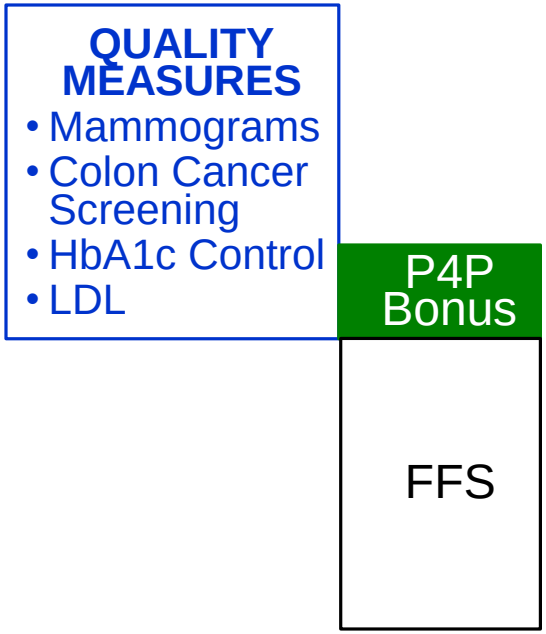
BETTER WAYS TO PAY FOR CANCER CARE
Creating Win-Win-Win Approaches for Oncologists, Cancer Patients, and Payers

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

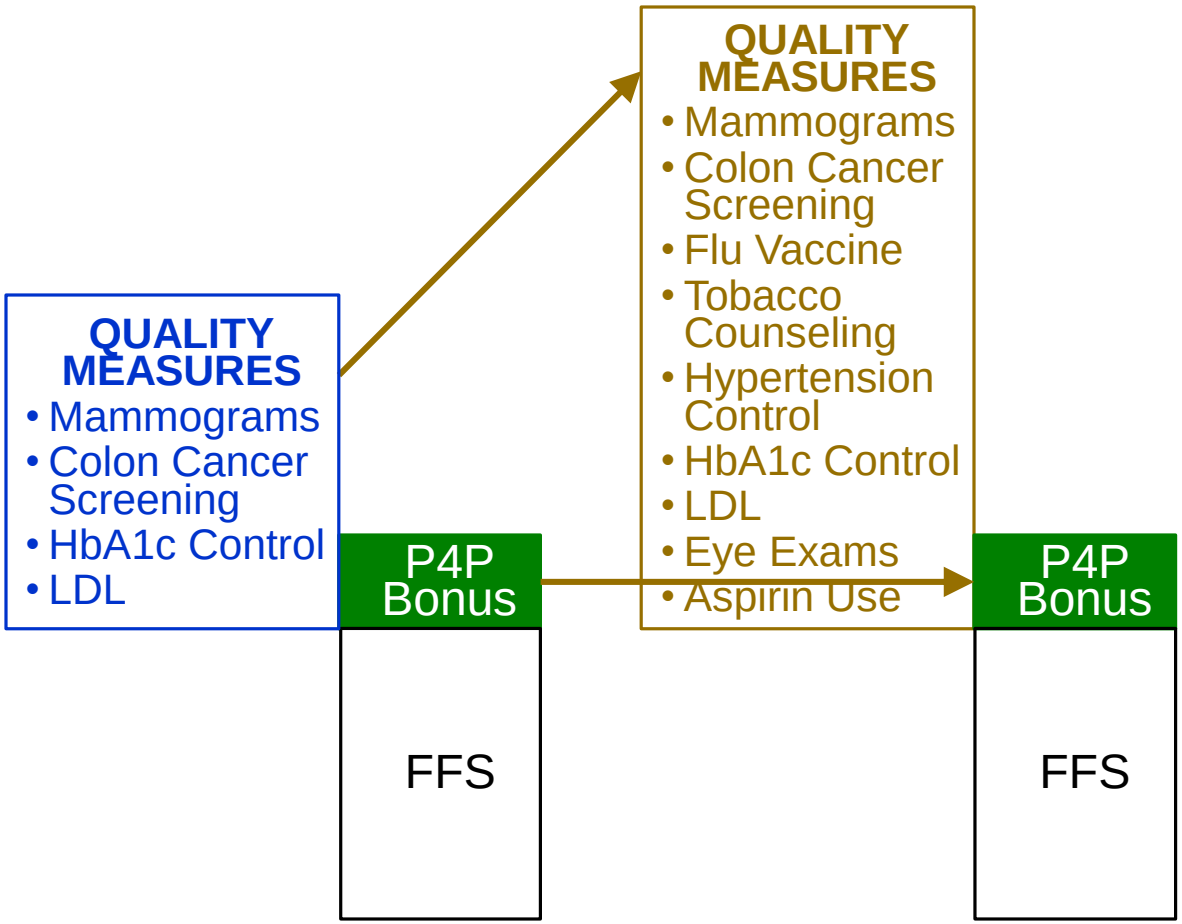
Physicians Are Understandably Skeptical About "Payment Reform"

HOW ALTERNATIVE PAYMENT MODELS ARE TYPICALLY DEVELOPED

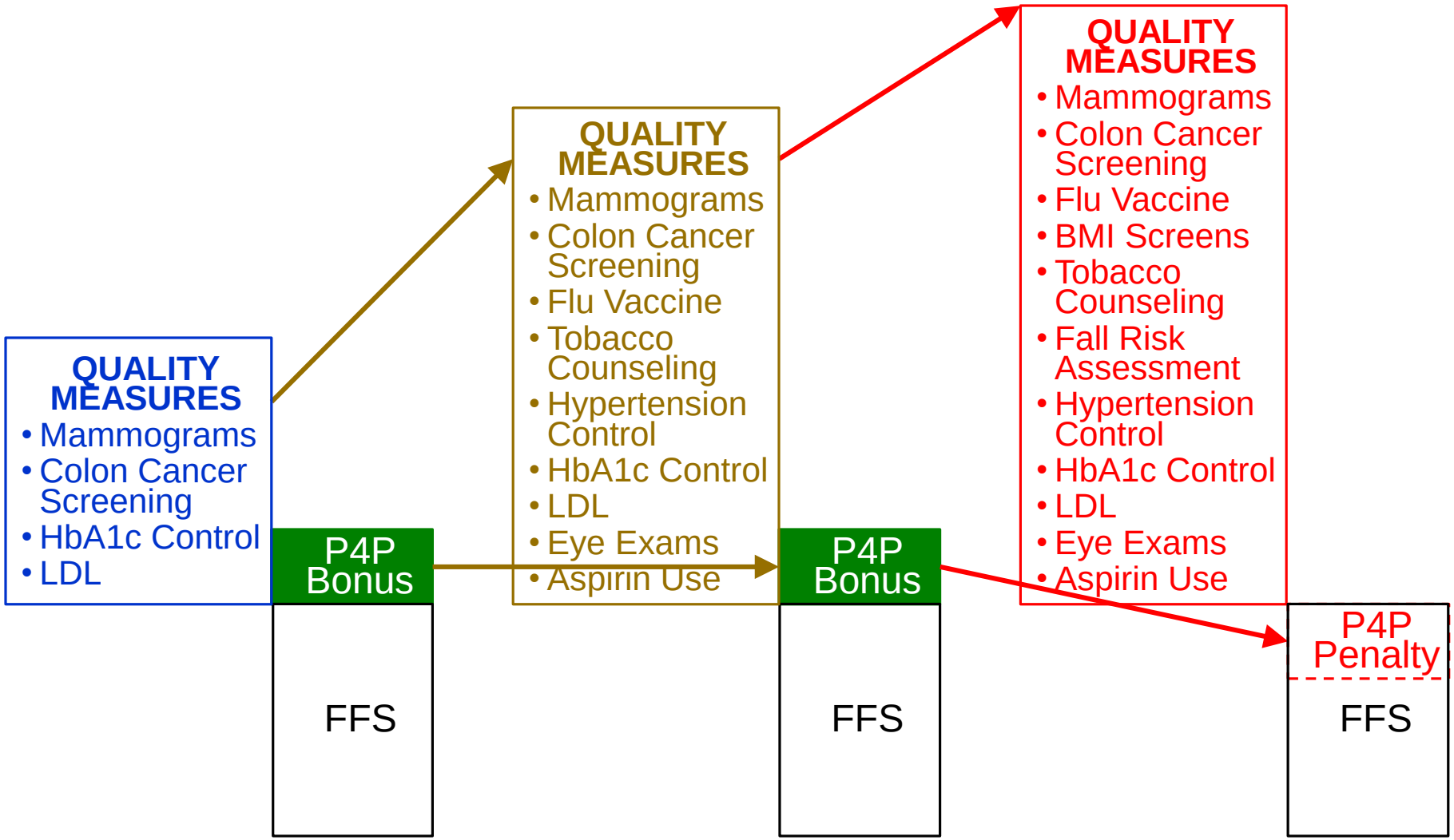
Typical "Value-Based Payment" Is a Tweak to Fee for Service



More Measure Burden Each Year, With the Same Small Bonuses



Bonuses Turn to Penalties With No Way to Support Better Care



Win-Lose Approaches Are the Wrong Way To Change Payment

WIN-LOSE APPROACHES

(THE DOMINANT MODE TODAY)

We Need Win-Win-Win Approaches to Payment Reform

WIN-LOSE APPROACHES

(THE DOMINANT MODE TODAY)

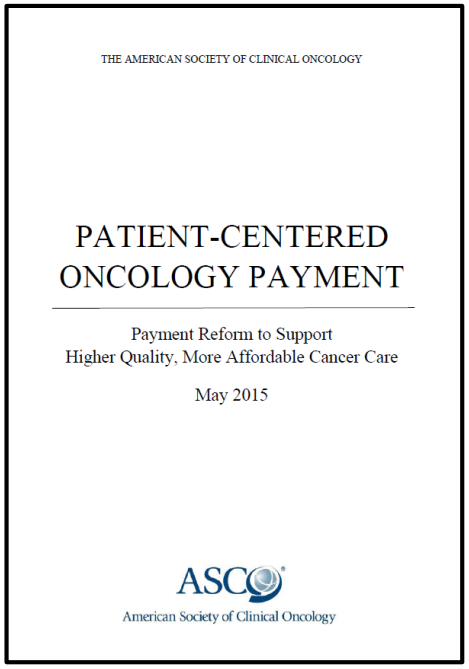
Medicare and Health Plans Define Payment to Benefit Payers → **Physicians Forced To Change Care to Align With Payment Systems** → **Patients and Physicians Can Both Lose**

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**



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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

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- 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

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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

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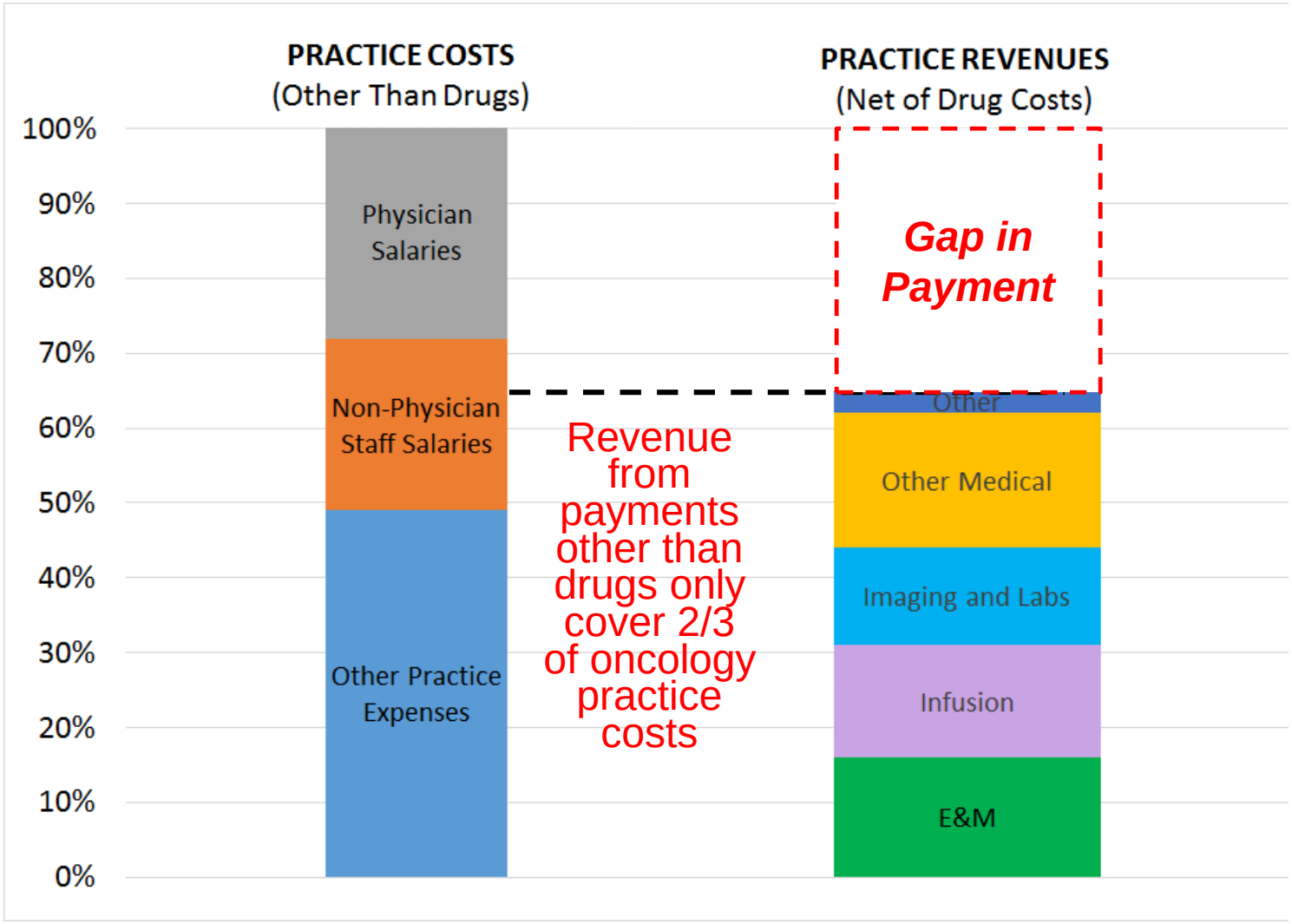
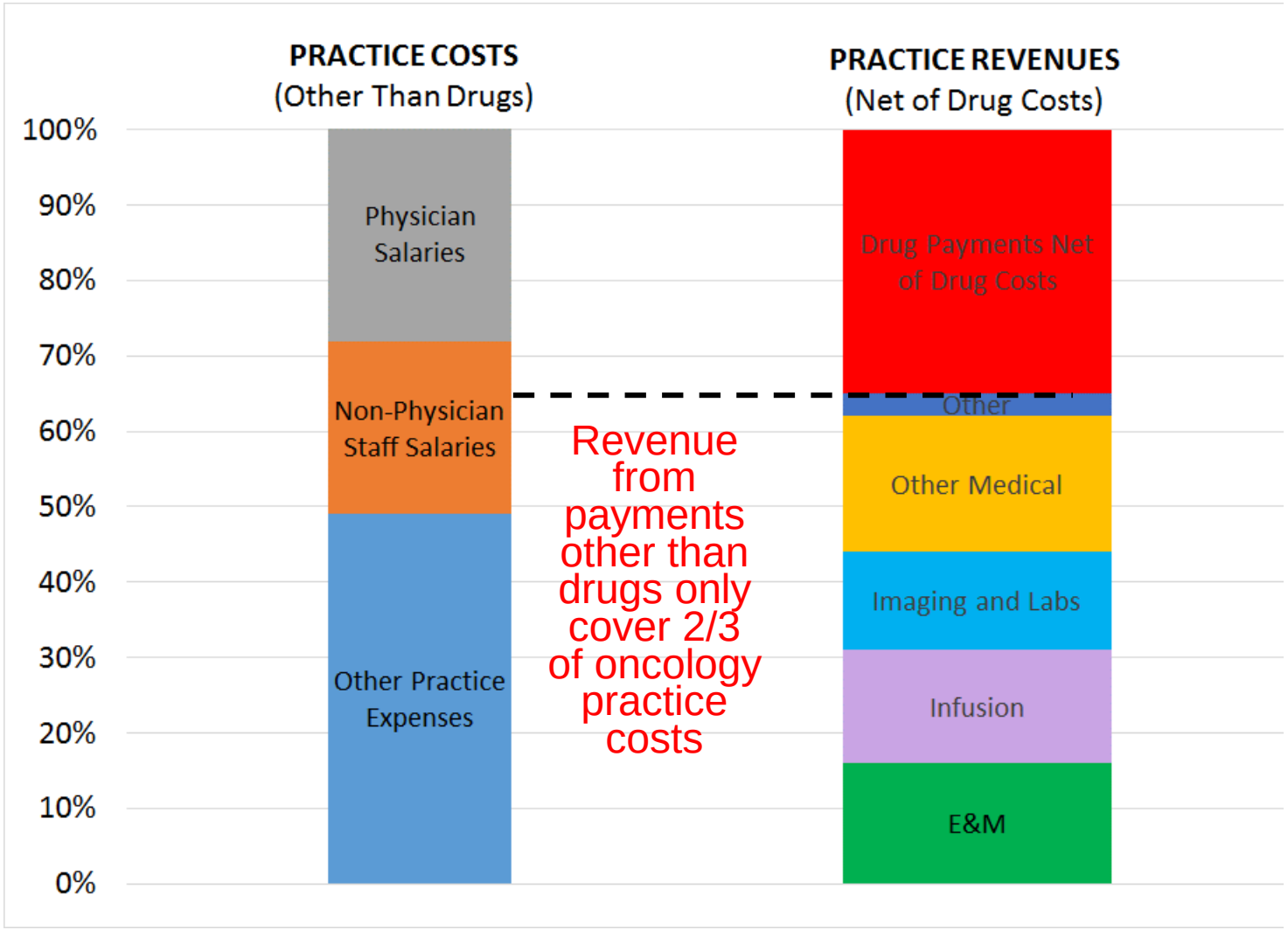
Current Service Payments Fall Far Short of Practice Costs



SOURCE:
Towle EL, Barr TR, Senese JL, "The National Practice Benchmark for Oncology, 2014 Report on 2013 Data" *Journal of Oncology Practice* November 2014

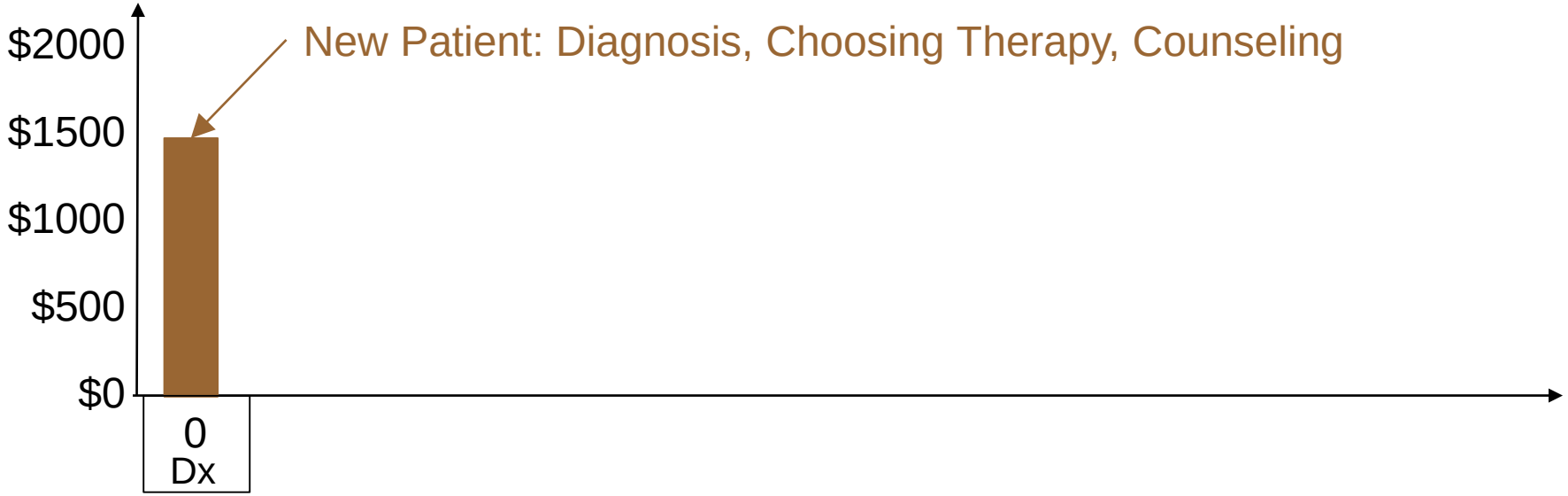
Without Drug Margins, Oncology Practices Couldn't Stay Afloat



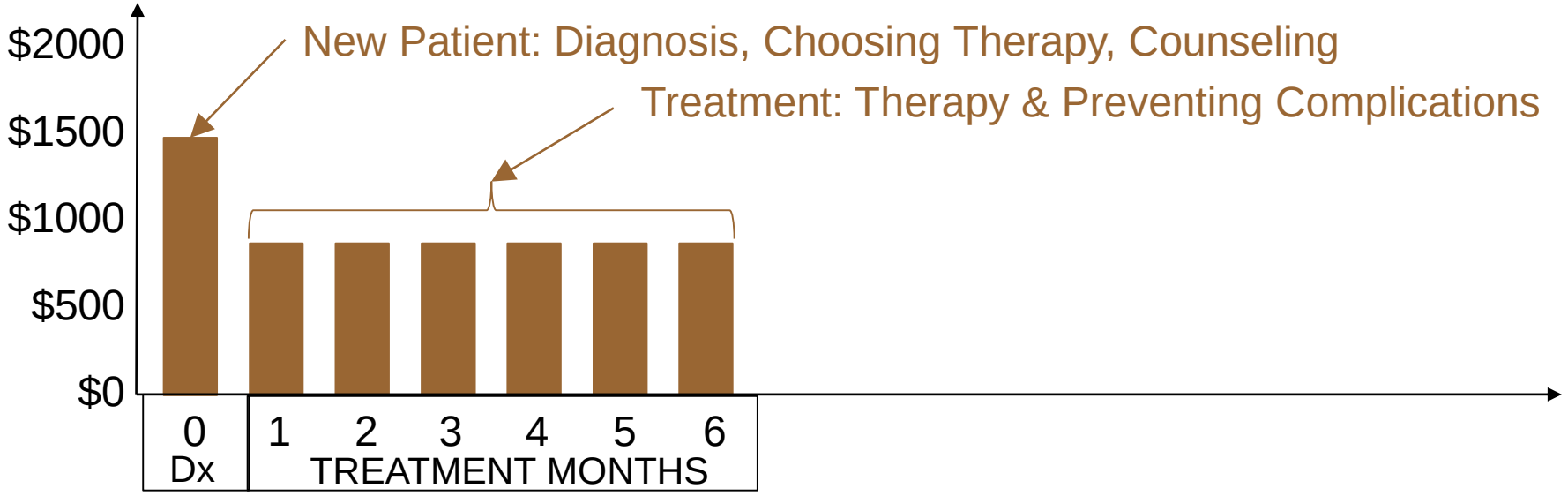
SOURCE:
Towle EL, Barr TR, Senese JL, "The National Practice Benchmark for Oncology, 2014 Report on 2013 Data" *Journal of Oncology Practice* November 2014

Payments Are Also Poorly Aligned to Phases of Cancer Care

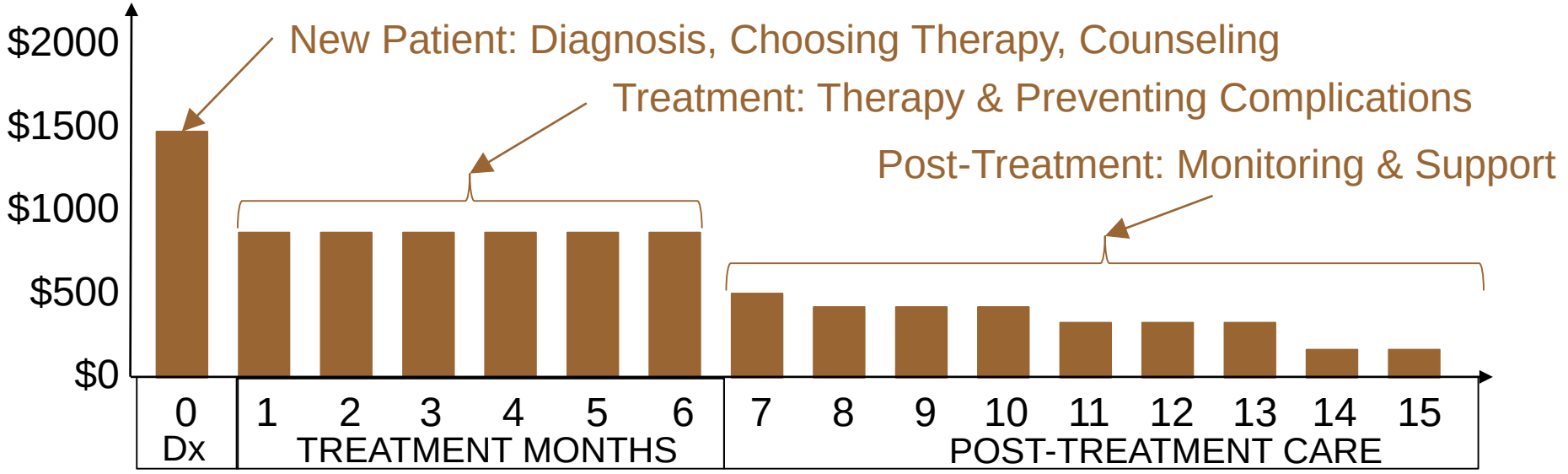
Today: Many Hours in Diagnosis, Treatment Planning & Counseling



