CENTER FOR
HEALTHCARE
QUALITY &
PAYMENT REFORM

BETTER CARE FOR CANCER PATIENTS AT LOWER COST: How Oncology Practices Can Improve Value While Remaining Financially Viable

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

www.CHQPR.org

PLEASE NOTE:

I am one of the 11 members of the Federal Physician-Focused Payment Model Technical Advisory Committee (PTAC).

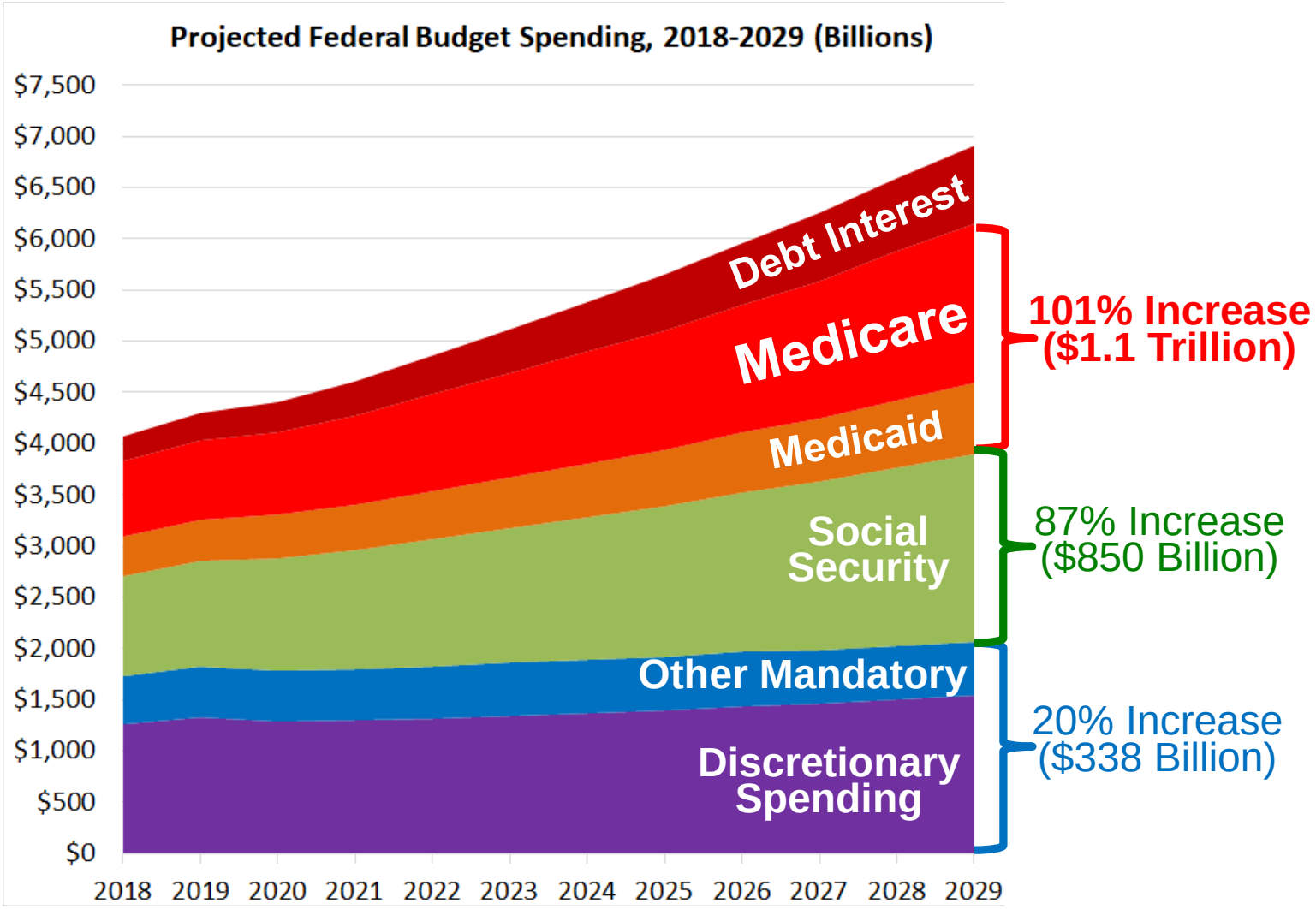
However,
my comments today reflect my *personal* opinions;
my comments do not represent official positions of the PTAC,
and other PTAC members may or may not agree with them.

I Have No Other Disclosures

What I Hope You Will Learn From This Presentation

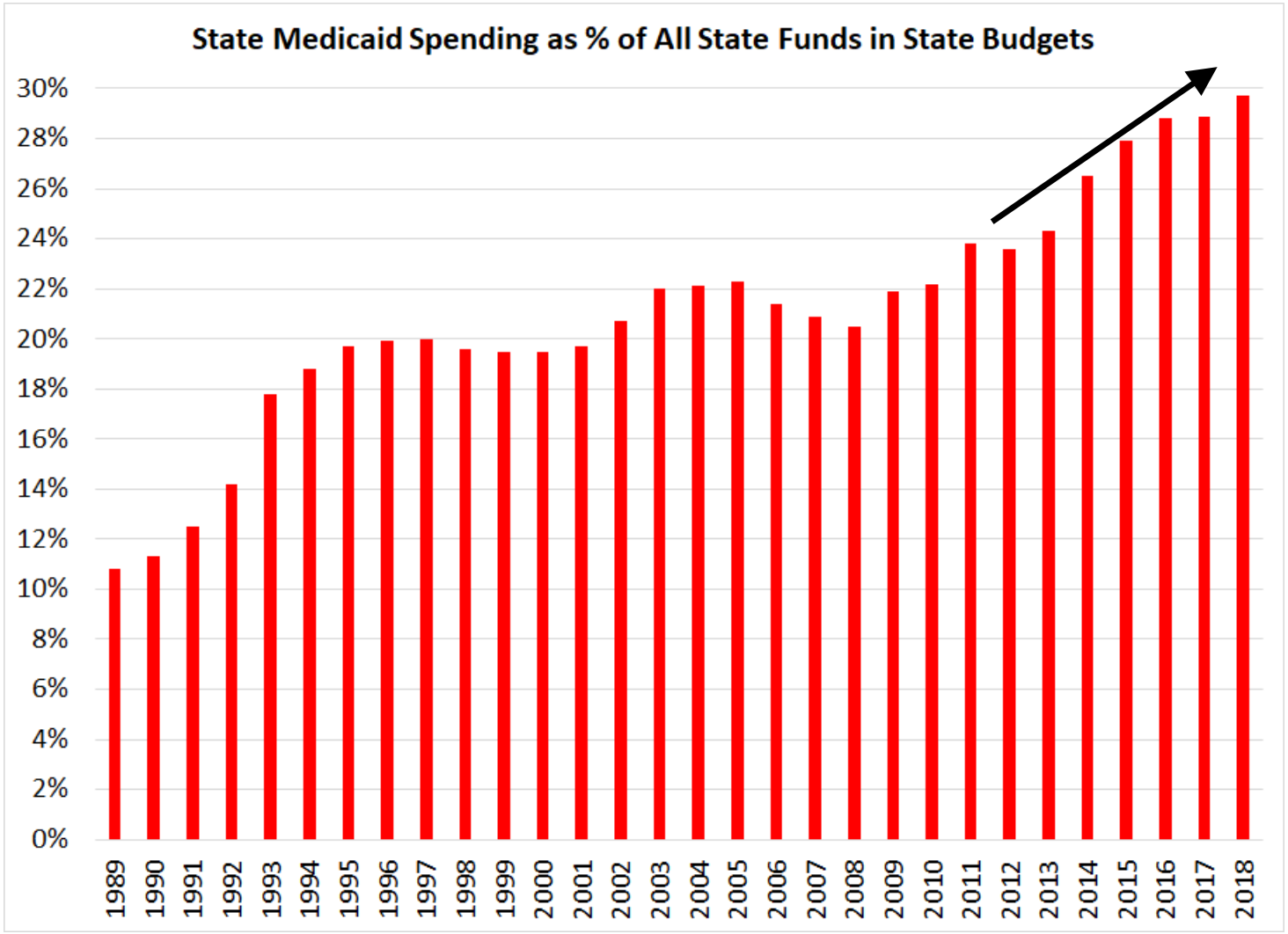
- How to reduce the Federal deficit
- How to reduce health insurance premiums
- How to create “value-based payment” for oncology that will:
  - Save money,
  - Improve care for cancer patients, and
  - Maintain the financial viability of oncology practices

U.S. Healthcare Spending is the Biggest Driver of Federal Deficits



Source: CBO

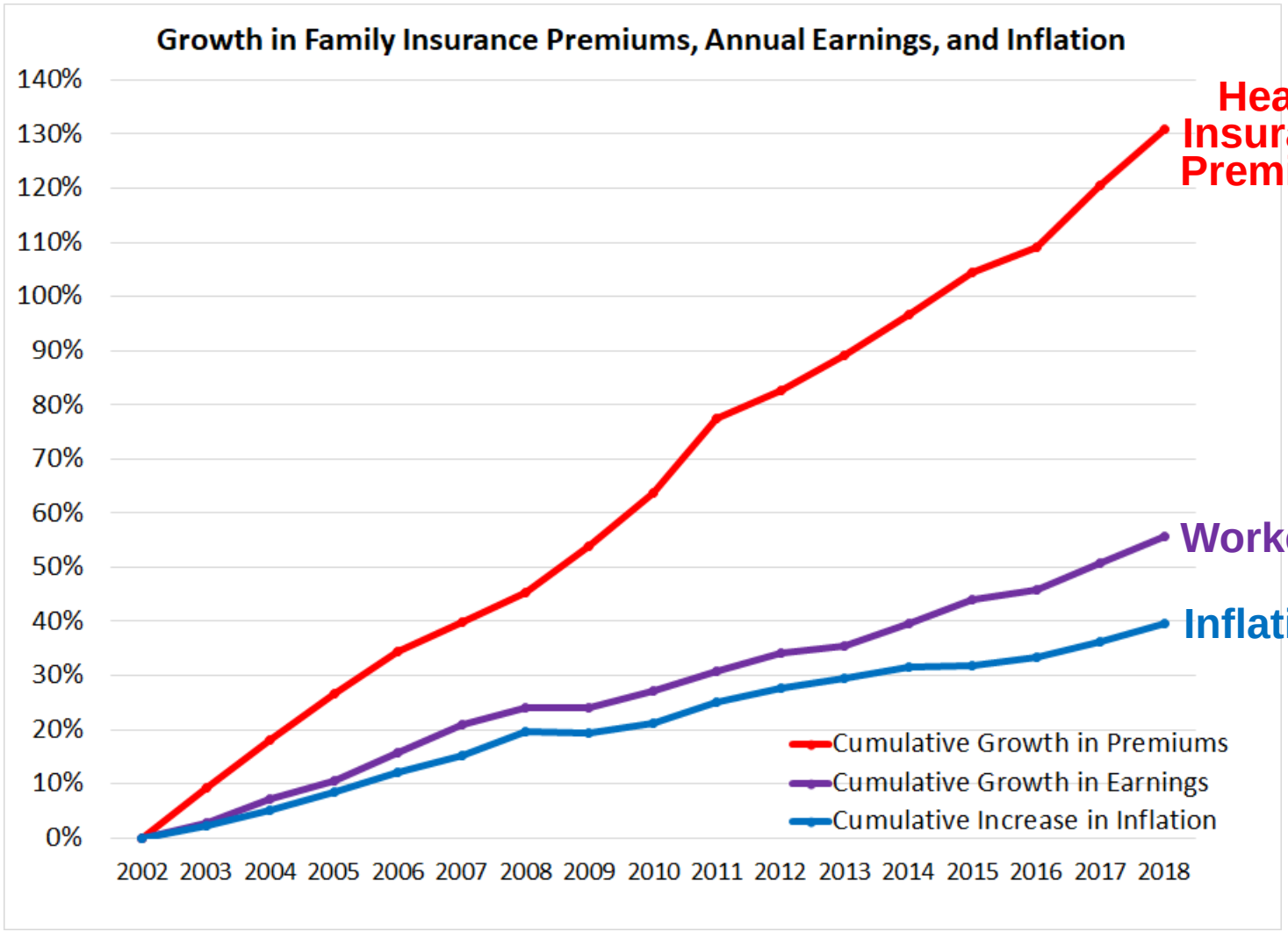
Increasing Share of State Budgets Goes to Medicaid Spending



Nearly 1/3 of All State Funds Are Now Used for Medicaid

Source: NASBO

Private Insurance Premiums Are Increasingly Unaffordable

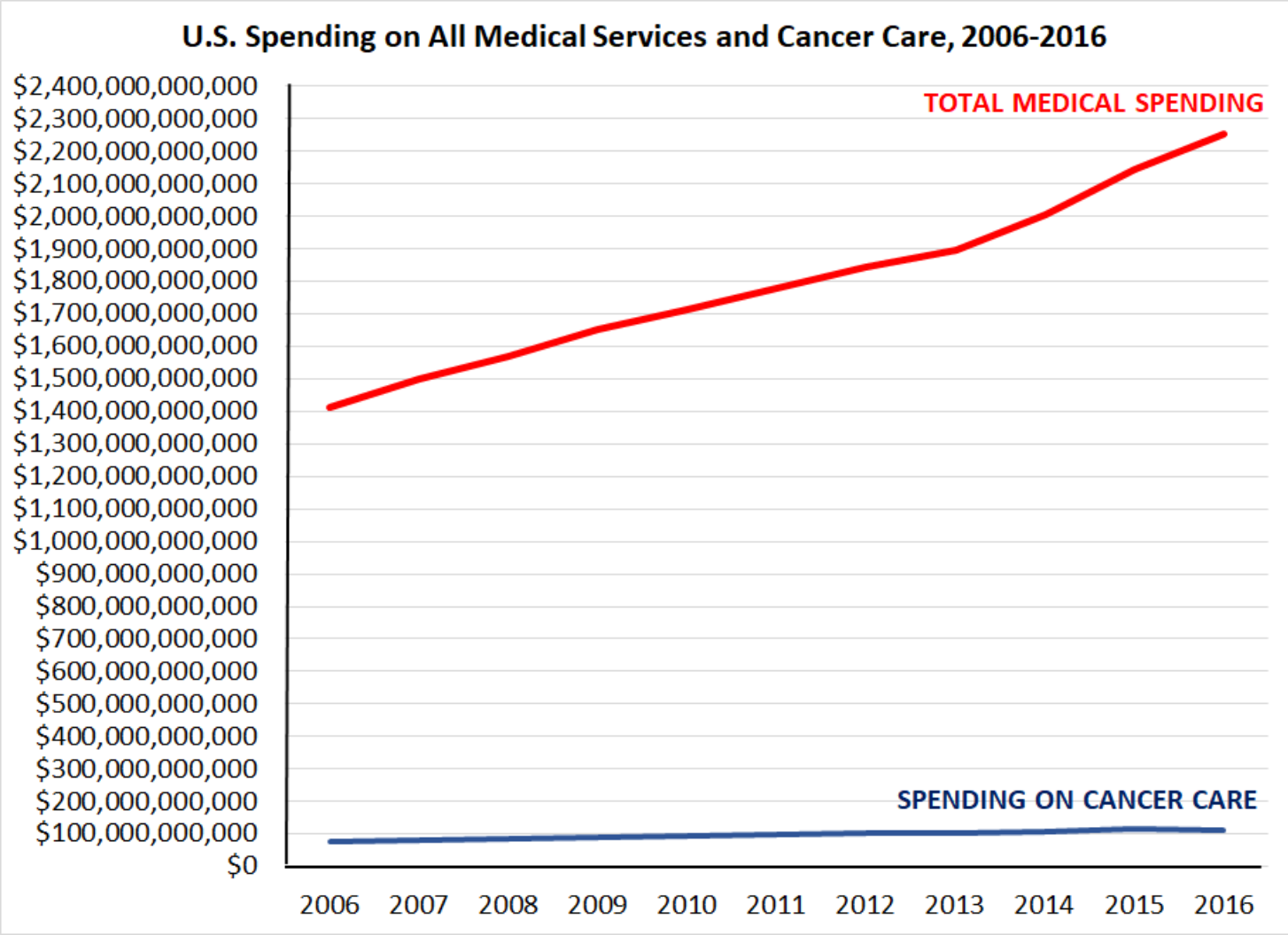


Source: Medical Expenditure Panel Survey & Bureau of Labor Statistics

The Impact of Cancer Care on U.S. Healthcare Spending

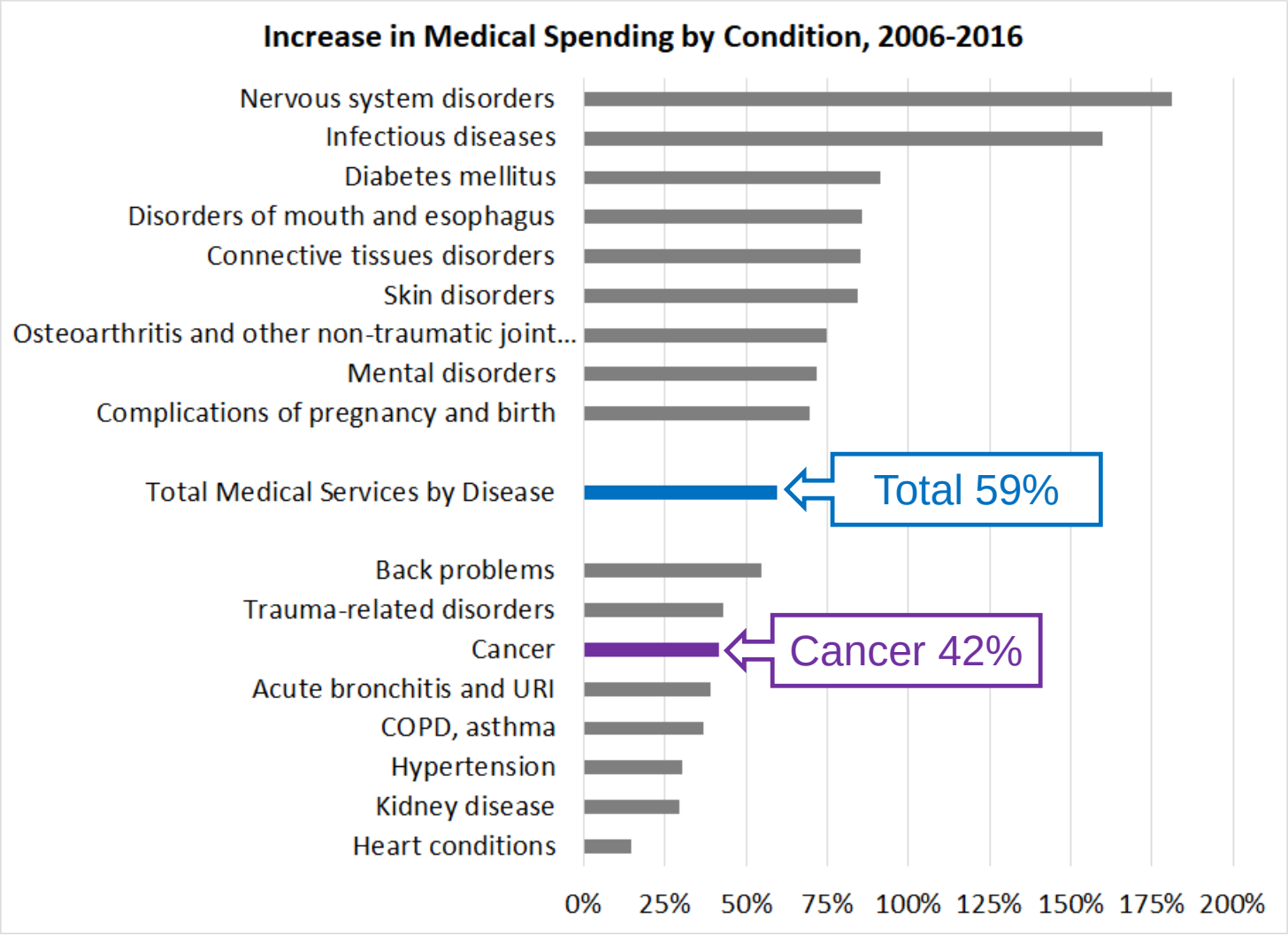
- How much of the increase in total healthcare spending in the U.S. over the past decade was due to the growth in the cost of cancer care?
  - 5%
  - 10%
  - 20%
  - 30%
  - 50%

Cancer Care Spending Was Only 3.9% of Total Spending Growth



SOURCE: U.S. Bureau of Economic Analysis, Health Care Satellite Account, 2016 Data (Released Sept. 2019)

Growth in Cancer Care Spending Less Than Many Other Diseases



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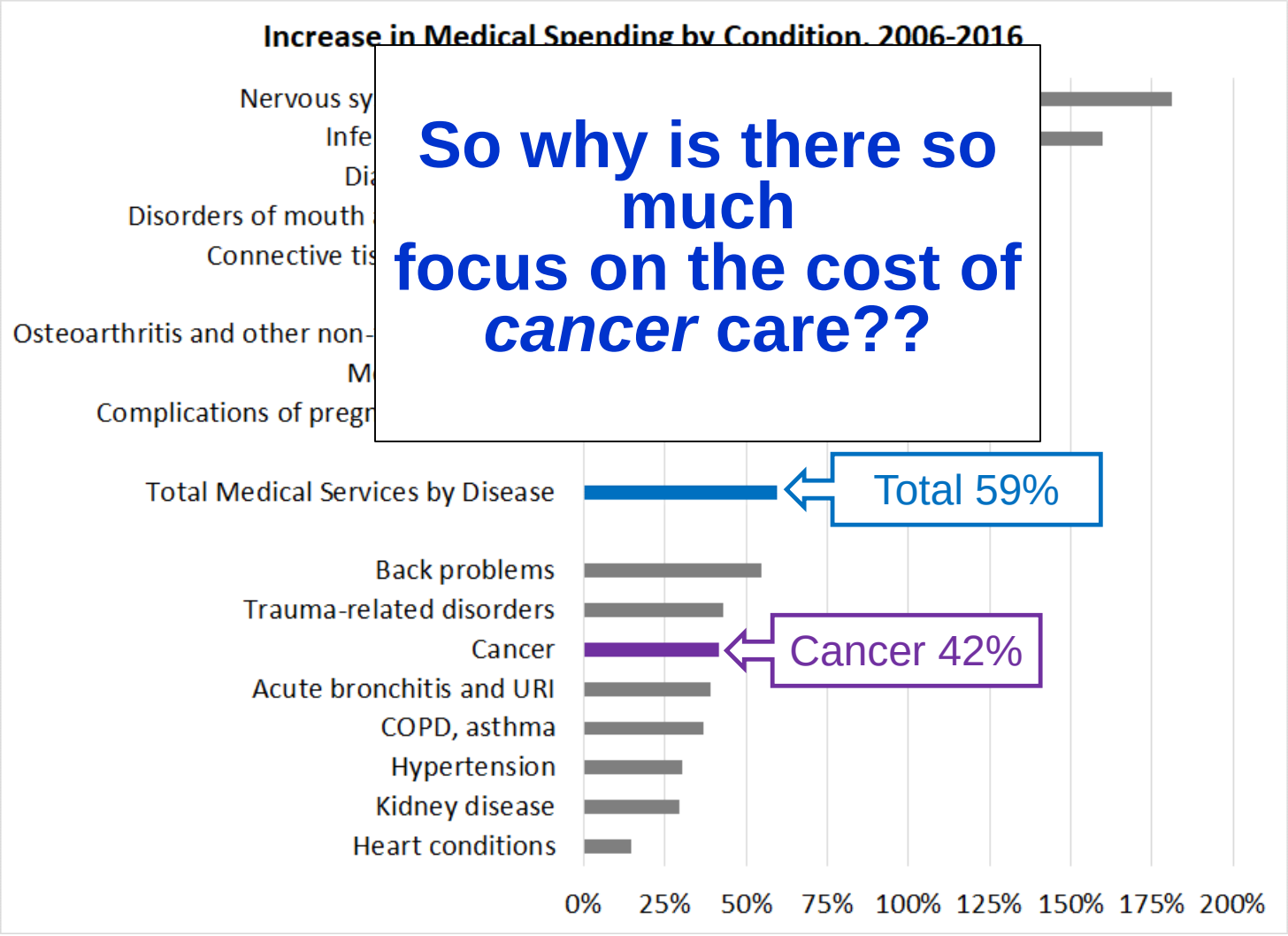

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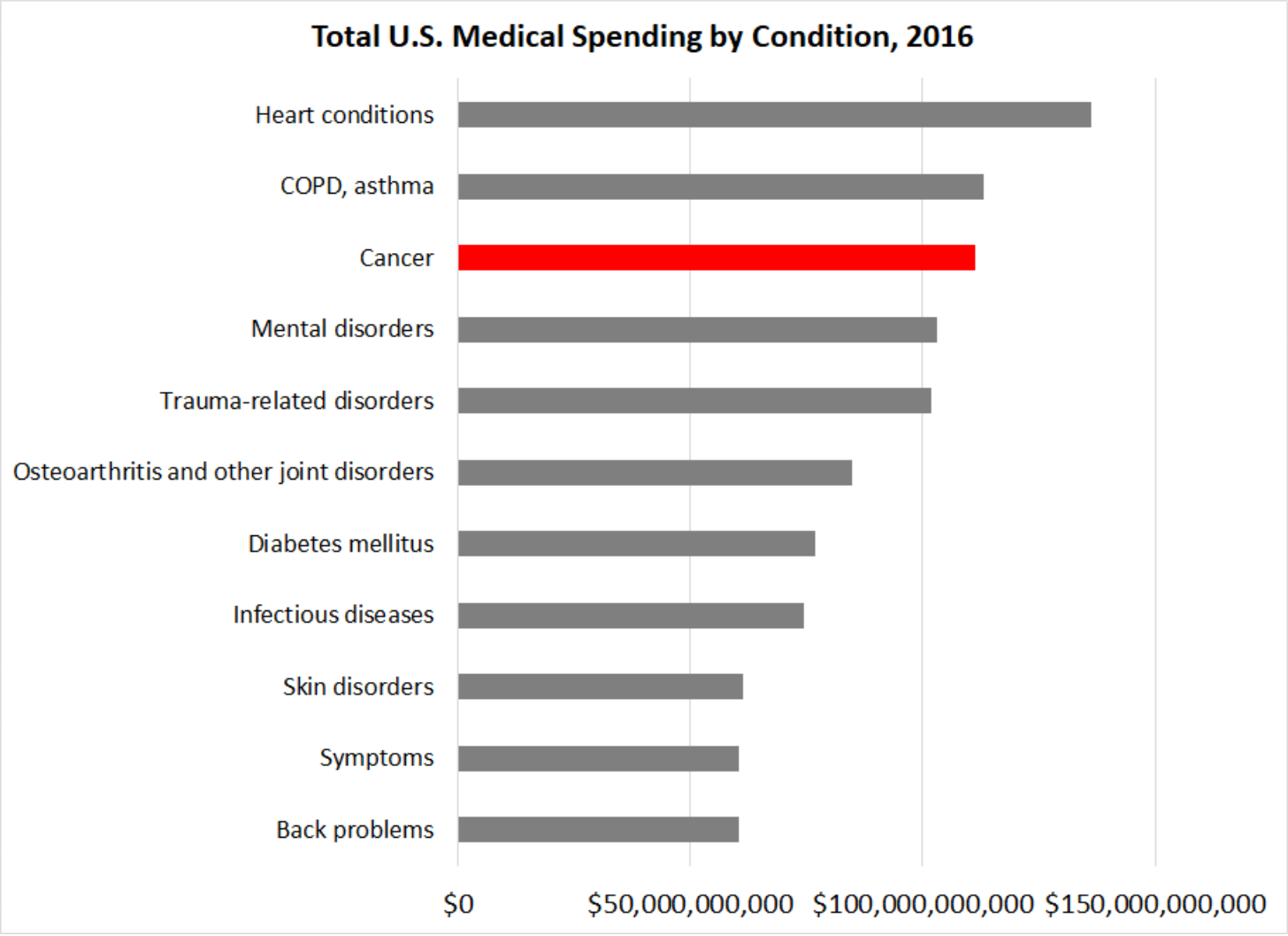
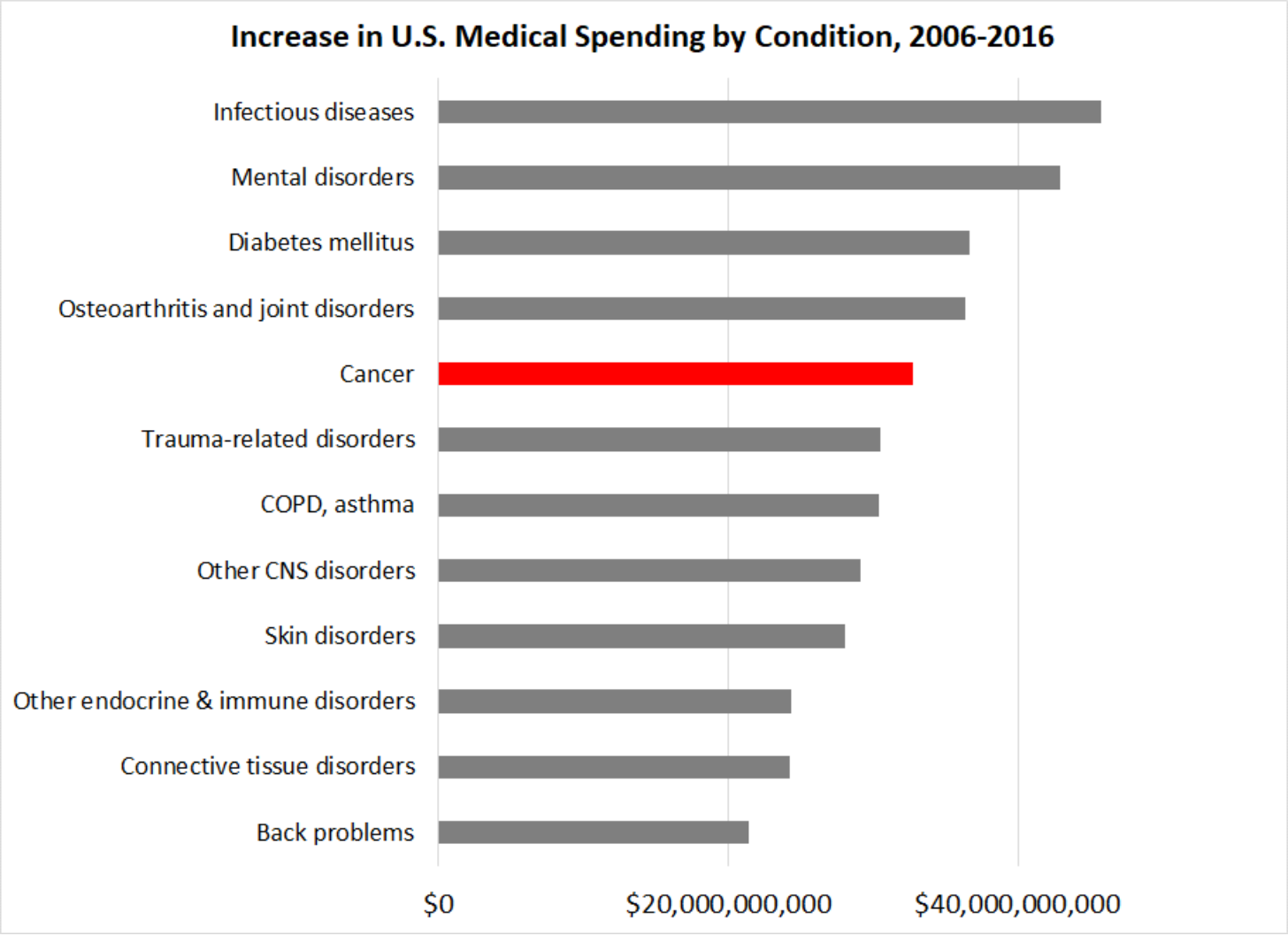
Cancer is The Third Largest Area of *Total* Spending



SOURCE: U.S. Bureau of Economic Analysis, Health Care Satellite Account, 2016 Data (Released Sept. 2019)

Cancer Was the 5th Largest $ Contributor to Total Cost Growth



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Can Cancer Spending Be Reduced Without Harming Patients??

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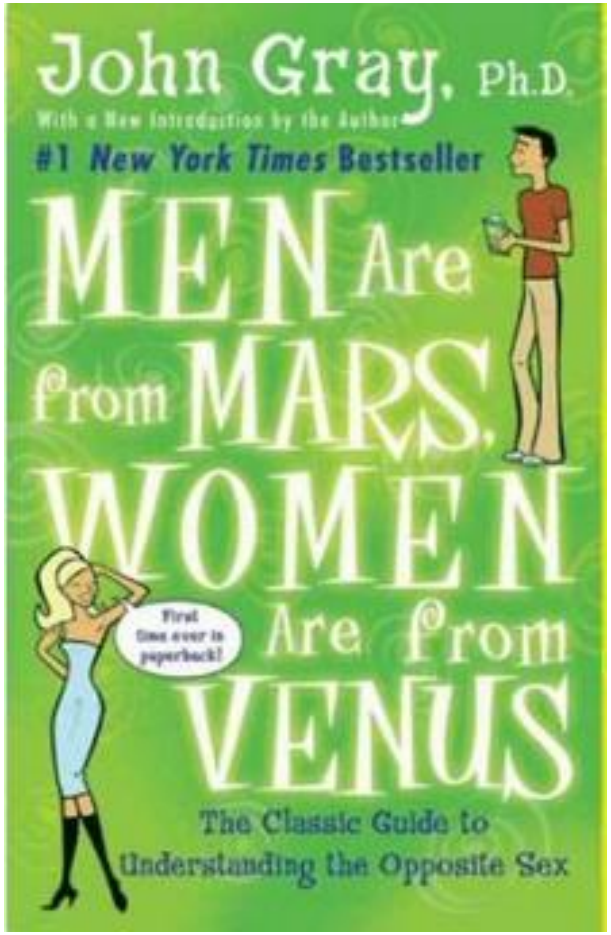

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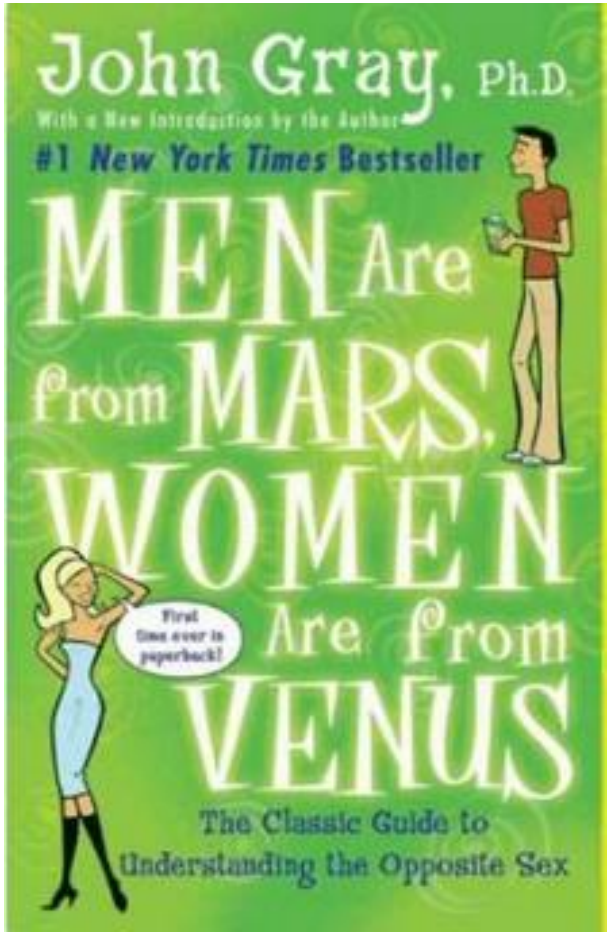
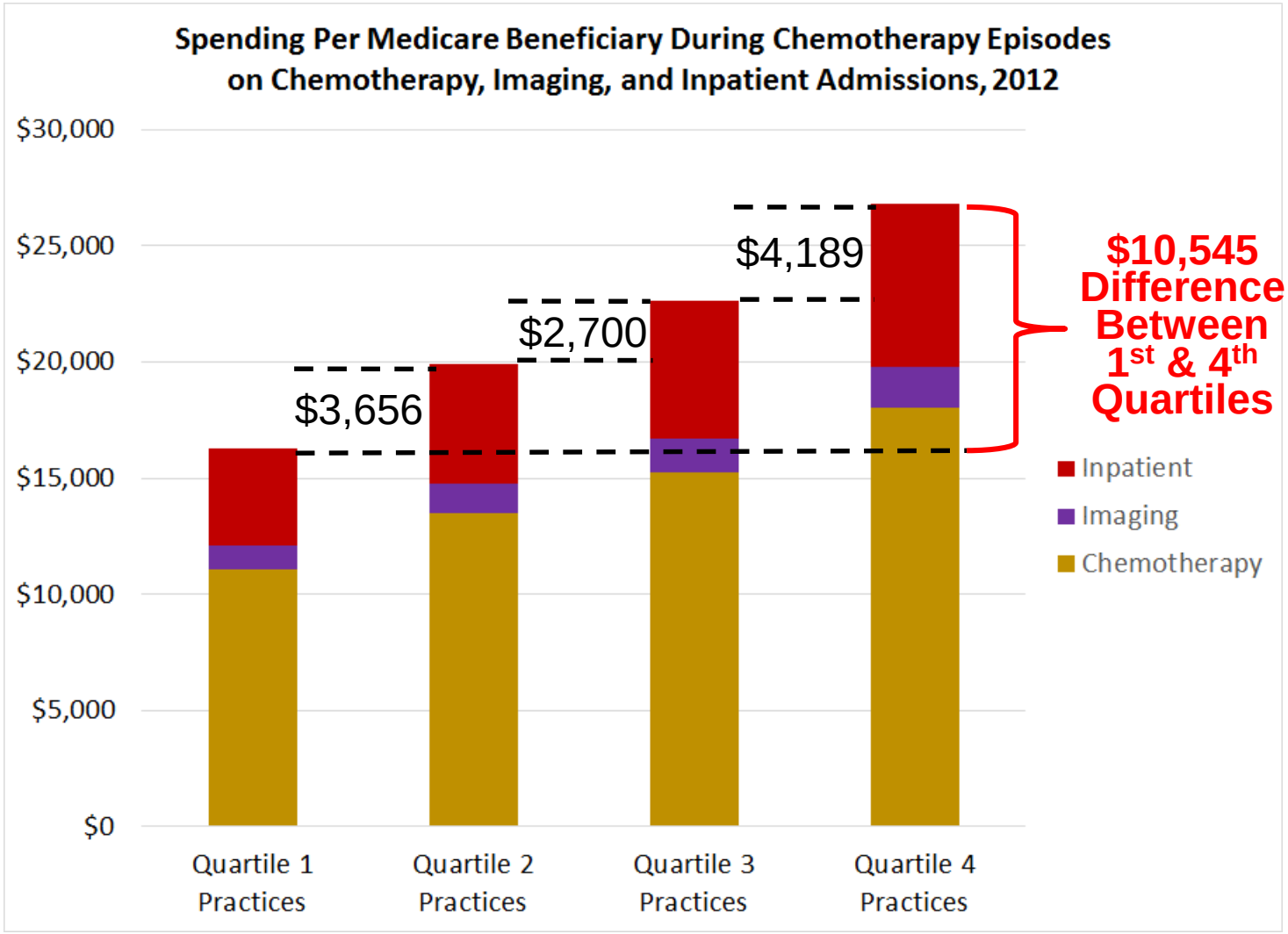


In Healthcare,
Payers Are From Mars,
Providers Are From Venus

How Payers See the Problems in Cancer Care

"MARS"
WHAT PAYERS SEE AS THE PROBLEMS IN CANCER CARE

Spending on Oncology Services Varies Significantly By Practice



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

Variation in Services Is Not Driven By Differences in Patients

Variation in the Cost of Radiation Therapy Among Medicare Patients With Cancer

By Anthony J. Paravati, MD, MBA, Isabel J. Boero, MS, Daniel P. Triplett, MPH, Lindsay Hwang, Rayna K. Matsuno, PhD, MPH, Beibei Xu, PhD, Loren K. Mell, MD, and James D. Murphy, MD, MS

Moores Cancer Center, University of California San Diego, La Jolla, CA; and Medical Informatics Center, Peking University, Beijing, People's Republic of China

Abstract

Purpose: Radiation therapy represents a major source of health care expenditure for patients with cancer. Understanding the sources of variability in the cost of radiation therapy is critical to evaluating the efficiency of the current reimbursement system and could shape future policy reform. This study defines the magnitude and sources of variation in the cost of radiation therapy for a large cohort of Medicare beneficiaries.

Patients and Methods: We identified 55,288 patients within the SEER database diagnosed with breast, lung, or prostate cancer between 2004 and 2009. The cost of radiation therapy was estimated from Medicare reimbursements. Multivariable linear regression models were used to assess the influence of patient, tumor, and radiation therapy provider characteristics on variation in cost of radiation therapy.

Results: For breast, lung, and prostate cancers, the median cost (interquartile range) of a course of radiation therapy was $8,600 ($7,300 to $10,300), $9,000 ($7,500 to $11,100), and $18,000 ($11,300 to $25,500), respectively. For all three cancer subtypes, patient- or tumor-related factors accounted for < 3% of the variation in cost. Factors unrelated to the patient, including practice type, geography, and individual radiation therapy provider, accounted for a substantial proportion of the variation in cost, ranging from 44% with breast, 43% with lung, and 61% with prostate cancer.

Conclusion: In this study, factors unrelated to the individual patient accounted for the majority of variation in the cost of radiation therapy, suggesting potential inefficiency in health care expenditure. Future research should determine whether this variability translates into improved patient outcomes for further evaluation of current reimbursement practices.

Journal of Oncology Practice 11(5), September 2015

…patient- or tumor-related factors accounted for <3% of the variation in cost. Factors unrelated to the patient, including practice type, geography, and individual radiation therapy provider accounted for …
44% [of] breast,
43% [of] lung, and
61% [of] prostate cancer [variation].

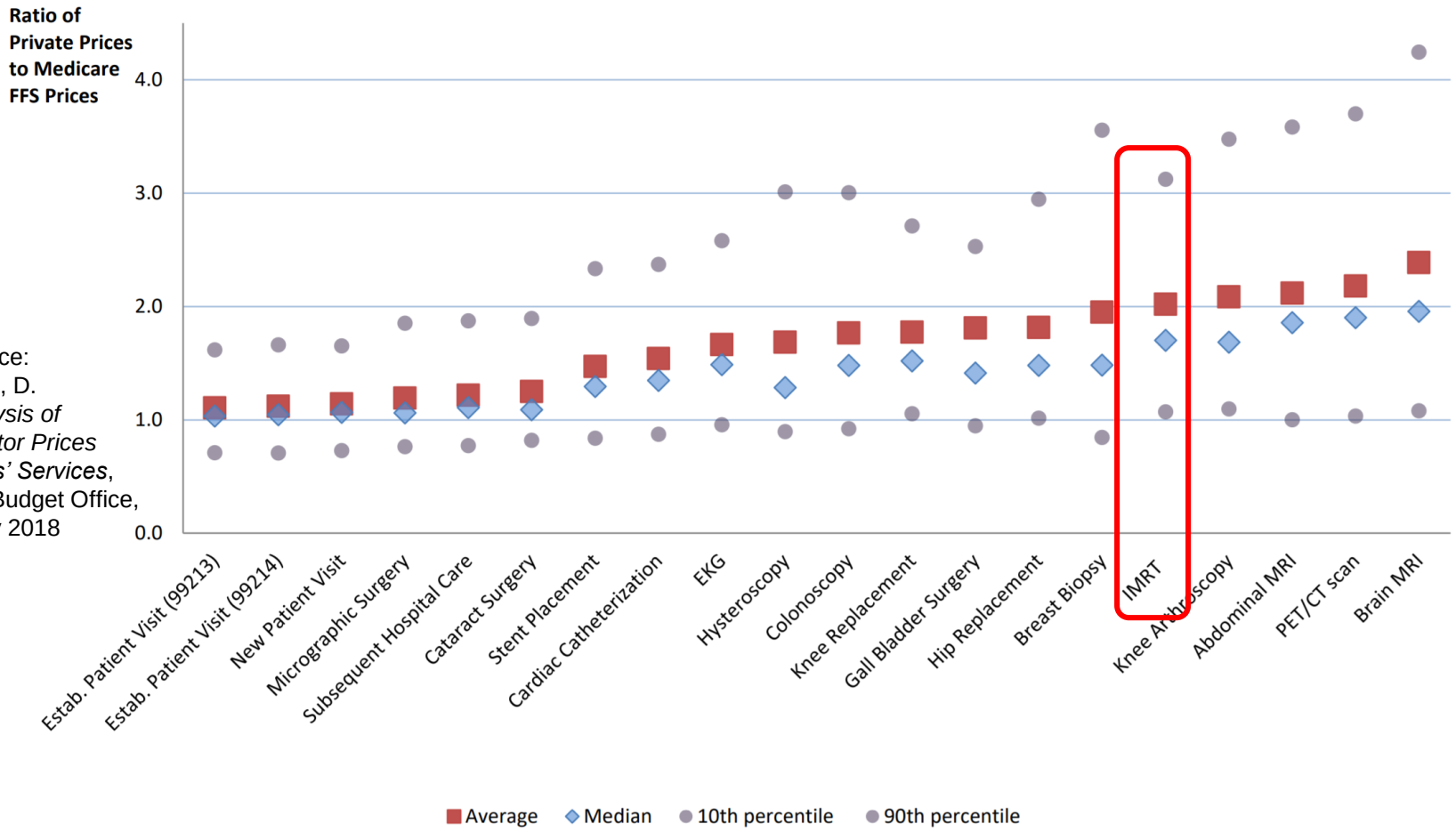
A Lot of Cancer Care is More Expensive Than Necessary

	Average Total Spending Per Patient Per Month		
Type of Cancer	**Community Practice**	**Hospital Practice**	**Difference**
Breast Cancer	$11,599	$19,279	+66%
Lung Cancer	$17,566	$26,980	+54%
Colorectal Cancer	$12,368	$19,346	+56%
All Cancers	$12,548	$20,060	+60%

Source: Gordan L et al. "Cost Differences Associated with Oncology Care Delivered in a Community Setting Versus a Hospital Setting: A Matched-Claims Analysis of Patients With Breast, Colorectal, and Lung Cancers," *Journal of Oncology Practice* 14(12): e729-e738 (December 2018).

3-Fold Variation in Price of Radiation Therapy Across U.S.

Figure 1. Commercial Prices for Selected Physicians' Services, 2014



Source:
Pelech, D.
An Analysis of Private-Sector Prices for Physicians' Services,
Congressional Budget Office,
January 2018

It's Bad Enough That Cancer Drugs Are So Expensive…

	Spending Per Patient	
	Rituximab	**Nivolumab**
Average Sales Price (ASP)	$23,880	$48,490

… But Oncologists Are "Profiting" From Ordering Expensive Drugs

	Spending Per Patient	
	Rituximab	**Nivolumab**
Average Sales Price (ASP)	$23,880	$48,490
+ 4.3%	$ 1,027	$ 2,085
Medicare Payment	$24,906	$50,575

… But Oncologists Are "Profiting" From Ordering Expensive Drugs

	Spending Per Patient	
	Rituximab	**Nivolumab**
Average Sales Price (ASP)	$23,880	$48,490
+ 4.3%	$ 1,027	$ 2,085
Medicare Payment	$24,906	$50,575
+15.0%	$ 3,582	$ 7,274
Commercial Payment	$27,461	$55,764

… But Oncologists Are "Profiting" From Ordering Expensive Drugs

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	Rituximab	**Nivolumab**
Average Sales Price (ASP)	$23,880	$48,490
+ 4.3%	$ 1,027	$ 2,085
Medicare Payment	$24,906	$50,575
+15.0%	$ 3,582	$ 7,274
Commercial Payment	$27,461	$55,764
+50.0%	$11,940	$24,245
Commercial Payment	$35,820	$72,735

How *Payers* See the Problems in Cancer Care

"MARS"
WHAT PAYERS SEE AS THE PROBLEMS IN CANCER CARE
Unwarranted variation in services
Overpayment for many services
Providers profiting from high-cost services

How *Providers* See the Problems in Cancer Care

"MARS"	*"VENUS"*
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Unwarranted variation in services	
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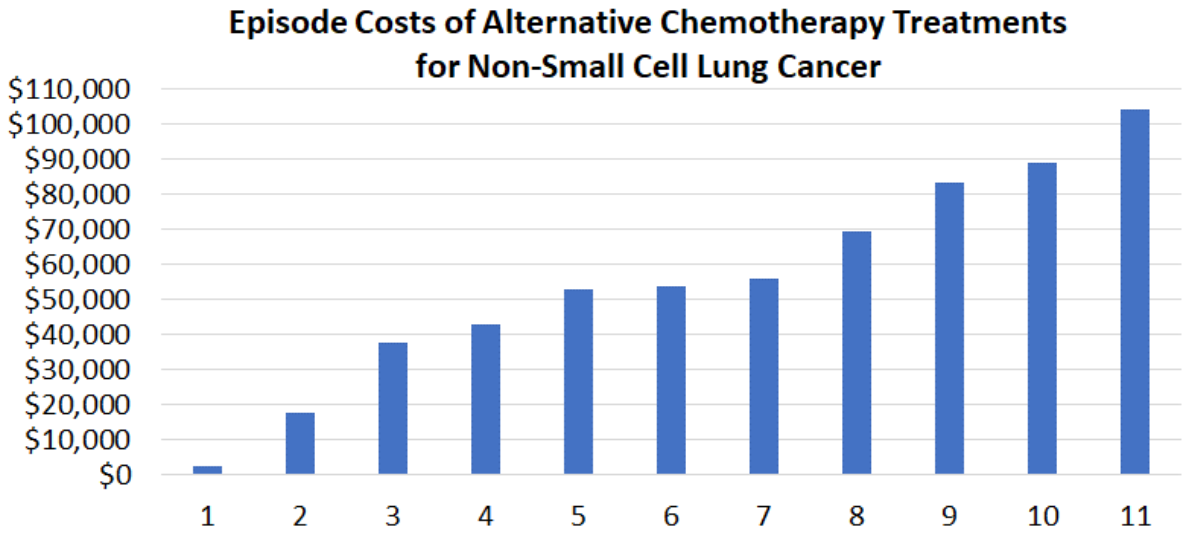
Providers profiting from high-cost services	

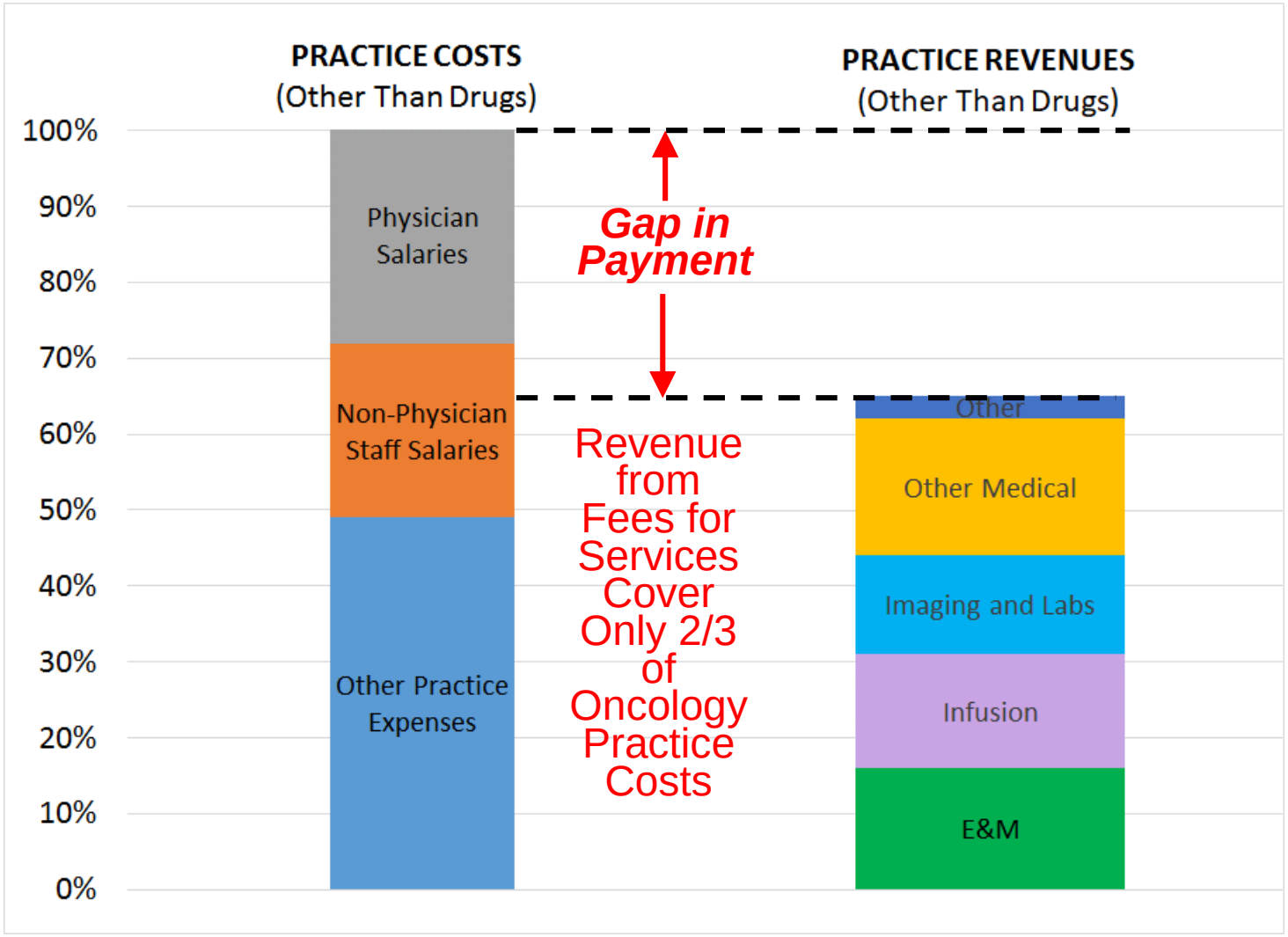
Treatment Costs Vary Because Patients Are *Different*



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

Ward JC et al. Impact on Oncology Practices of Including Drug Costs in Bundled Payments. *Journal of Oncology Practice* 14(5), May 2018

Oncology Practices Are Paid Far Less Than Services Cost



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

What Oncology Practices Do 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.

Most of Those Activities Aren't Paid For

WHAT ONCOLOGY PRACTICES DO

Diagnosis and Treatment Planning

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- 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.)

No Payments for Many Services When Parenteral Therapy is Used

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 payments for care management services to help patients address complications without ED visits)

No Payment for Most Services 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.

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.)

Few Payments for Services to Patients After Treatment 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.

HOW PRACTICES ARE PAID

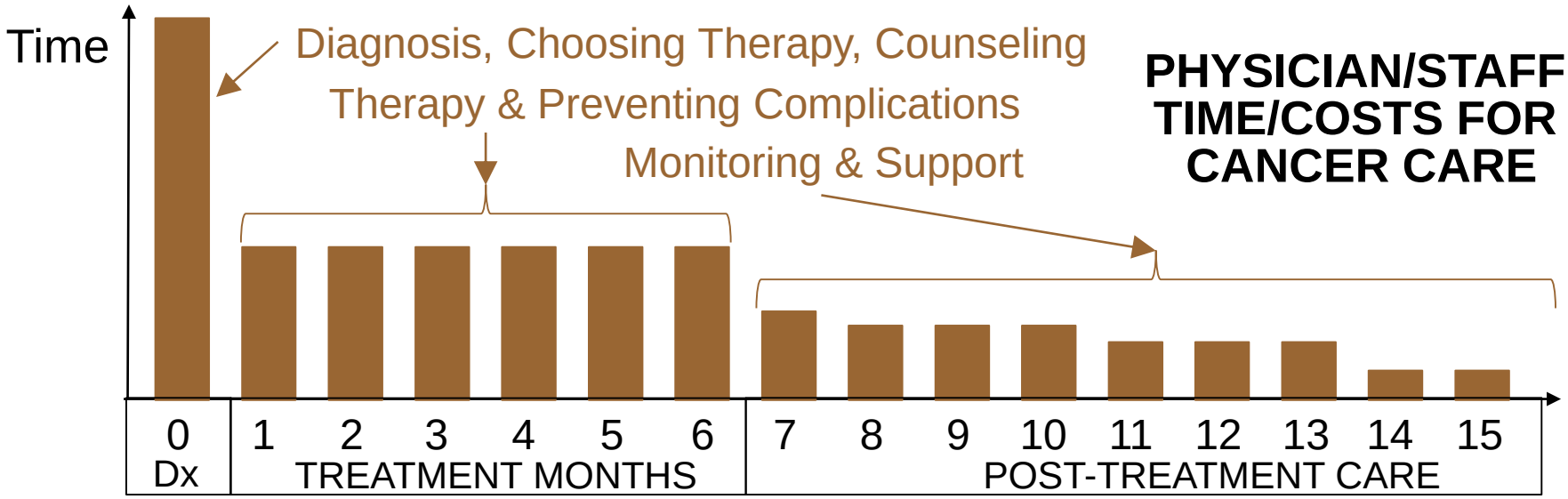
- E&M payments for face-to-face visits with physicians

(No payments for services delivered by nurses, social workers, financial counselors, etc.)

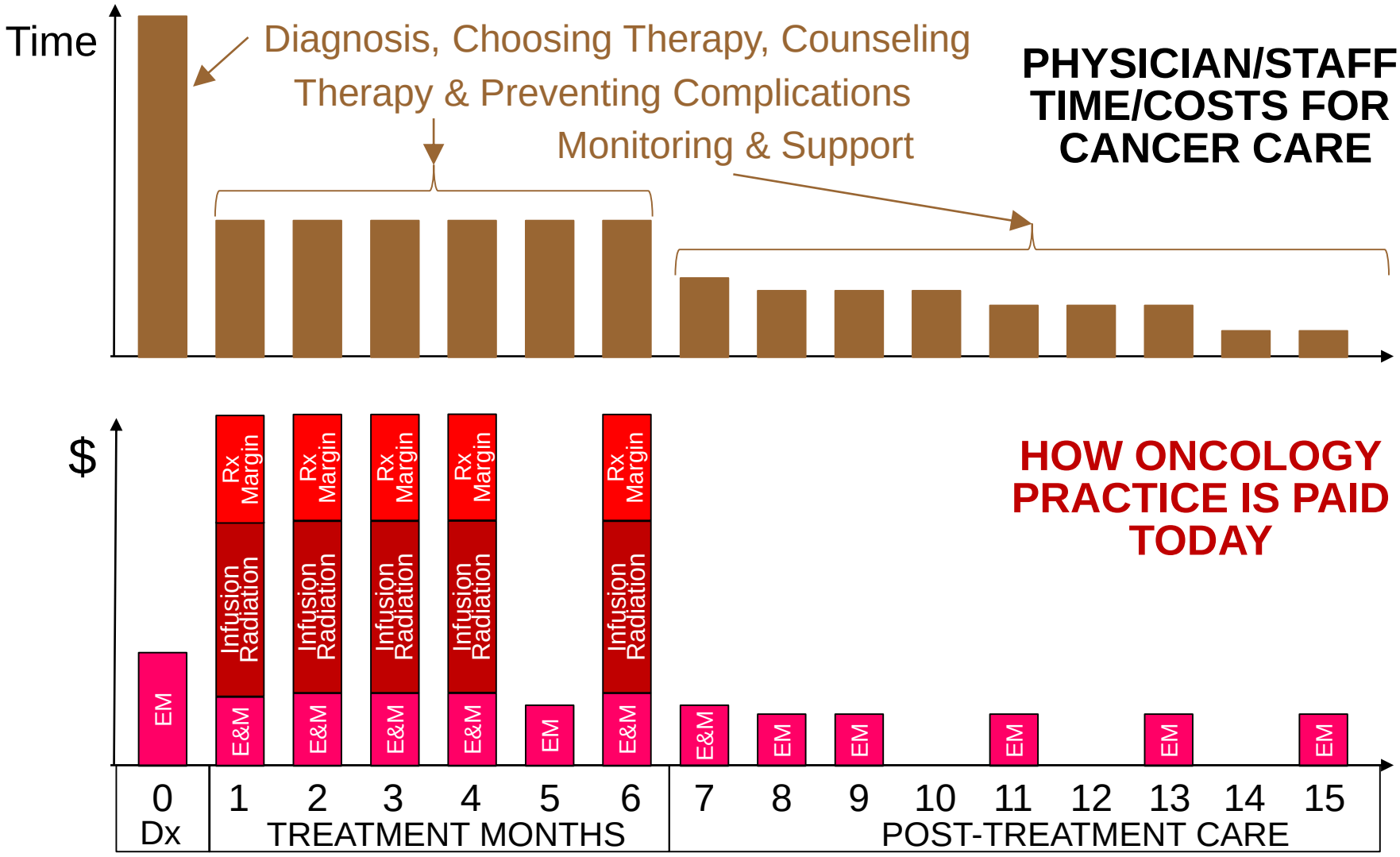
(No payments for time spent by physicians on phone calls with patients and other physicians, etc.)

