Managing Cost and Quality
Oncology Payment Reform
The MACRA Accelerator

The Arizona Clinical Oncology Society
November 13, 2015

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Senior Director Clinical Affairs
American Society of Clinical Oncology
ASCO’s Clinical Affairs Department

*Helping practices survive and thrive…today AND in the future*

- Approved by the Board in 2014 to provide direct support and services to oncology practices
- In response to
  - Rapid escalation in scope of issues
  - Increasingly volatile practice environment
    - Economic pressures
    - Consolidations, mergers
    - Focus on value
    - Shifting care models
    - Growing administrative burden
Financial Disclosure

I have not had any relevant financial relations during the past 12 months to disclose.
Off-Label Use Disclosure(s)

I do not intend to discuss an off-label use of a product during this activity.
Clinical Affairs Department

• Hands on help
  – Practice efficiency
  – Staffing models/work flow
  – Quality reporting/QI projects
  – Learning networks
  – Template contracts/agreements

• Information and analysis
  – Practice trends
  – Economic analysis
  – Performance measurement
  – Payment reform
Initiatives

• PracticeNet
• Clinical Affairs Data Workshop
• Consulting services
• Practice Administrators Network
• Payment reform: Patient-Centered Oncology Payment (PCOP)
• Practice Division
• A rapid learning network for oncology practice knowledge – benchmarking, standards and best practices
  – Initial focus on administrative, operational, financial and quality improvement activities
• Peer to peer interactive collaboration for knowledge sharing
• Quarterly benchmarks produced by practice and by physician, compared against a national database of similar practices
  – Segmentation across types of practices, cohorts of physicians
• Annual “state of your practice” assessment for key production and cost measurements
• Easy data submission – No Personal Health Information
• Data elements from practice management system
  – Provider NPI
  – Number of units for each service provided (by HCPS code)
  – Date of service
  – Place of service
  – Total revenue by service
• Supplemented with survey data
  – Practice expenses, staffing information; other data will be added as requested by PracticeNET participants
Networking opportunities
  – Peer to peer meetings
    • Optional, not required
    • Agenda driven by practice needs
    • First meeting, spring 2016
  – Moderated listserv

Enrollment is open!
  – First practices have enrolled and are submitting data
  – For more information…. Elaine.towle@asco.org or PracticNET@asco.org
Sample report
ABC Cancer Center
Any town, AZ

September, 2015
How busy are your physicians?

NOTE: This is sample data for illustrative purposes only.
How busy is your infusion center?

NOTE: This is sample data for illustrative purposes only.
Clinical Practice Data Workshop

• A new data resource to support the work of Clinical Affairs, Policy & Advocacy, and other ASCO departments and initiatives
Medicare Public Use Files (PUF)

Data workshop includes

- Publicly available data from CMS
  - Medicare provider Utilization and Payment Data: Physician and Other Supplier Public Use File (PUF), CY 2012 and 2013
  - Medicare Provider Utilization and Payment Data: Part D Prescriber for CY2013
  - Physician Compare

- The Medicare PUF includes utilization, payment (allowed amount and Medicare payment) and submitted charges organized by National Provider Identifier (NPI), Healthcare Common Procedure Coding System (HCPCS) code, and place of service
- Now available for calendar years 2012 and 2013
- Contains 100% final-action physician/supplier Part B non-institutional line items for the Medicare fee-for-service population
Why?

• Because these data are public, complete, and very detailed.
• Others will misunderstand and/or misrepresent “conclusions” that are reached and preached from these data.
• This gives you the opportunity to see how you compare to the population of oncologists.
Clinical Affairs Data Workshop

- We have added work relative value units (wRVU) to the PUF files
  - The “ASCO PUF”
- Also adding data from practices participating in PracticeNET
- Additional information will be added as available: survey data; data from analytical work performed by ASCO when such use is authorized
- Data aggregation processes allow analysis across disparate data sources and analysis is necessary to get meaning from any data… big or small
Physician Services, Medicare Only
Consulting Services

• Practice infrastructure
• Strategic planning
• Payment reform preparation and implementation
• Clinical trial site infrastructure development
Practice Administrators Network

• Important part of the team
  – Important to your practice and important to ASCO

• Encouraging practice administrator involvement in ASCO activities
  – Membership is available – Affiliated Member
  – Expanded membership benefits coming soon

• Practice Administrators Workgroup (CPC)
  – Plans for significant expansion
Oncology Payment Reform

• Rationale
• MACRA Effect
• ASCO Payment Reform Initiative
• Patient Centered Oncology Payment Model
• PCOP Implementation
Cancer Costs Skyrocketing

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

- 2004
- 2010
- 2020 Projected
Most Oncology Spending Does Not Go to the Oncology Practice

90%+ of spending pays for drugs, laboratory tests, imaging studies, surgical procedures, emergency room visits, and hospitalizations.

