aceso global
where hospitals meet the healthcare system

Utilization and Payment in Cancer Care – US Experience

Maureen Lewis, PhD
CEO

17 February 2017

Is oncology different?

- In the US costs are rising much faster than other diseases
- Clear problem with overuse of some aspects of services
- Little attention to costs, cost effectiveness or outcomes of alternative therapies
- Clinical care changes as new drugs therapies come on the market

Why oncology services under used?

- High cost of care, due to
  - Excessive use of hospitalizations and tests with uncertain value
  - High costs of inputs (imported/brand products/unnecessary tests and treatment)
  - Inadequate following of patients under treatment
- Lack of public or private insurance coverage
- Ignorance of evidence or unwillingness to adapt

Why are oncology services over used?

- Payers and payment system offer no restrictions and minimal oversight of provider diagnosis and treatment patterns
- No co-payment by patients
- No incentives for efficiency or quality:
  - Under use of treatment guidelines
  - Fragmented care with multiple providers – physician, hospital, pharmacy
  - Greater reliance on hospitalizations and ER
  - No harnessing of innovation that could lower use and raise quality of care

Many of the characteristics of under- and over-use overlap

- Characteristics of quality health care improve performance, outcomes, and costs
- The world of medicine is changing, and it affects oncology and medicine in general
  - More technology
  - Integrated approaches increasingly needed
  - Clinical protocols become more important in fast changing world of medicine

Key Issues for Oncology Care

US/EU efforts to improve access and control costs of oncology care

- Driven by realization of under and over use of oncology care
- Rising costs for oncology diagnosis and treatment
- Costs are “out of control”

Key issues: Organization of services

- Recent evidence points to the importance of:
  - careful use of tests and treatment option
  - integrated care
  - treatment teams
  - Clinical guidelines \ protocols (big issue in FFS)
  - following patients during treatment
  - use of generics where advised

Key issues: Delivery and Payment

- Delivery systems need to embrace change and adapt to improve quality and lower costs
- Payment systems key to incentives for achieving these goals

Private-Public consensus on need for change

- American Society of Clinical Oncology
- Medicare/Medicaid –federal public insurance organizations (payers)
- Private health care plans (payers)
- Patient advocacy organizations

