

Specialty Payment Model Opportunities Assessment and Design

Oncology Technical Expert Panel

November 20, 2013

Baltimore, MD

Overview of the Day and Project

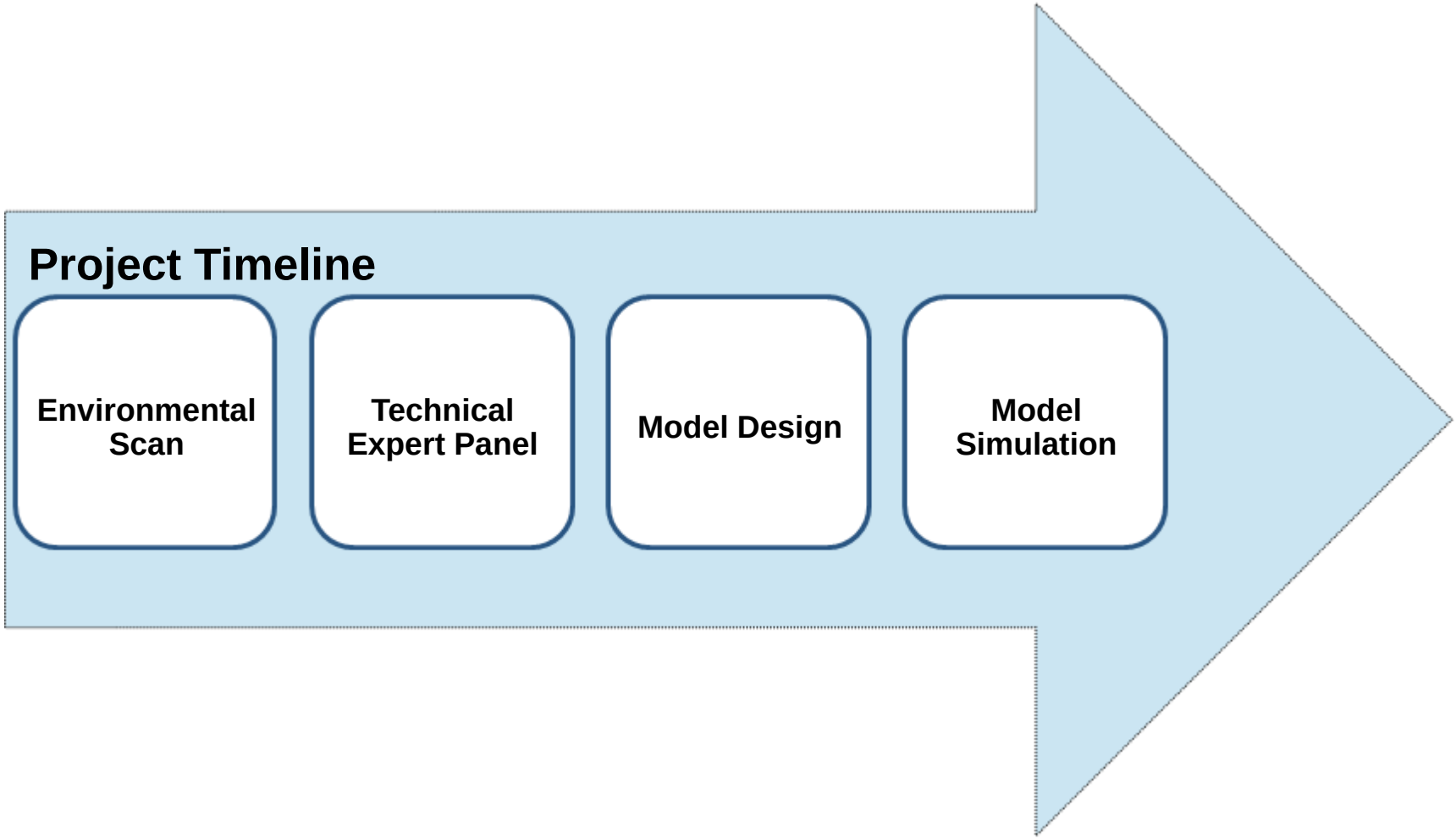
Agenda

Time	Topic
8:30 – 8:45	Welcome and Introductions
8:45 – 9:00	Overview of the Day and Project
9:00 – 9:30	Overview of Redesign Framework
9:30 – 10:30	Alternative 1: Clinical Pathways
10:30 – 10:45	Break
10:45 – 11:45	Alternative 2: PCOMH
12:00 – 1: 00	Alternative 3: Bundled Payment (Working Lunch)
1:00 – 1:45	Alternative 4: Oncology ACO
1:45 – 2:15	RAND Approach to Data Analysis
2:15 – 2:30	Break
2:30 – 3:45	Elements to Support Redesign Framework
3:45 – 4:00	Concluding Remarks
4:15	Shuttle to BWI

Project Overview

- **Comprehensive scan of the payment model environment.**
- **Inclusion of ideas and opinions from a broad range of interested stakeholders regarding opportunities for novel payment models in oncology.**
- **Insightful analysis and assessment of the opportunities for novel payment models identified.**
- **Collaboratively designed payment models for CMS.**
- **Development of medical specialty payment model options that can be realistically executable in CMS's current business environment.**

Project Overview



Environmental Scan Methodology

- **The project team conducted a comprehensive environmental scan:**
  1) literature review of the existing peer-reviewed and grey literature and popular media
  2) 39 semi-structured strategic stakeholder interviews

- **Stakeholders included academic researchers, providers in community and academic settings, payers, patient advocates, representatives of care management organizations, leaders of companies that offer services and commodities to oncologists and health systems, and heads of specialty organizations, among others.**

- **Following each recorded interview, comprehensive notes were then coded and summarized by two separate team members.**

Common Stakeholder Themes

- **Movement toward payment models that incent higher-value cancer care is essential**
  - Transition from volume-based reimbursement to a focus on payment for episodes of care would align physician payment the delivery of high quality care
- **New payment models should tie quality metrics and performance to payment**
- **Opinions diverge in how best to design a new model**
  - Some believe the model should be built on top of the existing fee-for-service
  - Others think that more innovative payment reform is necessary
- **Future payment models must also consider the following:**
  - Workforce issues, site of service cost differentials, focus on true payment reform and not simply reform of drug policy.
- **Opportunities center on reimbursement around episodes of care managed by a medical oncologist**
  - Future reform efforts may be expanded to include additional specialties, such as radiation and surgical oncology,
  - At this time, an incremental transition to case-based payments to medical oncologists would provide a positive step in improving the delivery of cancer care at lower costs.

TEP Goals

- **Provide input on how to best design an alternative approach based on the following elements:**
  - Care delivery reform
  - Payment reform
  - Requirements for provider groups
  - Potential unintended consequences

Common Questions for Alternative Model Discussions

- What are the considerations for different settings?
- What are the barriers to implementing the proposed alternative payment model?
- What would make an alternative approach attractive to providers and payers?
- What is the impact on the patient and patient engagement?

