APM Bundled Payments In Oncology

A Strategic Visioning Discussion

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Where are we?
Redesigning Incentives to Drive High-Value Cancer Care

Commercial payers are admittedly uncertain about how to redesign provider incentives to driver high-value cancer care. In an attempt to find an effective and feasible approach, they are actively experimenting with different models.

Hard to Keep a Foot in Two Boats

Competing Priorities in FFS and Value-Based Payment Models

Differences in Incentives for Fee-for-Service and Value-Based Contracts

Contract Model	1. Fee-for-service contract	2. Value-based contract
Payment Model Incentivizes	• Increasing patient volumes • Increasing number of services provided to each patient • Maximizing the revenue generated per service • Maximizing the number of high-cost services provided	• Reducing the total cost of care • Improving quality • Avoiding overutilization of services • Prioritizing coordinated care

Change Takes Time

Three Key Dimensions to Organizational Readiness

Organizational Leadership and Culture

- Leadership able to articulate clear version
- Commitment to clinical excellence and standardization
- Stakeholder amendable to change
- Alignment of hospital's and physician goals
- Willingness to be self-critical

Data Analytics Capability

- Cost accounting
- Quality reporting
- Ability to integrate data across systems

Cross-Continuum Focus

- Timely access to care
- Proactive symptom management
- Multidisciplinary care
- Palliative care
- Survivorship care
- End-of-life planning

Lessons Learned

Weigh the burden of developing and administering a bundle against the number of patients that it would cover and its potential benefits

- ❑ Seek out the highest volume payers in your market when considering who to partner with for bundles
- ❑ Assess the potential impact of bundled payment on patient experience
- ❑ Be open to the possibility that bundles might not be a good option for your program
- ❑ Budget substantial time and resources to find an accurate price point for bundles
- ❑ Streamline administrative processes to make bundle rollout as efficient as possible

Consider creating radiation therapy bundles

- ❑ Assess commercial payer interest in radiation therapy bundle in your market

Lessons Learned Cont'd

Build trust with payers in your market

- ❑ Assess if and how your program has worked to provide value-based care
- ❑ Craft a strategy to maintain and/or improve value, and share it with payers

Take advantage of the wealth of data that payers have

- ❑ Offer to share staging data with payers as a bargaining chip
- ❑ Use data from payers to understand your costs as well as costs your patients incur outside of your system to prepare for being responsible for total cost of care

Use data to drive continuous performance improvement

- ❑ Leverage insights form internal and payer data to develop strategies to reduce costs and provide higher quality care

Current Landscape

Public and Private Payors

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Radiation Therapy Bundles on the Horizon

Congress Mandated CMMI Radiation Therapy APM

Factors Making Radiation Therapy an Attractive Target for APMs

Clear treatment endpoints make it easier to determine episode length and attribute patients

Relatively standardized with fewer unexpected costs, making it easier to determine payment rate

Potential to reduce costs by changing clinical practices (e.g., type on technology, hypofractionation)

Radiation Oncology APM

Radiation Bundling (Episode based payment model) 2020

Qualify as Alternative Payment Model (APM) = 5% incentive bonus

Opportunity to earn back withholds

2% - professional and technical

2% - quality (professional)

1% - beneficiary experience

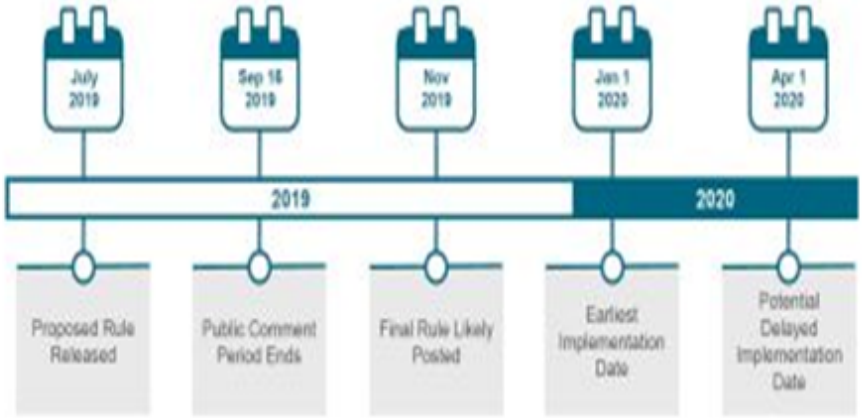
Payment

Technical (↓ 5%) (equipment, supplies, personnel, and related costs)

