Alternative Payment Arrangements and Service Delivery Models for Oncology Care

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Is oncology different?

• In the US costs are rising much faster than other diseases
• Clear problem with overuse of some aspects of services
• Little attention to costs, cost effectiveness or outcomes of alternative therapies
• Clinical care changes as new drugs therapies come on the market
Why oncology services under used?

• High cost of care, due to
  – Excessive use of hospitalizations and tests with uncertain value
  – High costs of inputs (imported/brand products/unnecessary tests and treatment)
  – Inadequate following of patients under treatment
• Lack of public or private insurance coverage
• Ignorance of evidence or unwillingness to adapt
Why are oncology services over used?

• Payers and payment system offer no restrictions and minimal oversight of provider diagnosis and treatment patterns

• No co-payment by patients

• No incentives for efficiency or quality:
  – Under use of treatment guidelines
  – Fragmented care with multiple providers – physician, hospital, pharmacy
  – Greater reliance on hospitalizations and ER
  – No harnessing of innovation that could lower use and raise quality of care
Many of the characteristics of under- and over-use overlap

• Characteristics of quality health care improve performance, outcomes, and costs

• The world of medicine is changing, and it affects oncology and medicine in general
  – More technology
  – Integrated approaches increasingly needed
  – Clinical protocols become more important in fast changing world of medicine
Key Issues for Oncology Care
US/EU efforts to improve access and control costs of oncology care

- Driven by realization of under and over use of oncology care
- Rising costs for oncology diagnosis and treatment
- Costs are “out of control”
Key issues: Organization of services

• Recent evidence points to the importance of:
  – careful use of tests and treatment option
  – integrated care
  – treatment teams
  – Clinical guidelines protocols (big issue in FFS)
  – following patients during treatment
  – use of generics where advised
Key issues: Delivery and Payment

• Delivery systems need to embrace change and adapt to improve quality and lower costs
• Payment systems key to incentives for achieving these goals
Private–Public consensus on need for change

- American Society of Clinical Oncology
- Medicare/Medicaid – federal public insurance organizations (payers)
- Private health care plans (payers)
- Patient advocacy organizations

⇒ Rising experimentation on how and what to change
Example of Physician Practice Oncology Reorganization of Care

- Expanded Office Hours
- 24 Hour Nurse Response to Patient Problems
- Proactive Coordination with Primary Care Provider
- Use of Integrative Medicine Modality
- Better Patient Education

Reduced ER & Hospital Admission by >50%

Source: Data-Driven Transformation to an Oncology Patient–Centered Medical Home (Sprandio et al., 2013)
Results of adoption of oncology treatment guidelines use

- Evidence-Based Treatment Guidelines
- Quality Measurement Systems

Lung cancer demonstration project: reduced chemotherapy costs by 37%¹

- Shared Decision-Making
- Redesign of Care Processes

Across 4,700 cancer patients at 46 sites: drug costs declined by 13%²

Sources: Cost Effectiveness of Evidence-Based Treatment of Non-Small-Cell Lung Cancer in the Community Setting (Neubauer et al., 2010); Documenting the Benefits and Cost Savings of a Multistate Cancer Program from a Payer’s Perspective. (Kreys and Koeller, 2013)
CMS Leading on Oncology Care Model Design
Affordable Care Act
Leading Change....
CMS Innovation Unit

- Focused on containing costs and raising quality
- Oncology Care Model (OCM) major multi-pronged approach to understanding how to promote change and ensure affordability of cancer treatment
- Major national demonstration projects launched in 2015

=> controlled experiments and evaluation
Improve health outcomes and reduce cost of care through improvements in efficiency, effectiveness, and quality of patient-centered comprehensive cancer care.

Source: Oncology Care Model: Key Drivers and Changes (CMS, 2016)
Explaining Oncology Care Management

<table>
<thead>
<tr>
<th>Primary Drivers</th>
<th>Summary Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive, Coordinated Cancer Care</td>
<td>Organization and treatment team arrangements</td>
</tr>
<tr>
<td>Continuous Improvement Driven By Data</td>
<td>Information for evidence-based medicine, and for insurers and providers</td>
</tr>
<tr>
<td>Management of OCM Payments</td>
<td>Efficiency in administration and spending by providers</td>
</tr>
<tr>
<td>OCM Payments</td>
<td>Active role of payers in encouraging better performance</td>
</tr>
</tbody>
</table>

Source: Oncology Care Model: Key Drivers and Changes (CMS, 2016)
Oncology Models Priority Data Sources

- Tracking of claims data
- Patients surveys
- Site visits
- Analysis of quality measurement data
- Time and motion studies
- Medical record audit
- Tracking of patient complaints and appeals
Oncology Model Quality Measures