Overview of Redesign Framework

Present State of Cancer Care Delivery

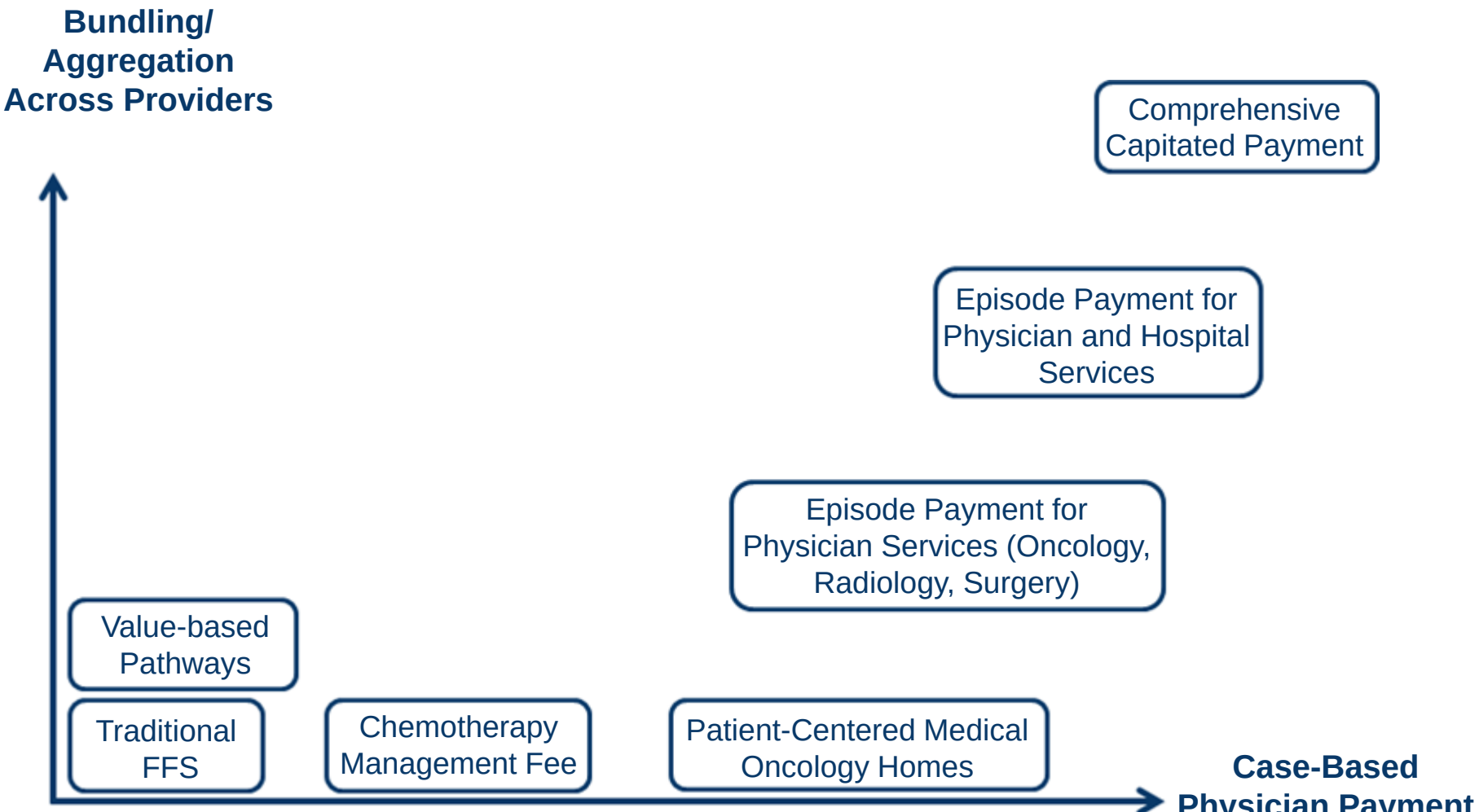
Misaligned Payment Incentives

Newly Aligned Payment Incentives

Dimensions of Payment Alternatives in Oncology

- New payment alternatives covering services that were previously excluded.
- Shift funds away from fee-for-service (can be in addition to or substitute).
- Payment for other providers.
- Capture shared-savings

Various Payment Reforms Options



Payment Reforms in Oncology
Examples of Current Approaches

- **Value-based Pathways**
  - Payment linked to practice adopting clinical pathways
  - Intended to address unexplained variations and eliminate low-value care
  - Payment initially for pathway participation, eventually pathway adherence
- **Chemotherapy Management Fee**
  - Alternate system for chemotherapy reimbursement
  - Redirects current ASP+6 reimbursement into a chemotherapy management fee
  - Potential cost savings for CMS
  - Improved quality of care
- **Oncology Medical Home Model**
  - PBPM care management fee for patients managed by medical oncologist
    - Gain sharing for reduced total cost of care potentially built into PBPM payment
  - Based on NCQA Patient-Centered Medical Home in primary care
  - Practices receive a “care coordination fee” for practice transformations
  - Expected to achieve Level III Recognition from NCQA over time