$\Rightarrow$ Rising experimentation on how and what to change

Example of Physician Practice Oncology Reorganization of Care

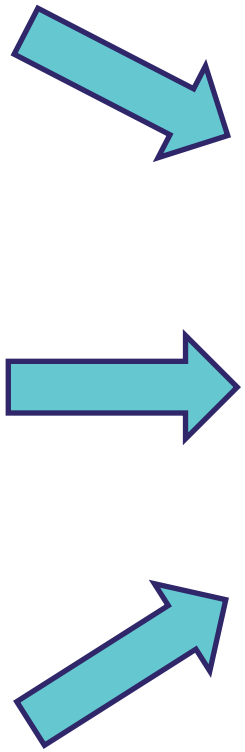
Expanded Office Hours

24 Hour Nurse Response to Patient Problems

Proactive Coordination with Primary Care Provider

Use of Integrative Medicine Modality

Better Patient Education



Reduced ER & Hospital Admission by >50%

Results of adoption of oncology treatment guidelines use

- Evidence-Based Treatment Guidelines
- Quality Measurement Systems

→ Lung cancer demonstration project: reduced chemotherapy costs by 37%

- Shared Decision-Making
- Redesign of Care Processes

→ Across 4,700 cancer patients at 46 sites: drug costs declined by 13%

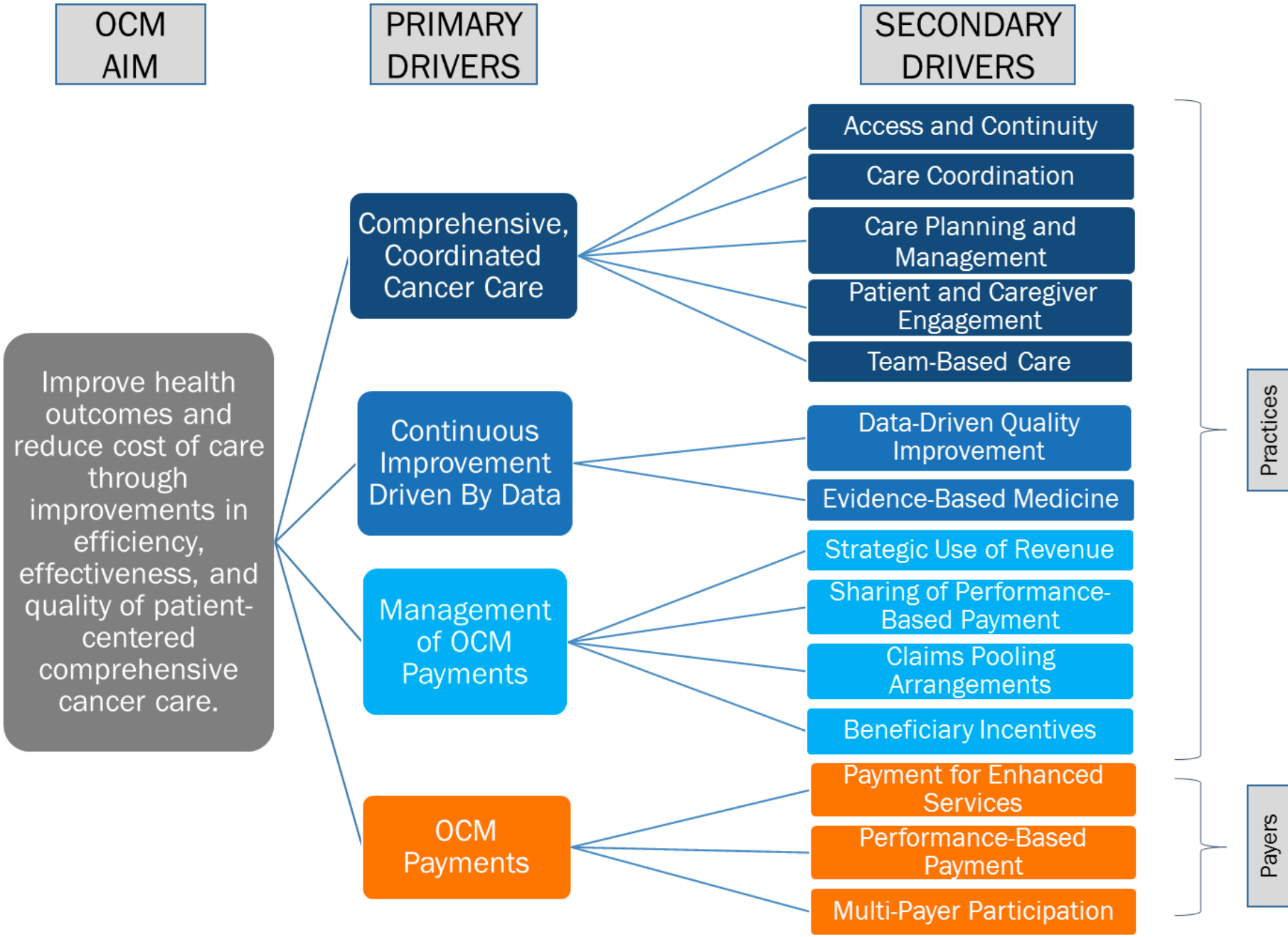
CMS Leading on Oncology Care Model Design

Affordable Care Act Leading Change….