- Clinical quality of care
- Communication and care coordination
- Person and caregiver centered experiences and outcomes
- Population health
- Efficiency and cost reduction
- Patient safety
What are the incentives to encourage adoption of new treatment models for oncology?
Payment Arrangements: Drivers of Change
# CMS Payment Arrangements for Oncology

<table>
<thead>
<tr>
<th>Payment Arrangement</th>
<th>Description</th>
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<tbody>
<tr>
<td>Fee For Service (FFS)</td>
<td><strong>Reimbursement for all costs</strong> incurred. Encourages high volume of care and bias toward costly services and drugs.</td>
</tr>
<tr>
<td>Diagnosis Related Groups (DRG)</td>
<td><strong>Prospective payment</strong> promotes efficiency in hospital care as hospitals are at risk for high costs. Encourages higher cost services and higher volume of care.</td>
</tr>
<tr>
<td>Bundled Payments</td>
<td><strong>Finance episodes of care</strong> with emphasis on continuity of care and avoidance of (re)hospitalizations and Emergency Department use. Effects mixed.</td>
</tr>
<tr>
<td>Accountable Care Organizations (ACO)</td>
<td><strong>Shared savings.</strong> Integrated care network with hospital(s), continuous and coordinated care services at clinics; emphasis on prevention; nurse-based care with patient follow up. Can improve quality and reduce costs.</td>
</tr>
</tbody>
</table>
CMS Experiments Evaluate Bundled Payments for Oncology
Oncology Care Model Experiments

- Objectives is raising quality and lowering costs through use of accepted and evidence-based processes and clinical guidelines
- 17 private payers participate with Medicare in creating incentives for care transformation with physician practices
- Payers design their own incentives for their beneficiaries
- Non-participating payers benefit from savings, better outcomes for their beneficiaries

Source: Oncology Care Model Overview (CMS)
Characteristics of Bundled Payment Experiment

• Episode based – only post diagnosis but through treatment (diagnosis phase is FFS)

• Bundled payment sets “target price” for the participating physician groups

• “Target price” 6% below current benchmark price – measuring ability to be more efficient

• “Practice transformative” – change the way oncology care is provided
Two-part payment system to incentivize quality of care

• Per beneficiary payment of $160 to physician practices to manage and coordinate care for an episode of care

• For beneficiaries who undergo chemotherapy treatment: performance-based payment over 6 months of care => incentive to lower the total cost of care and improve care during treatment episode or payment reduced
# CMS Oncology Bundle Payment Models

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode</strong></td>
<td>All DRGs + acute patients</td>
<td>Selected DRGs; inpatient + post-acute period</td>
<td>Selected DRGs; post-acute period only</td>
<td>Selected DRGs; inpatient + readmissions</td>
</tr>
<tr>
<td><strong>Services Included</strong></td>
<td>All hospital services paid as part of MS-DRG payment</td>
<td>All non-hospice hospital + outpatient services</td>
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<td>All non-hospice hospital + outpatient services</td>
</tr>
<tr>
<td><strong>Payment</strong></td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Prospective</td>
</tr>
</tbody>
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Source: Bundled Payment Fact Sheet (CMS)
Results from CMS Oncology Bundle Payment: Model 2

Model 1 inconclusive, Models 3 and 4 samples too small for measuring outcomes

Most savings come from changes in **post-acute care**
- Improved communication between inpatient and discharge facilities
- Less time spent in costly institutional care
- Decreased readmissions
- Reduced care costs by a small amounts in many areas

Net impact: **savings of $513** for an episode of care...
- 15% reduction in discharges to institutions for post-acute care
- 2 – 3.5% decrease in unplanned readmissions

...Despite $1266 increase in inpatient stay costs

Source: First BCPI Evaluation Report (CMS)
Results from Bundled Payments for Orthopedics Experiment

• Saved orthopedic hospitals > $1.6 million in 2015
• Additional revenue for physicians
• Decreasing the overall cost of care
• BPCI improved patient care due to improved algorithms, cost control and case management
• Average savings per case:
  – $1969 for arthroplasties
  – $ 975 for hip and femur fractures.

Source: Bundled Payments for Care Improvement: Lessons Learned in the First Year (Althausen & Mead 2016)
Key Messages and Considerations

• Private and public providers and payers have an interest in improving quality and controlling costs – the alternative isn’t affordable
• Public and private need to work together
• Payers must play an oversight role if costs containment and better quality are to be achieved
• Objective is transformative clinical practice
• Patient centered care increasingly clear as objective to change practices
• Use of clinical guidelines/pathways/protocols is critical — and many physicians resistant
• Data are key to effective oversight
  — providers need to track performance
  — payers need data to achieve desired outcomes
Obrigada!
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