Fees for oncology practice services represent less than 10% of spending for cancer patients during episodes of chemotherapy treatment.

Analysis of total spending in 2012 for commercially insured patients during an “episode” of chemotherapy treatment (treatment months through the second month after treatment ends)
Most Oncology Drug Spending is Driven By a Few Expensive Drugs

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
<th>Unit Cost</th>
<th>Pre-AUTH</th>
<th>Total Spending</th>
<th>Cumulative</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>INJECTION, BEVACIZUMAB, 10 MG</td>
<td>$5,074</td>
<td>Y</td>
<td>$5,728,632</td>
<td>17%</td>
</tr>
<tr>
<td>2</td>
<td>INJECTION, PEGFILGRASTIM, 6 MG</td>
<td>$3,708</td>
<td>Y</td>
<td>$4,971,854</td>
<td>14%</td>
</tr>
<tr>
<td>3</td>
<td>INJECTION, OXALIPLATIN, 0.5 MG</td>
<td>$4,527</td>
<td></td>
<td>$4,467,799</td>
<td>13%</td>
</tr>
<tr>
<td>4</td>
<td>INJECTION, TRASTUZUMAB, 10 MG</td>
<td>$2,999</td>
<td>Y</td>
<td>$4,000,865</td>
<td>12%</td>
</tr>
<tr>
<td>5</td>
<td>INJECTION, PEMETREXED, 10 MG</td>
<td>$4,781</td>
<td>Y</td>
<td>$2,576,902</td>
<td>7%</td>
</tr>
<tr>
<td>6</td>
<td>INJECTION, DOCETAXEL, 1 MG</td>
<td>$2,979</td>
<td></td>
<td>$1,673,928</td>
<td>5%</td>
</tr>
<tr>
<td>7</td>
<td>INJECTION, PALONOSTROON HCL, 25</td>
<td>$319</td>
<td></td>
<td>$1,074,060</td>
<td>3%</td>
</tr>
<tr>
<td>8</td>
<td>INJECTION, LEVOLEUCOVORIN</td>
<td>$1,769</td>
<td></td>
<td>$815,550</td>
<td>2%</td>
</tr>
<tr>
<td>9</td>
<td>INJECTION, CETUXIMAB, 10 MG</td>
<td>$3,757</td>
<td>Y</td>
<td>$807,772</td>
<td>2%</td>
</tr>
<tr>
<td>10</td>
<td>INJECTION, FULVETRANT, 25 MG</td>
<td>$1,518</td>
<td></td>
<td>$759,090</td>
<td>2%</td>
</tr>
<tr>
<td>11</td>
<td>INJECTION, PACITAXEL, 30 MG</td>
<td>$582</td>
<td></td>
<td>$667,329</td>
<td>2%</td>
</tr>
<tr>
<td>12</td>
<td>INJECTION, PACITAXEL PROTEIN-</td>
<td>$2,725</td>
<td>Y</td>
<td>$659,403</td>
<td>2%</td>
</tr>
<tr>
<td>163</td>
<td>ALL DRUGS</td>
<td>$739</td>
<td></td>
<td>$34,661,727</td>
<td>100%</td>
</tr>
</tbody>
</table>

Significant savings possible through more appropriate use
Reductions in 3 Potentially Overused Drugs Creates Significant Overall Savings

### Commercial Spending on Oncology Drugs Under Medical Benefits for Breast, Colon and Lung Cancer Patients in Maine, 2012

