Alternative Payment in Oncology: Today & Tomorrow

- Bundled Price Specific Treatment
- Oncology Model (OCM)
- Pay for Pathways Compliance
- Pay for Enhanced Services
- Capitation
- Bundled Price Episode of Care
- Shared Savings 2-sided risk
- Shared Savings 1-sided risk
- Increasing Financial Risk
- MACRA
- Oncology Medical Home*

Volume-Based Fee-for-Service

*OMH Key Features: pathways compliance; pro-active care management; end-of-life planning

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2017 Cancer Center Business Summit
Alternative Payment in Oncology: Today & Tomorrow

- **Kelly Blair**: Oncology Service Line Survey 2016 Results
- **Lili Brillstein**: Health Plan Episodes of Care
- **Larry Strieff, MD**: Medical Group Episodes of Care
- **Cynthia Terrano**: Health System multiple APMs
- **Dave Terry**: Bundles, Risk and Future Outlook
Alternative Payment in Oncology: Today & Tomorrow

• Panelists will describe briefly their respective APM(s), why they are participating in them and with what result?

• Question: Can we expect to see shift of financial/insurance risk in oncology on a broad scale anytime soon? For example, prospective bundled pricing or 2-sided shared savings?
Alternative Payment in Oncology: Today & Tomorrow

Kelly Blair, M.P.A.
Vice President, Consulting
Sg2
Niles, Illinois
Kblair@sg2.com
Sg2 was interested in understanding where our clients were in the *journey from volume to value* in cancer care.

In Q4 2016, we surveyed *cancer service line leaders* across our member organizations.

This survey was meant to be *qualitative* in nature and was not designed or intended to produce results of statistical significance.

**Where Are We Today, and Where Are We Going Tomorrow?**

- Nearly 75% of respondents came from community hospitals or regional health systems.

**Which option below best describes your organization?**

- 48.1%: Community hospitals with provider-based/hospital outpatient cancer department
- 25%: Independent/private oncology medical group
- 11.5%: Large national health system
- 13.5%: Regional health system/IDN
- 0%: Stand-alone academic comprehensive cancer center
- 1.9%: Academic medical center

IDN = integrated delivery network.

Nearly 75% of respondents came from community hospitals or regional health systems.
Movement (or Not) Toward Value-Based Care Models

• Of those who responded, 64% were **NOT** participating in any form of value-based or alternative payment programs.
• Of those who were participating, 80% of those were Oncology Care Model (OCM) participants.
• The majority of respondents did not plan to enter into any value-based contracts in 2017.
• Most cited lack of operational readiness as the primary reason for **NOT** participating.
The Predominant Experiment Will Be OCM...

What type of oncology-specific value-based or alternative payment program is your organization participating in? (Select all that apply.)

- CMS (the Oncology Care Model [OCM])
- Commercial payer–shared savings (upside only)
- Commercial payer–shared savings (two-sided risk)
- Commercial payer–bundled pricing (episodes of care)
- Commercial payer–payment for pathways compliance
- Commercial payer–payment for care coordination (eg, oncology medical home)
- Other (Please describe)

What will we learn from the OCM pilot?

- What types of value-based contracts do you plan to enter into with payers in 2017? (Select all that apply.)

What will we NOT learn from the OCM pilot that we need to advance the industry?
Actions and Reactions From the Field...

“Designing workflow changes is still in process. Its been a tough road.”

“Physician engagement is needed.”

“(I’m still) trying to capture patient list.”

We hired a care coordinator and financial advocate.

“I would encourage organizations to have [an oncology-specific EMR] in place before undertaking an initiative.”

“The organization] must have a sufficient balance sheet and future cash flows to mitigate expenses and offset loss of FFS revenue.”

Which changes have you made to your cancer program in response to or anticipation of value-based payment models? (Select all that apply.)

- Staffing changes: 72.7%
- Implement or standardize protocols: 36.4%
- Redesign care delivery: 36.4%
- IT investment (e.g., care coordination): 45.5%
- Financial database development: 0%
- Payer contract negotiation: 18.2%
- Financial database development: 27.3%

FFS = fee-for-service.
Our Respondents Are Still Focused on Fundamentals...

1. EMR adoption/optimization
2. Palliative care programs
3. Data and analytics
4. Standardization
5. Expanding infusion services

ACO = accountable care organization; PFP = Pay for Performance
Are We (Dare I Say...) Overconfident?