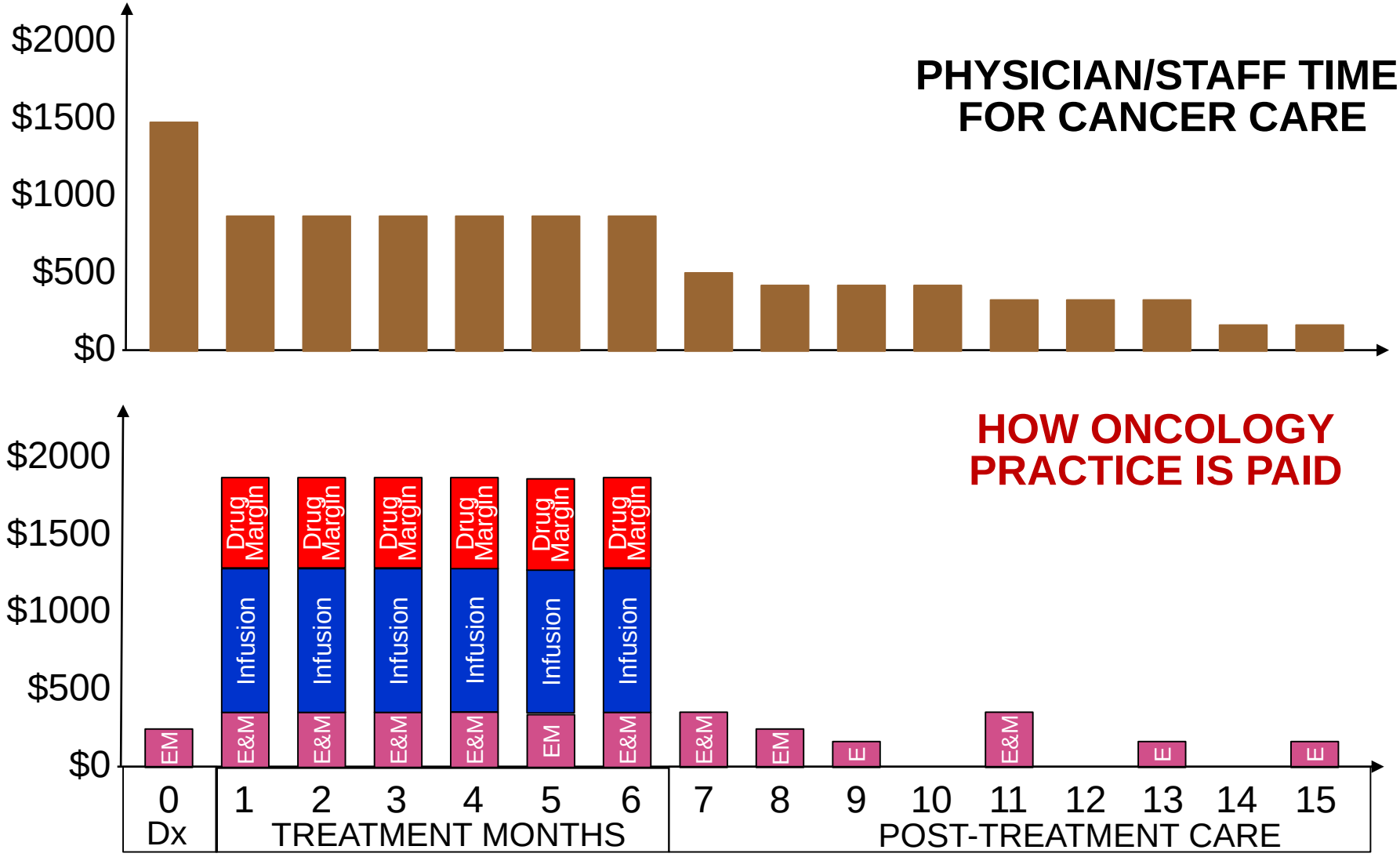
Today: Costs to Deliver Treatment & Help Avoid Complications



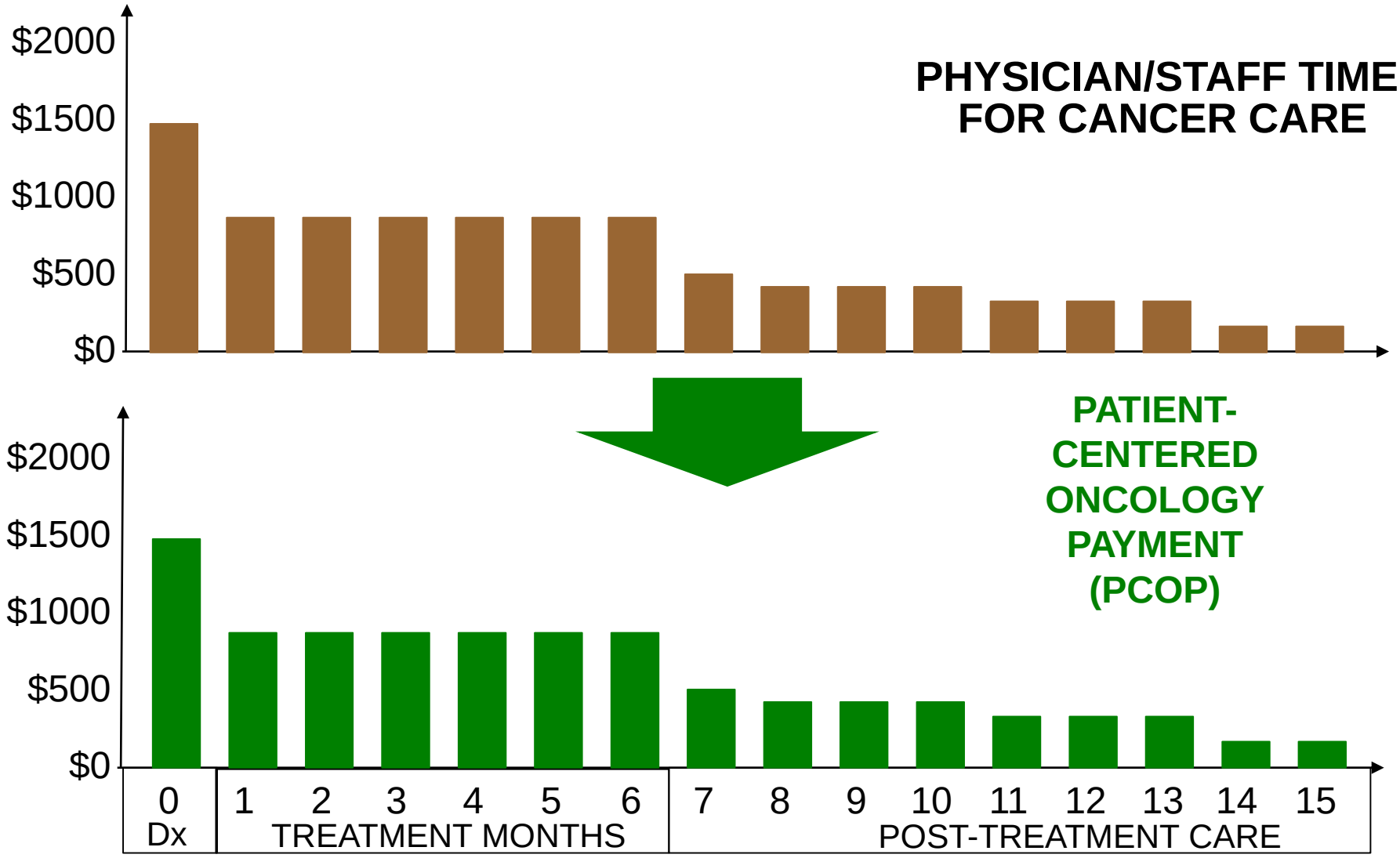
Today: Many Months of Follow-Up Monitoring & Survivorship Care



FFS: Large Payments for Infusions, Inadequate Payment Before & After



Goal of ASCO's PCOP Proposal is to Better Match Payment to Services



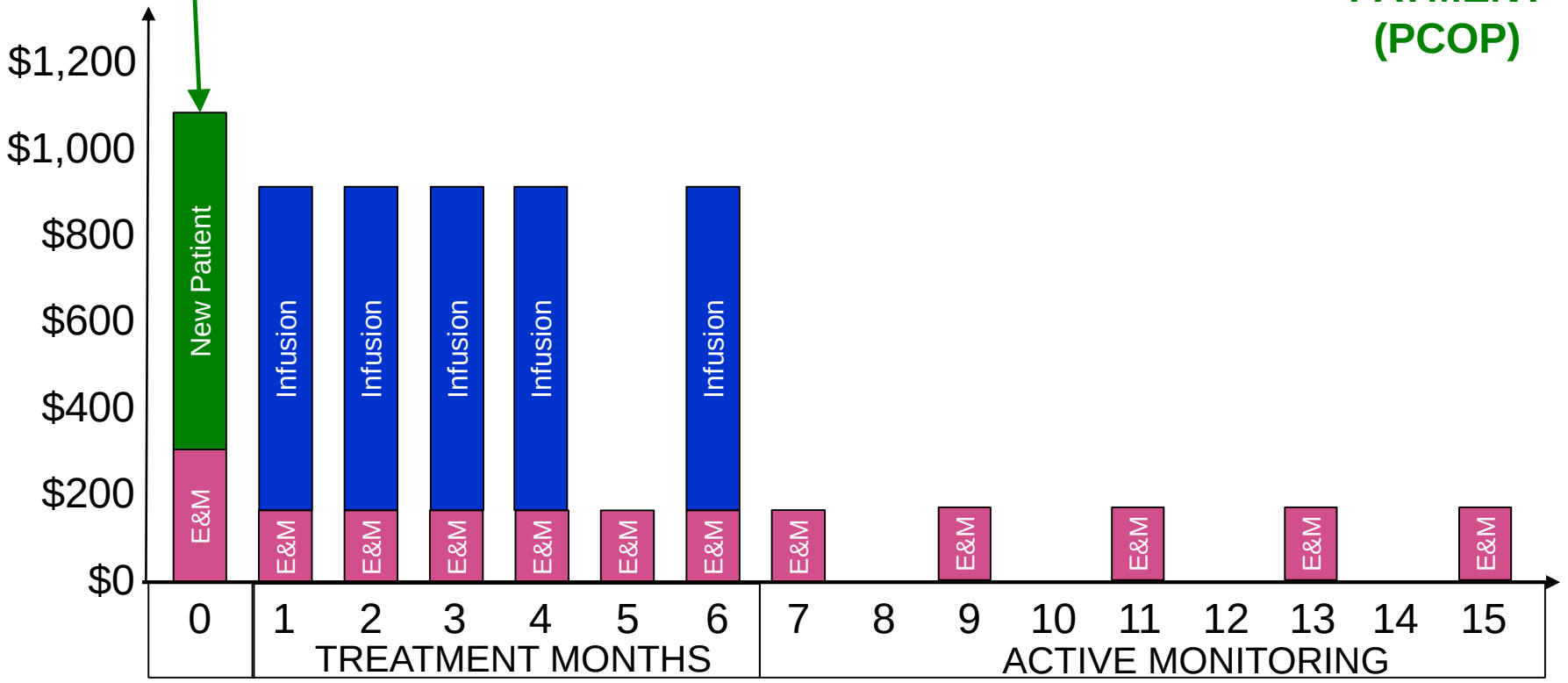
Start With Existing FFS Payments

PATIENT-CENTERED ONCOLOGY PAYMENT (PCOP)

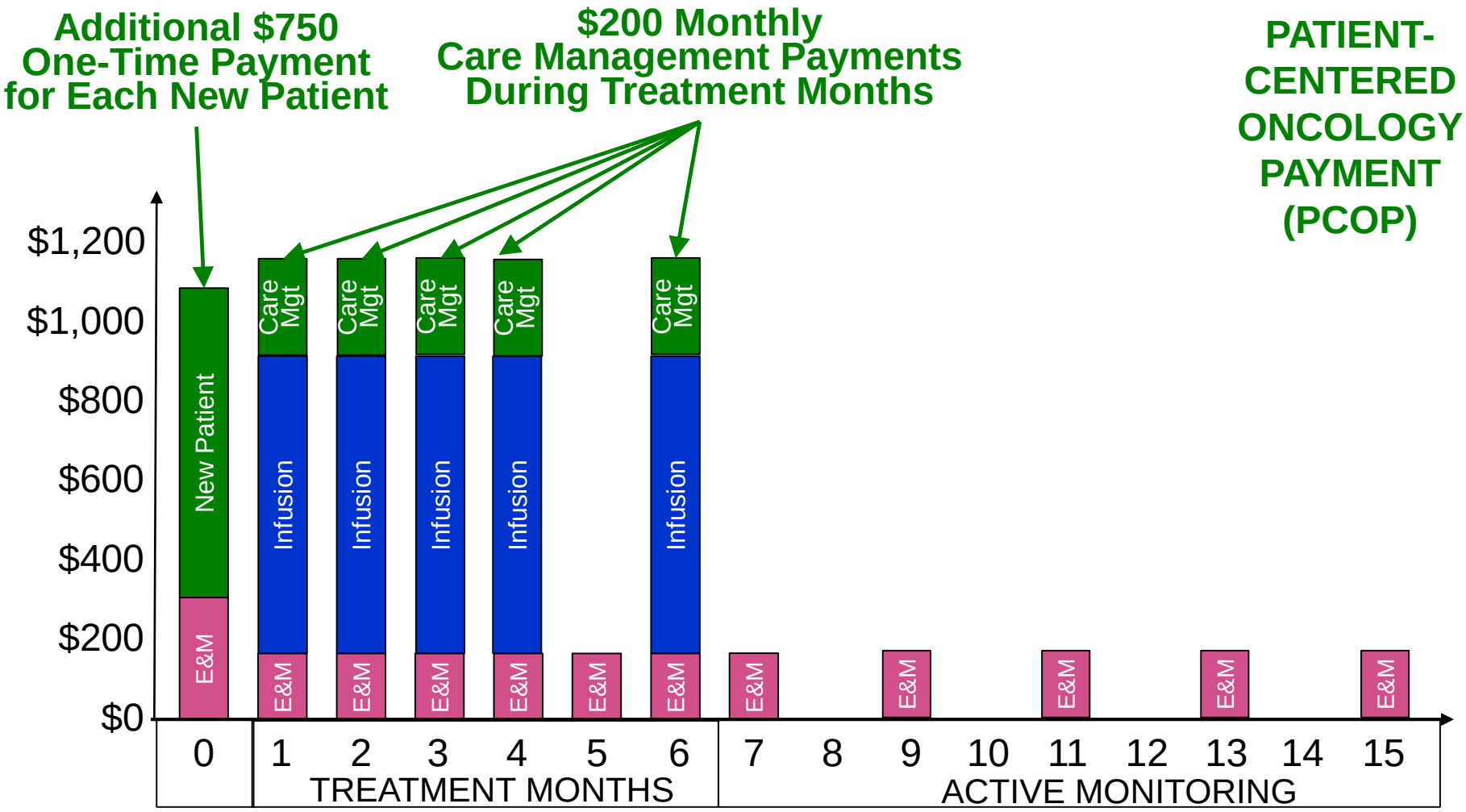
+1. Significant New Payment During Crucial Planning Stage

Additional $750 One-Time Payment for Each New Patient

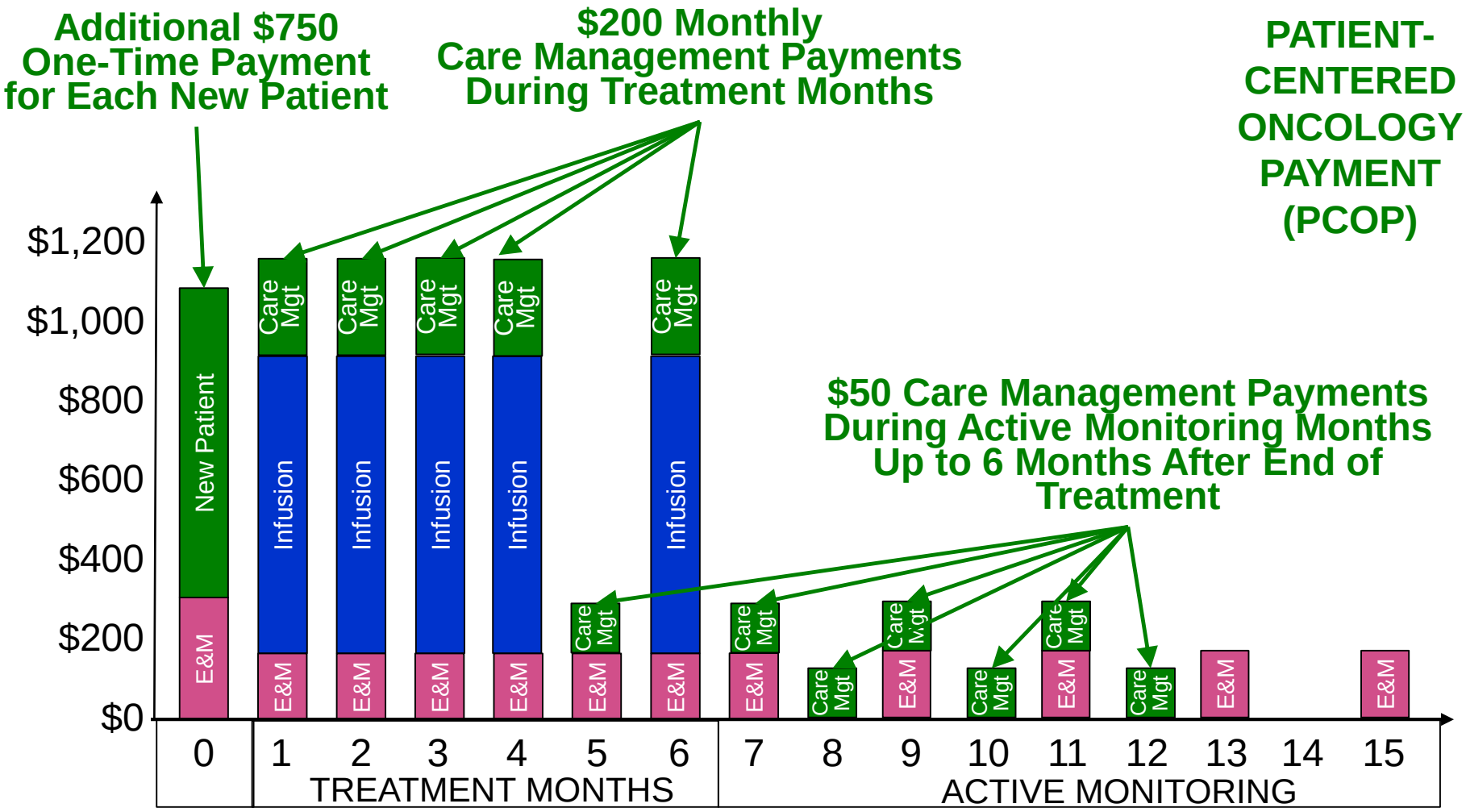
PATIENT-CENTERED ONCOLOGY PAYMENT (PCOP)



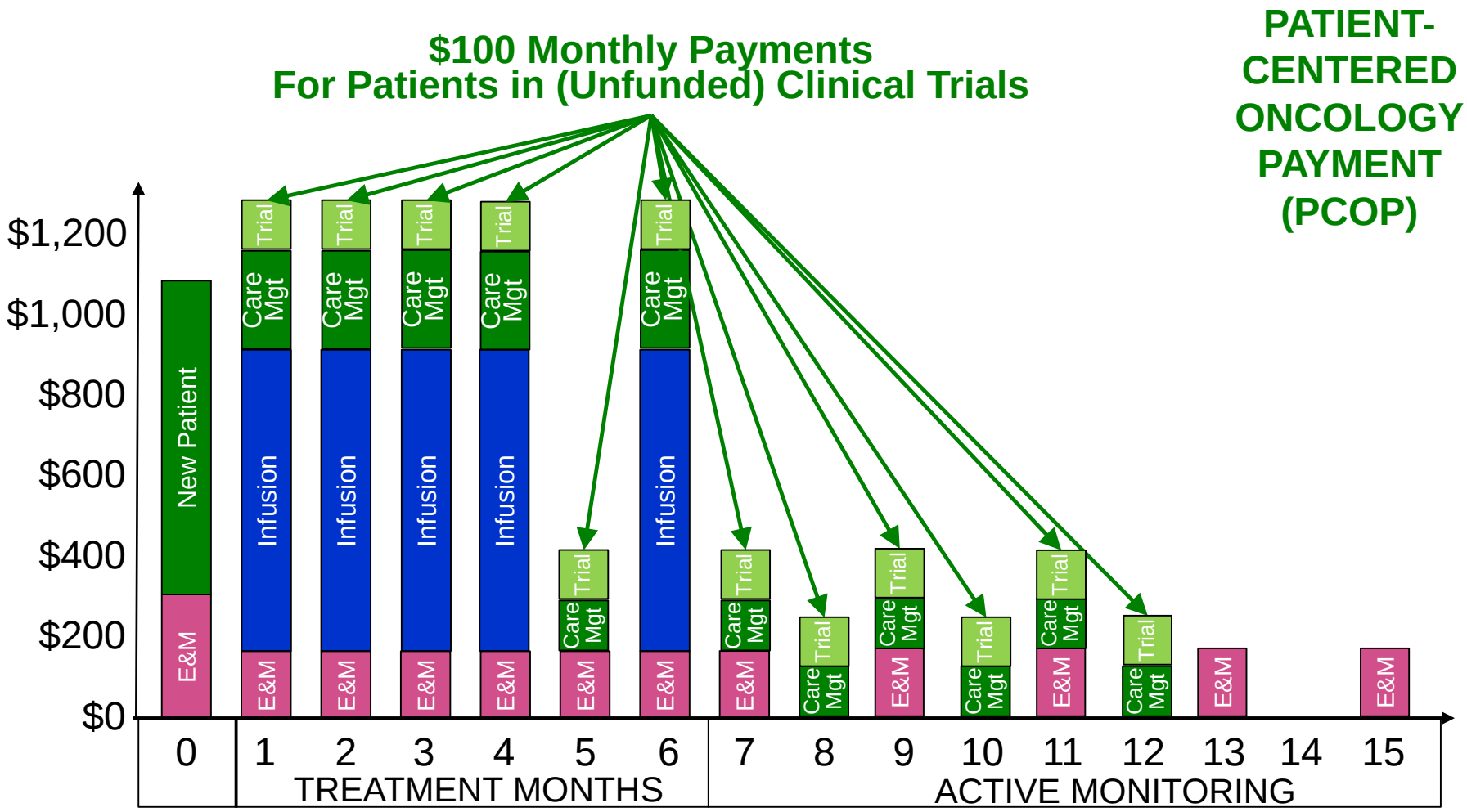
+2. Flexible Care Management Payments During Treatment