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Pre-Authorization</th>
<th>Unit Cost</th>
<th>Anthem</th>
<th>Total Spending</th>
<th>Cumulative</th>
<th>Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 J9035 INJECTION, BEVACIZUMAB, 10 MG</td>
<td>$5,074</td>
<td>Y</td>
<td>$5,728,632</td>
<td>17%</td>
<td>$5,728,632</td>
<td>17%</td>
</tr>
<tr>
<td>2 J2505 INJECTION, PEGFILGRASTIM, 6 MG</td>
<td>$3,708</td>
<td>Y</td>
<td>$4,971,854</td>
<td>14%</td>
<td>$10,700,486</td>
<td>31%</td>
</tr>
<tr>
<td>3 J9263 INJECTION, OXALIPLATIN, 0.5 MG</td>
<td>$4,527</td>
<td></td>
<td>$4,467,799</td>
<td>13%</td>
<td>$15,168,285</td>
<td>44%</td>
</tr>
<tr>
<td>4 J9355 INJECTION, TRASTUZUMAB, 10 MG</td>
<td>$2,999</td>
<td>Y</td>
<td>$4,000,865</td>
<td>12%</td>
<td>$19,169,149</td>
<td>55%</td>
</tr>
<tr>
<td>5 J9305 INJECTION, Pemetrexed, 10 MG</td>
<td>$4,781</td>
<td>Y</td>
<td>$2,576,902</td>
<td>7%</td>
<td>$21,746,052</td>
<td>63%</td>
</tr>
<tr>
<td>6 J9171 INJECTION, DOCETAXEL, 1 MG</td>
<td>$2,979</td>
<td></td>
<td>$1,673,928</td>
<td>5%</td>
<td>$23,419,580</td>
<td>68%</td>
</tr>
<tr>
<td>7 J2469 INJECTION, PALONOSETRON HCL, 25</td>
<td>$319</td>
<td></td>
<td>$1,074,060</td>
<td>3%</td>
<td>$24,494,040</td>
<td>71%</td>
</tr>
<tr>
<td>8 J0641 INJECTION, LEVOSULFURRON</td>
<td>$1,769</td>
<td></td>
<td>$815,550</td>
<td>2%</td>
<td>$25,309,590</td>
<td>73%</td>
</tr>
<tr>
<td>9 J9055 INJECTION, CETUXIMAB, 10 MG</td>
<td>$3,757</td>
<td>Y</td>
<td>$807,772</td>
<td>2%</td>
<td>$26,117,362</td>
<td>75%</td>
</tr>
<tr>
<td>10 J9395 INJECTION, FULVESTRANT, 25 MG</td>
<td>$1,518</td>
<td></td>
<td>$759,090</td>
<td>2%</td>
<td>$26,876,452</td>
<td>78%</td>
</tr>
<tr>
<td>11 J9265 INJECTION, PACLITAXEL, 30 MG</td>
<td>$582</td>
<td></td>
<td>$667,329</td>
<td>2%</td>
<td>$27,543,781</td>
<td>79%</td>
</tr>
<tr>
<td>12 J9264 INJECTION, PACLITAXEL PROTEIN-</td>
<td>$2,725</td>
<td>Y</td>
<td>$659,403</td>
<td>2%</td>
<td>$28,203,184</td>
<td>81%</td>
</tr>
<tr>
<td>163 ALL OTHERS</td>
<td>$164</td>
<td></td>
<td>$6,458,543</td>
<td>19%</td>
<td>$34,661,727</td>
<td>100%</td>
</tr>
<tr>
<td>163 ALL DRUGS</td>
<td>$739</td>
<td></td>
<td>$34,661,727</td>
<td>100%</td>
<td>$34,661,727</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: ASCO
Most Imaging Costs Result From a Few Types of Imaging Studies

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Unit Cost</th>
<th>Total</th>
<th>Cumulative</th>
<th>Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITH CONTRAST MATERIAL(S)</td>
<td>$832</td>
<td>$885,890</td>
<td>25%</td>
<td>$885,890</td>
</tr>
<tr>
<td>2</td>
<td>COMPUTED TOMOGRAPHY, THORAX; WITH CONTRAST MATERIAL(S)</td>
<td>$435</td>
<td>$629,953</td>
<td>19%</td>
<td>$1,515,853</td>
</tr>
<tr>
<td>3</td>
<td>MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM);</td>
<td>$926</td>
<td>$291,814</td>
<td>9%</td>
<td>$1,807,667</td>
</tr>
<tr>
<td>4</td>
<td>COMPUTED TOMOGRAPHY GUIDANCE FOR PLACEMENT OF RADIATION THERAPY FIELDS</td>
<td>$434</td>
<td>$142,890</td>
<td>4%</td>
<td>$1,950,527</td>
</tr>
<tr>
<td>5</td>
<td>MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND/OR WITH CONTRAST</td>
<td>$1,381</td>
<td>$139,482</td>
<td>4%</td>
<td>$2,090,009</td>
</tr>
<tr>
<td>6</td>
<td>UNLISTED DIAGNOSTIC RADIOGRAPHIC PROCEDURE</td>
<td>$784</td>
<td>$125,381</td>
<td>4%</td>
<td>$2,215,390</td>
</tr>
<tr>
<td>7</td>
<td>ULTRASONIC GUIDANCE FOR NEEDLE PLACEMENT (EG, BIOPSY, ASPIRATION, INJECTION,</td>
<td>$210</td>
<td>$85,245</td>
<td>3%</td>
<td>$2,300,635</td>
</tr>
<tr>
<td>8</td>
<td>FLUOROSCOPIC GUIDANCE FOR CENTRAL VENOUS ACCESS DEVICE PLACEMENT,</td>
<td>$172</td>
<td>$73,059</td>
<td>2%</td>
<td>$2,373,694</td>
</tr>
<tr>
<td>9</td>
<td>COMPUTED TOMOGRAPHY, HEAD OR BRAIN; WITH CONTRAST MATERIAL(S)</td>
<td>$593</td>
<td>$70,606</td>
<td>2%</td>
<td>$2,444,300</td>
</tr>
<tr>
<td>10</td>
<td>MAGNETIC RESONANCE (EG, PROTON) IMAGING, ABDOMEN; WITHOUT CONTRAST</td>
<td>$1,496</td>
<td>$67,326</td>
<td>2%</td>
<td>$2,511,626</td>
</tr>
<tr>
<td>11</td>
<td>COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL IN</td>
<td>$1,181</td>
<td>$49,616</td>
<td>1%</td>
<td>$2,561,242</td>
</tr>
<tr>
<td>ALL OTHER</td>
<td></td>
<td>$159</td>
<td>$810,032</td>
<td>24%</td>
<td>$3,371,274</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$353</td>
<td>$3,371,274</td>
<td>100%</td>
<td>-$136,300</td>
</tr>
</tbody>
</table>
Most Testing Costs Result from a Few Frequent or High Cost Tests