On a scale from 1 to 10, how confident are you in your organization’s ability to be successful with oncology-based payment models?
Sg2, a Vizient company, is the health care industry’s premier authority on health care trends, insights and market analytics.

Our analytics and expertise help hospitals and health systems achieve sustainable growth and ensure ongoing market relevance through the development of an effective System of CARE.

Sg2.com  847.779.5300
Alternative Payment in Oncology: Today & Tomorrow

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Episodes of Care
A Value-Based Model for Specialty Care

Cancer Center Business Summit

Lili Brillstein, MPH
Director, Episodes of Care
January 2017
Our patient-centered programs include more than 6,000 physicians that are committed to improving the quality of care.

More than 800,000 Horizon BCBSNJ members are in patient-centered programs, including Patient-Centered Medical Homes, Accountable Care Organizations and Episodes of Care Programs.
Episodes of Care

Value-based model designed to engage specialists and refocus health care delivery and reimbursement on quality and value rather than volume.

Full spectrum of health care services related to and delivered for a specific medical condition, illness, procedure or health care event during a defined time period.

Horizon is leading the nation
Largest commercial episodes program in the US
EOC Primary Goal

Standardize & Optimize Care and Cost of Care

Compare like patients and like outcomes
Study variation in utilization and cost of care
Retrospective Model

- Contract with an Episode Conductor

- All providers of care within the continuum of the episode are paid at their contracted fee for service rates

- Episode assessment is made, post episode
  - Quality
  - Patient Experience
  - Total Cost of Care

If metrics are met, savings are shared
Upside only
Current Episode Portfolio

- Hip Replacement
- Knee Replacement
- Knee Arthroscopy
- Colonoscopy
- Pregnancy
- Hysterectomy
- CHF
- CABG
- Crohn’s with fully integrated Behavioral Health
- Low back pain/Laminectomy
- Shoulder Replacement
- GERD
- Diverticulitis

- Oncology: Breast Cancer, Colon Cancer, Lung Cancer, Prostate Cancer, Prostatectomy
Standard EOC Program vs. COTA Oncology EOC

“Standard” Prometheus-defined Algorithms
   Stratification based on claims

COTA
   Stratification based on clinical criteria extracted from EHR
A new digital classification for cancer patients

- **ICD-9 Code:** 174.9
- **Therapy Type:** Adjuvant
- **Progression Track:** 0
- **Sex:** Female
- **Age:** 49
- **Estrogen Receptor:** Positive
- **Progesterone Receptor:** Positive
- **Her2neu:** Negative
- **Tumor Size:** <1mm
- **Nodal Involvement:** None
- **Metastatic Sites:** None
- **ECOG at Presentation:** 0
- **OncotypeDX:** 12

01.02.01.000015.1.0

<table>
<thead>
<tr>
<th>Neoplasm of the breast</th>
<th>Phenotype 15</th>
<th>Therapy Type 1 (Adjuvant)</th>
<th>Progression Track 0 (No prior treatment)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
Not Just Apples to Apples …

- Allows for more precise stratification of members and episodes
- Includes clinical and claims/cost information
- Disease state and stage considered
- Precise ability to compare truly like patients with like disease to allow for standardization and optimization of care
Partnership & Collaboration: Keys to Success

• Collaboration at Every Level, & Simplicity are key
  – Defining episode construct, intent, launch
  – Establishing metrics
  – Creating workable model
  – Fluidity, Willingness to change

• Physicians are the clinical experts in charge of the care
  – Providers make clinical care decisions

• Patient is center stage
Alternative Payment in Oncology: Today & Tomorrow

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**Hill Physicians Medical Group**

- Independent Physician Association founded in 1984
- Provider network: 3,800 providers and consultants
  - 980 Primary Care
  - 2,260 Specialists (170 Oncologists)
- Service the Northern California area
  - 300,000 Members
  - 5 Regions - 9 Counties

**California Marketplace – 2014 HMO Enrollment**

- Group Practices Including Kaiser ~9 Million (55%)
- IPAs ~4.2 Million (26%)
- Foundations & Comm. Clinics ~2.5 Million (15%)
- Univ of Calif & County Groups ~630K (4%)
The Model
Two Linked Modules - Act as Checks & Balances