(No payments for palliative care services to patients)

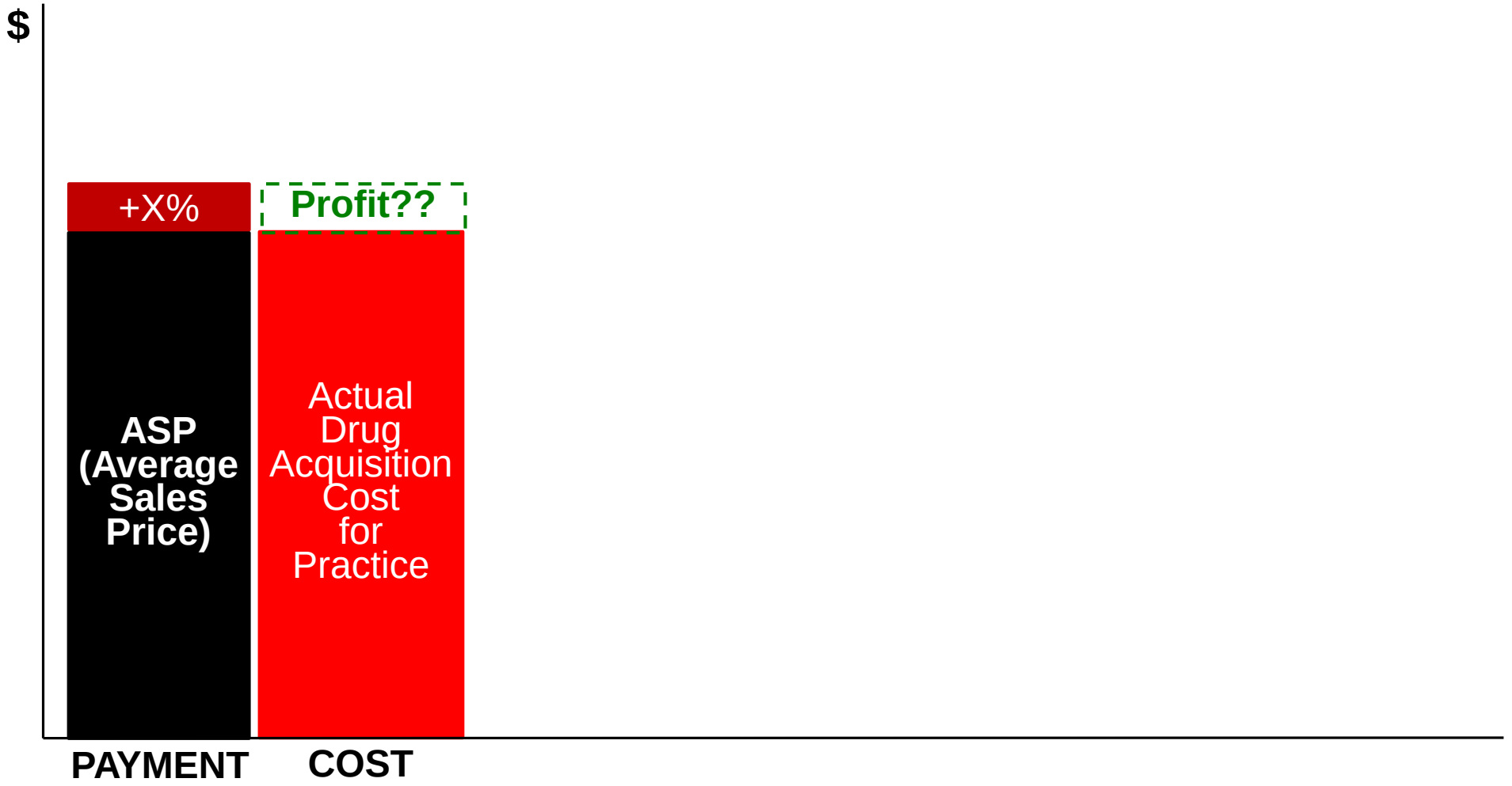
How Oncology Practices Spend Their Time



Payments to Oncology Practices Don't Match Their Time & Costs

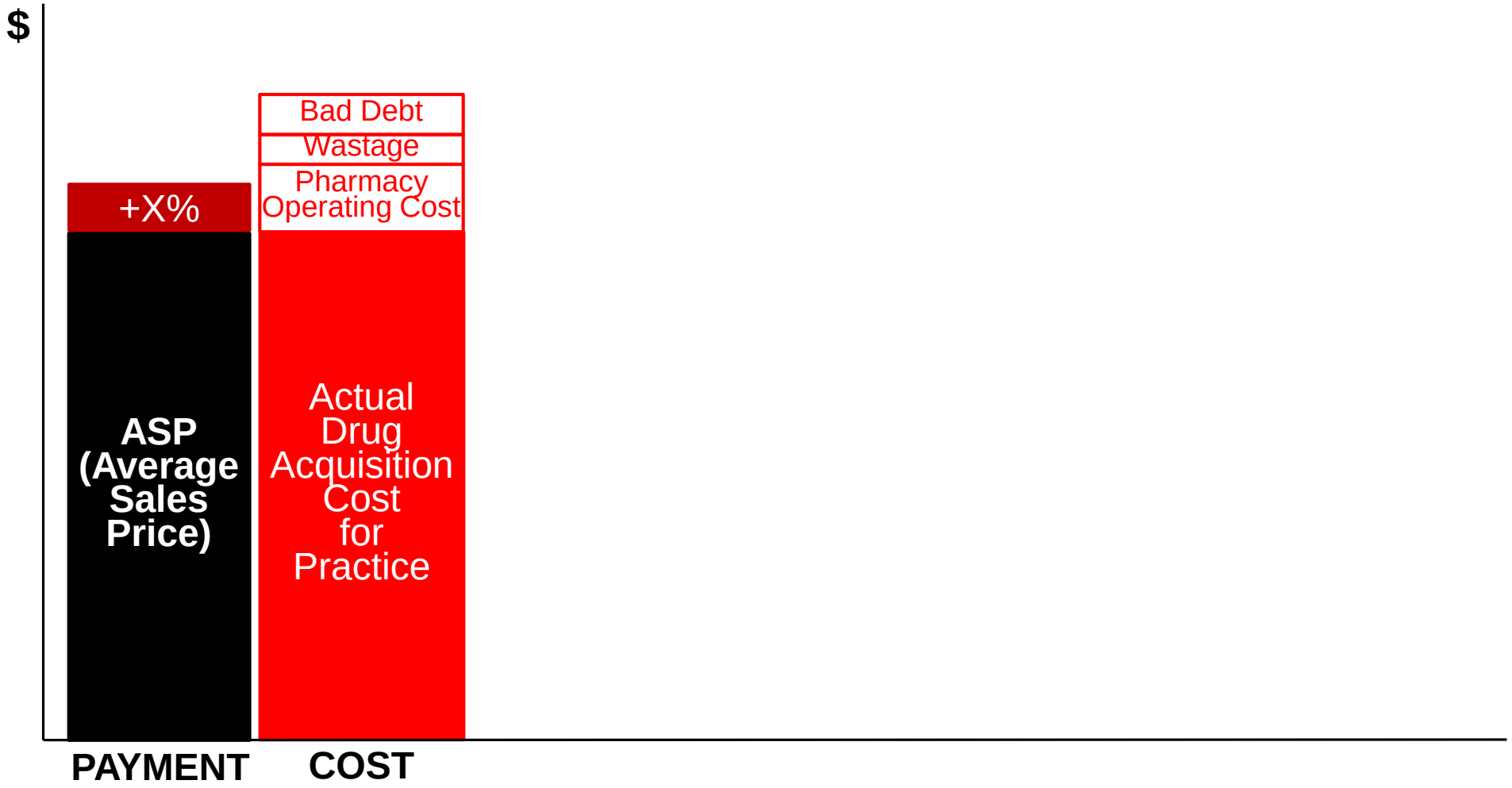


ASP + X% Might *Appear* to Create Profits for Oncologists…



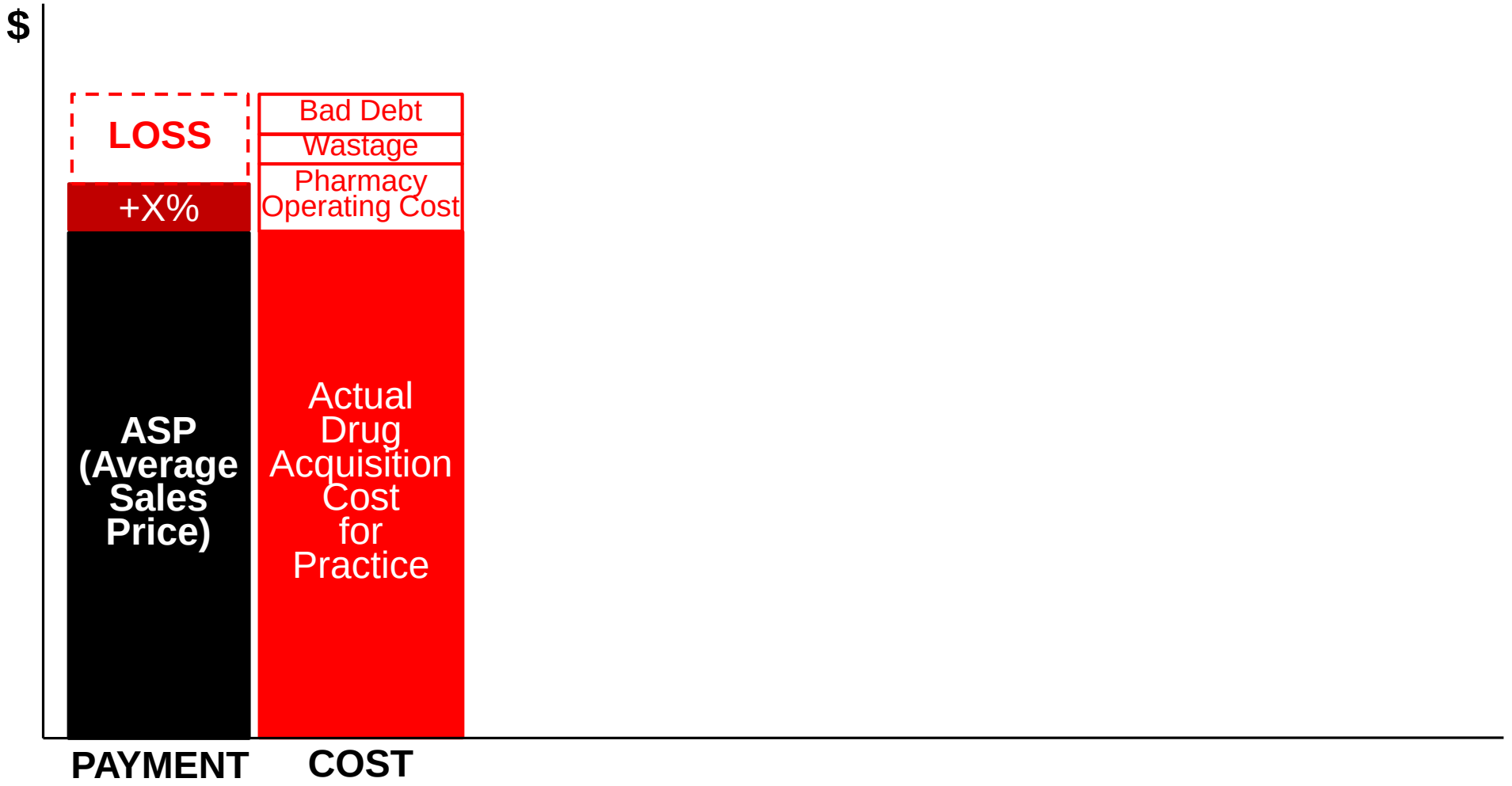
NOTE: *Chart not drawn to scale*

…But the Oncology Practice Has Costs Beyond Drug Acquisition…



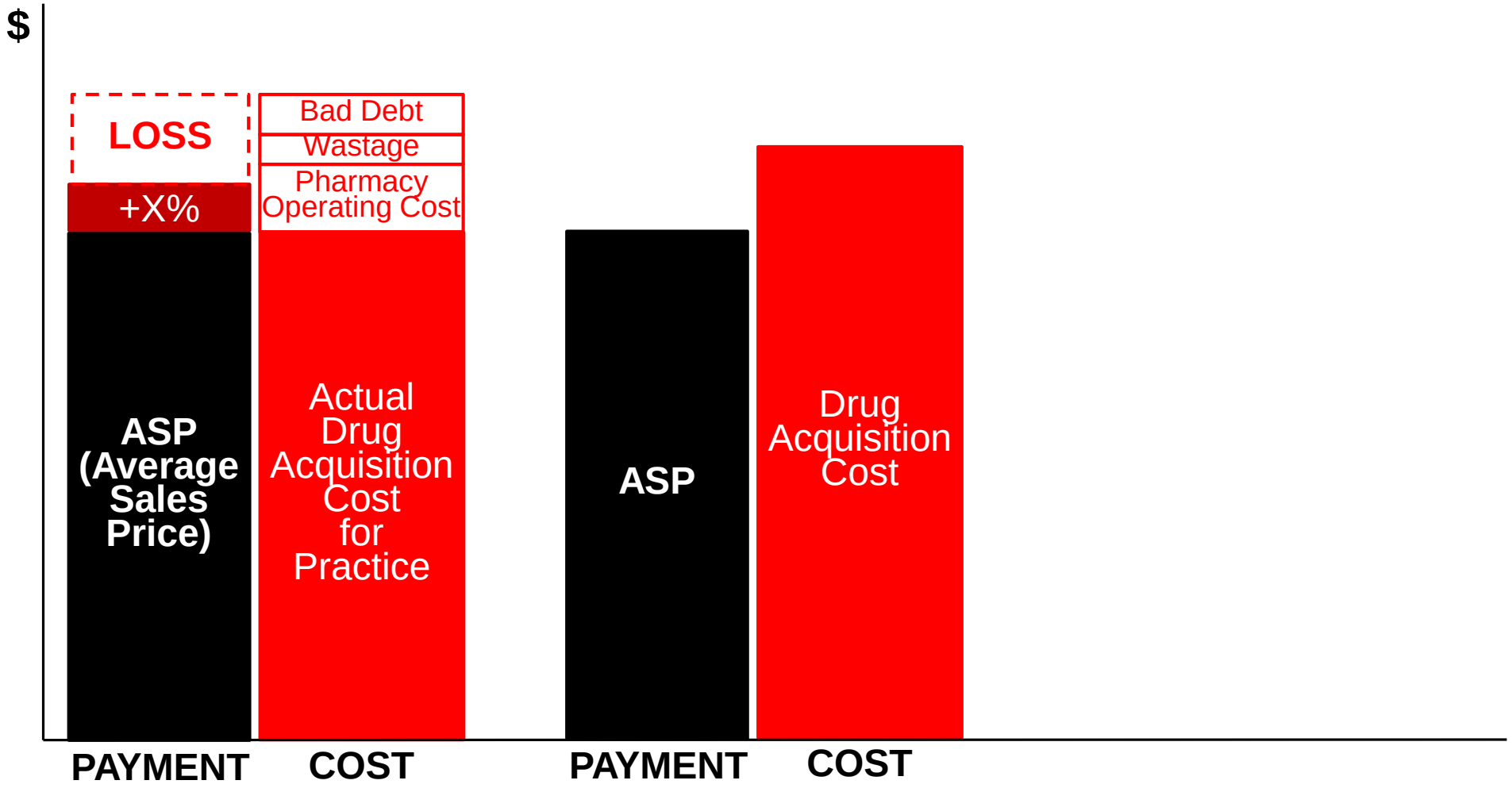
NOTE: *Chart not drawn to scale*

…Resulting in Losses, Not Profits



NOTE: *Chart not drawn to scale*

There is No Guarantee a Practice Can Actually *Buy* a Drug at "ASP"



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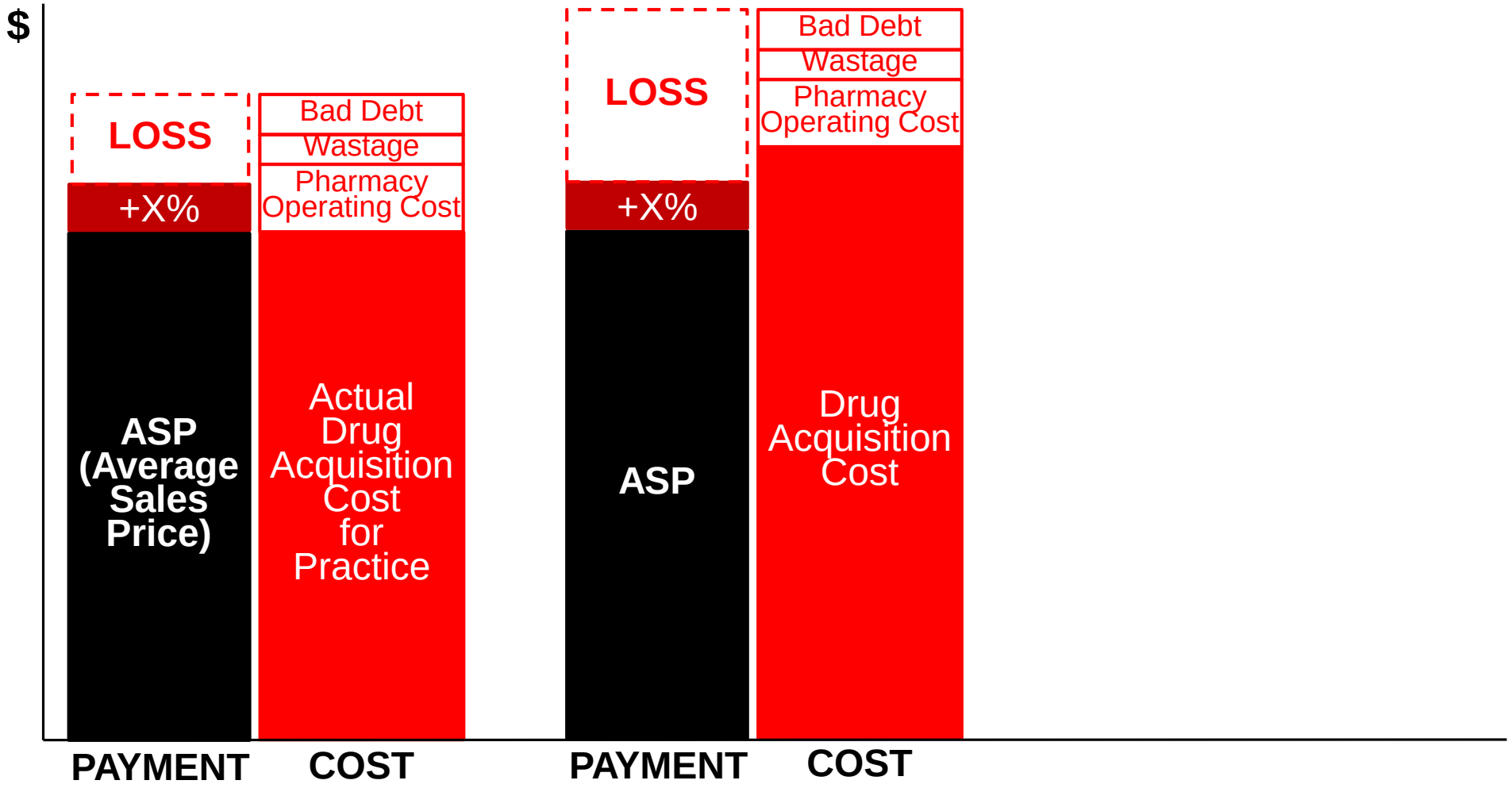
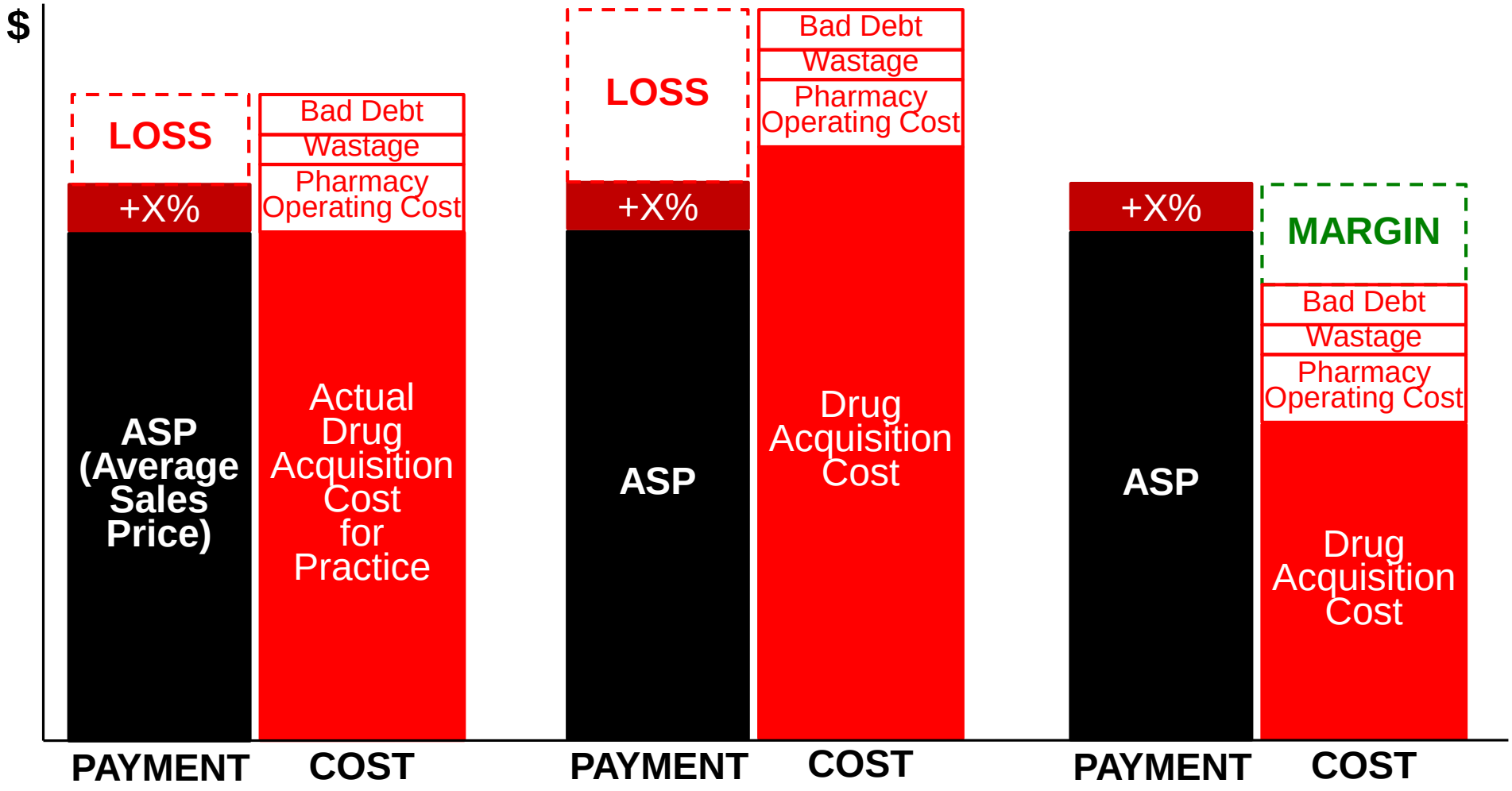
So Losses Can Be Much Greater



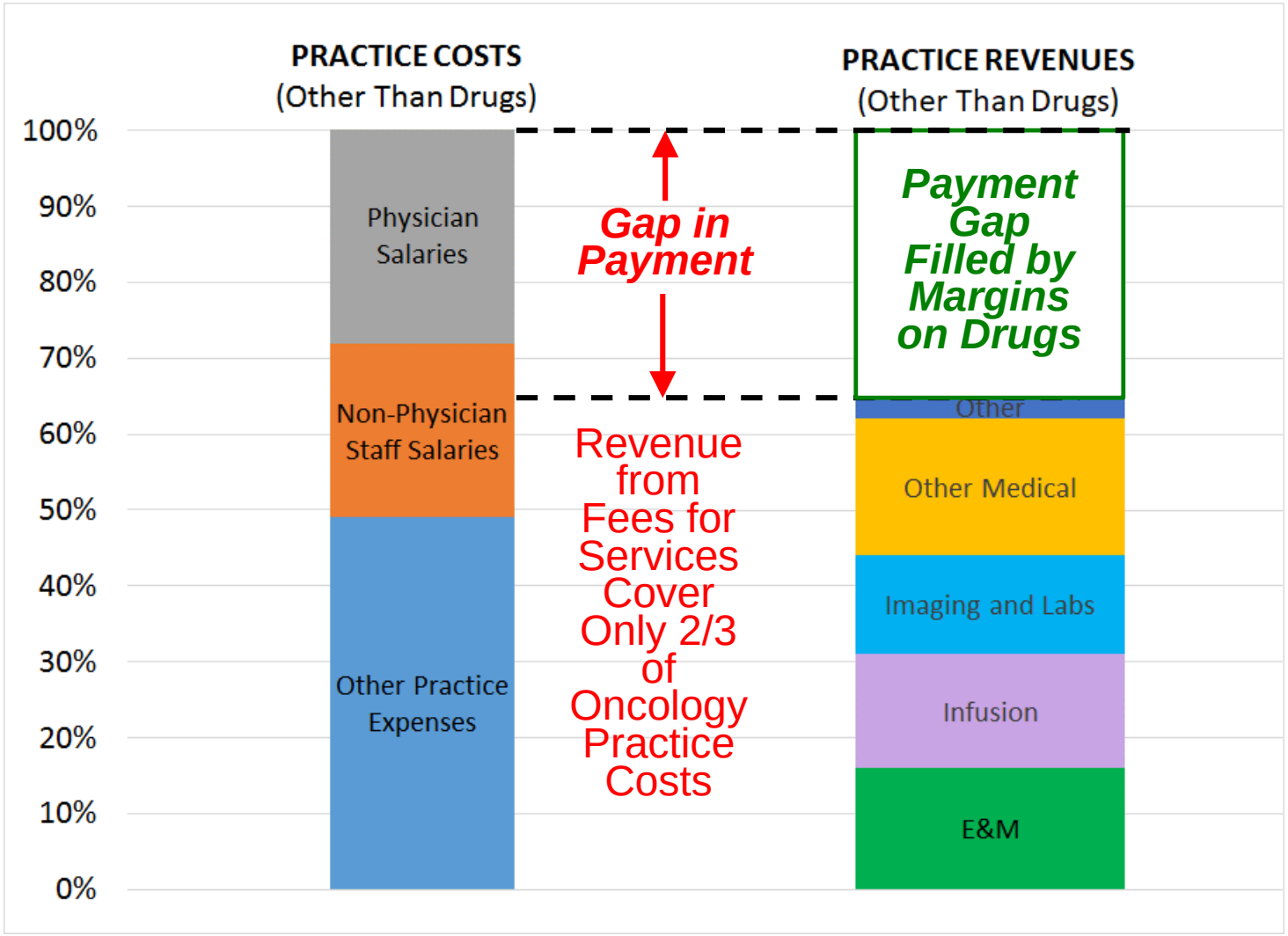
NOTE: *Chart not drawn to scale*

When There is a Profit, It Offsets Losses on Other Drugs



NOTE: *Chart not drawn to scale*

Without Drug Margins, Oncology Practices Couldn't Stay Afloat



SOURCE:
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What *Payers* See as the Problems in Cancer Care

"MARS"	*"VENUS"*
WHAT PAYERS SEE AS THE PROBLEMS IN CANCER CARE	**WHAT PROVIDERS SEE AS THE PROBLEMS IN CANCER CARE**
Unwarranted variation in services	
Overpayment for many services	
Providers profiting from high-cost services	

What *Providers* See as the Problems in Cancer Care

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WHAT PAYERS SEE AS THE PROBLEMS IN CANCER CARE	**WHAT PROVIDERS SEE AS THE PROBLEMS IN CANCER CARE**
Unwarranted variation in services	Wide variation in patient needs
Overpayment for many services	Underpayment for many services
Providers profiting from high-cost services	Cross-subsidies needed to cover costs

What Do Payers Propose as Solutions in Cancer Care?

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WHAT PAYERS PROPOSE AS SOLUTIONS

What Payers Propose as Solutions in Cancer Care

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WHAT PAYERS PROPOSE AS SOLUTIONS
Prior authorization

What Payers Propose as Solutions in Cancer Care

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WHAT PAYERS PROPOSE AS SOLUTIONS
Prior authorization
Lower payments for services
Cuts in drug payments + Specialty pharmacies

What Do Providers Propose as Solutions in Cancer Care?

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Prior authorization	
Lower payments for services	
Cuts in drug payments + Specialty pharmacies	

What Providers Propose as Solutions in Cancer Care

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WHAT PAYERS PROPOSE AS SOLUTIONS	**WHAT PROVIDERS PROPOSE AS SOLUTIONS**
Prior authorization	Accreditation
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Cuts in drug payments + Specialty pharmacies	

What Providers Propose as Solutions in Cancer Care

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Prior authorization	Accreditation
Lower payments for services	Higher payments for services
Cuts in drug payments + Specialty pharmacies	Higher margins in buy-and-bill

The Payer Approaches Won't Solve Any of the Problems

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The Provider Proposals Won't Solve Any of the Problems, Either

"MARS"	*"VENUS"*
WHAT PAYERS SEE AS THE PROBLEMS IN CANCER CARE	**WHAT PROVIDERS SEE AS THE PROBLEMS IN CANCER CARE**
Unwarranted variation in services	Wide variation in patient needs
Overpayment for many services	Underpayment for many services
Providers profiting from high-cost services	Cross-subsidies needed to cover costs

WHAT PAYERS PROPOSE AS SOLUTIONS	**WHAT PROVIDERS PROPOSE AS SOLUTIONS**
Prior authorization	Accreditation
Lower payments for services	Higher payments for services
Cuts in drug payments + Specialty pharmacies	Higher margins in buy-and-bill

Can "Value-Based" Payment Do Better?

"MARS"	*"VENUS"*
WHAT PAYERS SEE AS THE PROBLEMS IN CANCER CARE	**WHAT PROVIDERS SEE AS THE PROBLEMS IN CANCER CARE**
Unwarranted variation in services	Wide variation in patient needs
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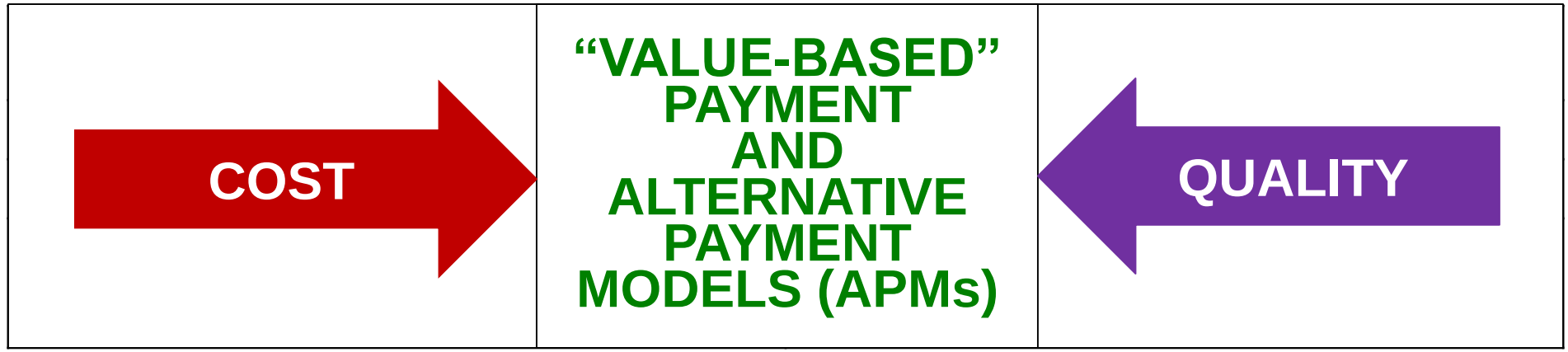

Can "Value-Based" Payment Do Better?

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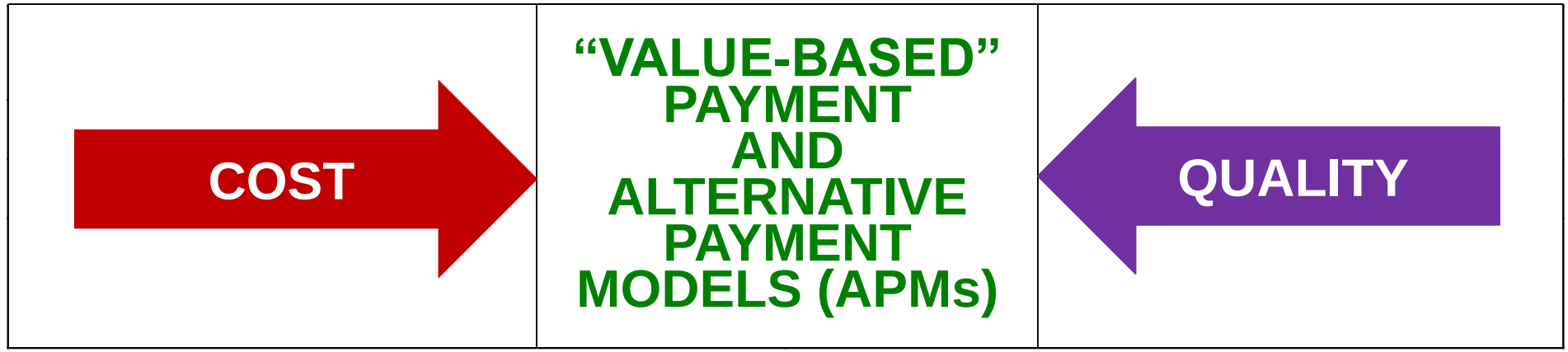

HOW DO YOU DEFINE "VALUE?"

A Commonly-Used Definition of Value

$$\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}$$

Which Would Be Higher Value Care?

$$\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}$$

	QUALITY	COST
Treatment #1	10 Year Survival	$50,000
Treatment #2	7 Year Survival	$30,000

Is it "Higher Value" to Die Three Years Sooner?

$$\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}$$

	QUALITY	COST	"VALUE"
Treatment #1	10 Year Survival	$50,000	0.20 Year/ $1000
Treatment #2	7 Year Survival	$30,000	0.23 Year/ $1000

Would Treatment #3 Be Higher Value Care?

$$\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}$$

	QUALITY	COST	"VALUE"
Treatment #1	10 Year Survival	$50,000	0.20 Year/ $1000
Treatment #2	7 Year Survival	$30,000	0.23 Year/ $1000
Treatment #3	20 Year Survival	$55,000	

Treatment #3 Scores Best on the Value Equation

$$\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}$$

	QUALITY	COST	"VALUE"
Treatment #1	10 Year Survival	$50,000	0.20 Year/ $1000
Treatment #2	7 Year Survival	$30,000	0.23 Year/ $1000
Treatment #3	20 Year Survival	$55,000	0.36 Year/ $1000

Could We Create an APM to Encourage Use of Treatment #3?

$$\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}$$

	QUALITY	COST	"VALUE"	APM?
Treatment #1	10 Year Survival	$50,000	0.20 Year/ $1000	
Treatment #2	7 Year Survival	$30,000	0.23 Year/ $1000	
Treatment #3	20 Year Survival	$55,000	0.36 Year/ $1000	

APM = "Alternative Payment Model"

No!

$$\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}$$

	QUALITY	COST	"VALUE"	APM?
Treatment #1	10 Year Survival	$50,000	0.20 Year/ $1000	
Tr tment #2	7 Year Survival	$30,000	0.23 Year/ $1000	
Treatment #3	20 Year Survival	$55,000	0.36 Year/ $1000	**No**

APM = "Alternative Payment Model"

MACRA Has a Specific Definition of What an APM Must Do

$$\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}$$

	QUALITY	COST	"VALUE"	APM?
Treatment #1	10 Year Survival	$50,000	0.20 Year/ $1000	
Treatment #2	7 Year Survival	$30,000	0.23 Year/ $1000	
Treatment #3	20 Year Survival	$55,000	0.36 Year/ $1000	**No**

An Alternative Payment Model (APM) under MACRA must:

- improve the quality of care without increasing spending;
- reduce spending without reducing the quality of care; or
- improve the quality of care and reduce spending

An APM Can't Increase Spending, Even With Much Better Outcomes

$$\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}$$

	QUALITY	COST	"VALUE"	APM?
Treatment #1	10 Year Survival	$50,000	0.20 Year/ $1000	
Treatment #2	7 Year Survival	$30,000	0.23 Year/ $1000	
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An Alternative Payment Model (APM) under MACRA must:

- improve the quality of care without increasing spending;
- reduce spending without reducing the quality of care; or
- improve the quality of care and reduce spending
- ~~significantly improve outcomes with higher spending~~

But an APM Could Encourage Use of Treatment #2

$$\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}$$

	QUALITY	COST	"VALUE"	APM?
Treatment #1	10 Year Survival	$50,000	0.20 Year/ $1000	
Treatment #2	7 Year Survival	$30,000	0.23 Year/ $1000	**Yes**
Treatment #3	20 Year Survival	$55,000	0.36 Year/ $1000	**No**

An Alternative Payment Model (APM) under MACRA must:

- improve the quality of care without increasing spending;
- reduce spending without reducing the quality of care; or
- improve the quality of care and reduce spending
- ~~significantly improve outcomes with higher spending~~

CMS Is Only Interested in APMs That Will *Reduce Spending*

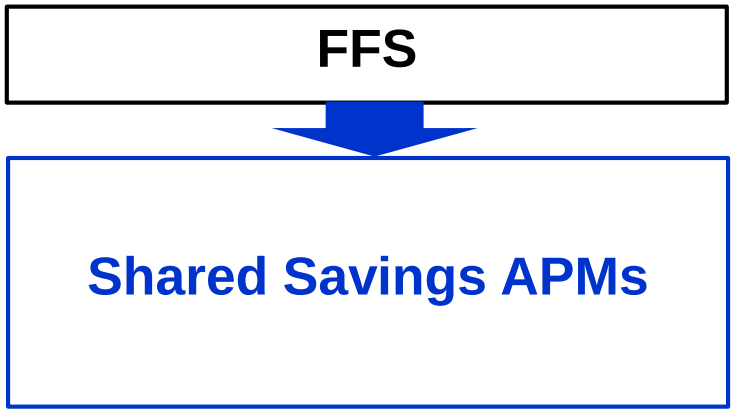
$$\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}$$

	QUALITY	COST	"VALUE"	APM?
Treatment #1	10 Year Survival	$50,000	0.20 Year/ $1000	
Treatment #2	7 Year Survival	$30,000	0.23 Year/ $1000	**Yes**
Treatment #3	20 Year Survival	$55,000	0.36 Year/ $1000	**No**

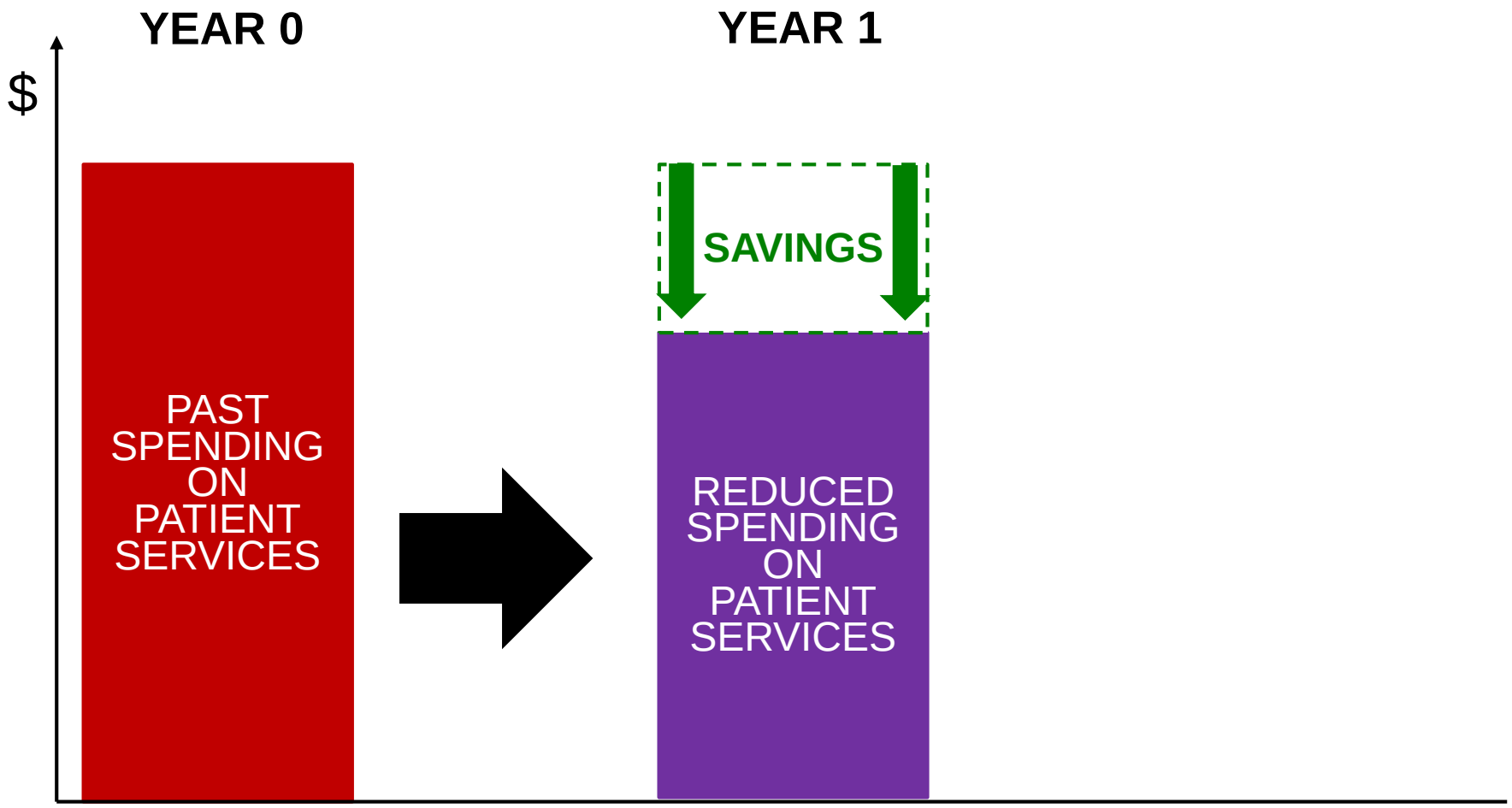
An Alternative Payment Model (APM) under MACRA must:

- ~~improve the quality of care without increasing spending;~~
- **reduce spending** without reducing the quality of care; or
- improve the quality of care and **reduce spending**
- ~~significantly improve outcomes with higher spending~~

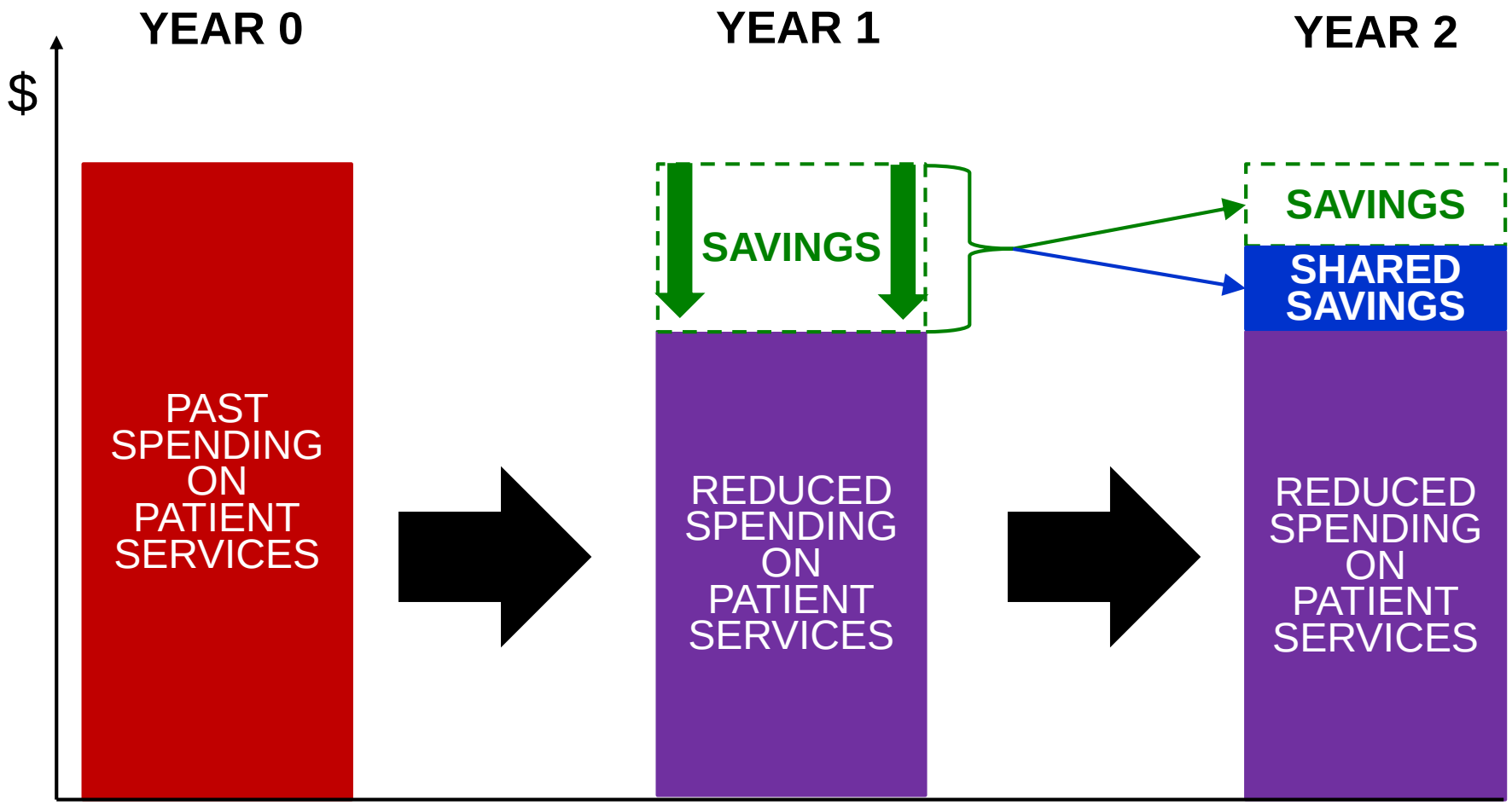
CMS APMs to Reduce Spending: Version 1



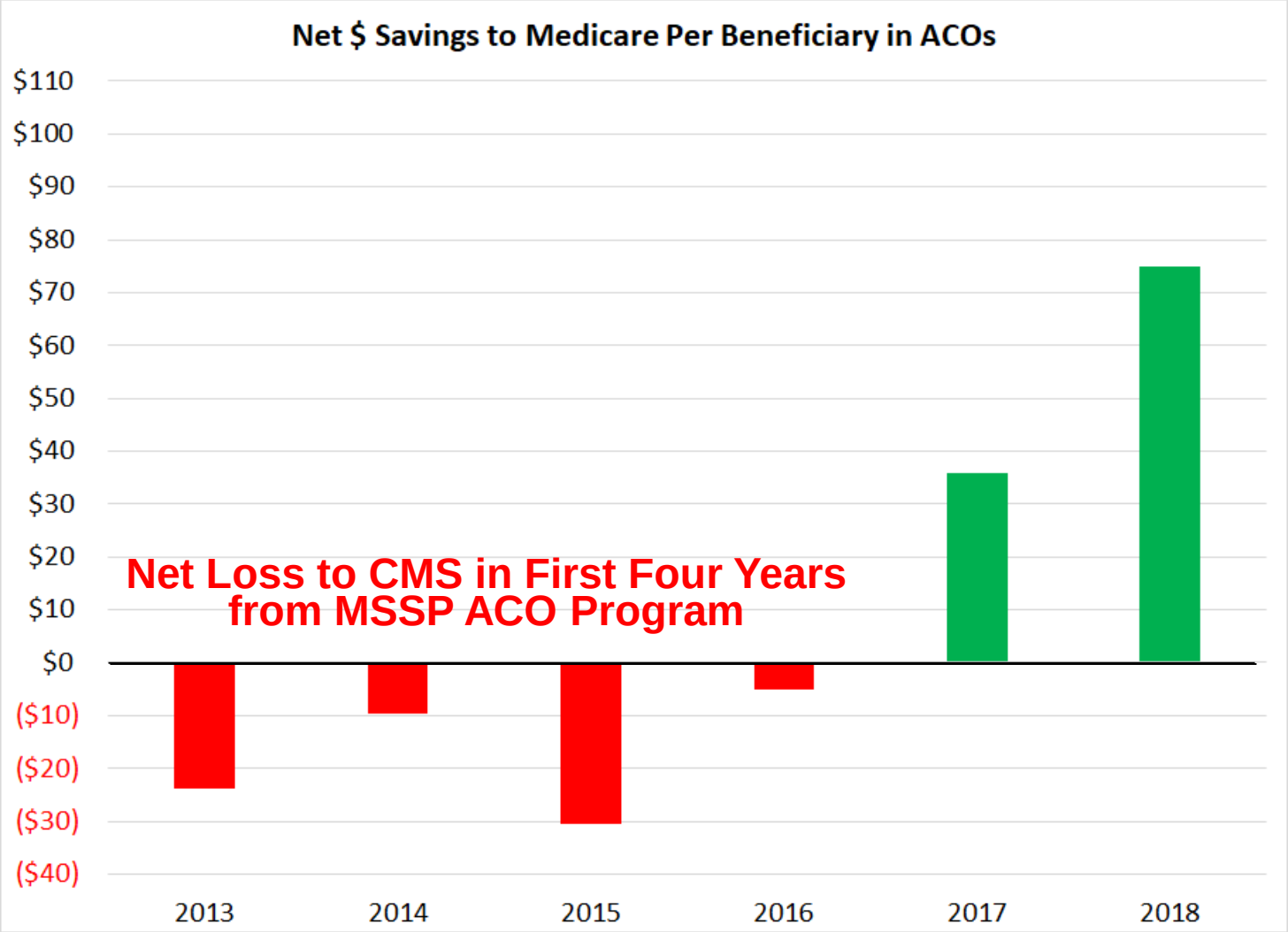
The “Shared Savings Model”: If You Save CMS $ in Year 1…



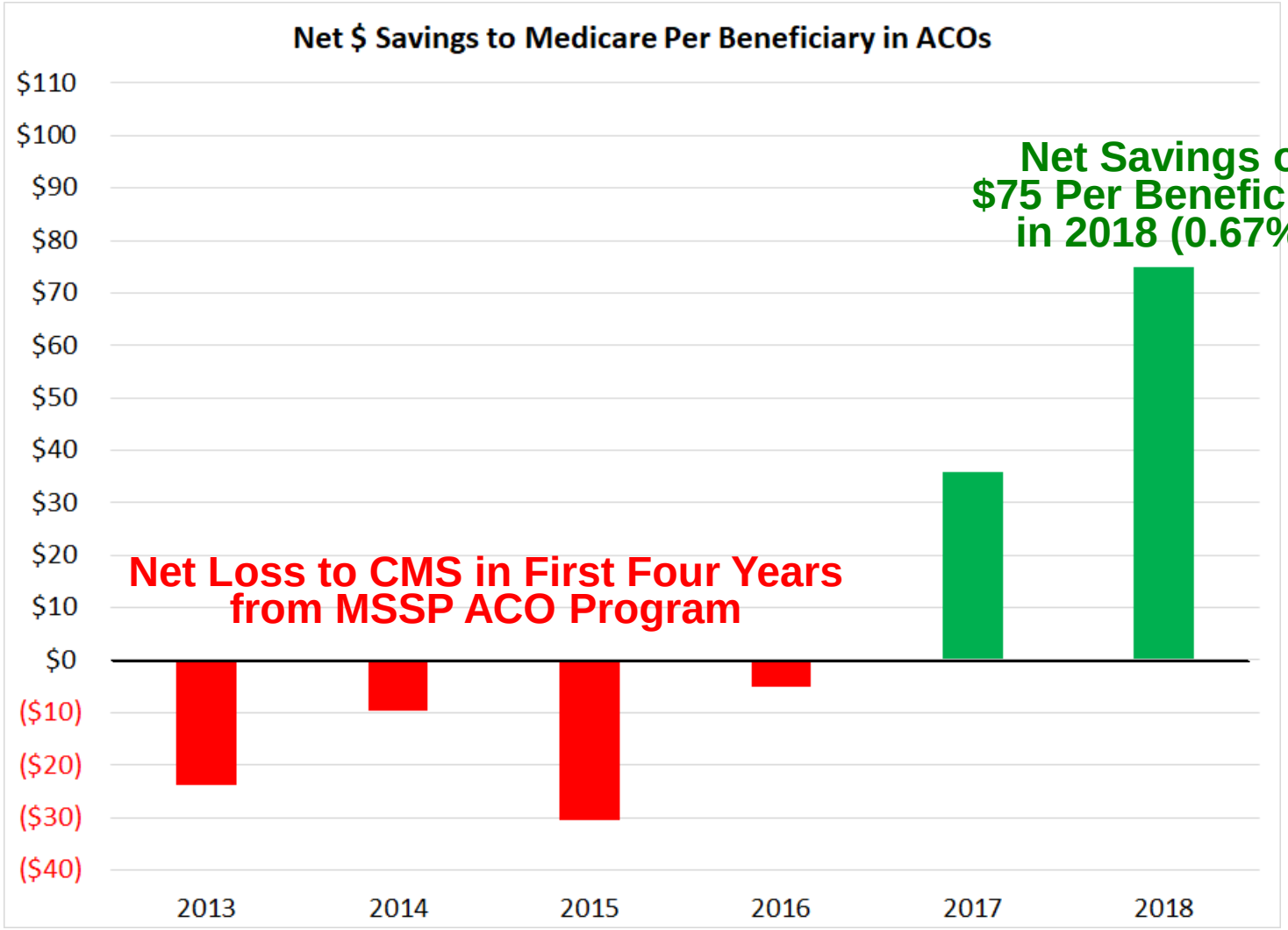
…CMS Will Give You a Bonus in Year 2 (Maybe)



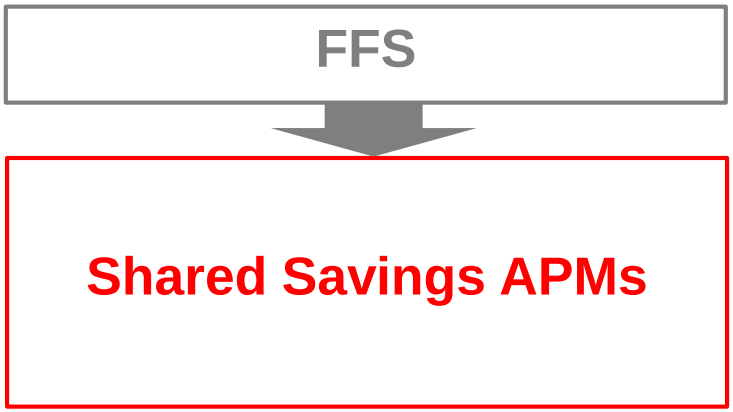
The "Shared Savings" Approach Hasn't Worked Very Well



Extremely Small Amounts When Savings Are Achieved

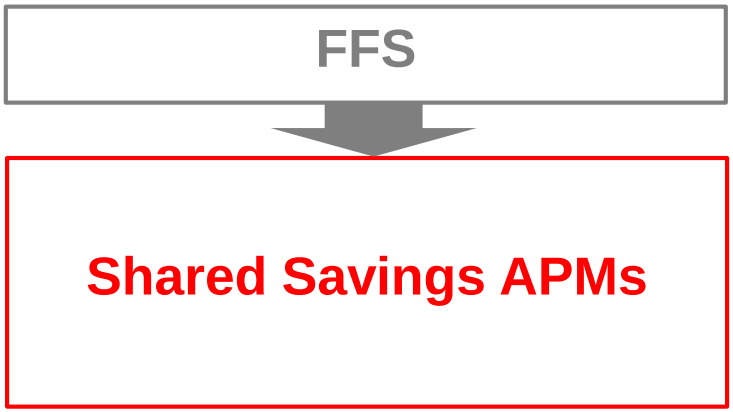


Why “Shared Savings” Doesn’t Work



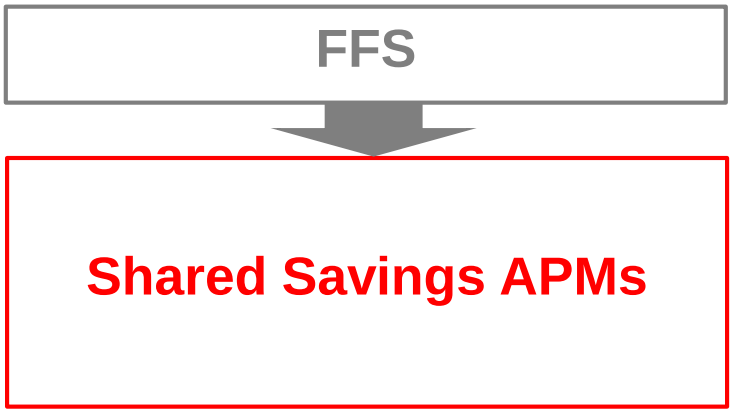
- No new payments for services that could help reduce spending

Why "Shared Savings" Is Bad for Patients



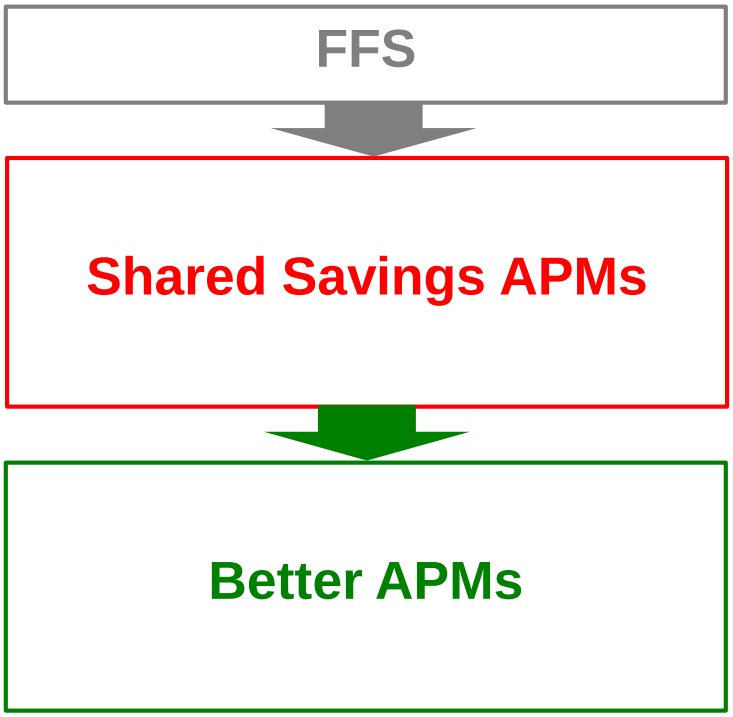
- No new payments for services that could help reduce spending
- Bonuses for savings regardless of how they are achieved

The Only Strength: No Downside Risk



- No new payments for services that could help reduce spending
- Bonuses for savings regardless of how they are achieved
- No downside risk if spending increases

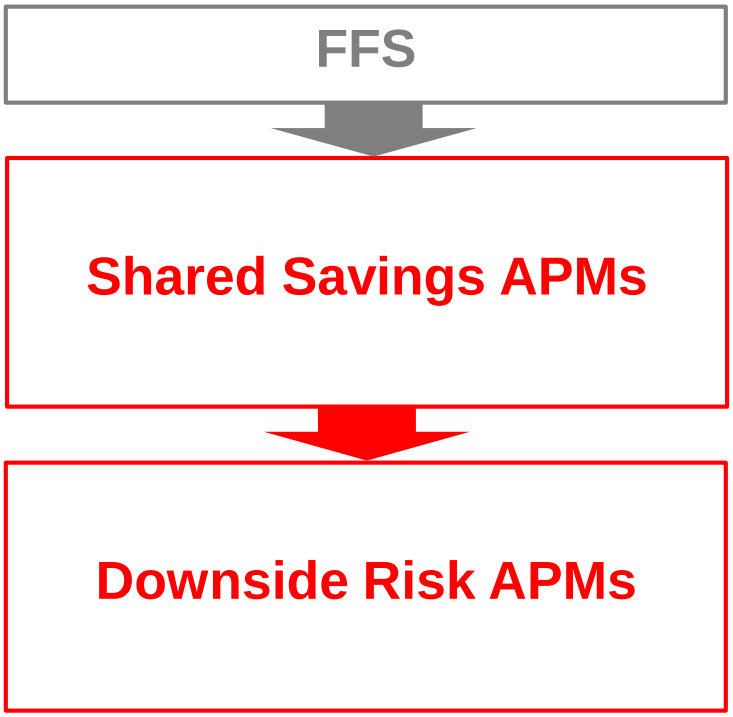
A Better APM Would Fix the Weaknesses



- No new payments for services that could help reduce spending
- Bonuses for savings regardless of how they are achieved
- No downside risk if spending increases

- **Adequate payments for high-value services, not bonuses based on savings**
- No downside risk if spending increases

But CMS and Other Payers Think the Answer is More "Risk"



- No new payments for services that could help reduce spending
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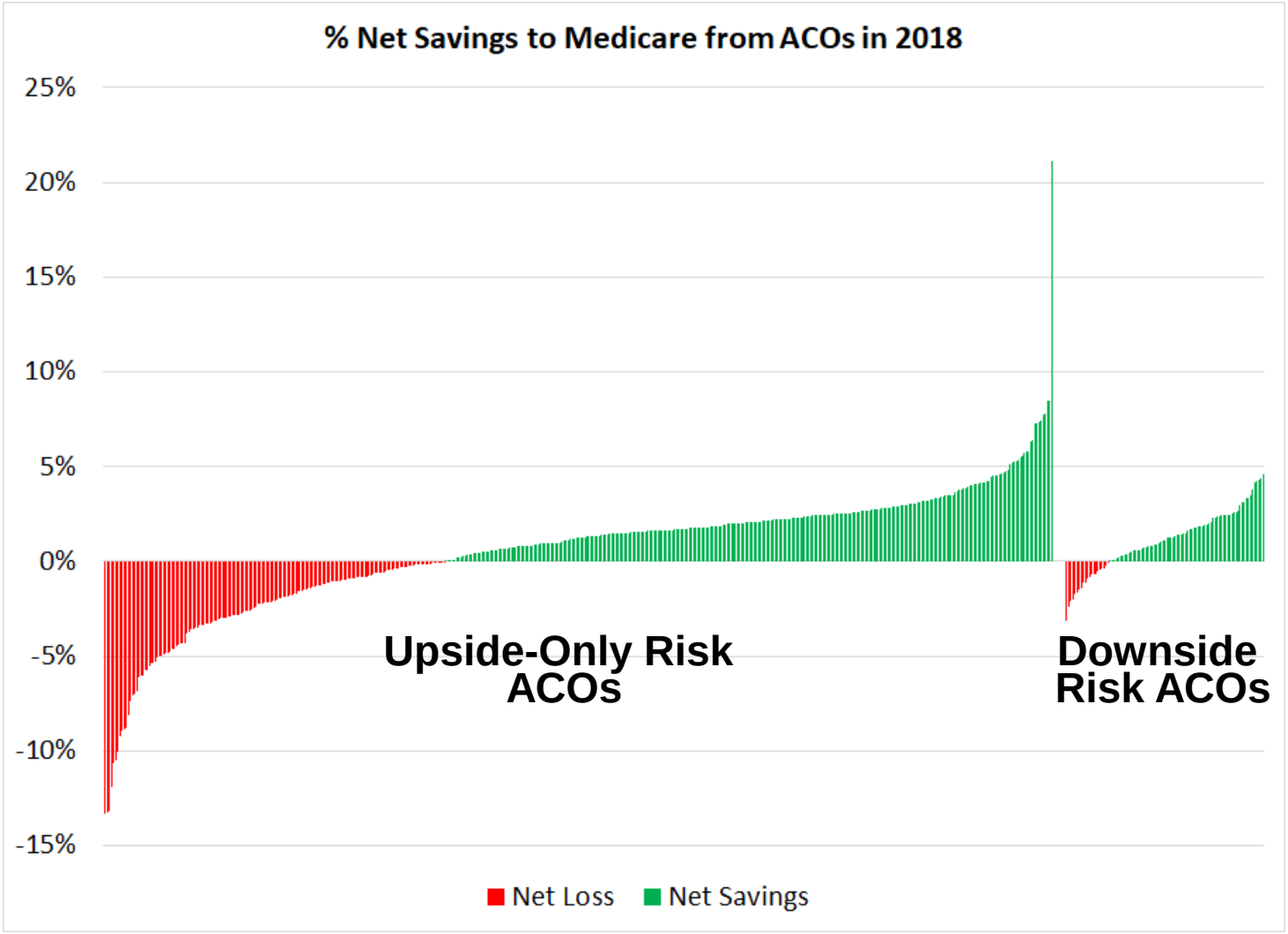
- No new payments for services that could help reduce spending
- Bonuses for savings regardless of how they are achieved
- **Downside risk if spending increases**

Do Downside Risk ACOs Save More Than Upside Risk ACOs?