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Unit Cost</th>
<th>Spending</th>
<th>Cumulative</th>
<th>Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>80053</td>
<td>COMPREHENSIVE METABOLIC PANEL</td>
<td>$62</td>
<td>$298,105</td>
<td>15%</td>
<td>$298,105</td>
</tr>
<tr>
<td>88307</td>
<td>LEVEL V - SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC</td>
<td>$358</td>
<td>$275,027</td>
<td>14%</td>
<td>$573,132</td>
</tr>
<tr>
<td>88342</td>
<td>IMMUNOHISTOCHEMISTRY (INCLUDING TISSUE)</td>
<td>$353</td>
<td>$230,701</td>
<td>11%</td>
<td>$803,833</td>
</tr>
<tr>
<td>85025</td>
<td>BLOOD COUNT; COMPLETE (CBC), AUTOMATED (HGB, HCT, RBC, WBC)</td>
<td>$37</td>
<td>$200,392</td>
<td>10%</td>
<td>$1,004,225</td>
</tr>
<tr>
<td>88305</td>
<td>LEVEL IV - SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC</td>
<td>$182</td>
<td>$121,449</td>
<td>6%</td>
<td>$1,125,674</td>
</tr>
<tr>
<td>88360</td>
<td>MORPHOMETRIC ANALYSIS, TUMOR IMMUNOHISTOCHEMISTRY (EG,</td>
<td>$249</td>
<td>$105,612</td>
<td>5%</td>
<td>$1,231,285</td>
</tr>
<tr>
<td>81211</td>
<td>BRCA1, BRCA2 (BRCA CANCER 1 AND 2) (EG, HEREDITARY BREAST)</td>
<td>$2,980</td>
<td>$65,563</td>
<td>3%</td>
<td>$1,296,848</td>
</tr>
<tr>
<td>82378</td>
<td>CARCINOEMBRYONIC ANTIGEN (CEA)</td>
<td>$76</td>
<td>$56,824</td>
<td>3%</td>
<td>$1,353,672</td>
</tr>
<tr>
<td></td>
<td>ALL OTHERS</td>
<td>$66</td>
<td>$661,189</td>
<td>33%</td>
<td>$2,014,861</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$2,014,861</td>
<td>100%</td>
<td>-67,684 $ 3%</td>
</tr>
</tbody>
</table>
25%+ of Admissions Are Likely Complications of Treatment

<table>
<thead>
<tr>
<th>Diagnosis Group</th>
<th>Admits</th>
<th>Diagnosis</th>
<th>Admits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neoplasms</td>
<td>111</td>
<td>32%</td>
<td></td>
</tr>
<tr>
<td>Diseases of the Digestive System</td>
<td>35</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Diseases of the Respiratory System</td>
<td>30</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Diseases of the Circulatory System</td>
<td>80</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Diseases of Blood and Blood-Forming Organs</td>
<td>29</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Injury and Poisoning</td>
<td>22</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>Symptoms, Signs and Ill-Defined Conditions</td>
<td>21</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>V-Codes</td>
<td>18</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Diseases of Nervous System and Sense Organs</td>
<td>14</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>Endocrine, Nutrition and Metabolic Disorders, and Immuni</td>
<td>14</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>Diseases of the Genitourinary System</td>
<td>9</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Diseases of the Musculoskeletal System</td>
<td>5</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Mental, Behavioral, and Neurodevelopmental Disorders</td>
<td>3</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Diseases of the Skin and Subcutaneous Tissue</td>
<td>3</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Infectious and Parasitic Diseases</td>
<td>2</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Congenital Abnormalities</td>
<td>1</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Complications of Pregnancy and Childbirth</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Conditions Originating in the Perinatal Period</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>347</strong></td>
<td><strong>100%</strong></td>
<td><strong>27%</strong></td>
</tr>
</tbody>
</table>