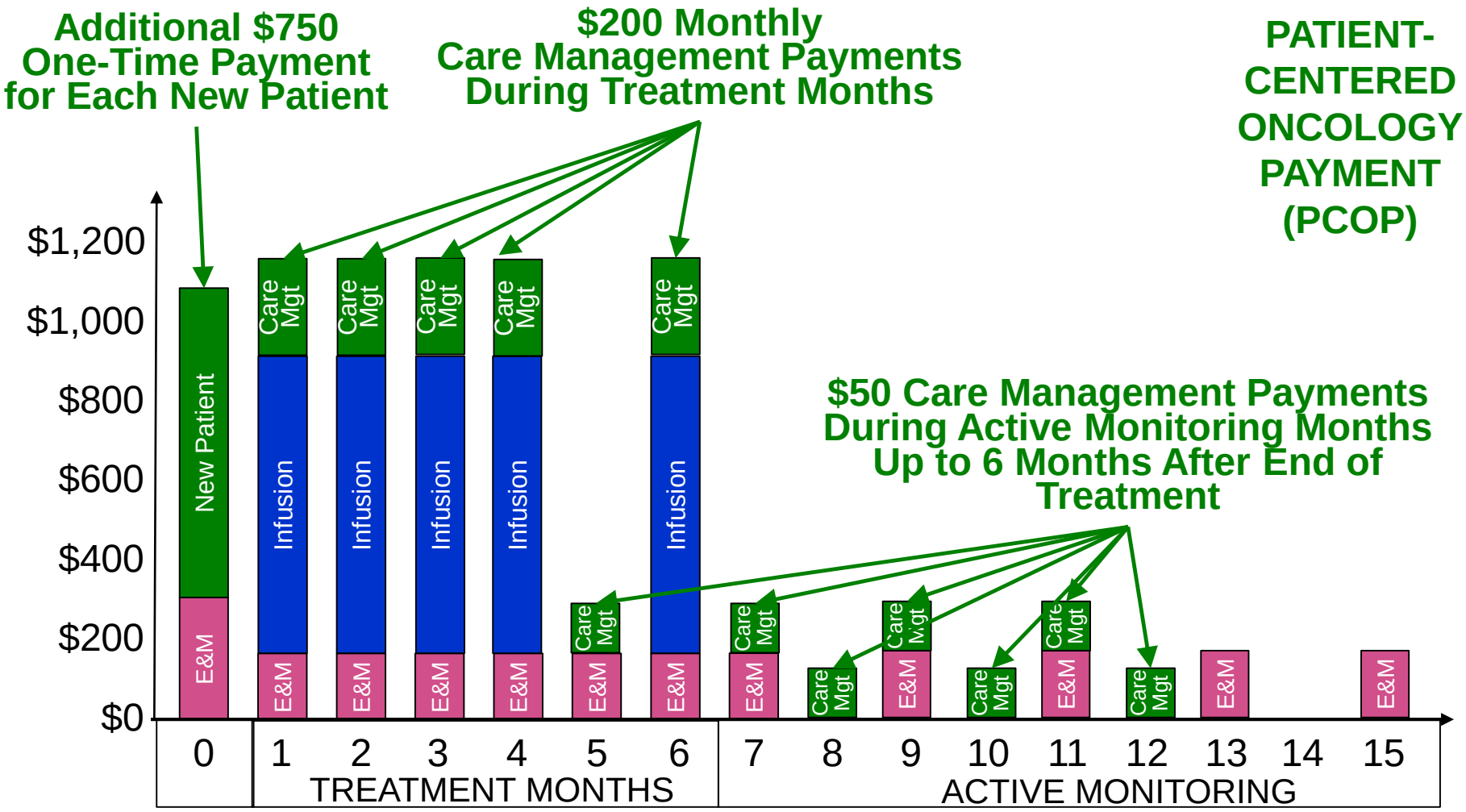
+3. Continued Smaller Care Mgt Payments After Treatment Ends



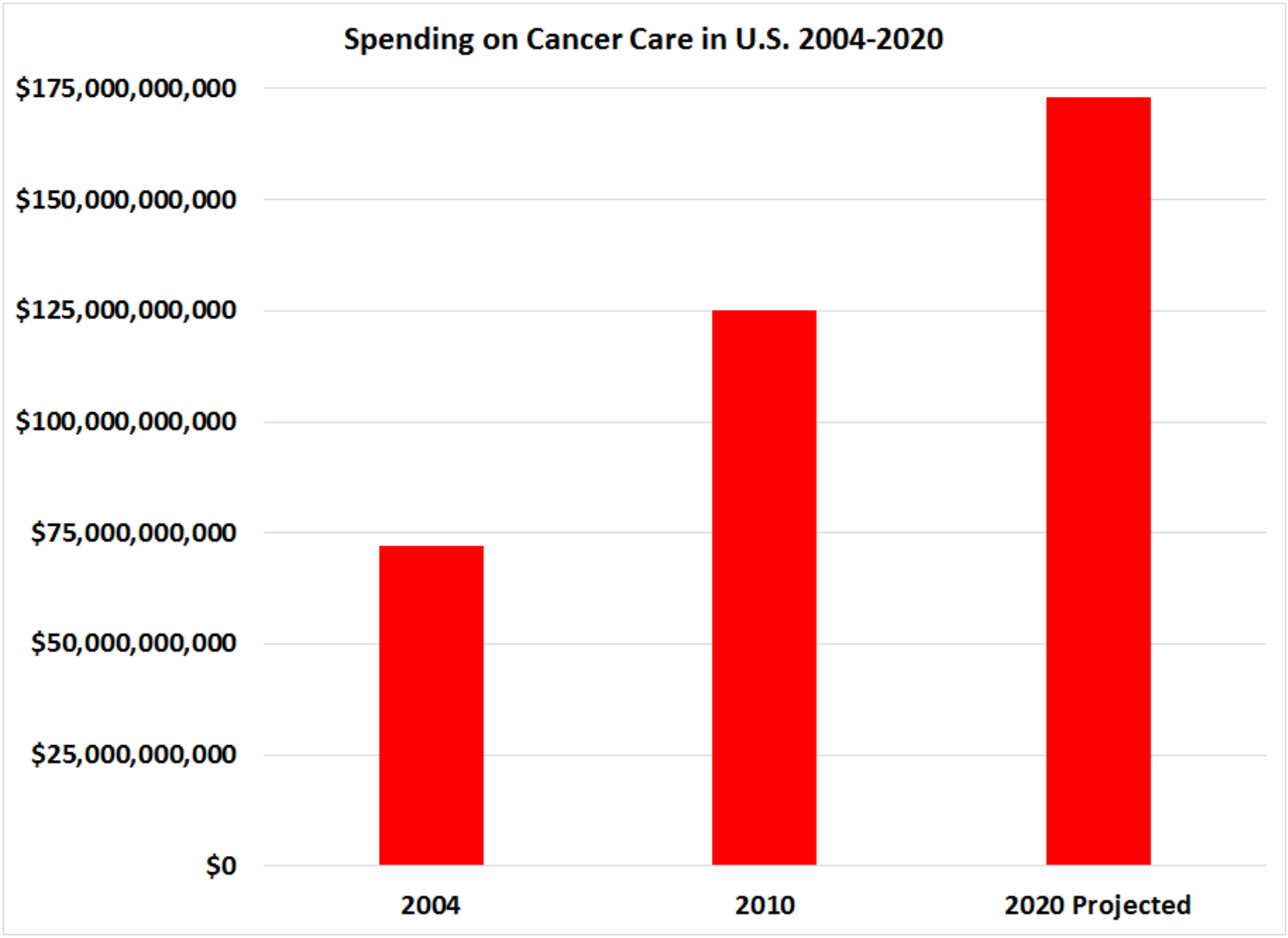
+4. Payment for Patients on Unfunded Clinical Trials



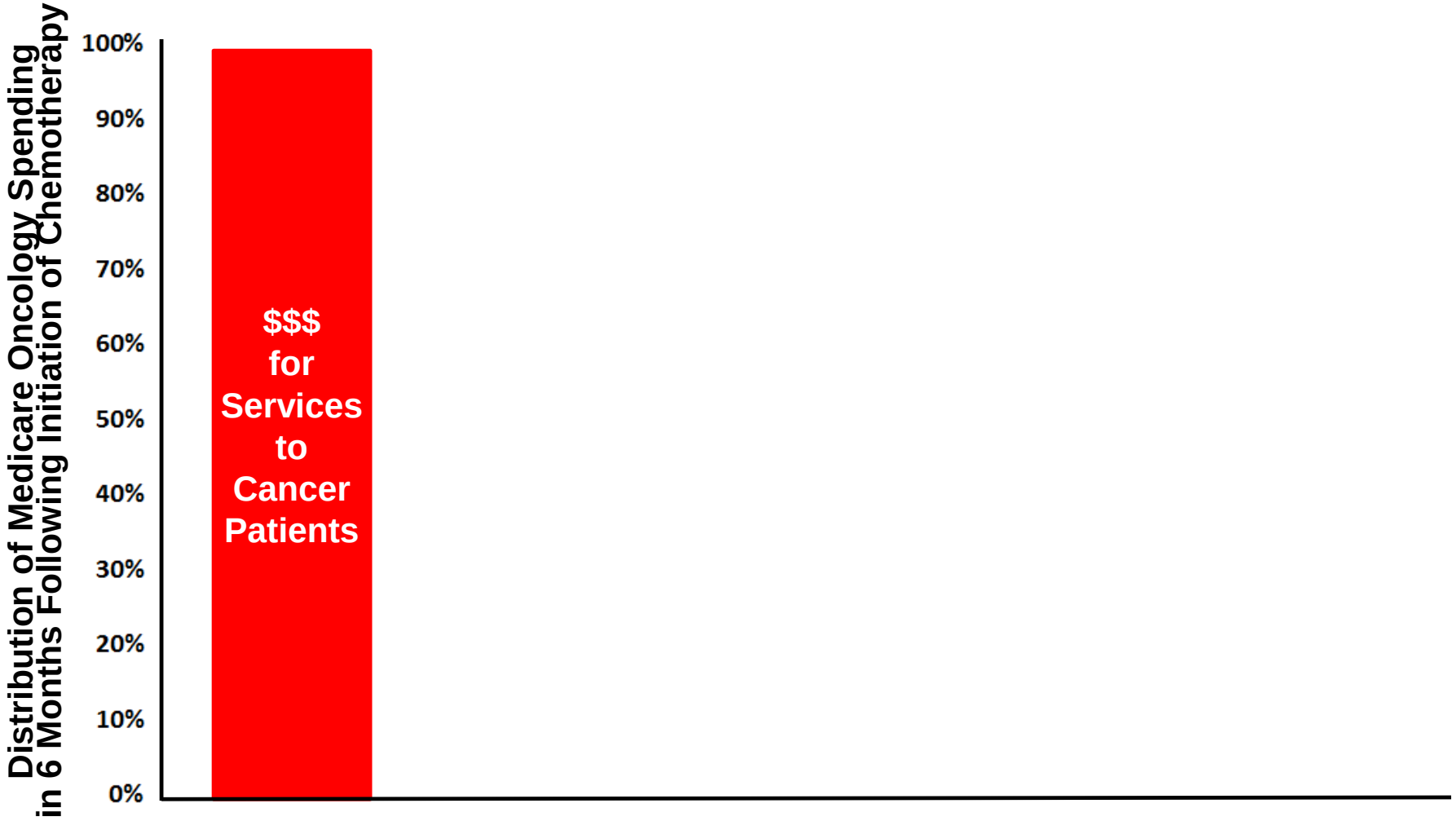
~$2,100/patient more from PCOP; 50% Increase from FFS Today



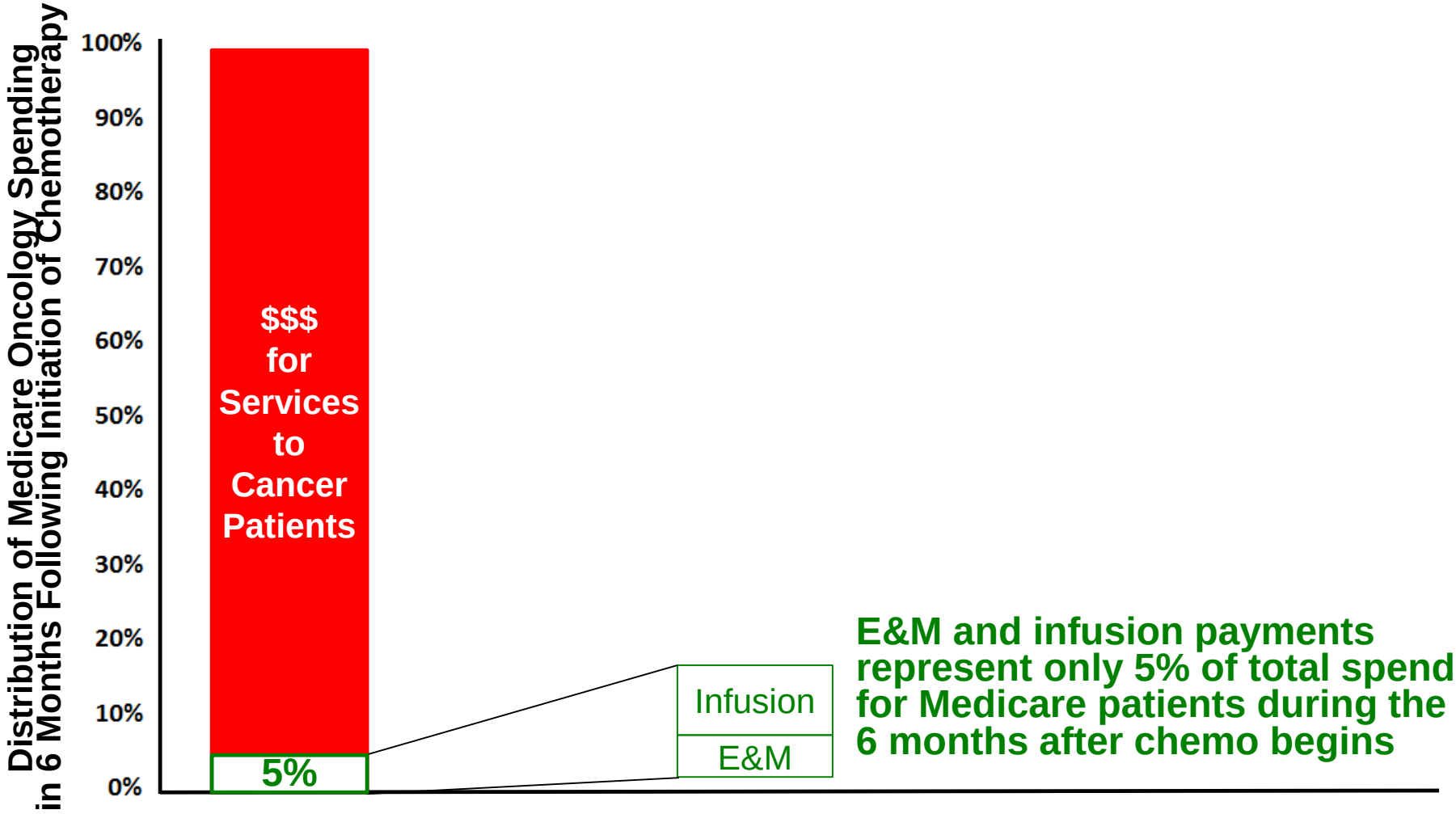
Can We Afford to Pay 50% More With Cancer Costs Skyrocketing?



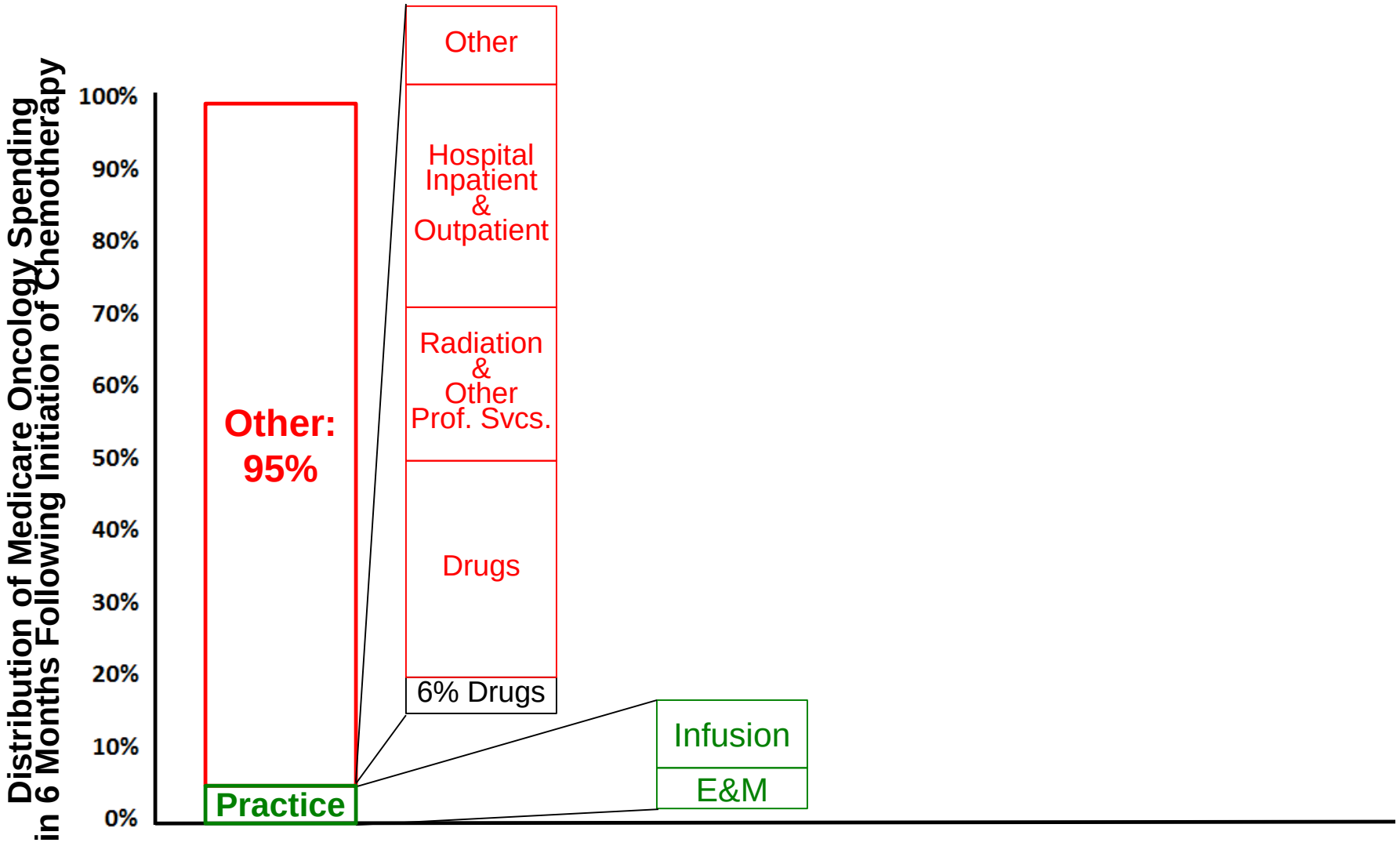
Where Does Spending on Cancer Patients Go Today?



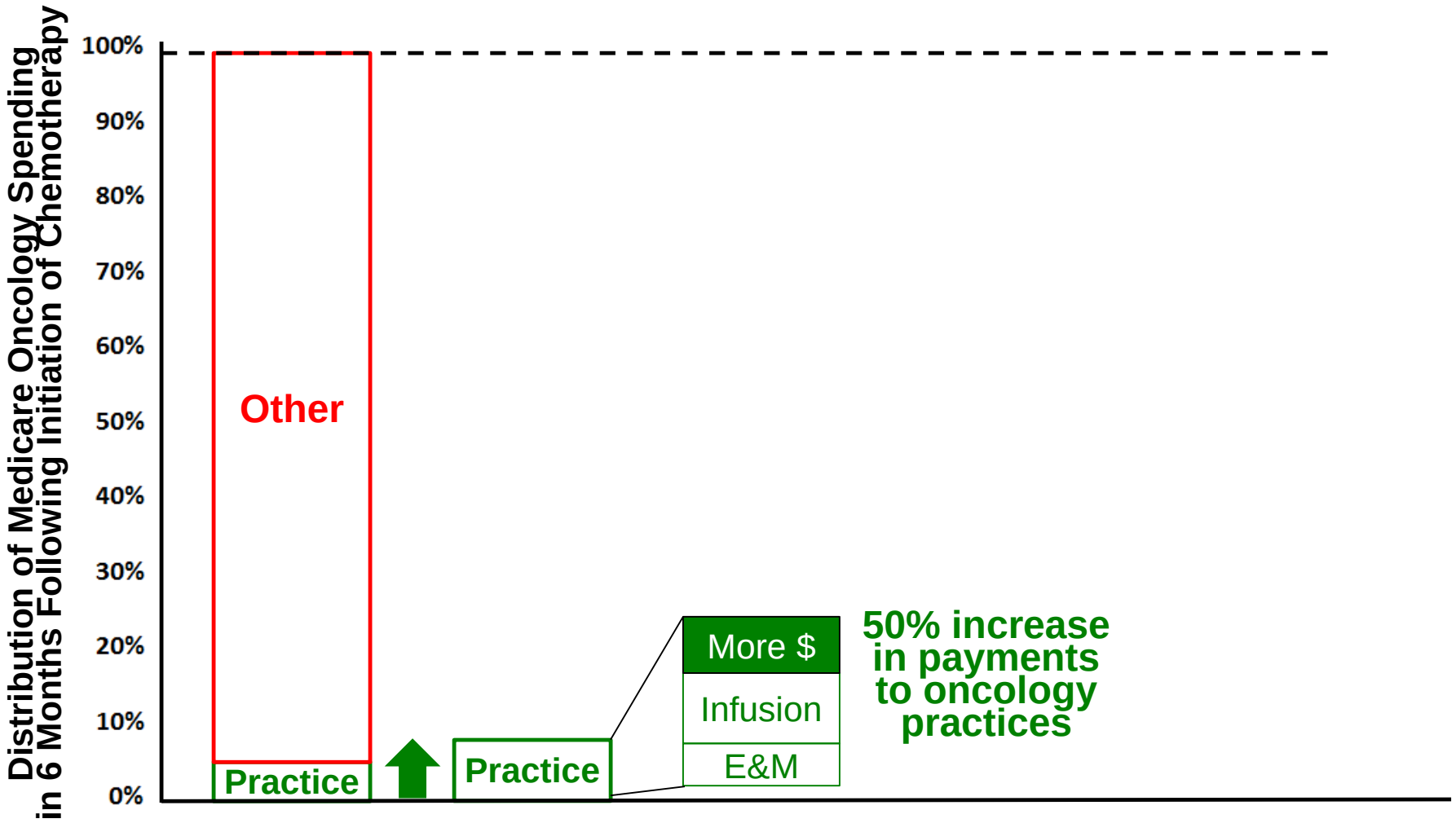
Most of the Money Does NOT Go to the Oncology Practice



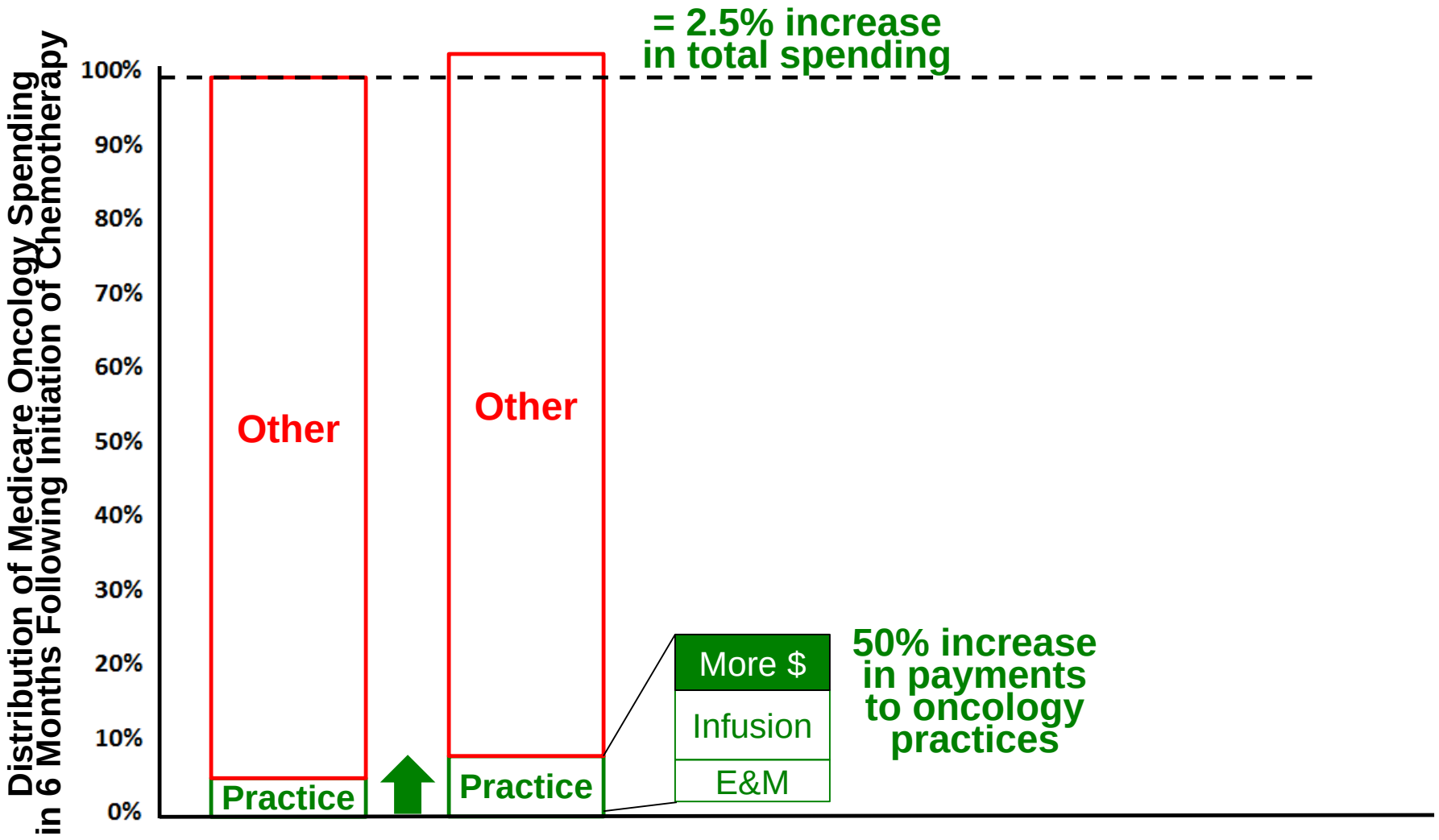
Most Money Goes to Drugs, Hospitals, and Other Services