Payment Reforms in Oncology
Examples of Current Approaches

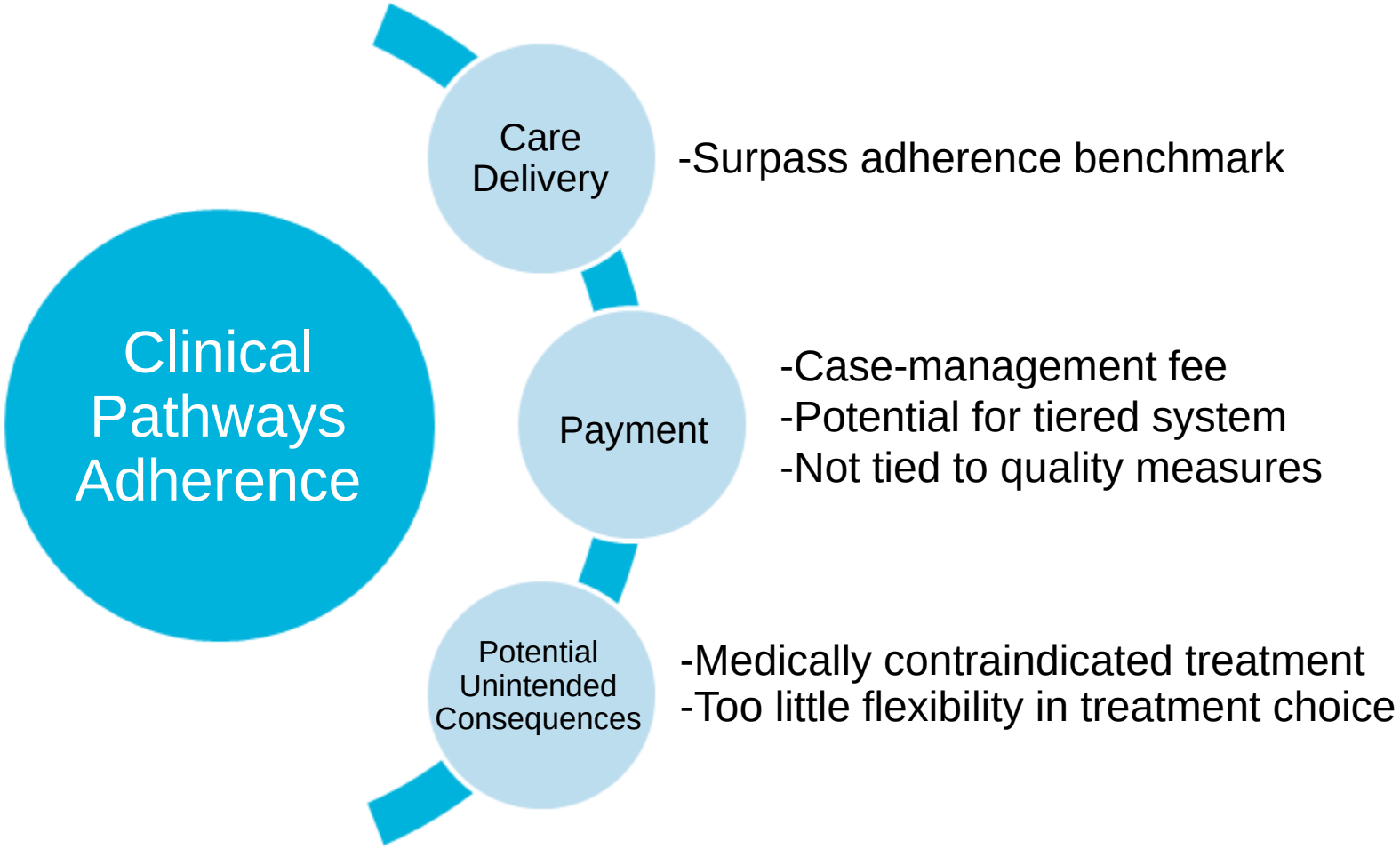
- **Episode Payments**
  - Inclusive payment for a set of services, may include multiple providers
  - Supports higher quality and efficiency
  - Initial trials with colon cancer and breast cancer bundles
  - Possible expansion to additional conditions and providers
- **Chemotherapy and Radiation Therapy Treatment Bundles**
  - Retrospective and/or prospective bundled payment for treatment course
  - Could be a step toward a larger model
  - May create heightened concerns of rationing
- **Oncology ACO**
  - ACO arrangement for broader set of cancer patients with shared savings
  - Relatively easy to operationalize
  - May be less well suited to smaller providers

Summary of Models

Domain	Model Features	Clinical Pathways	PCOMH	Bundled Payment Model	ACOs
Delivery	Evidence-based pathways use	✓	✓	✓	✓
	Use of quality and performance standards	✓	✓	✓	✓
	High level of provider accountability		✓	✓	✓
	Patient-centered focus		✓		✓
	Care coordination focus		✓	✓	✓
	Structural transformation required		✓		✓
	Encourages careful provision of care		✓	✓	✓
	Low administrative burden	✓			
	Potential inclusion of other specialties/areas		✓		✓
Payment	Shifts current FFS codes into case payments		✓	✓	✓
	Existing pilots in progress	✓	✓		✓
	Potential for continued savings over time		✓	✓	✓
	Case management fee	✓	✓		
	Care coordination/Infrastructure development fee		✓		
	Potential for global payment			✓	✓
	Level of provider risk	Minimal	Minimal	High	High
Quality	Payment tied to quality and performance			✓	✓
	Standardized Patient-Reported Outcomes				
Comprehensiveness	Level of shift from current system	Minimal	Moderate	High	High
	Level of comprehensiveness of model	Minimal	Moderate	High	High

Alternative 1

Alternative 1: Clinical Pathways



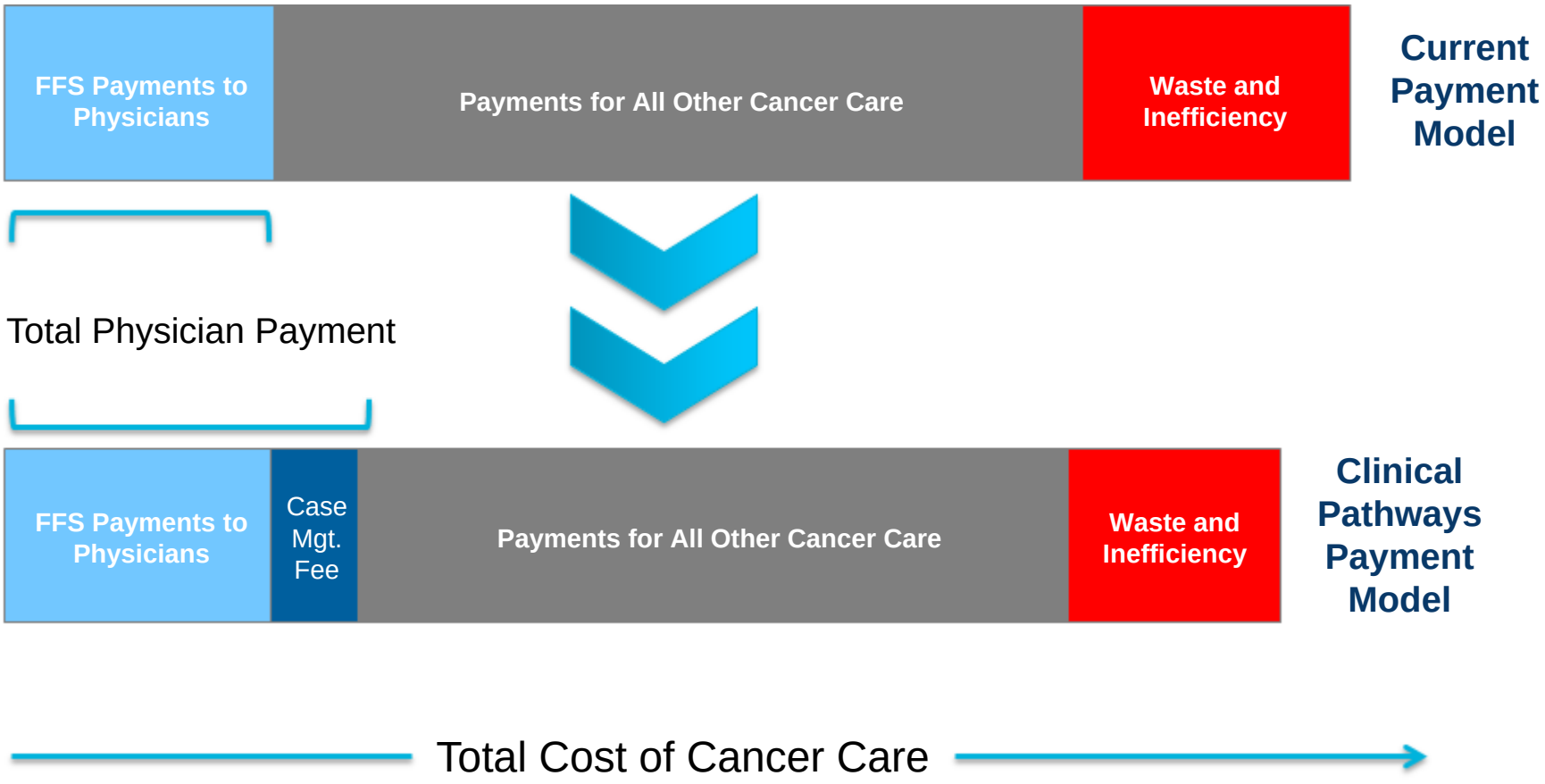
Alternative 1: Clinical Pathways Care Delivery Structure