Hospital Admissions for Breast, Colon, and Lung Cancer Patients During and Immediately Following Oncology Treatment in Maine, 2012
Large Reductions in Avoidable Hospitalizations Are Possible

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

FIGURE 3  Average emergency room (ER) evaluations at Delaware County Memorial Hospital of the Drexel Hill office population per chemotherapy patient per year, 2004–2010 (YTD).
Spending on Drugs, Imaging, and Hospitals Varies by More Than 60%

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
## Savings From Better Care

### Costs and Savings from Improved Payment for Oncology Care

Based on 2012 Average Part A & B Spending During Chemotherapy Treatment for Medicare Beneficiaries with Breast, Colon, or Lung Cancer

<table>
<thead>
<tr>
<th></th>
<th>Current Average Spending Per Beneficiary</th>
<th>With Proposed New Payments and Estimated Savings</th>
<th>% Change</th>
<th>$ Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>During and 2 Months After Treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy/Drugs</td>
<td>$25,131</td>
<td>$23,372</td>
<td>-7%</td>
<td></td>
</tr>
<tr>
<td>Lab Tests</td>
<td>$583</td>
<td>$553</td>
<td>-5%</td>
<td></td>
</tr>
<tr>
<td>Imaging</td>
<td>$1,503</td>
<td>$1,428</td>
<td>-5%</td>
<td></td>
</tr>
<tr>
<td>ED/Ambulance</td>
<td>$421</td>
<td>$295</td>
<td>-30%</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>$7,100</td>
<td>$4,970</td>
<td>-30%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>$10,920</td>
<td>$10,920</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>$45,657</td>
<td>$41,538</td>
<td>-9%</td>
<td>($4,120)</td>
</tr>
</tbody>
</table>
A New Acronym

Medicare Access and CHIP Reauthorization Act
SGR is Repealed and Replaced with MACRA

...Creates two tracks for providers

Alternative Payment Models

Merit-Based Incentive Payment System
Merit-Based Incentive Payment System (MIPS)

Meaningful Use (MU)

Physician Quality Reporting System (PQRS)

Value Based Modifier (VBM)
MIPS: General Structure

- Excludes physicians in alternative payment model
- Starts 2019—based on 2017 performance
- Penalties/bonuses budget neutral, so bonus size dependent on how many people get penalties
- Scores will be reported publically in Physician Compare
- “Exceptional” practices could win extra 10% bonus funded with $500m in new money
MIPS Potential Impact

Resource Use

Quality Reporting

EHR MU

Clinical Improvement Activities

Composite Score 1-100

Threshold

High Performers +27%

Flat

Low Performers -9%
This is NOT in the distant future

- HHS required to publish final plan for MIPS and APM measure development by **May 1, 2016**
- First list of measures to be published Nov 1, 2016
- HHS may contract with physician organizations to develop measures
What is An Alternative Payment Model (APM)?

- Comprises “significant” share of provider revenue
  - 25% 2019-2020
  - 50% 2021-2022
  - 75% 2023 and on

- Carries two-sided risk

- Includes financial incentives (e.g., bonus, shared savings)

- Includes quality measurement

Stay Tuned...Implementing Rules Still to be Written
"...moving away from the old way of doing things, which amounted to 'the more you do, the more you get paid.'"

Sylvia M. Burwell
HHS Secretary
MACRA Bottom Line

• Strong incentives to participate in APMs

• Consolidated quality reporting incentivizes participation in qualified clinical data registries

• Will motivate practice transformation/infrastructure

• Implementing rules will be critical, e.g.,
  – Defining and assigning risk
  – Determining appropriate quality measures
ASCO’s Efforts to Respond to Payment Reform

• Promoting Adherence to Evidence-Based Medicine:
  – ASCO Guidelines
  – “Choosing Wisely” Campaign
  – Clinically Meaningful Outcomes in Cancer Research

• Commitment to Quality Improvement:
  – Quality Oncology Practice Initiative and Training Program
  – Virtual Learning Collaborative to Improve Palliative Care
  – Cultivating a learning healthcare system: CancerLinQ

• Supporting Value Purchasing and Considerations:
  – Developing tools to support physician-patient value discussion
  – Payment Reform Model
The ASCO Payment Reform Premise

