The Oncology Reimbursement Landscape: The Times They are a Changin’

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Figure 2. Projected annual family health insurance premium costs and average household income in the United States.

- Household Income
- 50 of Household Income
- Family Health Insurance Premiums
- Family Premium + OOP Costs

OOP = out-of-pocket.
Cancer care costs rising faster than overall healthcare

Source: Blue Cross Blue Shield Association
Moving Away From Fee For Service

"...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

goal to achieve 50% of Medicare payments through alternative payment models by 2018.
Inherent in the evolution of reimbursement is increasing risk

*Increasing incentives for care quality, coordination and efficiencies*

**Volume-based reimbursement**

**Value-based reimbursement**

**RISK**

**Fee for Service:** Payments are linked to the number of services provided

**Pay for Performance:** Payments are linked with the quality and outcomes of healthcare provided

**Shared Savings:**

*Upside only:* There is no performance risk to providers even if they experience higher costs or if they do not achieve quality performance goals

*Upside-Downside:* Requires providers to share in the financial risk by accepting some accountability for costs that greatly exceed the goals

**Isolated Bundled Payments:** Reimbursement on the expected costs for clinically-defined episodes of care (e.g., hip & knee replacement).

Providers accept some accountability for costs that greatly exceed goals (target price) but gain if costs fall below goals

**Partial/Blended Capitation (Risk):** A single payment is made for a defined set of services, while other services involved in a patient’s care are paid for on a fee-for-service basis

**Full/Global Capitation (Risk):** Whole networks of hospitals and physicians band together to receive single fixed monthly payments for enrolled health plan members. Payment is made on a per member basis

**Volume-based reimbursement**

**Value-based reimbursement**

**Changes in Reimbursement Landscape**
Bridging the Gap

**Volume to Value**

**Volume-Based First Curve**
- Fee-for-service reimbursement
- High quality not rewarded
- No shared financial risk
- Acute inpatient hospital focus
- IT investment incentives not seen by hospital
- Stand-alone care systems can thrive
- Regulatory actions impede hospital-physician collaboration

**Value-Based Second Curve**
- Payment rewards population value: quality and efficiency
- Quality impacts reimbursement
- Partnerships with shared risk
- Increased patient severity
- IT utilization essential for population health management
- Scale increases in importance
- Realigned incentives, encouraged coordination

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The Gap
The Forces For Change

• Public Payers
  – Medicare Oncology Care Model
  – Medicare ASP Rule
  – Specialty Specific Alternative Payment Models-MACRA
  – Medicaid Managed Care Organizations

• Private Payers
  – Oncology Medical Homes-Several Insurers-Aetna
  – United Health Care Episode Payment Pilot
  – WellPoint Cancer Quality Program
Oncology Care Model - Key Features of the Model

- 6 month episodes begin when chemo (IV or oral) administered/filled
- Multiple 6 months episodes allowed as long as patient receiving chemo
- Patient management fee of $160 paid monthly to practice throughout the 6 month episode
- Benchmark price derived from national data for each episode (using 2012-2015 data), risk adjusted, and adjusted for practice use of novel therapeutics, and actual cost experience, then trended forward using experience of national practices not in the model.
- The Target amount is then the benchmark amount with the discount rate applied
  - Phased in 2 sided risk adjustment (one sided for 2 then 2 sided for 3) with 2.75% discount instead of 4%
- Difference between target amount and actual expenditures (Including the patient management fee) is your performance payment which are subject to adjustment for meeting quality targets
- If practice does not achieve savings by end of year 3 they are out
Risk-Adjustors

- Cancer type
- Age
- Sex
- Dual eligibility for Medicaid and Medicare
- Selected non-cancer comorbidities
- Receipt of selected cancer-directed surgeries
- Receipt of bone marrow transplant
- Receipt of radiation therapy
- Source of episode trigger (Part B or Part D)
- Institutional status
- Participation in a clinical trial
- History of prior chemotherapy use
- Episode length
- Hospital referral region
Practice Specific Adjustments

• **Novel Therapy Adjuster**- Ratio of amount spent for novel therapies compared to total expenditures for your practice compared with national ratio for non-OCM practices. Total amount discounted by 20%. No negative adjustment. Can only gain.
  
  – Novel Therapy defined as new therapy approved by FDA in previous 2 years for a specific indication

• **Experience Adjuster**- Will look at the sum of each practices actual risk adjusted episode expenditures in the baseline compared to expected based on the model. If higher, this amount will be reduced by 50% and then applied to the baseline price. No negative adjustment
  
  – For example, if your practice is 20% more expensive than predicted, you will get a 10% adjuster to your baseline price.
# OCM Quality Metrics

