Oncology Payment Reform: What’s In and What’s Out?

Ronald Barkley, MS, JD
September 12, 2015
Financial Disclosures

- I do not currently have any relevant financial relations to disclose
Off-Label Use Disclosures

- I **do not intend** to discuss off-label uses of products during this activity.
1. **What** is the current state of alternative payment initiatives in oncology?

2. **Where** is it likely to be headed?

3. **What** can you do about it?
1. U.S. healthcare is criticized as being fragmented, inefficient, inaccessible and terribly expensive

2. In response, U.S. healthcare is undergoing a transformation from “volume-based” fee-for-service to something that is “value-based.” Catalyzed in large part by federal health reform -- the Affordable Care Act ("ACA")

3. As a high cost service with high variability, cancer care is subject to particular scrutiny

4. Alternative payment model (APM) initiatives are crystallizing the transformation. Premise: without meaningful payment reform, you don’t get meaningful delivery reform
### Chronology of Alternative Payment in Oncology

<table>
<thead>
<tr>
<th>Circa</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>Medicare- DRG 481  BMT bundled rate</td>
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<tr>
<td>2008</td>
<td>Health Plan-initiated drug pathways programs</td>
</tr>
<tr>
<td>2009</td>
<td>United Healthcare “episodes” pilot</td>
</tr>
<tr>
<td>2010</td>
<td>Oncology Medical Home - reduced overall spend thru pro-active care coordination</td>
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<tr>
<td>2012</td>
<td>Oncology ACO – add hospital to oncology medical home</td>
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<tr>
<td>2012</td>
<td>Bundled price – procedure/treatment specific</td>
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<td>2013</td>
<td>Bundled price – cancer type specific</td>
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<tr>
<td>2014</td>
<td>2nd Generation Health Plan Initiatives - Anthem CCQP; Aetna OMH; United Healthcare episodes 2.0 + head &amp; neck bundles</td>
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<td>2015</td>
<td>CMMI Oncology Care Model (OCM)</td>
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Health Plans discover the cost effectiveness of adherence to evidence-based pathways. Oncologists paid a premium for compliance with pathways, often incentivized as a premium on % drug mark-up and exemption from pre-authorization requirements. Vendors such as Cardinal P4; Via Oncology.
United Healthcare Episode Pilot (2009-2012)

UHC episode payment model. Pre-pay of drug margin replaces “buy & bill” mark-up. Five practices nationally. Results: $33M net savings in UHC’s total cancer spend over 3-year study period. 11% per year. Paradoxically, drug spend increased in the UHC pilot. UHC Phase 2 launched 2015. 11 participating practices.
Enhanced payment for 3 core functions: (1) pathways compliance, (2) pro-active care coordination (keep Tx patients out of the ER) and (3) disciplined advance care planning. Early lesson learned: don’t do it w/o Health Plan reciprocity. **OMH shown to reduce the overall cancer spend by about 12%**
$19M CMMI grant to demonstrate that Oncology Medical Home can achieve savings in Medicare’s cancer spend. 7 practices nationally. Concluded June 2015
### Oncology Medical Home – Source of Savings

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<tr>
<th>Source</th>
<th>% Reduction</th>
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<tr>
<td>Drug pathways compliance</td>
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<td>Avoidable ER utilization</td>
<td>0.6% to 1.1%</td>
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<tr>
<td>Avoidable hospital admissions</td>
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<tr>
<td>Diagnostics (imaging, lab)</td>
<td>0.2% to 0.5%</td>
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<tr>
<td>End-of-life care management</td>
<td>0.9% to 1.9%</td>
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<tr>
<td>Total potential savings</td>
<td>6.7% to 13.5%</td>
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**References:**
1. John D. Sprandio, MD, Consultants in Medical Oncology & Hematology. Oncology Patient Centered Medical Home ® Analysis of OPCMH savings conducted by third party actuary 2010.
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About 2/3 of the savings comes from avoidable hospital events.
**Oncology Medical Home – Practice Perspective**

**Goal:** to create a reimbursement model designed around new sources of value that will be sustainable through and post healthcare reform

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**Current Fee-for-Service Model**

- Invest in process re-design
- Drop pre-cert alters # FTEs

**Future base w/o value-based contracts**

- Enhanced drug fees
- IT Office workflow efficiencies
- Care mgt / quality fees
- Shared savings

**Revenue Growth**

**Value-based sustainable model**

A “reset button” for bundles/episodes

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Adopted from Aetna Oncology Medical Home. October 2014.
Goal: to achieve meaningful oncology payment reform

TOTAL COST OF CANCER CARE

Current Model

- Waste and Inefficiency
  - Payment for all other cancer care
    - FFS payment to MDs

Future Model

- Waste and Inefficiency
  - Payment for all other cancer care
    - Care coordination pmt. to MDs
    - Case management pmt. to MDs
    - FFS payment to MDs