Professional (↓ 4%) (physician services)

5 year model to test lowering expenditure by CMS by 3% on radiation oncology services

Timing for Implementation of RO APM



Radiation Oncology Bundle Specifically

No matter what happens, start preparing now

While we wait to learn the details of the bundle, cancer program need to start developing strategies to decrease costs and improve quality. Best-in-class radiation oncology programs are doing the following:

1. **Ensuring adherence to evidence-based care:** Encourage the development of more clinical evidence and rapidly incorporate new information on cost and patient outcomes into treatment protocols. After implementing clinical pathways, one cancer program increased its use of hypofractionation for breast patients from 5% to 77% in just 3 years.

2. **Facilitating shared decision making:** Engage patients in treatment decisions that factor in costs to the patient, outcomes and their goals for care. Jefferson Health's decision counseling program helps low-risk prostate cancer patients select the treatment that aligns with their goals.

3. **Finding ways to improve safety:** Seek new opportunities to improve safety and compliance with processes and protocols. Northwell Health developed its Smarter Radiation Oncology program consisting of evidence-based pathways, daily peer review to ensure consensus on directives and contours, and rescheduling requirements designed to ensure every step occurs sequentially. Over a 22-month period, their peer review corrected issues in 25% of cases, saving time in the long run by reducing the number of treatment plans that require modification later on.

4. **Revamping investment strategy:** Invest in technologies that promote higher-value care. In the past, capital equipment's ROI was primarily determined by its impact on cash flow and capacity. These are still important, but you also need to consider nontraditional returns, such as cost avoidance resulting from reduced toxicities.

Building the Home Example – Commerical Payors

Cigna Collaborative Care Uses Financial Incentives to Drive Change

Cigna and Practice Contributions to Cigna Collaborative Care for Oncology

Cigna

- Financial incentives (i.e., patient management fee and opportunity for shared savings)
- Patient database (i.e., daily inpatient utilization reports)
- Operational support (i.e., access to non-clinical navigator, case manager, next-day admitted patient reports, learning collaborative)

Oncology Practices

- Provide 24/7 patient access
- Employ an RN oncology care coordinator for attributed patients
- Engage patients in shared decision making supported by evidence-based guidelines
- Report on six quality measures, including palliative care assessment and distress screening

Improve the **affordability of care** and provider cancer patients **a single point of care** that ensures all of their **needs are met**

The Oncology Care First Model

With Oncology Care Model (OCM) set to end in just over a year and a half, we've been wonder when the Center or Medicare and Medicaid Innovation (CMMI) would share its intentions for the next phase of oncology payment reform. We got a glimpse on Friday, November 1, when CMMI published an informal FRI on the Oncology Care First (OCF) model. With comments on this model due by November 24

OCF would replace OCM in 2021

The OCF would start January 1, 2021, and run for 5 years. The biggest change is the addition of a prospective population payment each month that would include payment for evaluation management (E&M) services, drug administration, and enhanced services (e.g., navigation).

Payment

1. **Prospective monthly population payment (MPP):** Essentially, this prospective payment would "bundle" reimbursement for E&M visits, drug administration, and enhanced services (e.g., navigation).
2. **Total cost of care:** Providers are on the hook for total costs over the six-month episode period, including drug costs.

Risk

The potential OCF Model would require all physician group participants that participated in COM to be in two-sided risk for the full duration of their participation with OCF Model.

Enhanced to OCM, the OCF would require participants to provide enhances services

1. Offer beneficiaries 24/7 access to a clinician with real-time access to their medical records.
2. To provide the core functions of navigation.
3. Document a care plant for beneficiaries that contains the 13 components of the **Institute of Medicine's** (IOM) Care Management Plan.
4. Treat beneficiaries with therapies consistent with nationally recognized clinical guidelines.

Oncology: 5 Year Blueprint Reframe

How to prepare for value-based and population-health initiatives?