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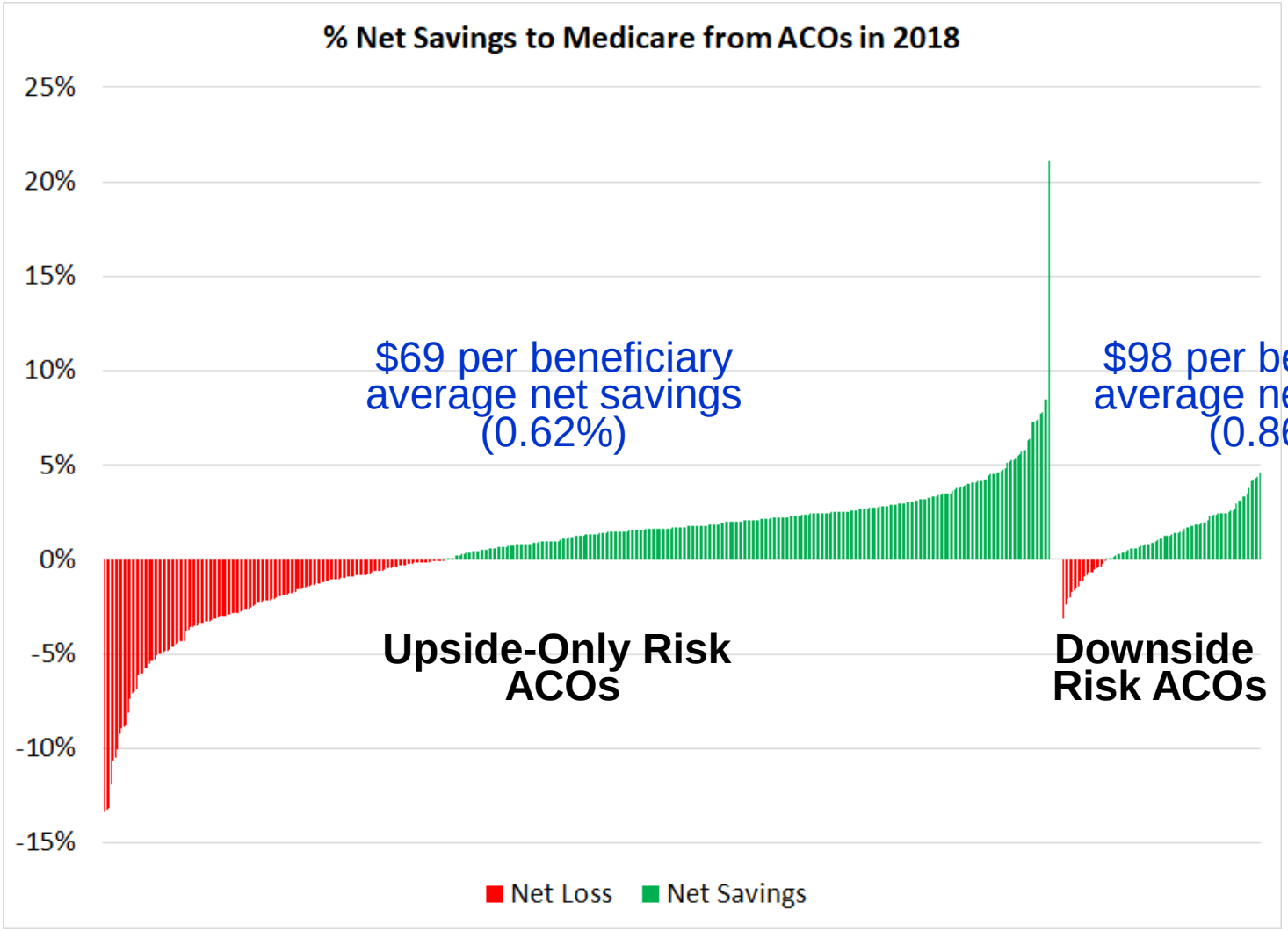
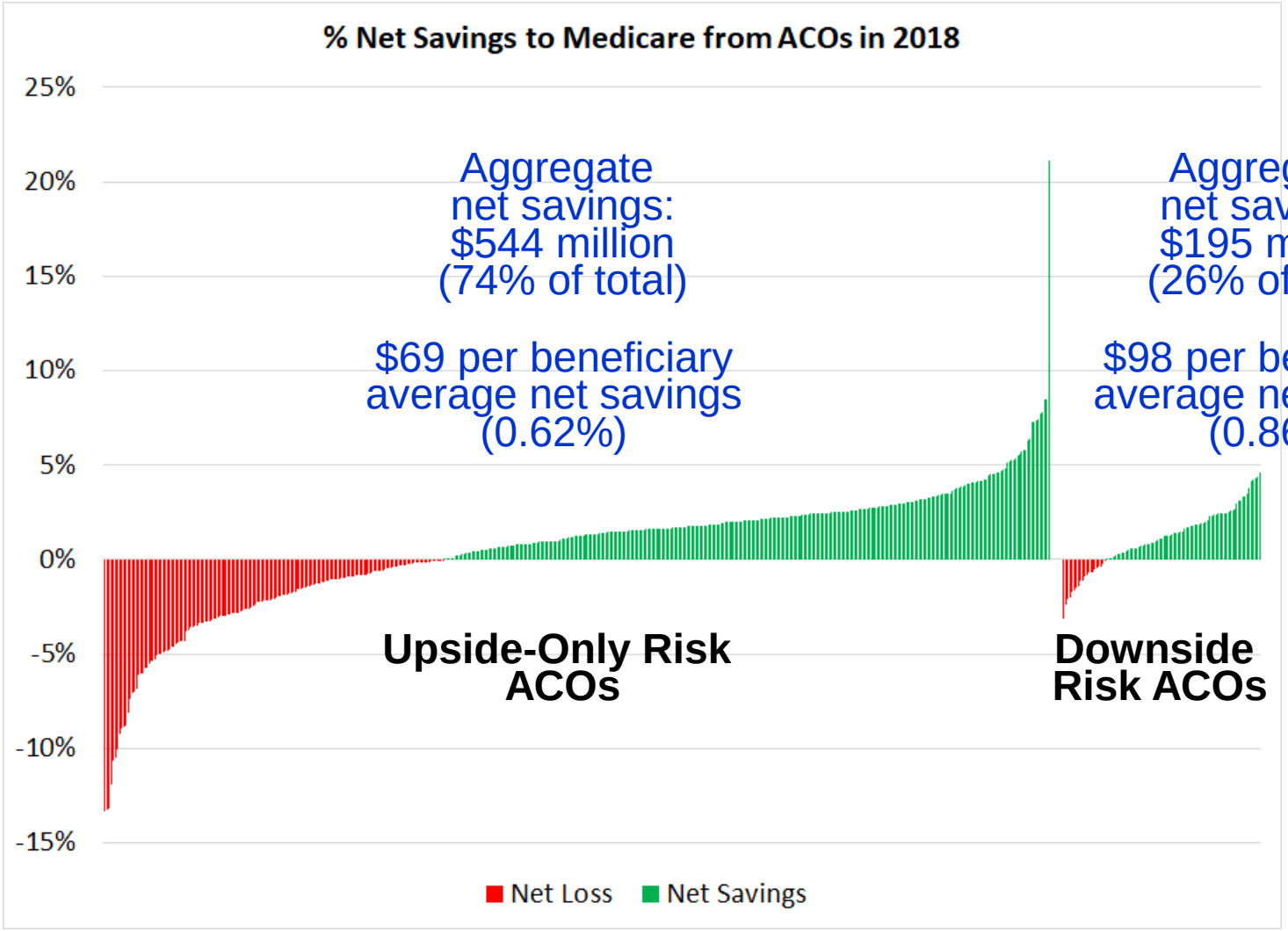
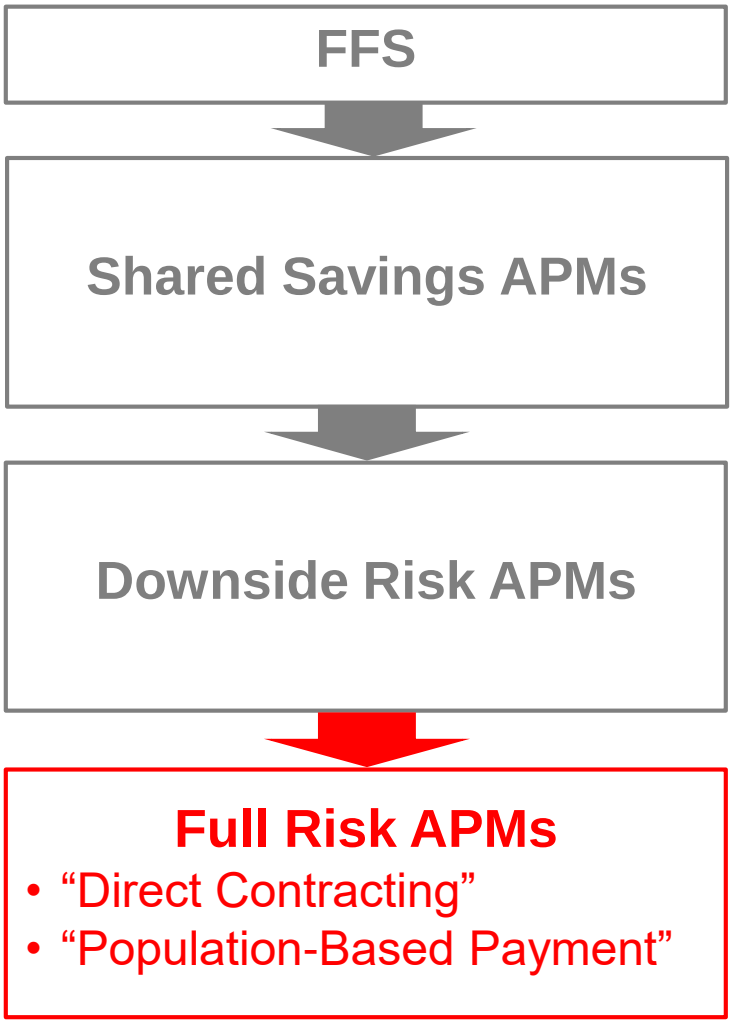


Majority of Savings Has Come From the Upside-Only ACOs



CMS's Goal: Full Risk for Providers



- No new payments for services that could help reduce spending
- Bonuses for savings regardless of how they are achieved
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- No new payments for services that could help reduce spending
- Bonuses for savings regardless of how they are achieved
- Downside risk if spending increases

- Capitation payments for patients in place of all fees for services
- Providers in an "ACO" are responsible for delivering or paying for all services the patients need

CMS Goal: Eliminate Fees and Give Full Risk to Providers

Shared S

Downsid

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pending increases

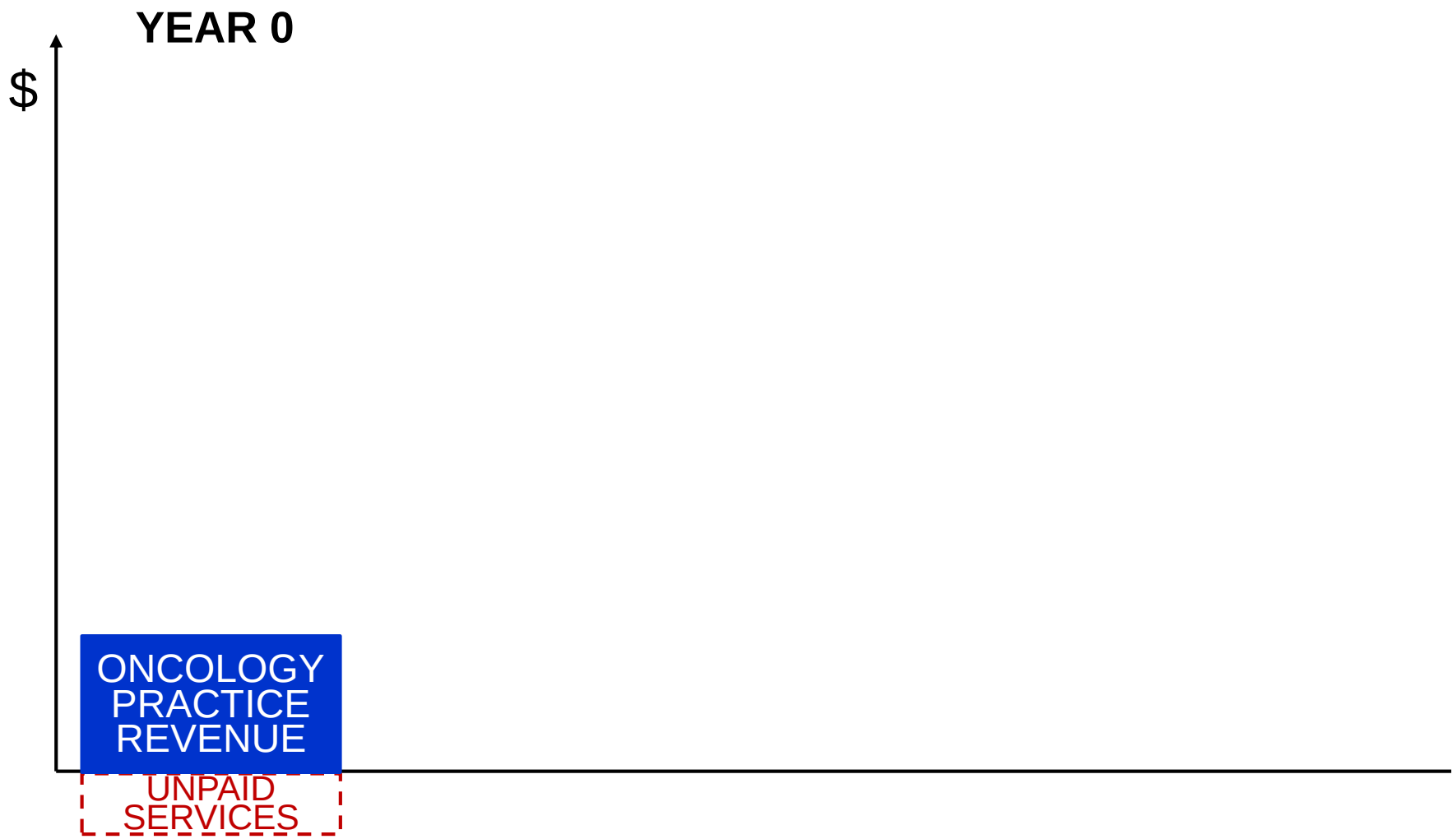
Full Risk APMs

- "Direct Contracting"
- "Population-Based Payment"

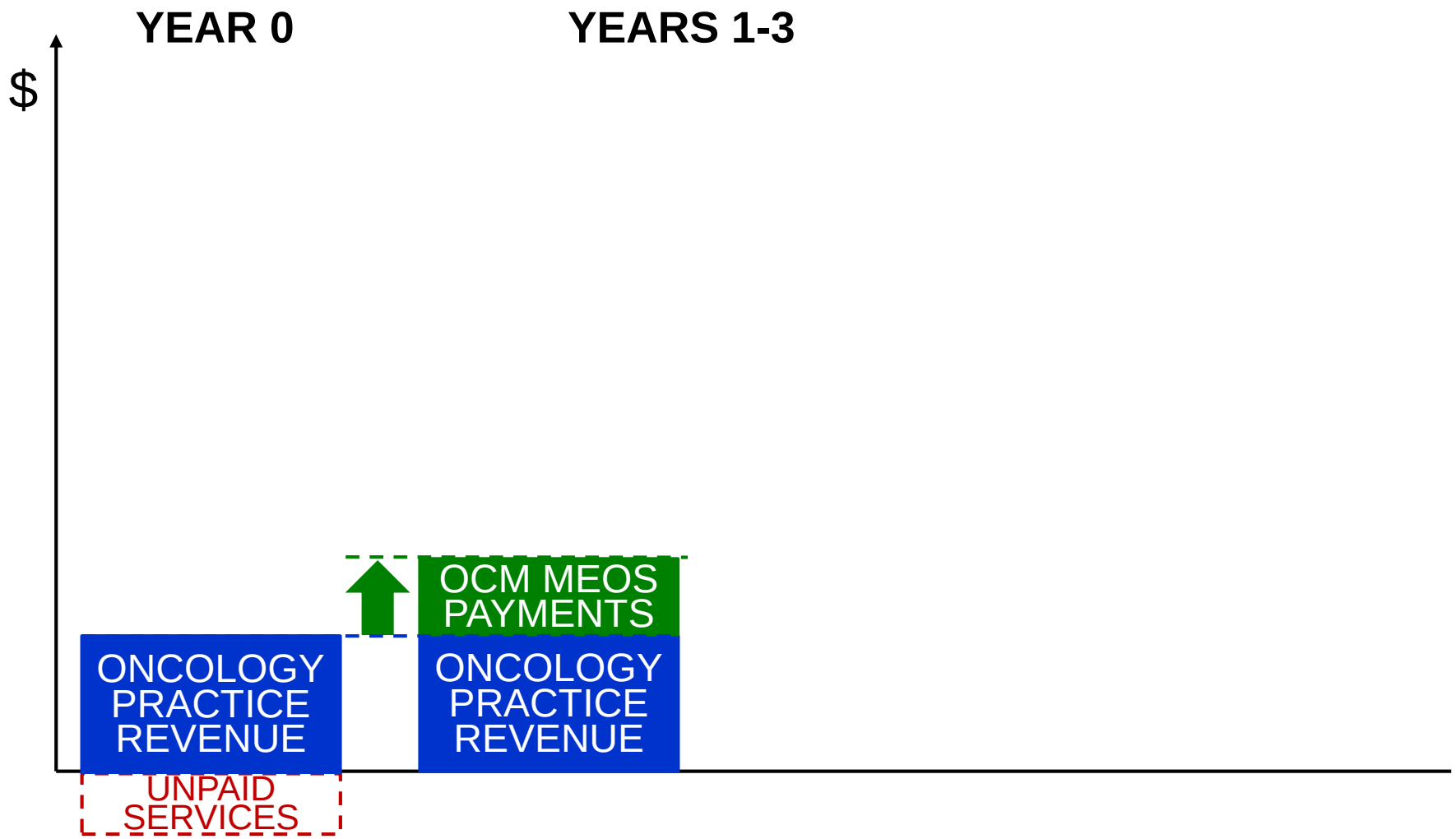
- Capitation payments for patients in place of all fees for services
- Providers in an "ACO" are responsible for delivering or paying for all services the patients need

“Value-Based” APMs in Oncology

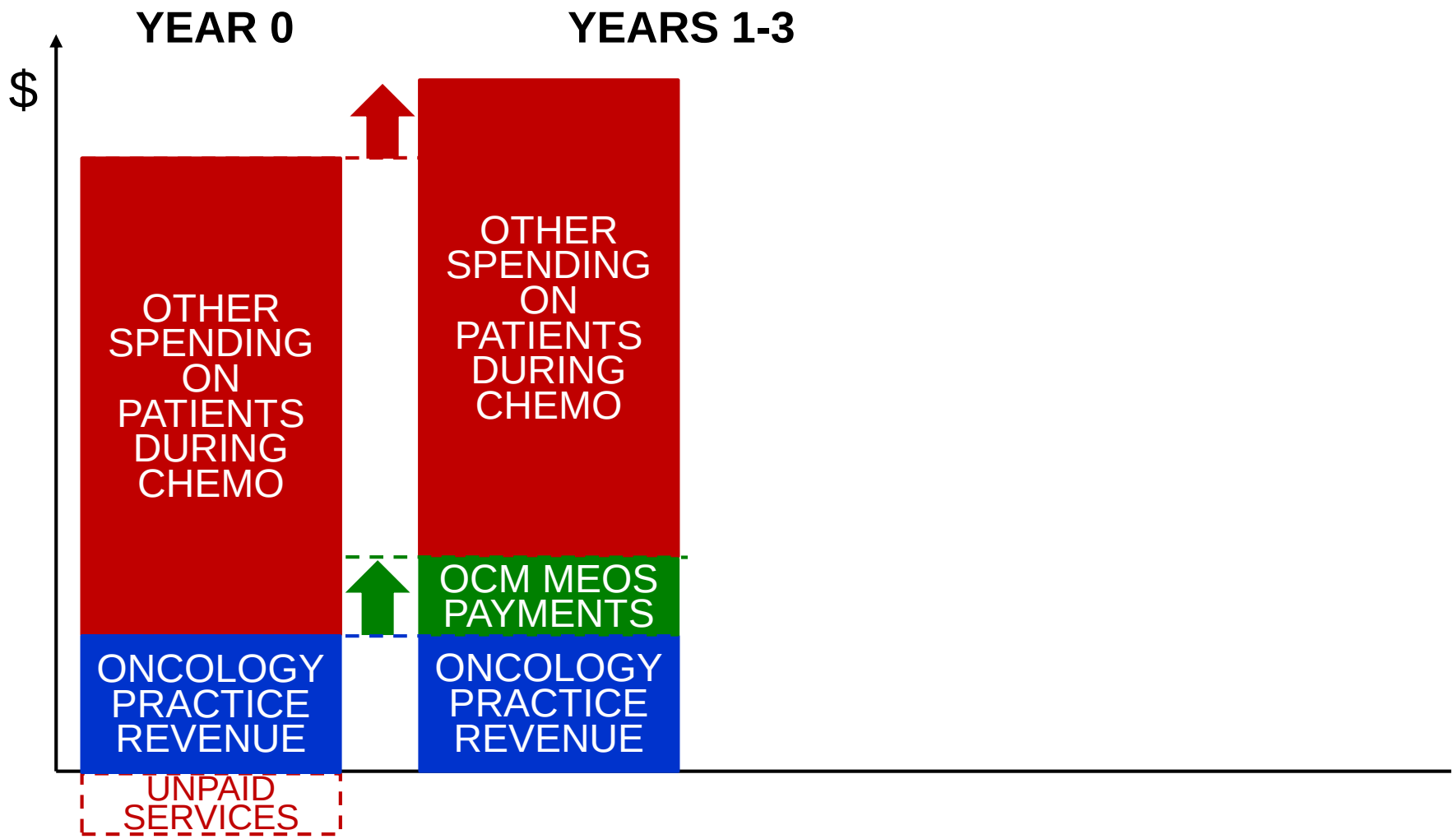
CMS Oncology Care Model for Medical Oncology (OCM)



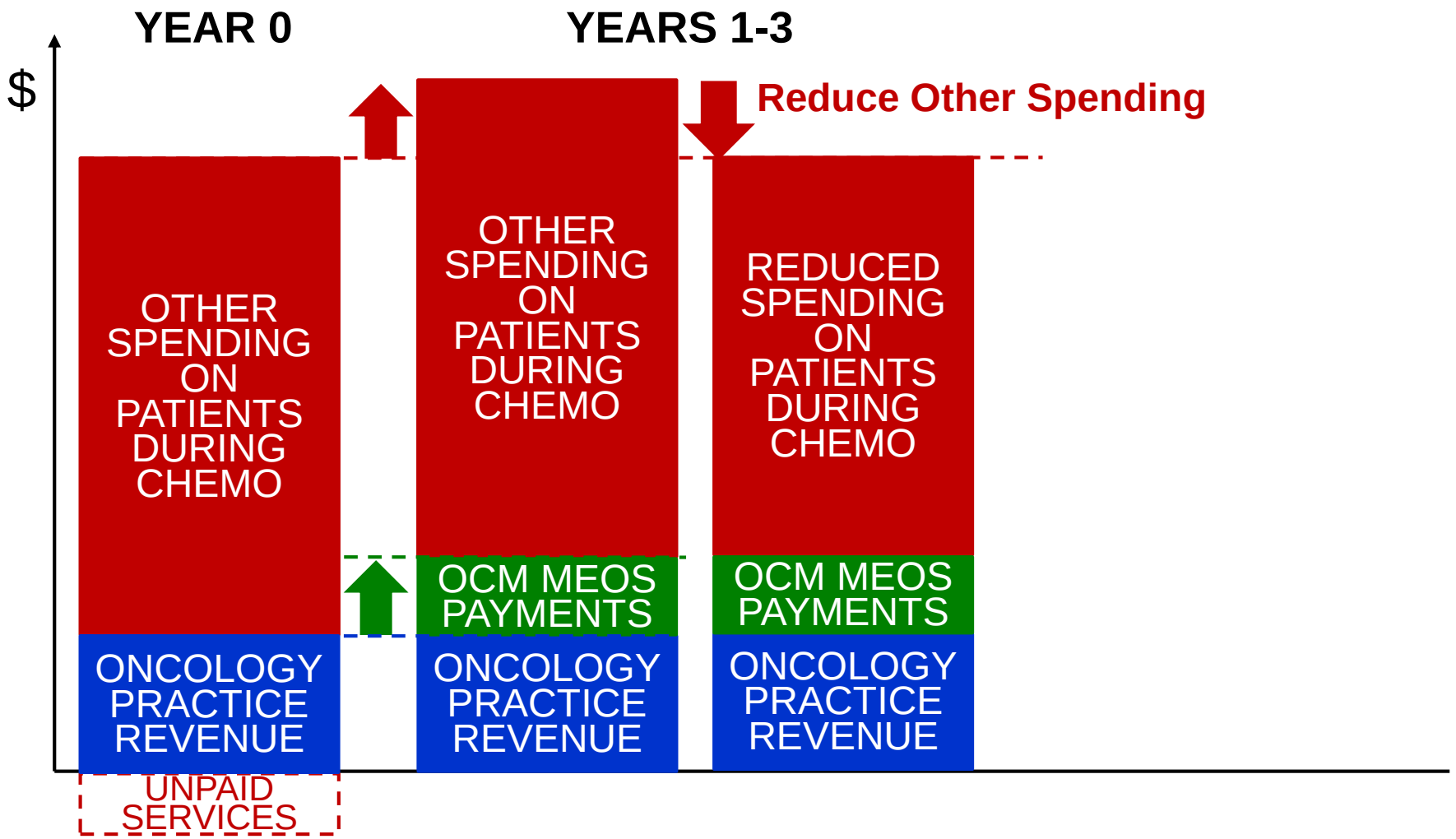
OCM Provides New Payments to Oncology Practices



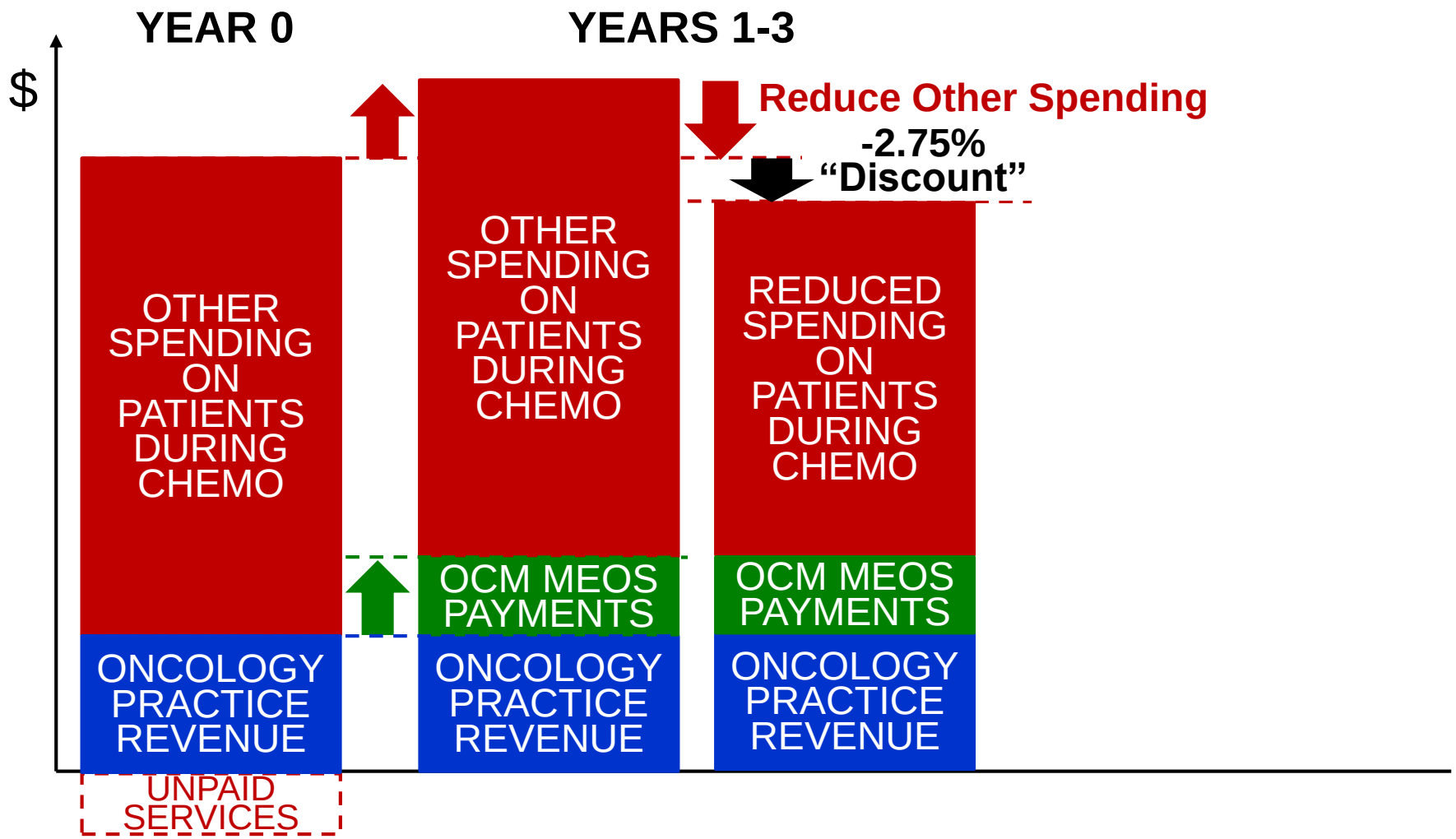
Since Higher Payments Aren't Budget Neutral for CMS…



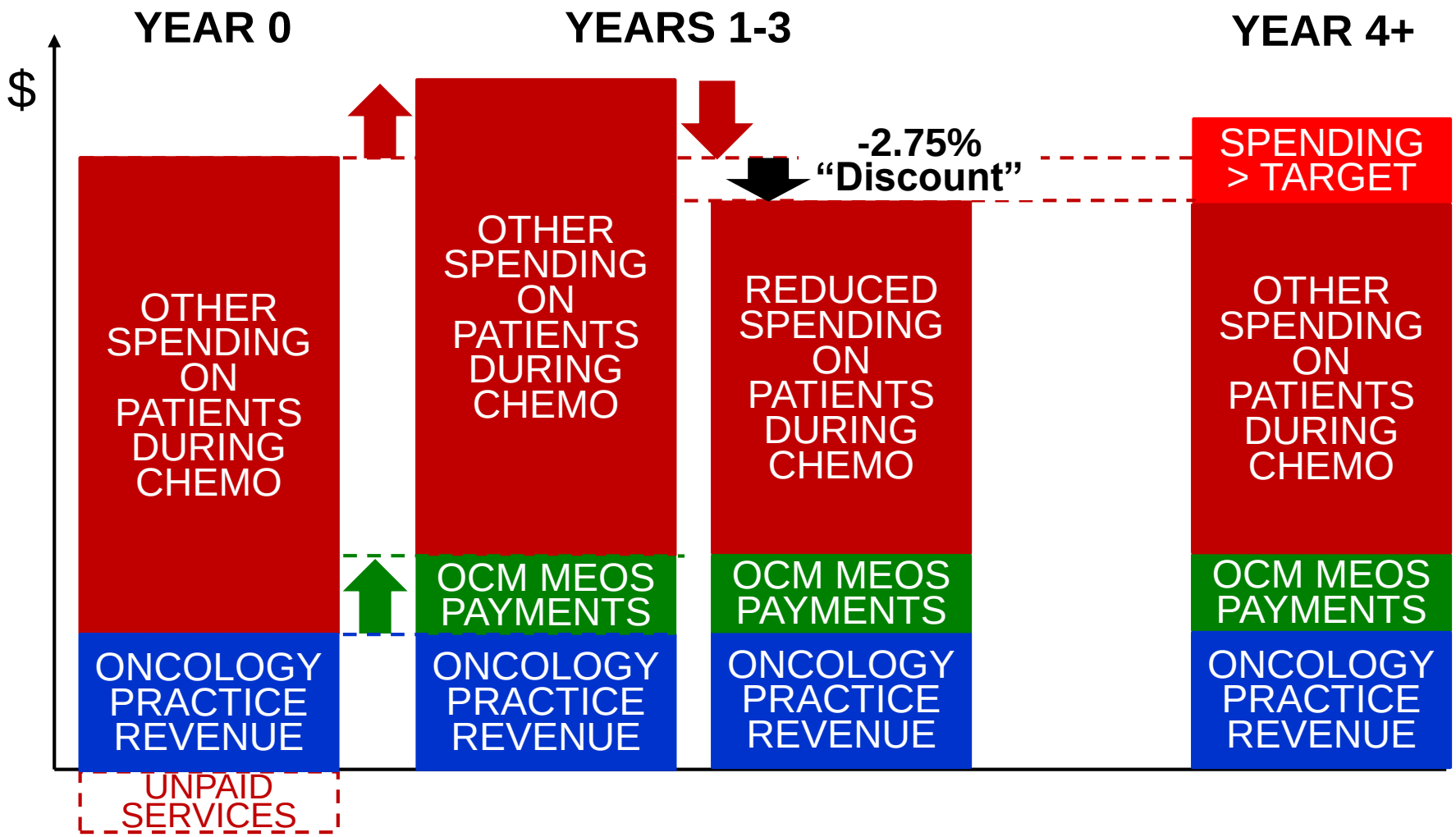
…CMS Wants the Practice to Find Savings to Offset the Payments…



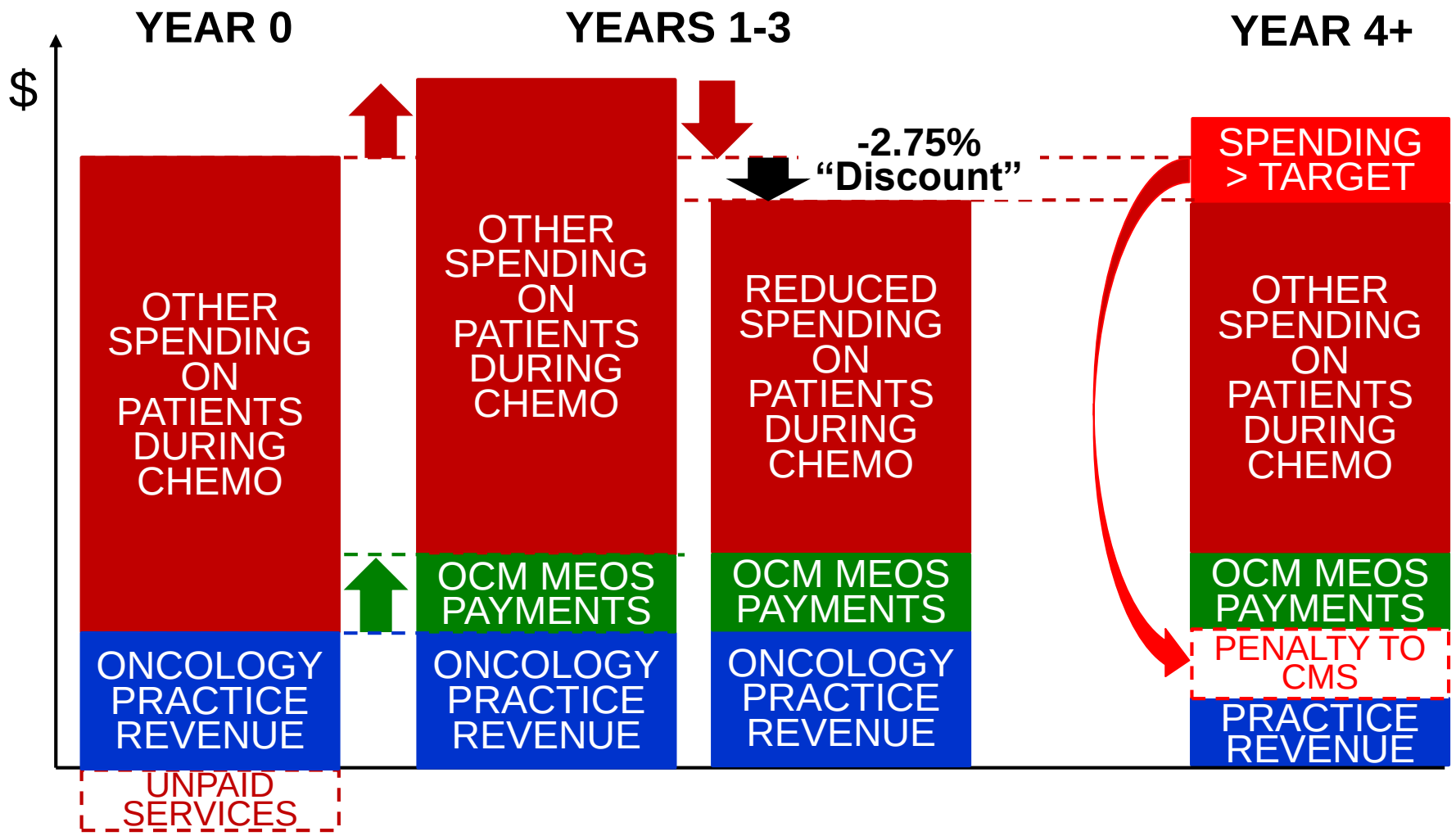
… Plus a 2.75% "Discount," So CMS Actually Spends Less



Starting in Year 4, If the Practice Doesn't Achieve The Savings…



…The Practice Has to Pay CMS Out of The Practice's Revenues



Although CMS "Risk Adjusts" Total Spending to Set Targets…

Adjustment Factors Used to Adjust Total Spending

- Sex
- Age
- Type of Cancer (Breast, Colon, Lung, Prostate, etc.)
- Number of Chronic Diseases
- Resident of a Nursing Facility?
- Prior Chemotherapy?
- Received Surgery?
- Receiving Radiation?
- Bone Marrow Transplant?
- Clinical Trial Participant?
- High Percentage of Patients Receiving "Novel Therapies"?

..CMS Fails to Adjust for the Most Important Factors Driving Costs

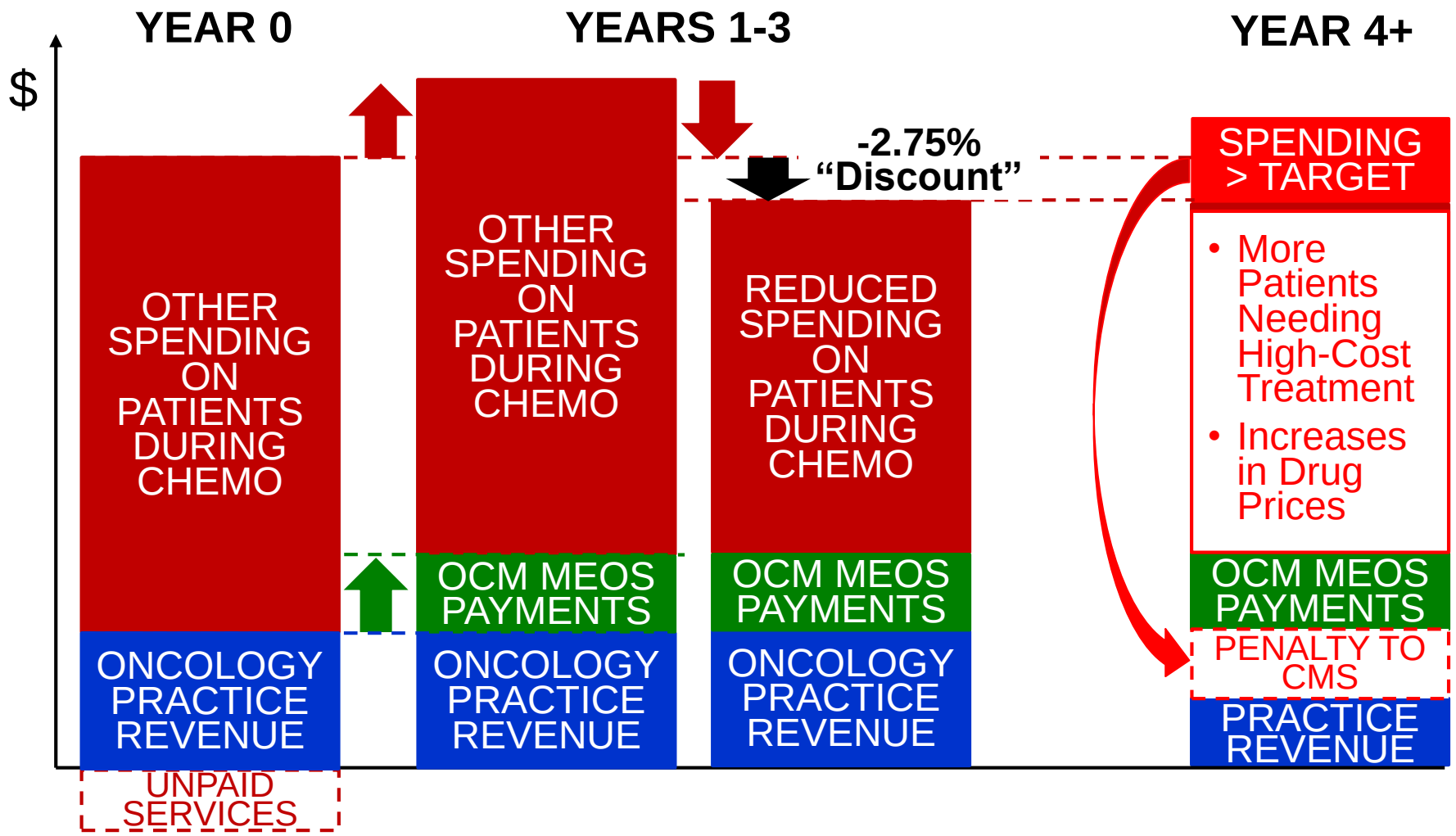
Adjustment Factors Used to Adjust Total Spending

- Sex
- Age
- Type of Cancer (Breast, Colon, Lung, Prostate, etc.)
- Number of Chronic Diseases
- Resident of a Nursing Facility?
- Prior Chemotherapy?
- Received Surgery?
- Receiving Radiation?
- Bone Marrow Transplant?
- Clinical Trial Participant?
- High Percentage of Patients Receiving “Novel Therapies”?

Factors Driving Spending That Are NOT Adjusted For

- Molecular Subtype of Cancer
- Stage of Cancer
- Line of Therapy
- Toxicity of Drugs
- Complexity of Oral Regimen
- Patient Performance Status
- Price Changes of Drugs

Result: Practice is At Risk For Things It Cannot Control



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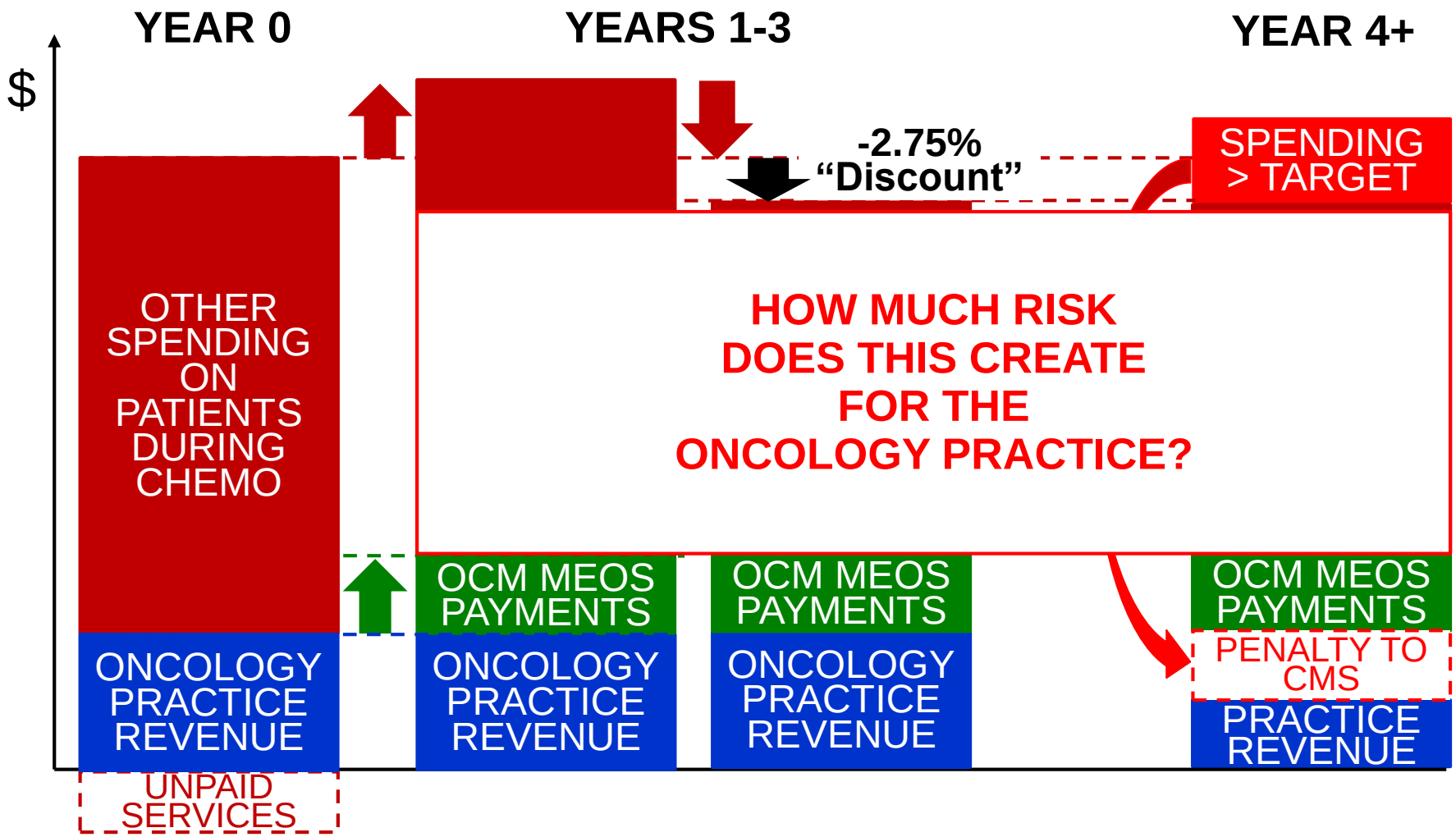
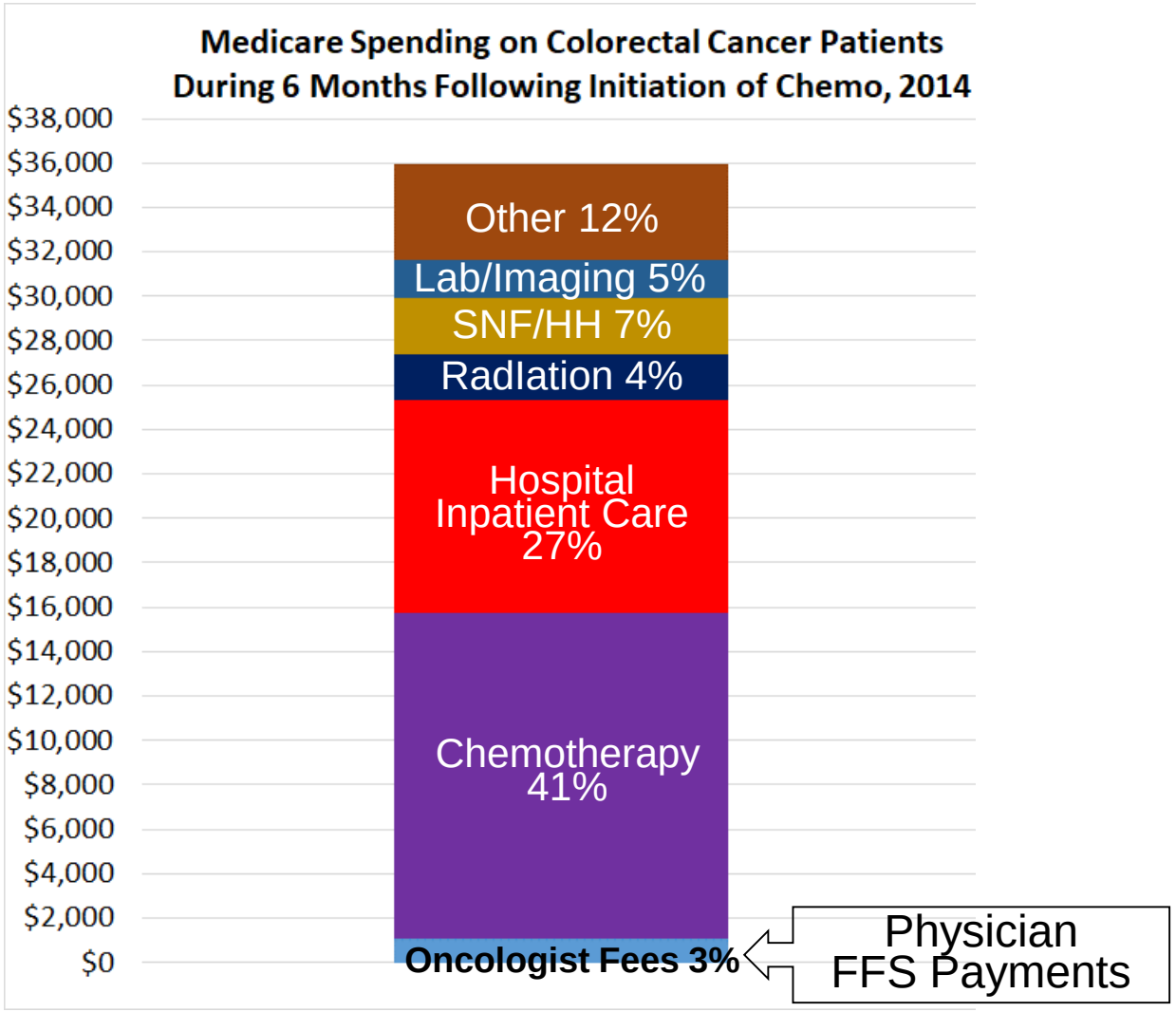
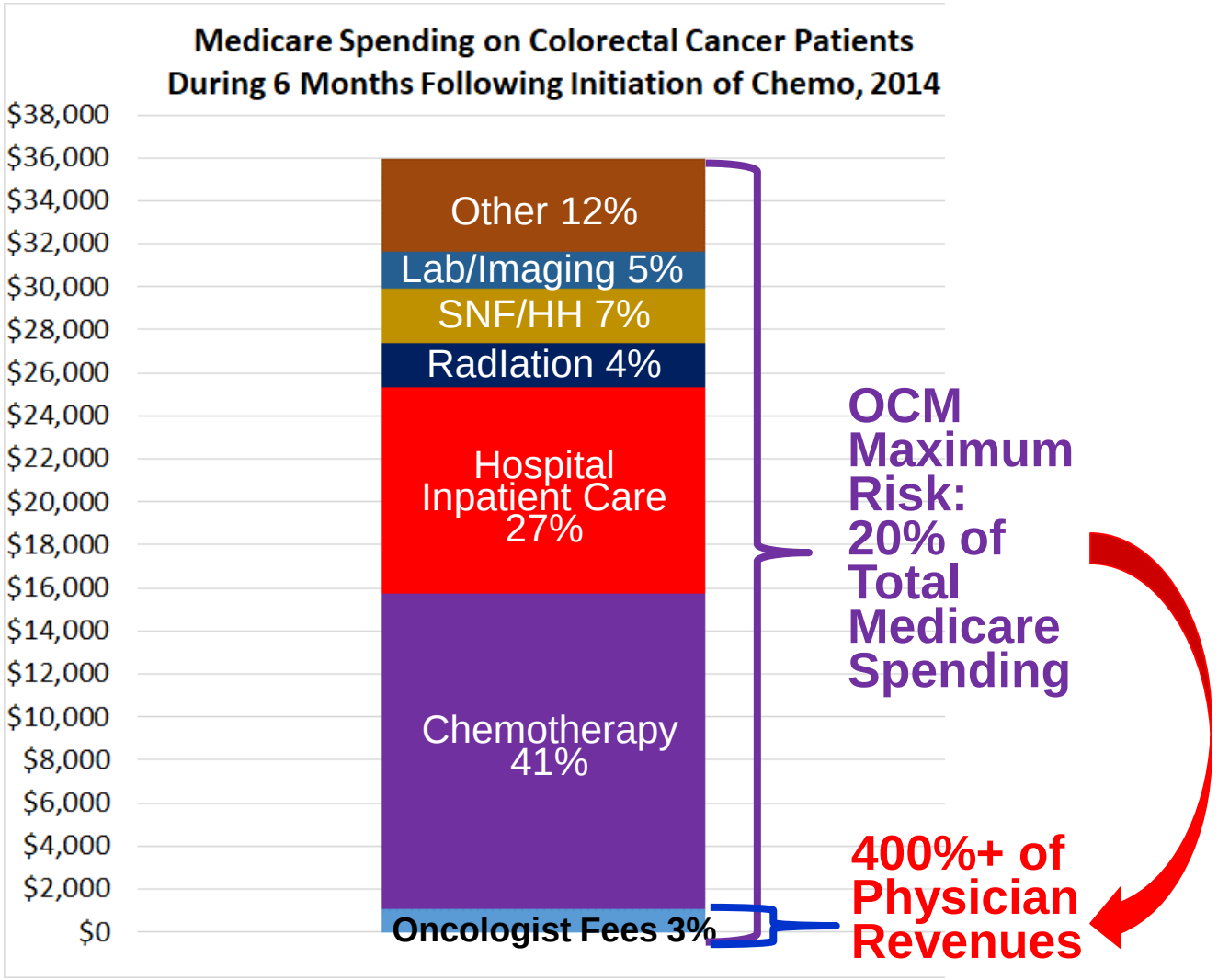


<5% of Spending During Chemo Goes to Oncology Practice Fees



20% Total Spending Risk in OCM >4x Oncologists' Fee Revenue



The Oncology Care Model (OCM) Penalizes Higher-Value Care

	QUALITY	COST	"VALUE"	OCM
Treatment #1	10 Year Survival	$50,000	0.20 Year/ $1000	
Treatment #3	20 Year Survival	$55,000	0.36 Year/ $1000	**Penalty**

OCM Rewards
Reductions in Spending

	QUALITY	COST	"VALUE"	OCM
Treatment #1	10 Year Survival	$50,000	0.20 Year/ $1000	
				
Treatment #2	7 Year Survival	$30,000	0.23 Year/ $1000	**Reward**
Treatment #3	20 Year Survival	$55,000	0.36 Year/ $1000	**Penalty**

OCM Financial Risk for *Cost* But Not for *Outcomes*

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:

- Good outcomes for any type of cancer

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
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- 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:

- Good outcomes for any type of cancer
- 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 other kinds of cancer and metastatic cancer

CMS's Proposed Radiation Oncology Model

- **Bundled Payments for Radiation Therapy Instead of Current Fees**
  - Eliminate separate payments for 100+ CPT/HCPCS codes
  - Pay a single amount for all radiation therapy services during a 90-day "episode"
  - Payment amount based on actual average episode spending in previous years
- **Limited Adjustment of Payments Based on Patient Needs**
  - Separate payments for 17 different types of cancer
  - Unspecified "case mix adjustment" based on claims, not clinical data
  - Additional adjustment based on problematic measure of provider "efficiency"
- **No Adjustments for Changes in Evidence or Technology**
- **Reductions in Payments Compared to Current Spending**
  - Payments reduced by arbitrary 4-5% "discount" to produce savings
  - Additional 2% of payments withheld until quality measures are calculated; only a portion of the withhold would be returned
  - Likely total net reduction in payments of >5% compared to past
- **Participation is mandatory for physician practices and hospitals in 40% of the country even though the model has never been tested and many of the details haven't been specified**

CMS APMs Are Actually Worse Than FFS

	Adequate Payment for High-Value Services?
Fee for Service	**No**
Shared Savings APMs • Track 1 ACOs • Primary Care	**No**
Downside Risk APMs • Track 2 ACOs • Episode Models • Oncology Care Model • Radiation Oncology Bundled Payment	**No**

CMS APMs Are Actually Worse Than FFS

	Adequate Payment for High-Value Services?	Rewards for Stinting on Patient Services?
Fee for Service	**No**	**No**
Shared Savings APMs • Track 1 ACOs • Primary Care	**No**	**Yes**
Downside Risk APMs • Track 2 ACOs • Episode Models • Oncology Care Model • Radiation Oncology Bundled Payment	**No**	**Yes**

CMS APMs Are Actually Worse Than FFS

	Adequate Payment for High-Value Services?	Rewards for Stinting on Patient Services?	Penalties for Having Sicker Patients?
Fee for Service	**No**	**No**	**No**
Shared Savings APMs • Track 1 ACOs • Primary Care	**No**	**Yes**	**No**
Downside Risk APMs • Track 2 ACOs • Episode Models • Oncology Care Model • Radiation Oncology Bundled Payment	**No**	**Yes**	**Yes**

CMS APMs Are Actually Worse Than FFS

	Adequate Payment for High-Value Services?	Rewards for Stinting on Patient Services?	Penalties for Having Sicker Patients?	Penalties for Costs Physicians Can't Control?
Fee for Service	**No**	**No**	**No**	**No**
Shared Savings APMs • Track 1 ACOs • Primary Care	**No**	**Yes**	**No**	**No**
Downside Risk APMs • Track 2 ACOs • Episode Models • Oncology Care Model • Radiation Oncology Bundled Payment	**No**	**Yes**	**Yes**	**Yes**

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

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

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TOP-DOWN PAYMENT REFORM

Medicare and Health Plans Define Payment Systems

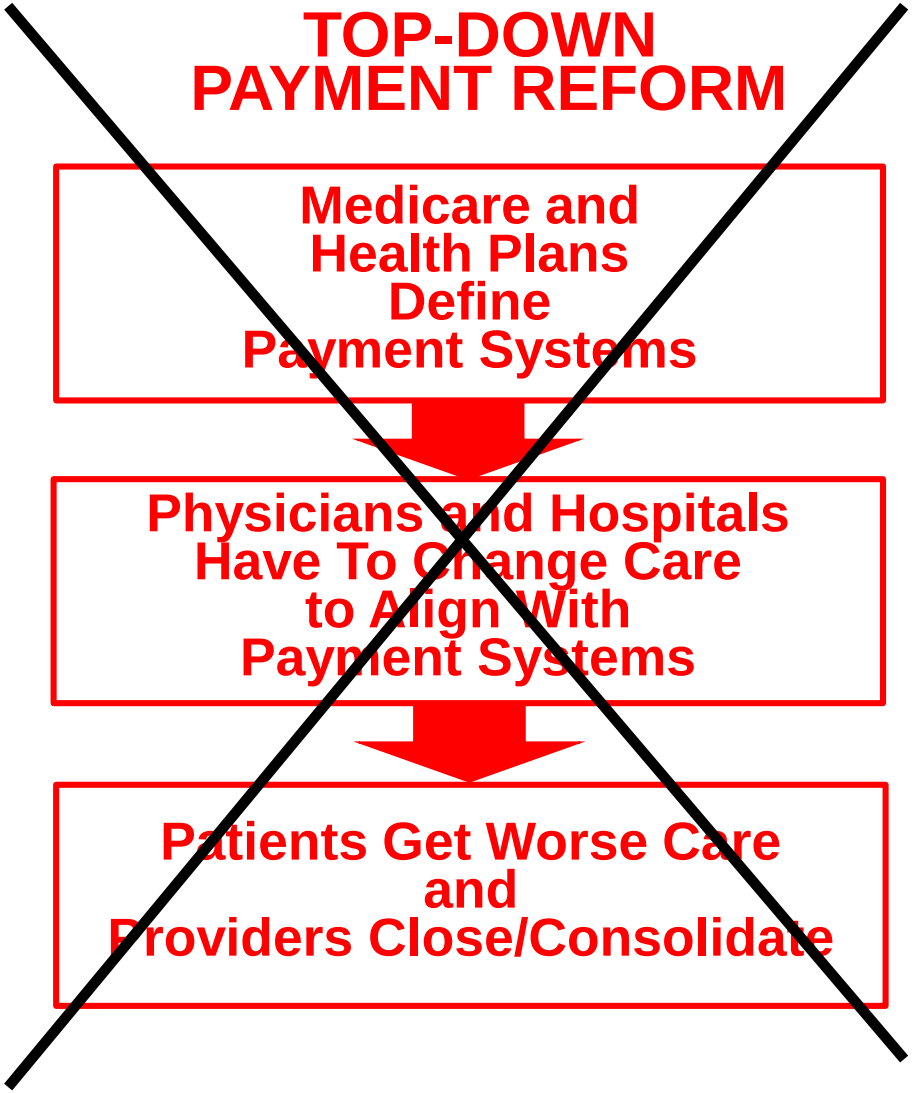
↓

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?



