Association of Community Cancer Centers

The Evolution of Oncology Payment Models

April 26, 2019
# Agenda

<table>
<thead>
<tr>
<th>I.</th>
<th>Background</th>
</tr>
</thead>
<tbody>
<tr>
<td>II.</td>
<td>Oncology Payment Models</td>
</tr>
<tr>
<td>III.</td>
<td>Episode-Based Payment Pilots</td>
</tr>
<tr>
<td>IV.</td>
<td>International Pricing Index</td>
</tr>
<tr>
<td>V.</td>
<td>Takeaways</td>
</tr>
</tbody>
</table>
I. Background
I. Background

Medicare and Medicaid Growth

About 3.6 million people age into Medicare every year, creating a greater impetus for the government and providers to rethink how care is delivered and funded.

**Population Projections**

- **80% increase by 2030**
- **52% increase by 2030**

**Projected Spending**

- **Medicare**
  - 2010: $521 billion
  - 2015: $647 billion
  - 2020: $893 billion
  - 2025: $1,282 billion

- **Medicaid**
  - 2010: $397 billion
  - 2015: $549 billion
  - 2020: $722 billion
  - 2025: $974 billion

Source: US Department of Health & Human Services (HHS), Administration on Aging.

Source: Centers for Medicare & Medicaid Services (CMS), National Health Expenditure Data.
I. Background

5% of Patients Responsible for 50% of Costs

In a fee-for-service (FFS) world, the top 5% of patients (by usage) drive margins; in a value-based world, the top 5% pose a financial challenge that must be well managed.

Note: Figures may not be exact due to rounding.
I. Background

US Spending by Disease Category

While cancer care is very expensive, on average only 6% of adults will develop cancer during their lifetime. Thus, spending on cancer care accounts for only 7% of US healthcare spending.

Note: Spending on dental services, nursing homes, and prescriptions that cannot be allocated to a specific disease not included above.

Source: Henry J. Kaiser Family Foundation analysis of Bureau of Economic Analysis Health Care Satellite Account (Blended Account) and National Health Expenditure data (accessed on March 17, 2017).
I. Background

US Spending on Oncology

US spending on oncology care is projected to grow rapidly, doubling between 2010 and 2020.

Estimated Annual US Spending on Oncology

*US Dollars in Billions*

<table>
<thead>
<tr>
<th>Year</th>
<th>Spending (Billions)</th>
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<td>2010</td>
<td>$34.3</td>
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<tr>
<td>2015</td>
<td>$49.0</td>
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<tr>
<td>2020</td>
<td>$79.8</td>
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</tbody>
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I. Background

US Spending on Oncology *(continued)*

Average spending per commercial patient increased by 62% from 2004 to 2014. Chemotherapy\(^1\) is a key cost driver and represents a growing share of total expenditures.

\(^1\) Chemotherapy includes cytotoxic chemotherapy, other chemo and cancer drugs, and biologic chemotherapy.

II. Oncology Payment Models
II. Oncology Payment Models

Increasingly Coordinated Care Models and Incentive Structures

To provide optimal patient care and to align with changing reimbursement mechanisms, providers must assume an increasingly large role in managing overall cancer care, which is becoming more complicated and requires greater integration.

Clinical Pathways
- Either commercially or internally developed
- Need to measure adherence and quality

Oncology Medical Homes
- Clinical integration and collaboration in care
- Staffing/operational model changes to increase access

ACO Strategies
- Engaged with primary and other specialty care providers
- Navigating attribution of population
- Population health management competencies

Episode-Based Payments
- Large patient cohort to diversify risk
- Confidence in ability to deliver high-quality, low-cost care
- Savings from appropriate use of high-cost drugs and reduced hospitalizations

Provider, Payer, and Patient Engagement

Shifting of Risk to Providers

Potential Savings
II. Oncology Payment Models

Clinical Pathways

• This model encourages physician adherence to evidence-based treatment regimens and cost-effective care.

• In 2015, about two-thirds of Anthem-insured cancer patients (breast, NSCL, or colon only) were treated on the pathway program.

• Today the program has pathways for more than 16 different cancers. Pathways were developed to help physicians select interventions based on clinical effectiveness, favorable toxicity profiles, and cost to patients. Physicians can receive enhanced reimbursement if they adhere to the pathways.

Sources:
AIM Specialty Health: http://www.aimspecialtyhealth.com/.
II. Oncology Payment Models

Oncology Medical Homes

- Aetna and Regional Cancer Care Associates (RCCA) collaborated to develop an oncology medical home in September 2016, including all patients who receive care at RCCA’s clinics in New Jersey and Maryland.
- RCCA physicians are responsible for arranging all patient healthcare needs and ensuring the use of evidence-based treatments.
- Physicians are incentivized for improved health and reduced costs.