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Moving Forward New Strategy

Minimize Clinical Variation

Change incentives for physician contracts to align with quality and variation: link to outcomes

Create Centers of Excellence across the System that define :

- high-quality, evidence-based care
- Future research
- Metrics for measuring quality
- System-wide tumor boards

Reduce Avoidable Complications

Develop of standardized referral networks, protocols of care, scheduling processes

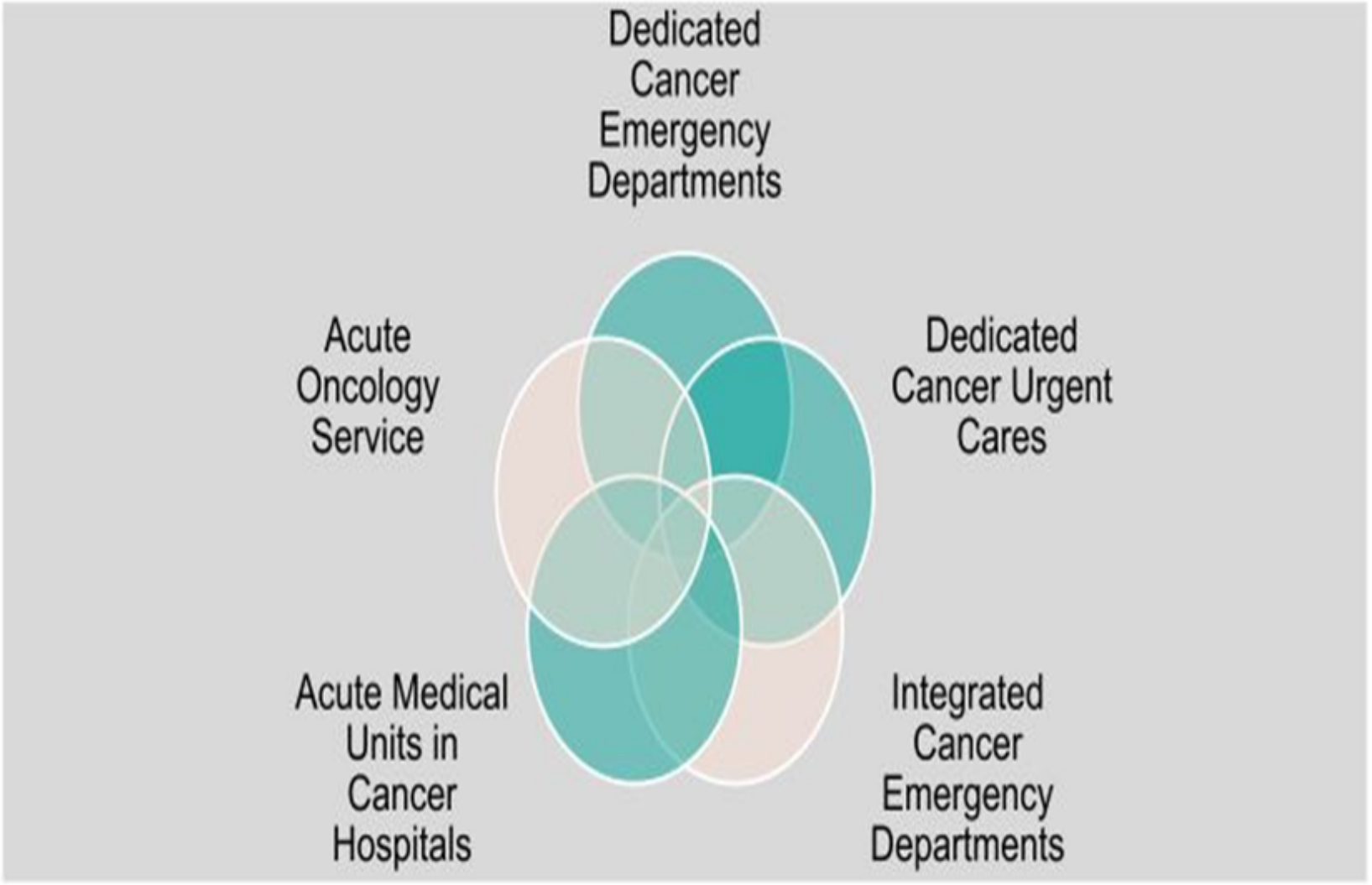
Dedicated APCs to manage patients urgent symptoms

Improve End of Life Care

Social Worker-led consult/intervention at initial diagnosis of non-curative disease

Develop Physician training programs to address difficult conversations, how to raise topics in a timely fashion.