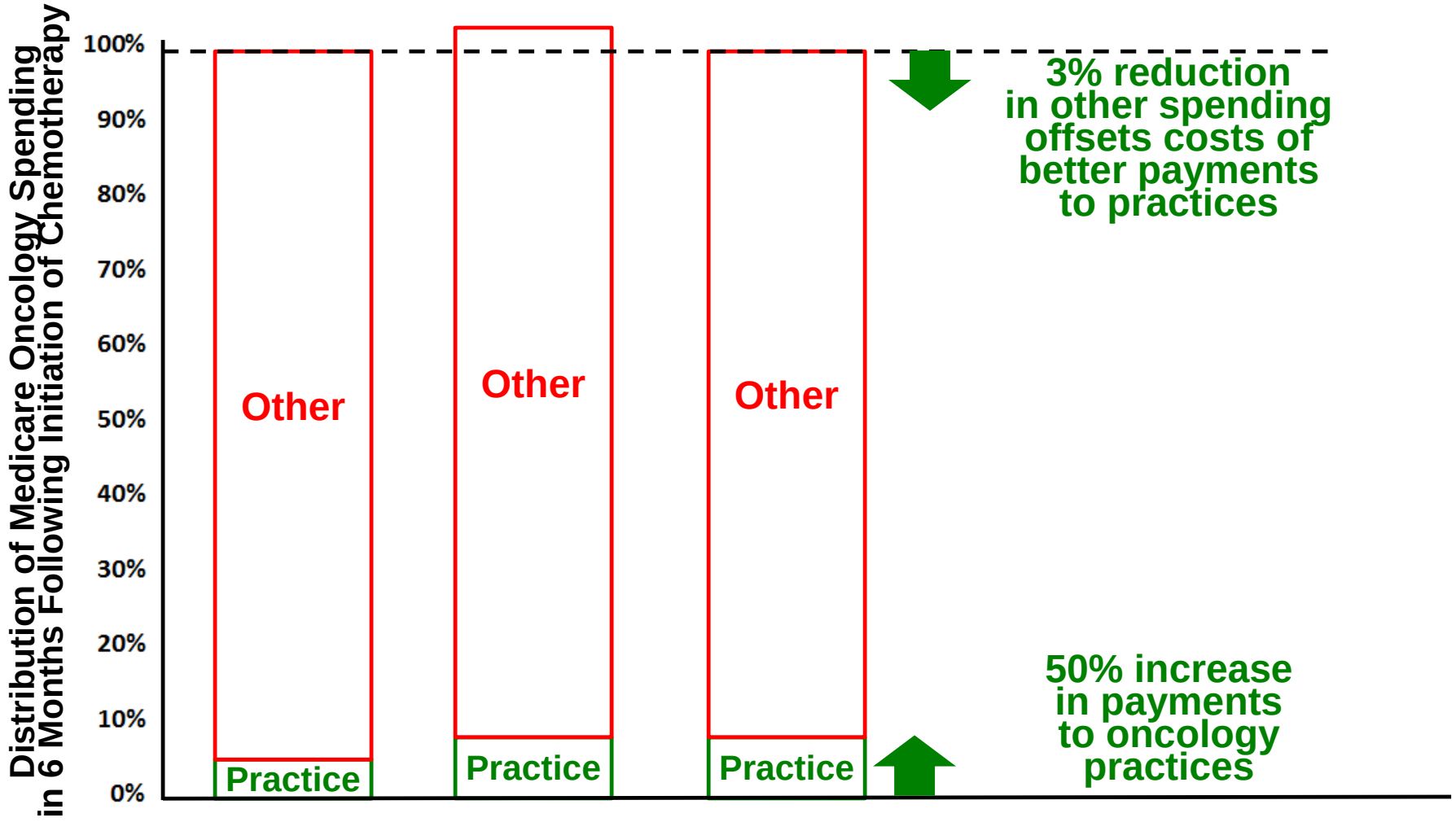
So, Even A *Big* Increase in Payments to *Oncology Practices*…



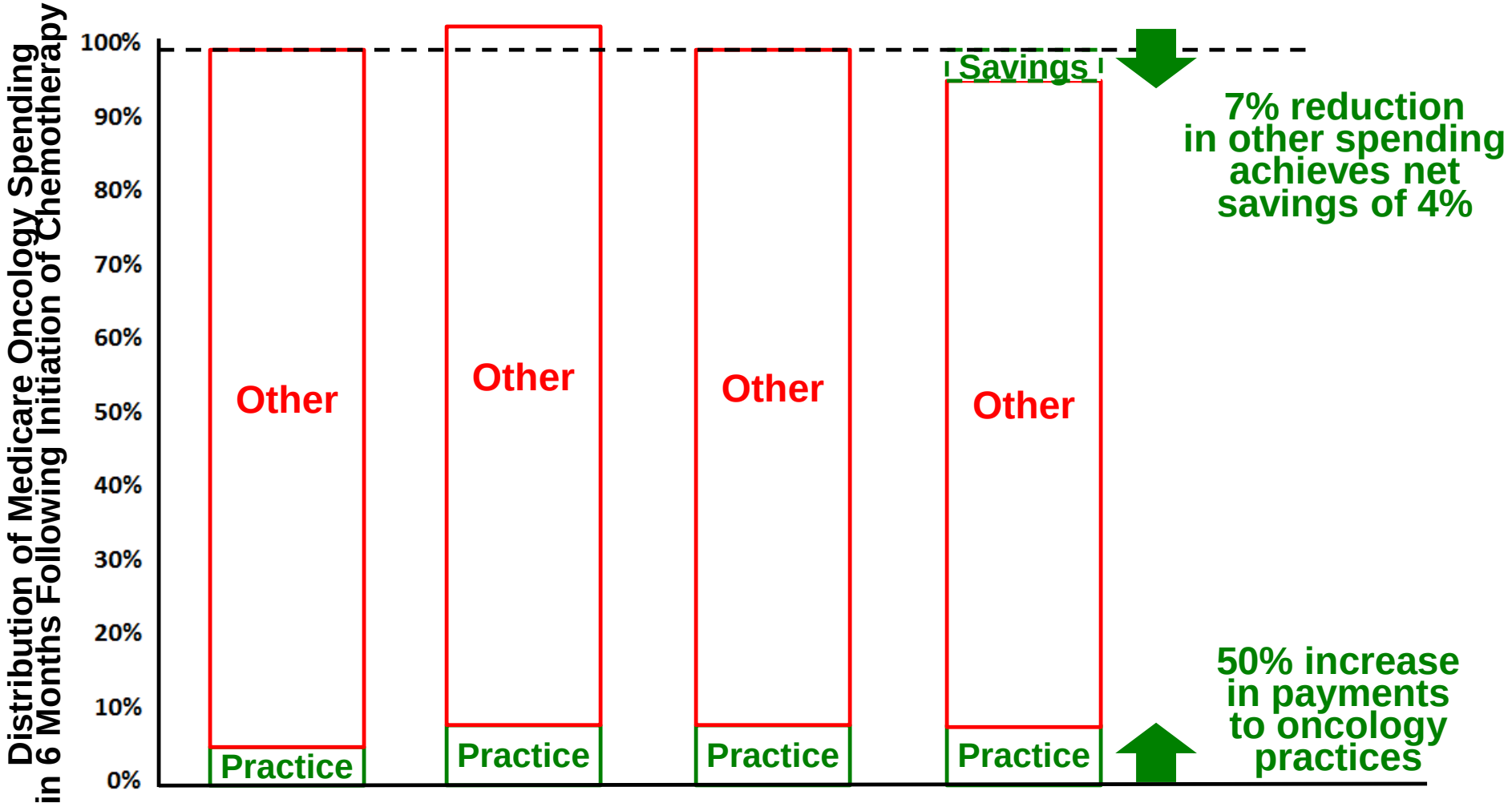
…Represents a *Small* Increase in *Total* Spending



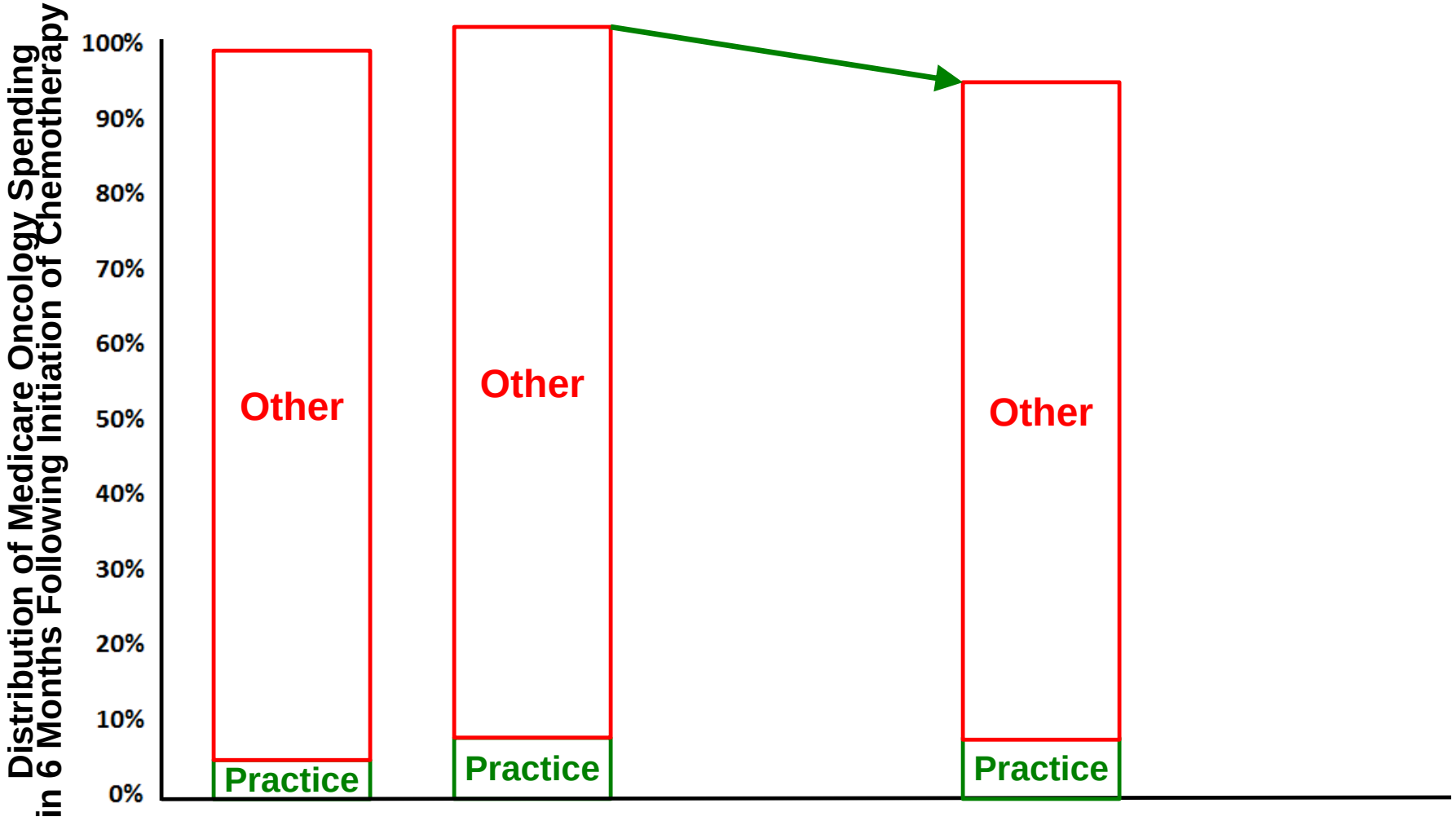
A Mere 3% Reduction in Other Spending Would Pay for This



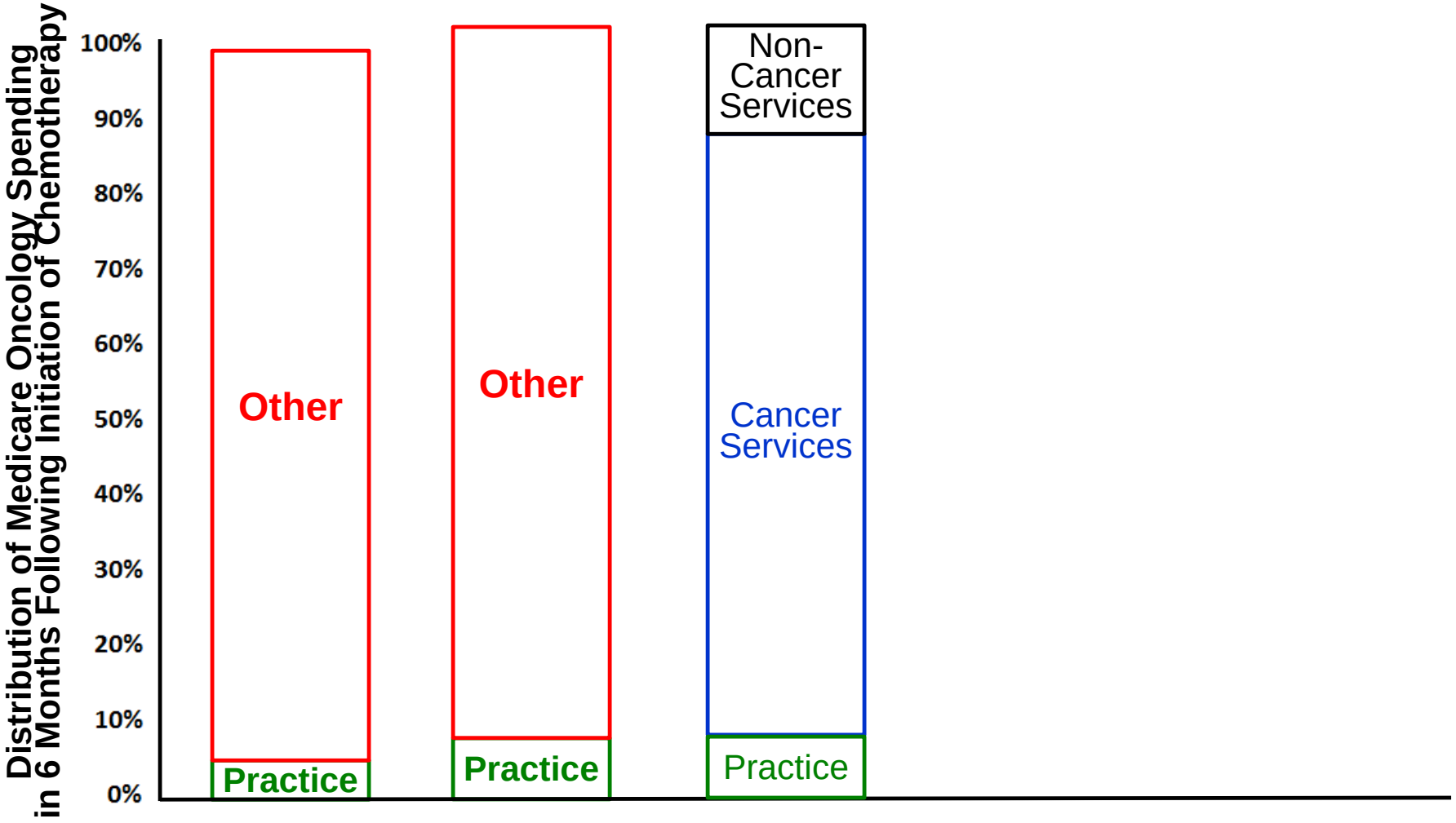
A 7% Reduction in Other Spending = 4% Net Savings



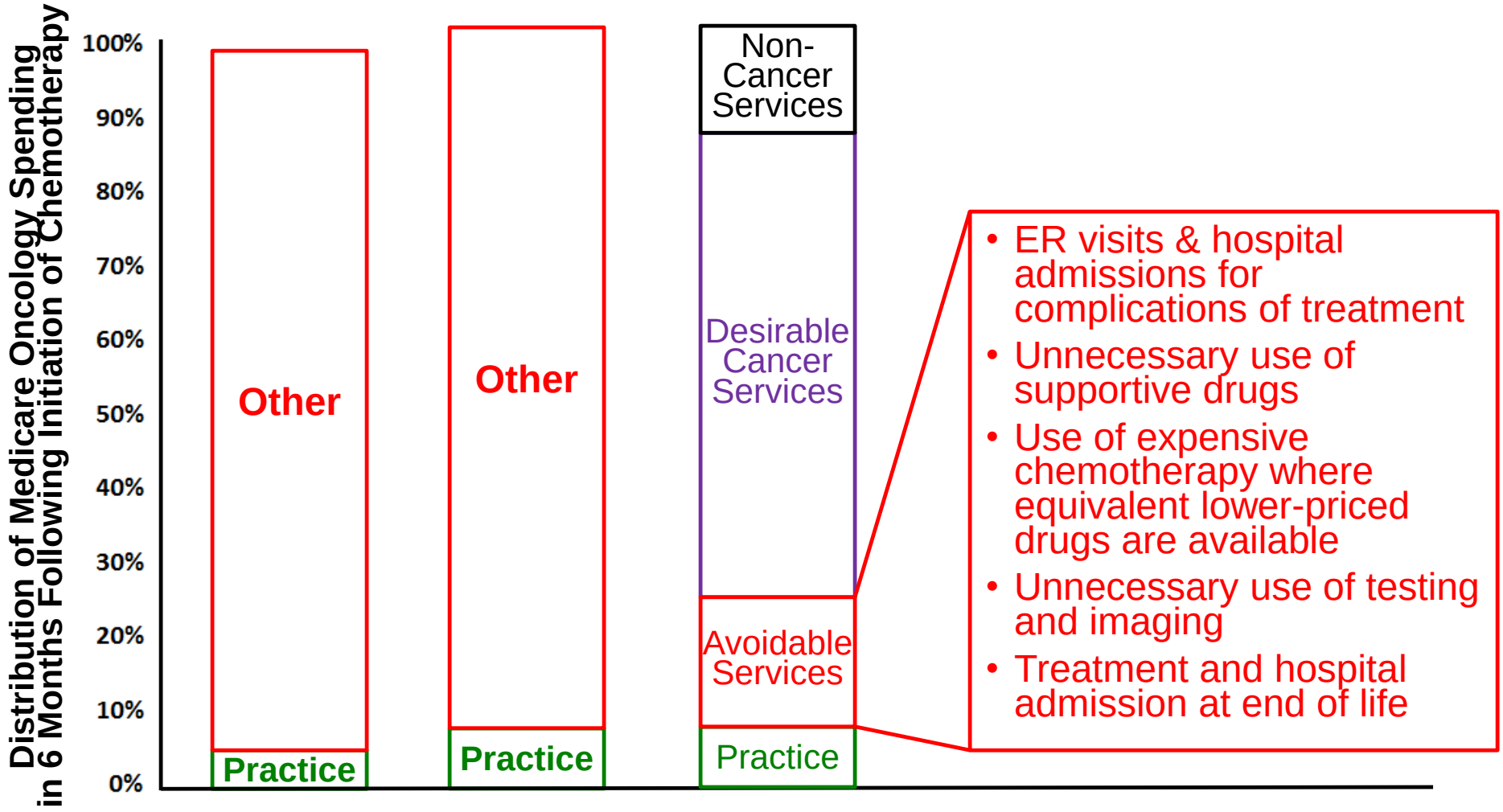
How Do You Reduce Other Spending w/o Harming Patients?



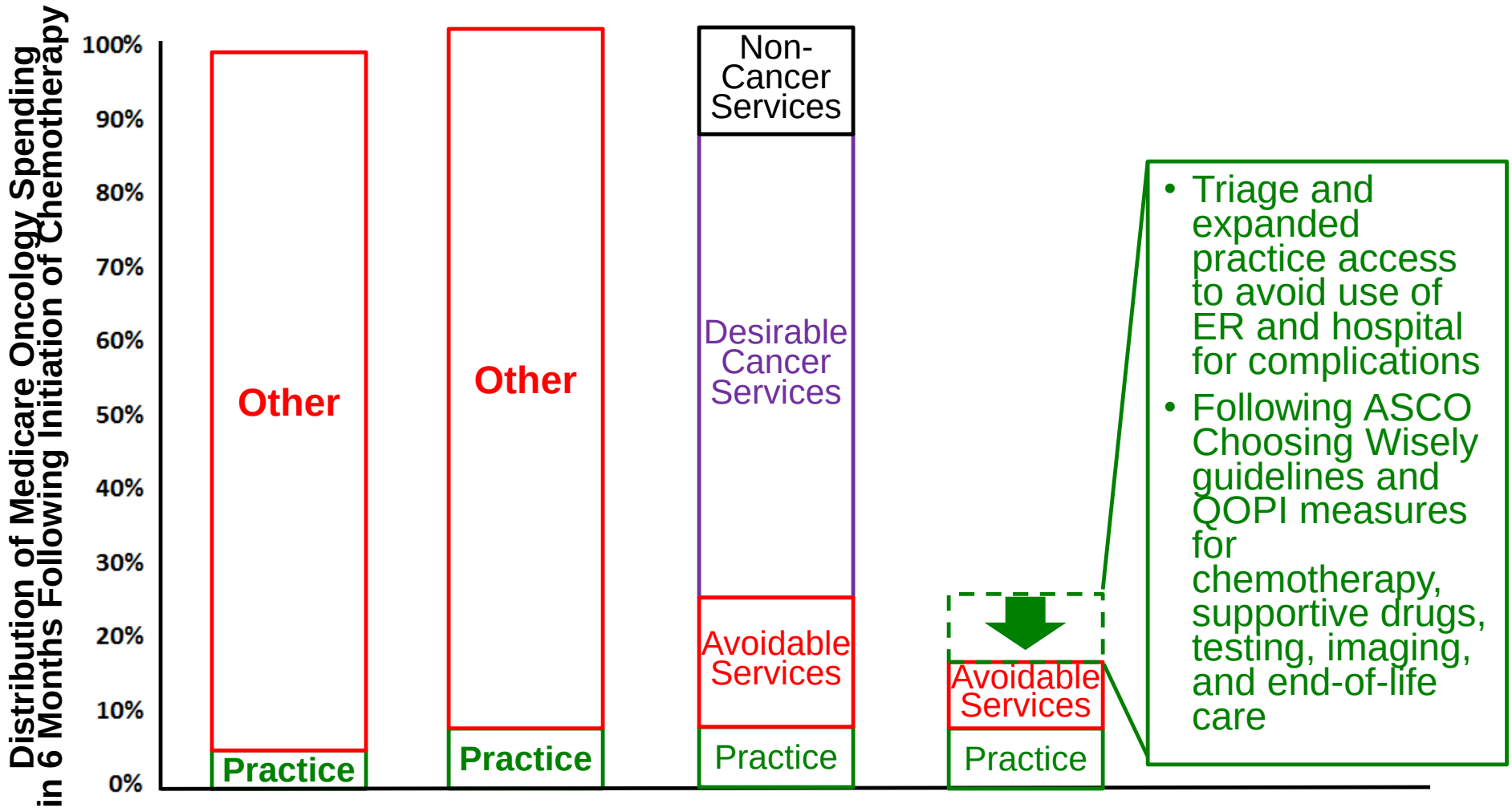
Break Down Other Spending Into *Actionable* Categories