- **Goal**
  - Improve adherence to evidence-based treatment
- **Changes to structure of care delivery:**
  - Benchmark (~80%) adherence to on-pathways regimens
- **Development of pathways:**
  - Payer-developed pathways
    - Internal development
    - Commercial purchase of existing pathways
  - Provider selection from a group of payer-approved pathways
  - Provider-developed pathways
  - NCCN cancer treatment compendia by cancer site

Alternative 1: Clinical Pathways Care Delivery Structure

- **Goal**
  - Minimize reliance on drug margins for practice revenue
- **Payment structure**
  - Case management fee
    - Currently non-standard among pilots
      - Range: ~$250.00-300.00
    - Overlaid on fee-for-service
  - Future directions
    - Some piloting shared savings arrangements
    - Tiered reimbursement
- **Payment conditions**
  - Initiation on first administration, conclusion upon final administration
  - Adherence of ~80% to on-regimen pathways
  - Limited risk, slightly more accountability

Alternative 1: Clinical Pathways Payment Model Schematic



Alternative 1: Clinical Pathways Advantages and Disadvantages

- Evidence-based treatment
- Standardized across providers
- Consensus-driven among providers interviewed
- Reasonable flexibility in adherence
- Begins to de-link reliance on payment from margin on drugs

- Minimal shift from current system
- Fear of providing medically-contraindicated treatment
- Payment overlays on fee-for-service
- Payment tied only to process measures
- Likely one-time savings
- Minimal change in provider incentives

Illustrative Clinical Example

- **Several pathways exist for Breast Cancer (non-metastatic)**
- **Practice uses a pathway for breast cancer and receives a standard payment for patients with this particular cancer**
- **Increase in payment levels if the adherence rate is at or above the minimum expected level**
  - Increases offset the cost of participation in the pathway
- **Decrease in payment levels if adherence is below the expected minimum level (degree of payment reduction is pre-determined and a fixed percentage)**
  - Unless practice can demonstrate that for patients with particular type of breast cancer, pathway does not cover the characteristics of that patient

Alternative 1: Clinical Pathways Discussion

- What are the considerations for different settings?
- What are the barriers to implementing clinical pathways?
- Should core or cancer-specific pathways have different weights to determining whether a provider receives a case management fee?
- What would make clinical pathways attractive to providers and payers?
- What is the impact on the patient and patient engagement?

Alternative 2

Alternative 2: Oncology Patient-Centered Medical Home

Care Delivery

-Substantial structural change required for accredited distinction

-Additional oncology-specific modifications

Payment

-Case-management fee

-Additional infrastructure development payment

Potential Unintended Consequences

-Minimal provider savings achieved

Alternative 2: Patient-Centered Medical Home Care Delivery Structure

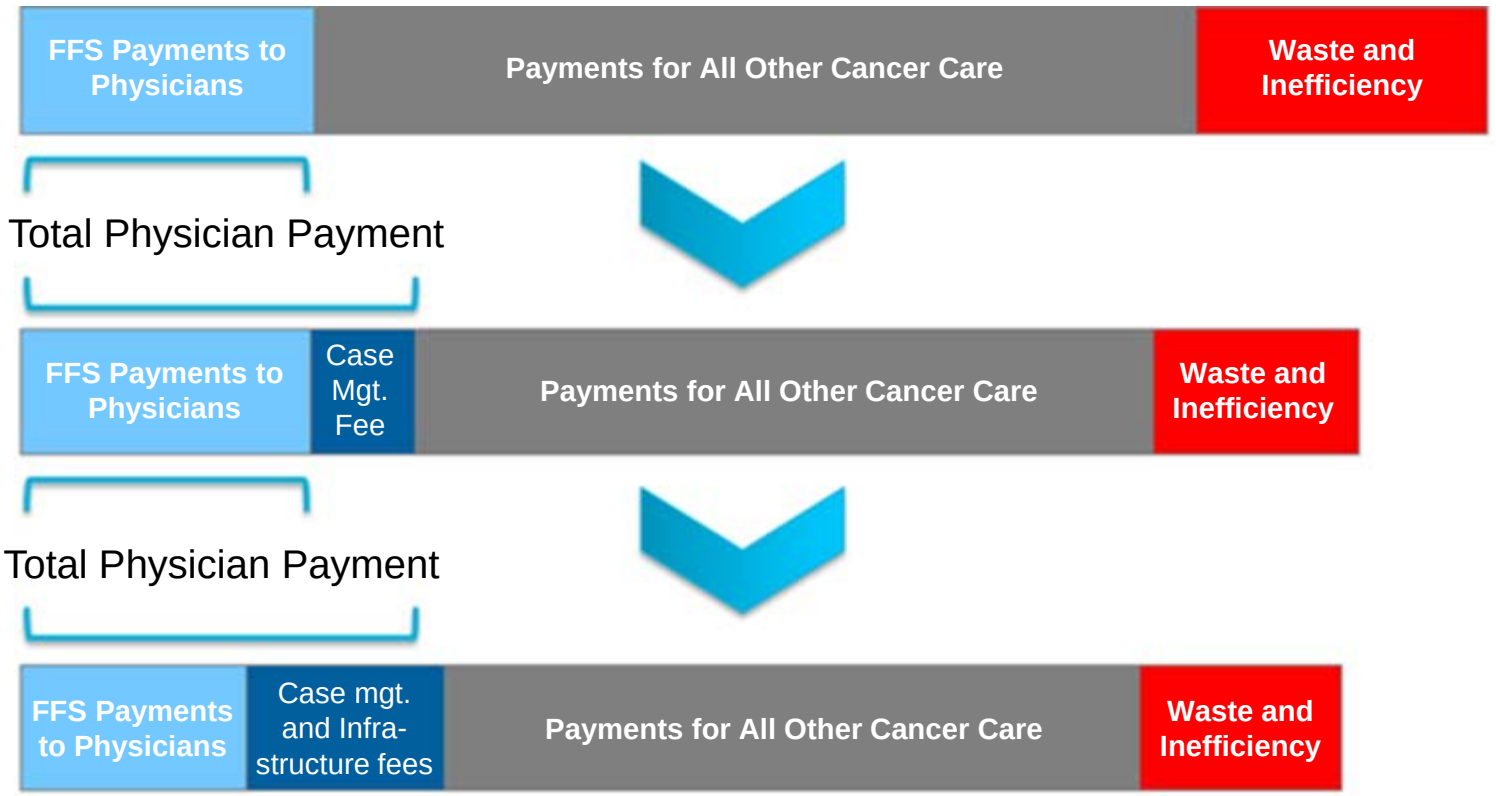
- **Goal**
  - Improve the quality, coordination and patient-centeredness of care
  - Reduce emergency department visits and hospitalizations