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

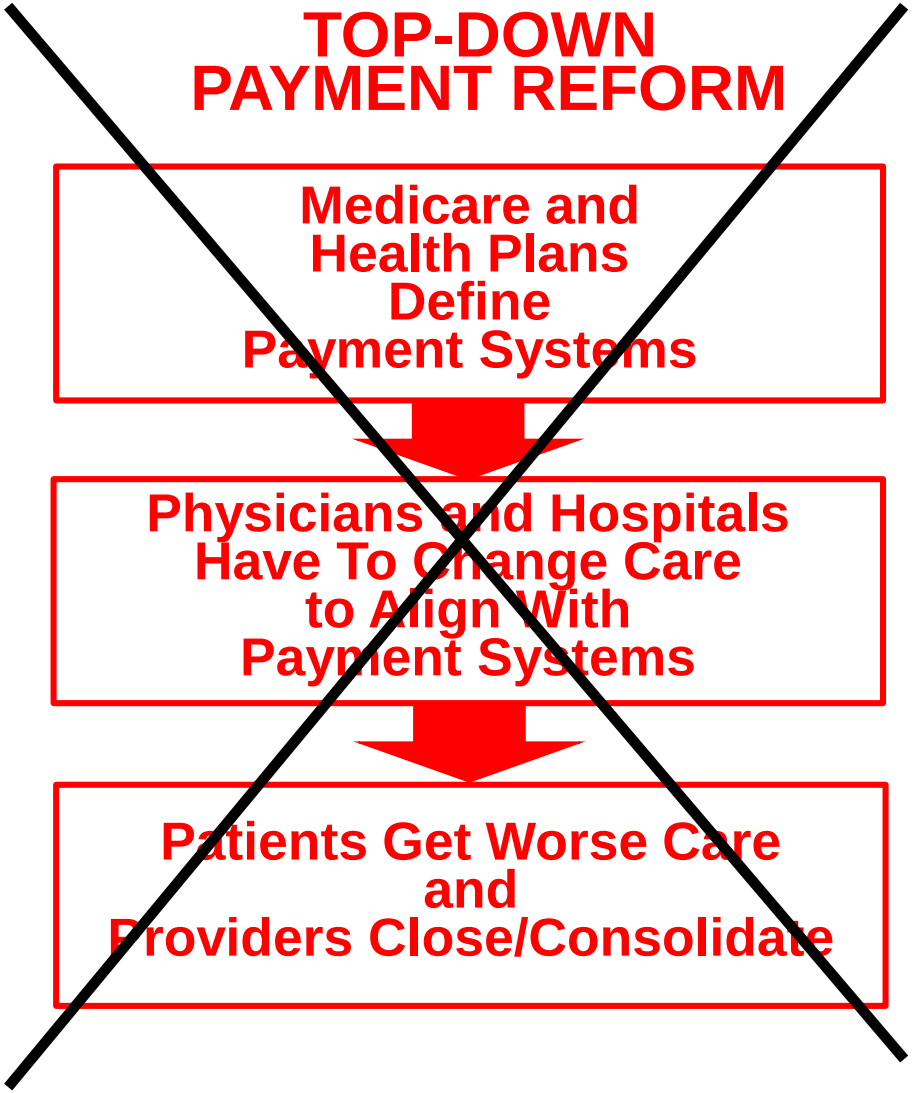
↓

Patients Get Worse Care and Providers Close/Consolidate

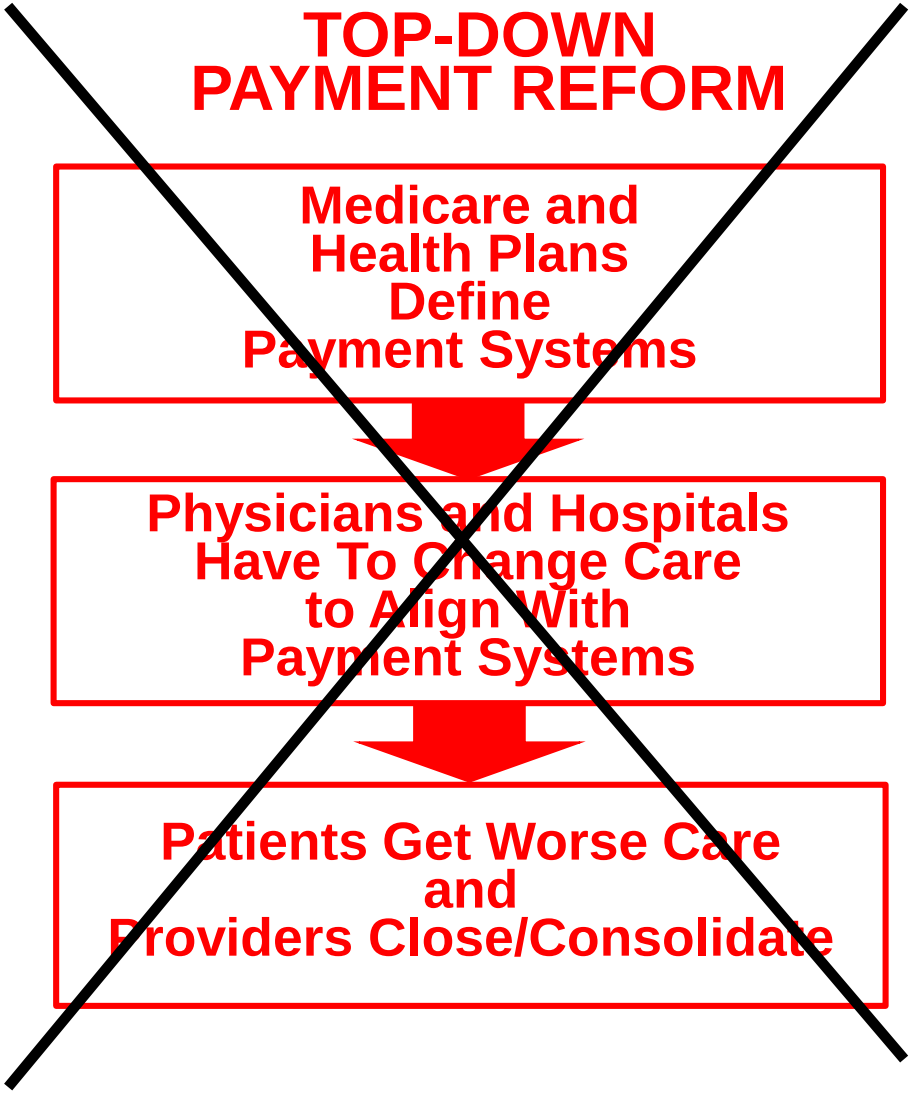
BOTTOM-UP PAYMENT REFORM

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

…Pay Adequately & Expect Accountability for Outcomes…

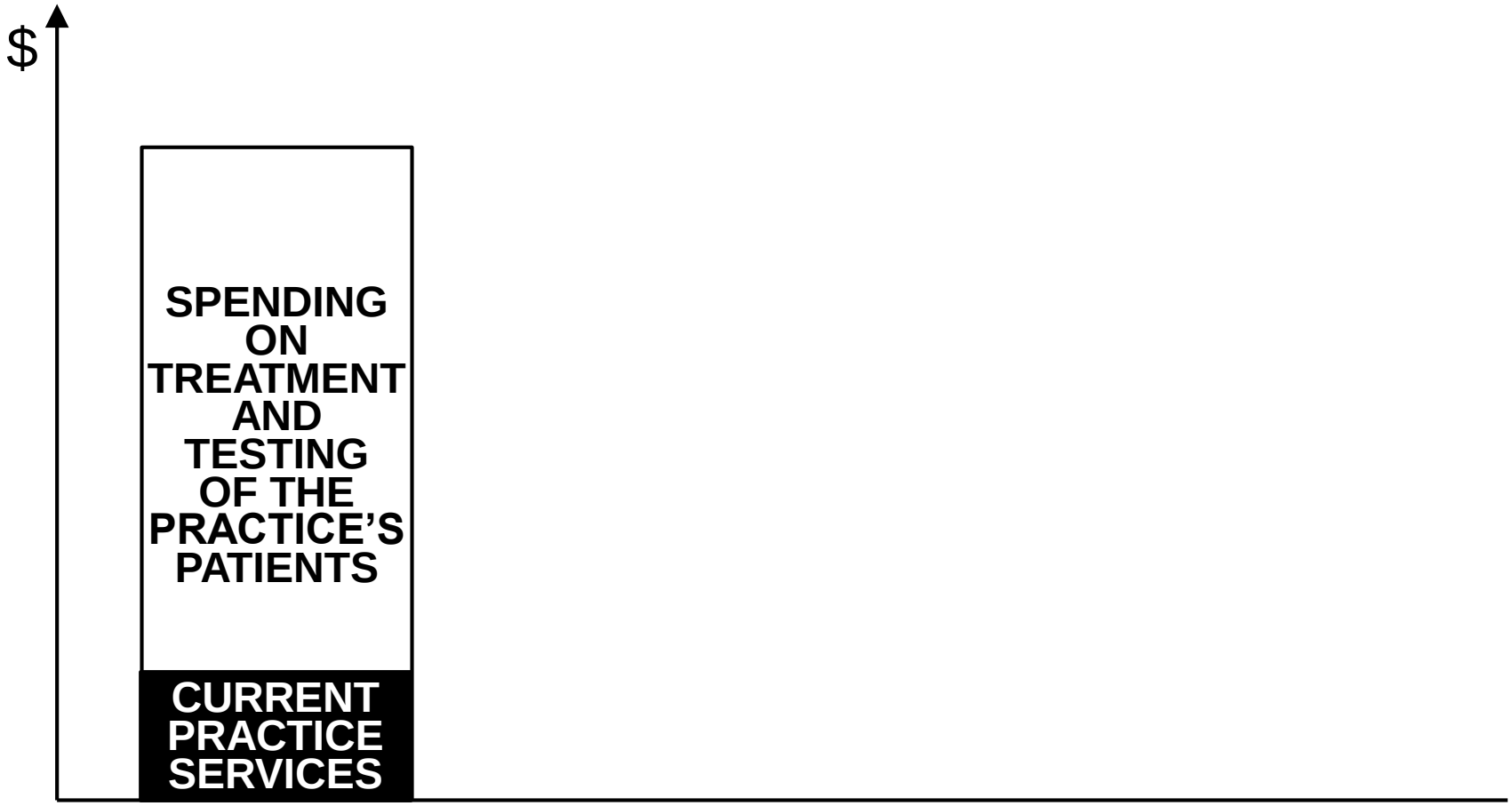


…So the Result is Better, More Affordable Patient Care

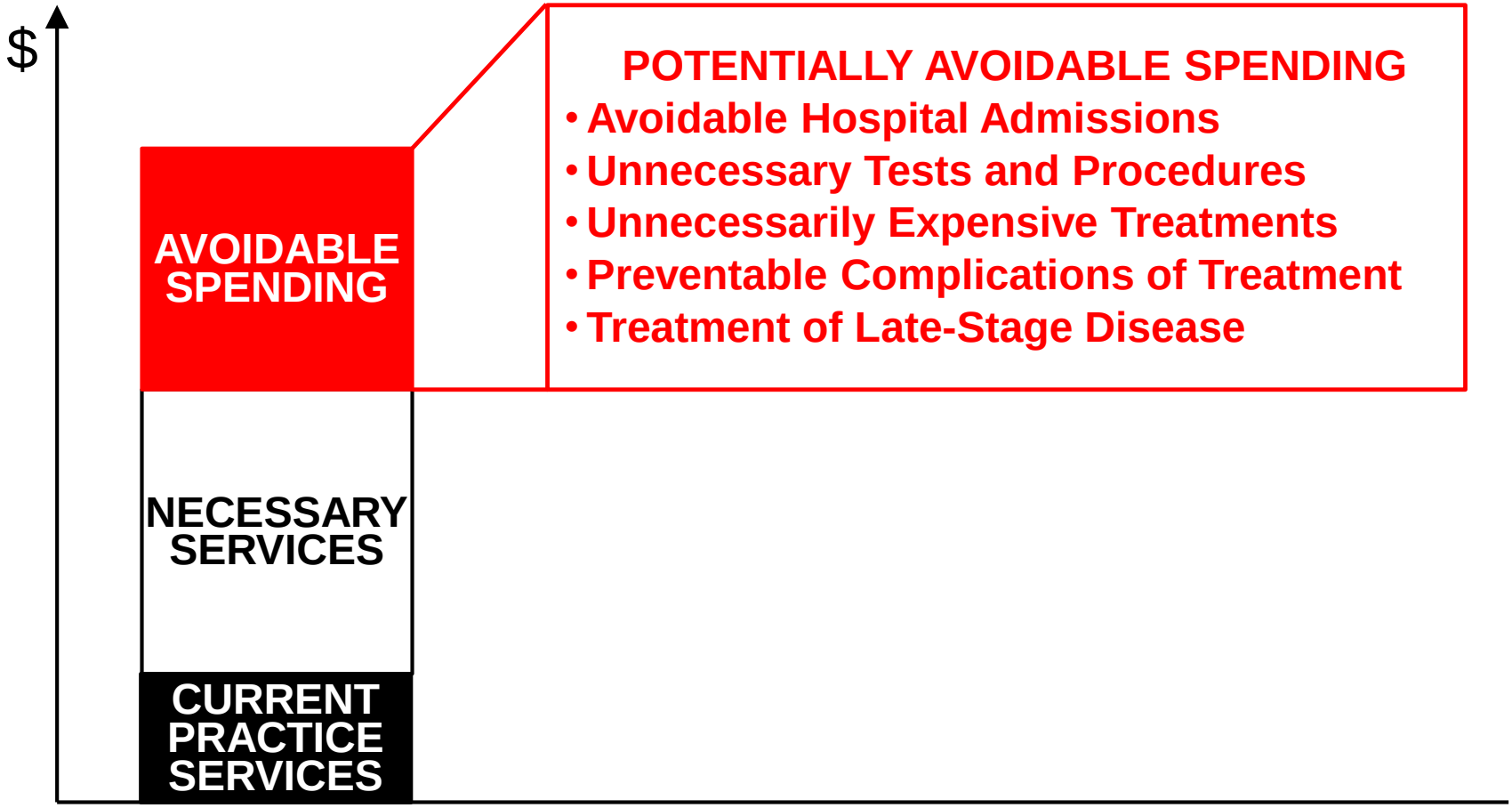


How Do You Define a *Good* Value-Based Alternative Payment Model?

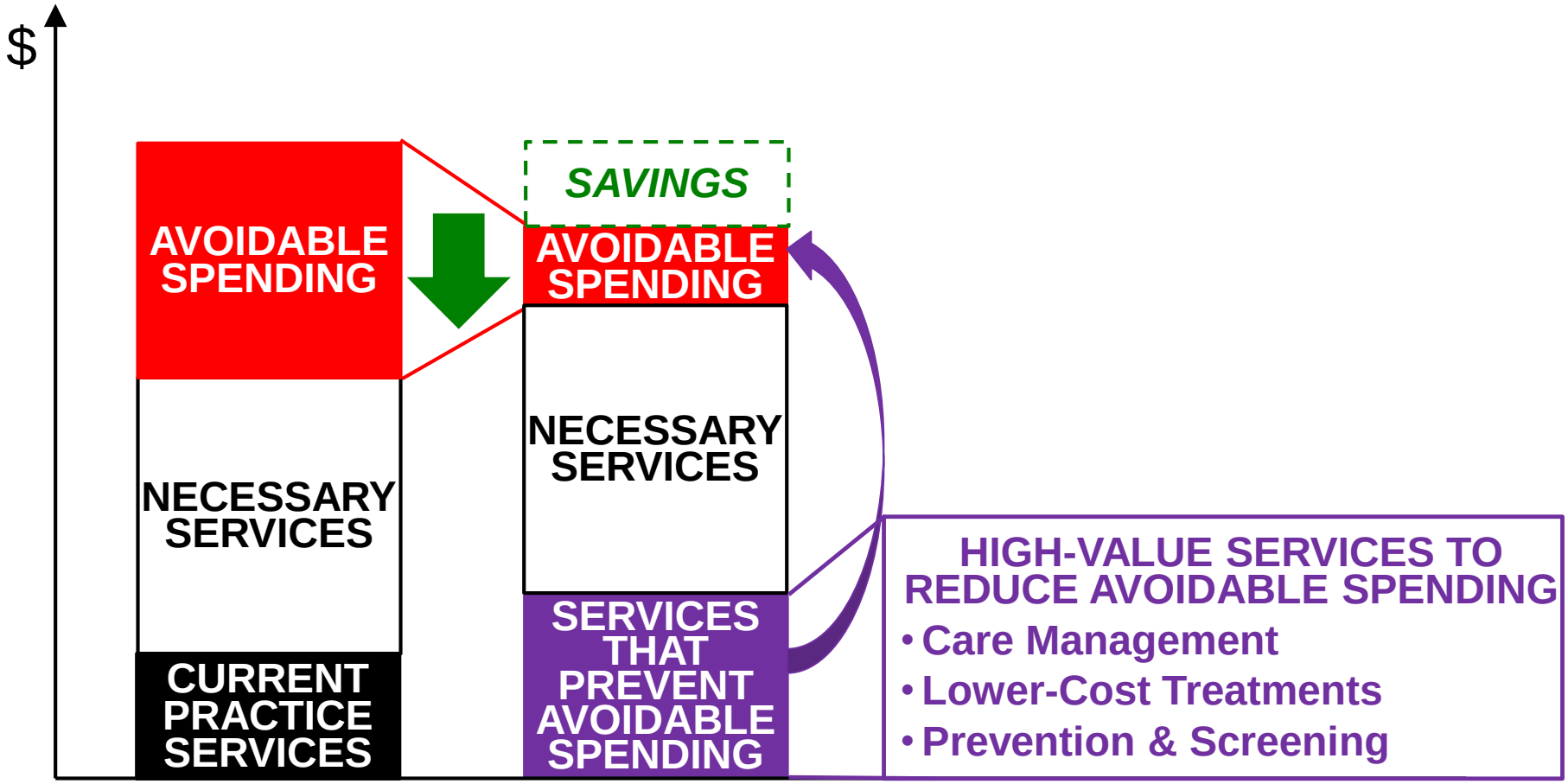
Starting with Current Spending on a Practice's Patients…



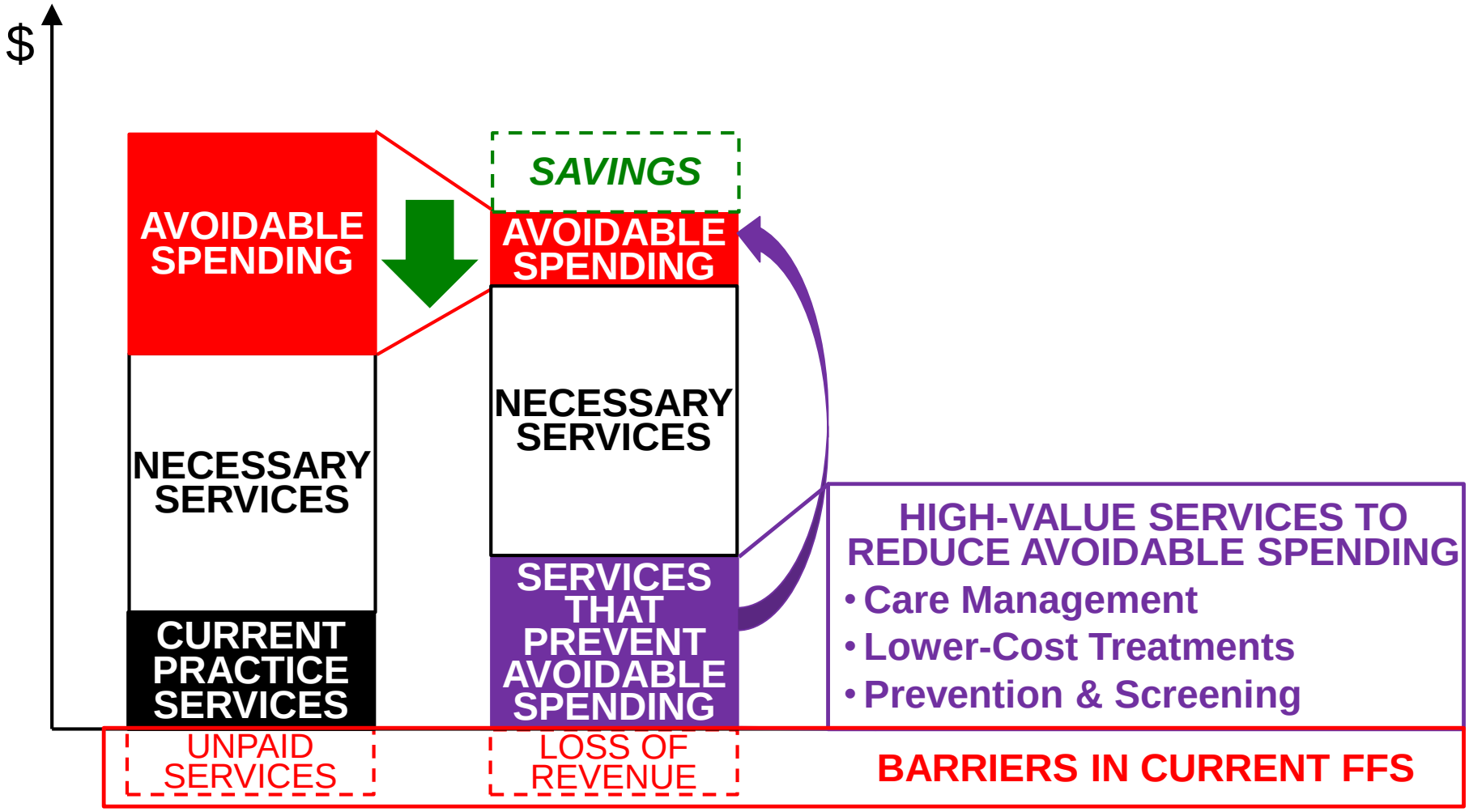
Step 1: Identify Specific Areas of *Avoidable* Spending



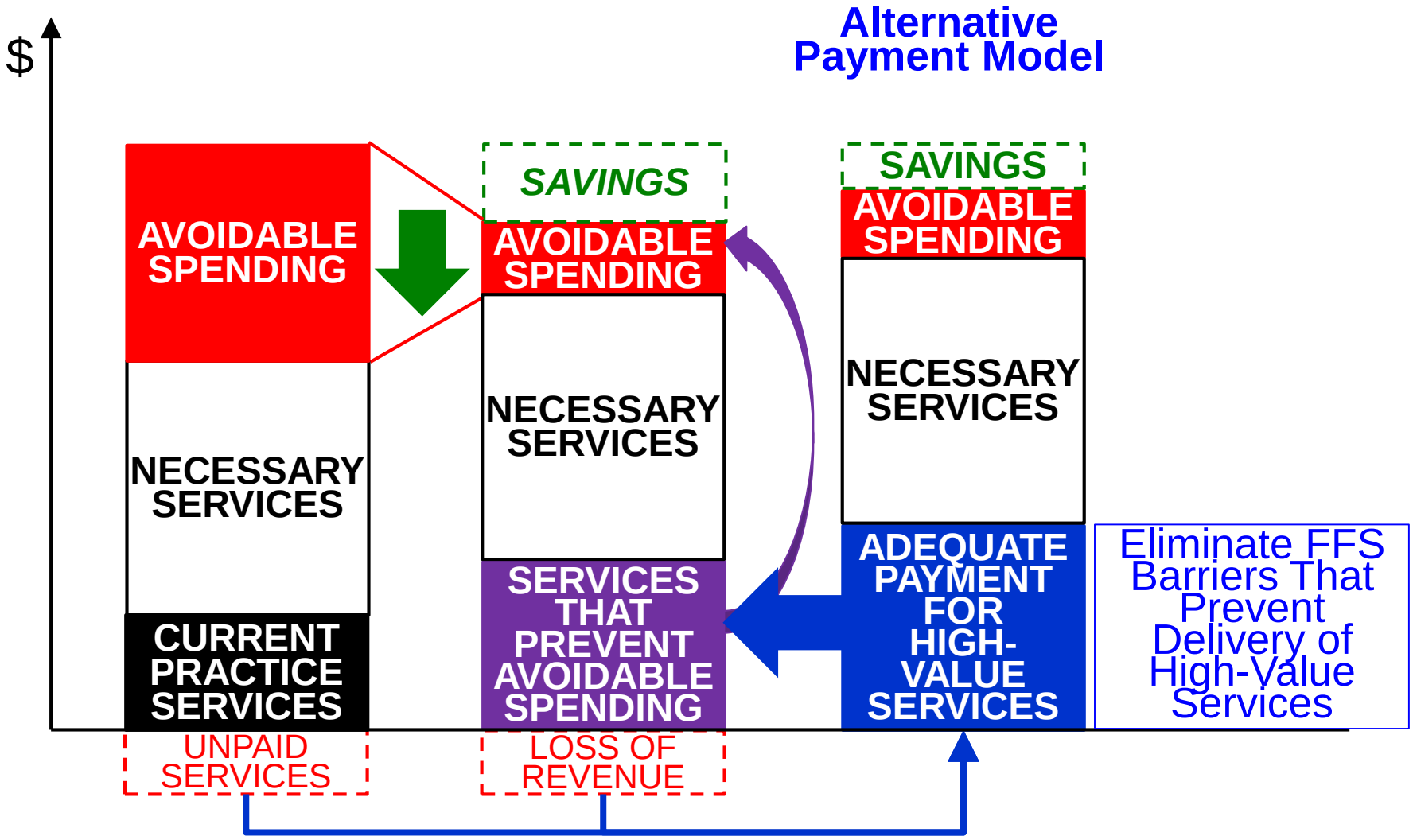
Step 2a: Design Services That Will Reduce Avoidable Spending



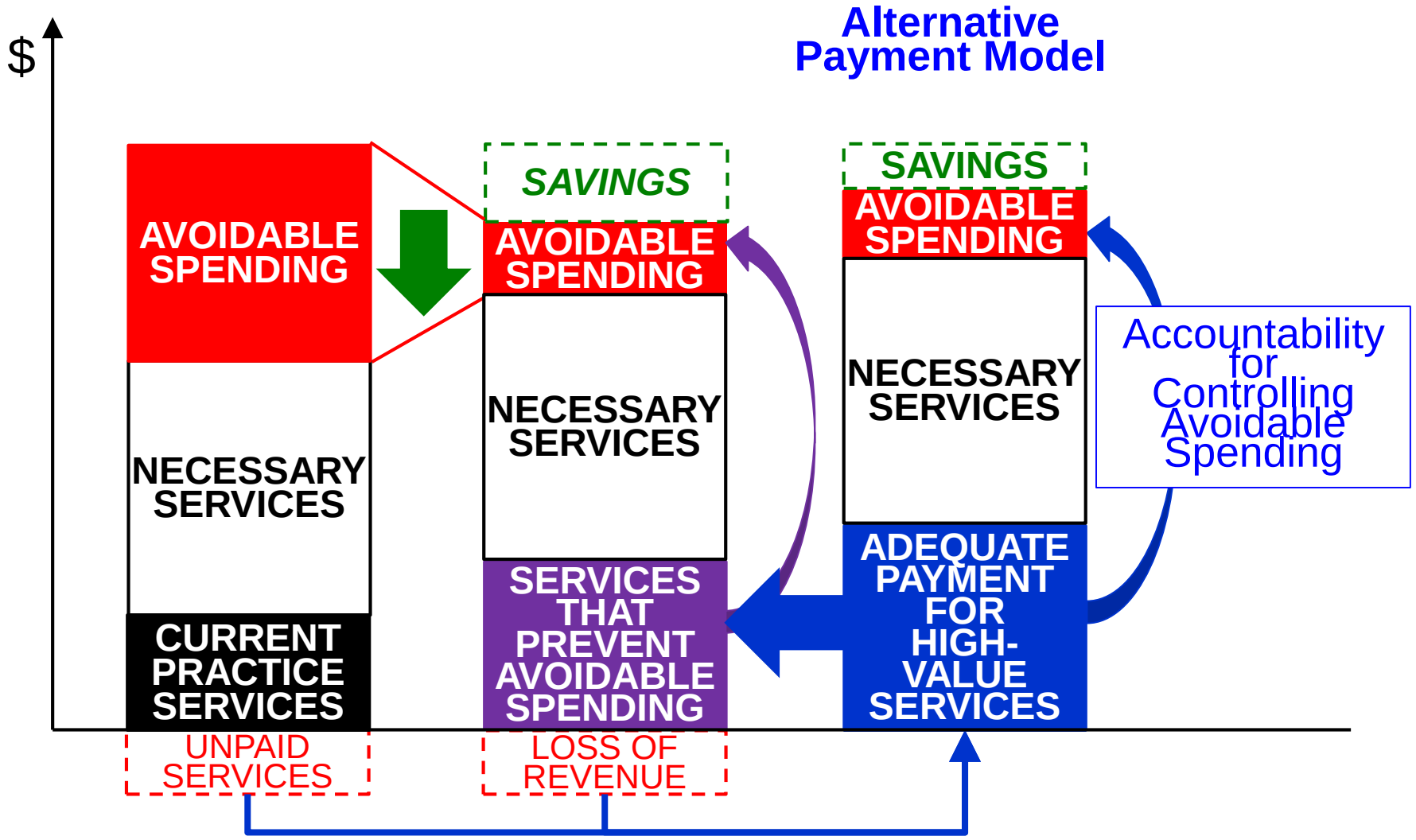
Step 2b: Identify Barriers in FFS to Delivery of High-Value Services



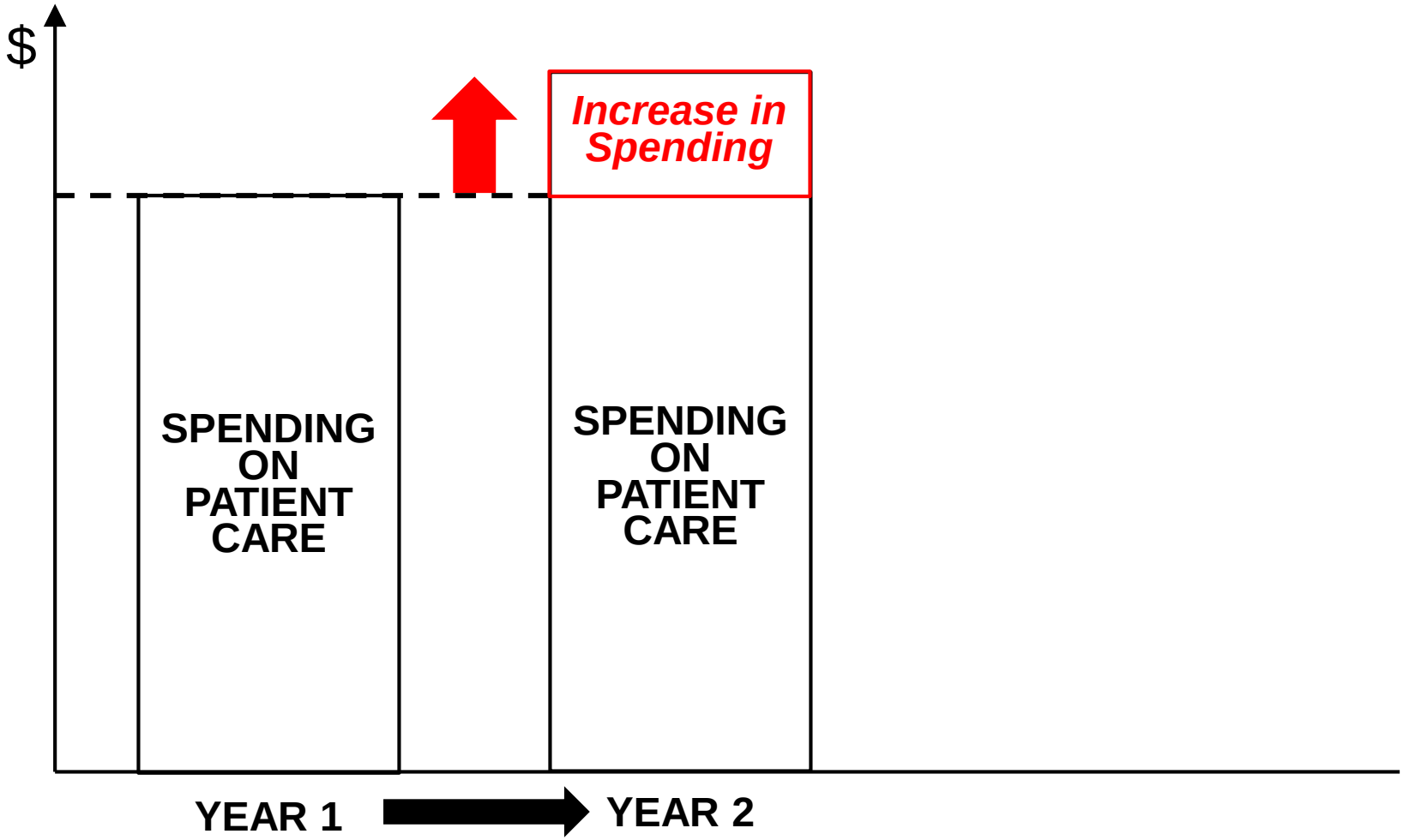
Step 3: Pay Adequately to Support Higher-Value Services



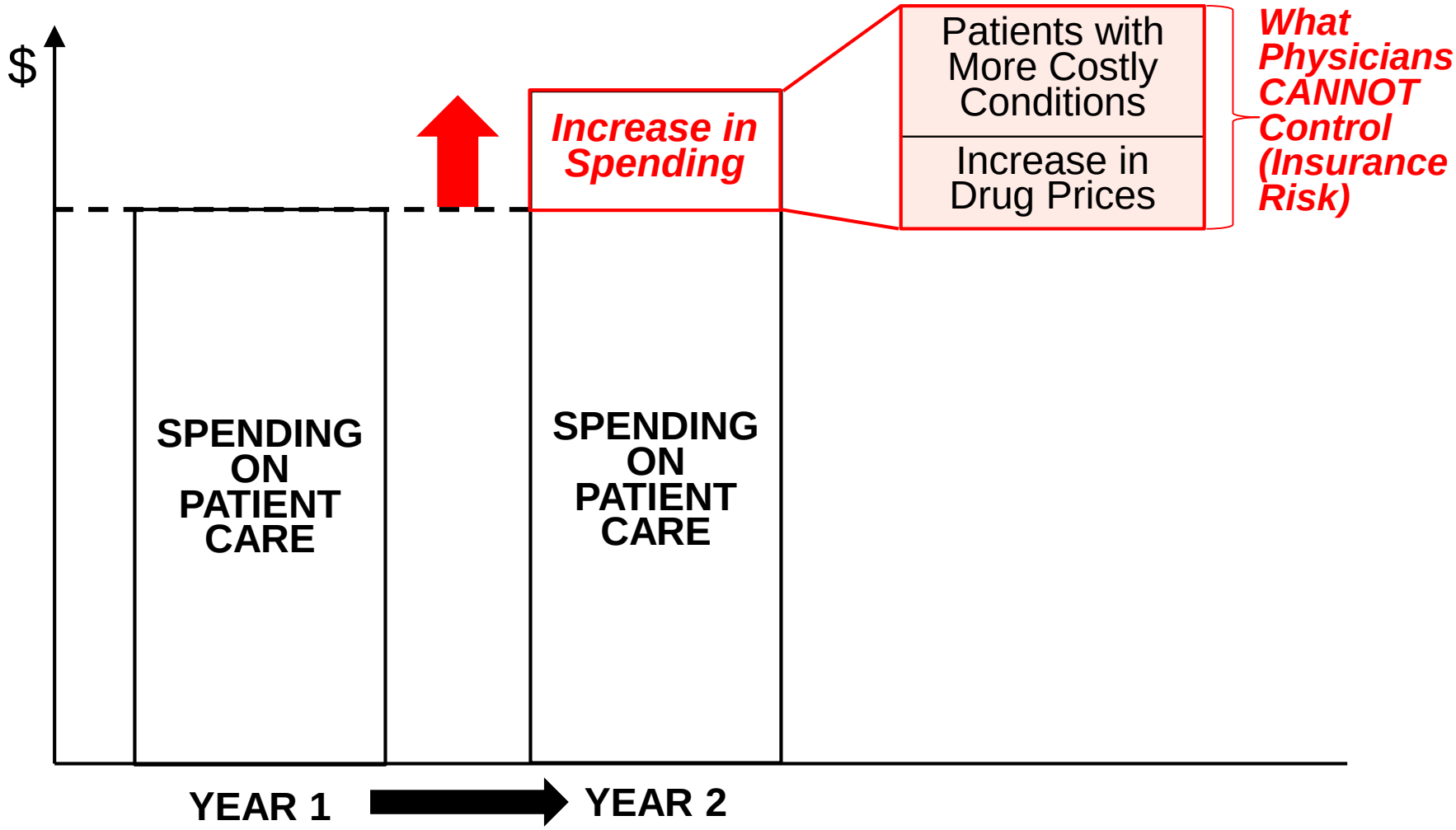
Step 4: Require Accountability for Cost&Quality *Providers Can Control*



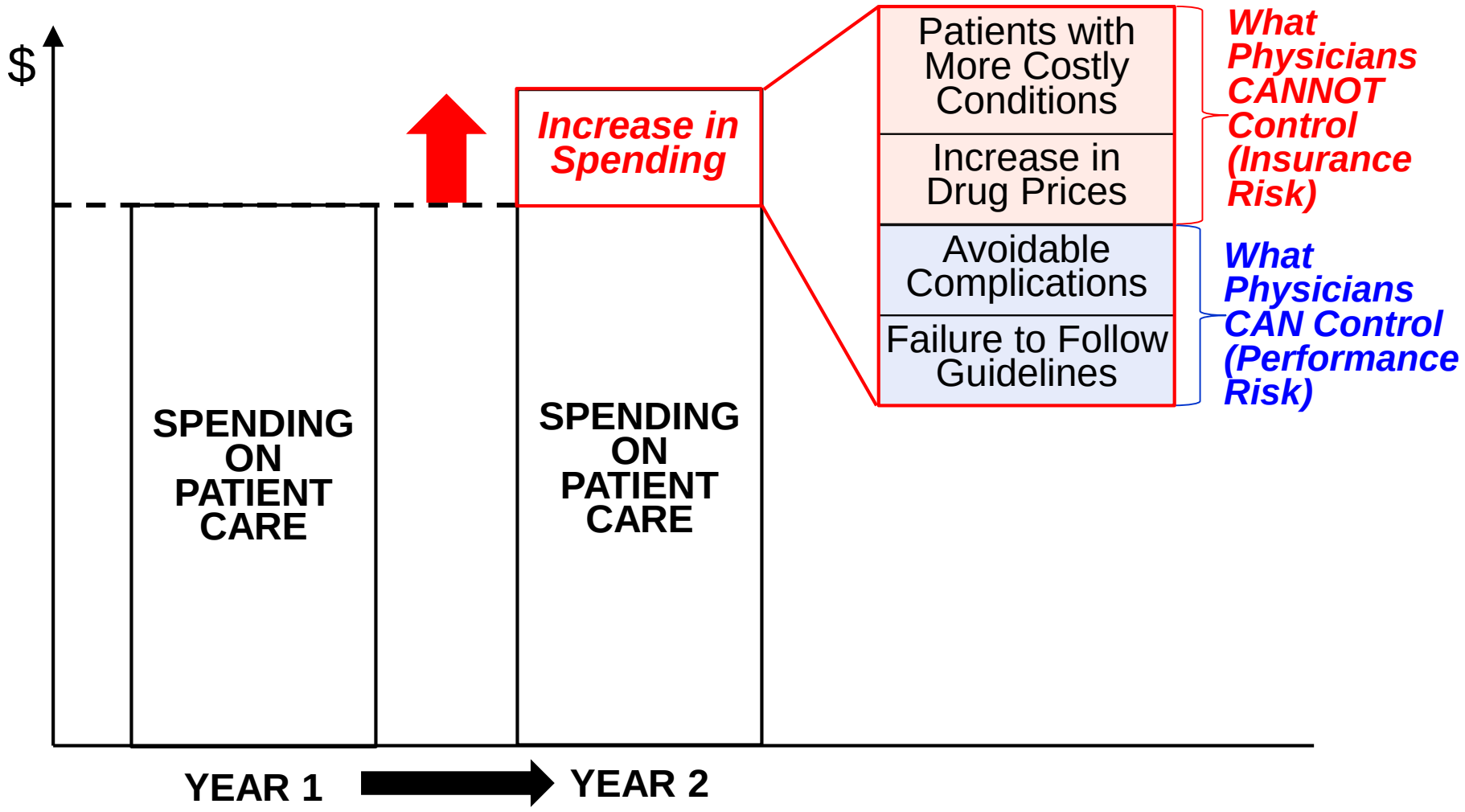
Accountability ≠ Putting Physicians at Risk for Total Spending



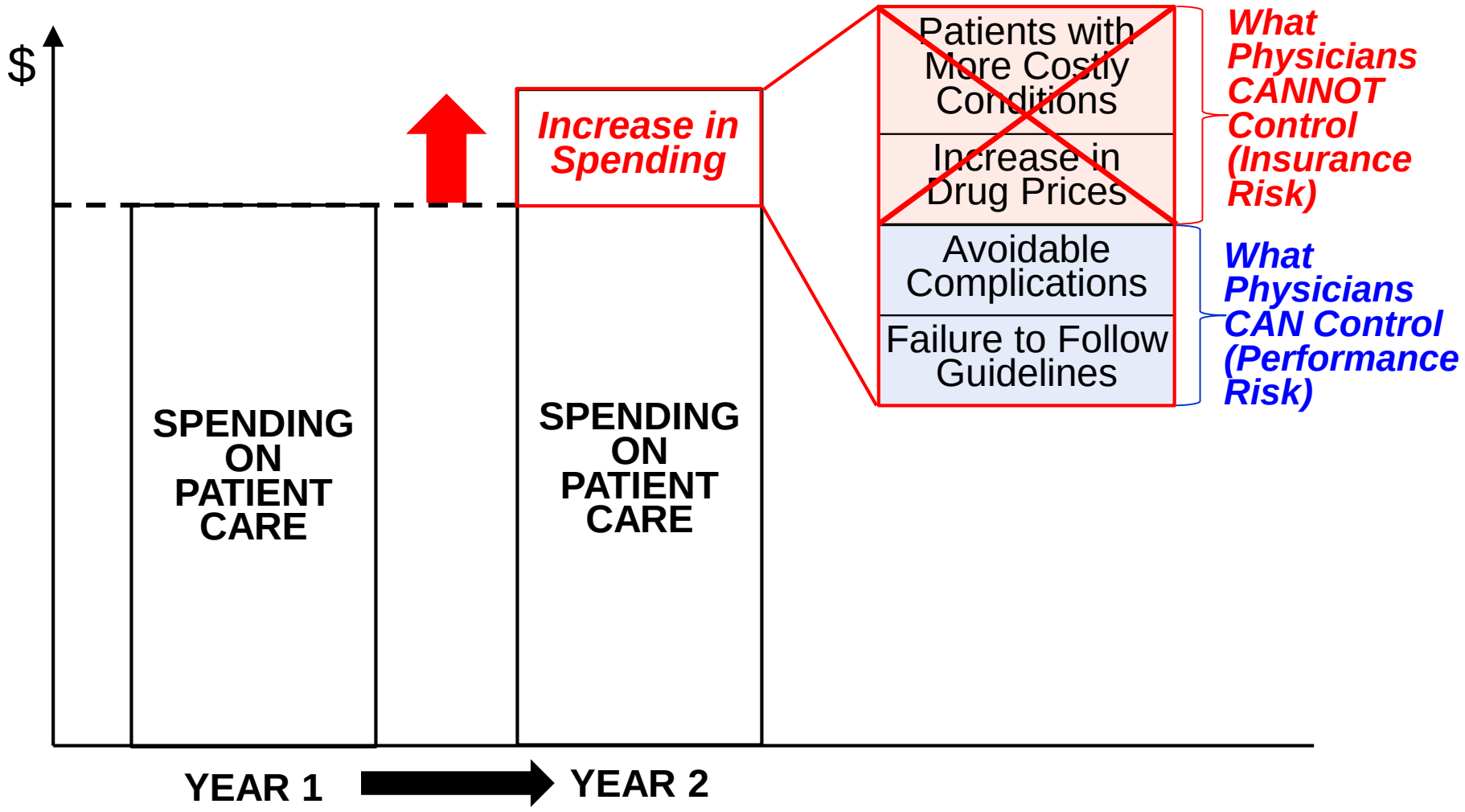
Physician Practices *Cannot* Control Severity of Disease or Drug Prices



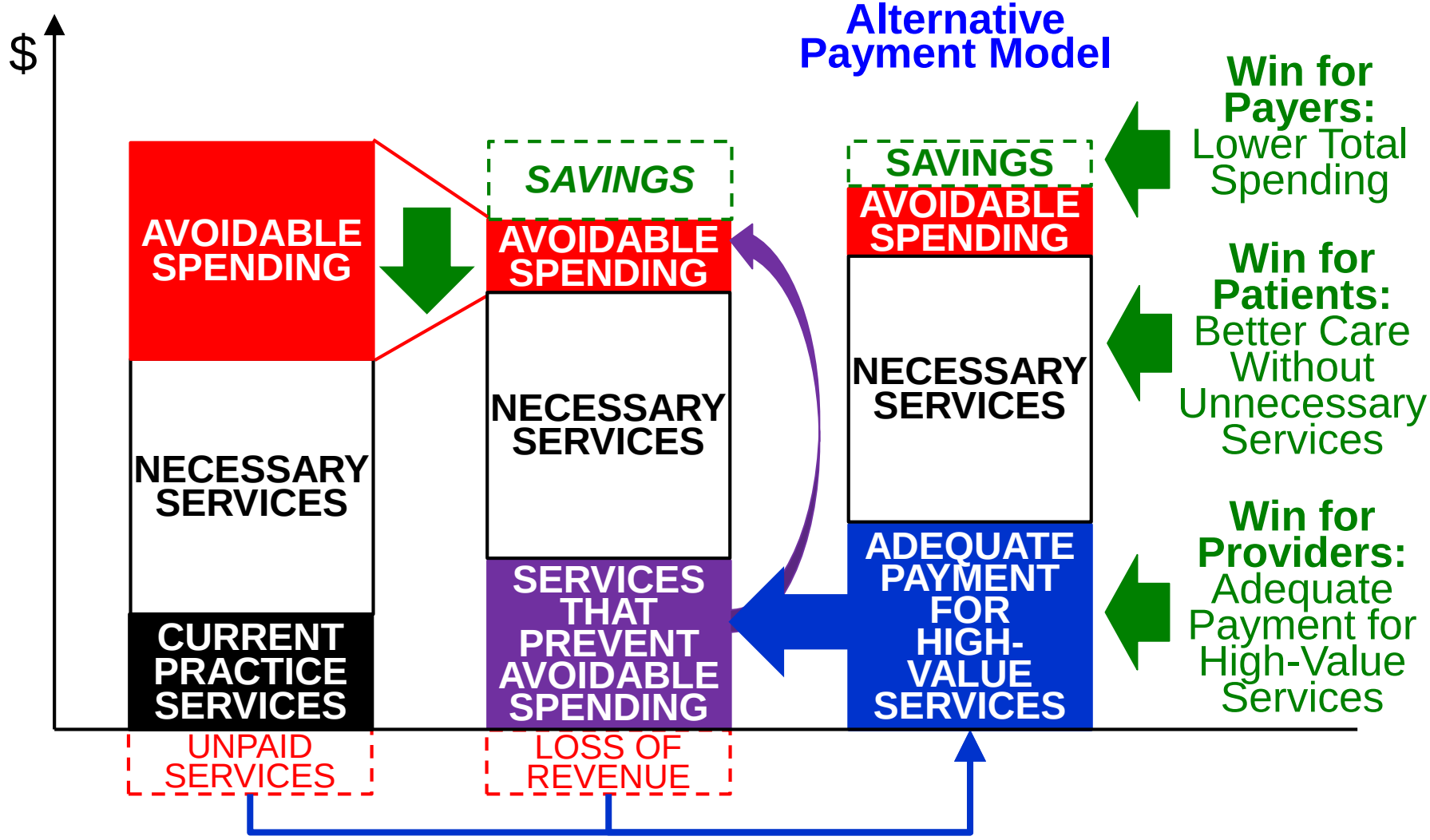
Physician Practices *Can* Reduce Complications & Avoidable Svcs



A *Good* APM Will Limit "Risk" to Things a Physician Can Control

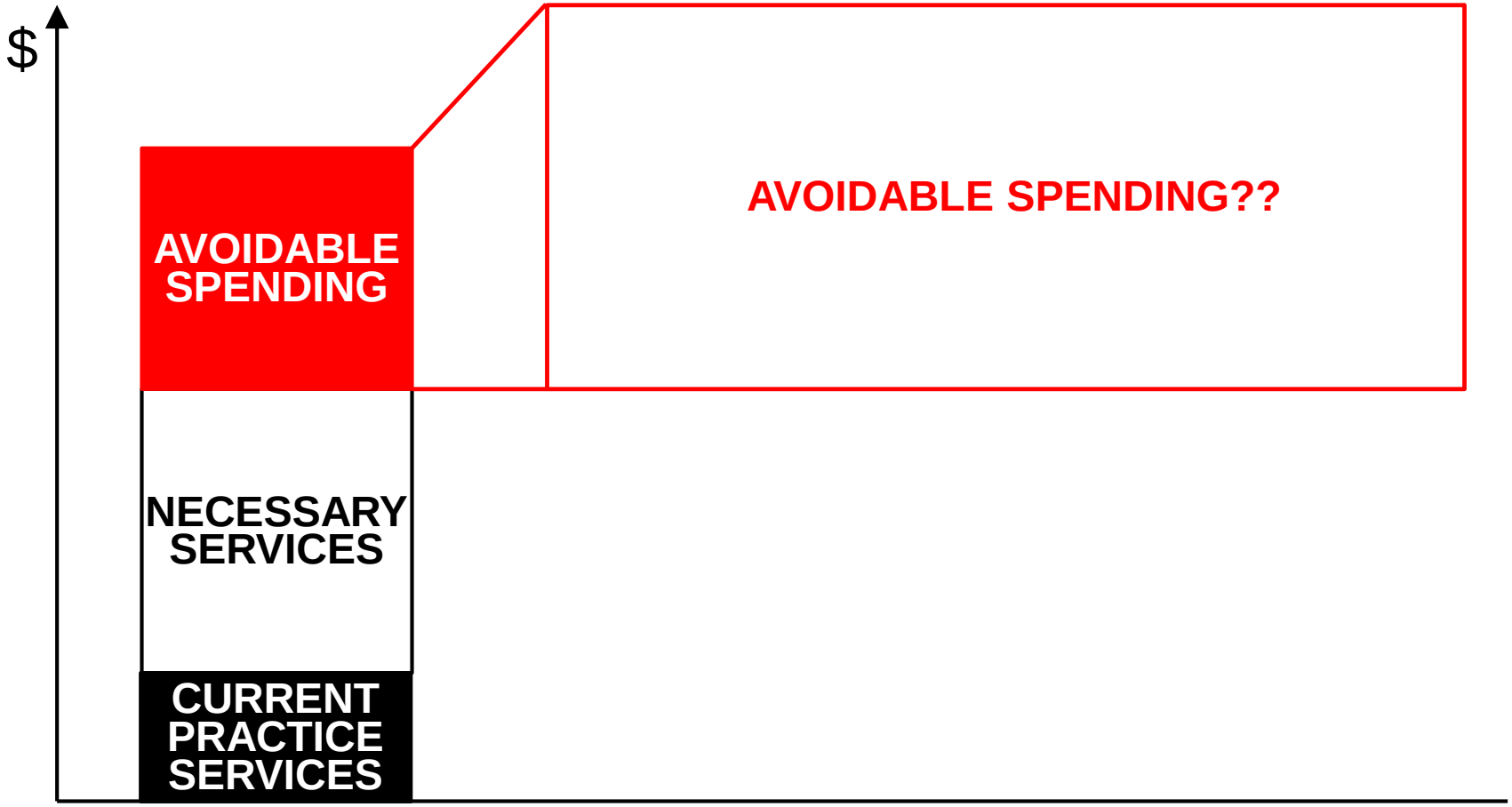


Good Alternative Payment Models Can Be Win-Win-Wins

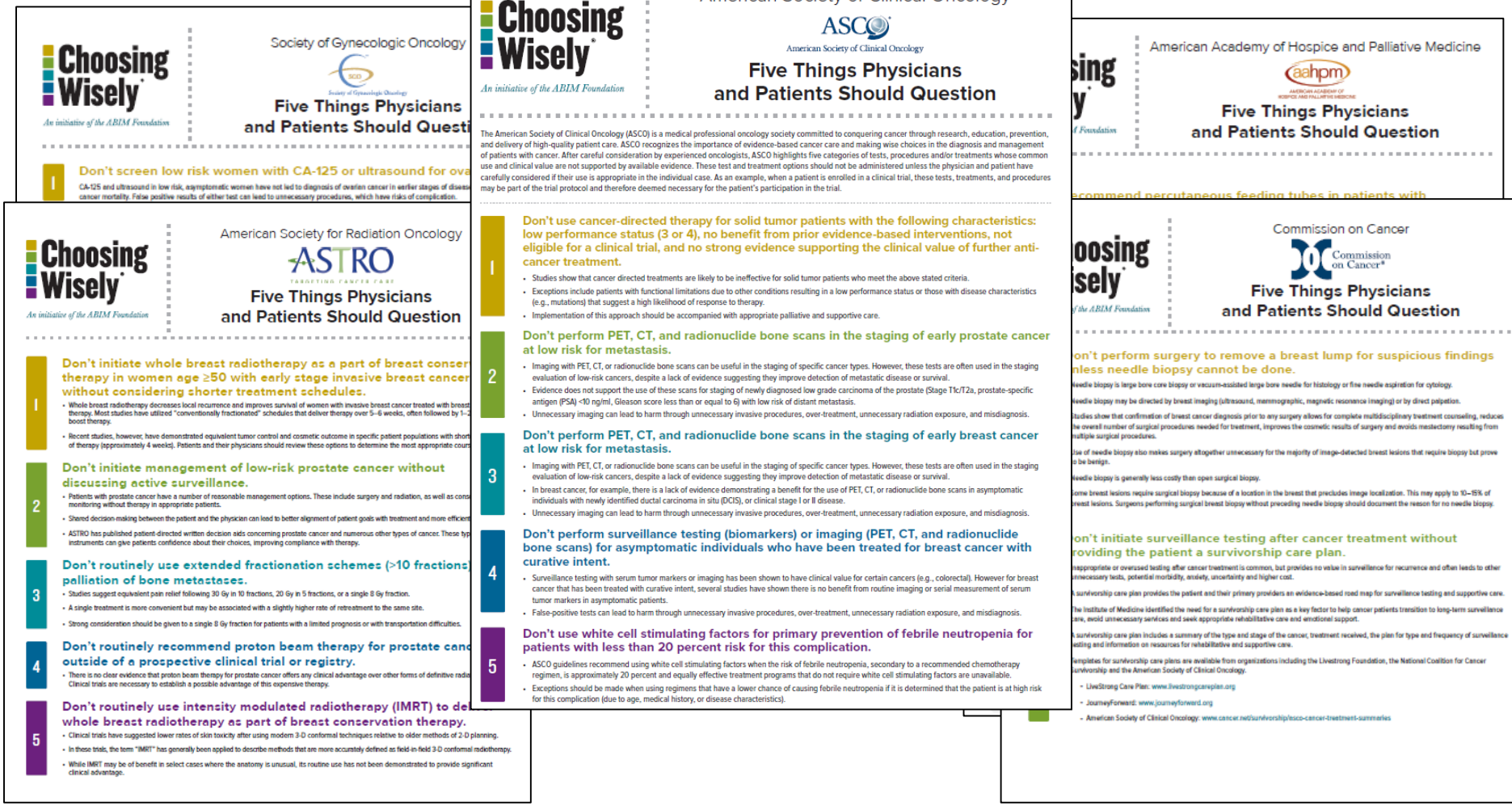


How Would This Work for Oncology Patients?

Step 1: Identify Specific Areas of *Avoidable* Spending



Choosing Wisely Identifies Areas of Avoidable Spending



Choosing Wisely
An initiative of the ABIM Foundation

Society of Gynecologic Oncology

Five Things Physicians and Patients Should Questi

1 Don't screen low risk women with CA-125 or ultrasound for ova

CA-125 and ultrasound in low risk, asymptomatic women have not led to diagnosis of ovarian cancer in earlier stages of diseas
cancer mortality. False positive results of either test can lead to unnecessary procedures, which have risks of complication.

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).

Choosing Wisely
An initiative of the ABIM Foundation

American Society for Radiation Oncology
ASTRO
TARGETING CANCER CARE

Five Things Physicians and Patients Should Question

1 Don't initiate whole breast radiotherapy as a part of breast conser therapy in women age ≥50 with early stage invasive breast cancer without considering shorter treatment schedules.

- Whole breast radiotherapy decreases local recurrence and improves survival of women with invasive breast cancer treated with breast therapy. Most studies have utilized "conventionally fractionated" schedules that deliver therapy over 5–6 weeks, often followed by 1–2 boost therapy.
- Recent studies, however, have demonstrated equivalent tumor control and cosmetic outcome in specific patient populations with short of therapy (approximately 4 weeks). Patients and their physicians should review these options to determine the most appropriate cours

2 Don't initiate management of low-risk prostate cancer without discussing active surveillance.

- Patients with prostate cancer have a number of reasonable management options. These include surgery and radiation, as well as cons monitoring without therapy in appropriate patients.
- Shared decision-making between the patient and the physician can lead to better alignment of patient goals with treatment and more efficient
- ASTRO has published patient-directed written decision aids concerning prostate cancer and numerous other types of cancer. These ty instruments can give patients confidence about their choices, improving compliance with therapy.

3 Don't routinely use extended fractionation schemes (>10 fractions) palliation of bone metastases.

- Studies suggest equivalent pain relief following 30 Gy in 10 fractions, 20 Gy in 5 fractions, or a single 8 Gy fraction.
- A single treatment is more convenient but may be associated with a slightly higher rate of retreatment to the same site.
- Strong consideration should be given to a single 8 Gy fraction for patients with a limited prognosis or with transportation difficulties.

4 Don't routinely recommend proton beam therapy for prostate canc outside of a prospective clinical trial or registry.

- There is no clear evidence that proton beam therapy for prostate cancer offers any clinical advantage over other forms of definitive radia Clinical trials are necessary to establish a possible advantage of this expensive therapy.

5 Don't routinely use intensity modulated radiotherapy (IMRT) to de whole breast radiotherapy as part of breast conservation therapy.

- Clinical trials have suggested lower rates of skin toxicity after using modern 3-D conformal techniques relative to older methods of 2-D planning.
- In these trials, the term "IMRT" has generally been applied to describe methods that are more accurately defined as field-in-field 3-D conformal radiotherapy.
- While IMRT may be of benefit in select cases where the anatomy is unusual, its routine use has not been demonstrated to provide significant clinical advantage.