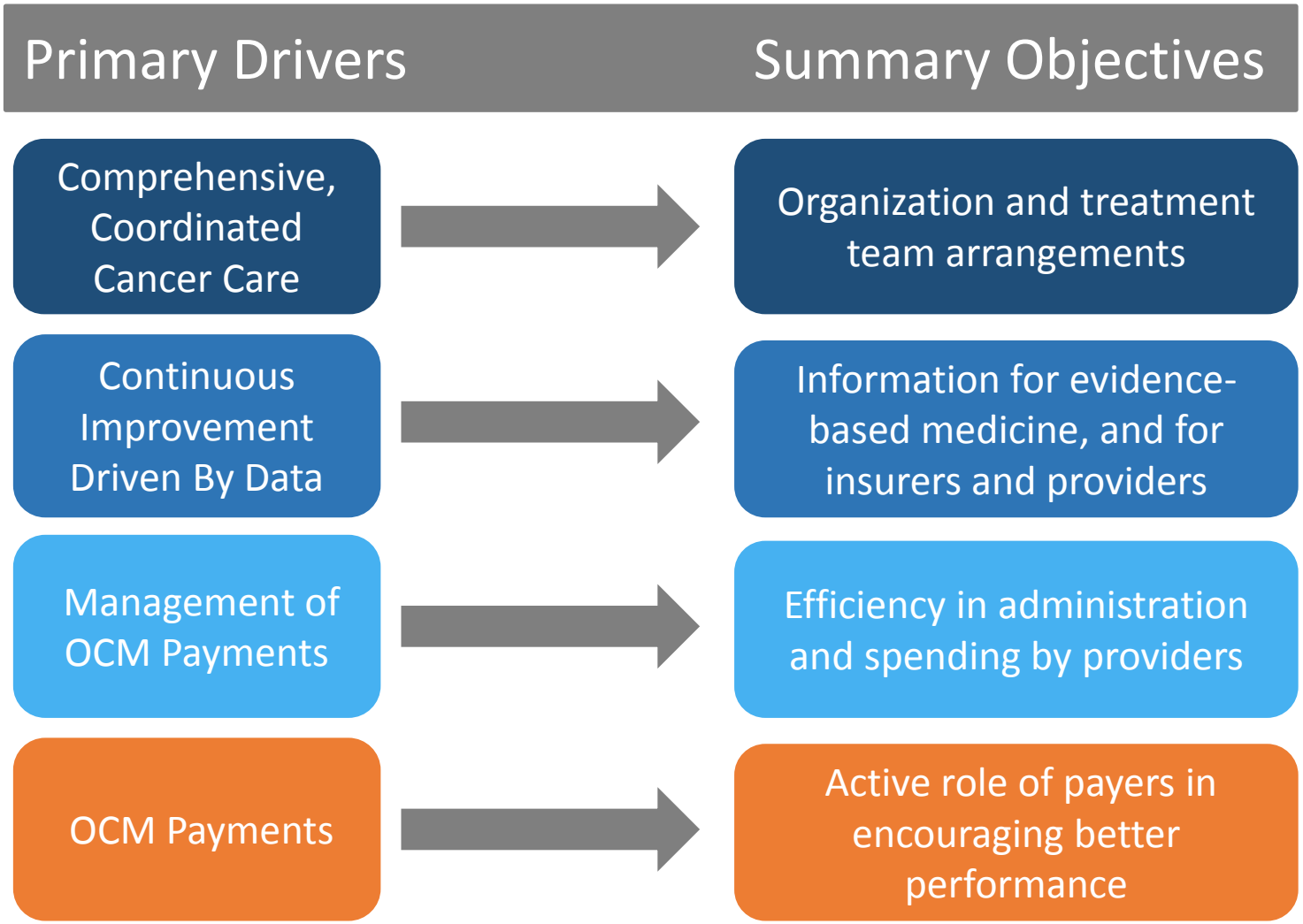
CMS Innovation Unit

- Focused on containing costs and raising quality
- Oncology Care Model (OCM) major multi-pronged approach to understanding how to promote change and ensure affordability of cancer treatment
- Major national demonstration projects launched in 2015

=> controlled experiments and evaluation


OCM AIM
PRIMARY DRIVERS
SECONDARY DRIVERS
Improve health outcomes and reduce cost of care through improvements in efficiency, effectiveness, and quality of patient-centered comprehensive cancer care.
Comprehensive, Coordinated Cancer Care
Continuous Improvement Driven By Data
Management of OCM Payments
OCM Payments
Access and Continuity
Care Coordination
Care Planning and Management
Patient and Caregiver Engagement
Team-Based Care
Data-Driven Quality Improvement
Evidence-Based Medicine
Strategic Use of Revenue
Sharing of Performance-Based Payment
Claims Pooling Arrangements
Beneficiary Incentives
Payment for Enhanced Services
Performance-Based Payment
Multi-Payer Participation
Practices
Payers

Explaining Oncology Care Management



Oncology Models Priority Data Sources

- Tracking of claims data
- Patients surveys
- Site visits
- Analysis of quality measurement data
- Time and motion studies
- Medical record audit
- Tracking of patient complains and appeals

Oncology Model Quality Measures

- Clinical quality of care
- Communication and care coordination
- Person and caregiver centered experiences and outcomes
- Population health
- Efficiency and cost reduction
- Patient safety

What are the incentives to encourage adoption of new treatment models for oncology?