- **Changes to structure of care delivery:**
  - See NCQA criteria for Level III Patient-Centered Medical Home and oncology-specific goals in handout
  - In action, above criteria are met in the following ways:
    - Adherence to clinical pathways
    - Patient navigators/care coordinators in place
    - Enhanced hours and augmented access to clinicians , telephone triage
    - Patient engagement and empowerment
    - Practice assumes primary responsibility for coordination of all cancer-related services

Alternative 2: Patient-Centered Medical Home Payment Structure

- **Goal**
  - Cost savings from better coordinated, more patient-centered care
  - Minimize unnecessary utilization of services
- **Payment structure**
  - Case management fee
    - Currently non-standard among pilots
    - Overlaid on fee-for-service
    - Intended to reimburse new delivery features of the model: extended hours, medication management, patient education, telephone triages service, etc.
  - Infrastructure development payment
    - Defray cost of practice transformations
    - Conditions unclear
- **Payment conditions**
  - Initiation on diagnosis, extends into survivorship phase of care
  - Must meet performance and outcomes benchmarks
  - Minimal risk, substantial increase in provider accountability

Alternative 2: Oncology PCMH Model Schematics



Alternative 2: Patient-Centered Medical Home Advantages and Disadvantages

-Patient-centered, coordinated care

-Includes use of pathways

-Incorporates quality targets

-Positive incremental shift from fee-for-service

-Shifts some current fee-for-service payments

-Payment tied to quality and performance

-Case-based payment

-Payment for practice transformations

-Moderate structural changes necessary

-Higher implementation costs

-Potential administrative burden

-Payment overlays on fee-for-service

-Limited change in provider incentives

Illustrative Clinical Example

- **Patient presents for a new visit upon initial diagnosis of cancer**
  - Standard flat payment level with no adjustment for type of cancer or other associated factors (one time payment) with practice required to demonstrate minimum competencies at initial visit
- **Patient with cancer has an estimated six month duration of treatment (six treatment months)**
  - PMPM established based on length of treatment which is predetermined by type of cancer/stage
  - PMPM fixed no matter what length of treatment is
- **Patient experiences complications which extend usual treatment length; complications arise which change course of treatment**
  - PMPM could terminate OR continue with risk adjusted payment levels
- **Potential payment for:**
  - Transitions from oncology to primary care
  - Non-treatment month payments (pt still under care of clinic primarily but not receiving treatment)

Clinical definitions and other issues

- **Treatment month definition**
  - 30 day period during which patient receives a treatment for cancer regardless of mode of delivery
- **Can Treatment months and transition payment months overlap?**
- **Definition of End of Treatment Episode**
  - The transition payment is the end?
- **Adjustments based on:**
  - Inclusion of cost of chemo?
  - Rate of ER visits and hospitalizations?
  - Patient preference?
    - E.g., if patient would rather have a different or more expensive drug than the pathway in a medical home chose; would need to determine level of patient responsibility for financial burden?

Alternative 2: Patient-Centered Medical Home Discussion

- What are the considerations for different settings?
- What are the barriers to implementing the proposed alternative payment model?
- What specific requirements or targets would be needed to support intended goals of using a case management fee?
- What would make an alternative approach attractive to providers and payers?
- What is the impact on the patient and patient engagement?

Alternative 3

Alternative 3: Bundled Payment Model

-Depends on services included in bundle

-Global payment for a group of services previously reimbursed fee-for-service

-Higher provider risk and perception of constrained resources

-Potential for lower quality care

Alternative 3: Bundled Payment Model Care Delivery Structure

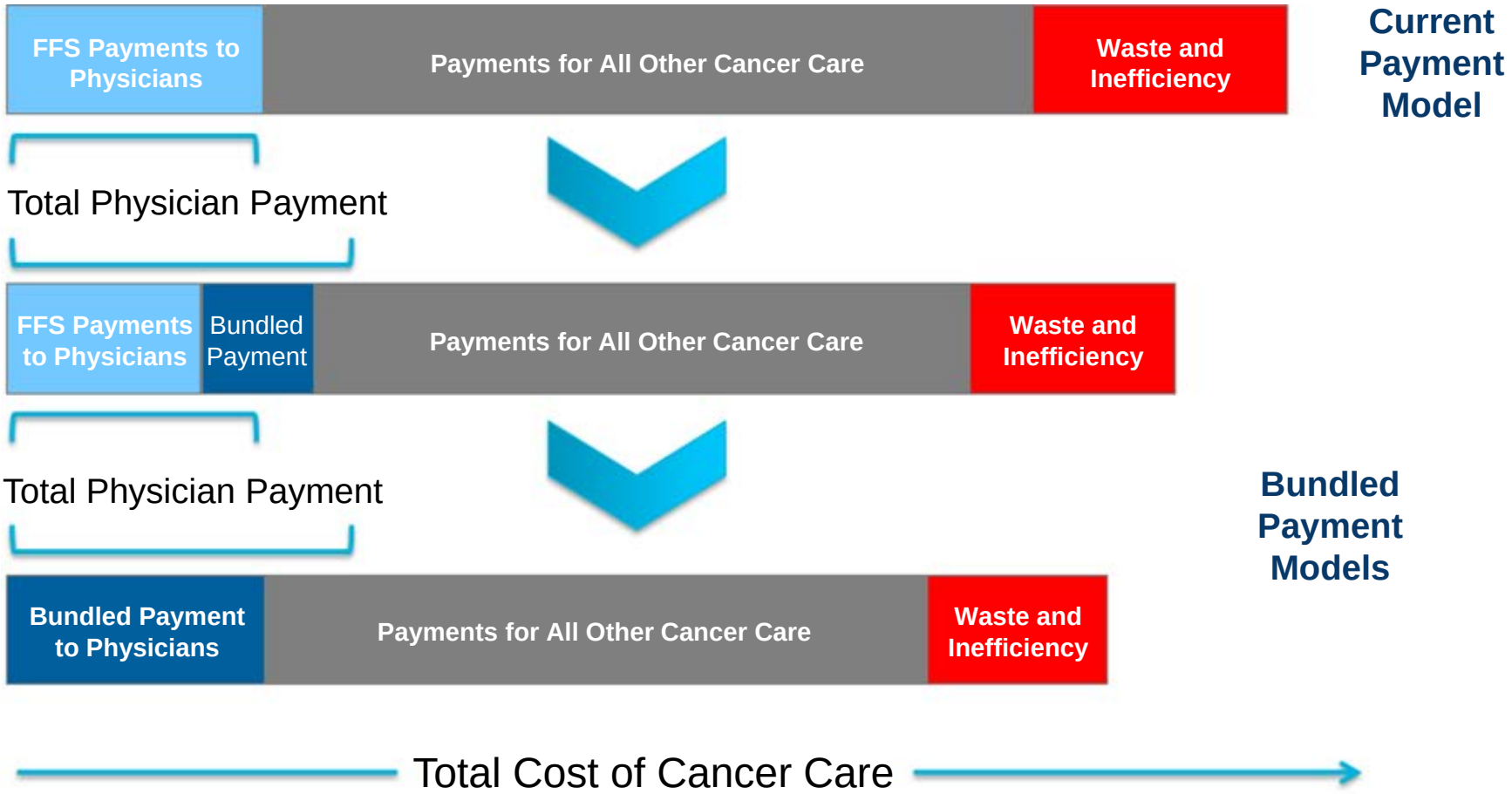
- **Goal**
  - Encourage providers to more carefully order the services they provide, and to favor lower cost options of equal effectiveness