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure Source</th>
<th>Available?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communication and Care coordination</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk-adjusted proportion of patients with all-cause hospital admissions within the 6-month episode</td>
<td>Claims</td>
<td>N/A</td>
</tr>
<tr>
<td>Risk-adjusted proportion of patients with all-cause ED visits that did not result in a hospital admission within the 6-month episode</td>
<td>Claims</td>
<td>N/A</td>
</tr>
<tr>
<td>Proportion of patients who died who were admitted to hospice for 3 days or more</td>
<td>Claims</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Person- and Caregiver-Experience and Outcome</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain assessment and management (NQF 0383 and 0384, PQRS 143 and 144)</td>
<td>Registry (practice-reported)</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (NQF 0418, PQRS 134)</td>
<td>Registry (practice-reported)</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient-Reported Experience of Care</td>
<td>Survey</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Clinical Quality of Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate cancer: Adjuvant hormonal therapy for high-risk beneficiaries (NQF 390)</td>
<td>Registry (practice-reported)</td>
<td>Yes</td>
</tr>
<tr>
<td>Timeliness of adjuvant chemotherapy for colon cancer (NQF 0223)</td>
<td>Registry (practice-reported)</td>
<td>Yes</td>
</tr>
<tr>
<td>Timeliness of combination chemotherapy for hormone receptor negative breast cancer (NQF 0559)</td>
<td>Registry (practice-reported)</td>
<td>Yes</td>
</tr>
<tr>
<td>Trastuzumab received by patients with AJCC stage I (T1c) to III Her2/neu positive breast cancer (NQF 1858)</td>
<td>Registry (practice-reported)</td>
<td>Yes</td>
</tr>
<tr>
<td>Hormonal therapy for stage I-IIIC estrogen receptor/progesterone receptor (ER/PR) positive breast cancer (NQF 0387 / PQRS 71)</td>
<td>Registry (practice-reported)</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Patient Safety</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of current medication (PQRS #130)</td>
<td>Registry (practice-reported)</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Performance Multiplier-Grading on a Curve

Table 4: Scoring of Claims-based Measures

<table>
<thead>
<tr>
<th>Claims-based measure performance range (P = performance rate)</th>
<th>Achievement points (Maximum = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>90th Percentile of national performance</td>
<td>10</td>
</tr>
<tr>
<td>60th Percentile</td>
<td>7.5</td>
</tr>
<tr>
<td>40th Percentile</td>
<td>5.0</td>
</tr>
<tr>
<td>20th Percentile</td>
<td>2.5</td>
</tr>
<tr>
<td>10th Percentile</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 6: Aggregate Quality Score Translated into Performance Multiplier

<table>
<thead>
<tr>
<th>Aggregate Quality Score (% of maximum points available)</th>
<th>Performance Multiplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>75% - 100%</td>
<td>100%</td>
</tr>
<tr>
<td>50% - 74%</td>
<td>75%</td>
</tr>
<tr>
<td>30% - 49%</td>
<td>50%</td>
</tr>
<tr>
<td>Less than 30%</td>
<td>0%</td>
</tr>
</tbody>
</table>
### Table 8: Example Performance-Based Payment Calculation

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>One-Sided Risk</th>
<th>Two-Sided Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Sum of Baseline Episode Prices</td>
<td>$2,500,000</td>
<td>$2,500,000</td>
</tr>
<tr>
<td>B</td>
<td>Adjustment for Trend</td>
<td>1.02</td>
<td>1.02</td>
</tr>
<tr>
<td>C</td>
<td>Adjustment for Novel Therapies</td>
<td>1.01</td>
<td>1.01</td>
</tr>
<tr>
<td>D</td>
<td>Benchmark Amount (A * B * C)</td>
<td>$2,575,500</td>
<td>$2,575,500</td>
</tr>
<tr>
<td>E</td>
<td>OCM Discount Rate</td>
<td>4.00%</td>
<td>2.75%</td>
</tr>
<tr>
<td>F</td>
<td>OCM Discount Amount (D * E)</td>
<td>$103,020</td>
<td>$70,826</td>
</tr>
<tr>
<td>G</td>
<td>Target Amount (D - F)</td>
<td>$2,472,480</td>
<td>$2,504,674</td>
</tr>
<tr>
<td>H</td>
<td>Actual Episode Expenditures</td>
<td>$2,300,000</td>
<td>$2,300,000</td>
</tr>
<tr>
<td>I</td>
<td>Difference (Target less Actual; G - H)</td>
<td>$172,480</td>
<td>$204,674</td>
</tr>
<tr>
<td>J</td>
<td>Performance Multiplier</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>K</td>
<td>Performance-Based Payment (I * J)</td>
<td>$129,360</td>
<td>$153,505</td>
</tr>
<tr>
<td>L</td>
<td>Final Performance-Based Payment, after Geographic Adjustment and Sequestration (K * 1.03 * 0.98)</td>
<td>$130,576</td>
<td>$154,948</td>
</tr>
</tbody>
</table>
Where Can The Savings Come From: Spending on First 6 months of chemotherapy patient

Source: RAND
Who is Most Likely To Benefit

- Low Quality, Low Cost
  - Poorly positioned to achieve bonus
  - Bonus depends on ability to implement and sustain dramatic practice transformation

- High Quality, Low Cost
  - Good position to get bonus
  - Can get bonus if you can drive down costs and maintain quality