**Case Rate Payments**
- Cancer dx are grouped
- Paid monthly
- Providers bear some risk
- Stop loss program protects providers

**Quality Management Program**
- Clinical Quality
- Patient Experience
- Utilization

**Case Rate portion is best described as a prospective variable contact cap by cohort**
## Part I: Case Rates

### Case Rates - Description

<table>
<thead>
<tr>
<th><strong>Case rates</strong> have different values for different cancer diagnosis groups</th>
<th><strong>All cancers grouped into diagnosis groupings</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Paid monthly</strong></td>
<td><strong>in situ excluded</strong></td>
</tr>
<tr>
<td><strong>Providers bear some risk</strong></td>
<td><strong>Includes all services provided to patient in MD office except imaging &amp; rad tx</strong></td>
</tr>
<tr>
<td><strong>Stop loss</strong> program protects providers</td>
<td><strong>Prospective, once case begins</strong></td>
</tr>
<tr>
<td></td>
<td><strong>At risk when costs exceed cumulative case rate but not yet at stop-loss</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Providers paid case rates AND reduced FFS after reaching stop loss</strong></td>
</tr>
</tbody>
</table>

**CALCULATED TO BE EQUIVALENT TO 100% FFS**
## Part II - QMP

<table>
<thead>
<tr>
<th>QMP Domains</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Quality</td>
<td>✤ Subset (25 - 30) of ASCO QOPI core measures</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>✤ CG-CAPHS</td>
</tr>
<tr>
<td></td>
<td>✤ Internally developed referring PCP satisfaction survey</td>
</tr>
<tr>
<td>Utilization</td>
<td>✤ IP bed days</td>
</tr>
<tr>
<td></td>
<td>✤ ED visits</td>
</tr>
<tr>
<td></td>
<td>✤ Infusion Center Use</td>
</tr>
<tr>
<td></td>
<td>✤ Chemo Initiation</td>
</tr>
</tbody>
</table>

**OPPORTUNITY FOR ADDITIONAL 10% INCENTIVE**

✤ These are **NEW** dollars that previously were not available to the oncologists
Example of the monthly rates: Breast Cancer Cohort

![Graph showing net_cost_per_mm, case_rate1, case_rate2, case_rate3, and case_rate4 over 24 months.](image-url)
Two Key Features

Stop loss
- Protects for new drugs during current case rate year
- No drug exclusions
- No prior authorizations

Annual Recalibration
- Provides longer term protection
Breast Cancer
Stop Loss Threshold (––) vs. Cumulative Case Rate Payments (—)
Risk & Stop-Loss Protection

Case Study: Lung Cancer Patient Receiving Opdivo 3 mg/kg every 2 weeks

- Practice risk: Set at specific dollar amount in contract (known $ risk)
- Practice exposed to risk: 14-17% of total case rate time
- Practice NOT at risk: 83-86% of total case rate time
Resource Use: Breast Cancer

Prior to OCR Implementation

After OCR Implementation

OCR Practice

OCR Practice

2003 2004 2005 2006 2007 2008 2009

2010 2011 2012 2013 2014 2015
Resource Use: All Cancers

Prior to OCR Implementation

OCR Practice

After OCR Implementation

OCR Practice
Next Steps

• Keep Program Mutually Sustainable for Providers and IPA

• Next Steep Road Ahead
  – Need Oncologists to be much more active/proactive in Managing IP Bed Days and ED
Alternative Payment in Oncology: Today & Tomorrow

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INSPIRED BEGINNING

Moffitt’s Singular Mission
To contribute to the prevention & cure of cancer.

- Statutorily created (1004.43, F.S.)
- Instrumentality of state
- Cigarette tax revenue
- Annual-line item appropriation

- Established in 1981
- Named after H. Lee Moffitt, former Speaker of the Florida House of Representatives and the impetus behind the Center.