- **Changes to structure of care delivery:**
  - Depends greatly on the services included in the bundle
  - Small bundles
    - Chemotherapy acquisition and administration bundle
  - Truly global bundles
  - Might consider inclusion of some or all of the following:
    - Inpatient care; post-acute care; chemotherapy regimen development; drug acquisition, administration, and symptom management; radiological services; oncologist professional services and patient E & M; emergency department visits; hospice stays; durable medical equipment; and care coordination.

Alternative 2: Patient-Centered Medical Home Payment Structure

- **Goal**
  - Transition current fee-for-service payments into case-based, global payments
- **Payment structure**
  - Global payment for a group of services previously reimbursed in a fee-for-service manner
  - Development depends on services included in the model
- **Payment conditions**
  - Initiation depends on intent of treatment
    - Intent to cure patients: bundle lasts length of treatment + ~60 days
    - Incurable cancer patients: bundle lasts arbitrary amount of time
  - Must meet performance and outcomes benchmarks
  - Risk depends on services included, increase in provider accountability

Alternative 3: Bundled Payment Schematics



Alternative 3: Bundled Payment Model Advantages and Disadvantages

-Can include other specialties & domains

-Flexibility in services included in bundle

-More global payment, encouraging efficiency and flexibility in adjusting to service needs of patient

-Stronger provider incentives to improve performance and reduce costs

-Greater shift for numerous current fee-for-service payments

-Tied to quality and performance

-Lower feasibility due to large shift from current system

-Potential for inappropriate or mis-treatment

-Perception of constrained resources

-Difficult to design and define bundles

Illustrative Cancer Example

- **Patient with metastatic colon cancer**
  - Bundle begins when patient begins in outpatient setting and includes professional services with:
    - radiation oncologist
    - medical oncologist
    - surgical oncologist
  - Includes all services related to treatment for inpatient, ambulatory services, infusion services, radiation therapy, emergency room visits and hospitalizations related to primary diagnosis of metastatic colon cancer
- **Chemotherapeutic drugs included in bundle**
  - Includes imaging related to primary diagnosis of cancer
- **Services not included in bundle**

Alternative 3: Bundled Payment Model Discussion

- What are the considerations for different settings?
- What are the barriers to implementing the proposed alternative payment model?
- What would make an alternative approach attractive to providers and payers?
- What is the impact on the patient and patient engagement?
- How should this model address pharmaceuticals?