Solutions/Models of Care



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Preparing for Value-Based Future

- Ensure adherence to evidence-based care reducing care variations: *VIA Pathways, etc.*
- Facilitate shared decision making and optimize clinical decision support
- Fine tune processes and protocols
- Closer ties with payers and employers (COE)
- Rethink investment strategy as we move quickly from volume to value
- Learn from first movers (early adopters of OCM)
- Address high clinical and operation costs associated with fee-for-service
  - **ED Utilization Example**

Action Item Recommendation

Urgent Care and Symptom Management Strategy

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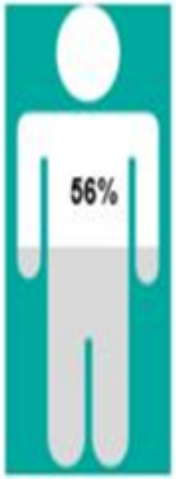
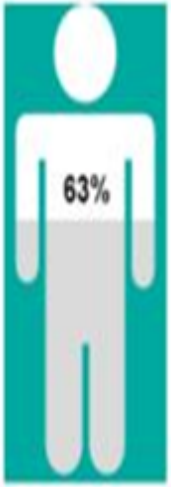
National Cost Implications: ED Utilization Example

Throughout their course of care, many cancer patients experience severe side effects including fatigue, pain, and nausea. When these symptoms aren't addressed in a timely way, they drive ED visits and hospitalizations that-if the symptoms were resolved promptly-could have been avoided.



Percentage of Medicare patients receiving chemotherapy who visit the ED each year



Percentage of ED visits by Medicare patients receiving chemotherapy that result in a hospitalization

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ED Costs Defined

Problem Defined: Data shows that each oncology patient has at least **two ED visits and one hospitalization** during chemotherapy treatment

The utilization accounts for significant avoidable costs. The actuarial firm Milliman estimates that the average cost for one chemotherapy-related ED visit is **$1800**. And if the visits results in hospitalization, the cost goes up to **$28,500**.

ED visits also negatively impact patient quality of care and satisfaction for myriad reasons:

- Immunocompromised patients are at risk for infection in the ED
- Patients are unfamiliar with ED clinicians
- ED cancer care teams don't usually have care coordination protocols
- ED clinicians and staff don't have oncology-specific training and expertise
- Patients may endure long wait times in the ED

Admissions and ED Visits

Starting in 2020, CMS will **hold providers accountable** for ED visits and hospitalizations by Medicare beneficiaries receiving chemotherapy.

Realizing that this ED utilization significantly impacts both cost and quality, CMS plans to hold providers accountable for ED visits and hospitalizations through the Outpatient Quality Reporting program.

OP-35: Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy

- Tracks cancer patients[2] having an ED visit of inpatient admission for one of ten conditions within 30 days of receiving chemotherapy
- Consists of two scores-one for inpatient admission rates and one for ED visit rates
- Impacts hospitals' outpatient Medicare payments beginning in 2020
- First cancer-specific measure in Outpatient Quality Reporting program

Ten Conditions Included

1. Anemia
2. Nausea
3. Dehydration
4. Neutropenia
5. Diarrhea
6. Pain
7. Emesis
8. Pneumonia
9. Fever
10. Sepsis

Size and Scope of the Problem

To address avoidable ED and hospital use, leaders must begin with an in-depth analysis to answer the following questions:

- How many cancer patients visit the ED each month?
- How many of those patients are hospitalized
- Why are patients visiting the ED?
- When do visits occur?
- Are there specific factors, such as tumor site, comorbidities, or lack of support at home, that are associated with increased ED visits and hospitalizations?
- What types of services and treatment are patients receiving in the ED?

Our own data: SMCS ED Utilization (6-month tracking)

✓567 encounters

✓344 unique patients

- Age Range: 27-94 years
  - Median Age: 67
  - Mean age: 66
- 187 (54%) female patients

- 15 pts (4%) did not have a PCP
- 329 pts (96%) had a PCP
  - 248 pts (72%) had a Sutter PCP
  - 96 pts (28%) did not have a Sutter PCP