American Academy of Hospice and Palliative Medicine
aahpm

Five Things Physicians and Patients Should Question

ecommend percutaneous feeding tubes in patients with

Commission on Cancer
Commission on Cancer

Five Things Physicians and Patients Should Question

on't perform surgery to remove a breast lump for suspicious findings nless needle biopsy cannot be done.

Needle biopsy is large bore core biopsy or vacuum-assisted large bore needle for histology or fine needle aspiration for cytology.

Needle biopsy may be directed by breast imaging (ultrasound, mammographic, magnetic resonance imaging) or by direct palpation.

Studies show that confirmation of breast cancer diagnosis prior to any surgery allows for complete multidisciplinary treatment counseling, reduces the overall number of surgical procedures needed for treatment, improves the cosmetic results of surgery and avoids mastectomy resulting from multiple surgical procedures.

Use of needle biopsy also makes surgery altogether unnecessary for the majority of image-detected breast lesions that require biopsy but prove to be benign.

Needle biopsy is generally less costly than open surgical biopsy.

Some breast lesions require surgical biopsy because of a location in the breast that precludes image localization. This may apply to 10–15% of breast lesions. Surgeons performing surgical breast biopsy without preceding needle biopsy should document the reason for no needle biopsy.

on't initiate surveillance testing after cancer treatment without roviding the patient a survivorship care plan.

Inappropriate or overused testing after cancer treatment is common, but provides no value in surveillance for recurrence and often leads to other unnecessary tests, potential morbidity, anxiety, uncertainty and higher cost.

A survivorship care plan provides the patient and their primary providers an evidence-based road map for surveillance testing and supportive care.

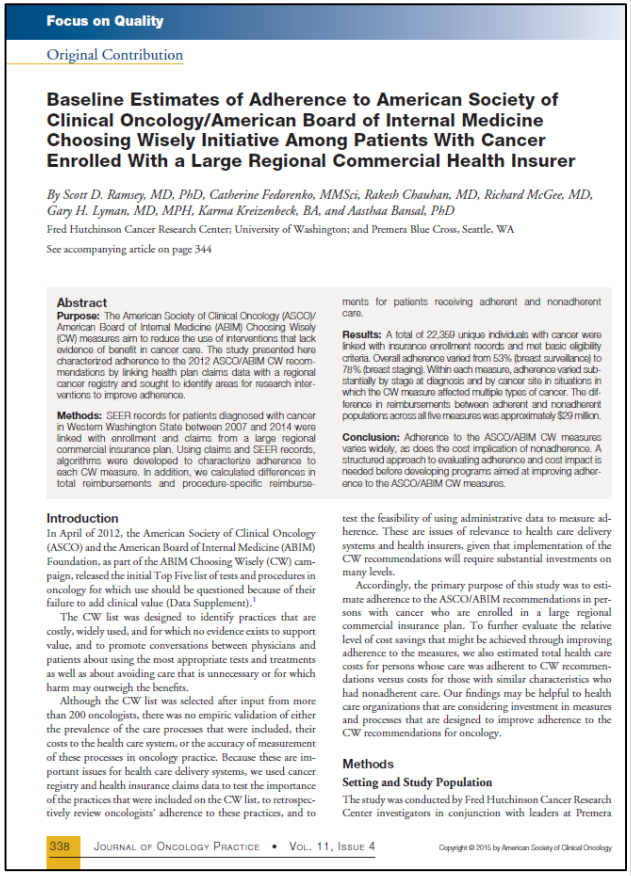
The Institute of Medicine identified the need for a survivorship care plan as a key factor to help cancer patients transition to long-term surveillance care, avoid unnecessary services and seek appropriate rehabilitative care and emotional support.

A survivorship care plan includes a summary of the type and stage of the cancer, treatment received, the plan for type and frequency of surveillance testing and information on resources for rehabilitative and supportive care.

Templates for survivorship care plans are available from organizations including the Livestrong Foundation, the National Coalition for Cancer Survivorship and the American Society of Clinical Oncology.

- LiveStrong Care Plan: www.livestrongcareplan.org
- JourneyForward: www.journeyforward.org
- American Society of Clinical Oncology: www.cancer.net/survivorship/esco-cancer-treatment-summaries

22%-47% Non-Adherence to Choosing Wisely Criteria



Focus on Quality

Original Contribution

Baseline Estimates of Adherence to American Society of Clinical Oncology/American Board of Internal Medicine Choosing Wisely Initiative Among Patients With Cancer Enrolled With a Large Regional Commercial Health Insurer

By Scott D. Ramsey, MD, PhD, Catherine Fedorenko, MMSci, Rakesh Chauhan, MD, Richard McGee, MD, Gary H. Lyman, MD, MPH, Karma Kreizenbeck, BA, and Aasthaa Bansal, PhD

Fred Hutchinson Cancer Research Center; University of Washington; and Premera Blue Cross, Seattle, WA

See accompanying article on page 344

Abstract

Purpose: The American Society of Clinical Oncology (ASCO)/American Board of Internal Medicine (ABIM) Choosing Wisely (CW) measures aim to reduce the use of interventions that lack evidence of benefit in cancer care. The study presented here characterized adherence to the 2012 ASCO/ABIM CW recommendations by linking health plan claims data with a regional cancer registry and sought to identify areas for research interventions to improve adherence.

Methods: SEER records for patients diagnosed with cancer in Western Washington State between 2007 and 2014 were linked with enrollment and claims from a large regional commercial insurance plan. Using claims and SEER records, algorithms were developed to characterize adherence to each CW measure. In addition, we calculated differences in total reimbursements and procedure-specific reimbursements for patients receiving adherent and nonadherent care.

Results: A total of 22,359 unique individuals with cancer were linked with insurance enrollment records and met basic eligibility criteria. Overall adherence varied from 53% (breast surveillance) to 78% (breast staging). Within each measure, adherence varied substantially by stage at diagnosis and by cancer site in situations in which the CW measure affected multiple types of cancer. The difference in reimbursements between adherent and nonadherent populations across all five measures was approximately $29 million.

Conclusion: Adherence to the ASCO/ABIM CW measures varies widely, as does the cost implication of nonadherence. A structured approach to evaluating adherence and cost impact is needed before developing programs aimed at improving adherence to the ASCO/ABIM CW measures.

Introduction

In April of 2012, the American Society of Clinical Oncology (ASCO) and the American Board of Internal Medicine (ABIM) Foundation, as part of the ABIM Choosing Wisely (CW) campaign, released the initial Top Five list of tests and procedures in oncology for which use should be questioned because of their failure to add clinical value (Data Supplement).[1]

The CW list was designed to identify practices that are costly, widely used, and for which no evidence exists to support value, and to promote conversations between physicians and patients about using the most appropriate tests and treatments as well as about avoiding care that is unnecessary or for which harm may outweigh the benefits.

Although the CW list was selected after input from more than 200 oncologists, there was no empiric validation of either the prevalence of the care processes that were included, their costs to the health care system, or the accuracy of measurement of these processes in oncology practice. Because these are important issues for health care delivery systems, we used cancer registry and health insurance claims data to test the importance of the practices that were included on the CW list, to retrospectively review oncologists' adherence to these practices, and to test the feasibility of using administrative data to measure adherence. These are issues of relevance to health care delivery systems and health insurers, given that implementation of the CW recommendations will require substantial investments on many levels.

Accordingly, the primary purpose of this study was to estimate adherence to the ASCO/ABIM recommendations in persons with cancer who are enrolled in a large regional commercial insurance plan. To further evaluate the relative level of cost savings that might be achieved through improving adherence to the measures, we also estimated total health care costs for persons whose care was adherent to CW recommendations versus costs for those with similar characteristics who had nonadherent care. Our findings may be helpful to health care organizations that are considering investment in measures and processes that are designed to improve adherence to the CW recommendations for oncology.

Methods

Setting and Study Population

The study was conducted by Fred Hutchinson Cancer Research Center investigators in conjunction with leaders at Premera

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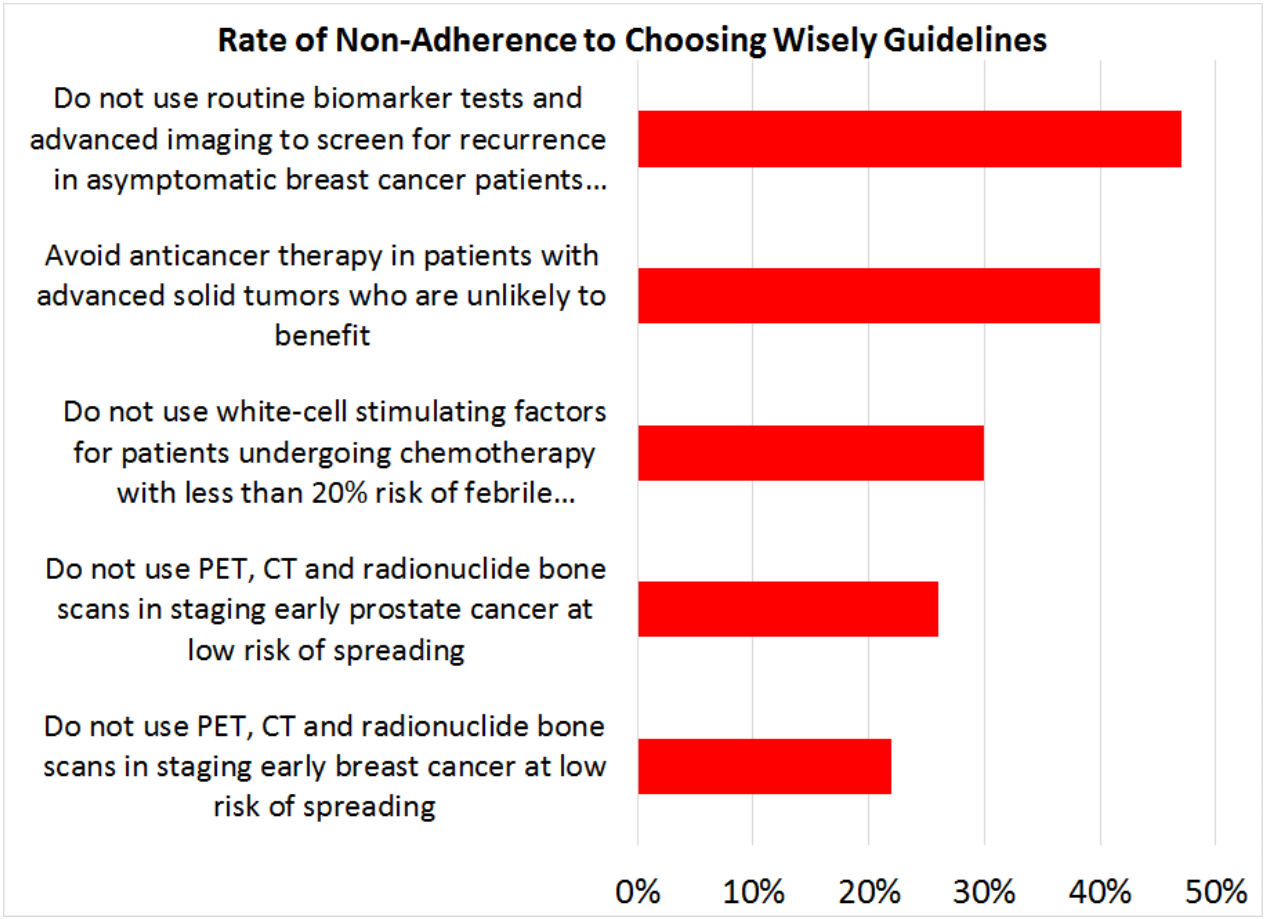
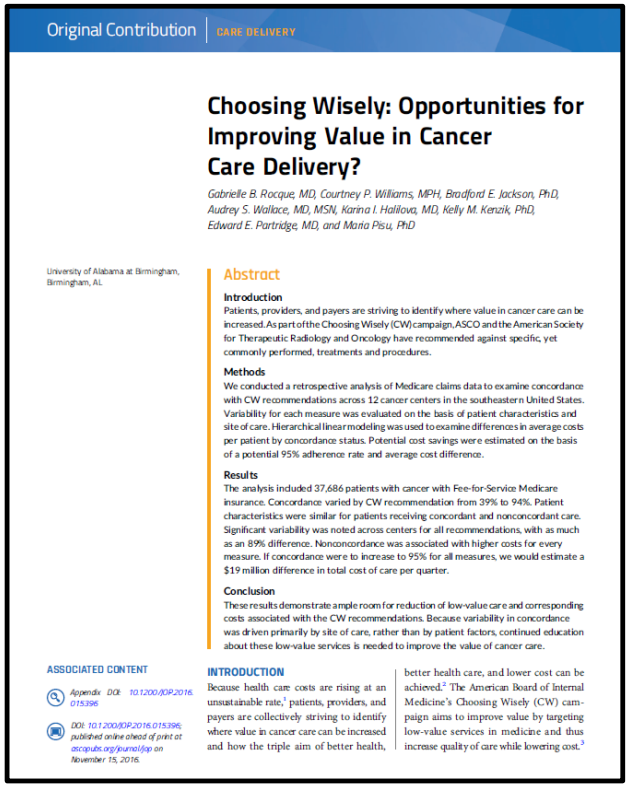


27%-40% Non-Adherence to Choosing Wisely Criteria



Original Contribution | CARE DELIVERY

Choosing Wisely: Opportunities for Improving Value in Cancer Care Delivery?

Gabrielle B. Rocque, MD, Courtney P. Williams, MPH, Bradford E. Jackson, PhD, Audrey S. Wallace, MD, MSN, Karina I. Halilova, MD, Kelly M. Kenzik, PhD, Edward E. Partridge, MD, and Maria Pisu, PhD

University of Alabama at Birmingham, Birmingham, AL

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Patients, providers, and payers are striving to identify where value in cancer care can be increased. As part of the Choosing Wisely (CW) campaign, ASCO and the American Society for Therapeutic Radiology and Oncology have recommended against specific, yet commonly performed, treatments and procedures.

Methods
We conducted a retrospective analysis of Medicare claims data to examine concordance with CW recommendations across 12 cancer centers in the southeastern United States. Variability for each measure was evaluated on the basis of patient characteristics and site of care. Hierarchical linear modeling was used to examine differences in average costs per patient by concordance status. Potential cost savings were estimated on the basis of a potential 95% adherence rate and average cost difference.

Results
The analysis included 37,686 patients with cancer with Fee-for-Service Medicare insurance. Concordance varied by CW recommendation from 39% to 94%. Patient characteristics were similar for patients receiving concordant and nonconcordant care. Significant variability was noted across centers for all recommendations, with as much as an 89% difference. Nonconcordance was associated with higher costs for every measure. If concordance were to increase to 95% for all measures, we would estimate a $19 million difference in total cost of care per quarter.

Conclusion
These results demonstrate ample room for reduction of low-value care and corresponding costs associated with the CW recommendations. Because variability in concordance was driven primarily by site of care, rather than by patient factors, continued education about these low-value services is needed to improve the value of cancer care.

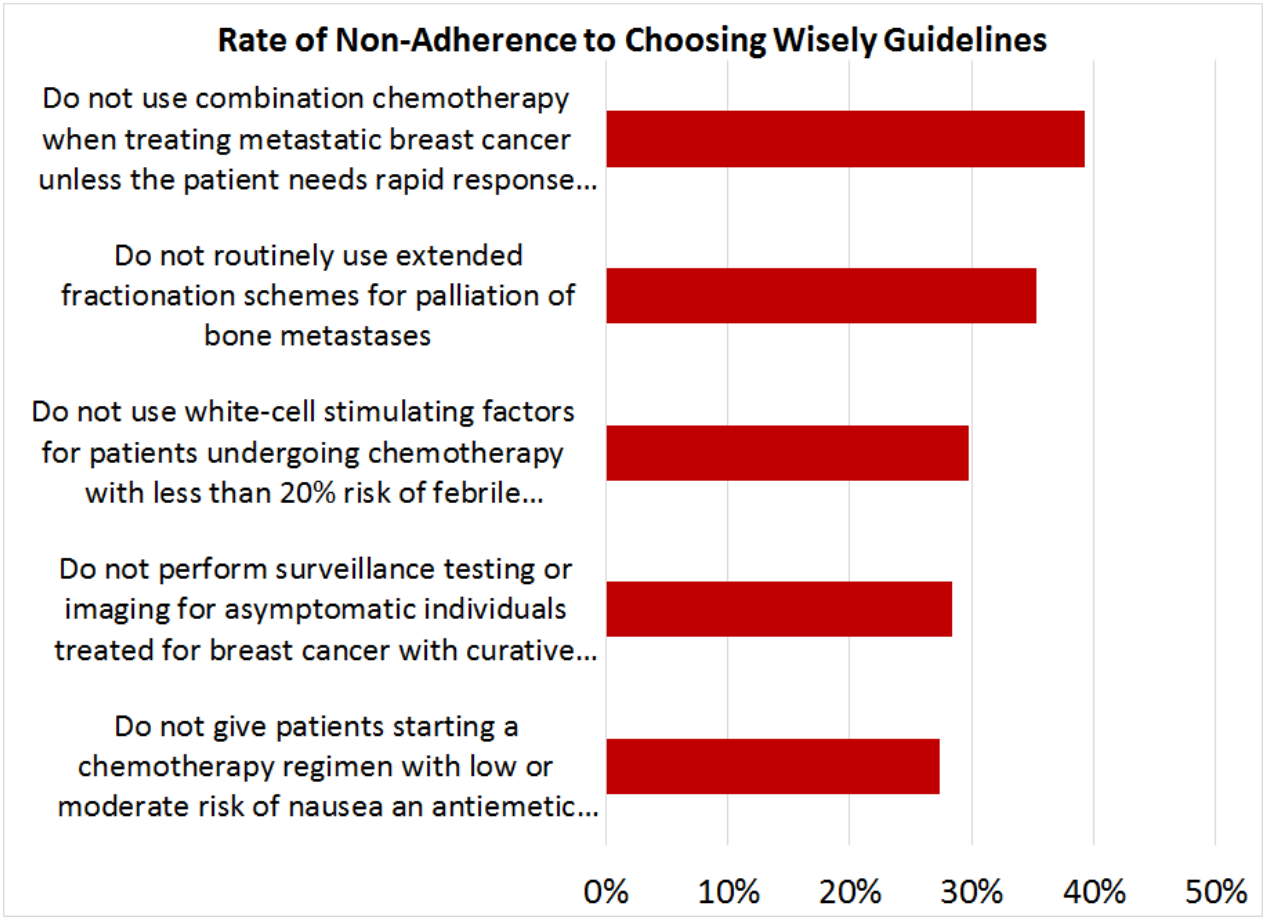
ASSOCIATED CONTENT

Appendix DOI: 10.1200/JOP.2016.015396

DOI: 10.1200/JOP.2016.015396; published online ahead of print at ascopubs.org/journal/jop on November 15, 2016.

INTRODUCTION

Because health care costs are rising at an unsustainable rate,[1] patients, providers, and payers are collectively striving to identify where value in cancer care can be increased and how the triple aim of better health, better health care, and lower cost can be achieved.[2] The American Board of Internal Medicine's Choosing Wisely (CW) campaign aims to improve value by targeting low-value services in medicine and thus increase quality of care while lowering cost.[3]



Example: 30% of Patients Receive CSFs Outside of Guidelines

Focus on Quality

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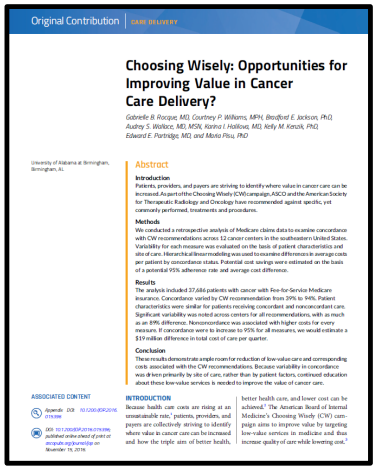

Original Contribution | CARE DELIVERY

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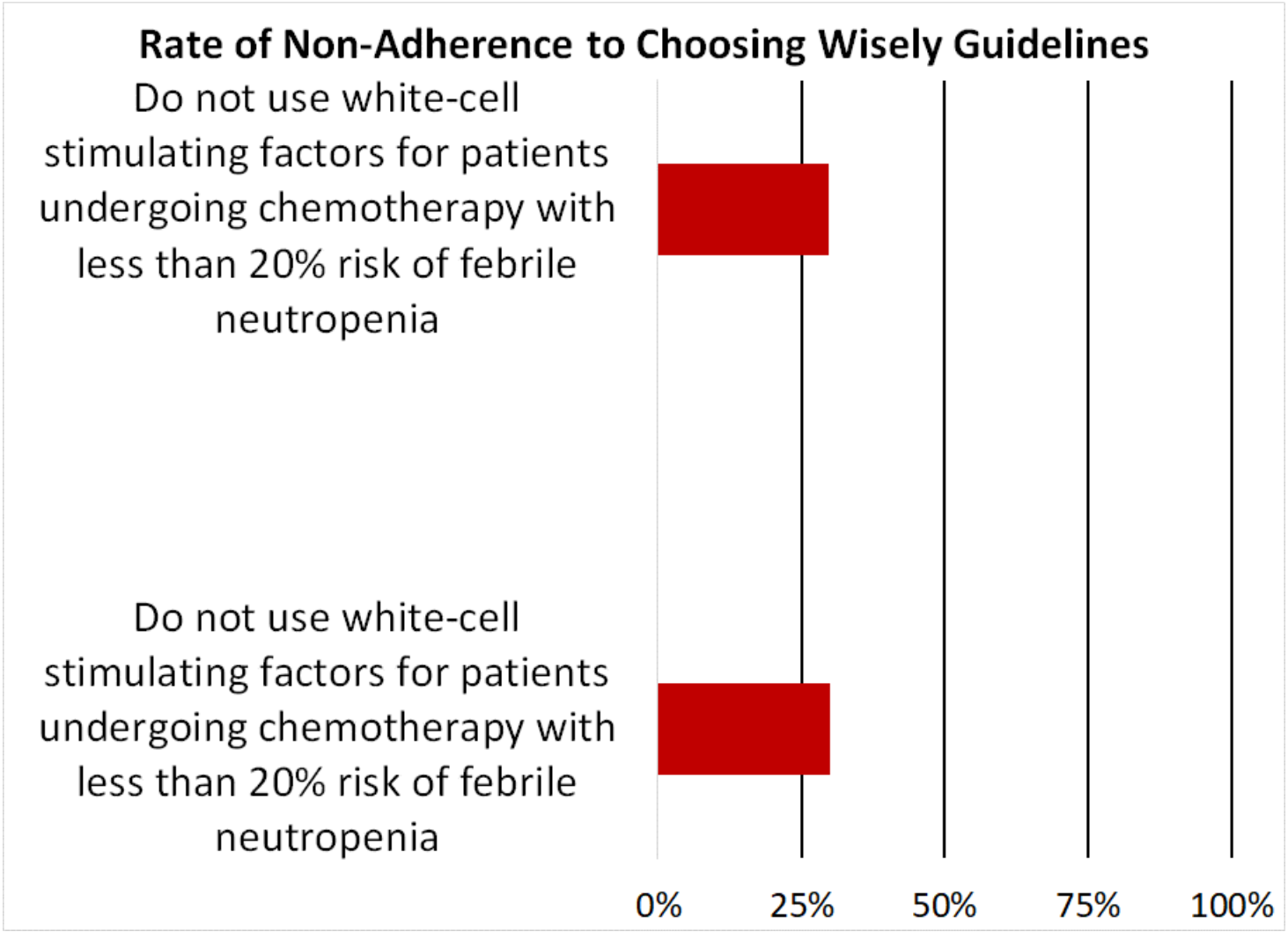
Appendix DOI: 10.1200/JOP.2016.013706

DOI: 10.1200/JOP.2016.010306; published online ahead of print at ascopubs.org/journal/jop on November 15, 2016

INTRODUCTION

Because health care costs are rising at an unsustainable rate,[1] patients, providers, and payers are collectively striving to identify where value in cancer care can be increased and how the triple aim of better health, better health care, and lower cost can be achieved.[2] The American Board of Internal Medicine's Choosing Wisely (CW) campaign aims to improve value by targeting low-value services in medicine and thus increase quality of care while lowering cost,[3]



Other Studies Have Found Even Higher Rates of Inappropriate Use

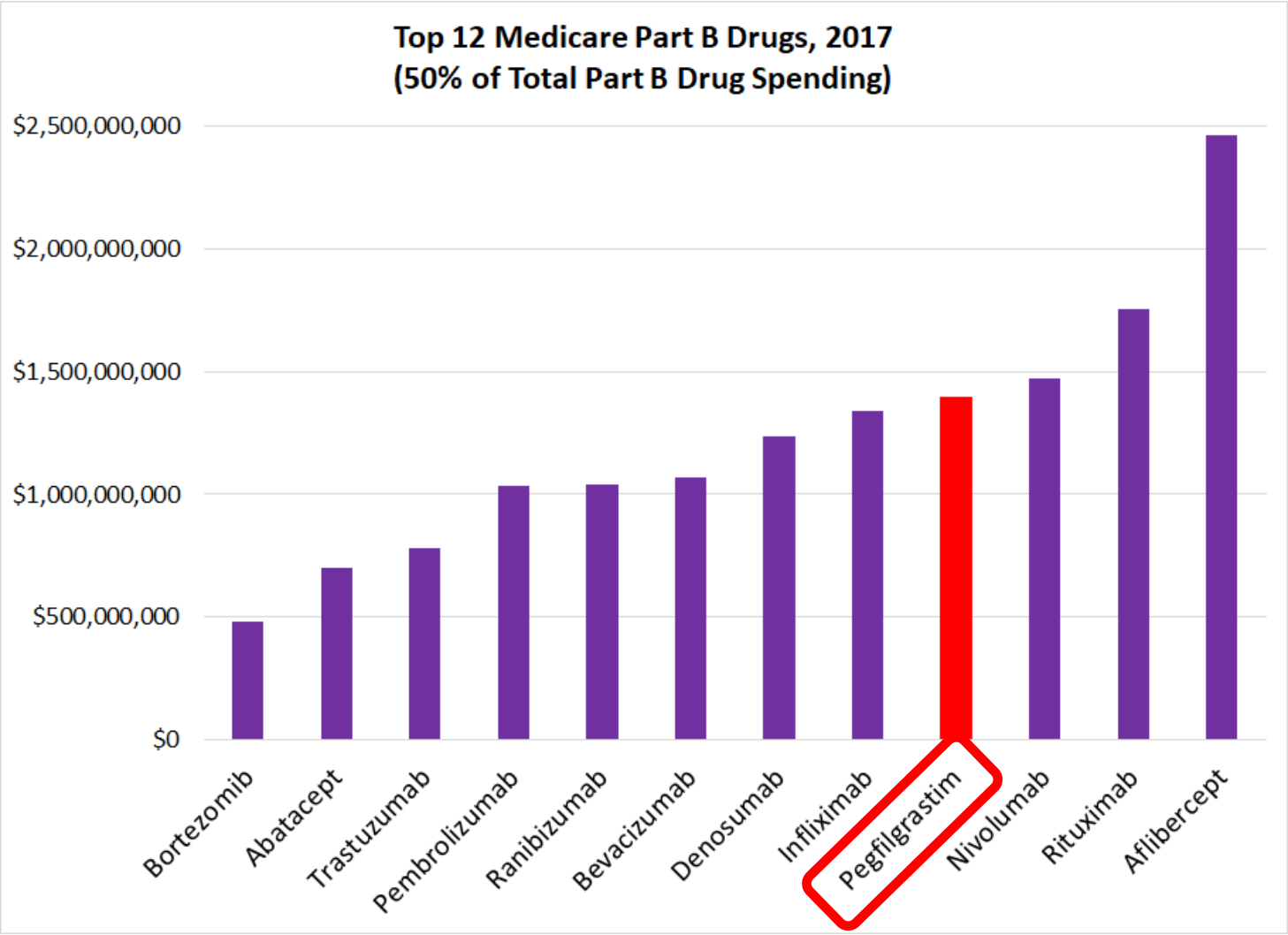
- A study of the use of Neulasta (pegfilgrastim) at an outpatient oncology clinic found that **approximately half of all cases using pegfilgrastim** for primary prophylaxis **were not consistent with published guidelines**, representing an avoidable cost of $8,093 per patient.

  (Waters GE et al. Comparison of Pegfilgrastim Prescribing Practice to National Guidelines at a University Hospital Outpatient Oncology Clinic. *Journal of Oncology Practice* 9(4):203. July 2013.)

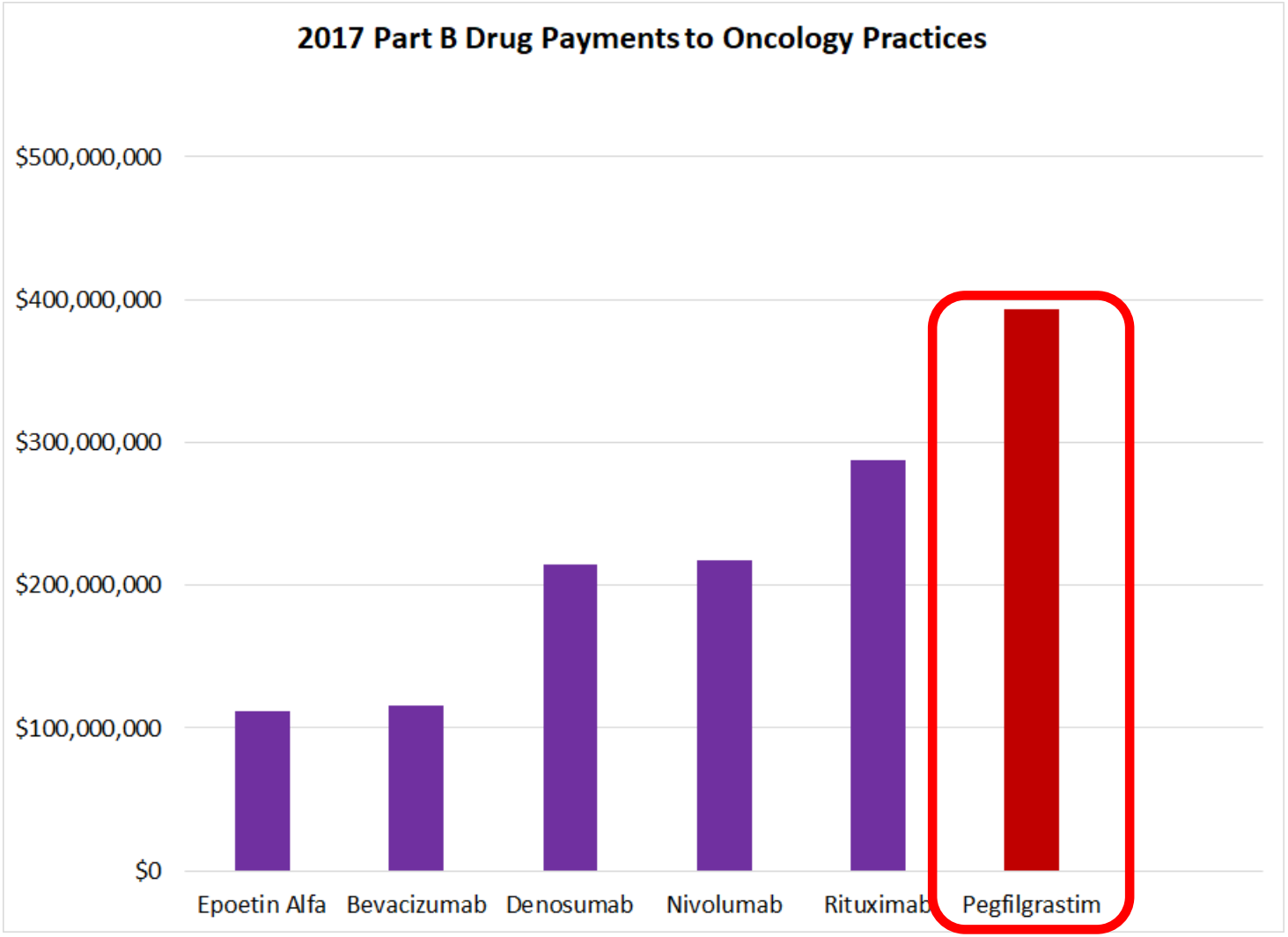
- A study of the use of myeloid colony-stimulating factors (CSF) such as pegfilgrastim in lung and cancer patients found that **96% of CSFs were administered in scenarios where CSF therapy is not recommended** by evidence-based guidelines.

  (Potosky AL et al. Use of Colony-Stimulating Factors With Chemotherapy: Opportunities for Cost Savings and Improved Outcomes. *Journal of the National Cancer Institute* 103:979-982. June 22, 2011.)

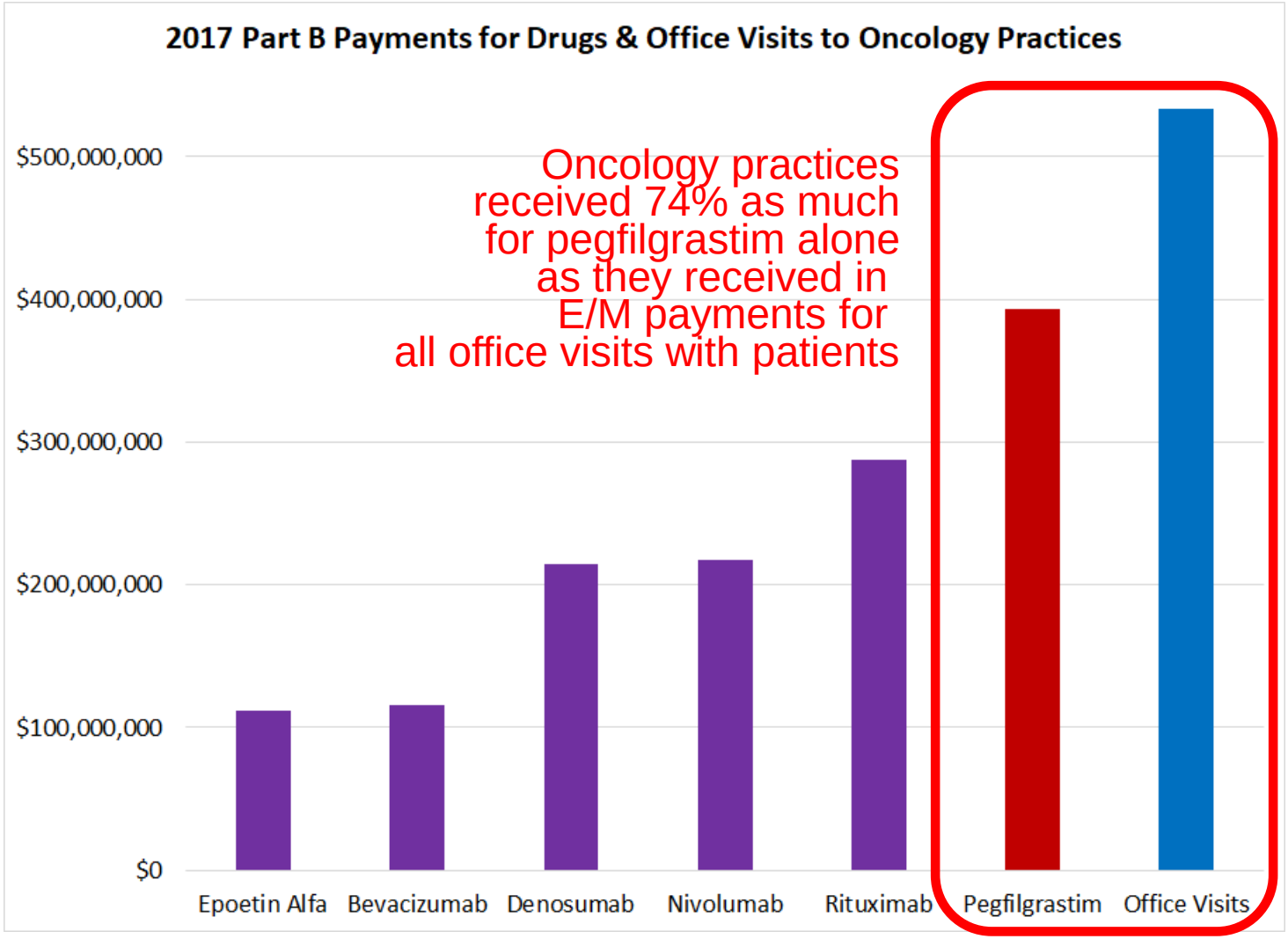
Pegfilgrastim is the #4 Part B Drug for Medicare



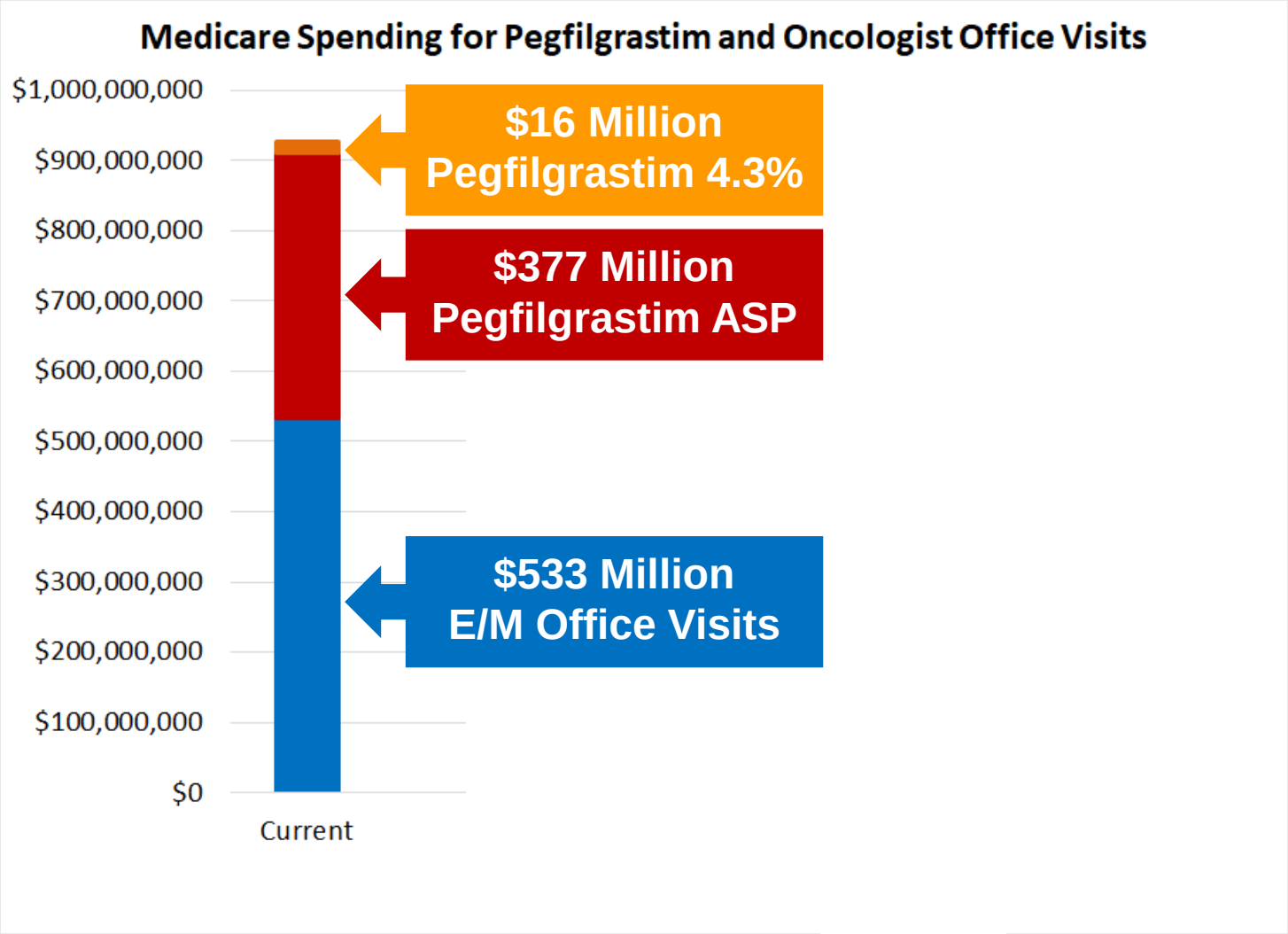
Pegfilgrastim is the #1 Part B Drug for Oncology Practices



Payments for Pegfilgrastim Are Almost As Much As Office Visits

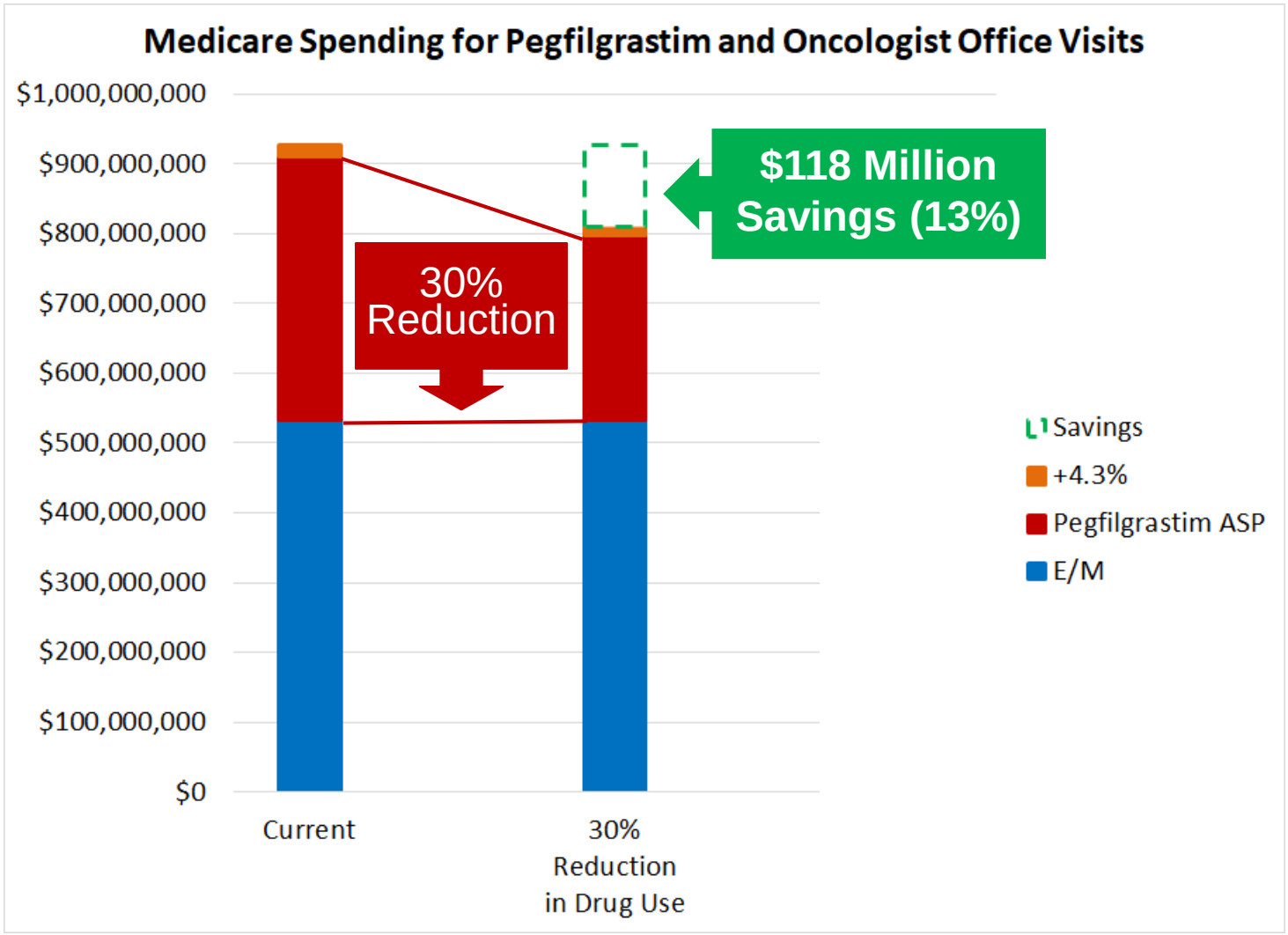


Almost $1 Billion in Medicare on Pegfilgrastim & E/M Office Visits



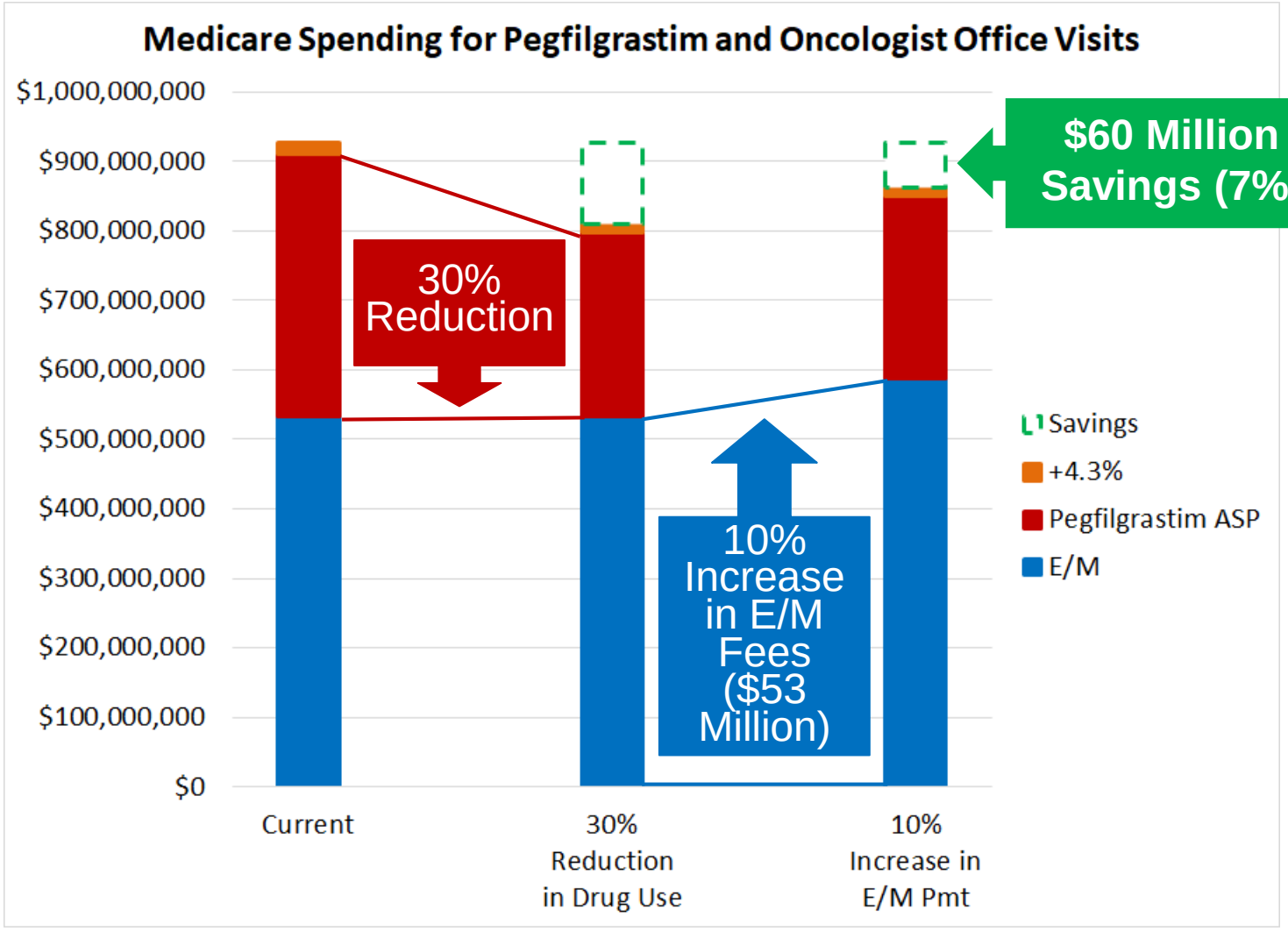
2017 Medicare Payments to Physicians in Office-Based Settings

Reducing 30% Overuse of Pegfilgrastim > $100 million



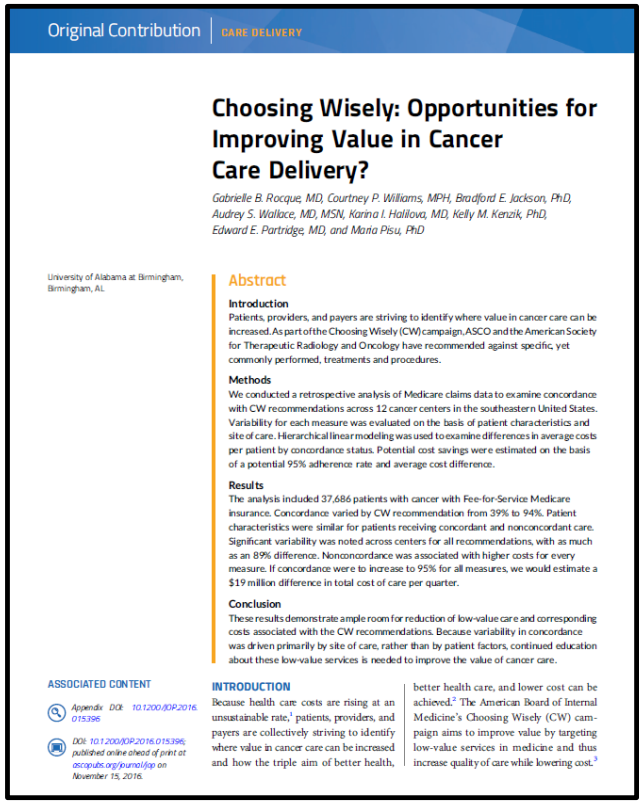
2017 Medicare Payments to Physicians in Office-Based Settings

You Could Increase Office Visit Fees by 10% and Still Save $



2017 Medicare Payments to Physicians in Office-Based Settings

Other Choosing Wisely Guidelines Could Also Saving Large $



Original Contribution | CARE DELIVERY

Choosing Wisely: Opportunities for Improving Value in Cancer Care Delivery?

Gabrielle B. Rocque, MD, Courtney P. Williams, MPH, Bradford E. Jackson, PhD, Audrey S. Wallace, MD, MSN, Karina I. Halilova, MD, Kelly M. Kenzik, PhD, Edward E. Partridge, MD, and Maria Pisu, PhD

University of Alabama at Birmingham, Birmingham, AL

Abstract

Introduction
Patients, providers, and payers are striving to identify where value in cancer care can be increased. As part of the Choosing Wisely (CW) campaign, ASCO and the American Society for Therapeutic Radiology and Oncology have recommended against specific, yet commonly performed, treatments and procedures.

Methods
We conducted a retrospective analysis of Medicare claims data to examine concordance with CW recommendations across 12 cancer centers in the southeastern United States. Variability for each measure was evaluated on the basis of patient characteristics and site of care. Hierarchical linear modeling was used to examine differences in average costs per patient by concordance status. Potential cost savings were estimated on the basis of a potential 95% adherence rate and average cost difference.

Results
The analysis included 37,686 patients with cancer with Fee-for-Service Medicare insurance. Concordance varied by CW recommendation from 39% to 94%. Patient characteristics were similar for patients receiving concordant and nonconcordant care. Significant variability was noted across centers for all recommendations, with as much as an 89% difference. Nonconcordance was associated with higher costs for every measure. If concordance were to increase to 95% for all measures, we would estimate a $19 million difference in total cost of care per quarter.

Conclusion
These results demonstrate ample room for reduction of low-value care and corresponding costs associated with the CW recommendations. Because variability in concordance was driven primarily by site of care, rather than by patient factors, continued education about these low-value services is needed to improve the value of cancer care.

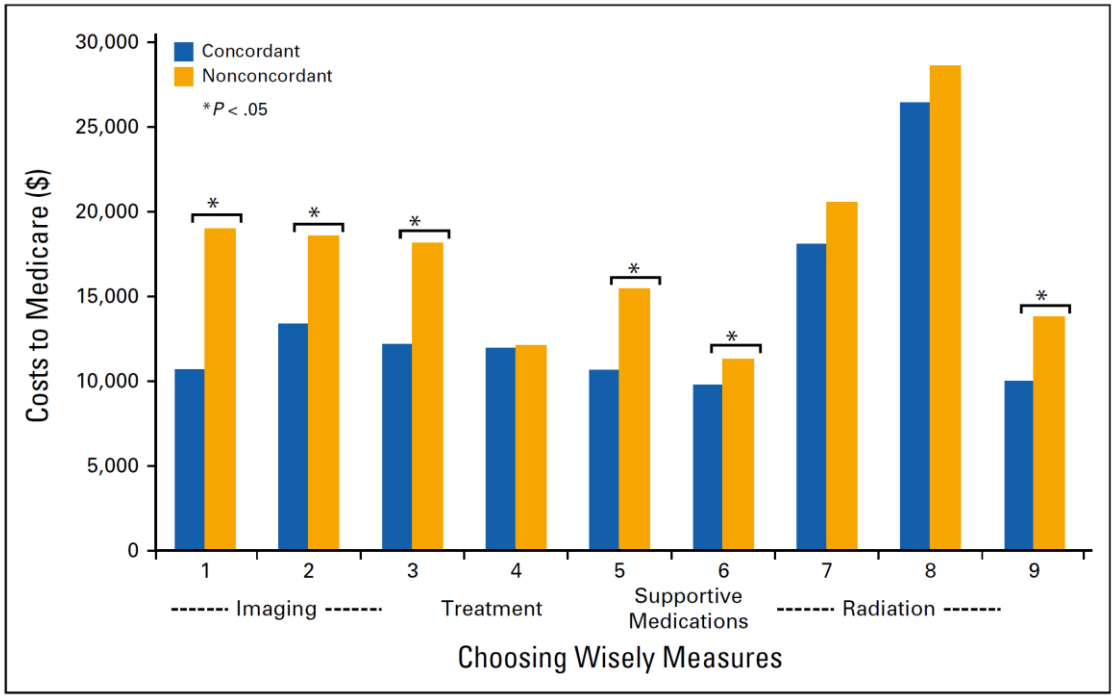
ASSOCIATED CONTENT

Appendix DOI: 10.1200/JOP.2016.015396

DOI: 10.1200/JOP.2016.015396; published online ahead of print at ascopubs.org/journal/jop on November 15, 2016.

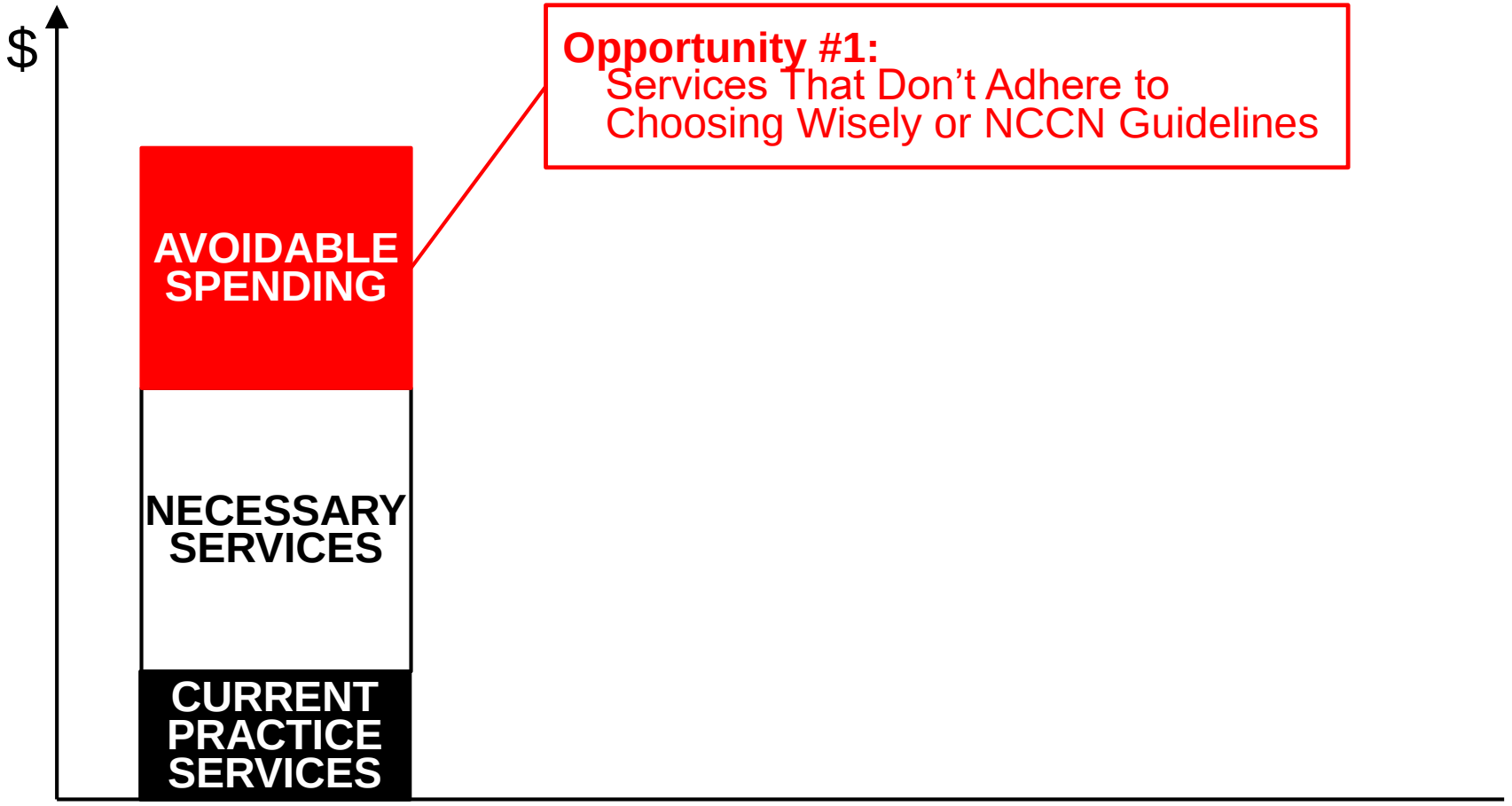
INTRODUCTION

Because health care costs are rising at an unsustainable rate,[1] patients, providers, and payers are collectively striving to identify where value in cancer care can be increased and how the triple aim of better health, better health care, and lower cost can be achieved.[2] The American Board of Internal Medicine's Choosing Wisely (CW) campaign aims to improve value by targeting low-value services in medicine and thus increase quality of care while lowering cost.[3]

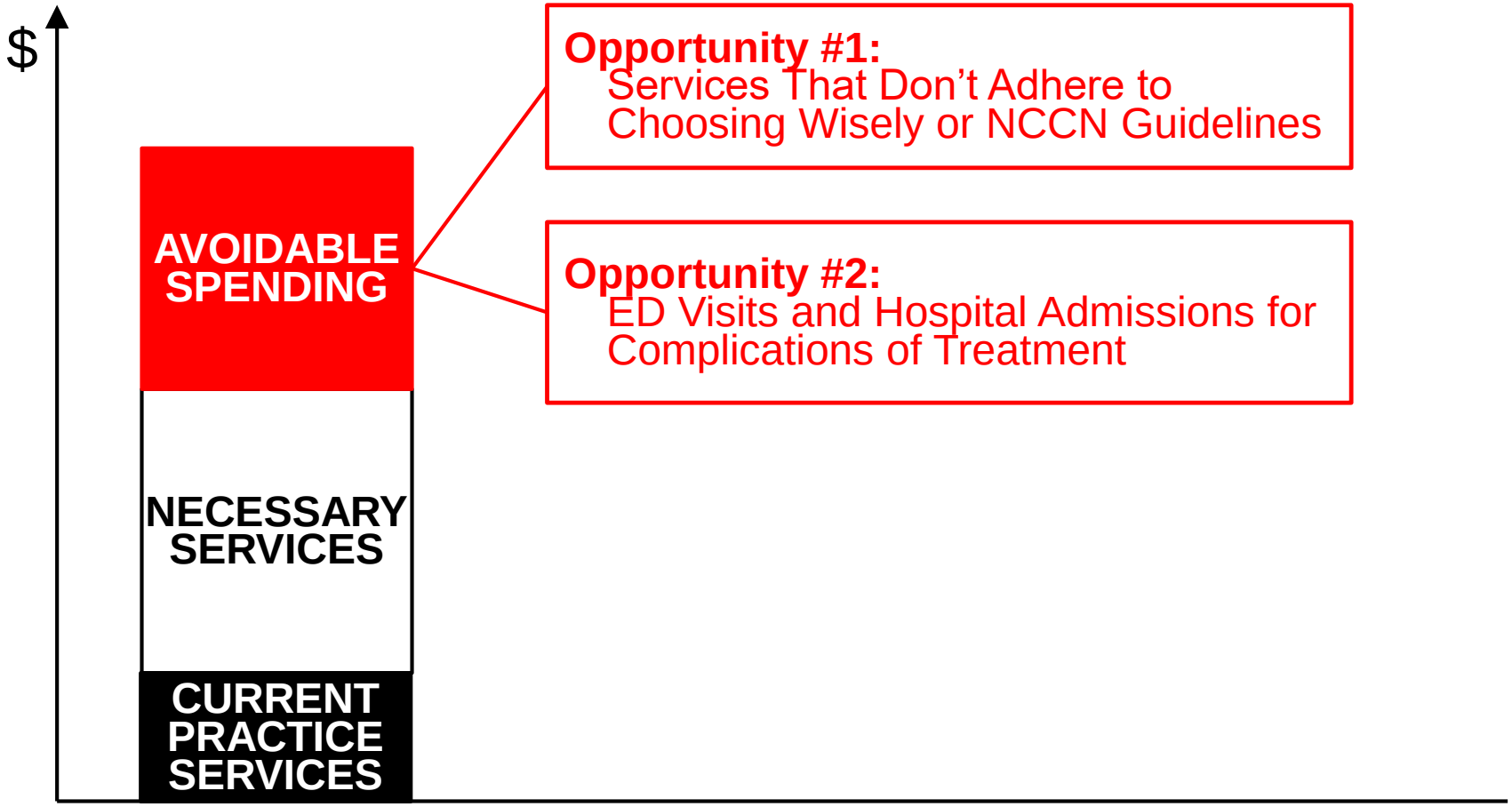


1: Imaging for staging prostate cancer
2: Imaging for staging early breast cancer
3: Imaging for surveillance
4: Use of combination chemotherapy treatment
5: Use of white cell-stimulating factors
6: Use of anti-emetics
7: Extended fractionation for palliation
8: Whole-breast radiotherapy in early stage breast cancer
9: IMRT for whole-breast radiotherapy

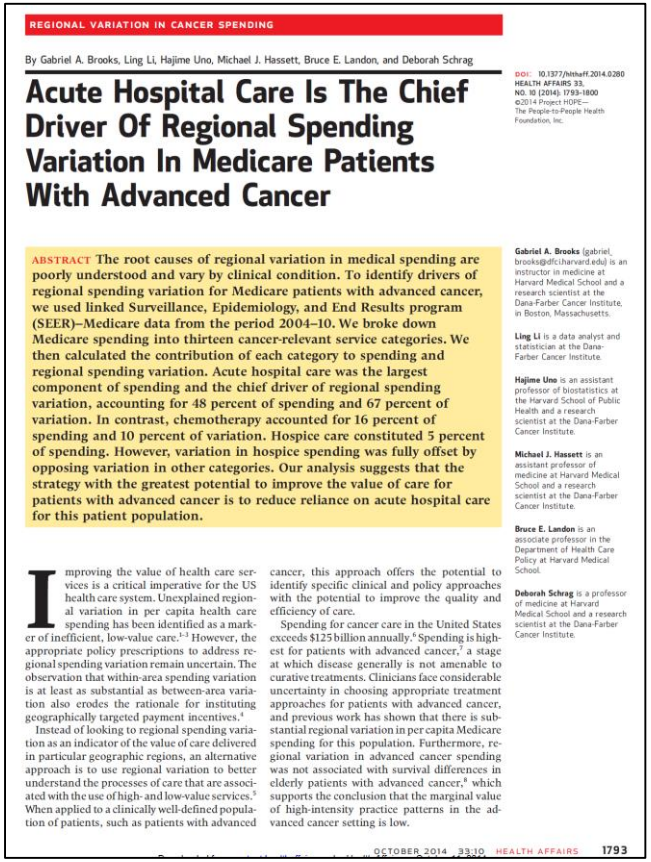
Areas of *Avoidable* Spending in Oncology, Part 1



Areas of *Avoidable* Spending in Oncology, Part 2



A Significant Portion of Cancer Spending is for ED Visits/Admits



REGIONAL VARIATION IN CANCER SPENDING

By Gabriel A. Brooks, Ling Li, Hajime Uno, Michael J. Hassett, Bruce E. Landon, and Deborah Schrag

Acute Hospital Care Is The Chief Driver Of Regional Spending Variation In Medicare Patients With Advanced Cancer

DOI: 10.1377/hlthaff.2014.0280
HEALTH AFFAIRS 33,
NO. 10 (2014): 1793–1800

ABSTRACT The root causes of regional variation in medical spending are poorly understood and vary by clinical condition. To identify drivers of regional spending variation for Medicare patients with advanced cancer, we used linked Surveillance, Epidemiology, and End Results program (SEER)–Medicare data from the period 2004–10. We broke down Medicare spending into thirteen cancer-relevant service categories. We then calculated the contribution of each category to spending and regional spending variation. Acute hospital care was the largest component of spending and the chief driver of regional spending variation, accounting for 48 percent of spending and 67 percent of variation. In contrast, chemotherapy accounted for 16 percent of spending and 10 percent of variation. Hospice care constituted 5 percent of spending. However, variation in hospice spending was fully offset by opposing variation in other categories. Our analysis suggests that the strategy with the greatest potential to improve the value of care for patients with advanced cancer is to reduce reliance on acute hospital care for this patient population.