Alternative 4

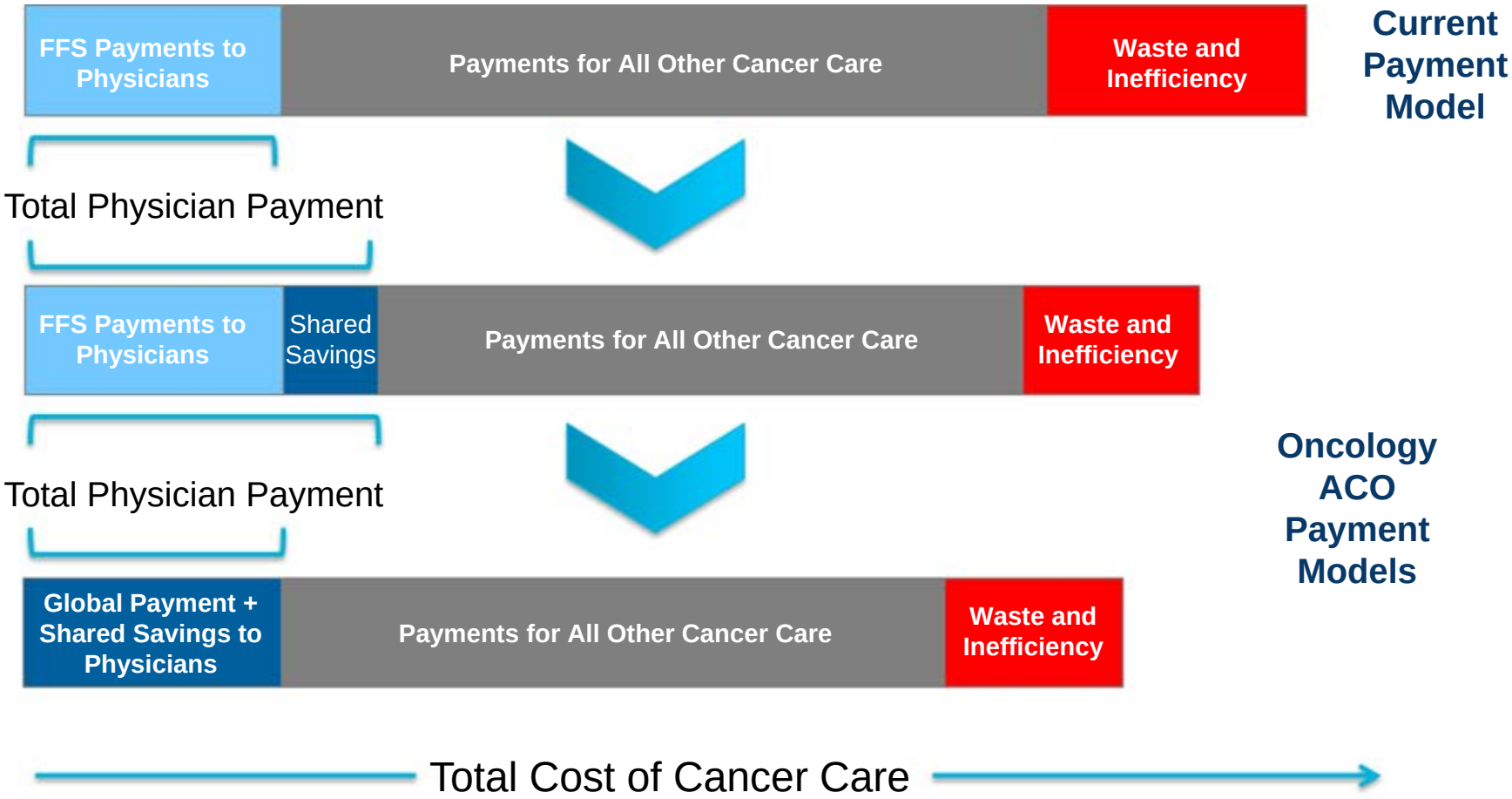
Alternative 4: Oncology ACOs

-Organized group of providers is accountable for the cost, quality, and overall care of a population

-Payment ranges from fee-for-service reimbursement to a transitional payment model to full global payment, depending on the maturity of the ACO

-Providing reduced or unnecessary care to save on costs

Alternative 4: Oncology Payment Model Schematics



Alternative 4: Oncology ACOs Payment Structure

- **Goal**
  - Transition current fee-for-service payments into case-based, global payments
  - Minimize unnecessary utilization of services
- **Payment structure**
  - Can take many forms, depending on ACO maturity
  - Majority of pilots are still fee-for-service with shared savings arrangements
    - Ideally, ACOs would function with providers under global capitation
    - Shared savings arrangements are generally standard
- **Payment conditions**
  - Must meet performance and outcomes benchmarks
  - Potential for high risk, high provider accountability
  - Initiation upon attribution to the ACO provider, ends up conclusion of treatment by the ACO provider

Alternative 4: Oncology ACOs Advantages and Disadvantages

-Can include other specialties and domains

-Increased provider accountability

-Comprehensive delivery model

-Potential for global payment

-Potential for high provider risk

-Flexibility in payment arrangement

-Tied to quality and performance

-Difficult to create provider networks

-Lower feasibility due to large shift from current system

-High up-front costs make it difficult for smaller provider groups to form an oncology ACO

-Potential for inappropriate or under-treatment

-Perceived constrained resources

-High-cost specialty inclusion can be challenging

Illustrative Cancer Example

- **Patient with new diagnosis of cancer attributed to oncology ACO**
  - Attributed provider (likely a medical oncologist but could be another type of specialist that is primary provider (plurality of services)
  - ACO takes main responsibility for:
    - Ongoing care in ambulatory settings
    - Transitions in care
    - Coordination with other providers/settings/etc.
- **Payments/Financing**
  - Services paid in FFS with potential for shared savings depending on risk
  - Payment changes first be based on quality outcome measurements
- **Patient is no longer attributed to ACO when certain thresholds met:**
  - Patient released from care of the primary provider
  - Death

Alternative 4: Oncology ACOs Discussion

- How would the considerations for an ACO model for oncology differ if the ACO was oncology-specific or if oncology was included in a Medicare ACO?
- What are the considerations for different settings?
- What are the barriers to implementing the proposed alternative payment model?
- What would make an alternative approach attractive to providers and payers?
- What is the impact on the patient and patient engagement?

RAND Analysis Approach

Peter Hussey

Health | Transformation

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RAND's Role

Provide quantitative analyses

To inform the development of new oncology payment models

Incorporate expert input into analyses

From TEP and other sources

Refine analytic approach

TEP discussion will inform specific research questions

TEP members will provide input on elements of analysis design

Key Questions

Opportunity Assessment	• What are the opportunities for improvement under new Medicare oncology payment models?
Model design	• What are the implications of key model design decisions?
Model Simulation	• What are the possible impacts of new payment models?

Data Sources

- **Medicare claims and enrollment files**
  - Utilization
  - Payments
  - Diagnoses
  - Limited beneficiary characteristics
  - Nationally representative
  - Available through 2013
- **SEER**
  - Clinical information (allows for validation of claims-based approach)
  - Not available for actual payment pilot
  - Not nationally representative
  - Available through 2010

Opportunity Assessment

How many Medicare beneficiaries eligible for the new payment model?

What level of payment and utilization accounted for by different categories of services?

Opportunities identified from historical utilization patterns

How much variation is there in payments and utilization by category of service?

- Variation between providers related to practice patterns (potential opportunity)

How much variation is there in payments and utilization by category of service?

- Variation between patients within providers related to patient characteristics (potential financial risk)

Identifying eligible beneficiaries

Claims-based - relies on diagnosis and procedure codes

- Patients with a claim with cancer dx
- Patients with a visit for cancer dx followed by chemotherapy
- Patients receiving radiation oncology services

Validation analysis

Compare SEER-based date of first dx with claims-based dx dates.

Categorizing Utilization

Type of Service

- Chemotherapy drugs
- Chemo administration
- Non-chemo oncology drugs
- Evaluation and management
- Imaging
- Laboratory
- XRT