Payment Arrangements: Drivers of Change

CMS Payment Arrangements for Oncology

Fee For Service (FFS)	**Reimbursement for all costs** incurred. Encourages high volume of care and bias toward costly services and drugs
Diagnosis Related Groups (DRG)	**Prospective payment** promotes efficiency in hospital care as hospitals are at risk for high costs. Encourages higher cost services and higher volume of care
Bundled Payments	**Finance episodes of care** with emphasis on continuity of care and avoidance of (re)hospitalizations and Emergency Department use. Effects mixed
Accountable Care Organizations (ACO)	**Shared savings.** Integrated care network with hospital(s), continuous and coordinated care services at clinics; emphasis on prevention; nurse-based care with patient follow up. Can improve quality and reduce costs

CMS Experiments Evaluate Bundled Payments for Oncology

Oncology Care Model Experiments

- Objectives is raising quality and lowering costs through use of accepted and evidence-based processes and clinical guidelines
- 17 private payers participate with Medicare in creating incentives for care transformation with physician practices
- Payers design their own incentives for their beneficiaries
- Non-participating payers benefit from savings, better outcomes for their beneficiaries

Characteristics of Bundled Payment Experiment

- Episode based – only post diagnosis but through treatment (diagnosis phase is FFS)
- Bundled payment sets “target price” for the participating physician groups
- “Target price ” 6% below current benchmark price – measuring ability to be more efficient
- “Practice transformative” – change the way oncology care is provided

Two-part payment system to incentivize quality of care

- Per beneficiary payment of $160 to physician practices to manage and coordinate care for an episode of care
- For beneficiaries who undergo chemotherapy treatment: performance-based payment over 6 months of care =>incentive to lower the total cost of care and improve care during treatment episode or payment reduced

CMS Oncology Bundle Payment Models

	Model 1	Model 2	Model 3	Model 4
Episode	All DRGs + acute patients	Selected DRGs; inpatient + post-acute period	Selected DRGs; post-acute period only	Selected DRGs; inpatient + readmissions
Services Included	All hospital services paid as part of MS-DRG payment	All non-hospice hospital + outpatient services	All non-hospice hospital + outpatient services	All non-hospice hospital + outpatient services
Payment	Retrospective	Retrospective	Retrospective	Prospective

CMS Oncology Bundle Payment Models

	Episode Definition	Services Included	Payment
Model 1	All DRGs & acute patients	All hospital services paid as part of MS-DRG payment	Retrospective
Model 2	Selected DRGs; inpatient + post-acute period	All non-hospice hospital & outpatient services	Retrospective
Model 3	Selected DRGs; post-acute period only	All non-hospice hospital & outpatient services	Retrospective
Model 4	Selected DRGs; inpatient + readmissions	All non-hospice hospital & outpatient services	Prospective

Results from CMS Oncology Bundle Payment: Model 2

Model 1 inconclusive, Models 3 and 4 samples too small for measuring outcomes

Most savings come from changes in **post-acute care**

- Improved communication between inpatient and discharge facilities
- Less time spent in costly institutional care
- Decreased readmissions
- Reduced care costs by a small amounts in many areas

Net impact: **savings of $513** for an episode of care…

- 15% reduction in discharges to institutions for post-acute care
- 2 – 3.5% decrease in unplanned readmissions

…Despite $1266 increase in inpatient stay costs

Results from Bundled Payments for Orthopedics Experiment

- Saved the orthopedic hospitals over $1.6 million in 2015
- Additional revenue for physicians
- Decreasing the overall cost of care
- BPCI improved patient care due to improved algorithms, cost control and case management
- Average savings per case:
  - $1969 for arthroplasties
  - $ 975 for hip and femur fractures.

Key Messages and Considerations

- Private and public providers and payers have an interest in improving quality and controlling costs – the alternative isn't affordable
- Public and private need to work together
- Payers must play an oversight role if costs containment and better quality are to be achieved

- Objective is transformative clinical practice
- Patient centered care increasingly clear as objective to change practices
- Use of clinical guidelines/pathways/protocols is critical – and many physicians resistant
- Data are key to effective oversight
  - providers need to track performance
  - payers need data to achieve desired outcomes

Obrigada!

mlewis@acesoglobal.org

acesoglobal

www.acesoglobal.org