costs</td>
<td></td>
</tr>
<tr>
<td>Savings</td>
<td>Hospital Admits</td>
</tr>
<tr>
<td></td>
<td>ED Visits</td>
</tr>
<tr>
<td></td>
<td>Testing</td>
</tr>
</tbody>
</table>

NOTE: Chart not drawn to scale
PCOP Option B: Bundled Monthly Budgets

CURRENT
- Hospital Admits
- ED Visits
- Testing
- Drug Costs

Accountability for ED Visits & Admits
Accountability for Following ASCO Appropriate Use Criteria

PCOP
- Savings
- Hospital Admits
- ED Visits
- Testing
- Drug Costs

OPTION A
- Savings
- Hospital Admits
- ED Visits
- Testing
- Drug Costs

OPTION B
- Savings
- Stop Loss
- Virtual Budget
- or Bundled Payment for Practice Expense, Drugs, Testing, ED Visits, and Hospital Admits

NOTE: Chart not drawn to scale
Oncology Practice + Payer Partnerships Needed

• Oncology practices can’t change the way they deliver care unless payers agree to pay them differently

• Oncology practices can’t even estimate potential savings from avoided ED visits, hospitalizations, and tests/imaging without data from payers on utilization and prices

• There is uncertainty on both sides:
  – Can the oncology practice meet performance targets?
  – Will the savings offset the higher payments?

• A true partnership is needed to create a win-win-win approach
A Different “Triple Aim”

• **Better Care for Patients (Win)**
  – Oncology practices have sufficient resources and flexibility to design care that matches patient needs
  – Oncology practices are not rewarded for stinting on care

• **Lower Spending for Payers (Win)**
  – Oncologists take accountability for reducing avoidable services which drive a significant portion of cancer spending

• **Financially Viable Oncology Practices (Win)**
  – Oncology practices are paid adequately to deliver high-quality care
  – Oncology practices are not put at risk for costs they cannot control