Identify the *Avoidable* Spending on Cancer Services



PCOP Payments Enable Practices to Reduce Avoidable Services



Large Reductions in Avoidable Hospitalizations Are Possible

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

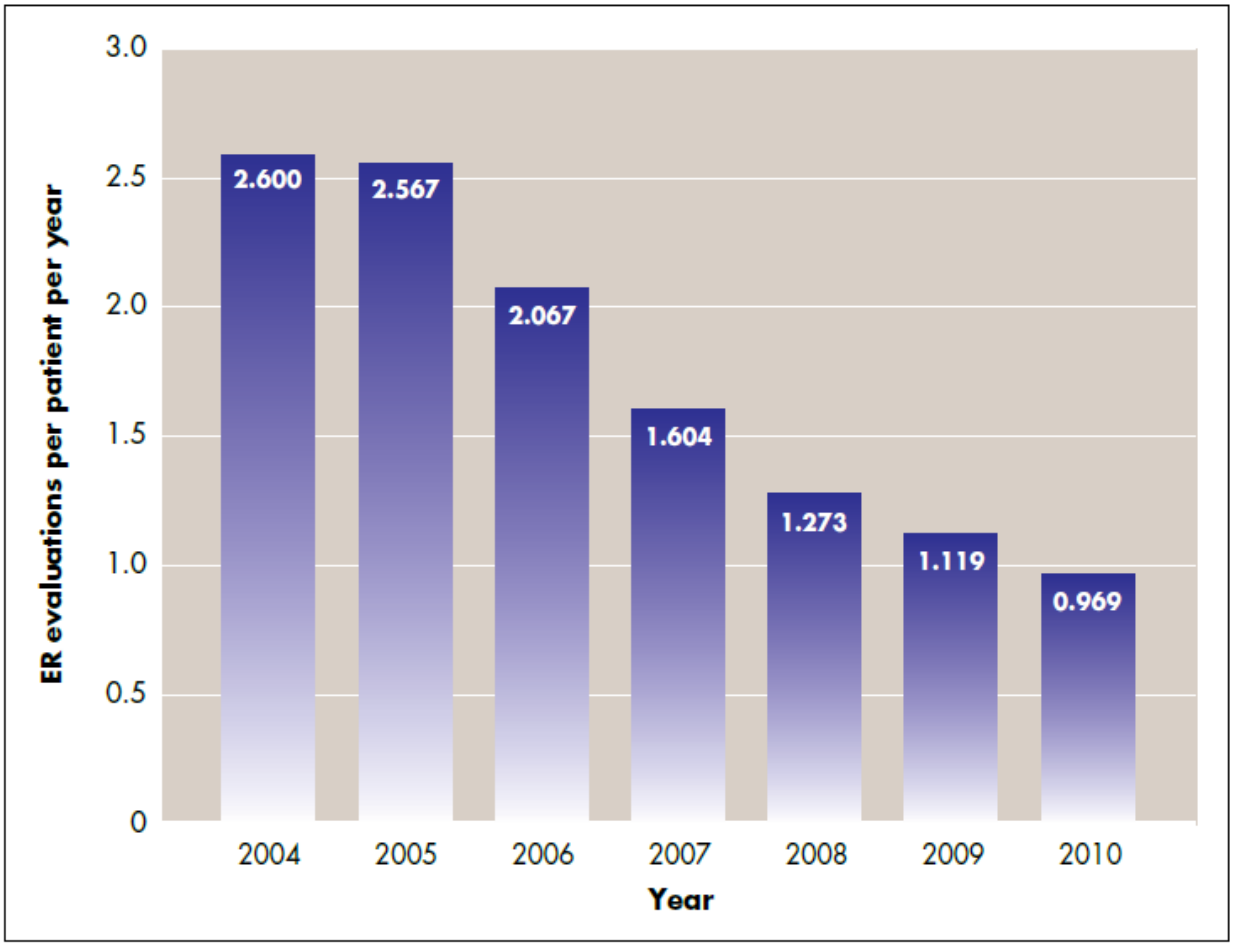
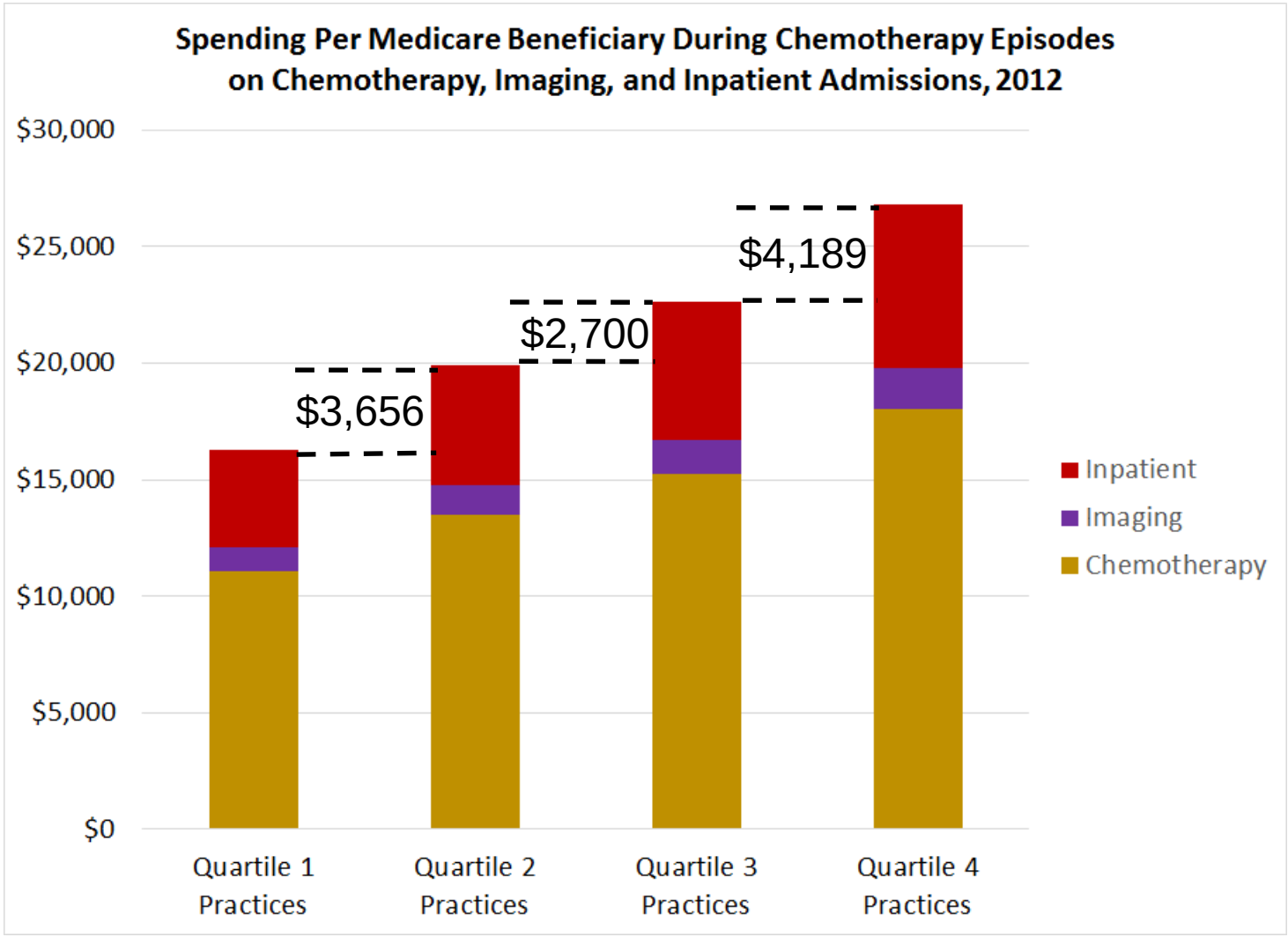


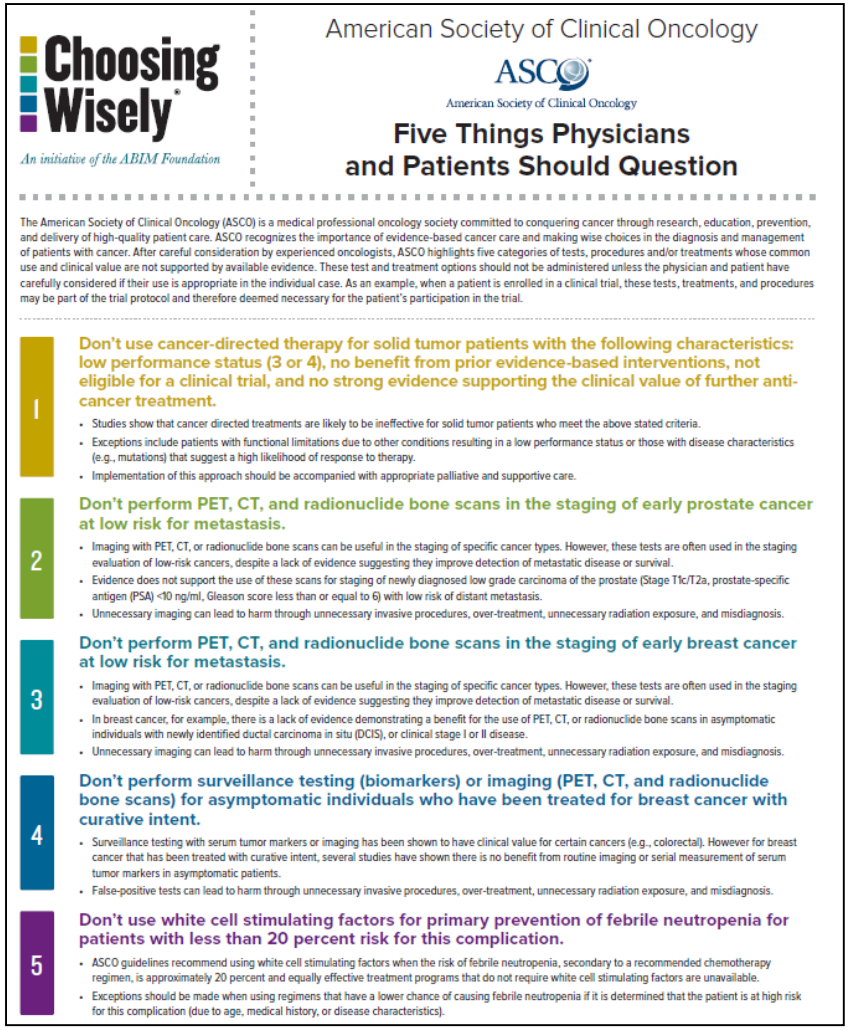
FIGURE 3 Average emergency room (ER) evaluations at Delaware County Memorial Hospital of the Drexel Hill office population per chemotherapy patient per year, 2004–2010 (YTD).

Reducing Spending Variation Would Save More Than PCOP $



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



Choosing Wisely®

An initiative of the ABIM Foundation

American Society of Clinical Oncology

ASCO

American Society of Clinical Oncology

Five Things Physicians and Patients Should Question

The American Society of Clinical Oncology (ASCO) is a medical professional oncology society committed to conquering cancer through research, education, prevention, and delivery of high-quality patient care. ASCO recognizes the importance of evidence-based cancer care and making wise choices in the diagnosis and management of patients with cancer. After careful consideration by experienced oncologists, ASCO highlights five categories of tests, procedures and/or treatments whose common use and clinical value are not supported by available evidence. These test and treatment options should not be administered unless the physician and patient have carefully considered if their use is appropriate in the individual case. As an example, when a patient is enrolled in a clinical trial, these tests, treatments, and procedures may be part of the trial protocol and therefore deemed necessary for the patient's participation in the trial.

1

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.

- Studies show that cancer directed treatments are likely to be ineffective for solid tumor patients who meet the above stated criteria.
- Exceptions include patients with functional limitations due to other conditions resulting in a low performance status or those with disease characteristics (e.g., mutations) that suggest a high likelihood of response to therapy.
- Implementation of this approach should be accompanied with appropriate palliative and supportive care.

2

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

- 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.
- Evidence does not support the use of these scans for staging of newly diagnosed low grade carcinoma of the prostate (Stage T1c/T2a, prostate-specific antigen (PSA) <10 ng/ml, Gleason score less than or equal to 6) with low risk of distant metastasis.
- Unnecessary imaging can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.

3

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

- 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.
- 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 individuals with newly identified ductal carcinoma in situ (DCIS), or clinical stage I or II disease.
- Unnecessary imaging can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.

4

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.

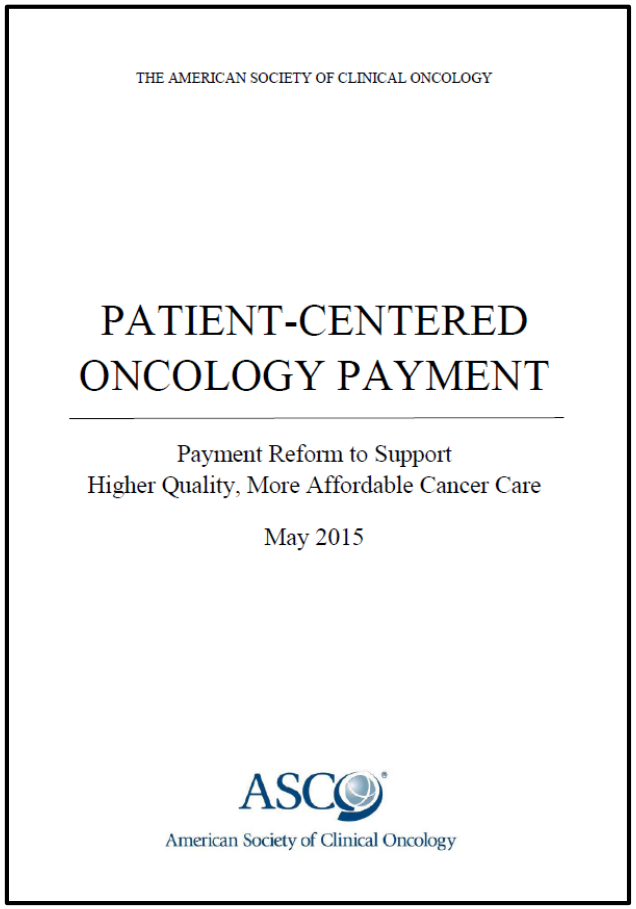
- Surveillance testing with serum tumor markers or imaging has been shown to have clinical value for certain cancers (e.g., colorectal). However for breast cancer that has been treated with curative intent, several studies have shown there is no benefit from routine imaging or serial measurement of serum tumor markers in asymptomatic patients.
- False-positive tests can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.

5

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, secondary to a recommended chemotherapy regimen, is approximately 20 percent and equally effective treatment programs that do not require white cell stimulating factors are unavailable.
- Exceptions should be made when using regimens that have a lower chance of causing febrile neutropenia if it is determined that the patient is at high risk for this complication (due to age, medical history, or disease characteristics).

Analysis of PCOP Shows Large Net Savings from Better Payment



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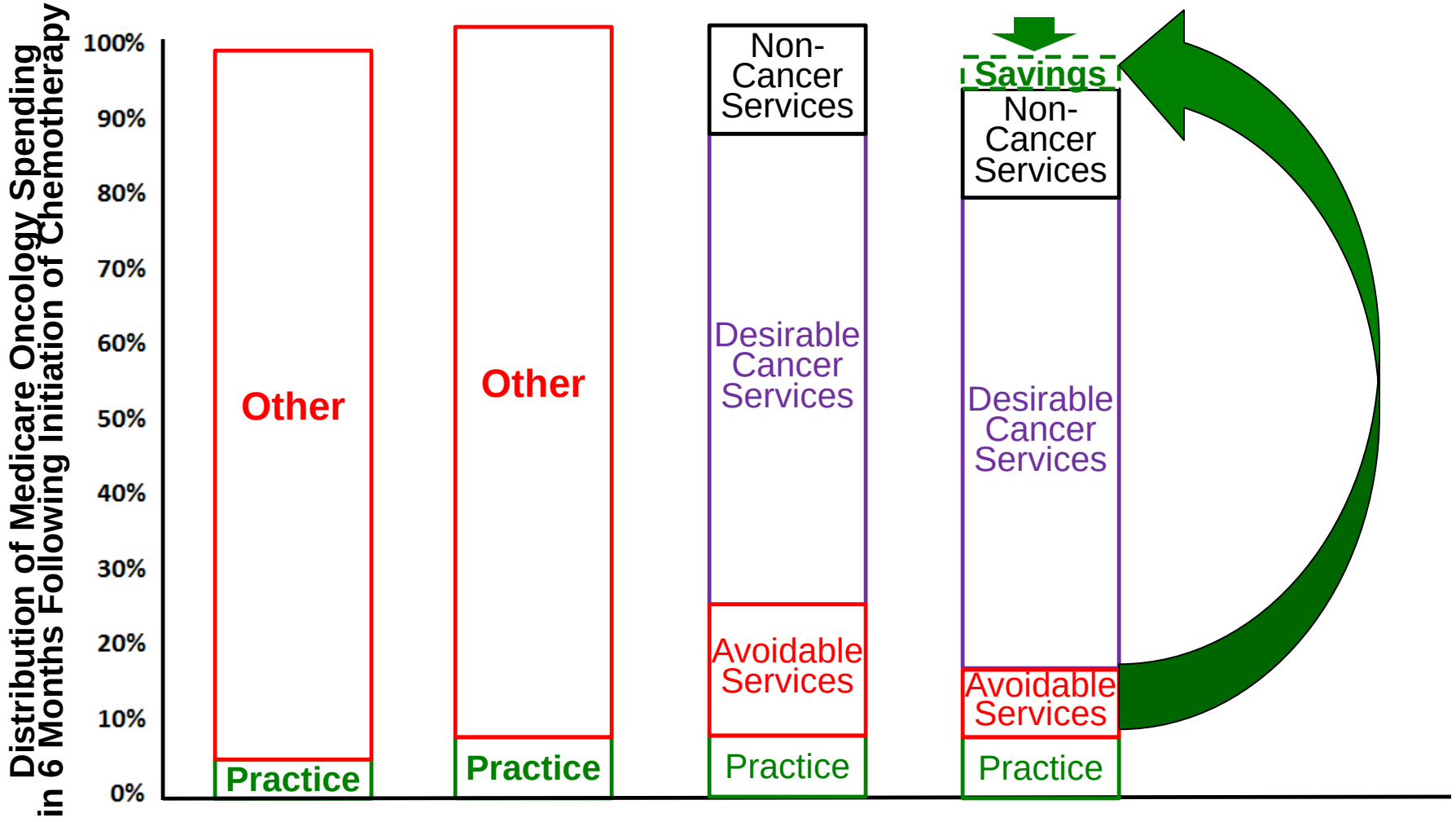
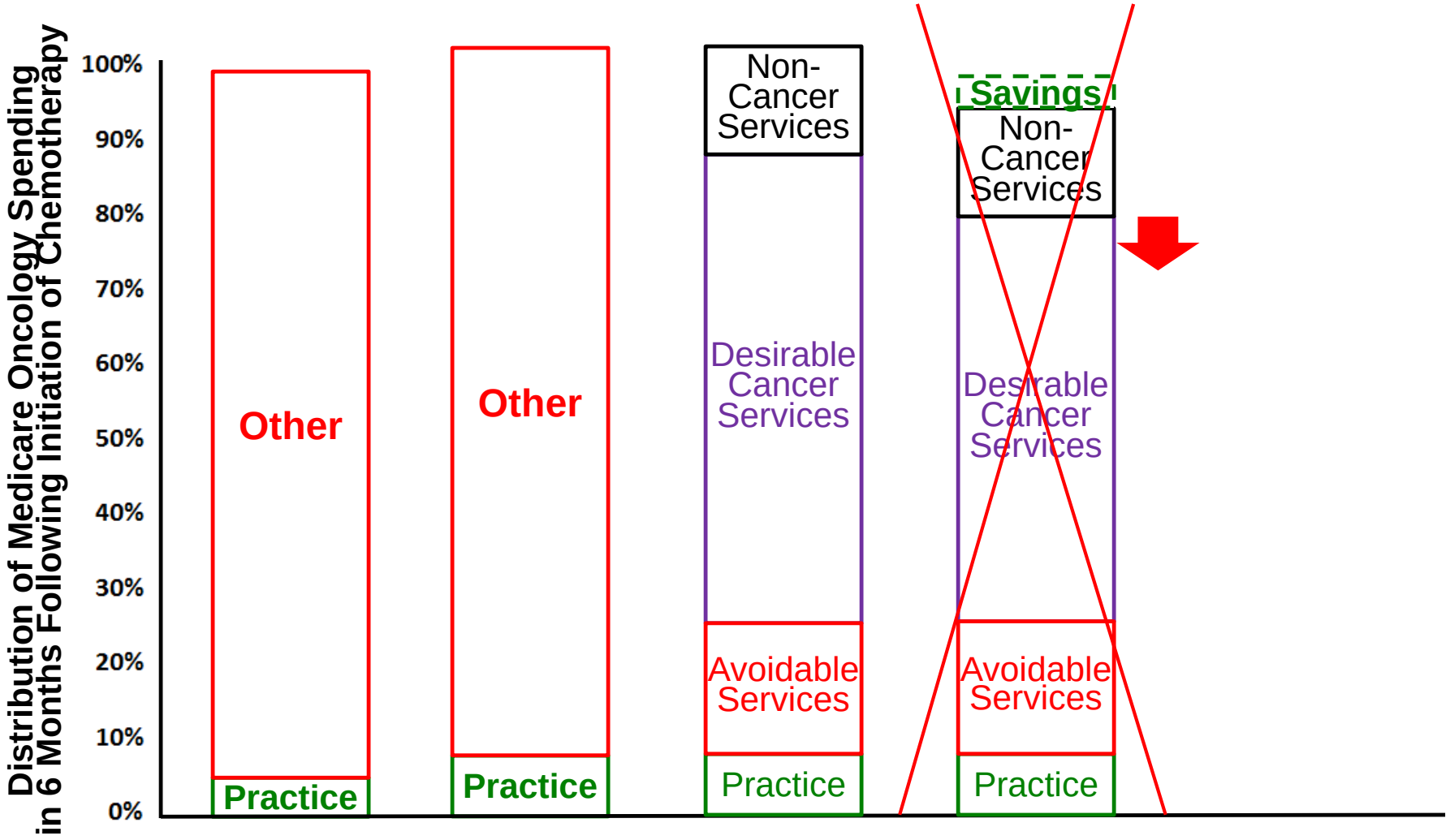
Costs and Savings from Patient-Centered Oncology Payment

	Current Average Spending Per Beneficiary	With Proposed New Payments and Estimated Savings	% Change
Month Prior to Treatment			
E&M Services	$296	$296	
PCOP		$750	
During and 2 Months After Treatment			
E&M Services	$2,071	$2,071	
Infusion Services	$1,904	$1,904	
PCOP		$1,190	
Chemotherapy/Drugs	$25,131	$23,372	-7%
Lab Tests	$583	$553	-5%
Imaging	$1,503	$1,428	-5%
ED/Ambulance	$421	$295	-30%
Inpatient	$7,100	$4,970	-30%
Other	$10,920	$10,920	0%
Months 3-6 After Treatment			
E&M Services	$120	$120	
PCOP		$220	
Total	**$50,048**	**$48,089**	**-3.9%**