TOTAL PAYMENTS FOR CANCER CARE

Current Model

- MD payments
  - All other payments

Future Model

- MD payments
  - All other payments

Adopted from Aetna Oncology Medical Home. October 2014.
Add a hospital to an Oncology Medical Home and you get an Oncology ACO. Expands the scope of services to broader continuum of care. Shared saving on total spend. The more you get into the scope, the bigger the economic “pie.”
Bundled Price - Procedure Specific (2012-2015)

A set price for a defined scope of services specific to a cancer treatment or procedure, such as radiation or complex cancer surgeries.
Bundled Price – Cancer Type Specific (2013-2015)

A set price for scope of services specific to a cancer type, such as breast, colon, lung. Hill Physicians Medical Group implemented oncology bundles in 2008 – this may represent a prototype for oncology bundled pricing with ACOs.
Some Capitation “One-Offs” (2010-2015)

Oncology provider paid on basis of per member per month rate (capitation) for population served. Found in tightly managed markets – requires narrow networks.

So. Cal Oncology Associates - CA

New Century Health - FL
Family Tree of Alternative Payment in Oncology

- Oncology Medical Home
- Capitation
- Bundles - Procedure Specific
- Bundles - Cancer Type Specific
- Shared Savings - two sided risk
- Shared Savings – one sided risk
- Pathways Compliance
- Care Management Fees
- Fee-for-Service

Increasing Level of Risk

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CMMI-Oncology Care Model (OCM)

- **Purpose is to:** Create incentives to furnish efficient, high quality care by enhancing services for Medicare fee-for-service beneficiaries undergoing chemotherapy treatment for cancer
- **And to:** Demonstrate reduced overall Medicare expenditures for the care of those same beneficiaries
- **Eligibility:** Physician practices that provide care for oncology patients undergoing chemotherapy for cancer (includes private and hospital-affiliated practices)
- **Participation:** Applications: June 2015; Acceptance: Dec 2015. About 125 practices expected (out of 450 letters of intent filed)
- **Commence Program:** Spring 2016
CMMI-Oncology Care Model (OCM)

- **Targeted Cancers:** Covers “high volume cancers”, which will include at least: breast, prostate, lung, colorectal, lymphoma, leukemia, ovarian, pancreatic
- **Multi-Payer Program:** Intended to involve commercial health plans running parallel with their own “OCM-like” programs
- **Two Part Payment Approach:** Per beneficiary per month (PBPM) care management fee ($160) plus performance-based payment based on savings against target price (OCM payments are in addition to standard Medicare fee-for-service payment)
- **Episode Period:** Total cost of care during a 6-month “episode” of care commencing with initiation of chemotherapy
- **OCM is an Oncology Medical Home model**
CMMI-Oncology Care Model (OCM)

- **Included expenditures**: Includes all Medicare Part A, Part B and certain Part D expenditures during the six-month episode of care (if patient on oral chemo, but not Part D, then no episode triggered)

- **Practice requirements**: Must satisfy six basic “practice requirements”

- **Quality & performance metrics**: 32 preliminary quality and performance improvement metrics (similar to what is measured/reported in various quality programs currently)

- **Risk option**: One-sided risk for first two years with option to convert to two-sided risk thereafter
1) Patient access 24/7 to clinician who has real time access to practice’s medical record

2) Attestation and use of ONC-certified EMR

3) Utilize data for Continuous Quality Improvement (CQI)

4) Provide core functions of patient navigation

5) Document care plan in accordance with IOM

6) Chemotherapy treatment consistent with nationally recognized clinical guidelines
OCM Quality Measures

Quality measure domains:
1) Clinical quality of care
2) Communication and care coordination
3) Person and caregiver centered experience and outcomes
4) Population health
5) Efficiency and cost reduction
6) Patient safety

Data sources:
1) Practice-reported
2) Medicare claims
3) Patient surveys

List undergoing refinement – to be finalized prior to practices signing agreements
### OCM Economics for a 10 Oncologist Practice

<table>
<thead>
<tr>
<th>Description</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Est. avg. overall expenditure/episode</td>
<td>$41,800</td>
<td>$41,800</td>
<td>$41,800</td>
</tr>
<tr>
<td>Est. Medicare FFS chemo pts/year</td>
<td>450</td>
<td>450</td>
<td>450</td>
</tr>
<tr>
<td>Care mgt fees ($160 x 6 = $960)</td>
<td>$432K</td>
<td>$432K</td>
<td>$432K</td>
</tr>
<tr>
<td>Benchmark expenditures</td>
<td>$18.8M</td>
<td>$18.8M</td>
<td>$18.8M</td>
</tr>
<tr>
<td>Less: CMS discount (4%)</td>
<td>$752K</td>
<td>$752K</td>
<td>$752K</td>
</tr>
<tr>
<td>Target Price</td>
<td>$18M</td>
<td>$18M</td>
<td>$18M</td>
</tr>
<tr>
<td>Overall expenditure savings target</td>
<td>8%</td>
<td>9%</td>
<td>10%</td>
</tr>
<tr>
<td>Est. actual exp. (includes care mgt fees)</td>
<td>$18M</td>
<td>$17.9M</td>
<td>$17.3M</td>
</tr>
<tr>
<td>Gain (target price less actual exp.)</td>
<td>$0</td>
<td>$100K</td>
<td>$700K</td>
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## OCM Economics for 10 Oncologist Practice