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MULTI-SITE CAMPUS

Main Campus

- Hospital
  - 206 Licensed Beds
  - 32-Bed BMT Unit
  - CRU

- Research Space
  - Wet Lab: 187,472 sf
  - Mouse Barrier Facility: 28,000 sf
  - Dry Lab: 36,205 sf
  - Cancer Screening: 29,846 sf
  - Clinical Research Space: 13,416 sf
  - Research Admin: 37,096 sf

International Plaza Campus

- Opened July 2011
  - Located Near Tampa International Airport
  - 2 Floors / 50,630 sf
  - Infusion (24 Chairs)
  - Radiation Therapy
  - Diagnostic Imaging
  - Clinical Trials

McKinley Campus

- Opened Outpatient Center Fall 2015
  - 30 Acres
  - 5 floors / 207,000 sf
  - Cutaneous / Breast Clinics
  - Infusion Center
  - Survivorship Services
  - Diagnostic Imaging
  - Outpatient Surgery
  - Genetic Risk Assessment
  - Clinical Research Unit
In March 2015, the cancer center earned the prestigious Magnet designation in recognition of its nursing excellence.

Moffitt’s NCI Designation Renewed In 2016

U.S. News Ranks Moffitt The Nation’s #6th Cancer Hospital
IMPORTANCE OF PATHWAYS

• Provide consistent, quality care with program-specific consensus
• Encourage collaboration and discussion surrounding best practices
• Personalize cancer care by patient factors and evidence rather than physician preference
• Understand costs in preparation for payer discussions about accountable care

- The Clinical Pathways Department was developed in 2009
- Moffitt filed a patent application in 2012
- The pathways became available online in August 2012
- Currently there are over 50 pathways
PAYMENT INNOVATION

Payment based on measures of quality, efficiency, cost, and patient experience

Value Based Payment Models

- Total Cost of Care
- Medical Home
- Bundle Payment Program
TOTAL COST OF CARE (TCOC)

Physician Services
Hospital Services
Other Services

Opportunity for Shared Savings

Quality Gate
Attribution- trigger event
Ten cancer programs
Market based trend
Data Sharing
CHEMOTHERAPY MEDICAL HOME

Key Features

- Chemotherapy trigger
- Care coordination (manage IP and ER)
- Breast, lung and colorectal cancers
- Prospective attribution

Reduced Cancer Related Drug Cost

Opportunity to improve trend for reducing ER & IP Visits

= Shared Savings Payment

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BUNDLED PAYMENT FRAMEWORK

Single Fixed Payment
From Payer to Provider

Transfers risk of patient complications and inefficient care to providers

- Physician Services
- Hospital Services
- Other Services
Goal: Demonstrate effectiveness of a bundle payment arrangement compared to the current fee for service model, while maintaining high quality care.

Key Features

- Early stage lung cancer with curative intent
- Surgery and radiation based bundles
- Single payment for each bundle
- Patients identified prospectively
- 3 year pilot program
Alternative Payment in Oncology: Today & Tomorrow

Dave Terry, M.B.A.
Chief Executive Officer
Archway Health
Watertown, Massachusetts
Dterry@archwayha.com
Archway Overview

100% Focused on Bundled Payment - it's all we do

Founded in 2014 with offices in Boston and NYC

Our team has been active in BPCI since its inception in 2011

Backed by AthenaHealth & Coverys - large medical malpractice insurance company

Active in all of the CMS bundled payment programs - BPCI, CJR, OCM, EPM

Convener in the BPCI program

Built a comprehensive, one stop shop bundled payment platform

Working with dozens of customers & hundreds of providers across the country

Real results - all of our partner hospitals & physicians are earning significant savings

Expanding beyond CMS into the commercial and self-insured employer markets

Archway Health
## CMS Bundled Payment Program Overview

<table>
<thead>
<tr>
<th></th>
<th>BPCI</th>
<th>CJR</th>
<th>OCM</th>
<th>EPM</th>
<th>Advanced BPCI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vol or Man?</td>
<td>Voluntary</td>
<td>Mandatory</td>
<td>Voluntary</td>
<td>Mandatory</td>
<td>Voluntary</td>
</tr>
<tr>
<td>Providers</td>
<td>1,457</td>
<td>767</td>
<td>196</td>
<td>1,150</td>
<td>TBD</td>
</tr>
<tr>
<td>Market $’s</td>
<td>$10B</td>
<td>$4B</td>
<td>$2B</td>
<td>$6B</td>
<td>TBD</td>
</tr>
<tr>
<td>Start Date</td>
<td>Q4 ’13</td>
<td>Q2 ’16</td>
<td>Q3 ’16</td>
<td>Q3 ’17</td>
<td>Early ’18</td>
</tr>
<tr>
<td>End Date</td>
<td>Q4 ’18</td>
<td>Q1 ’21</td>
<td>Q2 ’21</td>
<td>Q4 ’21</td>
<td>5 years</td>
</tr>
<tr>
<td>Clinical Focus</td>
<td>Many</td>
<td>Joints</td>
<td>All Oncology</td>
<td>AMI, CABG</td>
<td>Many</td>
</tr>
<tr>
<td>Episode Initiators</td>
<td>Hospitals, Specialists, Post-Acute</td>
<td>Hospitals</td>
<td>Specialists</td>
<td>Hospitals</td>
<td>Specialists</td>
</tr>
<tr>
<td>Notes</td>
<td>Many providers earning gains</td>
<td>Hospitals slow to move</td>
<td>Very big deal for Onc groups</td>
<td>Hosps. seem motivated</td>
<td>Targeted to meet MACRA APM requirements</td>
</tr>
</tbody>
</table>
The OCM program is unique in its program design, pricing model, and impact it has on participating practices.