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Ling Li is a data analyst and statistician at the Dana-Farber Cancer Institute.

Hajime Uno is an assistant professor of biostatistics at the Harvard School of Public Health and a research scientist at the Dana-Farber Cancer Institute.

Michael J. Hassett is an assistant professor of medicine at Harvard Medical School and a research scientist at the Dana-Farber Cancer Institute.

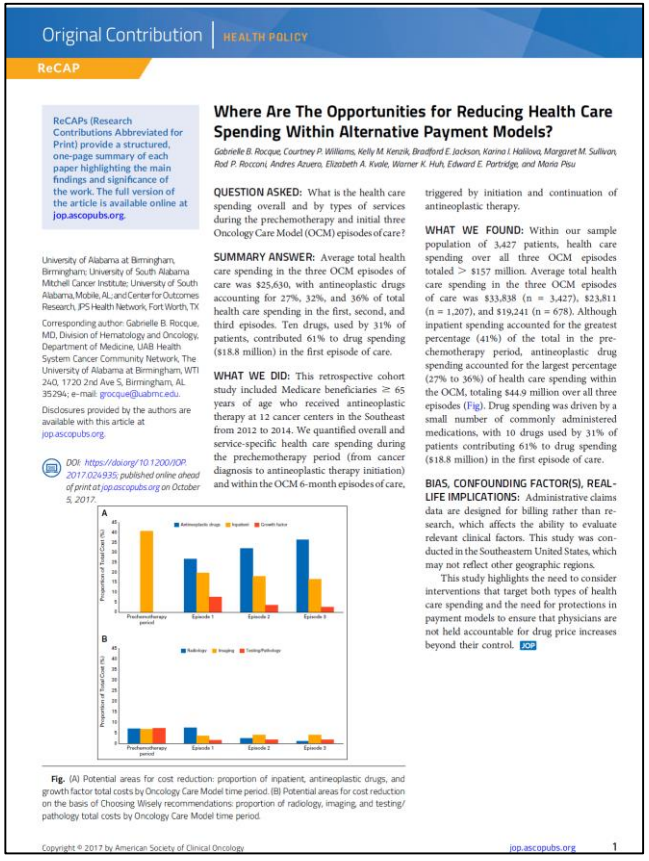
Bruce E. Landon is an associate professor in the Department of Health Care Policy at Harvard Medical School.

Deborah Schrag is a professor of medicine at Harvard Medical School and a research scientist at the Dana-Farber Cancer Institute.

Improving the value of health care services is a critical imperative for the US health care system. Unexplained regional variation in per capita health care spending has been identified as a marker of inefficient, low-value care.[1–3] However, the appropriate policy prescriptions to address regional spending variation remain uncertain. The observation that within-area spending variation is at least as substantial as between-area variation also erodes the rationale for instituting geographically targeted payment incentives.[4]

Instead of looking to regional spending variation as an indicator of the value of care delivered in particular geographic regions, an alternative approach is to use regional variation to better understand the processes of care that are associated with the use of high- and low-value services.[5] When applied to a clinically well-defined population of patients, such as patients with advanced cancer, this approach offers the potential to identify specific clinical and policy approaches with the potential to improve the quality and efficiency of care.

Spending for cancer care in the United States exceeds $125 billion annually.[6] Spending is highest for patients with advanced cancer,[7] a stage at which disease generally is not amenable to curative treatments. Clinicians face considerable uncertainty in choosing appropriate treatment approaches for patients with advanced cancer, and previous work has shown that there is substantial regional variation in per capita Medicare spending for this population. Furthermore, regional variation in advanced cancer spending was not associated with survival differences in elderly patients with advanced cancer,[8] which supports the conclusion that the marginal value of high-intensity practice patterns in the advanced cancer setting is low.



Original Contribution | HEALTH POLICY

ReCAP

ReCAPs (Research Contributions Abbreviated for Print) provide a structured, one-page summary of each paper highlighting the main findings and significance of the work. The full version of the article is available online at jop.ascopubs.org.

Where Are The Opportunities for Reducing Health Care Spending Within Alternative Payment Models?

Gabrielle B. Rocque, Courtney P. Williams, Kelly M. Kenzik, Bradford E. Jackson, Karina I. Halilova, Margaret M. Sullivan, Rod P. Rocconi, Andres Azuero, Elizabeth A. Kvale, Warner K. Huh, Edward E. Partridge, and Maria Pisu

University of Alabama at Birmingham, Birmingham; University of South Alabama Mitchell Cancer Institute; University of South Alabama, Mobile, AL; and Center for Outcomes Research, JPS Health Network, Fort Worth, TX

Corresponding author: Gabrielle B. Rocque, MD, Division of Hematology and Oncology, Department of Medicine, UAB Health System Cancer Community Network, The University of Alabama at Birmingham, WTI 240, 1720 2nd Ave S, Birmingham, AL 35294; e-mail: grocque@uabmc.edu.

Disclosures provided by the authors are available with this article at jop.ascopubs.org.

DOI: https://doi.org/10.1200/JOP.2017.026935; published online ahead of print at jop.ascopubs.org on October 5, 2017.

QUESTION ASKED: What is the health care spending overall and by types of services during the prechemotherapy and initial three Oncology Care Model (OCM) episodes of care?

SUMMARY ANSWER: Average total health care spending in the three OCM episodes of care was $25,630, with antineoplastic drugs accounting for 27%, 32%, and 36% of total health care spending in the first, second, and third episodes. Ten drugs, used by 31% of patients, contributed 61% to drug spending ($18.8 million) in the first episode of care.

WHAT WE DID: This retrospective cohort study included Medicare beneficiaries ≥ 65 years of age who received antineoplastic therapy at 12 cancer centers in the Southeast from 2012 to 2014. We quantified overall and service-specific health care spending during the prechemotherapy period (from cancer diagnosis to antineoplastic therapy initiation) and within the OCM 6-month episodes of care, triggered by initiation and continuation of antineoplastic therapy.

WHAT WE FOUND: Within our sample population of 3,427 patients, health care spending over all three OCM episodes totaled > $157 million. Average total health care spending in the three OCM episodes of care was $33,838 (n = 3,427), $23,811 (n = 1,207), and $19,241 (n = 678). Although inpatient spending accounted for the greatest percentage (41%) of the total in the prechemotherapy period, antineoplastic drug spending accounted for the largest percentage (27% to 36%) of health care spending within the OCM, totaling $44.9 million over all three episodes (Fig). Drug spending was driven by a small number of commonly administered medications, with 10 drugs used by 31% of patients contributing 61% to drug spending ($18.8 million) in the first episode of care.

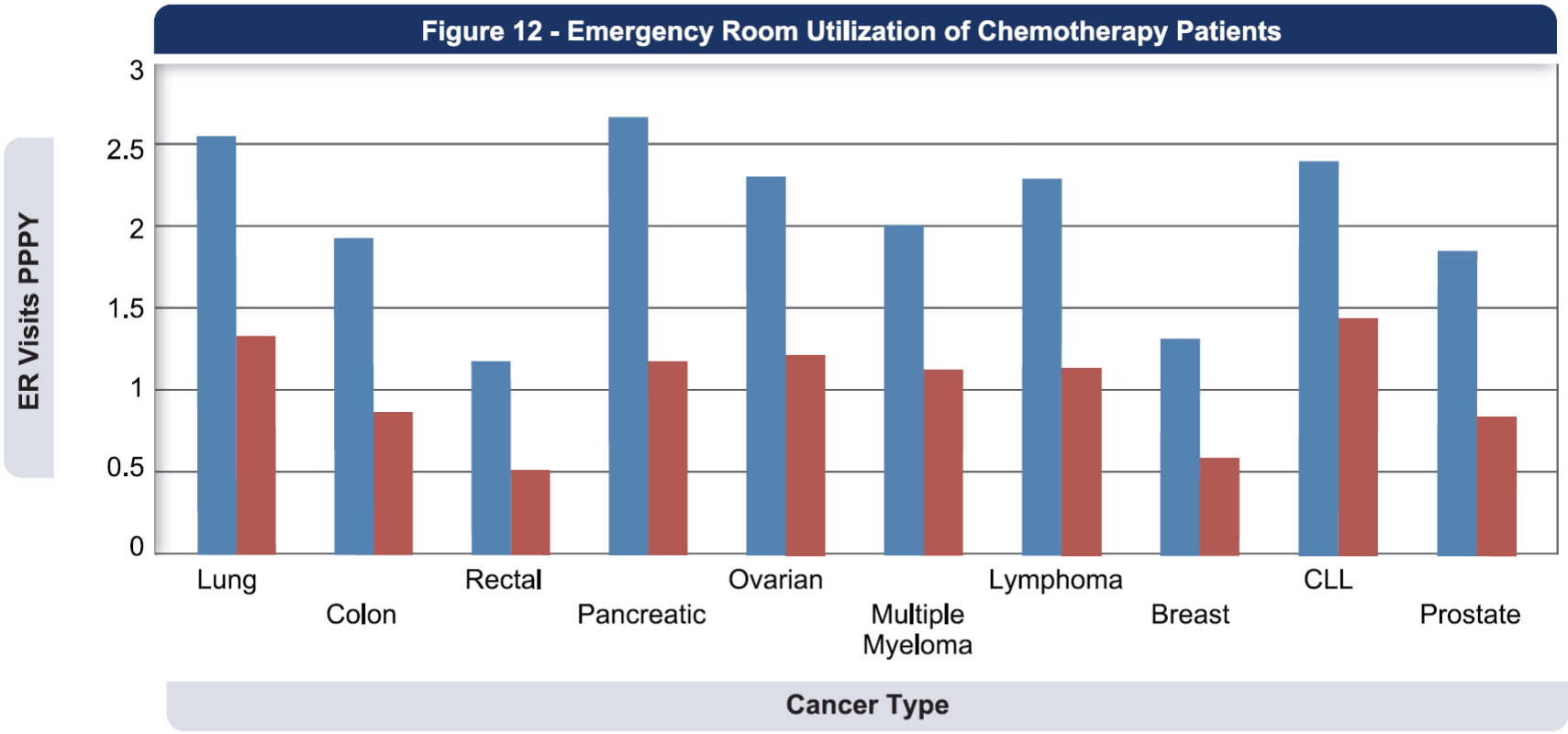
BIAS, CONFOUNDING FACTOR(S), REAL-LIFE IMPLICATIONS: Administrative claims data are designed for billing rather than research, which affects the ability to evaluate relevant clinical factors. This study was conducted in the Southeastern United States, which may not reflect other geographic regions.

This study highlights the need to consider interventions that target both types of health care spending and the need for protections in payment models to ensure that physicians are not held accountable for drug price increases beyond their control. JOP

Fig. (A) Potential areas for cost reduction: proportion of inpatient, antineoplastic drugs, and growth factor total costs by Oncology Care Model time period. (B) Potential areas for cost reduction on the basis of Choosing Wisely recommendations: proportion of radiology, imaging, and testing/pathology total costs by Oncology Care Model time period.

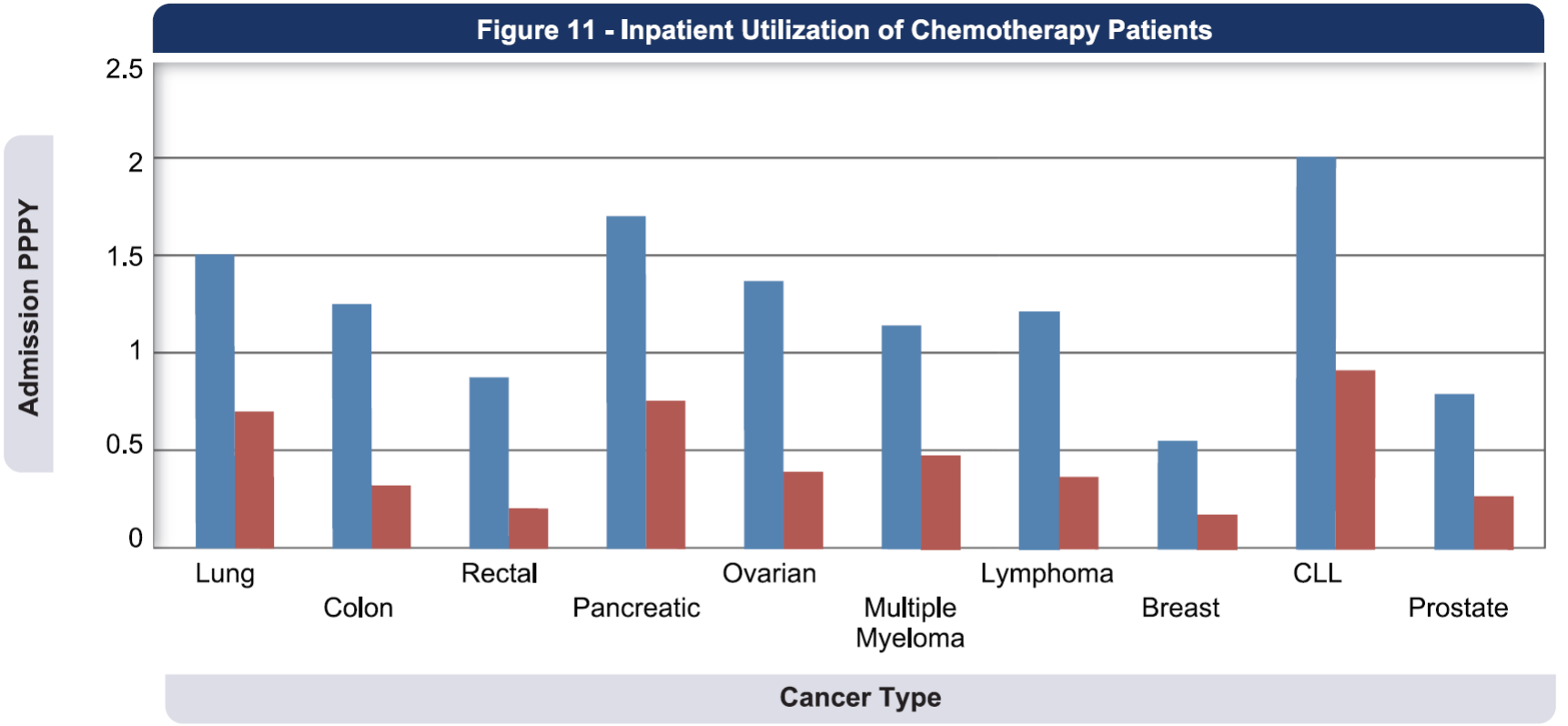
ED visits and inpatient admissions represent 10-30% of spending during chemotherapy and radiation therapy for cancer

High Frequency of ED Visits, 40-50% Are Treatment-Related



SOURCE:
Fitch K and Pyenson B,
Cancer Patients Receiving Chemotherapy: Opportunities for Better Management,
Milliman (March 30, 2010)

Many Unplanned Hospital Admissions Related to Treatment



SOURCE:
Fitch K and Pyenson B,
Cancer Patients Receiving Chemotherapy: Opportunities for Better Management,
Milliman (March 30, 2010)

Large Reductions in ED Visits & Hospitalizations Are Possible

Oncology patient-centered medical home and accountable cancer care

John D. Sprandio, MD

Consultants 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 gained considerable traction across the United States. In 2004, we began re-engineering 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 suit practice/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.

Medical oncologists are playing an ever-expanding role in the delivery of cancer care. The current and future challenges they face in their efforts to deliver effective, efficient, and appropriate cancer care are broad, and solutions to the rising costs of cancer care continue to be sought. The patient-centered medical home (PCMH) model has emerged as a partial solution to the fragmented delivery of primary healthcare. In many instances, the delivery of cancer care is also fragmented—fraught with deficiencies in communication, coordination, and accountability. The oncology PCMH (OPCMH) model of cancer care may potentially serve as a practice framework for oncologists. The OPCMH model attempts to promote a value-based agenda that facilitates physician accountability, encourage clinical integration between like-minded medical oncology groups, enhance communication and coordination of care with primary care PCMH models, and collaborate with payers while maintaining a focus on patient needs and evidence-based care.

A backward glance at the PCMH model

A combination of factors has led to the rapid acceptance of the PCMH model in the delivery of primary care: (1) physician 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 actionable 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 Medicaid 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 team.[1,2]

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 care-team approach, engage and educate patients to enhance involvement in their care, and create innovative ways of communicating with all parties involved.

EMR systems

When fully implemented and enhanced, EMR systems have the potential to promote a culture of continuous improvement that creates practice efficiencies. Furthermore, EMRs can 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

Manuscript received November 16, 2010; accepted December 3, 2010.

Correspondence to: John D. Sprandio, MD, Consultants in Medical Oncology and Hematology, PC, 2100 Keystone Avenue, Suite 502, MOB, Drexel Hill, PA 19026; telephone: 610-622-3818; fax: 610-622-6407; e-mail: jsprandio@cmoh.org.

Commun Oncol 2010;7:565–572

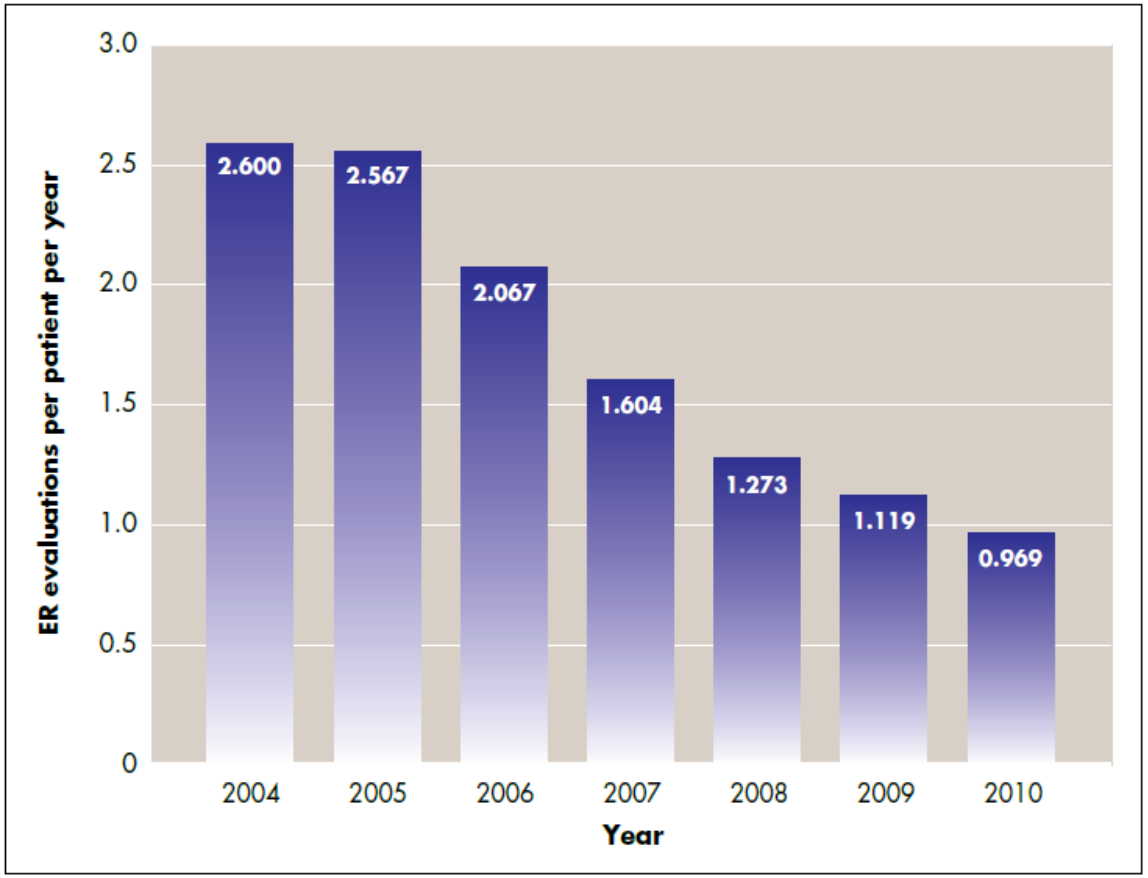


FIGURE 3 Average emergency room (ER) evaluations at Delaware County Memorial Hospital of the Drexel Hill office population per chemotherapy patient per year, 2004–2010 (YTD).

Reductions in ED Visits/Admits Will Reduce Spending

MEDICARE INNOVATION

By Erin Murphy Colligan, Erin Ewald, Sarah Ruiz, Michelle Spafford, Caitlin Cross-Barnet, and Shriram Parashuram

Innovative Oncology Care Models Improve End-Of-Life Quality, Reduce Utilization And Spending

DOI: 10.1377/hlthaff.2016.1303
HEALTH AFFAIRS 36,
NO. 3 (2017): 433–440

ABSTRACT Three models that received Health Care Innovation Awards from the Centers for Medicare and Medicaid Services (CMS) aimed to reduce the cost and use of health care services and improve the quality of care for Medicare beneficiaries with cancer. Each emphasized a different principle: the oncology medical home, patient navigation, or palliative care. Comparing participants in each model who died during the study period to matched comparators, we found that the oncology medical home and patient navigation models were associated with decreased costs in the last ninety days of life ($3,346 and $5,824 per person, respectively) and fewer hospitalizations in the last thirty days of life (fifty-seven and forty per 1,000 people, respectively). The patient navigation model was also associated with fewer emergency department visits in the last thirty days of life and increased hospice enrollment in the last two weeks of life. These promising results can inform new initiatives for cancer patients, such as the CMS Oncology Care Model.

Erin Murphy Colligan is a social science research analyst at the Center for Medicare and Medicaid Innovation, in Baltimore, Maryland.

Erin Ewald is a research scientist at NORC at the University of Chicago in Bethesda, Maryland.

Sarah Ruiz is a senior scientist at the National Institute on Disability, Independent Living, and Rehabilitation Research, in Washington, D.C. This work was completed while she was a senior research scientist at NORC at the University of Chicago.

Michelle Spafford (spafford-michelle@norc.org) is a research scientist at NORC at the University of Chicago.

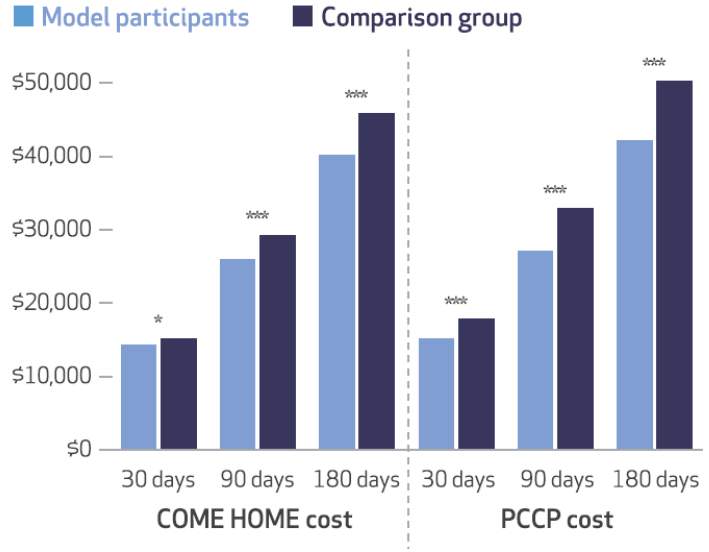
Caitlin Cross-Barnet is a social science research analyst at the Center for Medicare and Medicaid Innovation.

Shriram Parashuram is a principal health economist at NORC at the University of Chicago.

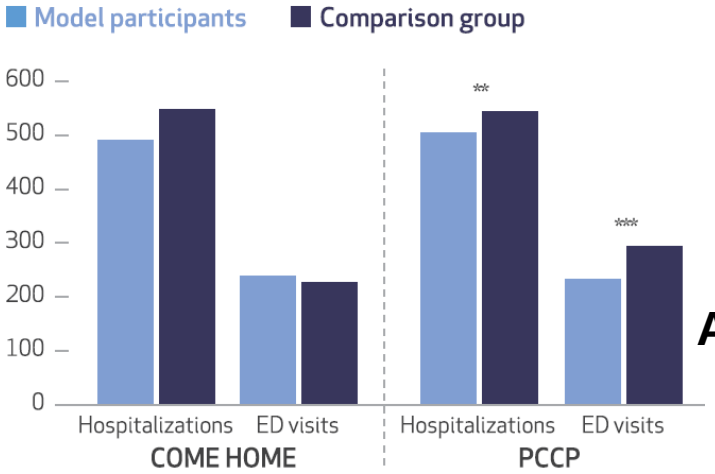
Medicare expenditures in the last year of life for beneficiaries with cancer range from $56,784 for those with melanoma to $140,891 for those with brain cancer. These far exceed the average $38,975 per beneficiary Medicare spending in the last year of life.[1,2] There were approximately 901,000 Medicare beneficiaries with cancer in the last year of life in 2010, and that number is expected to increase to 1.2 million in 2020.[3] Total costs of cancer care in the last year of life amounted to $37 million in 2010 and will approach $50 million in 2020.[3] Much end-of-life spending results from high rates of hospitalizations, emergency department (ED) visits, and stays in the intensive care unit in patients' last months.[4,5] A substantial proportion of hospitalizations and ED visits at the end of life are avoidable and thus represent an area for improved quality of care and patient satisfaction and for reduced utilization.[6–9]

High utilization of cancer treatment at the end of life not only poses a burden to the health care system, but it also may represent poor outcomes from the perspective of patients. Previous studies suggest that patients with advanced cancer prefer to have less aggressive treatment and more spiritual support and palliative care, and to avoid intensive inpatient settings at the end of life.[10,11] In fact, the National Quality Forum has recognized the need to emphasize the importance of palliative options for cancer care at the end of life. It has endorsed the use of several measures as indicators of poor quality of care at the end of life, such as the use of chemotherapy in the last fourteen days of life, multiple ED visits and stays in the intensive care unit in the last thirty days of life, and enrollment in hospice for fewer than three days.[12]

Though hospice is designed to facilitate patients' end-of-life preferences, keeping patients at home or in a nonclinical environment while reducing pain and psychological stress and pro-

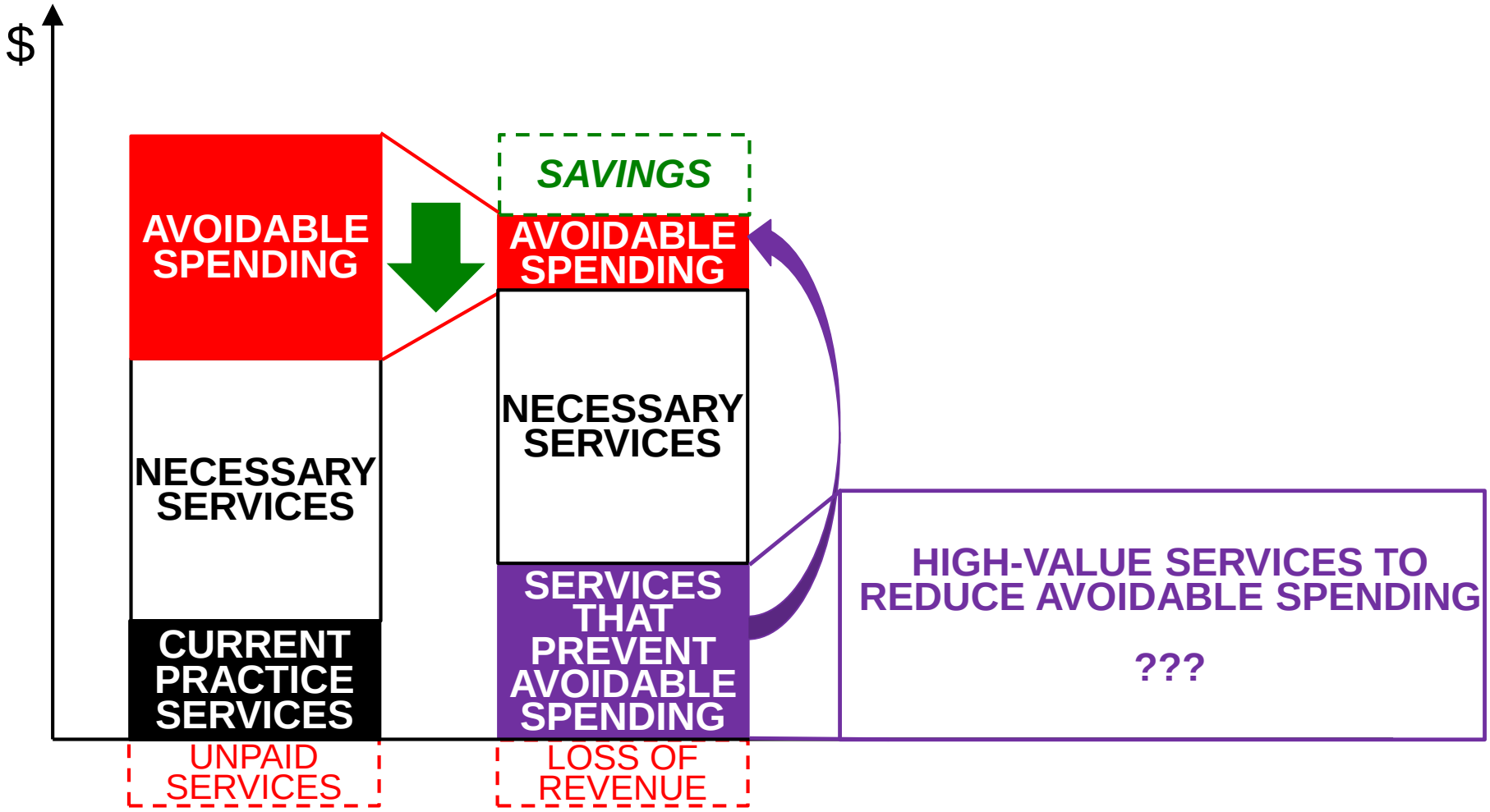


13-16% Lower Spending



7-10% Fewer Hospital Admissions

Step 2a: Design Services That Will Reduce Avoidable Spending



Changes in Care Delivery to Reduce Avoidable Spending

Opportunity for Higher-Value Care	Change in Care Delivery Needed
Reduce/eliminate use of expensive tests and treatments that are not based on evidence	
Reduce ED visits and hospital admissions for treatment-related complications	

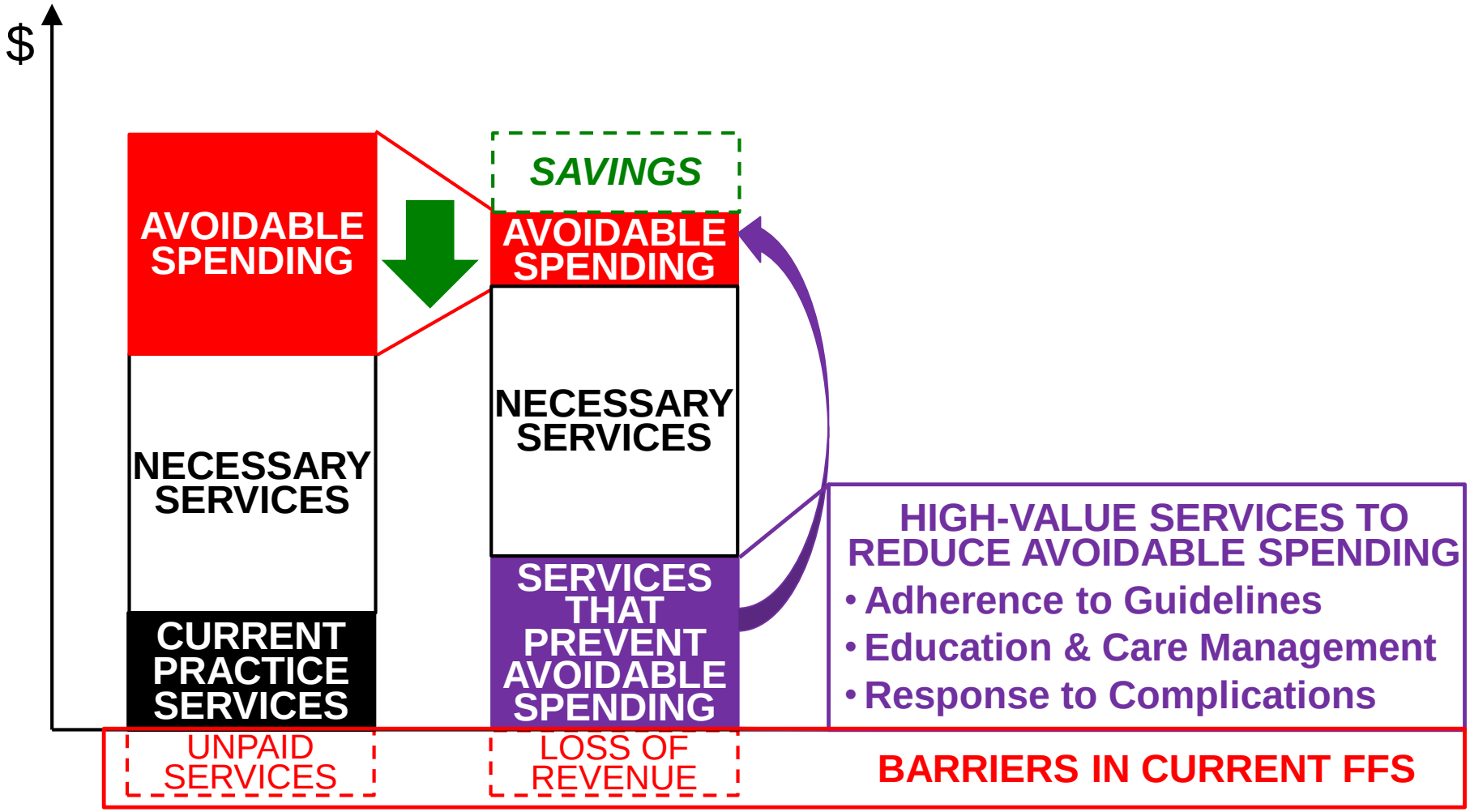
Changes in Care Delivery to Reduce Avoidable Spending

Opportunity for Higher-Value Care	Change in Care Delivery Needed
Reduce/eliminate use of expensive tests and treatments that are not based on evidence	Determination of which treatments are consistent with current evidence or guidelines
	Reduction in use of expensive drugs or radiation treatments that are currently overused
Reduce ED visits and hospital admissions for treatment-related complications	

Changes in Care Delivery to Reduce Avoidable Spending

Opportunity for Higher-Value Care	Change in Care Delivery Needed
Reduce/eliminate use of expensive tests and treatments that are not based on evidence	Determination of which treatments are consistent with current evidence or guidelines
	Reduction in use of expensive drugs or radiation treatments that are currently overused
Reduce ED visits and hospital admissions for treatment-related complications	Patient education and proactive monitoring
	24/7 triage and patient assistance
	Office-based IV hydration

Step 2b: Identify Barriers in FFS to Delivery of High-Value Services



What's Stopping Practices From Doing This Today?

Opportunity for Higher-Value Care	Change in Care Delivery Needed	Barriers in Current Payment System
Reduce/eliminate use of expensive tests and treatments that are not based on evidence	Determination of which treatments are consistent with current evidence or guidelines	
	Reduction in use of expensive drugs or radiation treatments that are currently overused	
Reduce ED visits and hospital admissions for treatment-related complications	Patient education and proactive monitoring	
	24/7 triage and patient assistance	
	Office-based IV hydration	

Lack of Payment for the Services Needed

Opportunity for Higher-Value Care	Change in Care Delivery Needed	Barriers in Current Payment System
Reduce/eliminate use of expensive tests and treatments that are not based on evidence	Determination of which treatments are consistent with current evidence or guidelines	No payment for time spent outside of office visits to plan patient treatment
	Reduction in use of expensive drugs or radiation treatments that are currently overused	
Reduce ED visits and hospital admissions for treatment-related complications	Patient education and proactive monitoring	
	24/7 triage and patient assistance	
	Office-based IV hydration	

Loss of Revenue From Using Fewer High-Margin Services

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Lack of Payment for the Services Needed

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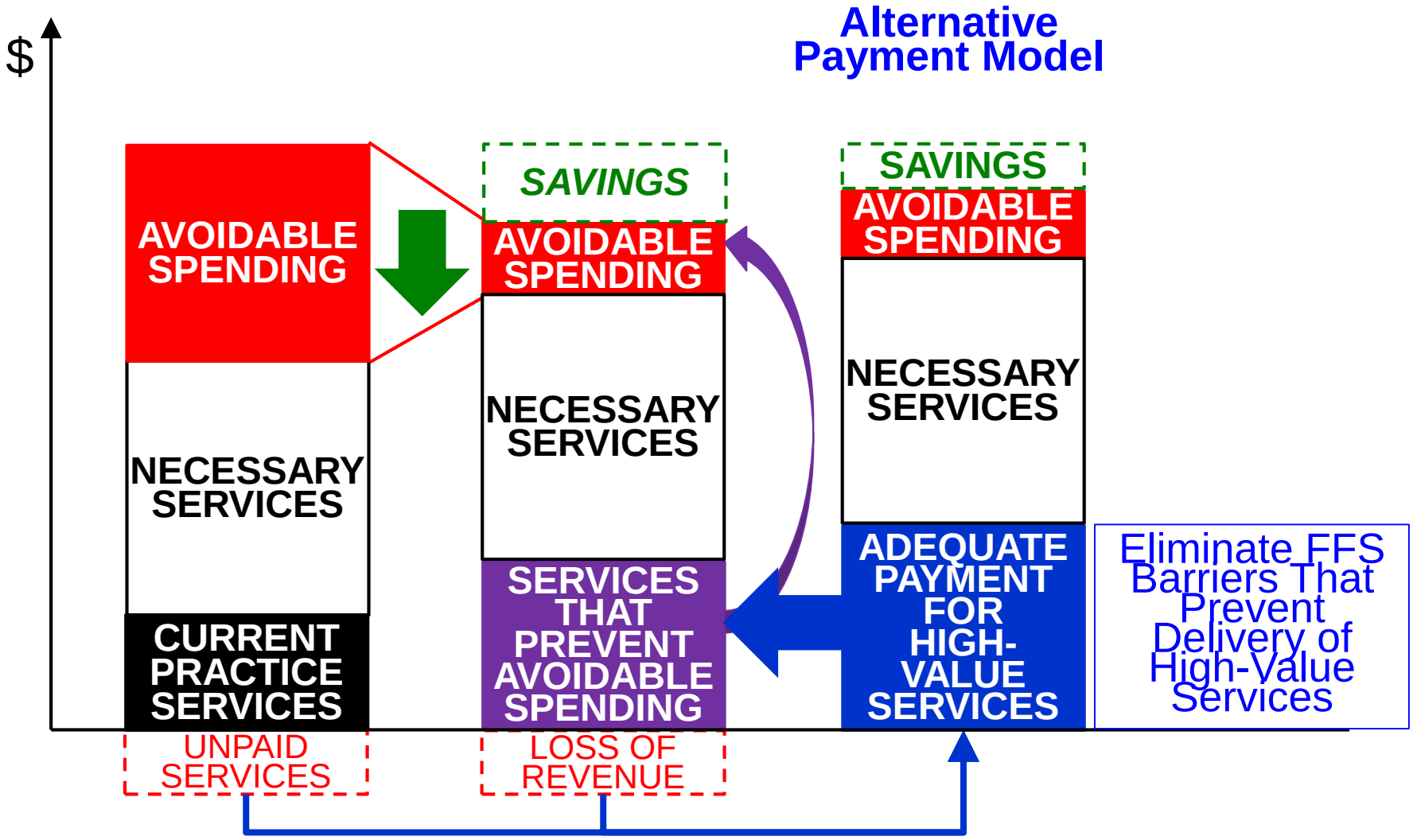
	Office-based IV hydration	Lower payments for IV hydration than for IV chemotherapy

Step 3: Pay Adequately to Support Higher-Value Services



Eliminating the Barriers in the Current Payment System

Opportunity for Higher-Value Care	Change in Care Delivery Needed	Barriers in Current Payment System	Changes in Payment Needed
Reduce/eliminate use of expensive tests and treatments that are not based on evidence	Determination of which treatments are consistent with current evidence or guidelines	No payment for time spent outside of office visits to plan patient treatment	
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	Office-based IV hydration	Lower payments for IV hydration than for IV chemotherapy	

Pay Adequately for High-Value Services

Opportunity for Higher-Value Care	Change in Care Delivery Needed	Barriers in Current Payment System	Changes in Payment Needed
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	24/7 triage and patient assistance	No fees for call response & triage	Payment for call response & triage
	Office-based IV hydration	Lower payments for IV hydration than for IV chemotherapy	Higher payment for IV hydration

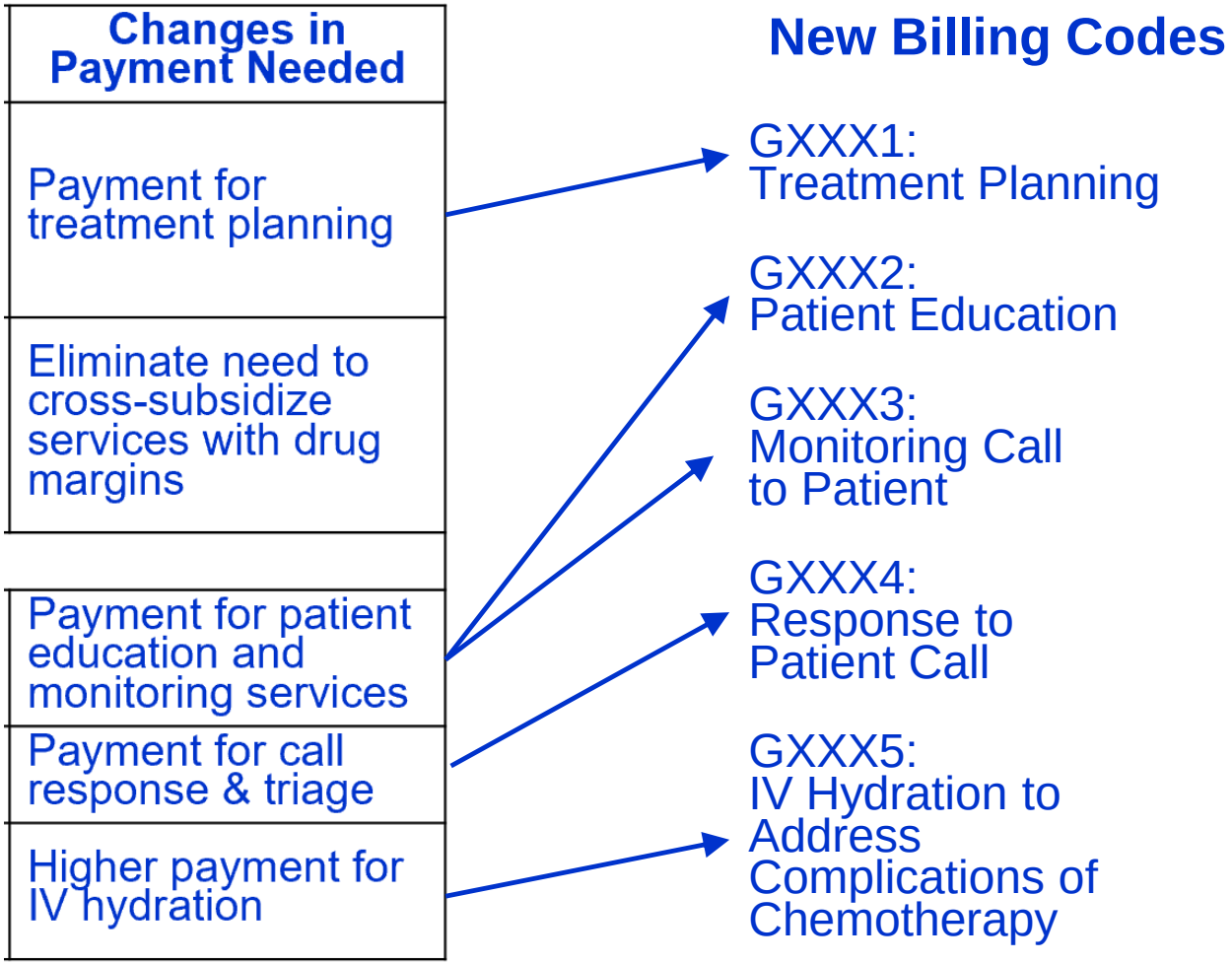
Reduce the Need and Opportunity for High Profits on Drugs

Opportunity for Higher-Value Care	Change in Care Delivery Needed	Barriers in Current Payment System	Changes in Payment Needed
Reduce/eliminate use of expensive tests and treatments that are not based on evidence	Determination of which treatments are consistent with current evidence or guidelines	No payment for time spent outside of office visits to plan patient treatment	Payment for treatment planning
	Reduction in use of expensive drugs or radiation treatments that are currently overused	Practice revenues will decrease if fewer expensive drugs and treatments are used	Eliminate need to cross-subsidize services with drug margins
Reduce ED visits and hospital admissions for treatment-related complications	Patient education and proactive monitoring	No fees for patient education and monitoring services	Payment for patient education and monitoring services
	24/7 triage and patient assistance	No fees for call response & triage	Payment for call response & triage
	Office-based IV hydration	Lower payments for IV hydration than for IV chemotherapy	Higher payment for IV hydration

How Do You Implement the Payment Changes?

Changes in Payment Needed
Payment for treatment planning
Eliminate need to cross-subsidize services with drug margins
Payment for patient education and monitoring services
Payment for call response & triage
Higher payment for IV hydration

Option 1: Create New Billing Codes for Unpaid Services



Do You Want Even More Fees for Narrowly-Defined Services?

60+ Codes Billed >100,000 Times Per Year

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New Billing Codes

GXXX1:
Treatment Planning

GXXX2:
Patient Education

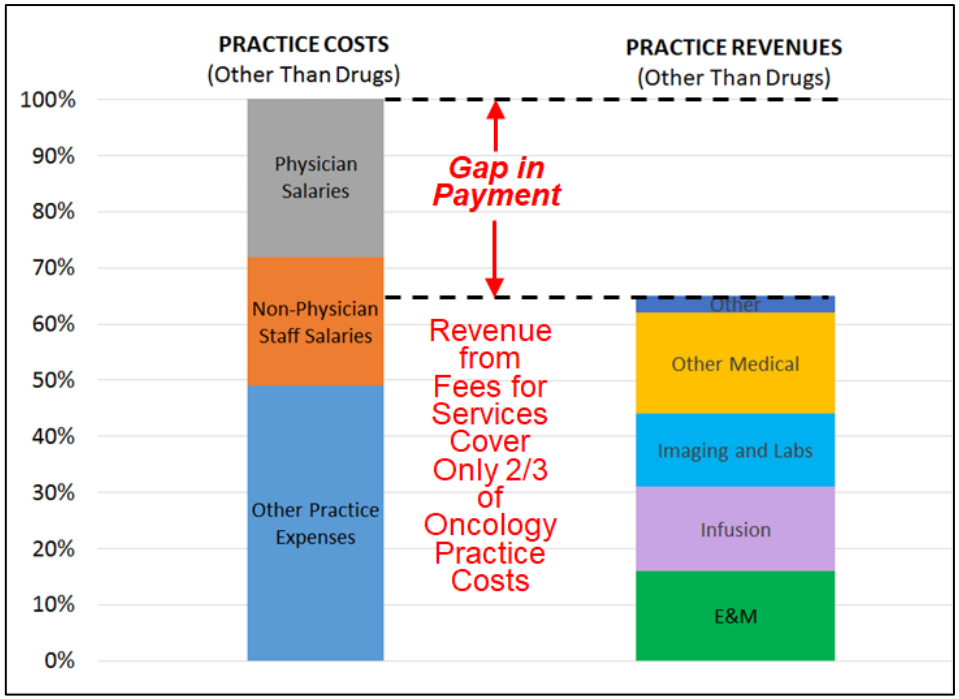
GXXX3:
Monitoring Call to Patient

GXXX4:
Response to Patient Call

GXXX5:
IV Hydration to Address Complications of Chemotherapy

The Problems With Fee for Service

Current Fees Don't Cover Practice Costs



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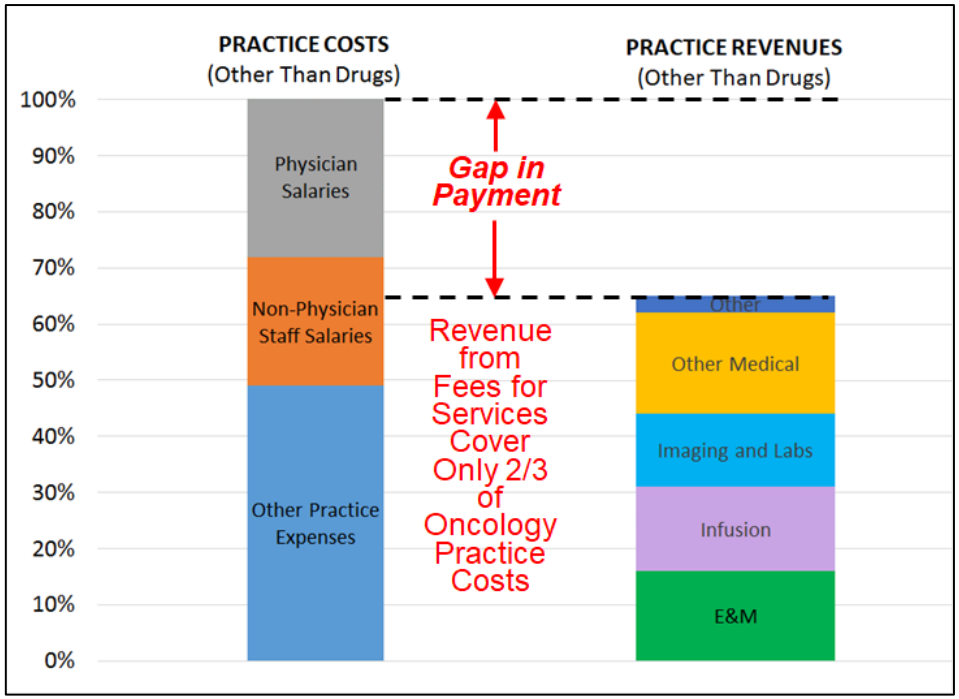
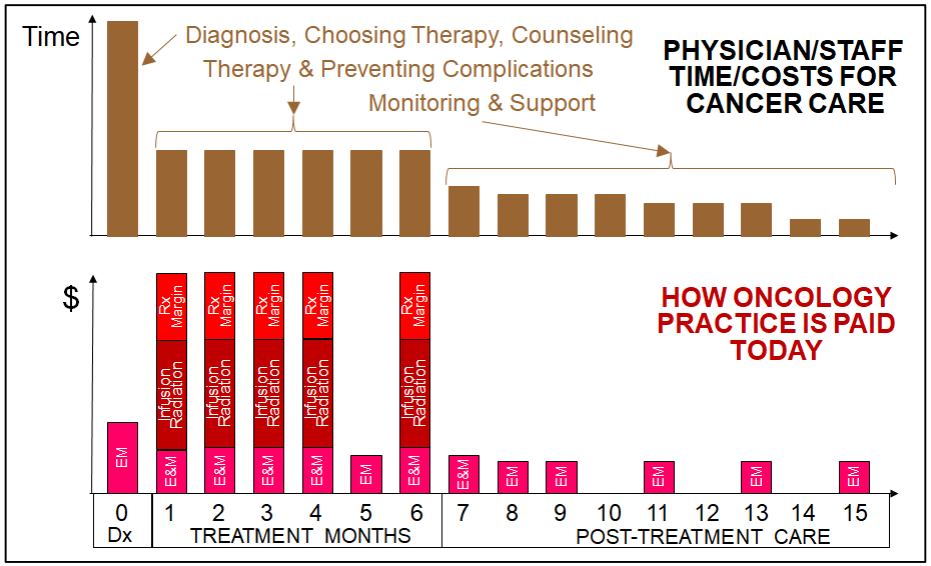


Current Fees Don't Align With the Care Patients Need



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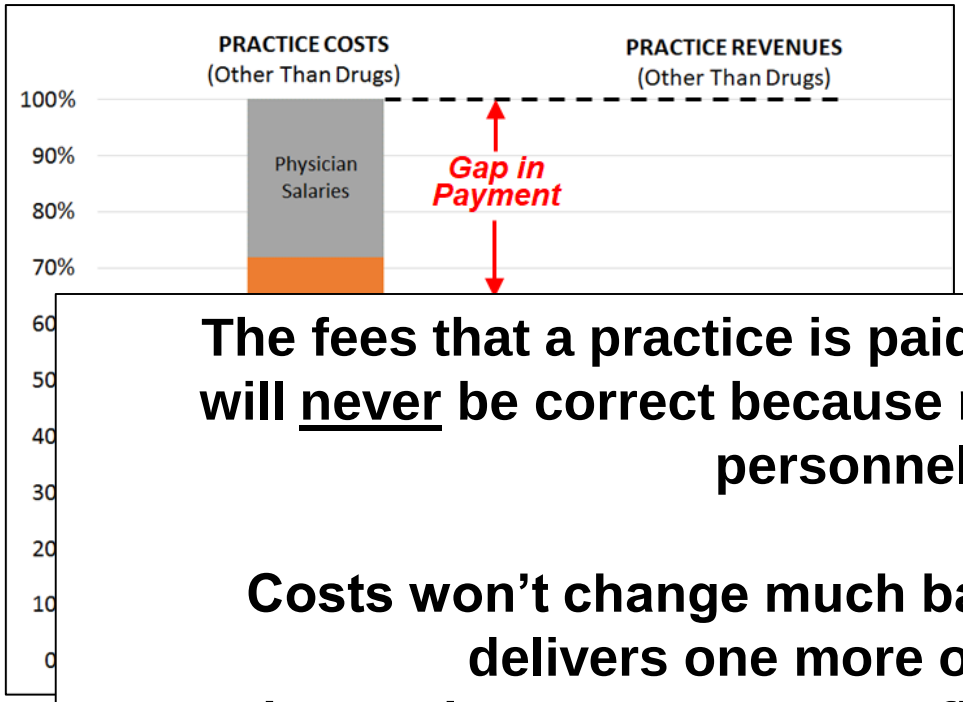

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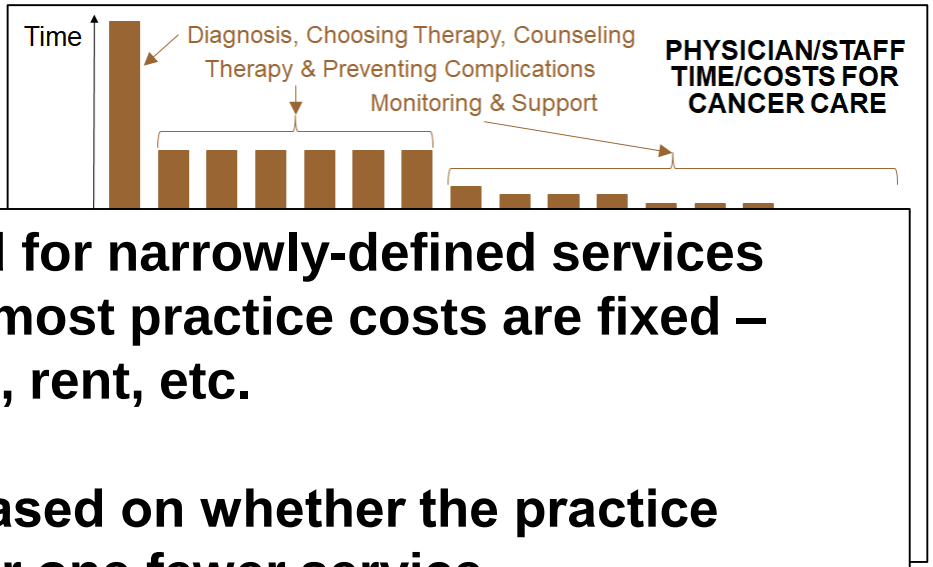

The fees that a practice is paid for narrowly-defined services will <u>never</u> be correct because most practice costs are fixed – personnel, rent, etc.

Costs won't change much based on whether the practice delivers one more or one fewer service, but under current FFS, profits will increase dramatically if patients receive unnecessary services and losses will increase if patients receive fewer services.