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<tr>
<td>Gain (target price less actual exp.)</td>
<td>$0</td>
<td>$100K</td>
<td>$700K</td>
</tr>
<tr>
<td>Times performance multiplier</td>
<td>80%</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>Performance based pmt (defer to YR 2)</td>
<td>$0</td>
<td>$85K</td>
<td>$665K</td>
</tr>
<tr>
<td>Add back care mgt fees</td>
<td>$752K</td>
<td>$752K</td>
<td>$752K</td>
</tr>
<tr>
<td>Est. total OCM pmts to practice</td>
<td>$752K</td>
<td>$837K</td>
<td>$1.47M</td>
</tr>
<tr>
<td>Less: OCM-specific staffing</td>
<td>$225K</td>
<td>$225K</td>
<td>$225K</td>
</tr>
<tr>
<td>Less: OCM-specific IT programming</td>
<td>$75K</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Net margin to practice from OCM</td>
<td>$452K</td>
<td>$612K</td>
<td>$1.2M</td>
</tr>
<tr>
<td>Est. payments from others (Anthem, Aetna, United, etc.)</td>
<td>$120K</td>
<td>$145K</td>
<td>$160K</td>
</tr>
</tbody>
</table>
## Where Is It Headed? Tipping Point

<table>
<thead>
<tr>
<th>Month</th>
<th>Program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2014</td>
<td>Anthem Cancer Care Quality Program</td>
<td>$350 per treatment patient per month for pathway + care coordination. Now in 13 states</td>
</tr>
<tr>
<td>June 2014</td>
<td>UHC episode findings published</td>
<td>Saves $33M in total spend = 11% savings per year over 3 years. Small “n” = 810</td>
</tr>
<tr>
<td>Oct 2014</td>
<td>Aetna Oncology Medical Home Program</td>
<td>Enhanced generic drug fees; “S” codes; shared savings</td>
</tr>
<tr>
<td>Dec 2014</td>
<td>MD Anderson – UHC</td>
<td>Bundled prices for head &amp; neck cancers. All care for one year. May add lung, prostate</td>
</tr>
<tr>
<td>Feb 2015</td>
<td>CMMI - OCM</td>
<td>Per episode care management fee plus performance-based pay (a.k.a. shared savings)</td>
</tr>
<tr>
<td>Apr 2015</td>
<td>Medicare Access &amp; Chip Reauthor Act (MACRA)</td>
<td>Mandates PFS transition from value-based to merit-based pay (MIPS) by 2019</td>
</tr>
<tr>
<td>June 2015</td>
<td>ASCO Value Framework</td>
<td>Starts the comparative effectiveness dialogue: clinical benefit-toxicity-cost</td>
</tr>
<tr>
<td>July 2015</td>
<td>Comprehensive Care for Joint Replacement (CCJR)</td>
<td>CMS mandates hip &amp; knee bundled price in 75 markets – analogy for oncology?</td>
</tr>
</tbody>
</table>
1. The market forces driving the transition from volume-based to value-based care aren’t going away

2. If you do pathways compliance + pro-active care management + disciplined advance care planning (the core features of Oncology Medical Home), you can cut the cancer spend by about 12%

3. There will be continued interest in narrow/preferred networks consisting of those providers who can demonstrate a differentiating value proposition

4. Health Plans will continue selective experimentation with APMs

5. CMS will learn from OCM and will push for assumption of 2-sided shared savings risk in OCM year 3 - 2019

6. This all could be precursor to shift of financial risk to providers

7. In oncology risk is likely to be translated as bundled/episode pricing

8. Timeframe: plays out over next 3-5 years
What Can You to Do About It?

1. Practices should be driving the transformation locally
2. Market assessment: got any motivated health plans or other key players (ACOs, IDNs, employers/coalitions)?
3. Organizational assessment: cultural and operational
4. Define scope of services: what are you good at/what can you deliver? How will you control variation – avoid outliers?
5. Economic analysis: identify total expenditures for your particular scope of services (professional, technical, hospital, other); claims history and true cost analyses; is there a pony in there? Identify the arbitrage opportunity
6. Impact analysis: financial and operational impact on the practice. What, if anything, is the risk of doing nothing?
7. “GO/NO GO” decision. Now or later?
8. Negotiate, implement, monitor, refine/course correct
Questions - Discussion

• What is the current state of alternative payment initiatives in oncology?
• Where is it likely headed?
• What to do about it?
• Thank you for your interest in today’s topic: Oncology Payment Reform: What’s In/Out?

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