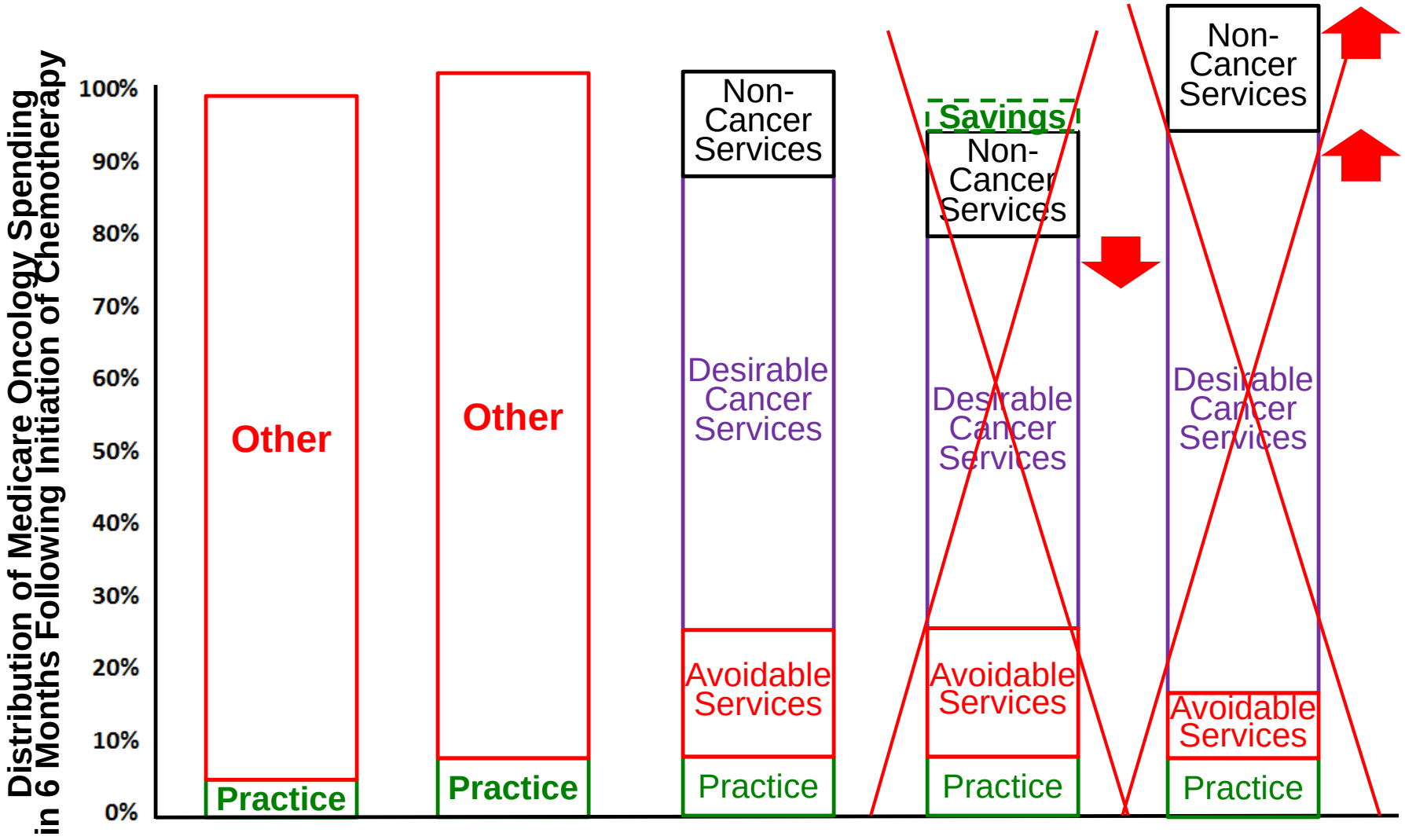
Reducing *Avoidable* Services Achieves Savings *w/o Rationing*



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

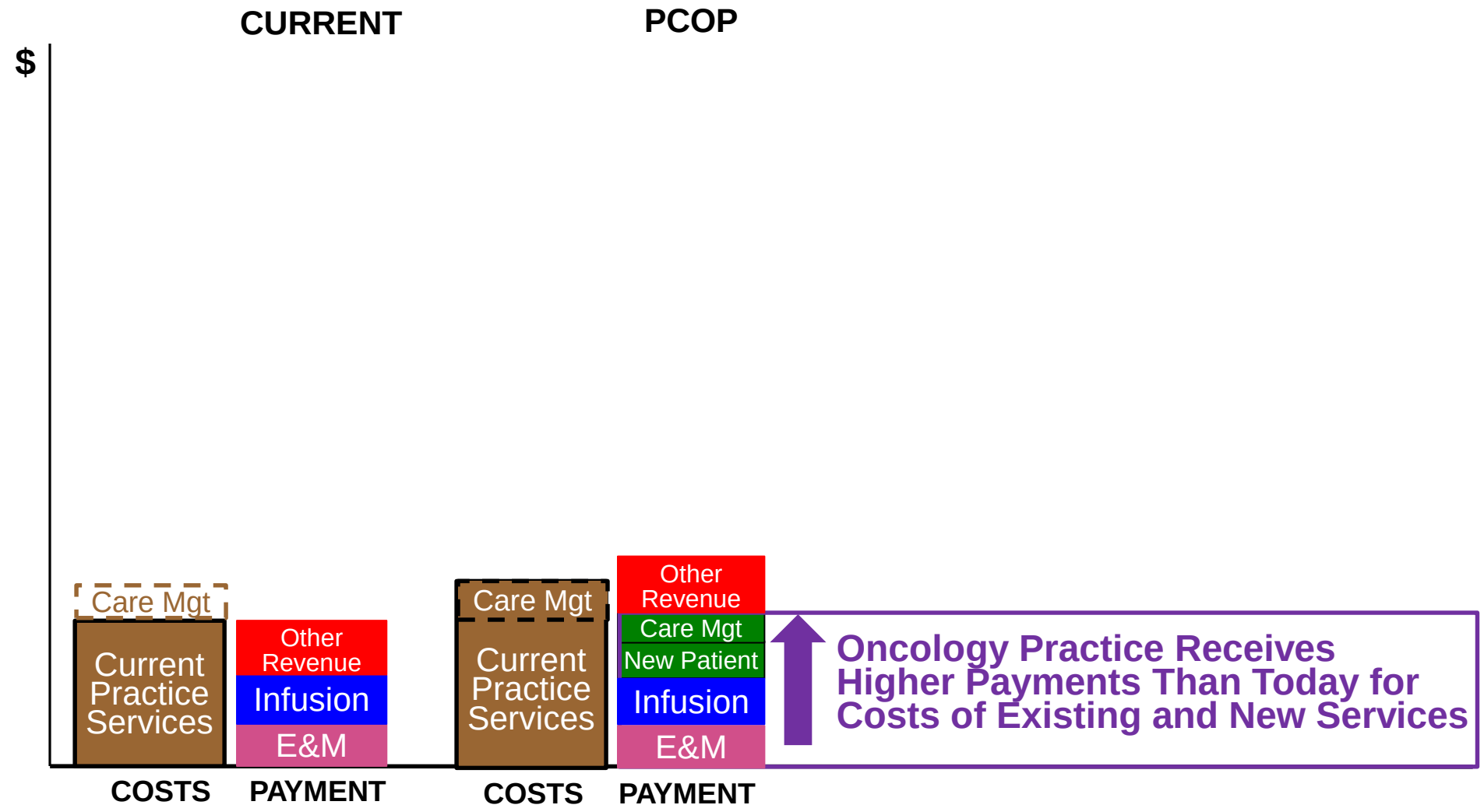
"Shared Savings" Payment Models

- 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)

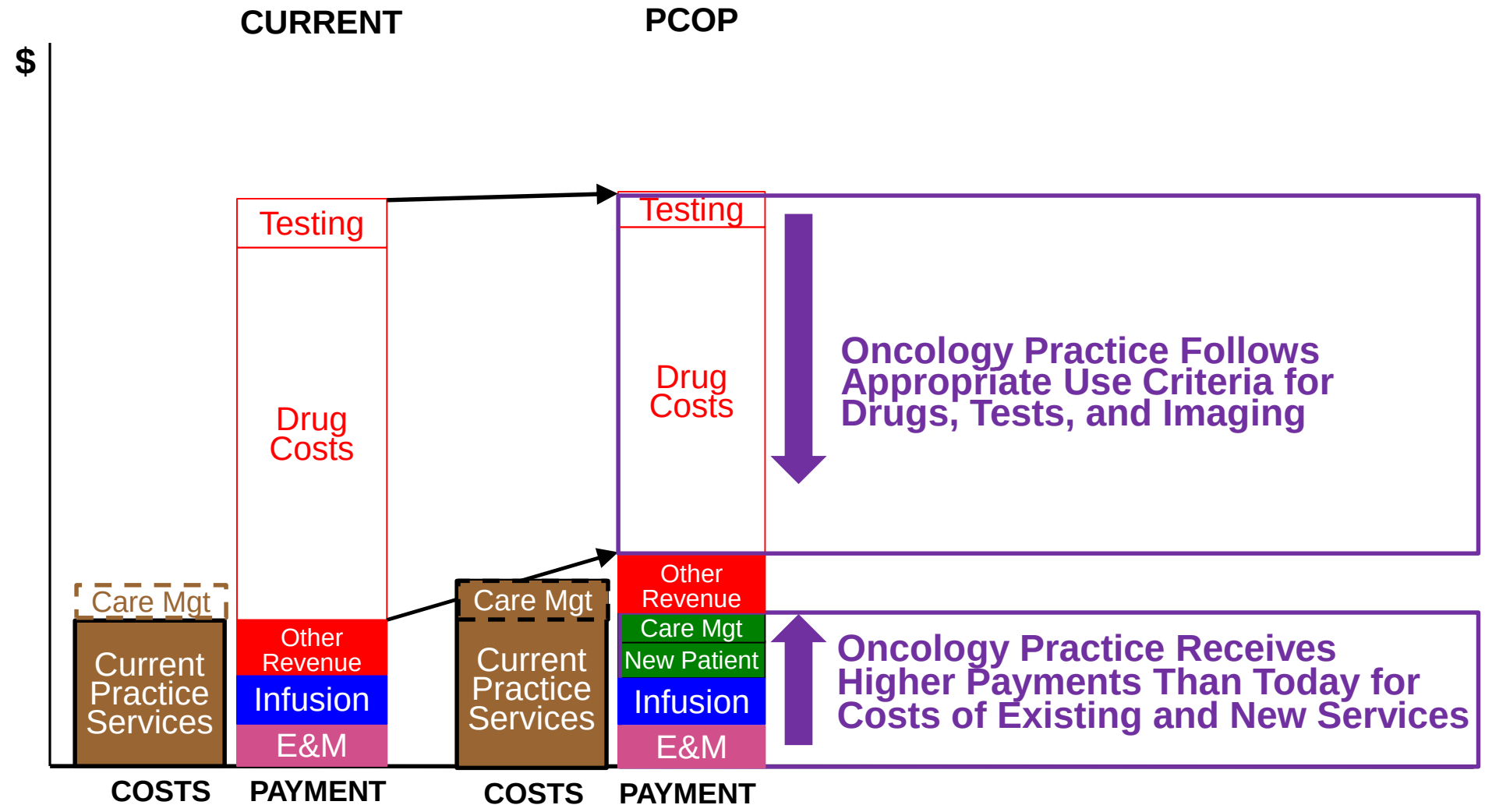
- Oncology practices receive adequate payment to cover costs of high-value patient services regardless of total spending
- Already efficient practices are able to continue operating and showing what is possible from high performance
- Practices that have been practicing inefficiently or inappropriately 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



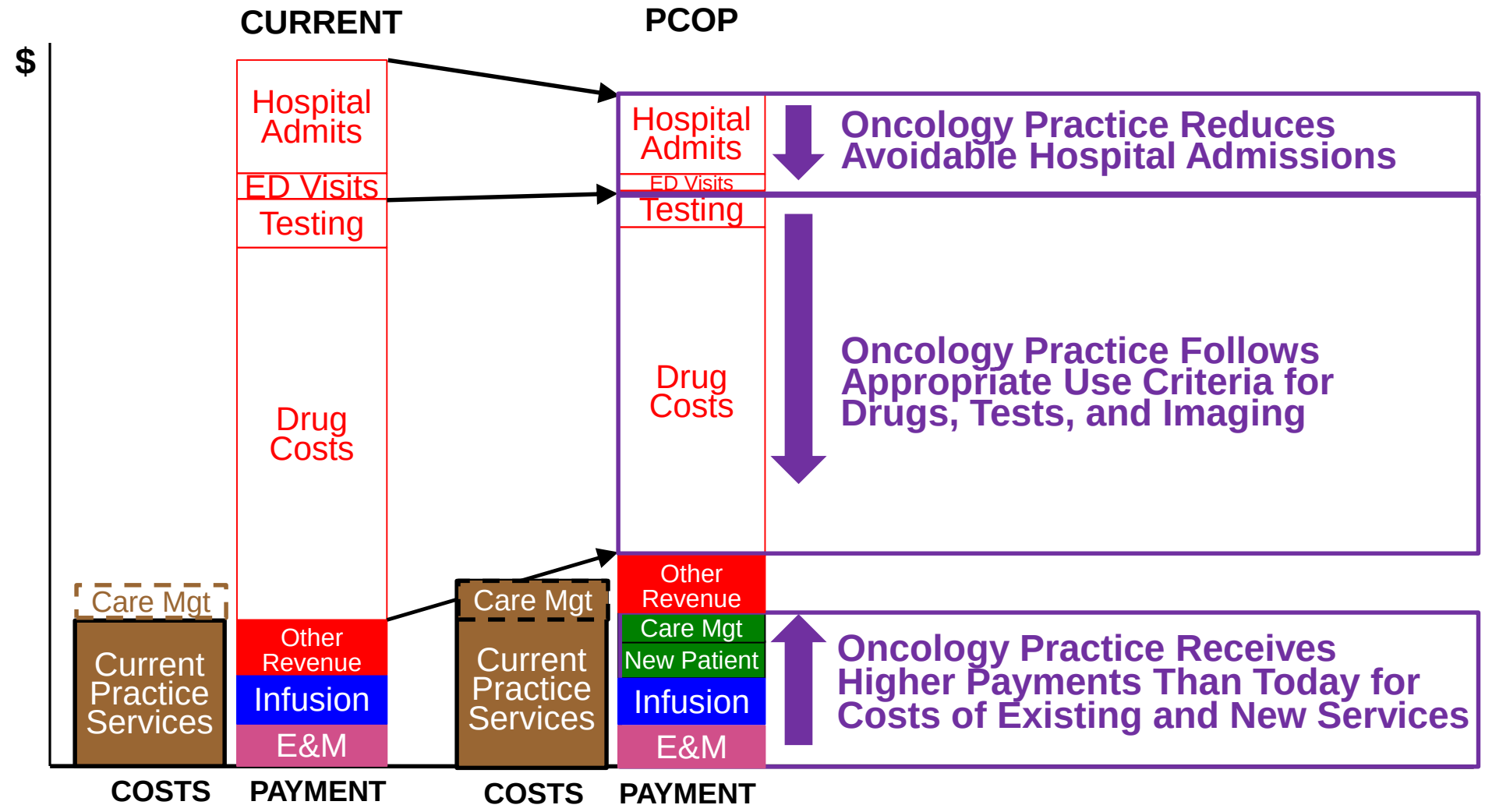
NOTE: *Chart not drawn to scale*

PCOP: Implement ASCO Guidelines For Drugs & Tests



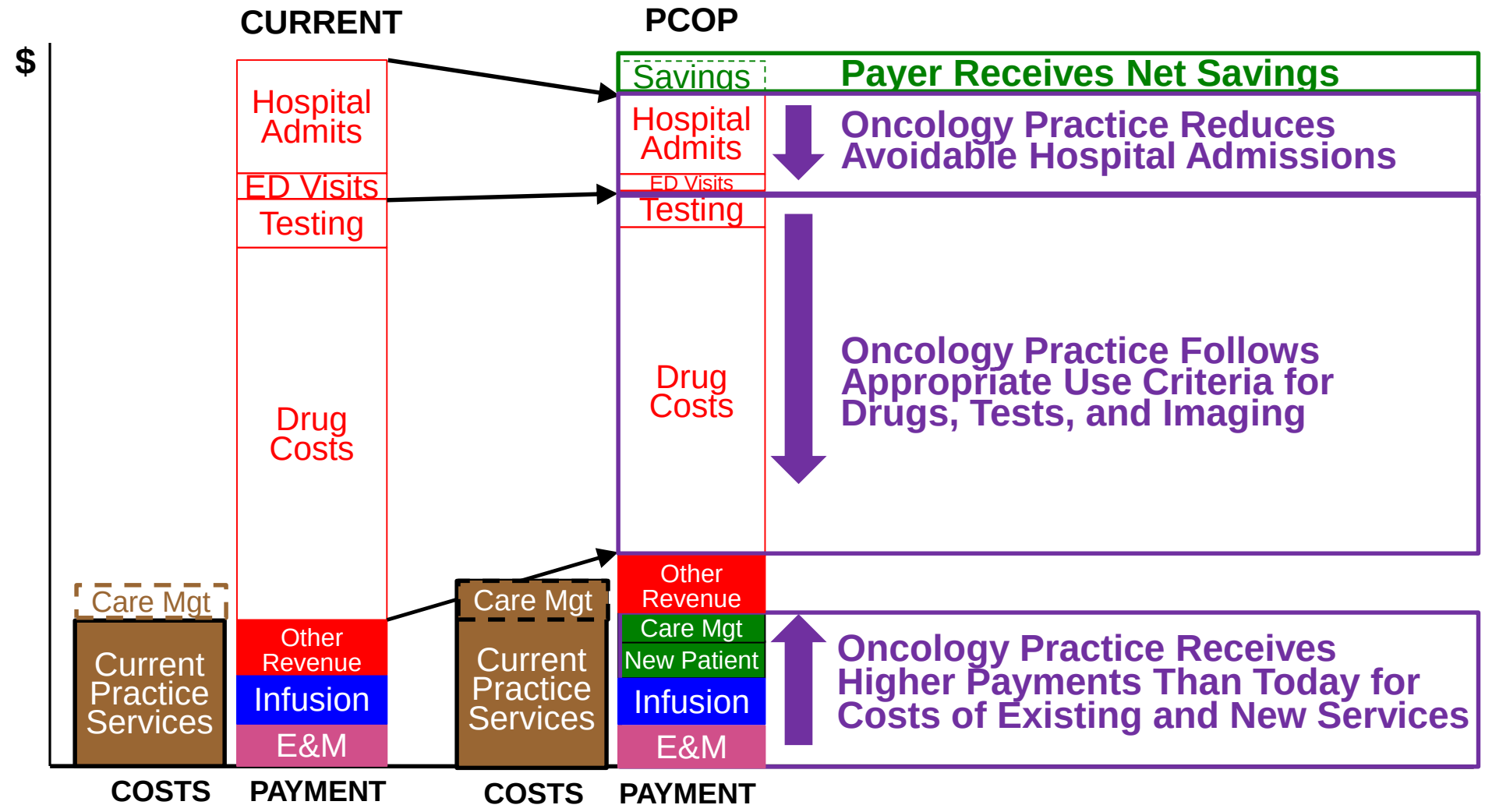
NOTE: *Chart not drawn to scale*

PCOP: Reduce Avoidable Hospital Admissions



NOTE: *Chart not drawn to scale*

Better Care, Better Payment, Savings for Payers = Win-Win-Win



NOTE: *Chart not drawn to scale*

How Does PCOP Compare to the CMMI Oncology Care Model?

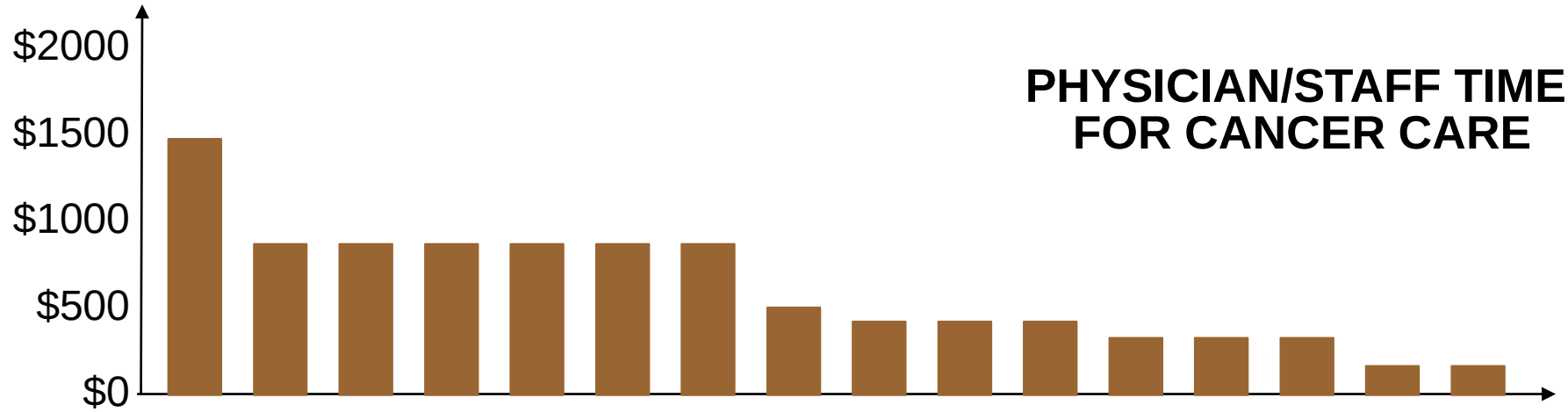
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

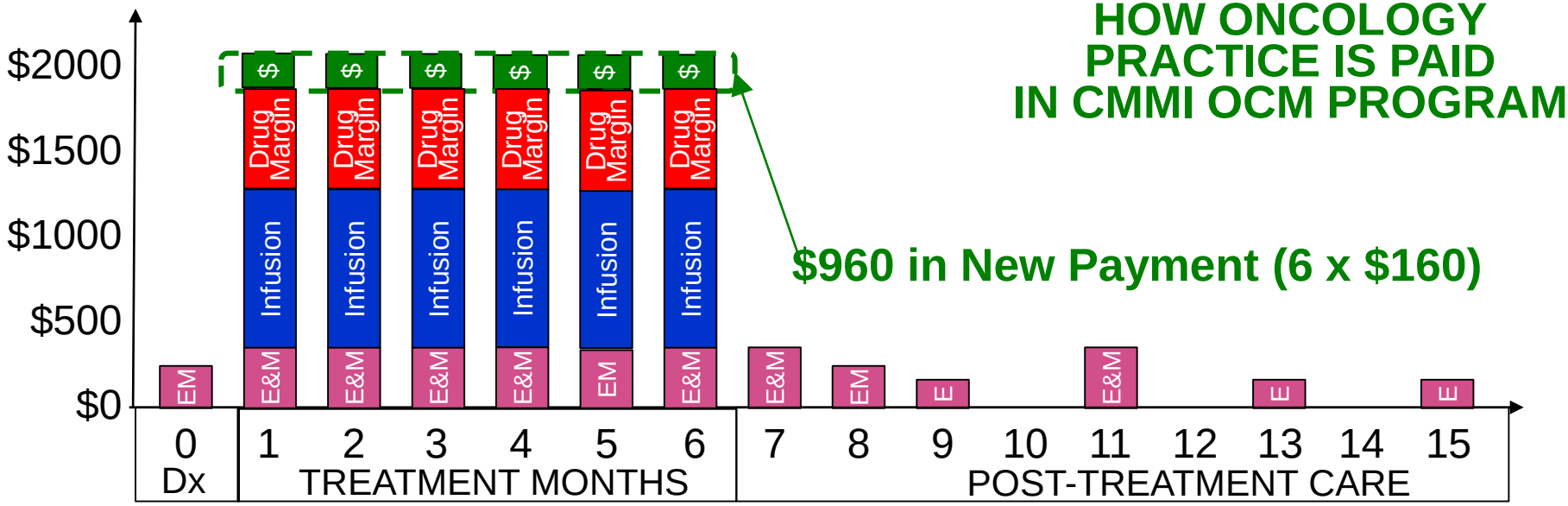
Oncology Care Model
Overview and Application Process

Centers for Medicare & Medicaid Services Innovation Center (CMMI)