- Consultants in Medical Oncology and Hematology (CMOH), a one-physician medical oncology practice in Philadelphia, has contracted with two regional payers to develop its own oncology care model.
- Through the program, CMOH implemented care coordination and evidence-based care measures that led to a 51% drop in ED visits, a 68% drop in inpatient admissions, and savings to payers of $1 million per physician per year.

- Humana launched its Oncology Model of Care in January 2019, offering additional payment to 16 participating cancer practices that improve performance on certain metrics over a one-year period.
- Quality measures include inpatient admissions, emergency room visits, medications ordered, and education provided to patients on their condition.
- Humana will meet with the practices twice annually to review performance on the metrics.

Sources:
Consultants in Medical Oncology and Hematology: http://www.patientcenteredoncology.com/about-cmoh.html.
II. Oncology Payment Models

ACO Strategies

- In 2012, Baptist Health South Florida and Advanced Medical Specialties formed the first oncology-specific accountable care organization (ACO), known as the Miami Cancer Institute.
- Practices shared any savings above 2% as long as quality metrics were hit.
- This savings goal was achieved in the first year.

Sources:

- In 2012, Moffit Cancer Center and Florida Blue joined to form a cancer-specific ACO.
- Major focuses include inpatient readmissions, generic drug prescribing, and increased guideline adherence.
II. Oncology Payment Models

Episode-Based Payments

Two case studies for recent episode-based payment pilot programs will be examined in the following section.

Oncology Care Model

- Commercial case study

- Medicare case study
- Five-year pilot: 2016–2021

Other Recent Activity: Mandatory Radiation Oncology Bundles

- The Trump administration recently announced plans for a mandatory radiation oncology pricing program.
- It is unclear whether this model will be introduced, given the historical pace of government innovation, strong industry concern regarding the proposal, and the general unpredictability of the Trump administration.
III. Episode-Based Payment Pilots
III. Episode-Based Payment Pilots

Commercial: MD Anderson and UnitedHealthcare

MD Anderson and UnitedHealthcare entered into a pilot program to test an oncology-focused bundled payment.

III. Episode-Based Payment Pilots
Commercial: MD Anderson and UnitedHealthcare (continued)

Bundle Design

Primary cancer treatment (surgery, radiation therapy, chemotherapy) and one year of care, including:
• Inpatient care
• Surgical reconstruction
• Emergency visits
• Diagnostic imaging
• Internal medicine
• Preventive care

III. Episode-Based Payment Pilots
Commercial: MD Anderson and UnitedHealthcare (continued)

MD Anderson and UnitedHealthcare’s bundle was deemed feasible, but it presented operational challenges. Cost and quality outcomes are not yet clear.

**Outcome**
- After a three-year pilot, it was determined that a single bundled payment for head and neck cancer patients was feasible.
- UnitedHealthcare has not yet expressed interest in expanding the program.¹

**Challenges**
- Claims submissions were difficult to do and required manual workarounds. Many billing systems are not well equipped for bundled payments.
- Payments for newer technology (e.g., proton therapy) were not included in the bundle.

**Next Steps**
- The bundle’s performance on quality and cost is still under evaluation.
- UnitedHealthcare is testing other bundles, such as a program with community medical oncologists.²

¹ “In the End, It Will Be Episode Payment.” Managed Care, May 1, 2017.
² “Study: New Cancer Care Payment Model Reduced Health Care Costs, Maintained Outcomes.” UnitedHealth Group, July 8, 2014.
III. Episode-Based Payment Pilots

Medicare: Oncology Care Model

This five-year CMS Medicare demonstration project is designed to improve care coordination, access, and appropriateness while lowering the total cost for Medicare beneficiaries receiving cancer treatment.

Program Aim
Promote whole-practice transformation through the use of aligned financial incentives, including performance-based payments, to improve care coordination, appropriateness of care, and access for FFS Medicare beneficiaries undergoing chemotherapy.

Program Participation
187 practices and 17 payers are currently participating in the Oncology Care Model (OCM).
III. Episode-Based Payment Pilots

Medicare: Oncology Care Model (continued)

Care episodes are six months in length and include all Medicare Part A and B services received by beneficiaries.

Episode Definition

• An episode is initiated when a beneficiary receives a qualifying chemotherapy drug (first Part B/D chemotherapy claim).
• Each episode lasts for six months.
• If a patient requires chemotherapy beyond those six months, they begin a new episode.
• Beneficiaries may initiate multiple episodes during the five-year model.