- Oncology Costs are a large and growing percentage of healthcare spending
- Oncologists can be part of the solution
- There are proven methods to reduce oncology costs and promote quality of care
- Requires practice transformation and resources
- MACRA legislation promotes Advanced Payment Models
- The ASCO Patient Centered Oncology Payment model facilitates enhanced patient care coordination, quality of care, and leads to reduced costs
ASCO Payment Reform Workgroup Members

- Anupama Acheson, MD*
- Jeffery Ward, MD*
- Robin Zon, MD, FACP, FASCO*
- Andrew Hertler, MD, FACP
- Blasé Polite, MD, MPH
- Christian A. Thomas, MD
- Dan Zuckerman, MD
- Denis Hammond, MD
- Ed Balaban DO, FACP, FASCO
- James Frame, MD, FACP
- Joel Saltzman, MD
- John Cox, DO, FACP, FASCO
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- Michael Diaz, MD
- Omar Eton, MD
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- Roscoe Morton, MD, FACP*
- W. Charles Penley, MD, FASCO
- Kavita Patel, MD, MS
- Harold Miller
- Don Moran/Kevin Kirby
- Deborah Kamin, PhD

  Providence Oncology and Hematology Care Clinic
  Swedish Cancer Institute Edmonds, WA
  Michiana Hematology Oncology
  New Century Health
  The University of Chicago – Oncology
  New England Cancer Specialists
  Mountain States Tumor Institute
  New Hampshire
  Penn State Hershey Medical Center
  Charleston Area Medical Center
  Lake Health University Hospital Seidman Cancer Center
  UTSW Parkland
  Sarah Cannon Cancer Services
  Florida Cancer Specialists
  Boston University Medical Center
  Center for Cancer and Blood Disorders – Texas
  The University of Chicago
  Medical Oncology and Hematology Association
  Tennessee Oncology
  Brookings
  Center for Healthcare Quality and Payment Reform
  The Moran Company
  ASCO
ASCO’s Approach to Oncology Payment Reform

Oncologists Identify What’s Needed for High-Value Cancer Care

Design Changes In Payment to Support Patient-Centered Care

Better Care, Lower Spending, Practices Stay Financially Viable
The Transformation of Oncology Payment

www.asco.org/paymentreform
ASCO Model

Patient-Centered Oncology Payment
Payment Reform to Support Higher Quality, More Affordable Cancer Care

- 3 options with transition away from fee-for-service
  - Add new codes to existing E&M codes to cover cost of services
  - Replace E&M codes with monthly payment codes that provide flexibility in how care is delivered
  - Bundled monthly payments that include both oncology practice costs and other costs such as tests, hospitalizations and/or drugs

- Episode of chemotherapy (IV or oral)
- Accountability in all three options… but for things oncologists can control
Opportunities to Reduce Spending During an Episode of Chemotherapy

Current Spending Per Patient

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

- **ER/Hospital Admissions**
  - ED visits and hospital admissions for chemotherapy-related complications
- **Other Services**
- **Testing**
  - Unnecessary tests
  - Unnecessary testing
- **Avoidable $**
  - Unnecessarily expensive drugs
  - Unnecessary drugs
  - Unnecessary end-of-life treatment
- **Drugs**
- **E&M Infusions**
Payments Do Not Match Activity

Diagnosis, Choosing Therapy, Counseling
Therapy & Preventing Complications
Monitoring & Support

PHYSICIAN/STAFF
TIME/COSTS FOR
CANCER CARE

HOW ONCOLOGY
PRACTICE IS PAID
Payment for care management, triage, and rapid response to complications leads to lower use of Emergency Rooms and fewer hospital admissions.
Pay to Support Value-Based Treatment

- Avoidable payments for services delivered by non-physicians and non-face-to-face services improve drug and test utilization and improve end of life care.
PCOP Episode of Chemotherapy (IV or Oral)

Additional One-Time Payment for Each New Patient

Monthly Care Management Payments During Treatment Months

PATIENT-CENTERED ONCOLOGY PAYMENT (PCOP)

Care Management Payments During Active Monitoring Months Up to 6 Months After End of Treatment