Option 2: Replace Current Fees With "Patient-Centered Payments"

60+ Codes Billed >100,000 Times Per Year

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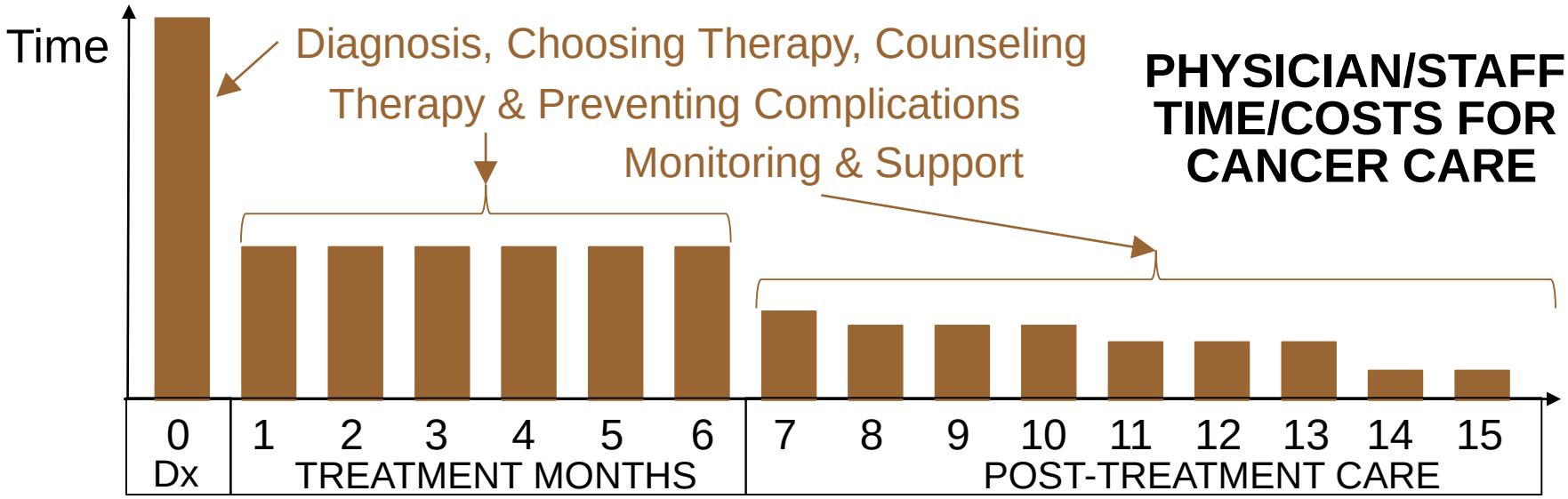
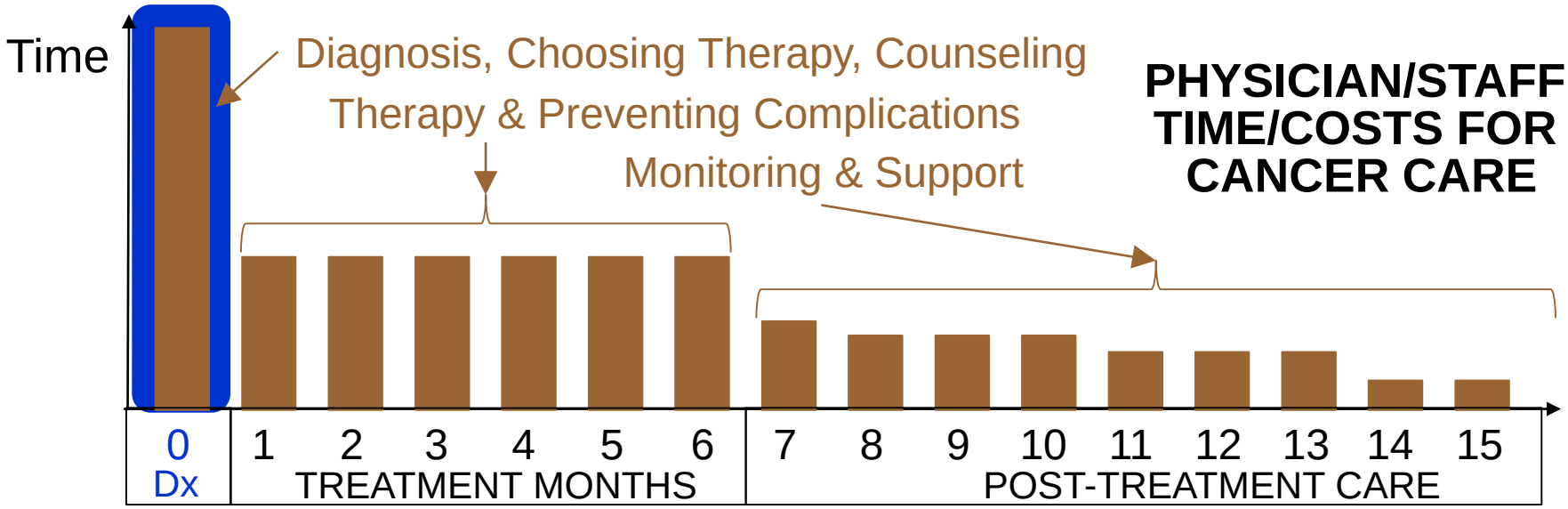
Patient-Centered Payment

1. New Patient Assessment and Treatment Planning Payment
2. Monthly Payment for Treatment and Care Mgt
3. Monthly Payment for Post-Treatment Survivorship Care
4. Monthly Payment for End-of-Life Support

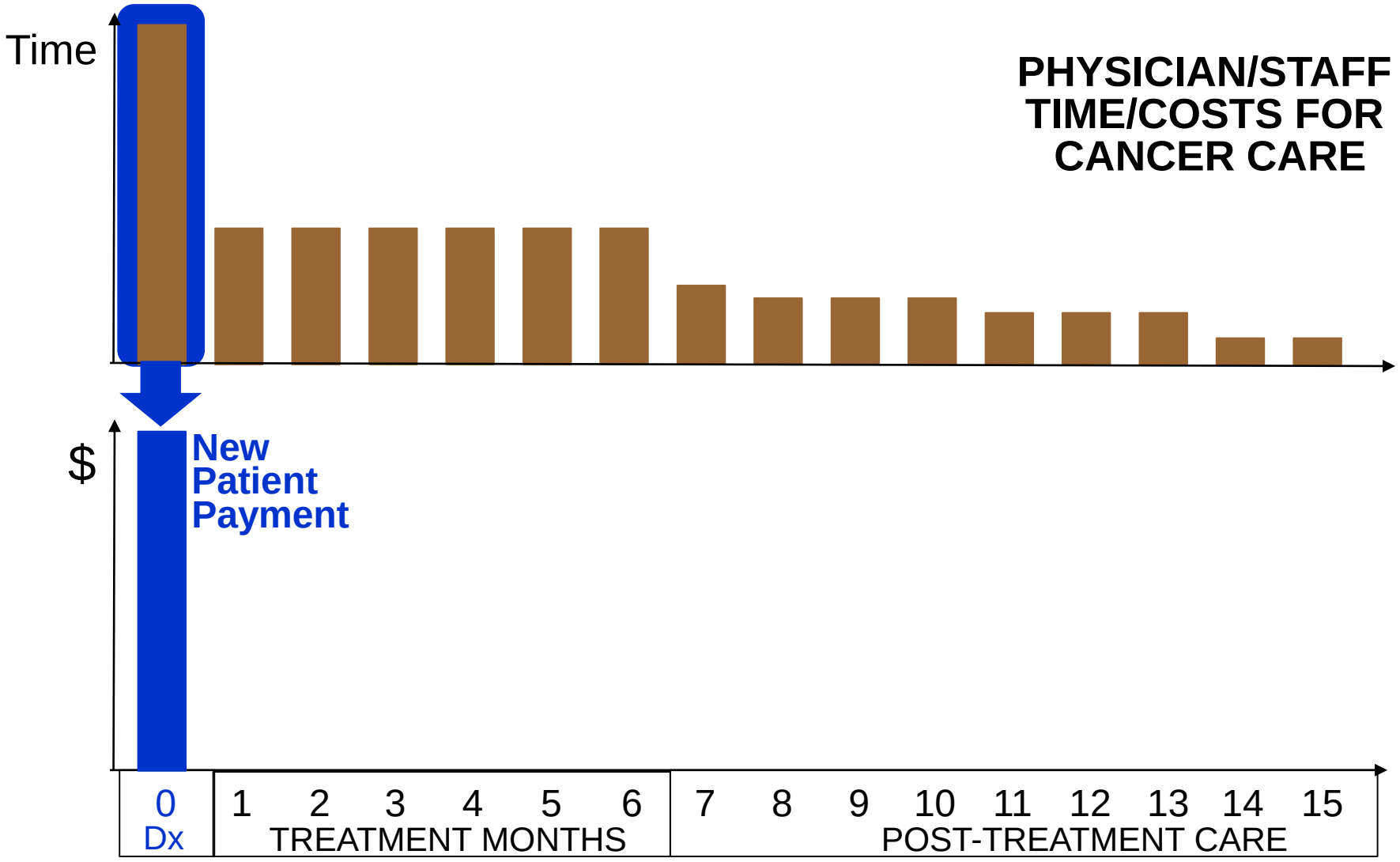
Start With How Oncology Practices Spend Their Time



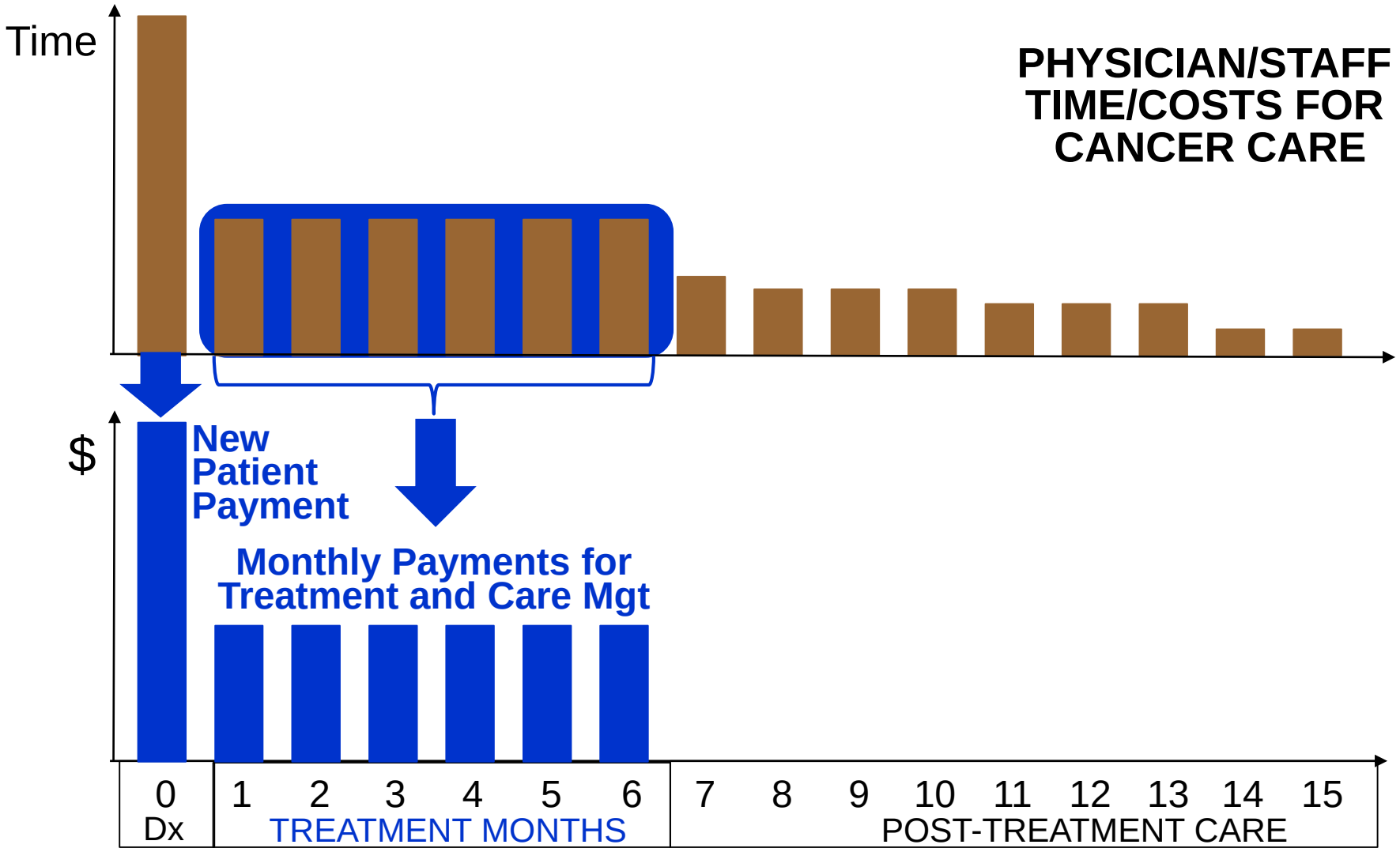
A Lot Time is Spent Before Treatment Begins



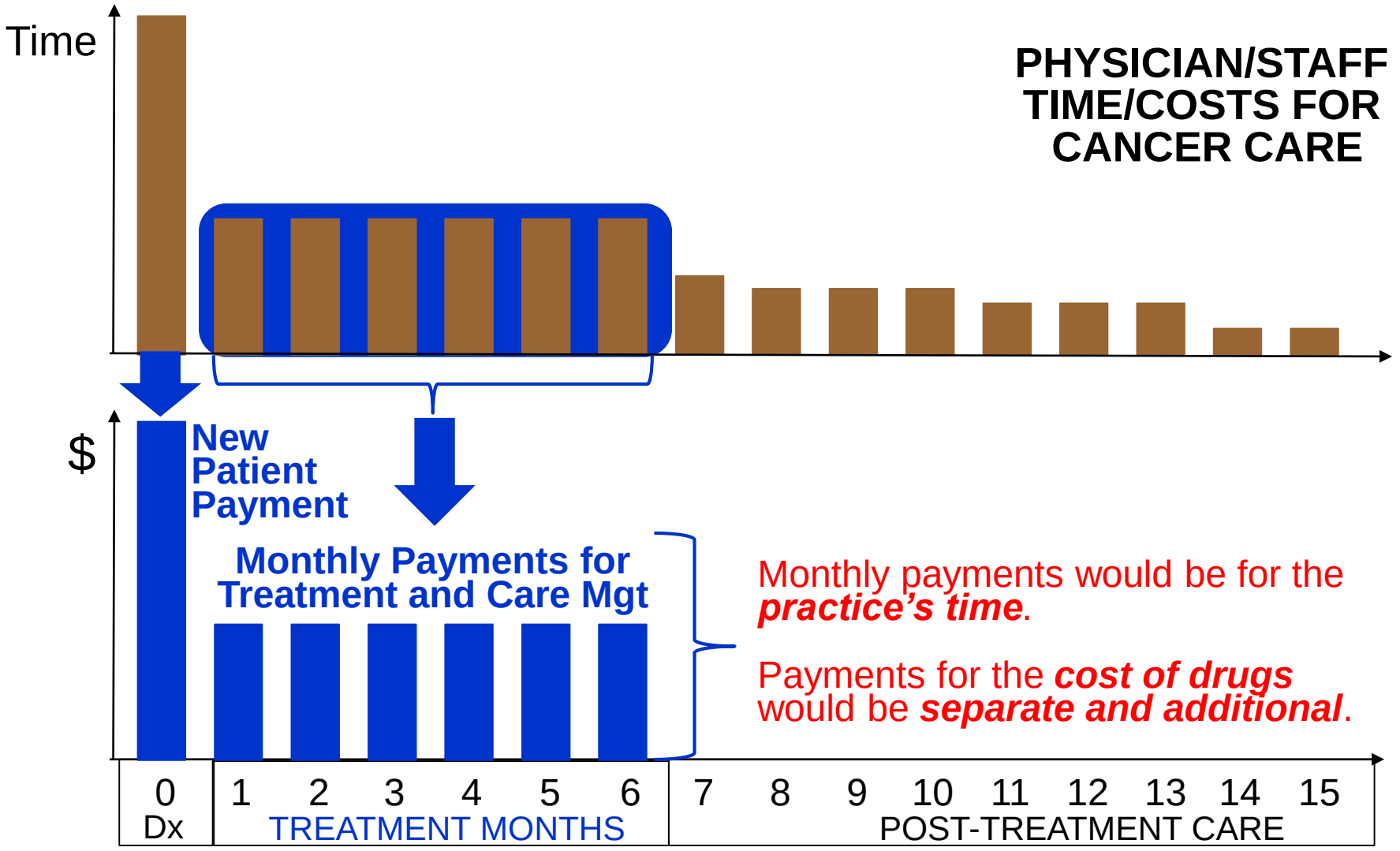
Create a Large Payment for Diagnosis & Treatment Planning



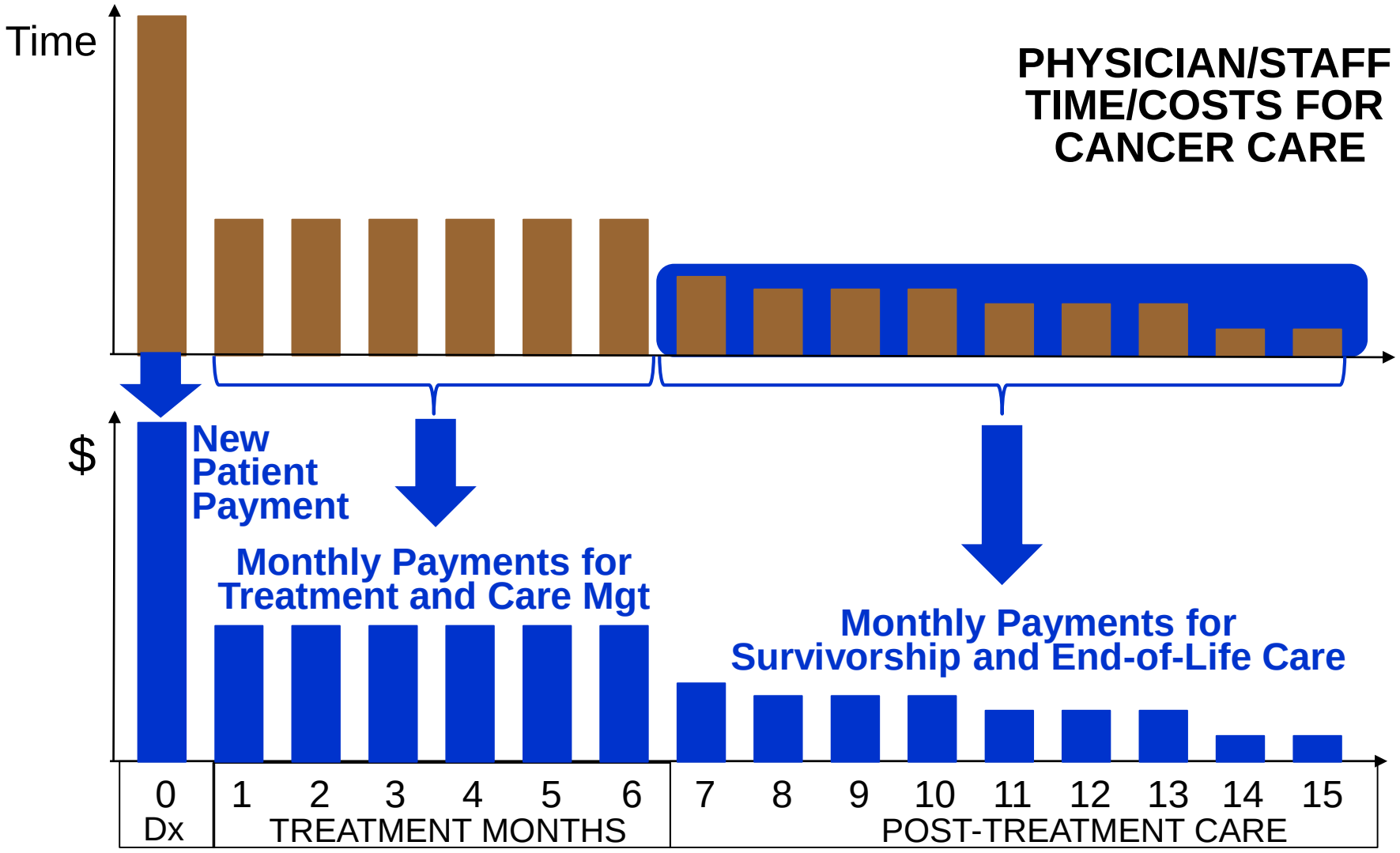
Create Monthly Payments for Treatment and Care Management



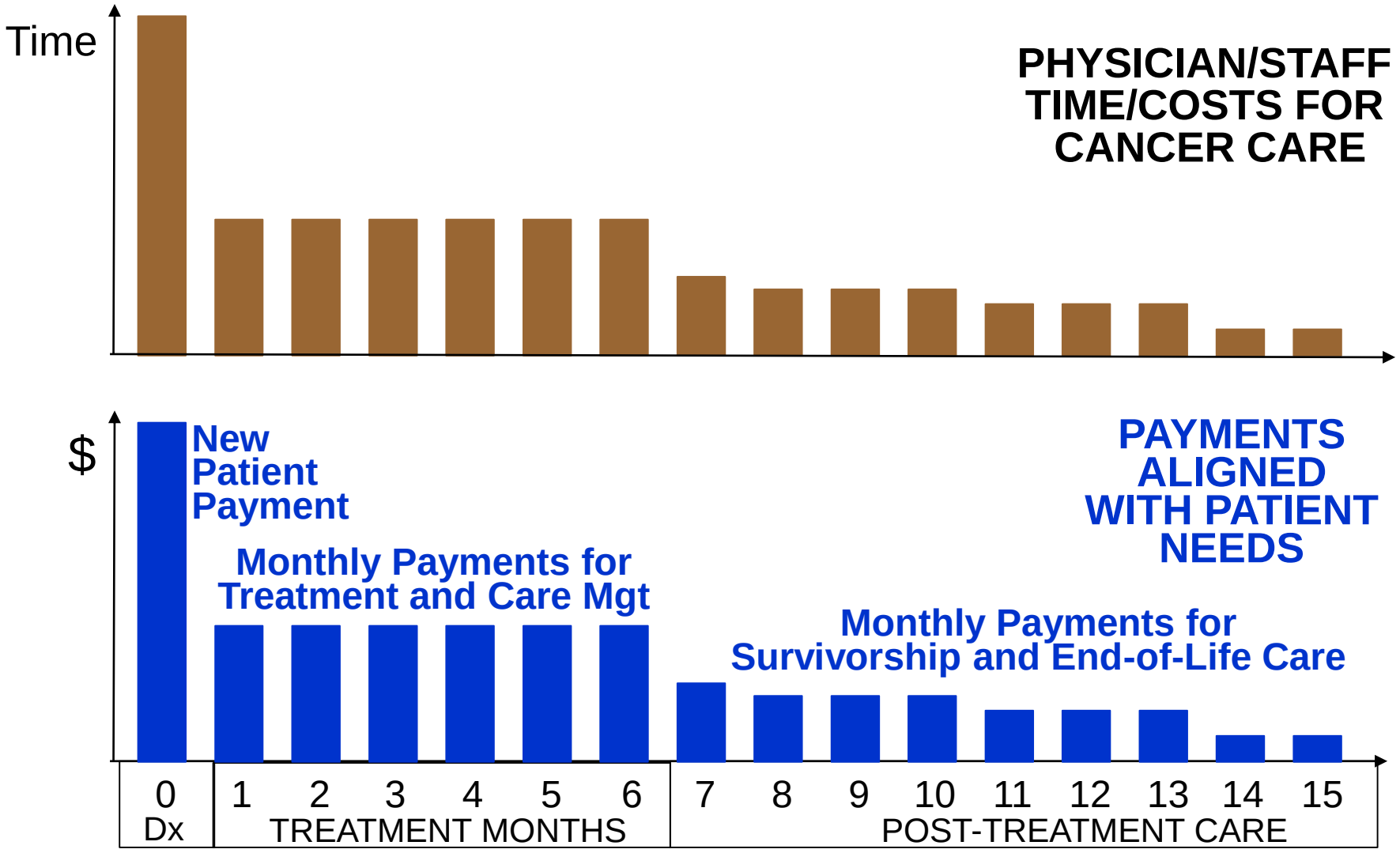
Payments Are for *People & Time*; Costs of *Drugs* Would Be Separate



Create Smaller Monthly Payments to Continue After Treatment Ends



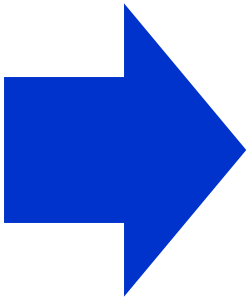
Payments Aligned With Time/Cost of Services That Patients Need



Payments Would Provide *Flexibility* As to *Who* Delivers Care & *How*

CPT-Based FFS

- Services delivered by physicians
- Face-to-face visits
- ~~Services delivered by nurses~~
- ~~Services delivered by pharmacists~~
- ~~Services delivered by counselors~~
- ~~Telephone and email support~~



Patient-Centered Payments

- Services delivered by physicians
- Face-to-face visits
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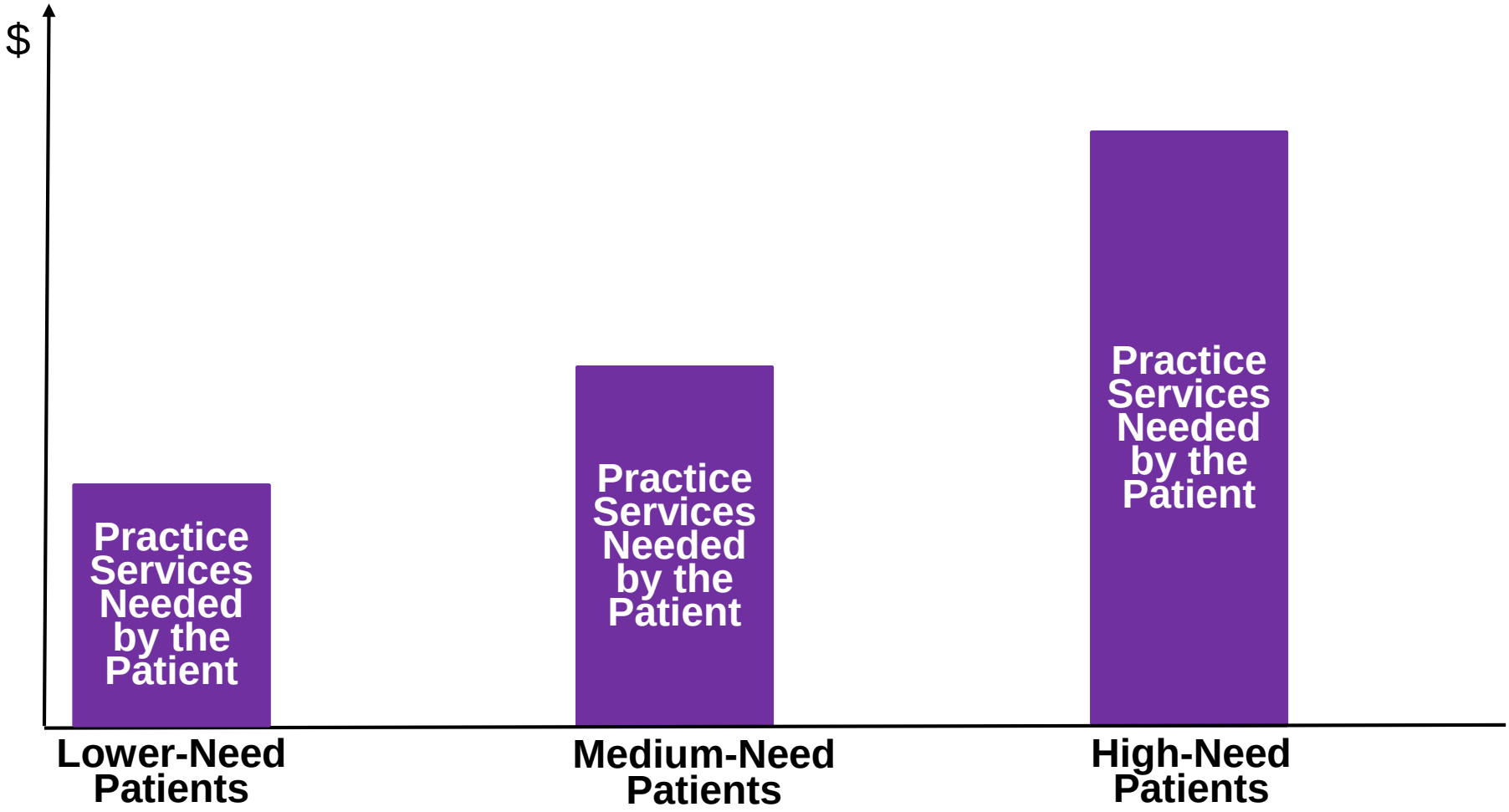
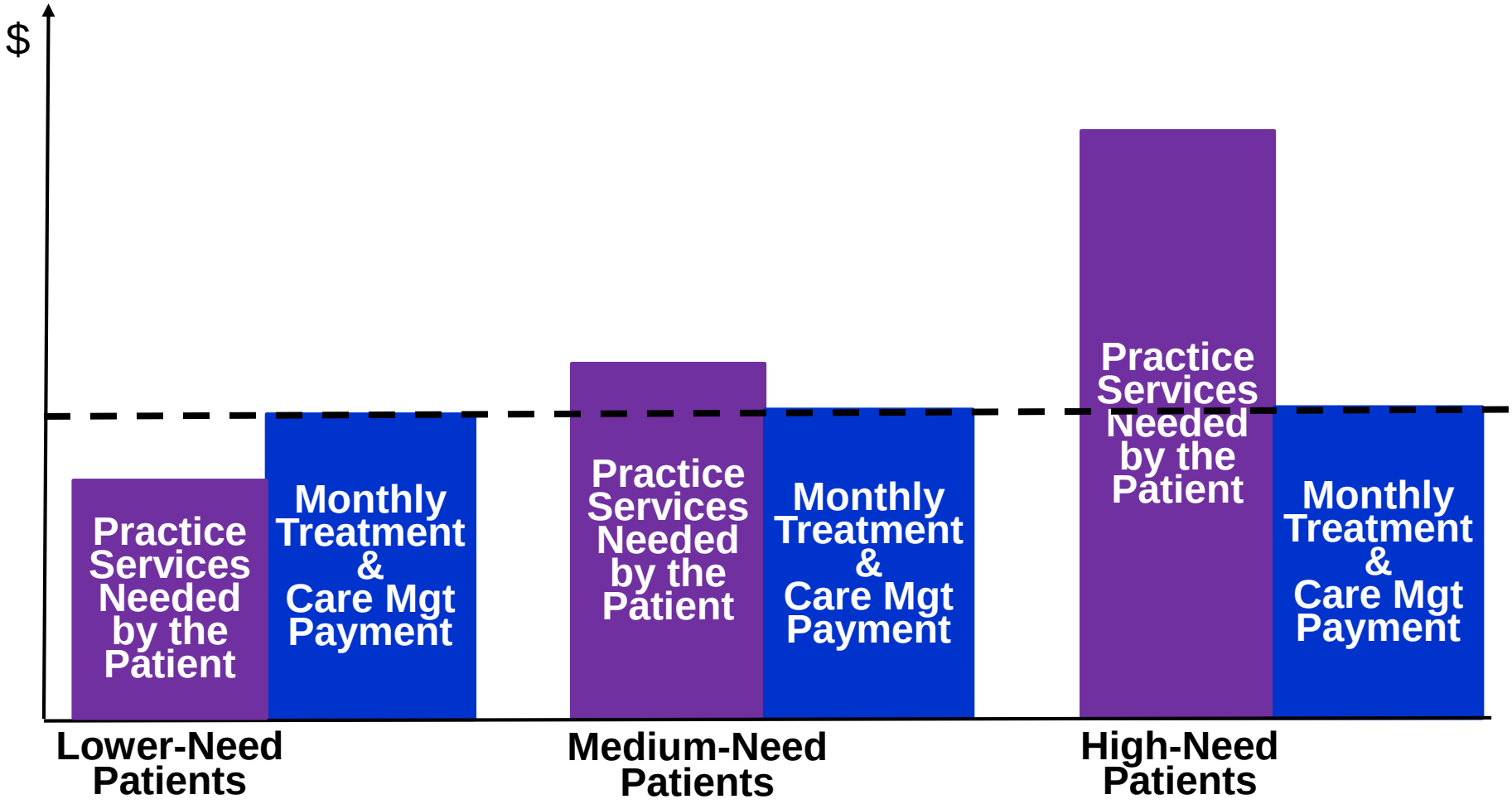
Different Patients Have Different Needs in Each Phase of Care



The Monthly Payments Can't Be the Same For Every Patient



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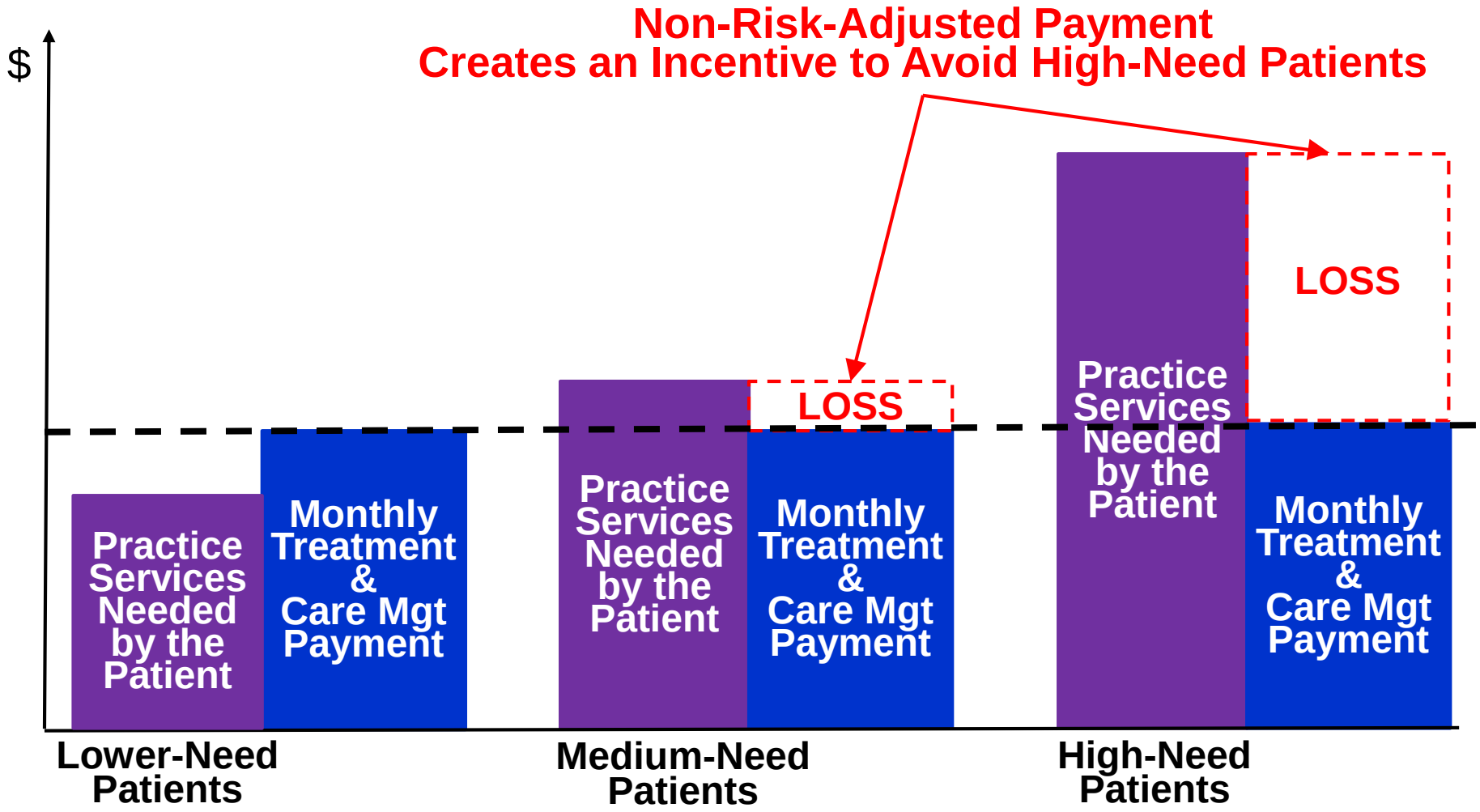
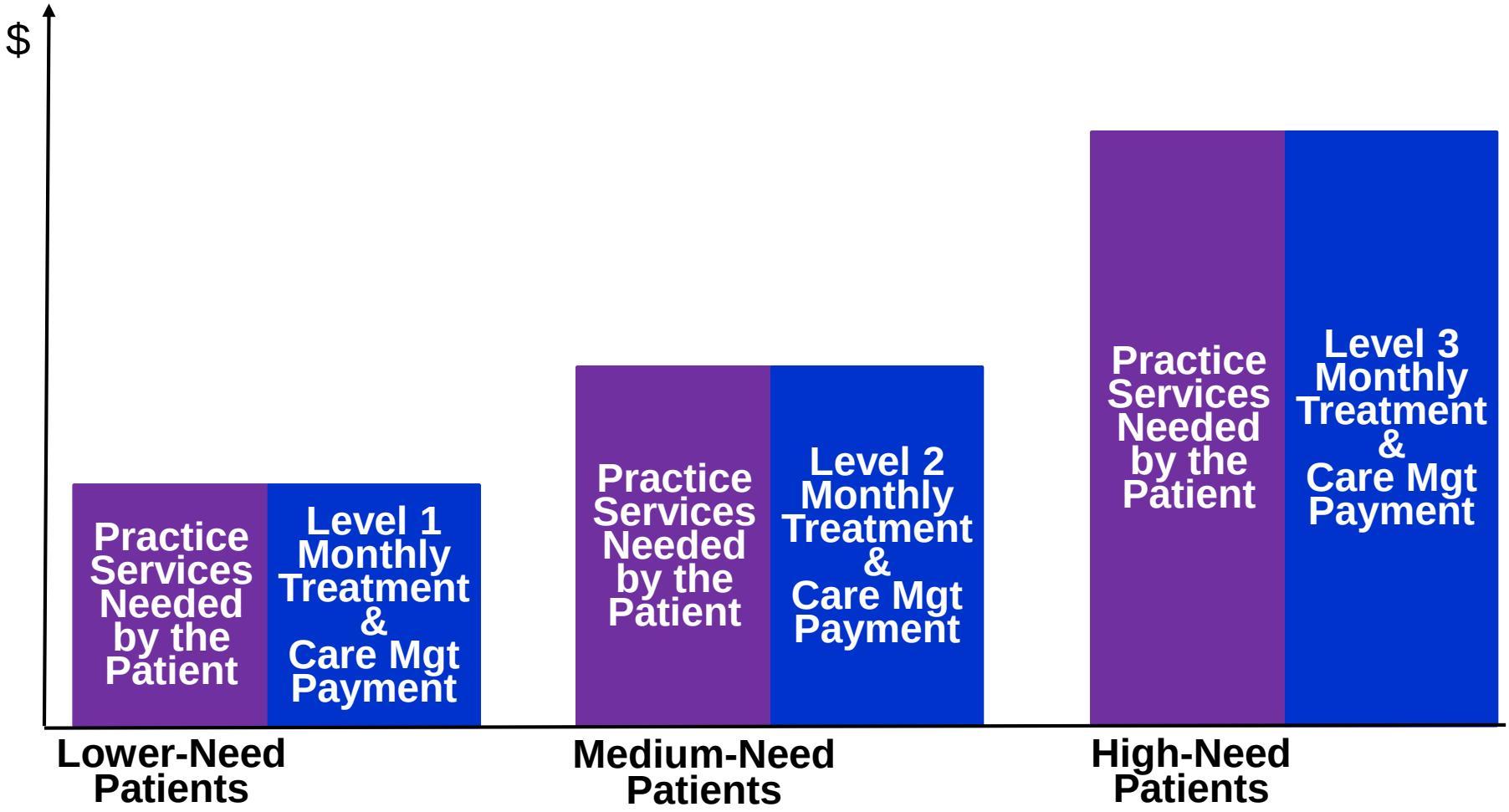
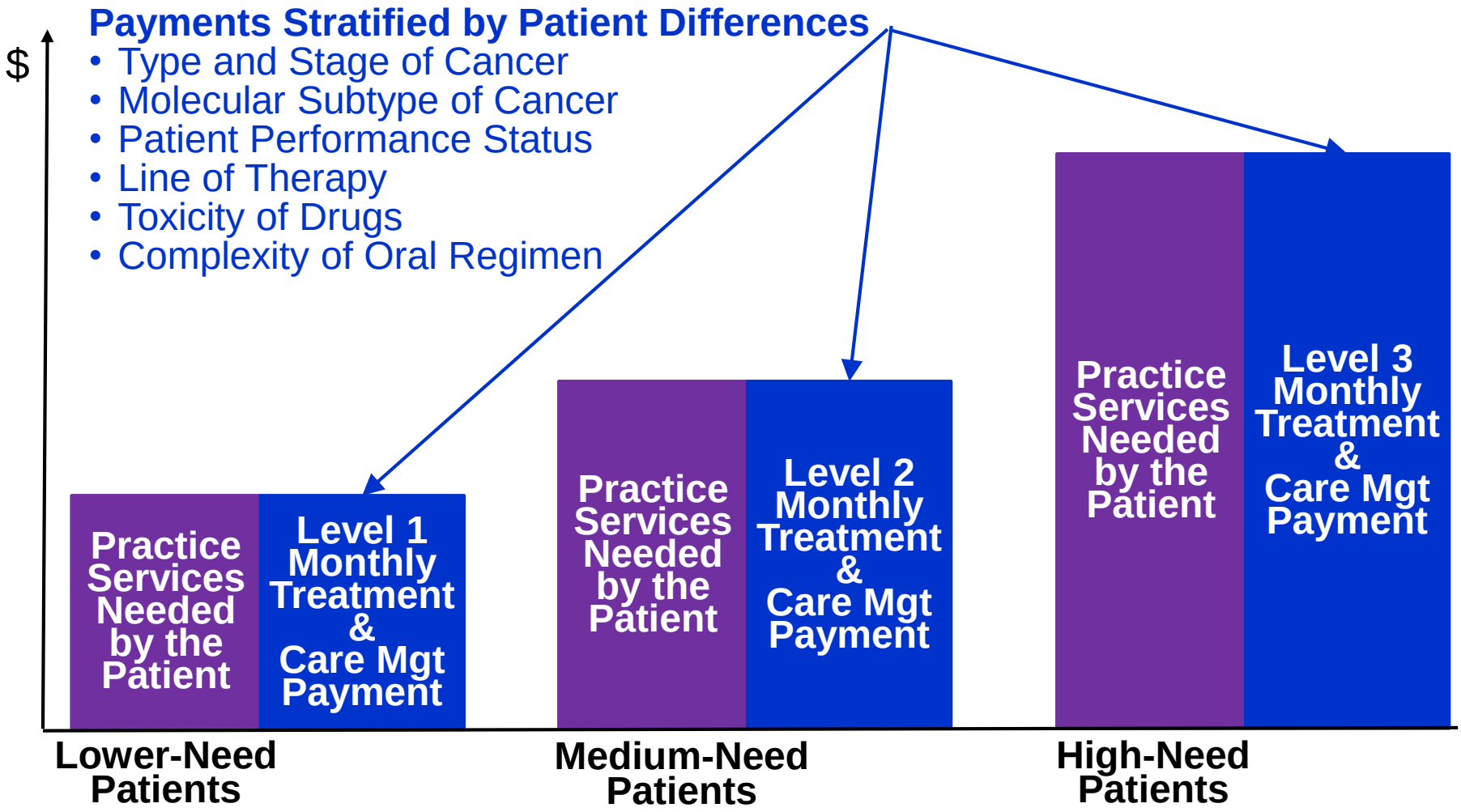


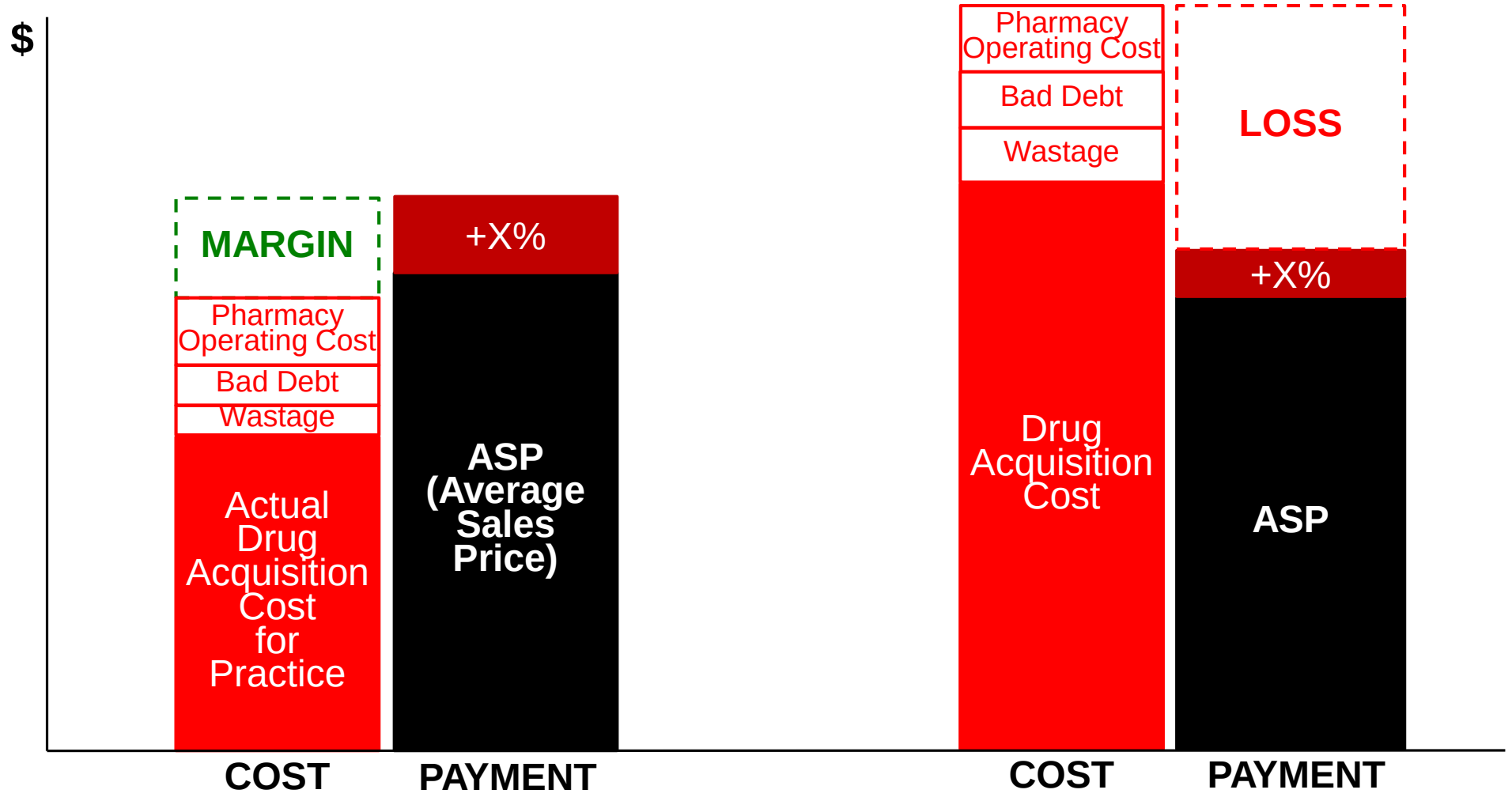
Different Levels of Payment for Patients With Different Needs



Stratification of Payments Based on Differences in *Clinical Needs*

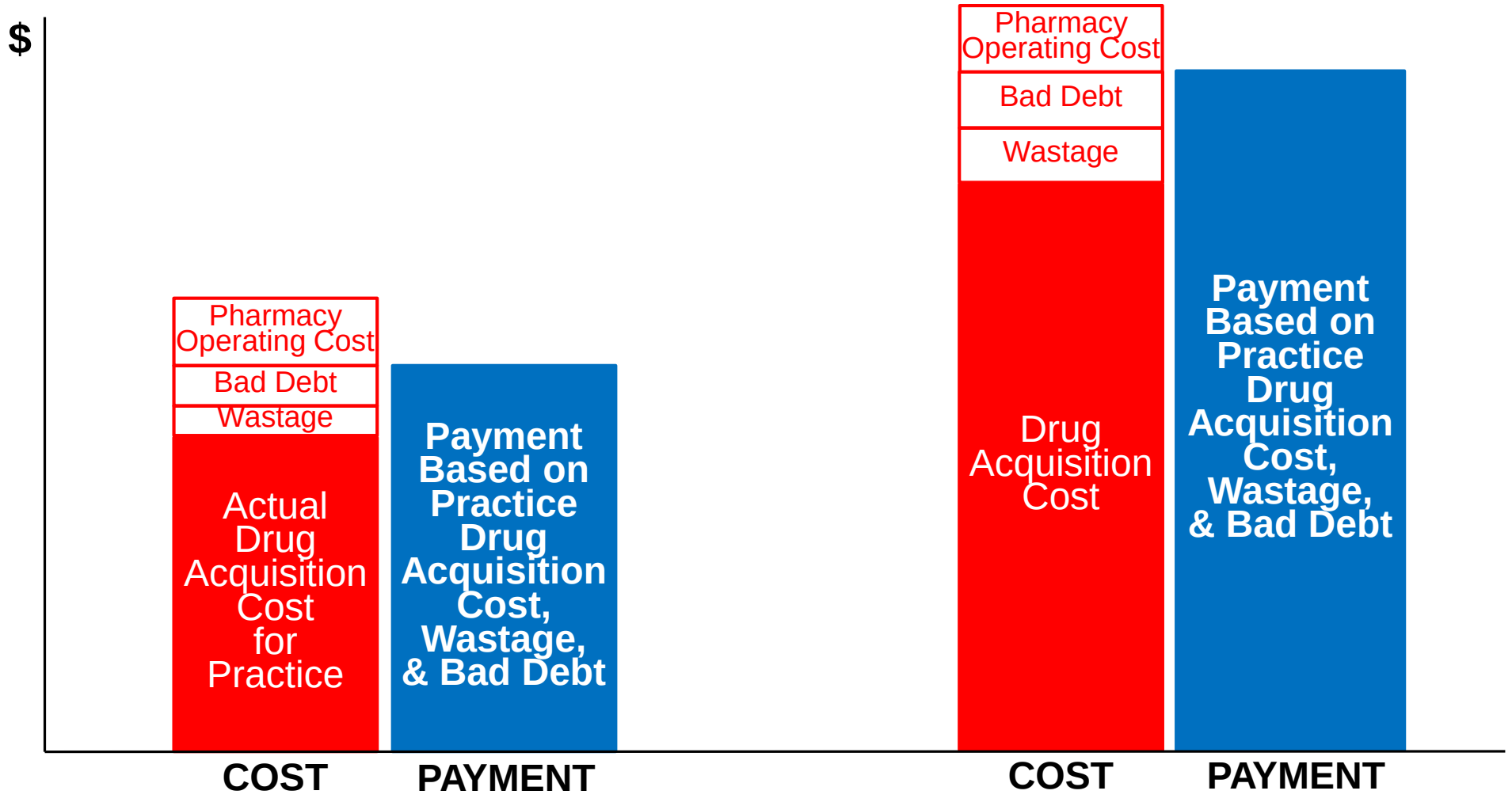


Instead of ASP+x% That Allows Large Profits & Losses on Drugs



NOTE: *Chart not drawn to scale*

Pay for Acquisition Costs of Drugs



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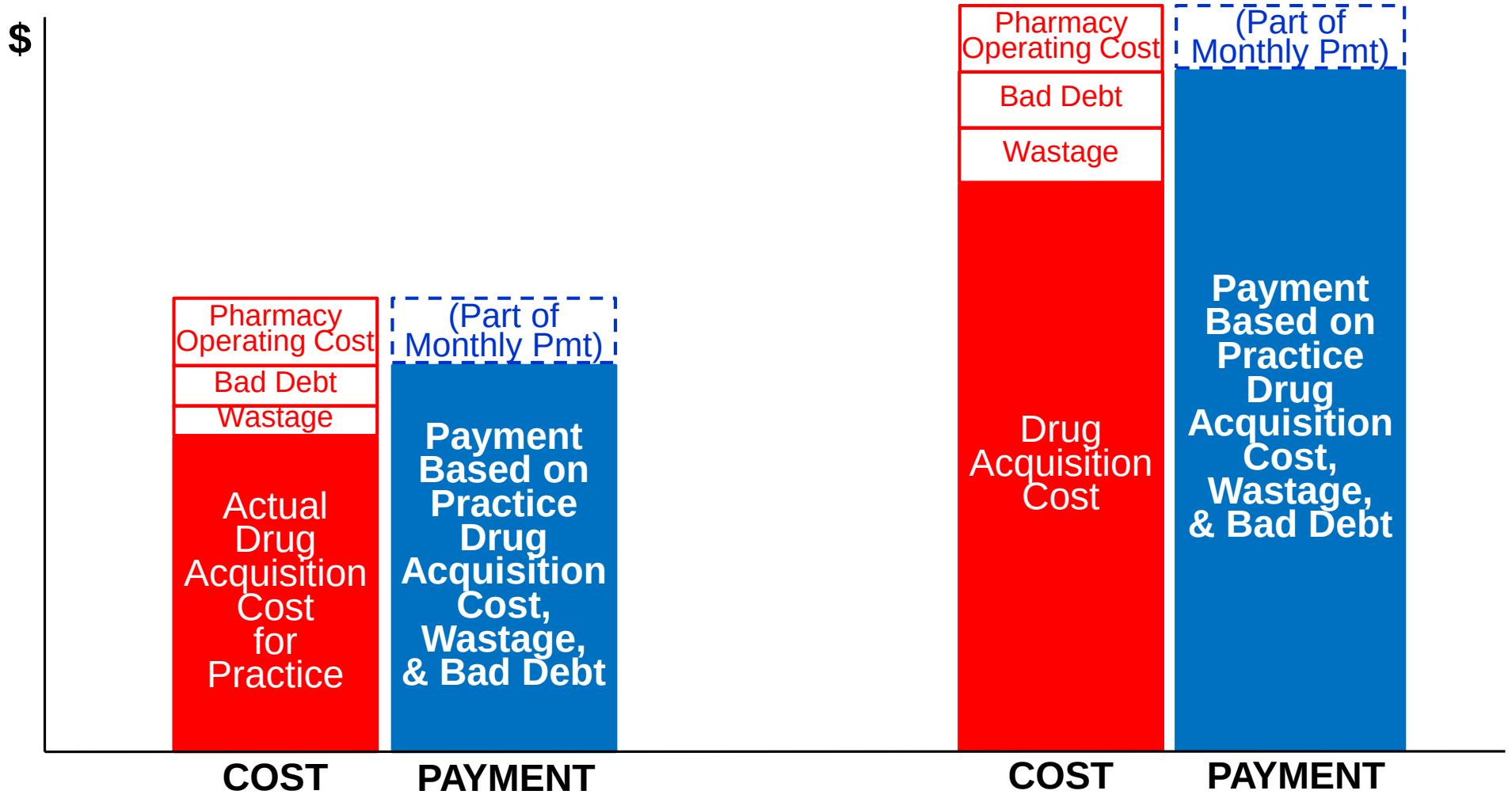
Pay for Acquisition Costs of Drugs + Pharmacy Operating Costs



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Instead of the Current Dysfunctional Payment System…

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INSTEAD OF:
Hundreds of Billing Codes

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86300 Immunologic analysis for tumor antigen
88185 Flow cytometry
G6002 Stereoscopic x-ray guidance for radiation
G6102 Radiation treatment delivery
G6013 Radiation treatment delivery
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Dozens of Unpaid Services

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Instead of the Current Dysfunctional Payment System…

INSTEAD OF: Hundreds of Billing Codes

99204 New Patient Office Visit – Level 4
99025 New Patient Office Visit – Level 5
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
96360 Intravenous infusion, hydration
96361 Intravenous infusion, hydration
96365 Intravenous infusion, non-chemotherapy
96366 Intravenous infusion, non-chemotherapy
96367 Intravenous infusion, non-chemotherapy
96372 Injection, non-chemotherapy
96375 Intravenous push, non-chemotherapy
96401 Subcutaneous chemotherapy administration
96402 Subcutaneous chemotherapy administration
96411 Push chemotherapy administration
96413 Infusion chemotherapy administration
96415 Infusion chemotherapy administration
96417 Infusion chemotherapy administration
96523 Irrigation of venous access device
36415 Insertion of needle to collect blood sample
77014 CT scan guidance for radiation
77263 Management of radiation therapy
77280 Management of radiation therapy simulation
77290 Management of radiation therapy simulation
77295 Management of radiation therapy 3D
77300 Calculation of radiation therapy dose
77301 Management of modulation radiotherapy planning
77334 Radiation treatment device design & construction
77336 Radiation therapy consultation
77338 Radiation therapy device design & construction
77427 Radiation treatment management
80048 Blood test, basic
80053 Blood test comprehensive
82378 CEA protein level
82607 Cyanocobalamin level
82728 Ferritin level
82784 Gammaglobulin measurement
83540 Iron level
83550 Iron binding capacity
83615 Lactate dehydrogenase level
83735 Magnesium level
84100 Phospate level
84443 Thyroid stimulating hormone level
84550 Uric acid level
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Losses Covered by Margins on Drugs

Flexible Payments Designed to Support Each Phase of Care

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Losses Covered by Margins on Drugs

PATIENT-CENTERED PAYMENT

New Patient Diagnosis and Treatment Planning Payment

Monthly Payment for Treatment and Care Mgt

Monthly Payment for Post-Treatment Survivorship Care

Monthly Payment for End-of-Life Support

Payments Matching Time Patients Need, Not # of Services Provided

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Losses Covered by Margins on Drugs

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- Level 2: High Need/Complexity

Monthly Payment for Treatment and Care Mgt
- Level 1: Low Need/Complexity
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Monthly Payment for Post-Treatment Survivorship Care
- Level 1: Low Need/Complexity
- Level 2: High Need/Complexity

Monthly Payment for End-of-Life Support
- Level 1: Low Need/Complexity
- Level 2: High Need/Complexity

Payment for Drug Acquisition Cost

Patient-Centered Payment is a *Better* Fee for Service System

This is still "fee for service," but the fees are based on cancer patients' needs and oncology practice costs, not on how many individual services are delivered.