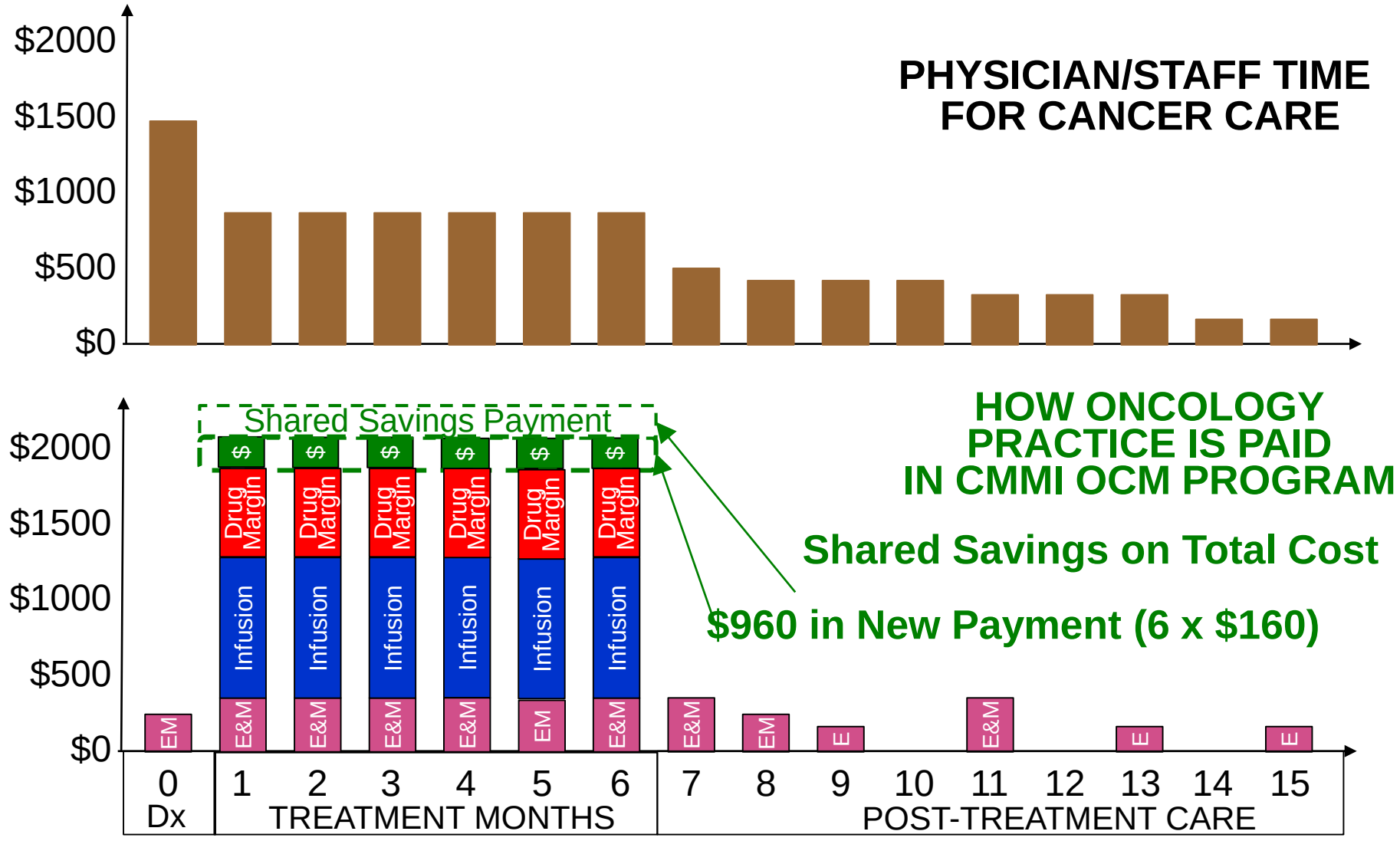
February 19, 2015

More Money During Treatment

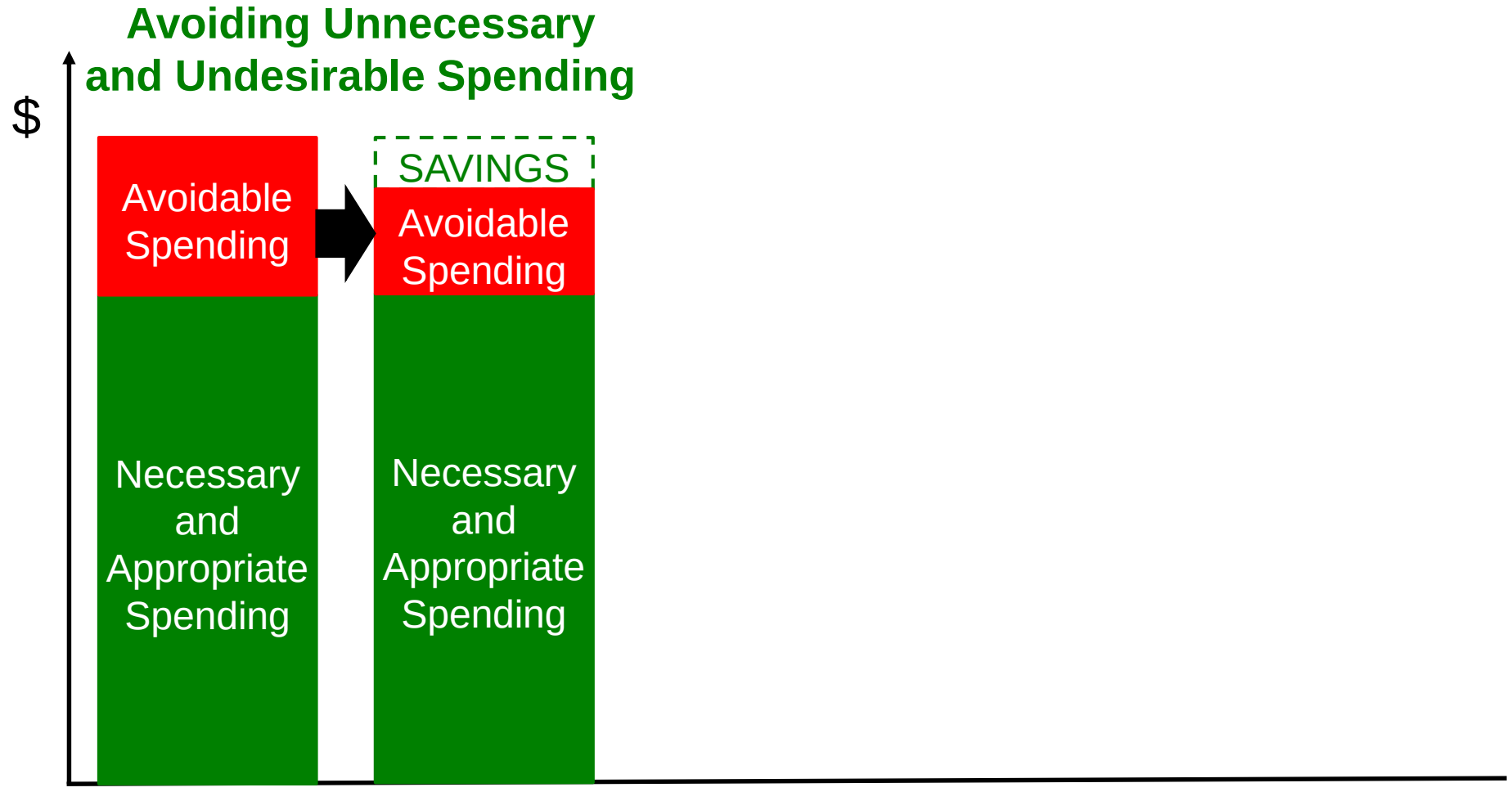




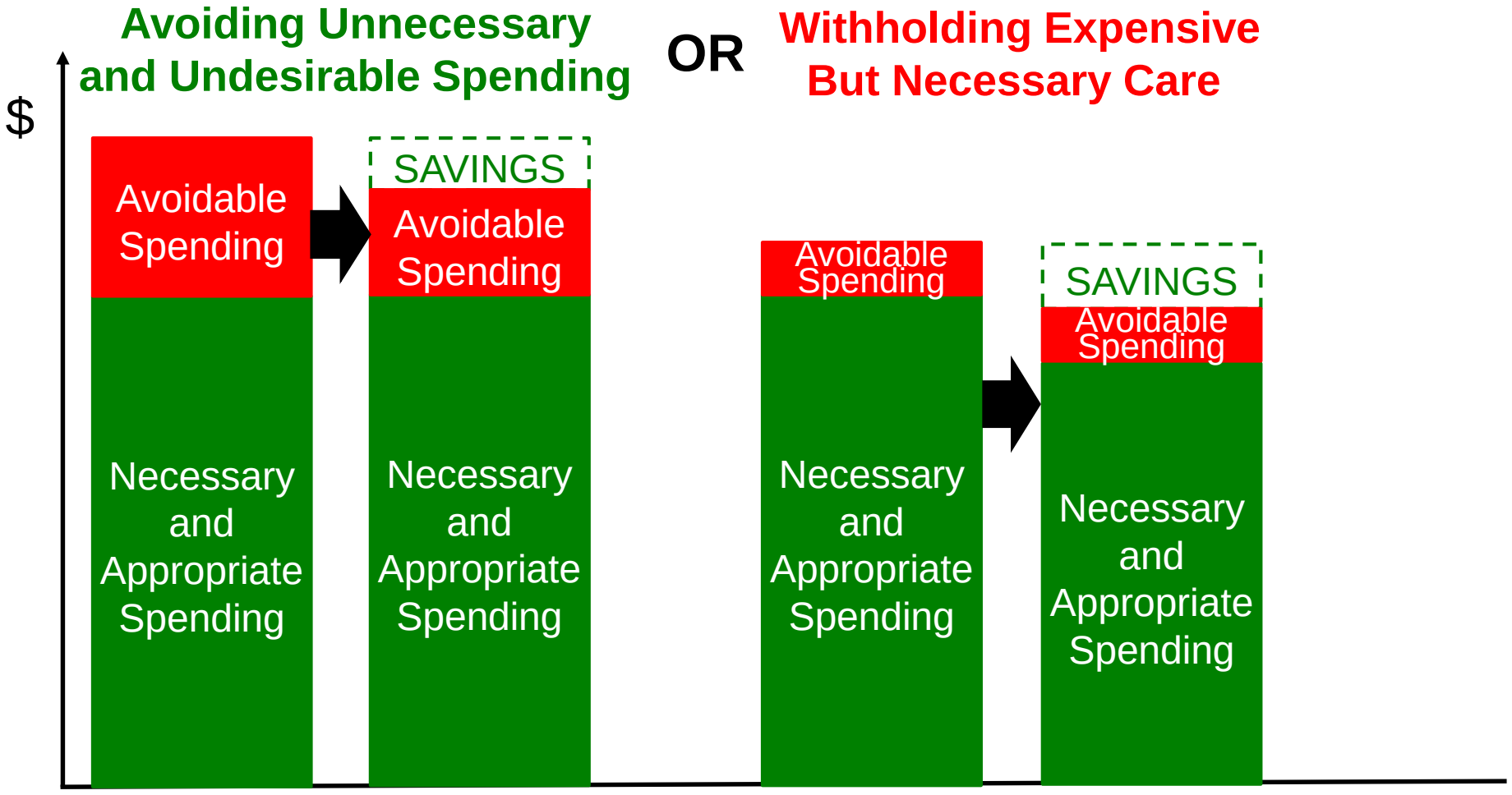
More Money During Treatment + Shared Savings on Total Spending



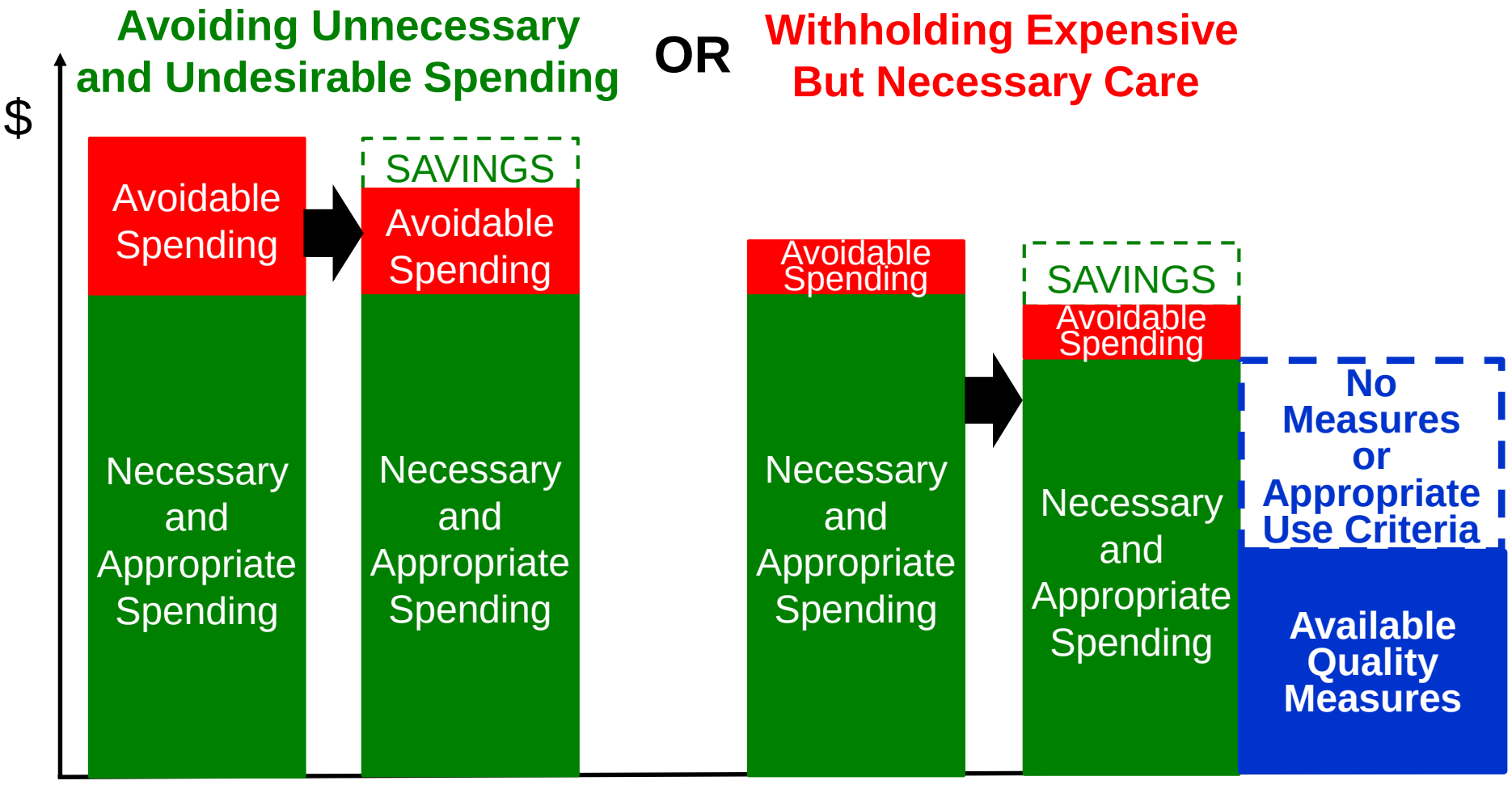
Where Will the Savings Come From?



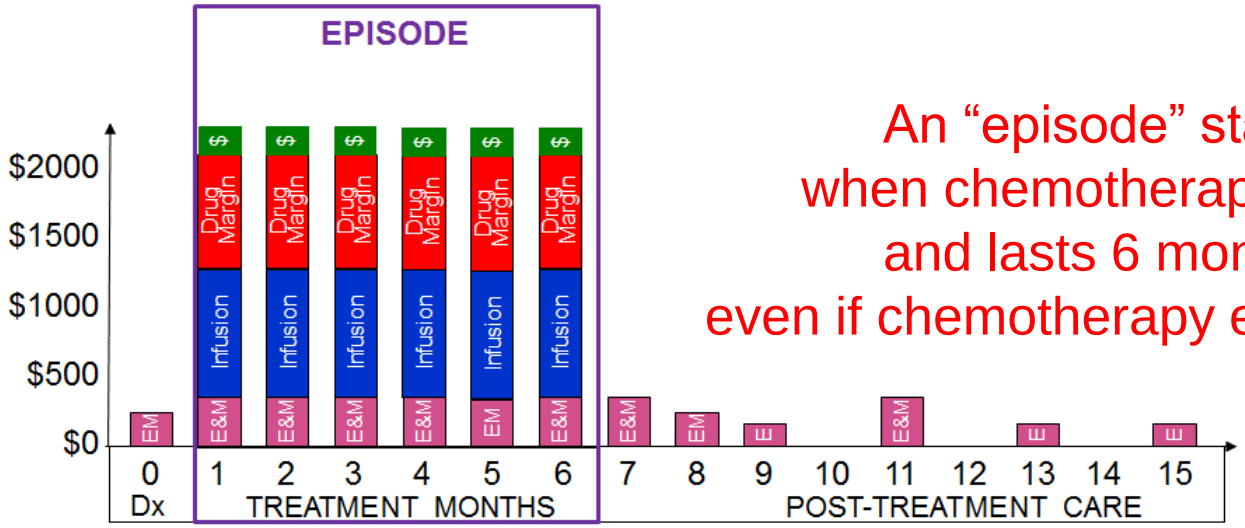
What if Your Practice Is Already Delivering High-Value Care?



A Long List of Quality Measures Can't Adequately Protect Patients

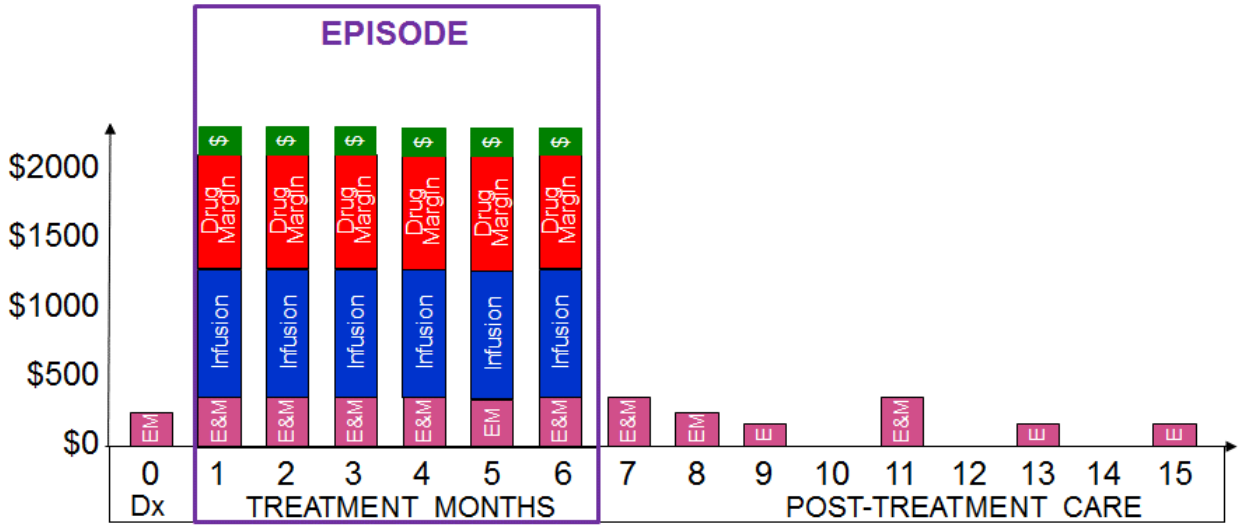


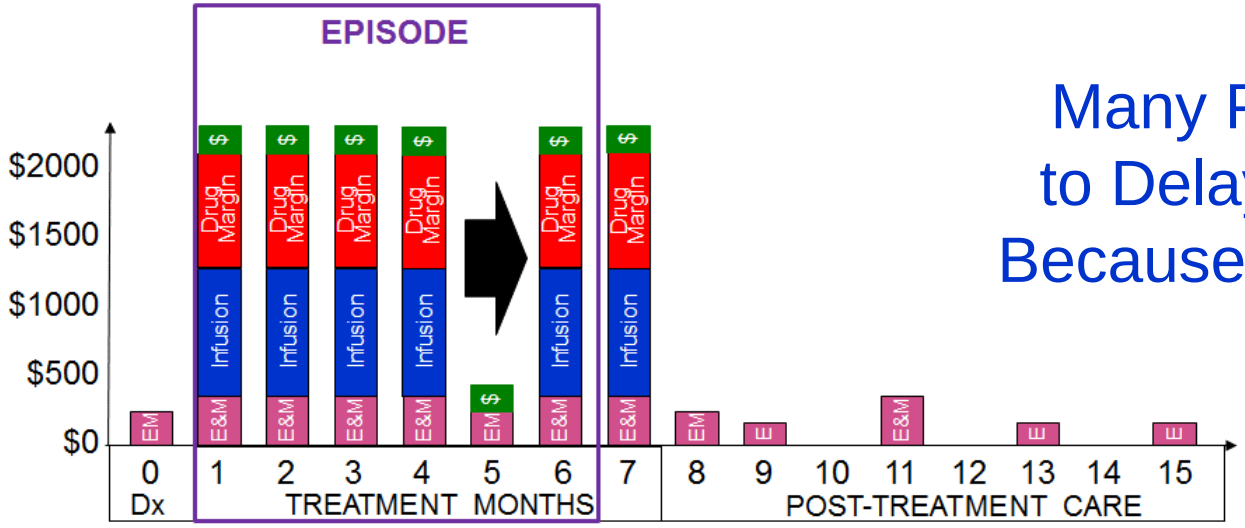
Extra Payments Are Made for *Fixed* 6 Month Episodes



An “episode” starts
when chemotherapy starts
and lasts 6 months
even if chemotherapy ends sooner

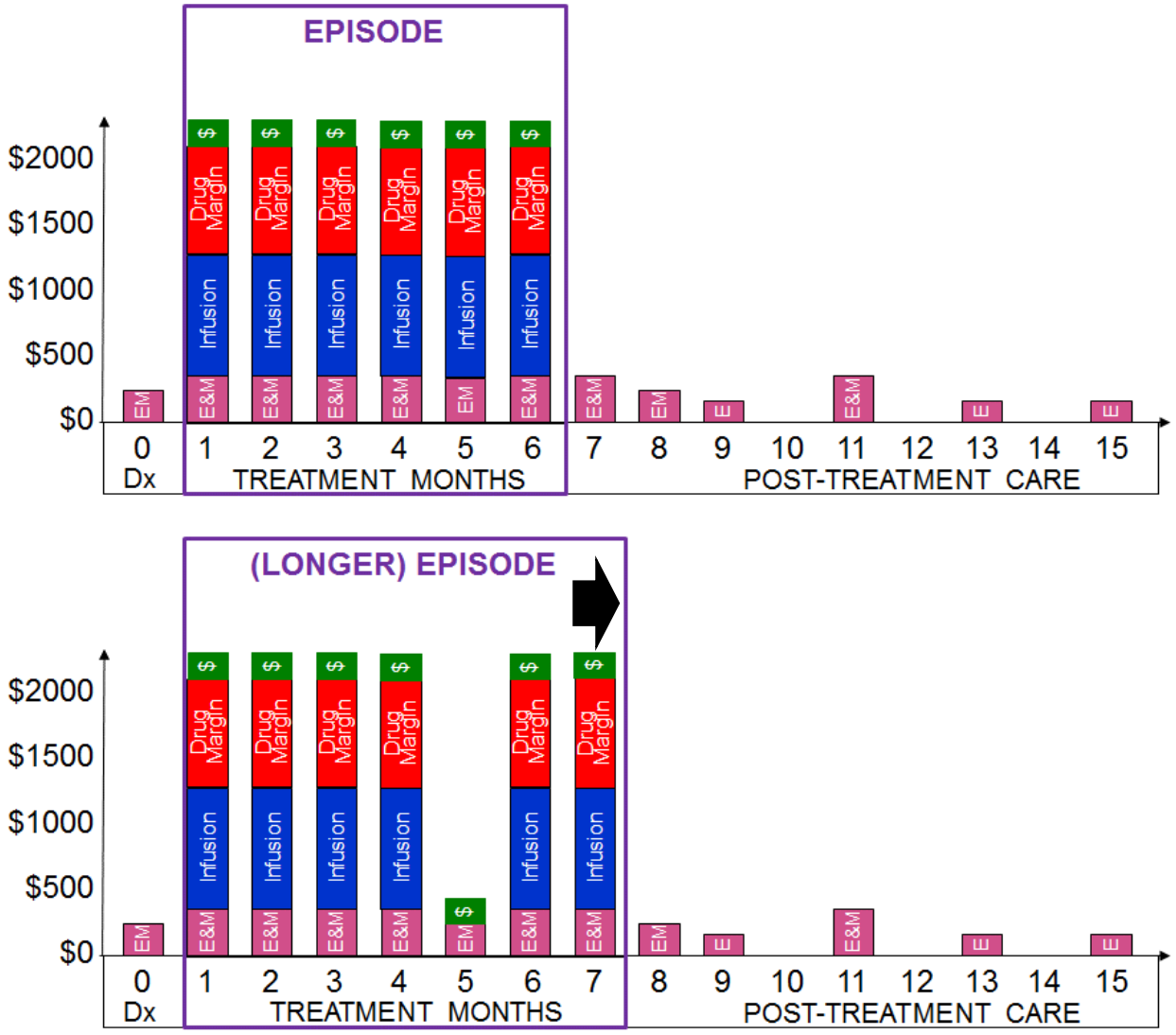
What Happens If One of the Patient's Treatments is Delayed?