Included Services

• All Medicare Part A and B services received by Medicare FFS beneficiaries during the episode
• Certain Part D expenditures: the Low-Income Cost-Sharing Subsidy (LICS) amount and 80% of the Gross Drug Cost Above the Catastrophic (GDCA) threshold

Source: CMS.

Although the OCM does not change how drugs are reimbursed, it incentivizes practices to select high-value options.
III. Episode-Based Payment Pilots
Medicare: Oncology Care Model (continued)

During OCM episodes, providers continue to bill for standard Medicare FFS payments; however, the program incorporates two additional payment mechanisms.

**Monthly Enhanced Oncology Services**

- The monthly enhanced oncology services (MEOS) payment provides OCM practices with financial resources to aid in effectively managing and coordinating care for Medicare FFS beneficiaries.
- The $160 per member per month (PMPM) payment can be billed for OCM FFS beneficiaries for each month of their six-month episodes.

**Performance-Based Payment**

- Performance-based payment (PBP) encourages OCM practices to improve care for beneficiaries and lower the total cost of care during the six-month episodes.
- PBP is calculated retrospectively on a semiannual basis based on the practice’s achievement on quality measures and reductions in Medicare expenditures below a target price.

Source: CMS.
III. Episode-Based Payment Pilots
Medicare: Oncology Care Model (continued)

Payments are calculated for the total cost for the episode of care (includes Part A, B, and D payments).

1. Calculate Benchmark
CMS calculates benchmark episode expenditures for OCM practices.
- Based on historical data
- Risk adjusted (including for geographic variation)
- Trended to applicable performance period
- Includes a novel therapies adjustment

2. Determine Target Price
Discount is applied to the benchmark to determine a target price for OCM-FFS episodes.

**Example:**
- Benchmark = $30,000
- Discount = 4%
- Target Price = $28,800

3. Compare Actual to Target
If actual OCM-FFS episode expenditures are below target, the practice could receive a PBP.

**Example:**
- Target Price = $28,800
- Actual = $25,000
- PBP = up to $3,800

Note: Actual expenditures include both FFS and MEOS payments.

4. Adjust Based on Performance
The PBP amount is adjusted based on the participant’s achievement across five quality domains.
- Communications and care coordination
- Person- and caregiver-centered outcomes
- Clinical quality of care
- Patient safety
- Clinical data

Source: CMS.
IV. International Pricing Index
IV. International Pricing Index

Proposal Overview

CMS is soliciting comments on a proposed model that is designed to test whether changing Part B drug reimbursement leads to higher-quality care for Medicare beneficiaries and reduced spending for the program.

The International Pricing Index (IPI) Model includes a three-pronged approach:

- Phasing down the Medicare reimbursement amount for selected Part B drugs to align with prices paid by foreign countries
- Allowing private-sector vendors to negotiate prices for drugs and compete for physician and hospital business
- Changing the 4.3% (postsequester) drug add-on payment to a flat payment amount

Who Will Participate?
Physician practices and hospital outpatient departments in select geographic areas (to be determined by CMS) will participate in the IPI Model.

What Drugs Are Included?
The IPI Model will initially focus on single-source drugs and biologicals.

What Is the New Payment Model?
For any drug where ASP is higher than international prices, CMS will pay for drugs based on a target price derived from the IPI. The target price will be phased in over five years.

Who Supplies the Drugs?
Private-sector vendors will take on the financial risk of acquiring and billing for drugs. Physicians and hospitals would be able to contract with multiple vendors for different drugs and to change vendors.

The proposed model would run from spring 2020 through 2025. CMS solicited comments from the public through December 31, 2018.
IV. International Pricing Index
Proposal Overview (continued)

**Proponents Say...**

- The model will allow private-sector vendors to negotiate prices for drugs and compete for physician and hospital business.
- Relying on an IPI and setting a target price rather than using ASP would result in an approximate 30% savings in total spending for the selected Part B drugs in the model.

**Opponents Say...**

- The index addresses a statistically insignificant portion of Medicare’s total drug expenditures and measures prices against foreign markets with significantly less buying power than the US.
- The model does not include a US-based cost-effectiveness analysis and therefore does not connect payment to drugs based on the value provided to the Medicare population.

Sources:
V. Takeaways
V. Takeaways

Performance Monitoring Exposes Payment Model Challenges

Annual CMS progress reports indicate that OCM providers are experiencing challenges with the program. Specifically, payment recoupments are placing a burden on practices, as many quickly reinvest this income into practice operations.