Best Practices to Minimize Cancer-Specific ED Utilization

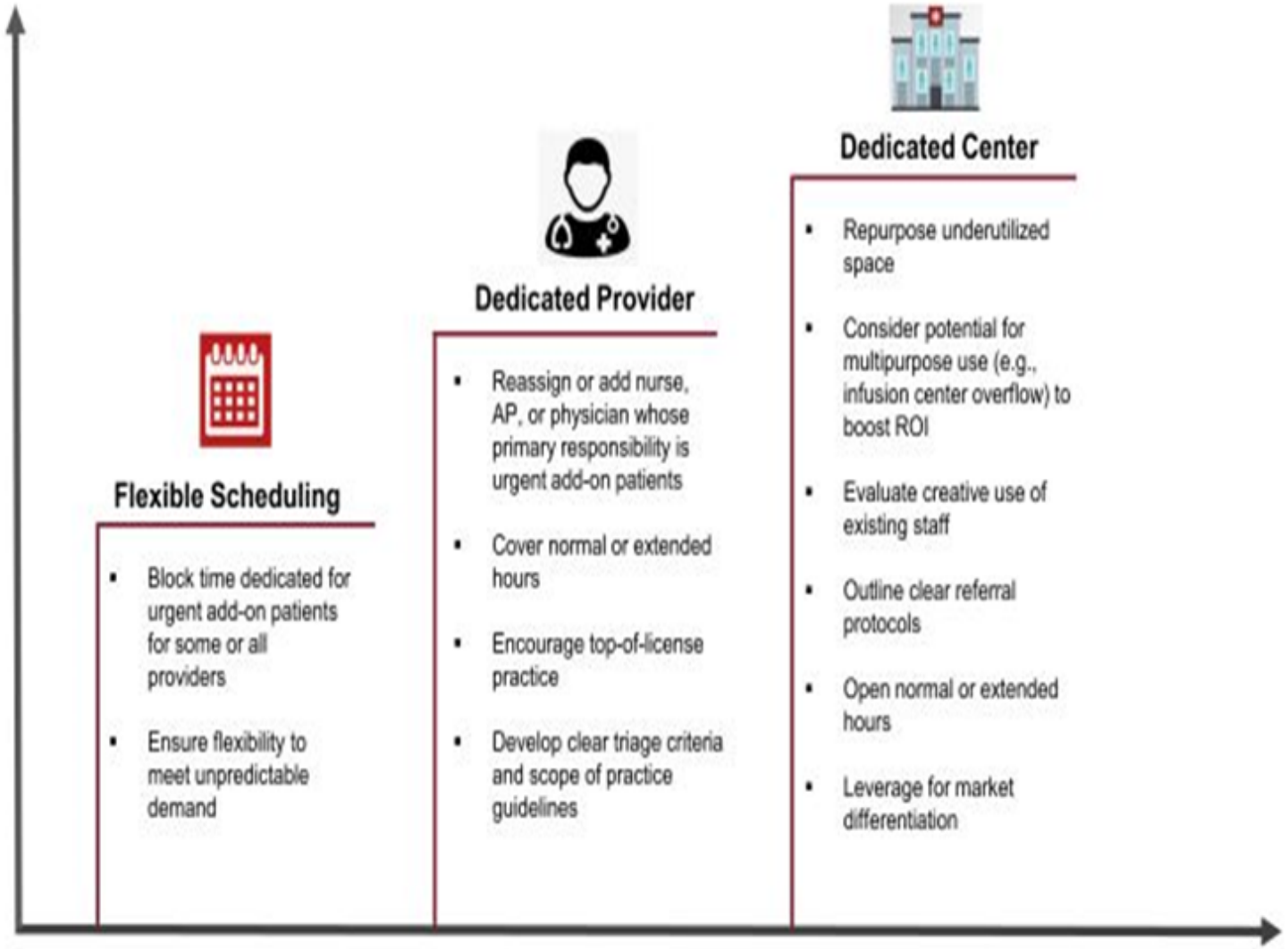
There are **three best practices** for cancer programs to reduce avoidable use of the ED and hospital.

Practice 1 Identify the drivers or avoidable ED and hospital utilization

Practice 2 Make it easy for patients to report their symptoms to their care team

Practice 3 Dedicate resources to manage urgent symptoms in the cancer center

Three Models of Urgent Symptom Support



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Transforming Patient Navigation

Acuity-Based Patient Navigation:

- Offers navigation to all cancer patients experiencing barriers to care;
- Matches correct resource to patient needs (RN/LCSW/Lay Navigator/Peer Navigation);
- Captures patients across all settings (Clinic/Inpatient/ED);
- Allows for cross coverage of limited navigation resources;
- Data-driven model, continued alignment with hospital-based metrics:
  - ✓ decreased ED visits for oncology patients
  - ✓ decreased hospital admissions for oncology patients
  - ✓ decreased hospital bed-days for oncology patients

Are There Any Questions?