<table>
<thead>
<tr>
<th>Treatment Months</th>
<th>Care Management Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>E&amp;M</td>
</tr>
<tr>
<td>2</td>
<td>Care Mgt</td>
</tr>
<tr>
<td>3</td>
<td>Care Mgt</td>
</tr>
<tr>
<td>4</td>
<td>Care Mgt</td>
</tr>
<tr>
<td>5</td>
<td>Care Mgt</td>
</tr>
<tr>
<td>6</td>
<td>Care Mgt</td>
</tr>
<tr>
<td>7</td>
<td>Care Mgt</td>
</tr>
<tr>
<td>8</td>
<td>Care Mgt</td>
</tr>
<tr>
<td>9</td>
<td>Care Mgt</td>
</tr>
<tr>
<td>10</td>
<td>Care Mgt</td>
</tr>
<tr>
<td>11</td>
<td>Care Mgt</td>
</tr>
<tr>
<td>12</td>
<td>Care Mgt</td>
</tr>
<tr>
<td>13</td>
<td>Care Mgt</td>
</tr>
<tr>
<td>14</td>
<td>Care Mgt</td>
</tr>
<tr>
<td>15</td>
<td>E&amp;M</td>
</tr>
</tbody>
</table>
Large Reductions in ED Visits Are Possible

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

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

COME HOME

• Medical Home model, 7 practices nationwide
• Significant reductions in hospital/ED use
Savings from 3 Drugs Has Significant Impact

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Injection, Bevacizumab, 10 MG</th>
<th>Unit Cost</th>
<th>Anthem</th>
<th>Total Spending</th>
<th>Cumulative</th>
<th>Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 J9035</td>
<td></td>
<td>$5,074</td>
<td>Y</td>
<td>$5,728,632</td>
<td>17%</td>
<td>-$1,145,726 (-20%)</td>
</tr>
<tr>
<td>2 J2505</td>
<td>Injection, Pegfilgrastim, 6 MG</td>
<td>$3,708</td>
<td>Y</td>
<td>$4,971,854</td>
<td>14%</td>
<td>-$1,988,741 (-40%)</td>
</tr>
<tr>
<td>3 J9263</td>
<td>Injection, Oxaliplatin, 0.5 MG</td>
<td>$4,527</td>
<td></td>
<td>$4,467,799</td>
<td>13%</td>
<td>$0</td>
</tr>
<tr>
<td>4 J9355</td>
<td>Injection, Trastuzumab, 10 MG</td>
<td>$2,999</td>
<td>Y</td>
<td>$4,000,865</td>
<td>12%</td>
<td>$0</td>
</tr>
<tr>
<td>5 J9305</td>
<td>Injection, Pemetrexed, 10 MG</td>
<td>$4,781</td>
<td>Y</td>
<td>$2,576,902</td>
<td>7%</td>
<td>-$515,380 (-20%)</td>
</tr>
<tr>
<td>6 J9171</td>
<td>Injection, Docetaxel, 1 MG</td>
<td>$2,979</td>
<td></td>
<td>$1,673,928</td>
<td>5%</td>
<td>$0</td>
</tr>
<tr>
<td>7 J2469</td>
<td>Injection, Palonosetron HCl, 25</td>
<td>$319</td>
<td></td>
<td>$1,074,060</td>
<td>3%</td>
<td>$0</td>
</tr>
<tr>
<td>8 J0641</td>
<td>Injection, Levoeleucovorin</td>
<td>$1,769</td>
<td></td>
<td>$815,550</td>
<td>2%</td>
<td>$25,309,590 (73%)</td>
</tr>
<tr>
<td>9 J9055</td>
<td>Injection, Cetuximab, 10 MG</td>
<td>$3,757</td>
<td>Y</td>
<td>$807,772</td>
<td>2%</td>
<td>$0</td>
</tr>
<tr>
<td>10 J9395</td>
<td>Injection, Fulvestrant, 25 MG</td>
<td>$1,518</td>
<td></td>
<td>$759,090</td>
<td>2%</td>
<td>$26,876,452 (78%)</td>
</tr>
<tr>
<td>11 J9265</td>
<td>Injection, Paclitaxel, 30 MG</td>
<td>$582</td>
<td></td>
<td>$667,329</td>
<td>2%</td>
<td>$0</td>
</tr>
<tr>
<td>12 J9264</td>
<td>Injection, Paclitaxel Protein-</td>
<td>$2,725</td>
<td>Y</td>
<td>$659,403</td>
<td>2%</td>
<td>$0</td>
</tr>
<tr>
<td>163</td>
<td>ALL DRUGS</td>
<td>$739</td>
<td></td>
<td>$34,661,727</td>
<td>100%</td>
<td>-$3,649,848 (-11%)</td>
</tr>
</tbody>
</table>

**Commercial Spending on Oncology Drugs Under Medical Benefits for Breast, Colon and Lung Cancer Patients in Maine, 2012**
Quality Measures Focused On Avoiding Underuse

QUALITY MEASURES

• Quality of Treatment Planning for a New Patient
  – QOPI Measures
  – Patient ratings of their experience of care