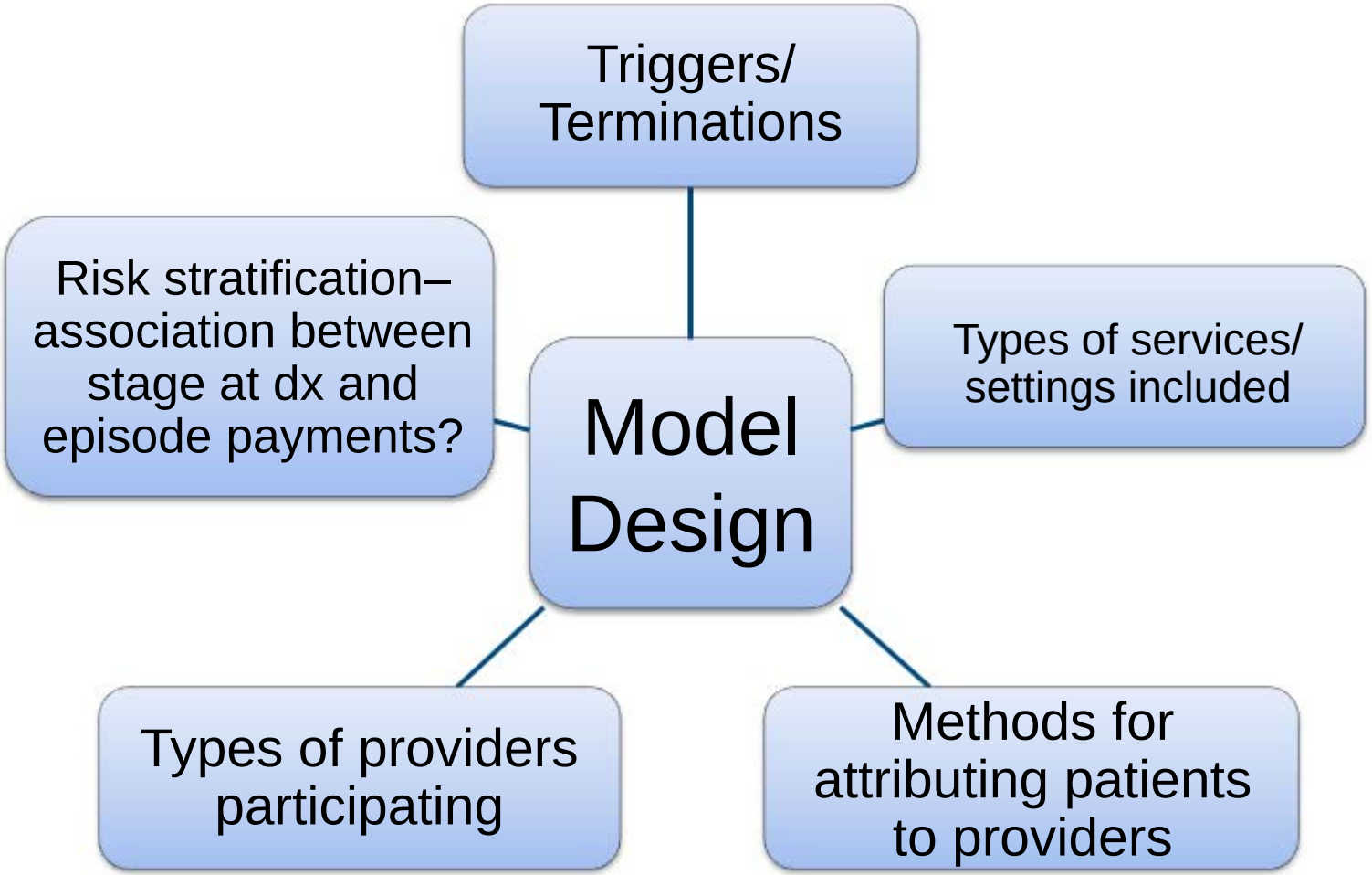
Place of Service

- Inpatient
- ED/obs unit
- Outpatient hospital
- Office
- Hospice
- SNF

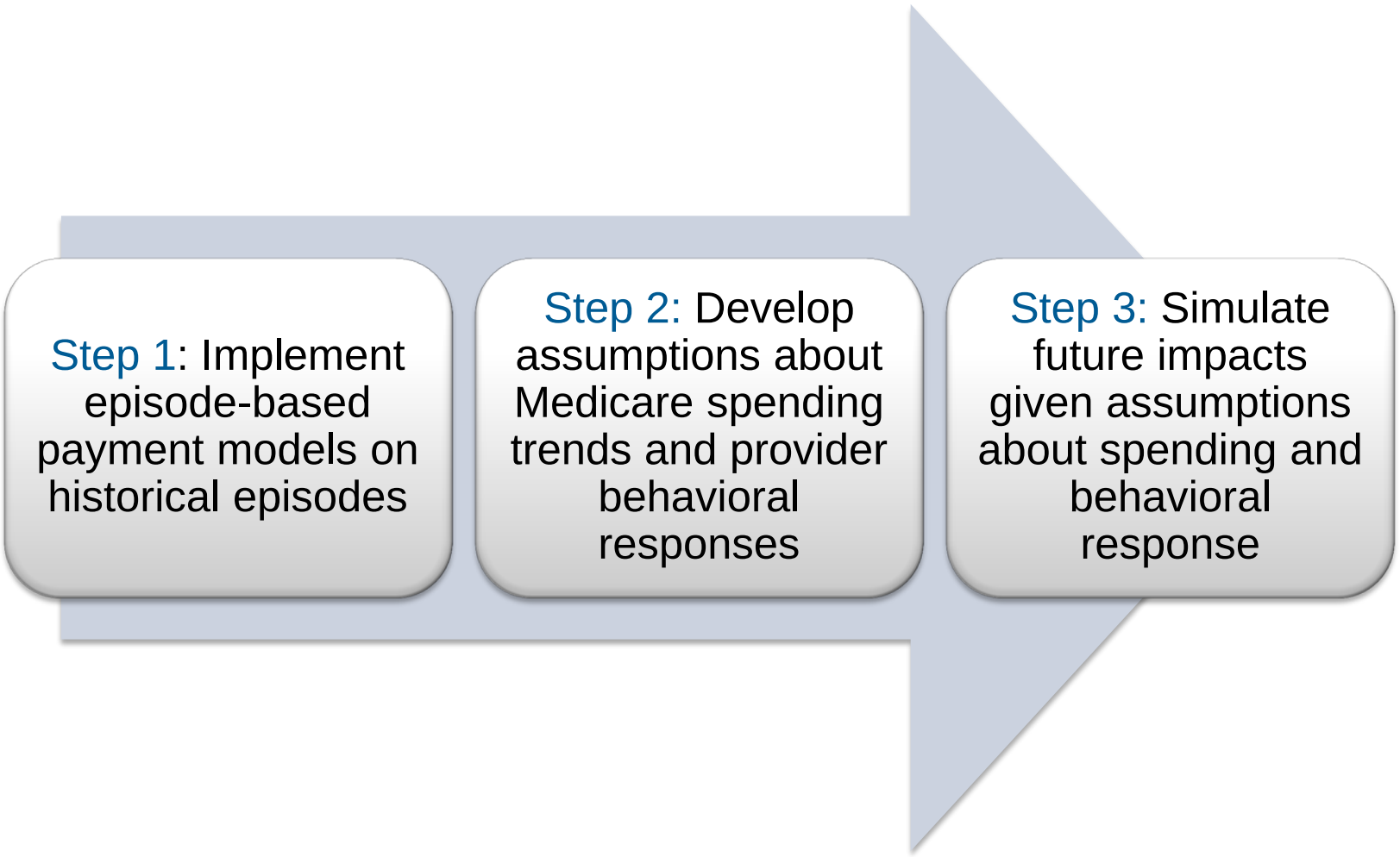
Type of Provider

- Medical oncologist
- Other oncologist
- Primary care
- Other

Model Design



Model Simulation



Questions for the TEP

- **What important questions related to payment model design should be addressed through quantitative analysis of historical utilization patterns?**
  - Potential supporting analyses include:
    - Off-label use
    - Risk adjustment with biological measures available in claims
    - Differences in treatment – hospital and community-based physicians
    - Regional variation in treatment
    - Tracing end-of-life utilization
    - Relapse vs. new cases
- **What types of assumptions should be incorporated into the model simulation?**

Elements to Support Redesign Framework

Recurring Themes

What are key elements within each category that require further development?

- **Performance measurement**
- **Data infrastructure**
- **Patient engagement**
- **Provider engagement**