OCM Performance Period One (PP1) Report

*July 2016 to January 2017*

Under the initial reconciliation process, fewer providers received their full expected PBP payments than was projected.

Additional claims incorporated through a true-up process caused an increase in episode costs for the majority of practices, either reducing or eliminating savings (and reversing bonuses already paid).

As a result of issues with practices properly identifying attributed beneficiaries or incorrectly calculating qualifying episodes, there was a high rate of payment recoupment on MEOS payments (average of 30% of total).

OCM Performance Period Two (PP2) Report

*January 2017 to July 2017*

Initial reconciliations for PBP payments improved approximately 46% between PP1 and PP2, attributable both to implementation of practice transformation activities and favorable changes in model calculation methodologies.

MEOS payment recoupments doubled to 60% from PP1, with the increase being largely attributed to ongoing challenges related to practices’ abilities to recreate CMS logic for identifying beneficiaries and carry-over mistakes from the first reporting period.

V. Takeaways

Sustainable Models Must Address Barriers

While new payment models are gaining popularity, there are several potential issues that must be addressed regardless of the specific model.

- **Sufficient Sample Size:**
  - Payment models need to be able to accumulate sufficient patients to demonstrate a statistically significant valid result.
  - The majority of US medical oncology practices have fewer than 10 physicians and work with dozens of insurance carriers, so one carrier might account for a fraction of practice volume.

- **Comparing Data over Time:**
  - During the time it might take for providers to enroll a critical mass of patients into a new payment program, the adoption of new drugs or breakthrough treatments will continue to change.
  - This creates challenges for establishing accurate cost comparisons across the program’s time period.

- **Impact of Incentive Dollars:**
  - Incentive dollars available need to be high enough to motivate behavioral changes, and often they are not high enough.

- **Connection between Payments and Value:**
  - Funding for an alternative payment program must be proportional to the value created.
  - Avoid situations such as paying a practice for only slightly improved outcomes over national averages when their cost of care is 30% higher than national benchmarks.

V. Takeaways
Lessons for Every Practice

Payment pilots continue to generate important information regarding opportunities to reduce the cost of cancer care.

- Active case management is needed.
- Utilization of standardized pathways is critical to reduce variation in cost and outcomes.
- Without data and analytics, it is impossible to manage or improve performance.
- Narrow networks are essential to ensure pathway compliance and cost management.
- Leadership must look for areas of innovation to drive cost reduction all over the practice.
- Provider engagement is critical; without it, change will be nearly impossible.
- Aligning a provider’s compensation with the incentives in the payment model can dramatically improve engagement/compliance.
- Coding and documentation (e.g., HCCs) are critical to getting credit for the complexity of a patient population.
- Infrastructure, infrastructure, infrastructure: people, processes, technology, and so forth are vital to generating and managing the information needed to manage change.
- Patient retention is important in a risk-based environment.
V. Takeaways
Lessons for Every Practice (continued)

Although the fate of today’s specific payment models is unknown, oncology will remain a focus area due to the high-cost nature of the specialty, with learnings from other specialty areas (e.g., cardiology, orthopedics) likely to be incorporated into future policies and programs. Practices should consider the following as they think about the future of oncology payment models:

• **The current system is not set up for alternative payment models:** Broad adoption of alternative payment models will be a challenge given the country’s fragmented healthcare system.

• **There is no silver bullet:** There is no one perfect model, and those that succeed in the long term will have to evolve over time.

• **It will never be easy:** Any model an organization adopts will present challenges in the beginning.

• **Practices will need to focus their efforts:** Practices can realistically only participate in one alternative payment model at a time, and whatever model is selected should ideally be applied across several payers.
V. Takeaways

Practices Should Continue to Focus on Value-Based Capabilities

CMS and commercial payers will continue to hone their payment innovation strategies in coming years, and as such, oncology practices should maintain a focus on developing value-based care capabilities. See appendix A for an overview of related strategic opportunities.

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<th>RATIONALIZED</th>
<th>INFORMED</th>
<th>RESPONSIVE</th>
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<tbody>
<tr>
<td>Dismantling silos to better coordinate care, align resources, and rally providers around a shared goal of high-quality care</td>
<td>Maximizing operational efficiency, expansion potential, and economies of scale</td>
<td>Balancing care quality, efficiency, accessibility, and cost in (re)distributing service lines</td>
<td>Managing and utilizing relevant data to make key clinical and organizational decisions</td>
<td>Harnessing change and using it to drive organizations forward</td>
</tr>
</tbody>
</table>
Questions & Answers

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