Source: Oncology Roundtable interviews and analysis
2016 Medicare Program
Part B Drug Payment Model Proposed Rule
Part B Drug Payment Model Proposed Rule

- Authority: CMMI ACA Waiver authority
- 5 year demonstration
- 2 Phases
  - Model Phase I
    - Tests adjustment to ASP + 6% Reimbursement
    - Begins later this year
  - Payment Model Phase II
    Test various Value Based Purchasing (VBP)
    Begins January 2017

Payment Model Phase I

- Mandatory Participation
- Random assignment by zip codes
  - Primary Care Service Area (PCSA)
- Proposed rate:
  - (ASP+2.5%)
  - Add on: $16.80
  - Subject to annual CPI for Medical Care
  - Calculated from difference in drug reimbursements divided by “drug days”
- System wide “revenue neutral”
- Sequestration applied

Solve this equation:

\[
(\text{ASP} + 0.86\% + 16.53) = (\text{ASP} + 2.5\% + 16.80) \times 2\
\]

90% Fail
Payment Model Phase II

- Mandatory Participation
- Tests Value Based Purchasing (VBP) approaches
  - Reference Pricing
  - Outcomes Based Pricing
  - Indication Based Pricing
  - Clinical Decision support Tools
  - Reduced Cost Sharing for Patients
- Bundling
- CAP

<table>
<thead>
<tr>
<th>ASP + 6% VBP Model</th>
<th>ASP + 6% VBP Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASP + 2.5%</td>
<td>ASP + 2.5%</td>
</tr>
</tbody>
</table>
ASCO Arguments Phase I

- Patient care will be adversely impacted
  - Disruption of patient services
- CMS proposal is not budget-neutral for oncology
  - CMS own estimates point to 1% decline in revenue
  - ASCO estimates loss of $250,000 for 10 person practice
  - Will eliminate funding necessary for practices to prepare for MACRA and OCM
- Current methodology is problematic
  - CMS does not adequately reimburse for other services provided
  - Proposed model exacerbates this problem
- Risk of incentivizing physicians to not prescribe best treatment
  - No real opportunities to switch drugs
  - No protections to ensure quality of care
- No impact on real cost of drug inflation: Launch Prices
ASCO Proposed Arguments
Phase II

• Not ready for January 2017 implementation. Request for Information would be a better way to go.

• Many of these proposals have been debated for years and not implemented with good reason
  – CAP
  – Least Costly Alternative (Reference Pricing)

• Pathways, QOPI, CancerLinQ and ASCOs value measures are better tools to manage care and measure quality and value
Current Status

• Comments are due Monday to CMS
• House and Senate Republicans have issued a very strong letter telling CMS to pull the rule
  – Senator Grassley has put CMS on notice that this violates Human Subject Research Protections
• Rep Buschon (IN) introduced legislation (HR 5122) to stop the implementation of the rule
• House and Senate Democrats have sent letter to CMS raising strong concerns with the demo but did not ask that the rule be pulled
• Go on ASCO ACT Network and urge your Congressman to support HR 5122 (1700 messages already from ASCO members)
ASCO’s Approach to Alternative Payment Model

1. **Oncologists Identify What’s Needed for High-Value Cancer Care**
2. **Design Changes In Payment to Support Patient-Centered Care**
3. **Better Care, Lower Spending, Practices Stay Financially Viable**
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

• Accountability in all three options... but for things oncologists can control
Opportunities to Reduce Spending During an Episode of Chemotherapy

Current Spending Per Patient

- **ER/Hospital Admissions**: ED visits and hospital admissions for chemotherapy-related complications
- **Other Services**: Unnecessarily expensive drugs, Value Based Pathways, Unnecessary drugs, Unnecessary end-of-life treatment
- **Testing**: Unnecessarily expensive tests, Unnecessary testing
- **Drugs**: Avoidable $
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

Payment for services delivered by non-physicians and for non-face-to-face services improves drug and test utilization and improves end of life care.
PCOP Option 1 (Episode of IV or Oral treatment) ~$2,100 (Medicare)/patient more per Episode

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)
Savings Will More Than Offset New Payments

- Current FFS Payment
  - ER/Hospital Admissions
  - Other Services
  - Testing
  - Avoidable $
  - Drugs
  - E&M Infusions
  - Non-E&M Care Mgt

- Patient-Centered Oncology Payment
  - ER/Admissions
  - Other Services
  - Testing
  - PCOP Pmts
  - E&M Infusions

- Changes:
  - > 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
Conclusions

• The Transition from Volume to Value is Upon Us

• The Transition will be clumsy with competing and potentially mutually exclusive incentives along the way

• Ultimately we ask for a system which:
  – Rewards us for restraining unnecessary costs which are under our control
  – Rewards us for achieving high quality care
  – Does not penalize us for costs which are not under our control (drug prices)
  – Does not penalize us for doing the right thing for the patient (Risk Adjustment)
  – Does not incentivize us to do more (move away from FFS)

• “We better start swimmin’ Or we w’ll sink like a stone”