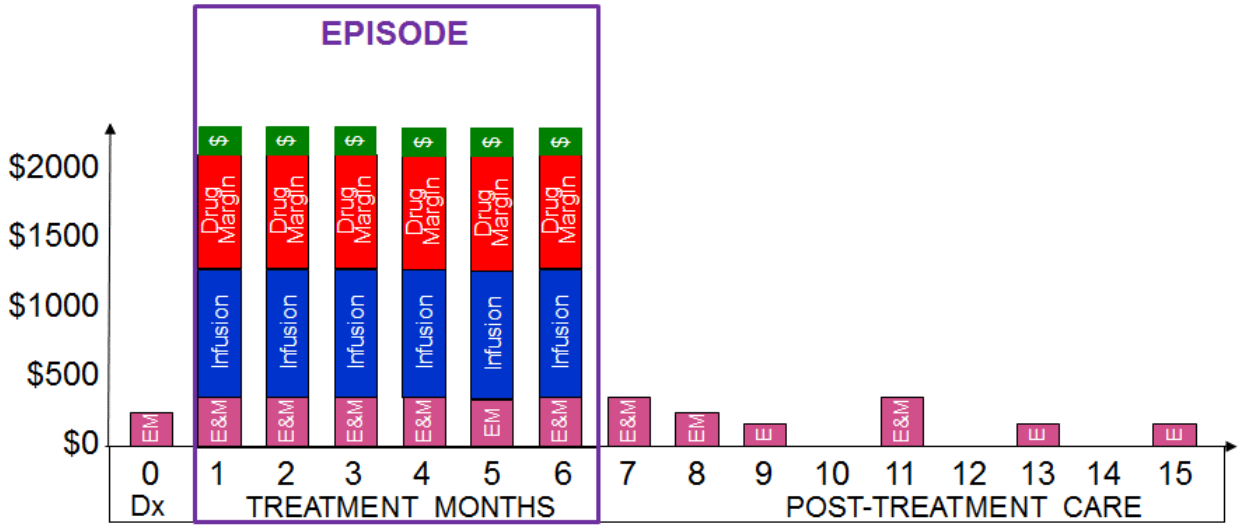


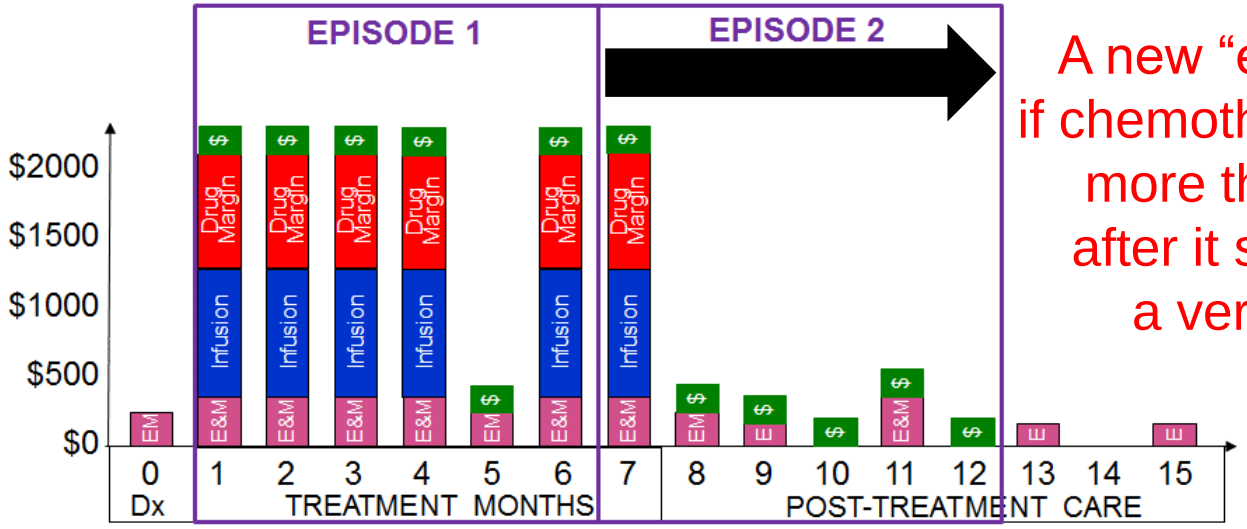
Many Patients Have to Delay a Treatment Because of Side Effects

Logic Would Say That It's Now a Longer (7 Month) Episode



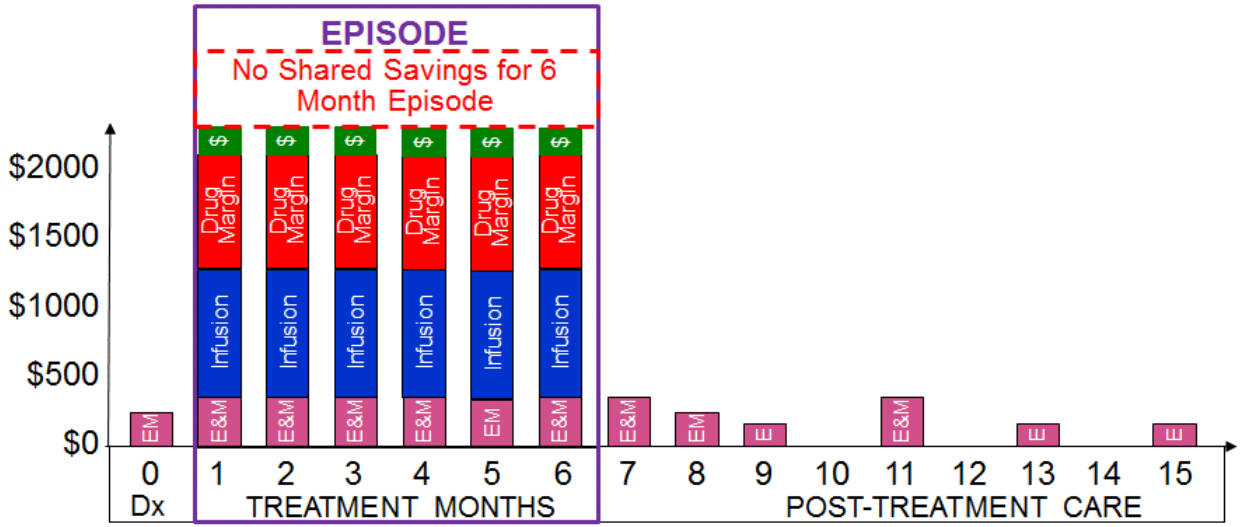
But CMMI Says It's a *New Episode* With $960 More in Payments



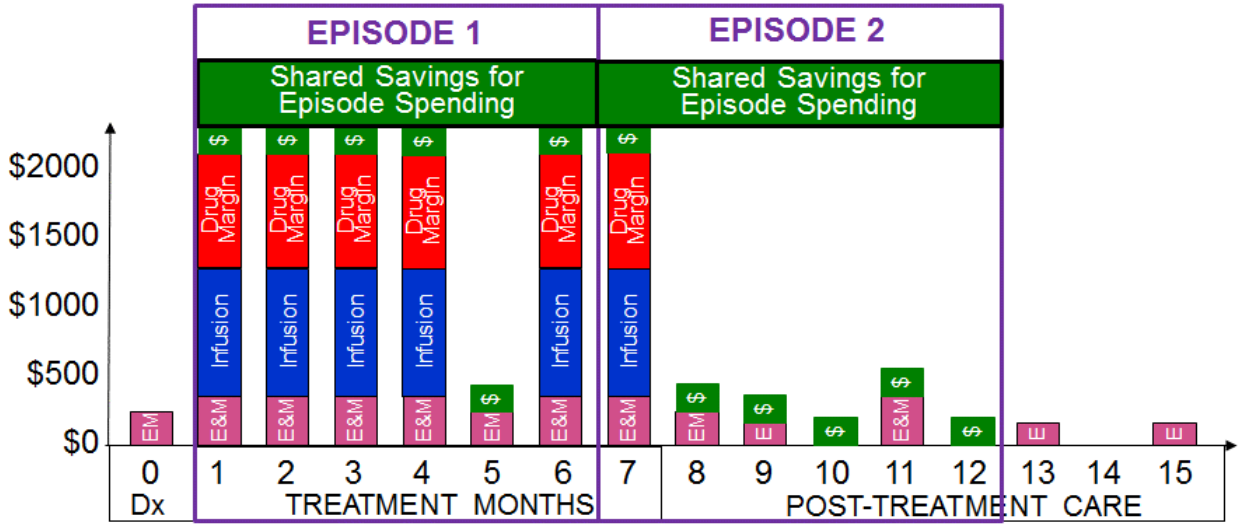


A new "episode" starts if chemotherapy continues more than 6 months after it starts, even for a very short time

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*
Quality P4P	**No**	**No**	**Yes**

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*
Quality P4P	**No**	**No**	**Yes**
Shared Savings	**No**	**No**	**No**

How Proposed Oncology Payment Models Meet Needs for Reform

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CMMI OCM	**Yes**	**No**	**No**

How Proposed Oncology Payment Models Meet Needs for Reform

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CMMI OCM	**Yes**	**No**	**No**
United "Episodes"	**No**	**No**	**Yes**

How Proposed Oncology Payment Models Meet Needs for Reform

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Anthem Cancer Care Quality	**Yes**	**No**	**Yes**

How Proposed Oncology Payment Models Meet Needs for Reform

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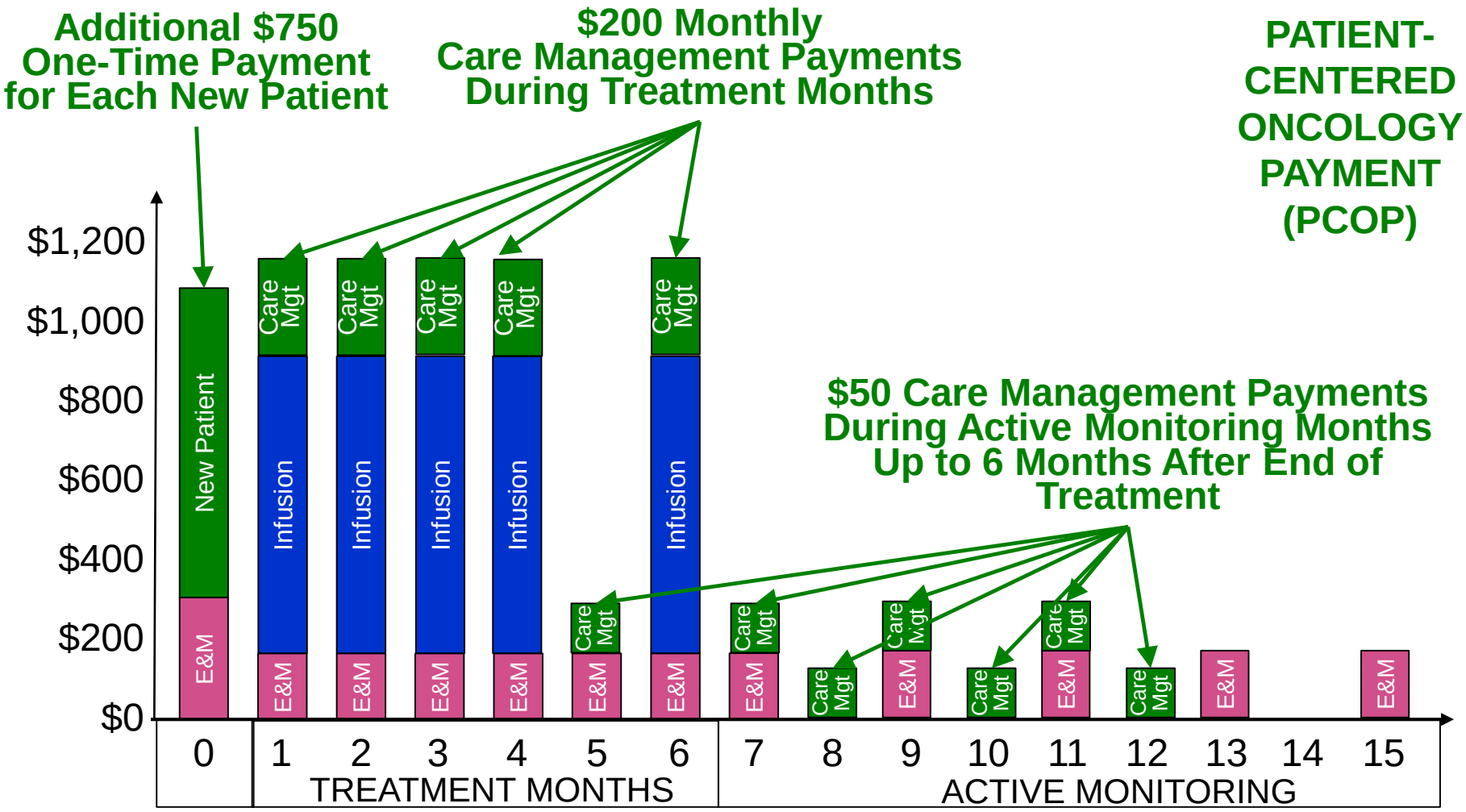
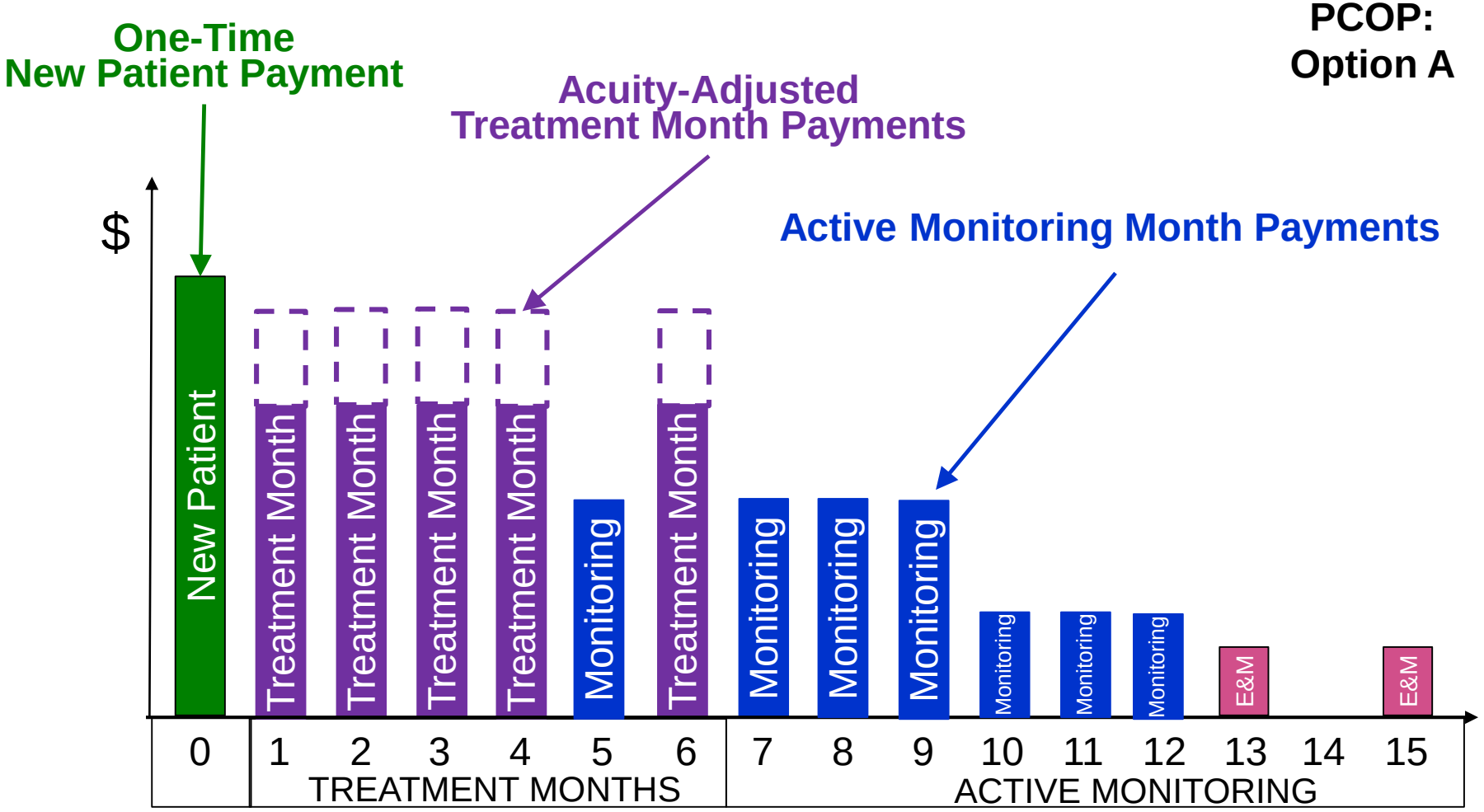
Shared Savings	**No**	**No**	**No**
CMMI OCM	**Yes**	**No**	**No**
United "Episodes"	**No**	**No**	**Yes**
Anthem Cancer Care Quality	**Yes**	**No**	**Yes**
PCOP	**Yes**	**Yes**	**Yes**

Basic PCOP Model Improves But Does Not Replace Current FFS



PCOP Option A: Consolidate Existing and New Payments



Dramatic Simplification of Coding and Billing

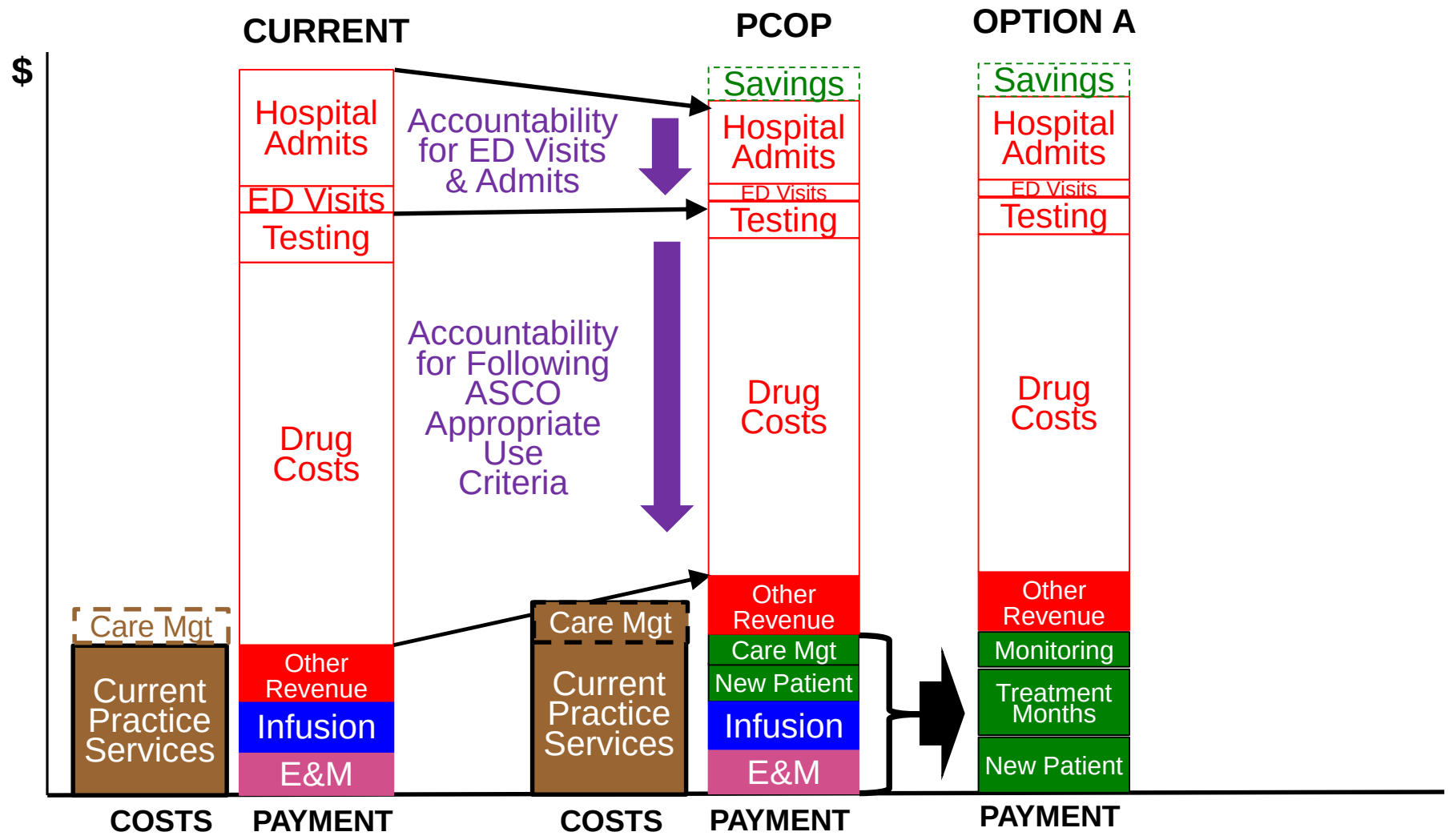
50+ Current Billing Codes

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
96405 Intralesional chemotherapy administration
96406 Intralesional chemotherapy administration
96409 Push chemotherapy administration
96411 Push chemotherapy administration
96413 Infusion chemotherapy administration
96415 Infusion chemotherapy administration
96416 Infusion chemotherapy administration
96417 Infusion chemotherapy administration
96420 Intra-arterial push chemotherapy
96422 Intra-arterial infusion chemotherapy
96423 Intra-arterial infusion chemotherapy
96425 Intra-arterial infusion chemotherapy
96440 Pleural cavity chemotherapy
96446 Peritoneal cavity chemotherapy
96450 CNS chemotherapy
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
96379 Unlisted injection or infusion, non-chemotherapy
96360 Intravenous infusion, hydration
96361 Intravenous infusion, hydration

< 10 New Codes

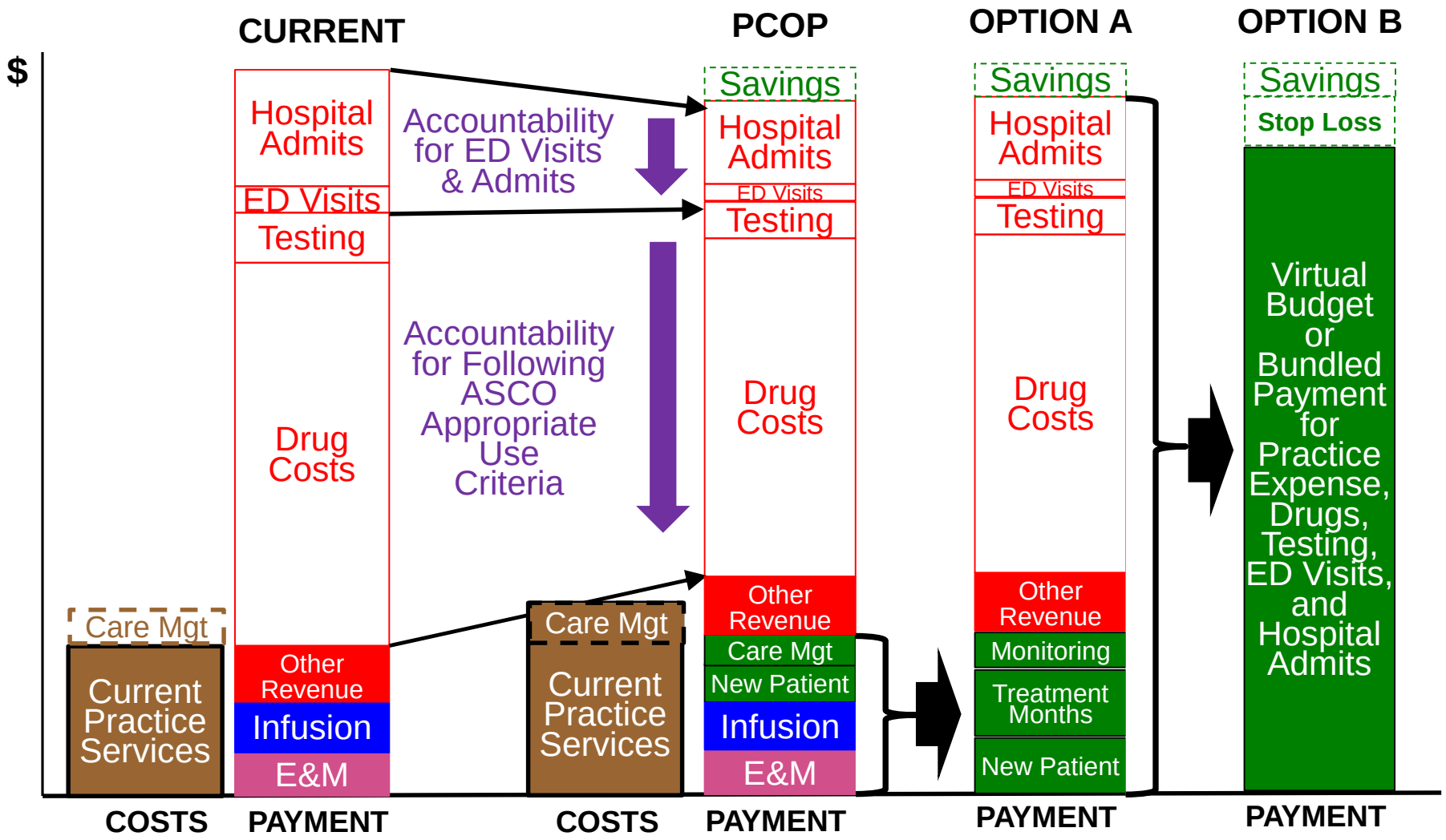
- New Patient Payment
- Treatment Month (4-6 Levels)
  - Patient characteristics
  - Treatment characteristics
  - Transitions
  - Clinical Trials
- Active Monitoring Month (2 Levels)

Same Accountability Components But Simpler, More Flexible Pmt



NOTE: *Chart not drawn to scale*

PCOP Option B: Bundled Monthly Budgets



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

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President and CEO

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www.CHQPR.org

www.PaymentReform.org