- **OCM is a big deal for participating practices - 50% of practice volume**
  - Much more significant than most other BP programs

- **The pricing model is complex**
  - Much different than the other CMS bundled payment programs
  - Proper and complete diagnosis coding is vital for practices
    - *Incomplete coding is costing practices hundreds of thousands of dollars*
  - We have found some biases in the pricing model for prostate and bladder cancers
    - *CMMI has committed to fixing the model for these cancer types*

- **Significant variation exists across the country and across practices**
  - Prescribing patterns
  - Hospital ER to Admission rates
  - Hospitalizations
  - By physician
  - Approach to end of life planning
Variation, however, is still the main driver of opportunity within the OCM program...
...we see this similar variation in all types of clinical areas.
Lessons Learned

In our experience the most effective bundle care programs drive clinical innovation through specialist engagement.

Data Analytics
- Biggest driver of improvement
- Deep understanding of data
- Aligned incentives

Specialist Engagement
- Identify opportunities & risks
- Prioritize areas for improvement

Innovation
- Better ways to care for acute & chronic patients
- New perspective on costs & outcomes
- Optimal provider, patient, payor alignment

Accountable Incentives - BP Contracts
- Basic requirement
- Creates new incentives for accountability & improvement
## Keys to Success - Specialty Networks

### Bundled Payment Payor Contracts

<table>
<thead>
<tr>
<th>Medicare</th>
<th>ACO’s</th>
<th>Self-Insured Employers</th>
<th>Commercial Plans</th>
<th>Medicare Advantage</th>
<th>Worker’s Comp</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>• BPCI</td>
<td></td>
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<tr>
<td>• OCM</td>
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<td></td>
</tr>
<tr>
<td>• Advanced BPCI</td>
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</tbody>
</table>

### Archway Bundled Payment Management Services Organization:

<table>
<thead>
<tr>
<th>Bundled Definitions &amp; Contract Development</th>
<th>Payor &amp; Employer Outreach &amp; Negotiations</th>
<th>Overall Program Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP Performance Analytics</td>
<td>Patient Tracking &amp; Care Management Support</td>
<td>Quality Tracking &amp; Improvement</td>
</tr>
<tr>
<td>Preferred Provider Network Development</td>
<td>BP claims processing &amp; revenue cycle management</td>
<td>Reinsurance</td>
</tr>
</tbody>
</table>

### Specific Services

<table>
<thead>
<tr>
<th>Orthopedics</th>
<th>Oncology</th>
<th>Cardiology</th>
<th>Obstetrics</th>
<th>Urology</th>
<th>GI</th>
<th>General Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Joints</td>
<td>• Breast</td>
<td>• PCI</td>
<td>• Deliveries</td>
<td>• TURPs</td>
<td>• Colon-oscopy</td>
<td>• Hernia</td>
</tr>
<tr>
<td>• Spine</td>
<td>• Lung</td>
<td>• CABG</td>
<td></td>
<td>• Bladder surg</td>
<td>• Endo</td>
<td></td>
</tr>
<tr>
<td>• Sports</td>
<td>• Colon</td>
<td>• CHF</td>
<td></td>
<td>• UTI</td>
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</tbody>
</table>

**Archway Health**
Challenge Question

• APMs in oncology have tended to consist mostly of an up-front care management fee plus a performance-based 1-sided retrospective shared savings payment

• Can we expect to see a shift of insurance risk in oncology on a broad scale anytime soon? And if so, in what form?