• Quality of Care During Treatment
  – QOPI Measures for All Patients and Cancer-Specific
  – Patient ratings of their experience of care

• Quality of Care Following Completion of Treatment
  – Patient ratings of their experience of care
  – Frequency of diagnostic testing

PAYMENT ADJUSTMENT

• Range of Acceptable Performance Defined in Advance Based on Levels Achieved by Other Practices

• Reductions in Payments if Performance Fell Below Minimum of Acceptable Range

ALTERNATIVE PAYMENT MODEL

• This model qualifies as an APM with double sided risk which potentially exempts a practice from MIPS
Must Follow Appropriate Use Criteria

Rate of Adherence to Appropriate Use Criteria

HIGH

LOW

100%
80%
Min%

Rate of Adherence to Appropriate Use Criteria

Choosing Wisely

American Society of Clinical Oncology

Five Things Physicians and Patients Should Question

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.

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

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

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.

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.
Bonus If ED/Hospital Use Better Than Target

- **GOOD**: Achieve Target Rate for ED Visits and Hospital Admits
- **HIGH**: High Rate of ED Visits and Hospital Admissions
- **LOW**: Low Rate of ED Visits and Admits

**$**
- **Care Mgt Payment**
- **New Patient Payment**
- **Infusion**
- **E&M**

**BONUS**
- **Care Mgt Payment**
- **New Patient Payment**
- **Infusion**
- **E&M**
Illustrative PCOP Increased Practice Resources (Medicare 2012 Fee Model ~$2,100/patient)

- Additional $750 One-Time Payment for Each New Patient
- $200 Monthly Care Management Payments During Treatment Months
- $50 Care Management Payments During Active Monitoring Months Up to 6 Months After End of Treatment

PATIENT-CENTERED ONCOLOGY PAYMENT (PCOP)
Illustrative Analysis: Savings Will More Than Offset New Payments

- 50% increase in payments to oncology practices
- > 4% reduction in total spending
- 30% reduction in ER visits & hospital admits
- 5-7% reduction in spending on drugs & tests
- 50% increase in payments to oncology practices
Illustrative Analysis Shows Large Potential Net Savings (2012 Medicare)

### Costs and Savings from Patient-Centered Oncology Payment

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

For 500 New Patients:

| Additional Practice Revenues | $1,080,000 |
| Net Payer Savings            | $979,802 |
Payments for Patients on Clinical Trials

Monthly Payments For Patients in (Unfunded) Clinical Trials

PATIENT-CENTERED ONCOLOGY PAYMENT (PCOP)
A Continuum for Practice Transformation

OPTION #1
New E&M Codes

OPTION #2
Monthly Payments

OPTION #3
Bundled Monthly Payments

Allows any practice—regardless of starting point—to participate in some alternative payment model
Implementation Strategy

- Gain input and support from ASCO Members
- Gain support from consumer advocacy groups
- Gain support from purchasers/payers
- Gain support from Congress/Administration/policy community
- Create and/or acquire tools to help practices implement new payment models
- Refine data analysis supporting the business case for PCOP
- Refine PCOP models based on input and analysis
- Develop additional guidelines and value-based measures
- Initiate discussions of multi-specialty coordination in oncology
PCOP Current Status

- Collecting/analyzing clinical/administrative data to better define payment amounts, risk corridors, unpaid services
  
  - Data Analysis Capability (including PHI)
  
  - Up dating Maine data

- Pursuing pilots
  - With multiple practices, diverse settings
  - Outreach to payers (CMS and commercial)

- Pursuing standard performance measures/programs
  - Clinical performance (overuse, underuse)
  - Care processes/management (hospitalizations, ER visits)
  - Practice Transformation Tools
  - Exploring expanding QOPI with eventual integration with CancerLinQ
Patient Centered Oncology Payment (PCOP) Model Challenges (details)

• Practice infrastructure transformation tools and systems
• Two sided risk needs more robust risk sharing
• Measurements
  – Care quality
  – System function
• Address pathways (pending ASCO statement on pathways)
Barriers to Pilot

• Payer Reluctance
• Integrated health system CFO
• CMS (Oncology Care Model)
  – Designate PCOP as APM for MACRA?
• Acquiring payer data for modeling (legal)
• Complexity and risk of bundled payment
• Contract negotiation
PCOP Model Opportunities

• Integration of oncology specialty with ACO’s
• Expansion beyond episode of therapy
  – Survivorship (intermediate and long term post therapy care and monitoring)
  – Multidisciplinary integration (i.e. surgery and RT)
    • Medical Oncology as “team leader”
FOR MORE INFORMATION AND TO EXPLORE IMPLEMENTATION

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www.asco.org/paymentreform