PATIENT-CENTERED PAYMENT

New Patient Diagnosis and Treatment Planning Payment
- Level 1: Low Need/Complexity
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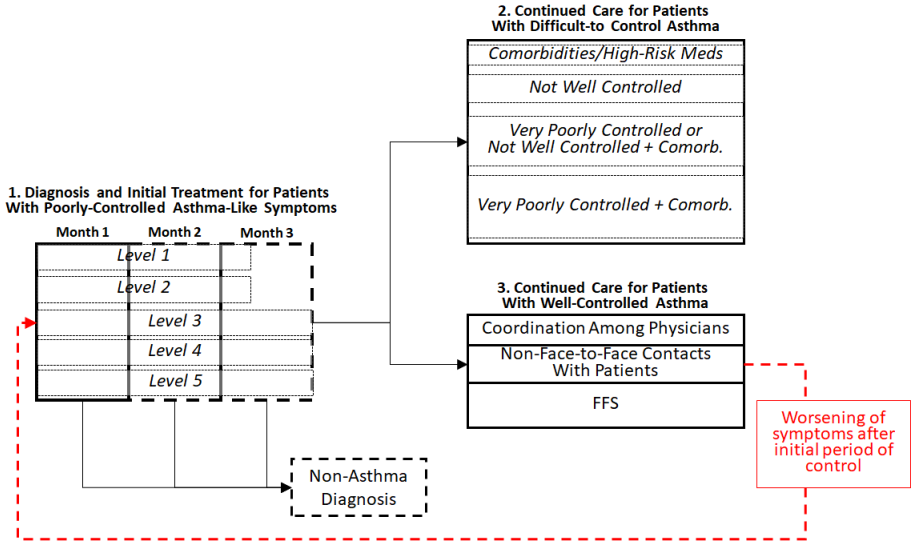
Payment for Drug Acquisition Cost

Other Specialties Are Developing Similar APMs for Other Conditions

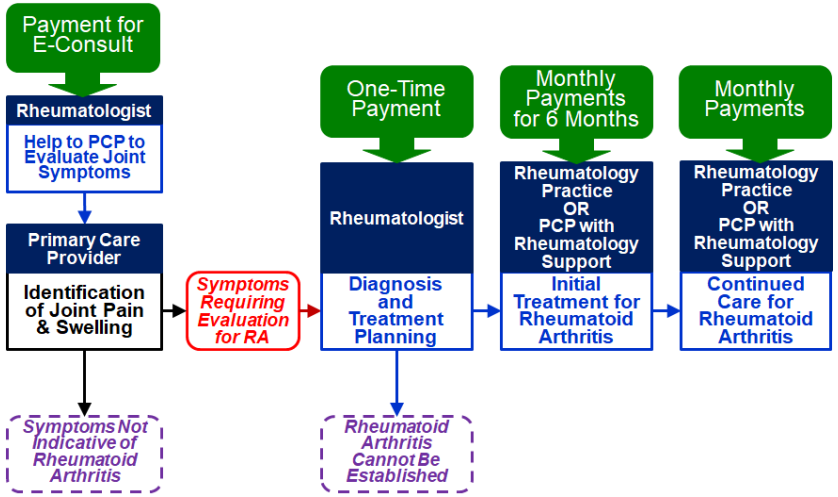
"Patient-Centered Asthma Care Payment"

(American College of Allergy, Asthma, and Immunology)

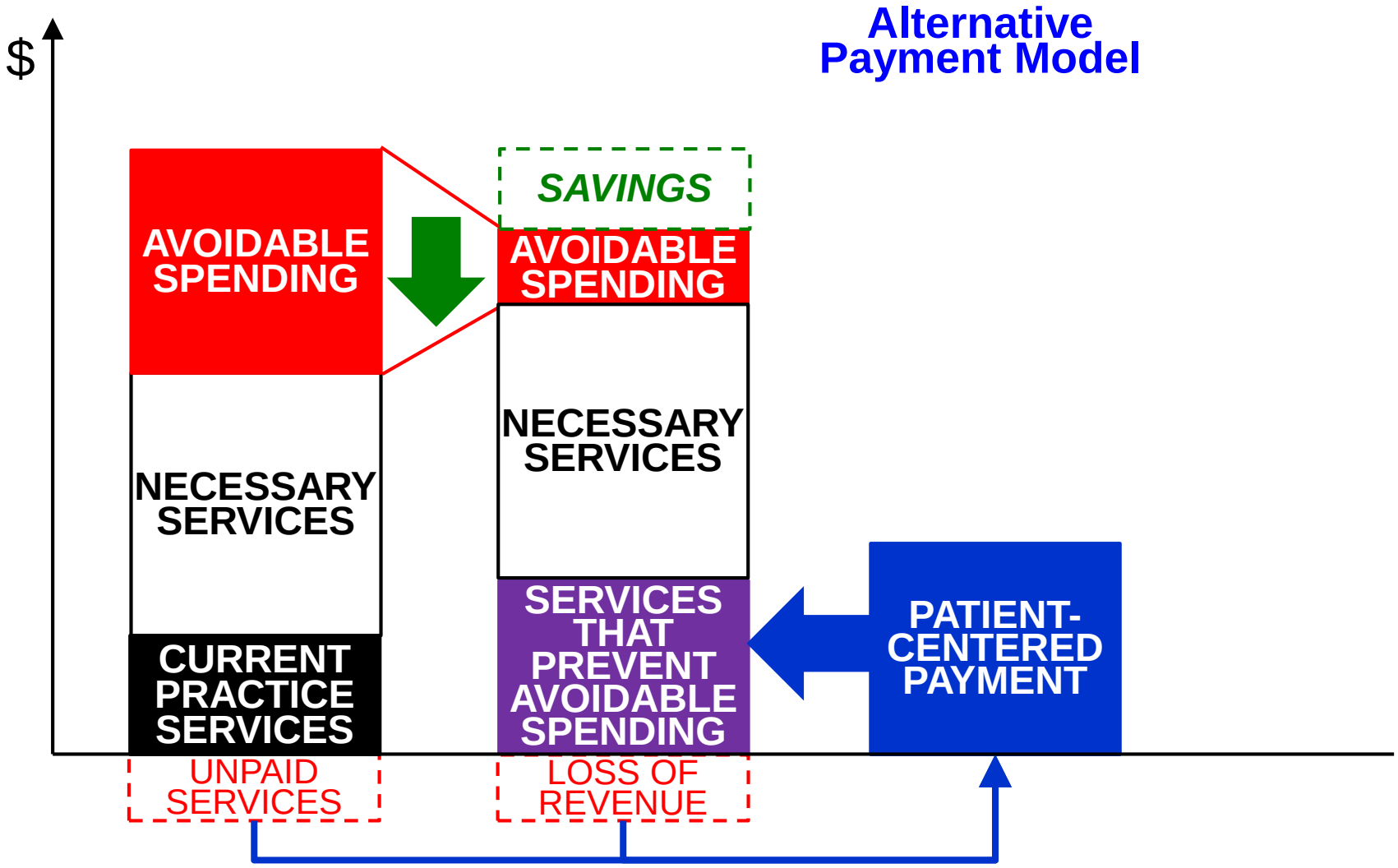


(Draft) Alternative Payment Model for Rheumatoid Arthritis Care

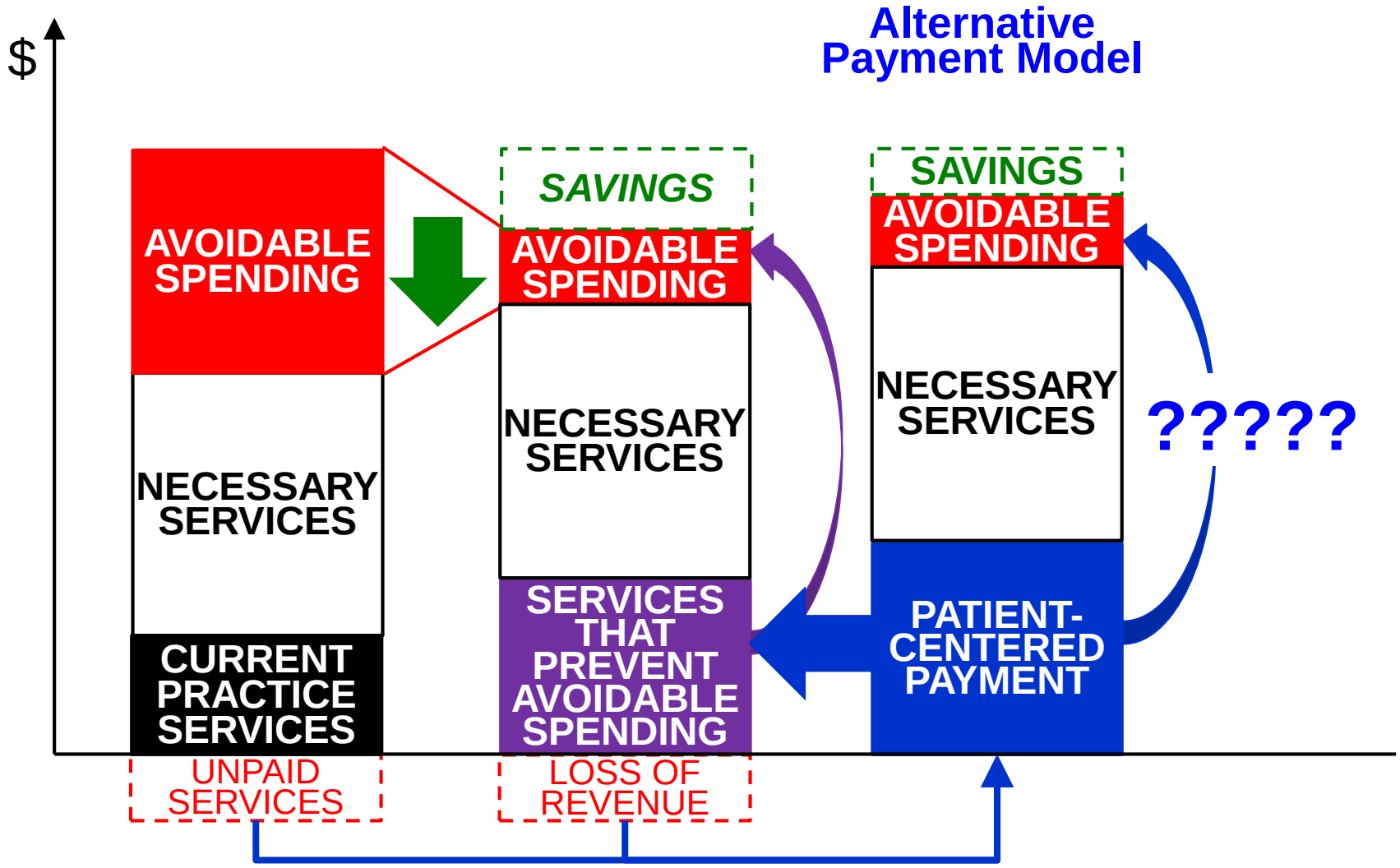
(American College of Rheumatology)



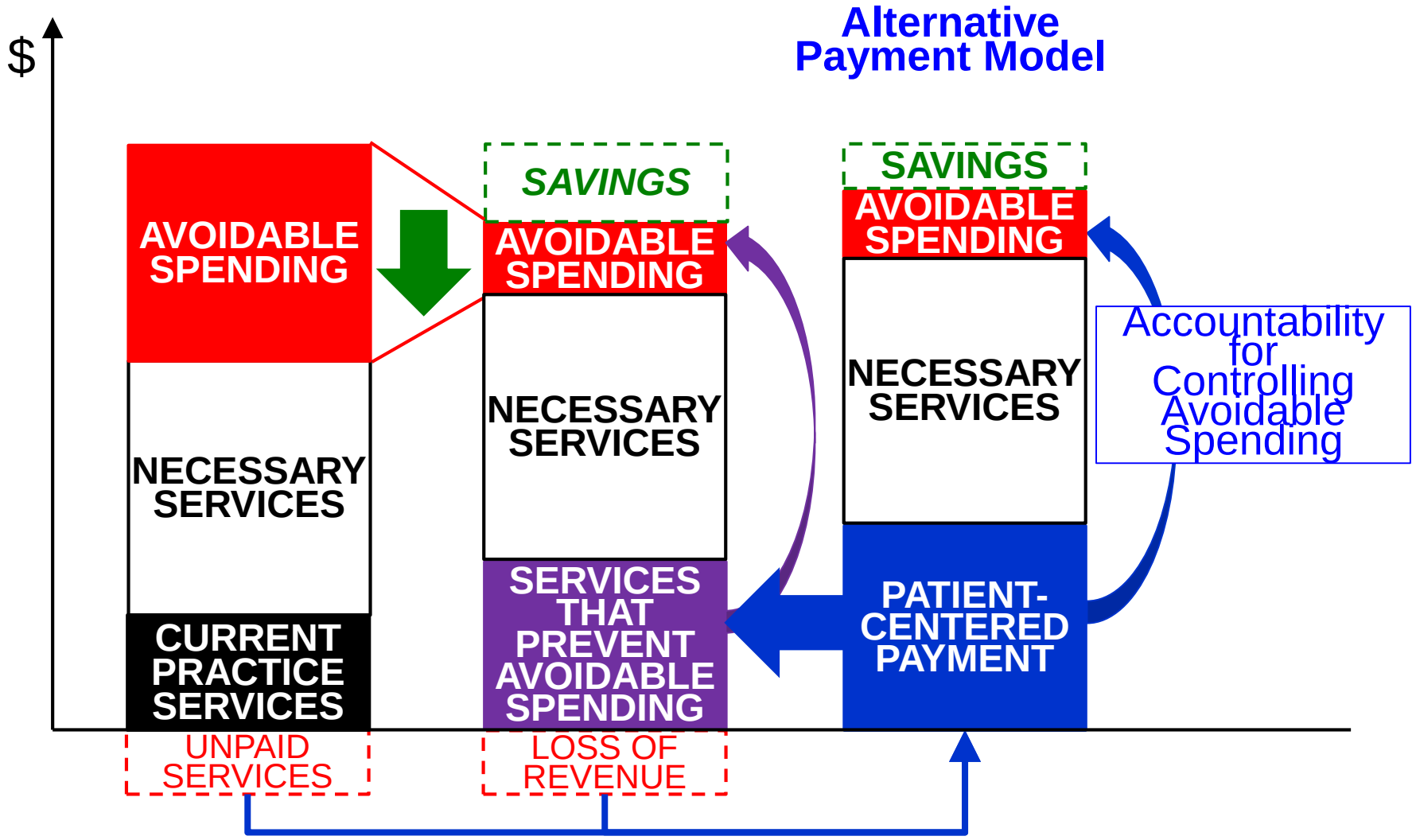
If Payers Pay Differently for Oncology Services…



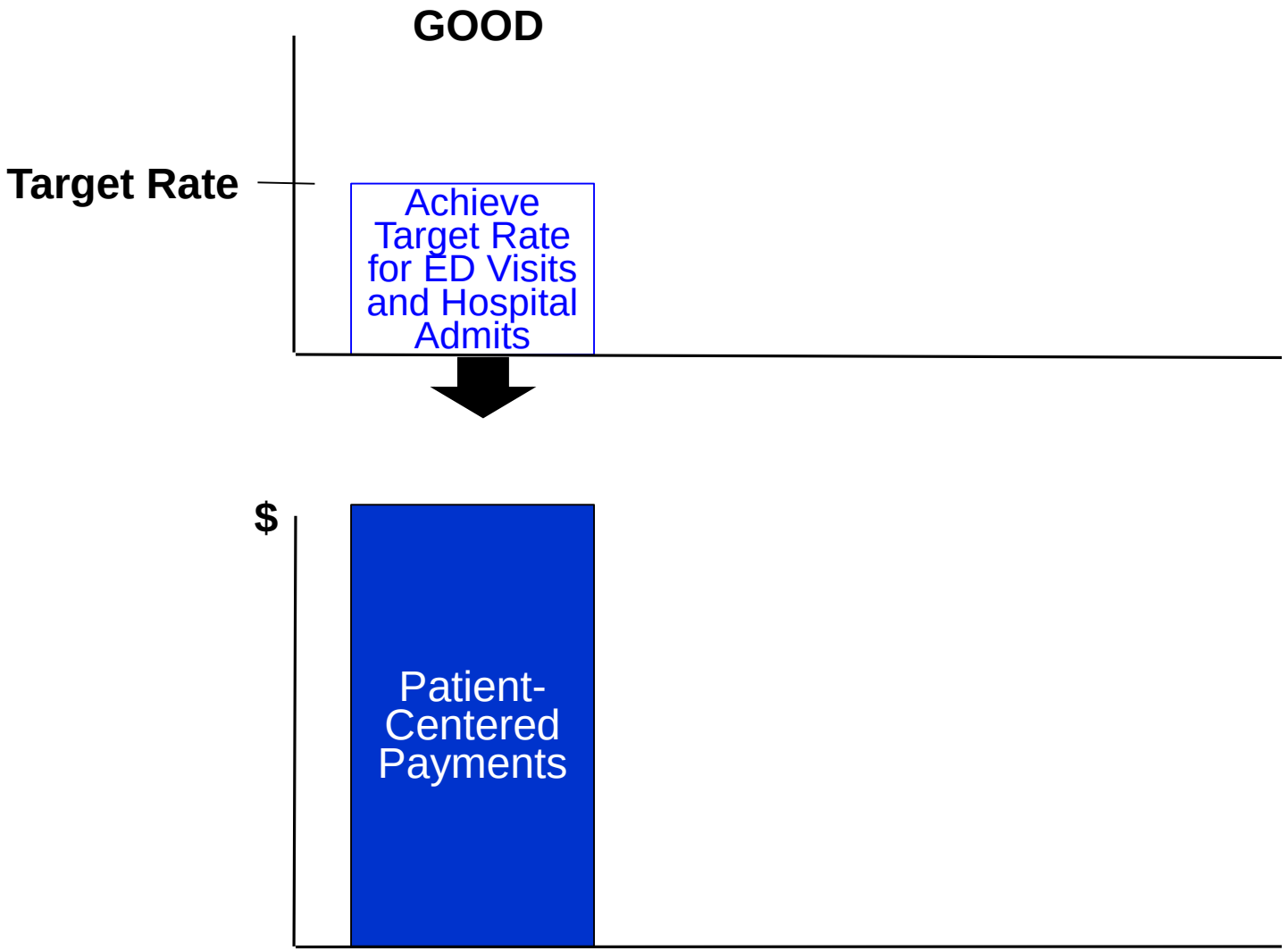
How Can They Be Sure Avoidable Spending Will Be Reduced?



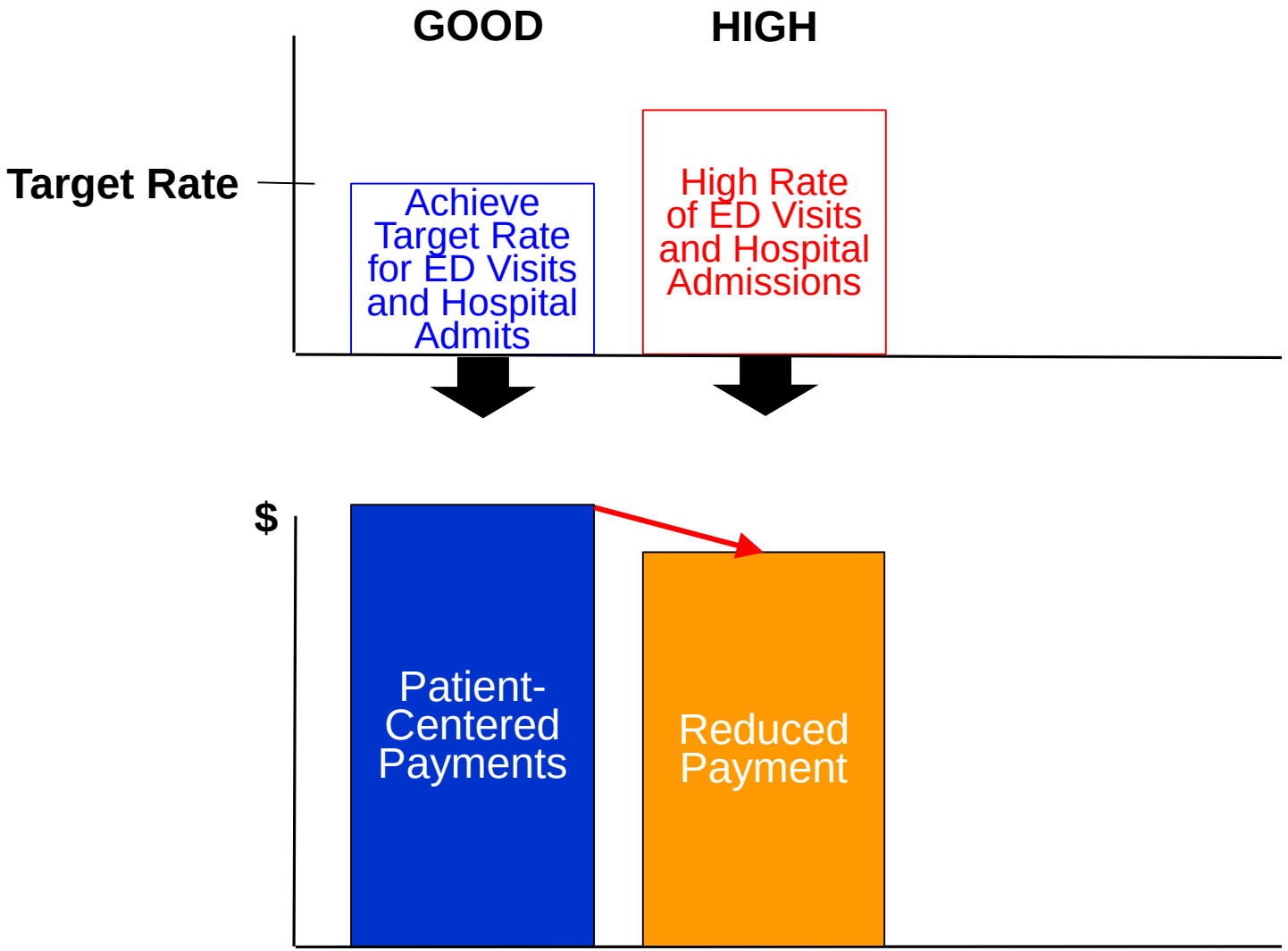
Step 4: Require Accountability for Cost&Quality *Providers Can Control*



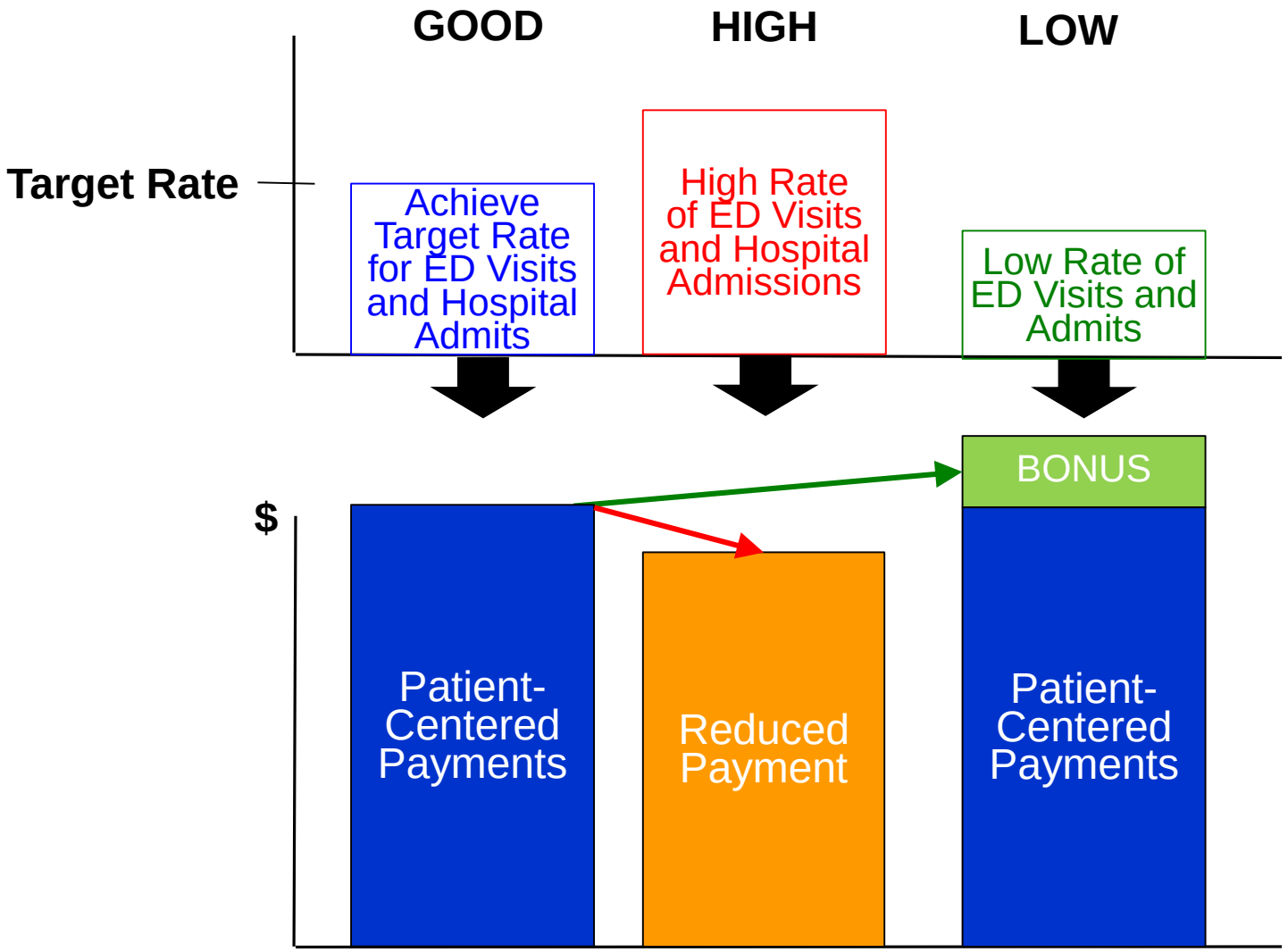
#1: Set a Goal/Target Rate for ED Visits and Hospital Admits



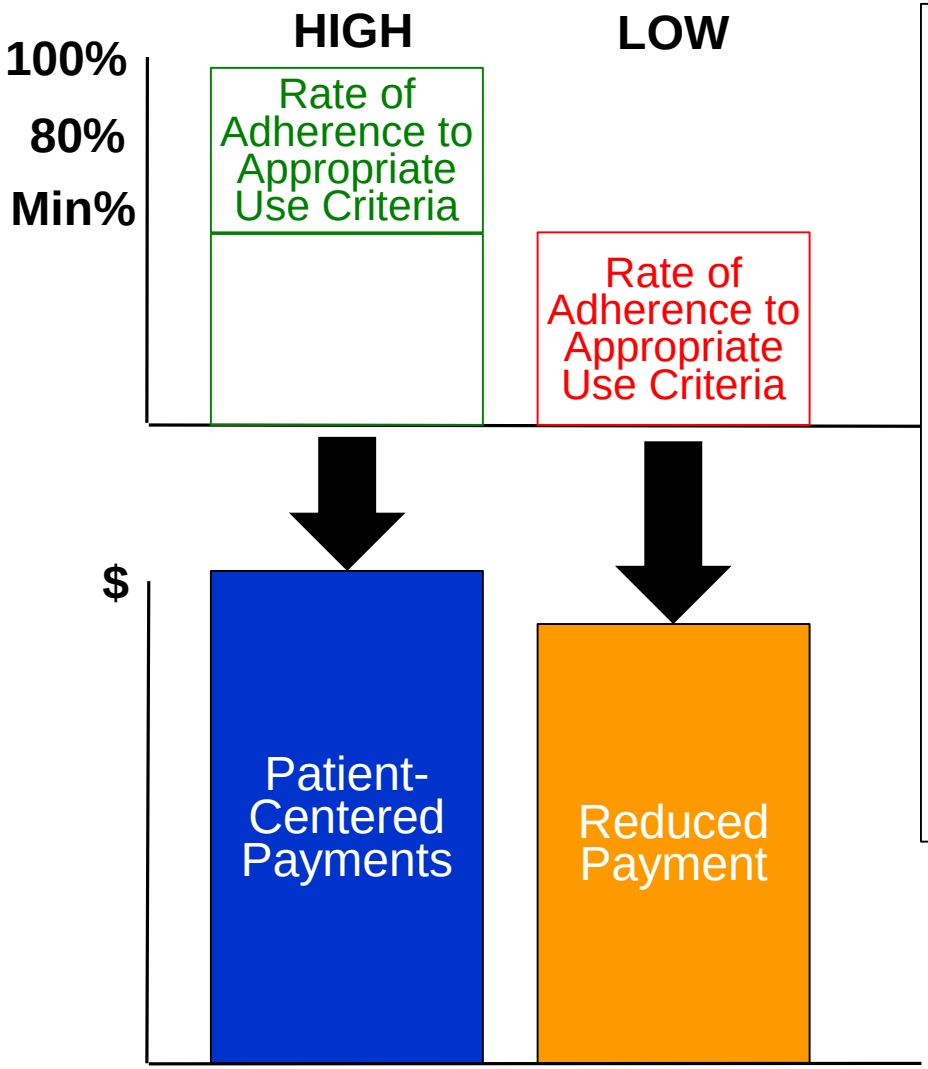
Reduce Payments If Rate of Admits Is Worse Than Target

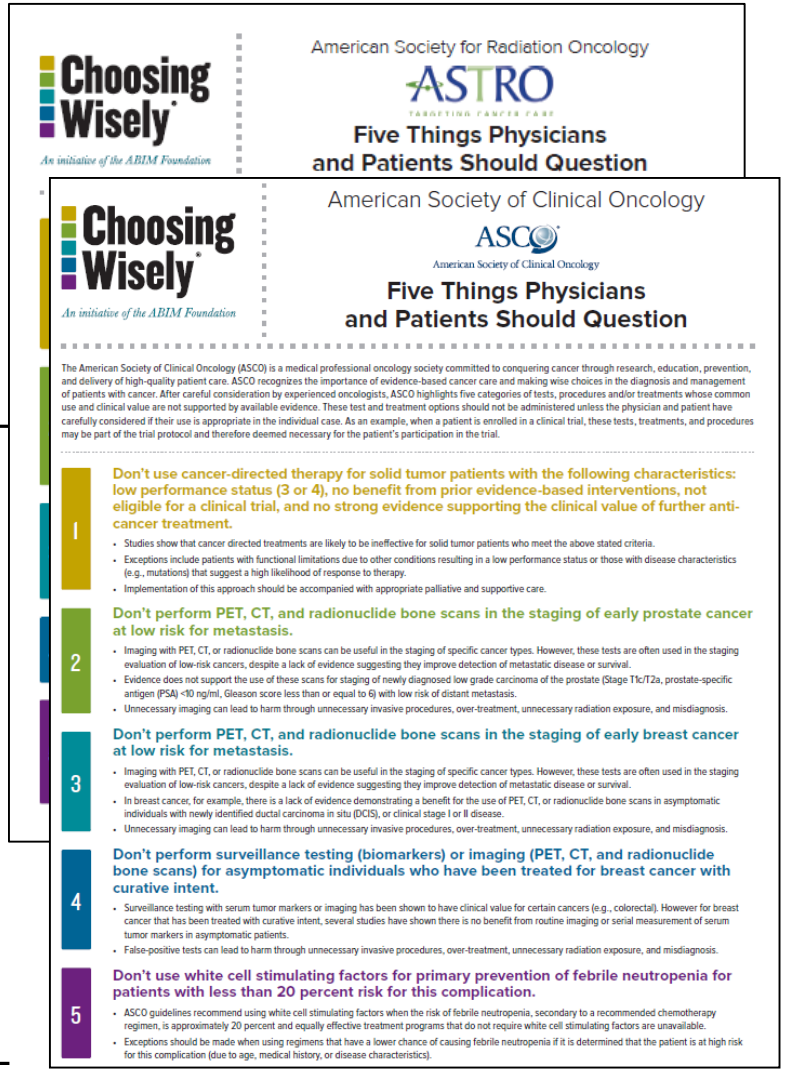


Bonus Payment If ED/Hospital Use Is Better Than Goal/Target



#2: Reduce Payment If Oncologist Does Not Follow Guidelines





Choosing Wisely
An initiative of the ABIM Foundation

American Society for Radiation Oncology
ASTRO
Five Things Physicians and Patients Should Question

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).

Instead of Multiple Pathways and Pre-Authorization Requirements...

TODAY

Payer-Specific Proprietary Pathway

Payer-Specific Proprietary Pathway

Payer-Specific Prior Authorization Requirements

Payer-Specific Prior Authorization Requirements

Oncologists Should Take Control of Appropriateness Decisions

TODAY

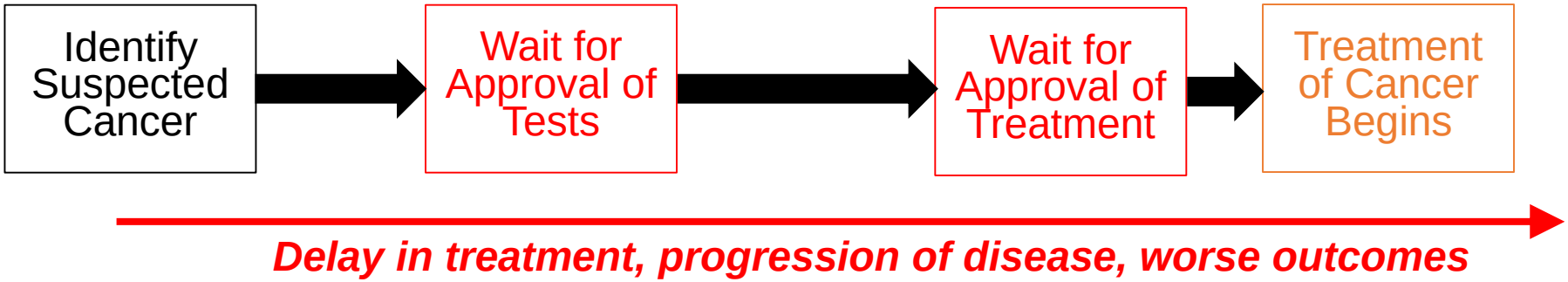
- Payer-Specific Proprietary Pathway
- Payer-Specific Proprietary Pathway
- Payer-Specific Prior Authorization Requirements
- Payer-Specific Prior Authorization Requirements

PATIENT-CENTERED PAYMENT

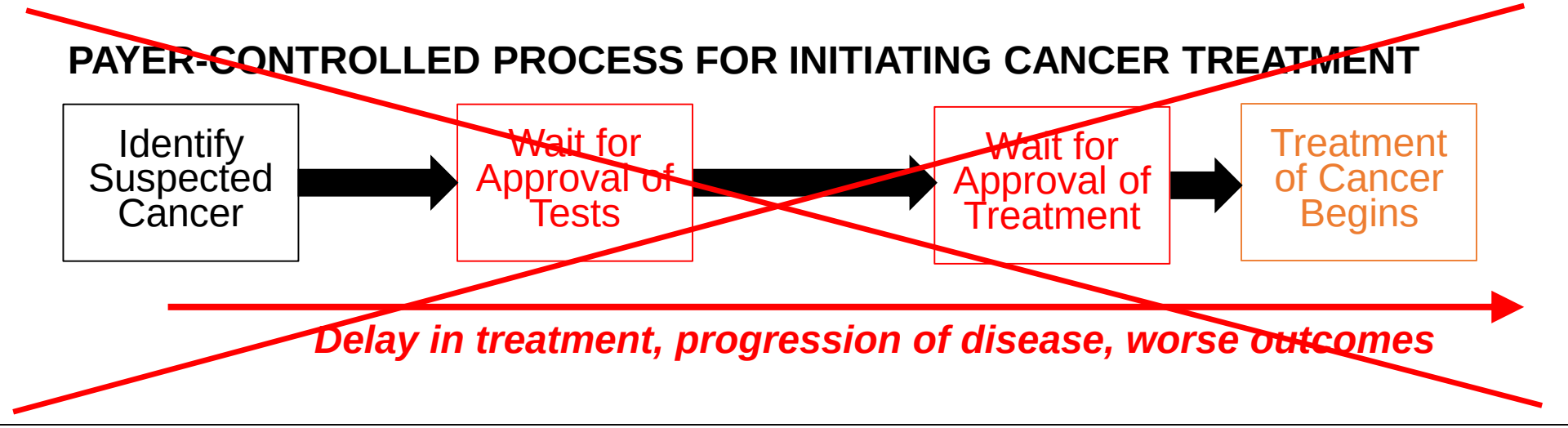
- Oncology Practice Accountable for Following Choosing Wisely and NCCN Guidelines

Instead of Delaying Treatment Waiting for Approval of Services…

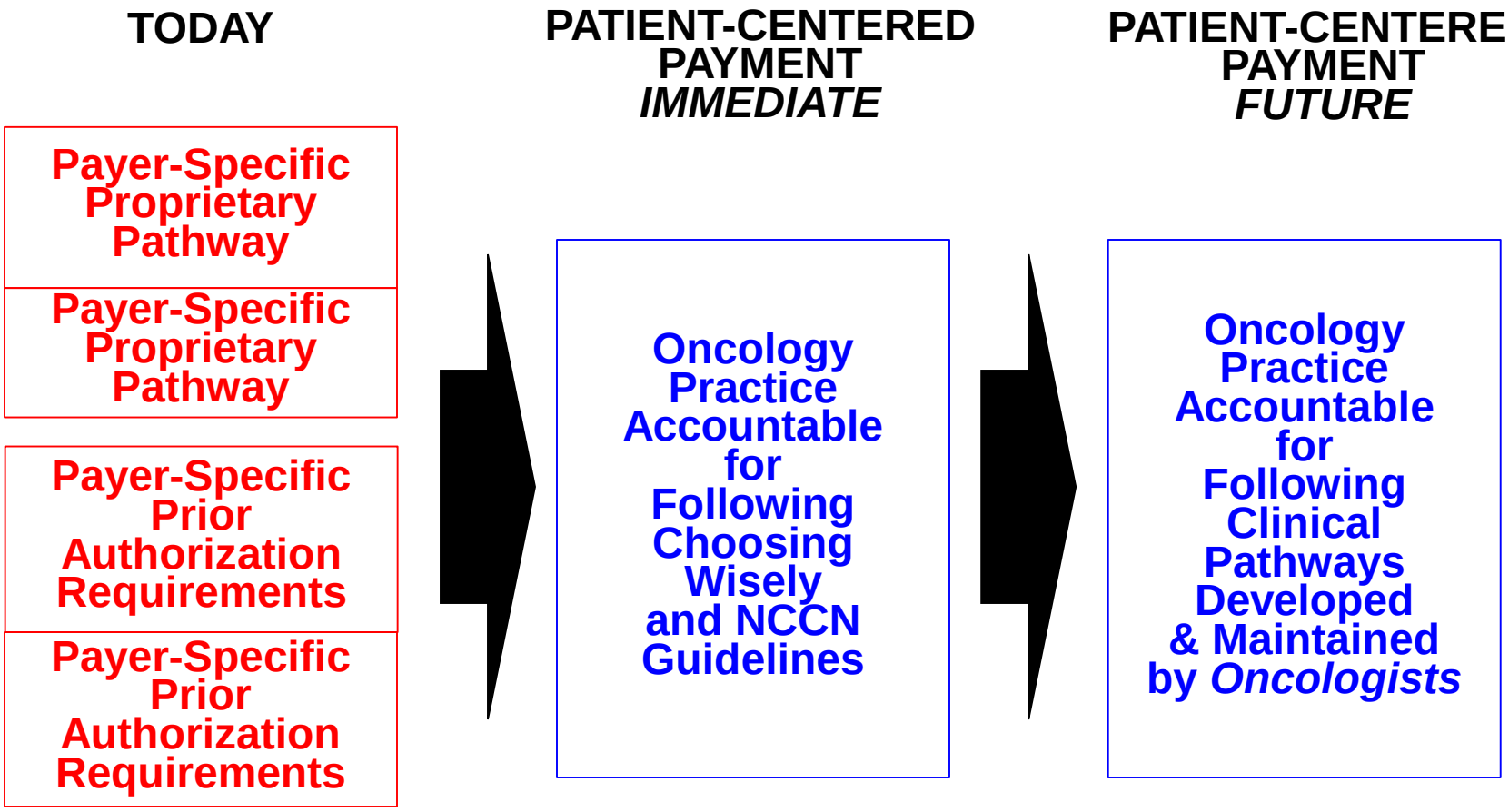
PAYER-CONTROLLED PROCESS FOR INITIATING CANCER TREATMENT



…Physician Accountability Enables Faster Treatment at Lower Cost

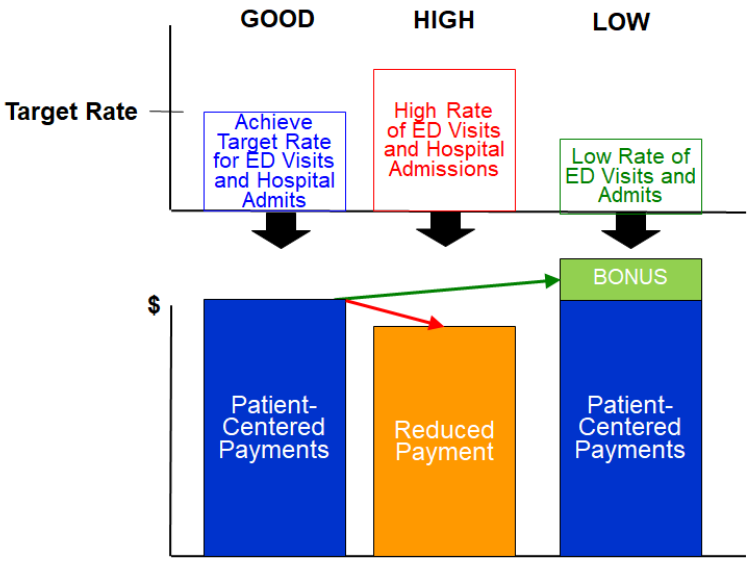


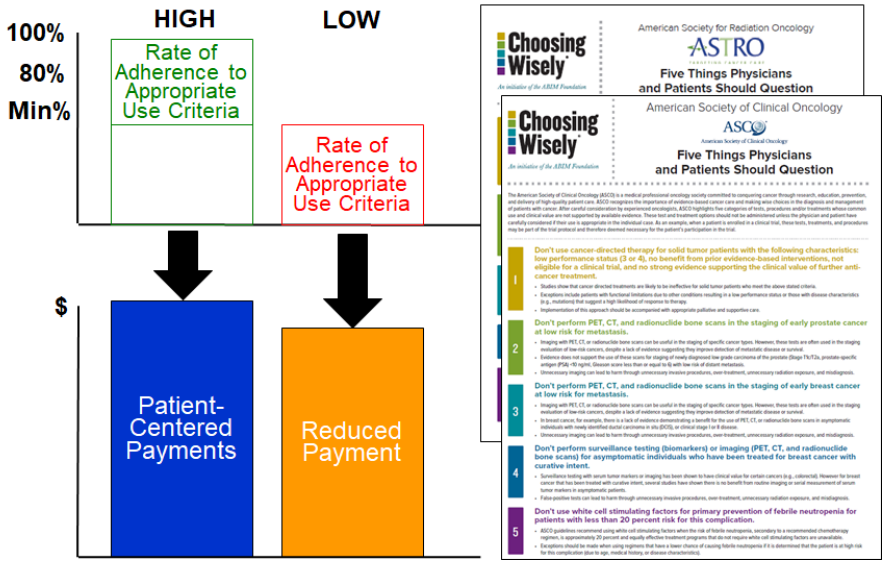
Oncologists Will Need to Define and Maintain Clinical Pathways



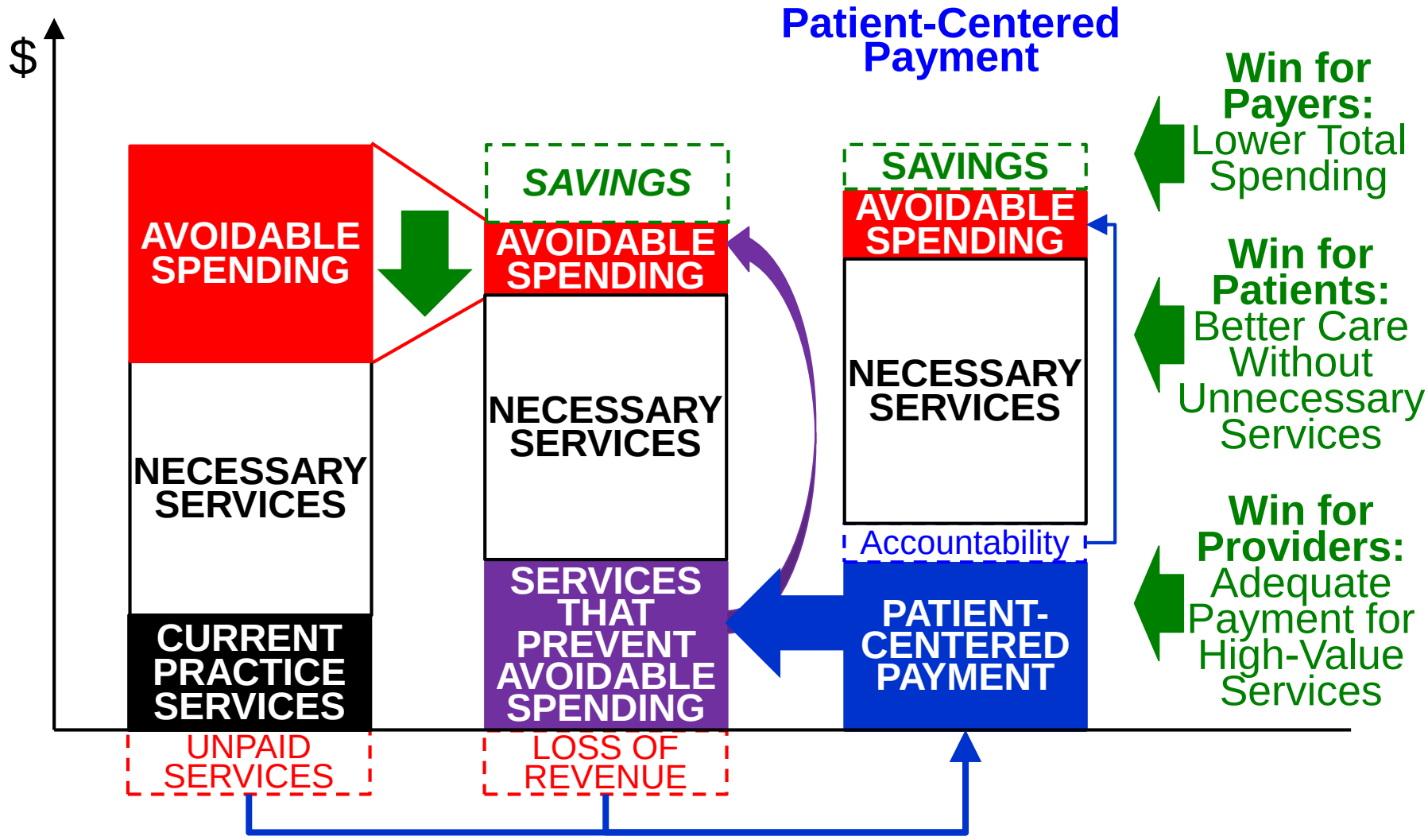
Payment is Tied to *Appropriate* Use & Outcomes, Not *Savings or Risk*

- Practices that are *already* performing efficiently and effectively receive payments that allow them to *maintain* that performance and *reduce their dependence on drug margins*
- Practices that are *not performing efficiently and effectively* have to improve performance in order to receive the payments – and they *achieve savings for purchasers* in the process





Patient-Centered Payment for Cancer Can Be a Win-Win-Win



Three Paths to the Future: Which Will Oncology Practices Choose?

VALUE-BASED PAYMENT

#1

#2

#3

Three Paths to the Future: Which Will Oncology Practices Choose?

VALUE-BASED PAYMENT

#1

FFS + P4P

- **Inadequate fees for practices**
- **Meaningless quality measures**
- **Burdensome prior authorization**
- **High costs for patients & payers**

#2

#3

Three Paths to the Future: Which Will Oncology Practices Choose?

VALUE-BASED PAYMENT

#1 FFS + P4P

- Inadequate fees for practices
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#2 PAYER-DEFINED APMs

- Inadequate payments for practices
- Risk for uncontrollable costs
- Problematic incentives to stint on care

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#3 PATIENT-CENTERED APM

- Adequate payments to address patient needs
- Accountability for aspects of cost & quality physicians can control

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

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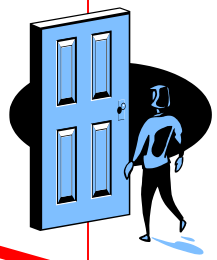

#2 PAYER-DEFINED APMs
- Inadequate payments for practices
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- Adequate payments to address patient needs
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If You Don’t Like Options 1 & 2, What Should You Do?

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

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2. Plan to retire in 2020

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

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~~2. Plan to retire in 2020~~

3. Take charge of value-based payment in oncology
   - Look at your own patient population, identify opportunities to reduce spending, and plan for care changes that would achieve savings if you can be paid the right way
   - Design a *patient-centered oncology payment model* that supports good care for patients & financial viability for practices
   - Take accountability for reducing avoidable spending
   - Demand that Medicare & health plans use *good* APMs
   - Refuse to participate in bad payer-designed APMs

Tell CMS What It *Should* Do Instead of Giving You "More Risk"

Public Listening Session: Potential Future Oncology Payment Model

Share

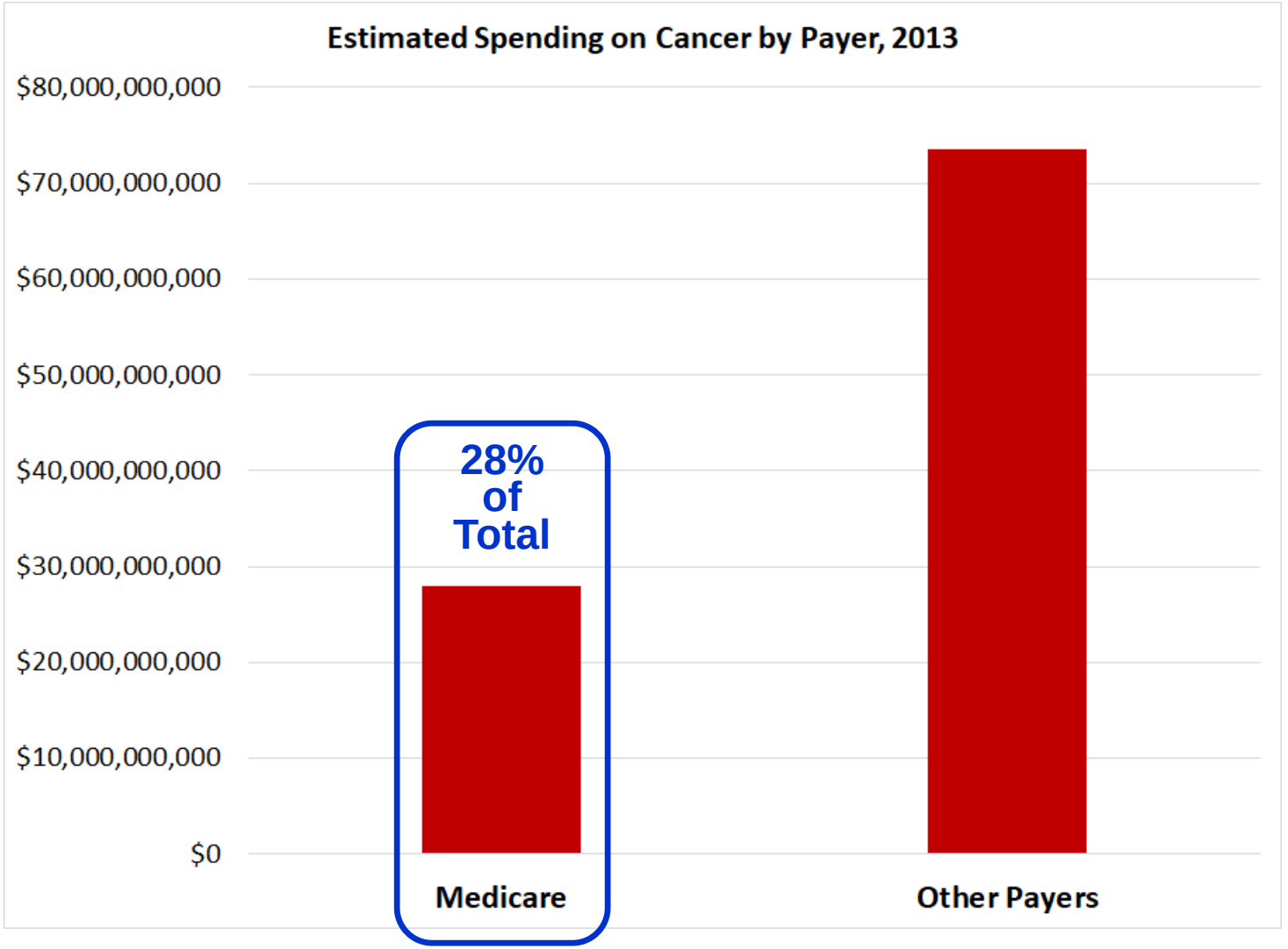
The Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (Innovation Center) is announcing a Public Listening Session to gather feedback on value-based payment to support high-quality oncology care. The Innovation Center intends to release additional materials before the November 4, 2019 Public Listening Session. The Innovation Center will make an announcement once the additional materials have been posted to the Innovation Center website.

We appreciate stakeholder support and engagement with the Innovation Center and the ongoing Oncology Care Model (OCM), and seek to continue to engage stakeholders as we develop a potential new payment and service delivery model that builds on OCM. To that end, the Innovation Center will hold a Public Listening Session to gather feedback on a potential future oncology payment model. The Innovation Center believes this public input will strengthen and enhance a potential future oncology payment model. CMS plans to release more information closer to the date of the Public Listening Session.

What:
Public Listening Session: Potential Future Oncology Payment Model

When:
Monday, November 4, 2019
1:00p.m. – 4:00p.m. EST

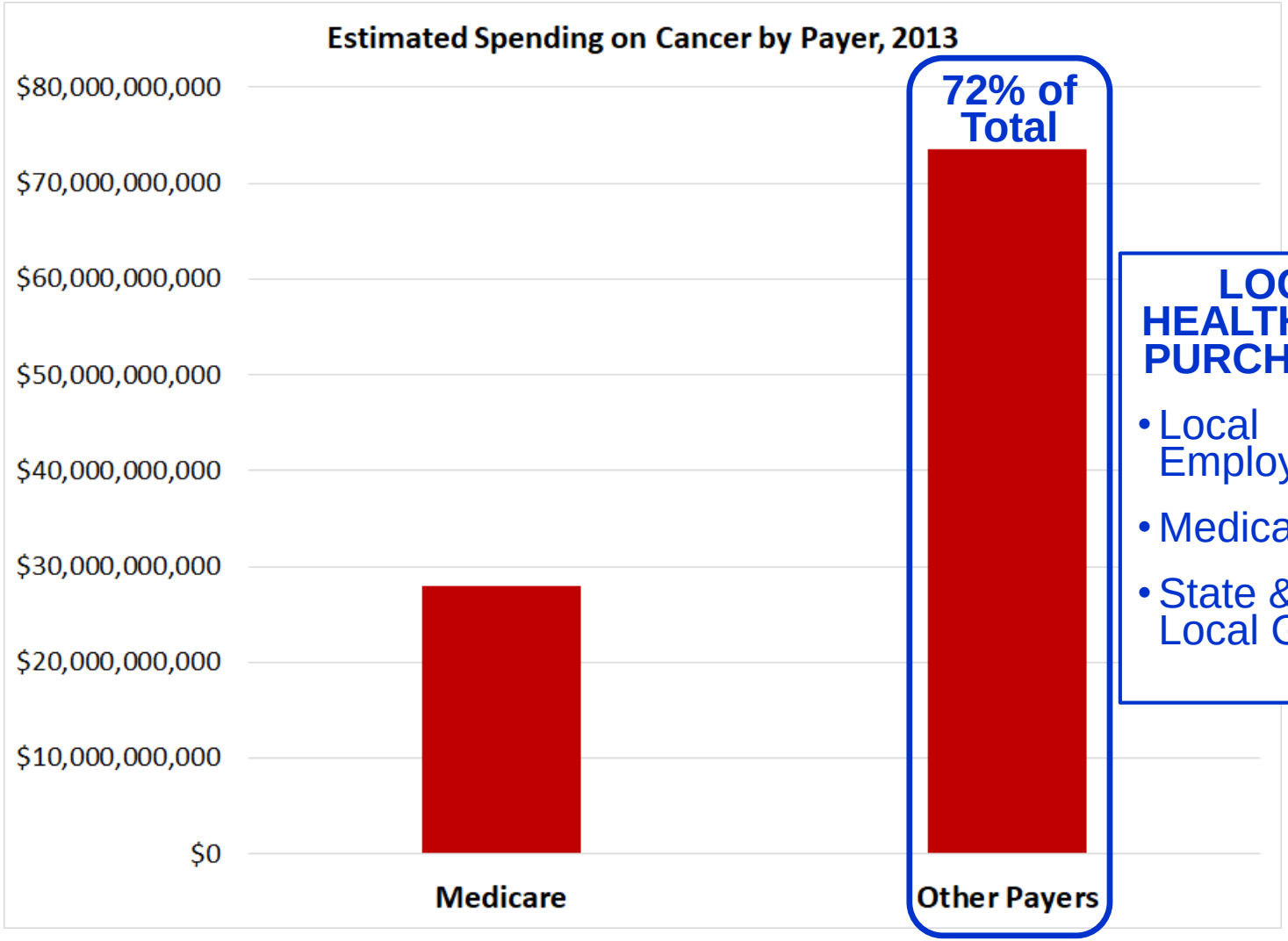
Why Should Medicare Dictate How Oncologists Are Paid?



SOURCES:
U.S. Bureau of Economic Analysis, Health Care Satellite Account, 2016 Data (Released Sept. 2019)

Ruiz ES et al, "National Cancer Expenditure Analysis in the United States Medicare Population, 2013," *Journal of Clinical Oncology* 37(15), May 2019

Patients & Purchasers in Your Community Want *Good* Cancer Care



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National Employers Are Fed Up With Current Approaches

THE WALL STREET JOURNAL.

Amazon Joins Trend of Sending Workers Away for Health Care

Employers pay staffers' expenses to travel to select hospitals and doctors, in bid to control costs

By Melanie Evans

Updated Oct. 15, 2019 12:06 pm ET

Employers are increasingly going the distance to control health spending, paying to send workers across the country to get medical care and bypassing local health-care providers.

One of the latest is Amazon.com Inc., AMZN 1.78% ▲ which will pay travel costs for workers diagnosed with cancer who choose to see doctors at City of Hope, a Los Angeles-area health system. More than 380,000 of the Seattle-based company's employees and families across the U.S. are eligible for the travel benefit.

Amazon now covers travel costs for staffers with cancer who see City of Hope doctors in the Los Angeles area. City of Hope employees review a patient case. PHOTO: CITY OF HOPE

Purchasers and Physicians Have Common Interests, But Don't Know It

"We've started talking directly to physicians,
and we've discovered that
what they want to *sell* is what we want to *buy*…"

Cheryl DeMars
CEO, The Alliance
(Employer Coalition in Wisconsin)

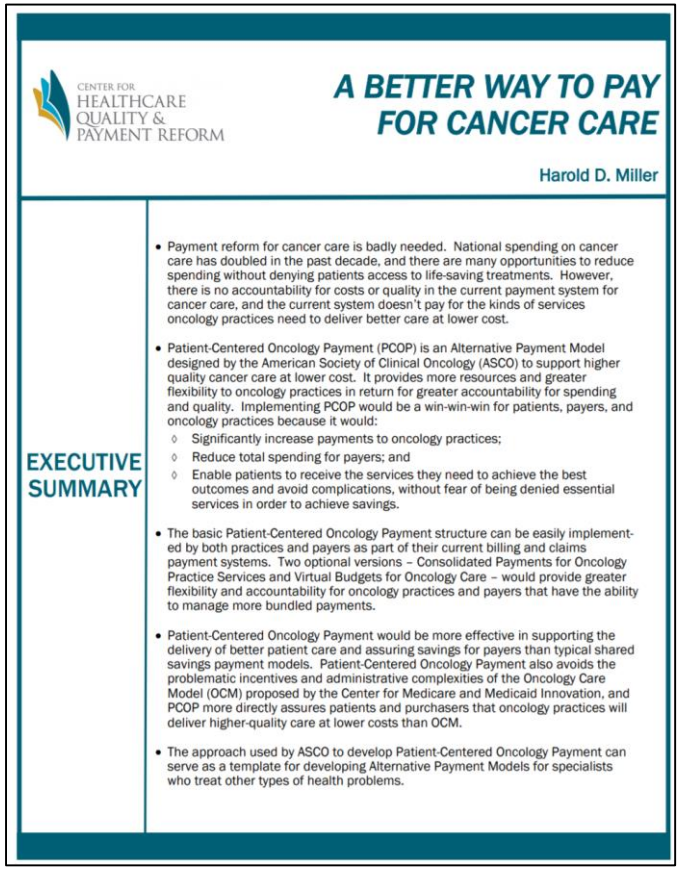
Take Back Control of Health Care!

Take charge of cost and quality in oncology

- Look at your own patient population, identify opportunities to reduce spending, and plan for care changes that would achieve savings if you can be paid the right way
- Design a *patient-centered oncology payment model* that supports good care for patients & financial viability for practices
- Take accountability for reducing avoidable spending
- Demand that Medicare & health plans use *good* APMs
- Refuse to participate in bad payer-designed APMs
- Develop provider-purchaser partnerships to develop win-win-win approaches to cancer care

More Details on How to Refine an Oncology APM

www.PaymentReform.org



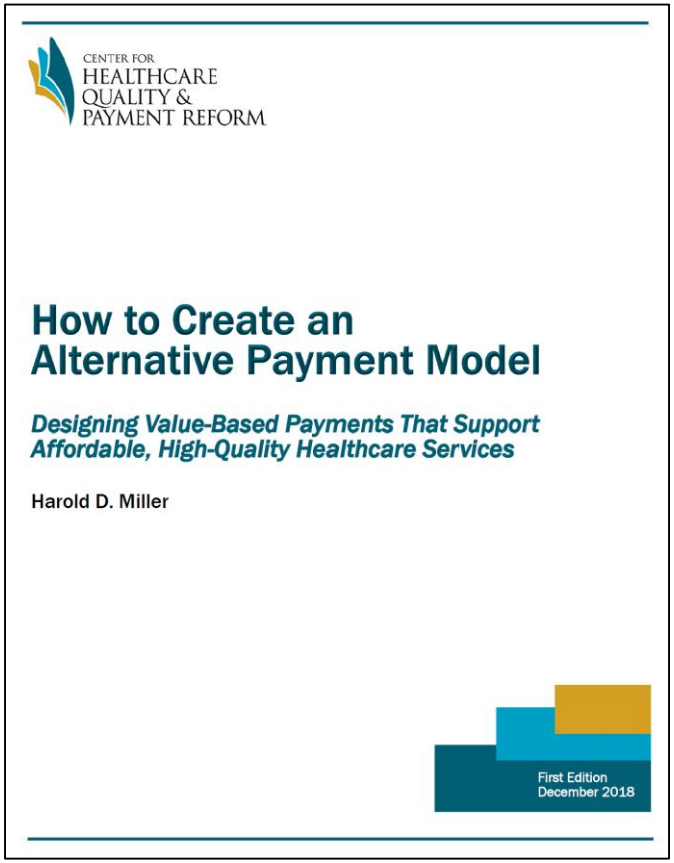
CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

A BETTER WAY TO PAY FOR CANCER CARE

Harold D. Miller

EXECUTIVE SUMMARY

- Payment reform for cancer care is badly needed. National spending on cancer care has doubled in the past decade, and there are many opportunities to reduce spending without denying patients access to life-saving treatments. However, there is no accountability for costs or quality in the current payment system for cancer care, and the current system doesn't pay for the kinds of services oncology practices need to deliver better care at lower cost.
- Patient-Centered Oncology Payment (PCOP) is an Alternative Payment Model designed by the American Society of Clinical Oncology (ASCO) to support higher quality cancer care at lower cost. It provides more resources and greater flexibility to oncology practices in return for greater accountability for spending and quality. Implementing PCOP would be a win-win-win for patients, payers, and oncology practices because it would:
  - Significantly increase payments to oncology practices;
  - Reduce total spending for payers; and
  - Enable patients to receive the services they need to achieve the best outcomes and avoid complications, without fear of being denied essential services in order to achieve savings.
- The basic Patient-Centered Oncology Payment structure can be easily implemented by both practices and payers as part of their current billing and claims payment systems. Two optional versions – Consolidated Payments for Oncology Practice Services and Virtual Budgets for Oncology Care – would provide greater flexibility and accountability for oncology practices and payers that have the ability to manage more bundled payments.
- Patient-Centered Oncology Payment would be more effective in supporting the delivery of better patient care and assuring savings for payers than typical shared savings payment models. Patient-Centered Oncology Payment also avoids the problematic incentives and administrative complexities of the Oncology Care Model (OCM) proposed by the Center for Medicare and Medicaid Innovation, and PCOP more directly assures patients and purchasers that oncology practices will deliver higher-quality care at lower costs than OCM.
- The approach used by ASCO to develop Patient-Centered Oncology Payment can serve as a template for developing Alternative Payment Models for specialists who treat other types of health problems.



CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

How to Create an Alternative Payment Model

Designing Value-Based Payments That Support Affordable, High-Quality Healthcare Services

Harold D. Miller

First Edition
December 2018

Today's Slides Are Available Here

www.PaymentReform.org

For More Information:

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