Federal Health Policy: How It May Affect Your Program

Association of Community
Cancer Centers

April 10, 2018

Agenda

I. Background

II. 340B Drug Discount Program

III. Outpatient Prospective Payment System (OPPS) Rule and Physician Fee Schedule (PFS)

IV. Merit-Based Incentive Payment System (MIPS)

V. Affordable Care Act (ACA) Rollback

VI. Drug Pricing Trends

VII. Oncology Care Model (OCM)

VIII. New Reimbursement Models

IX. Takeaways

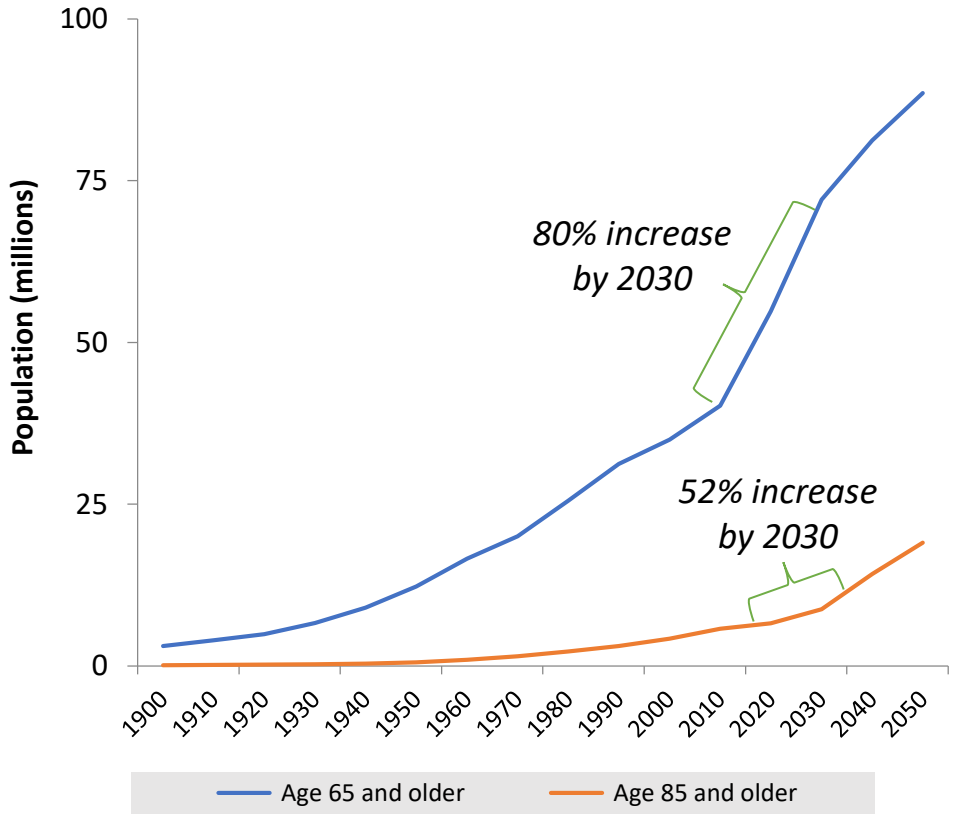
I. Background

I. Background

Medicare and Medicaid Growth

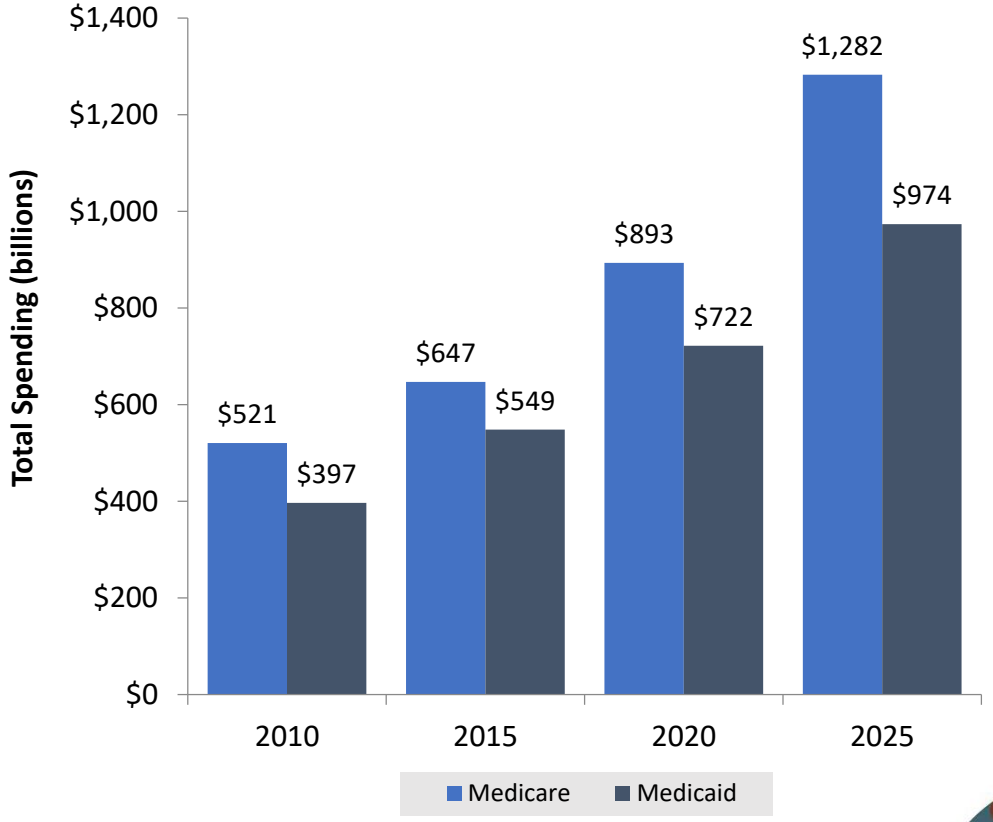
About 3.6 million people age into Medicare every year, creating a greater impetus for the government and providers to rethink how care is delivered and funded.

Population Projections



Source: US Department of Health & Human Services (HHS), Administration on Aging.

Projected Spending

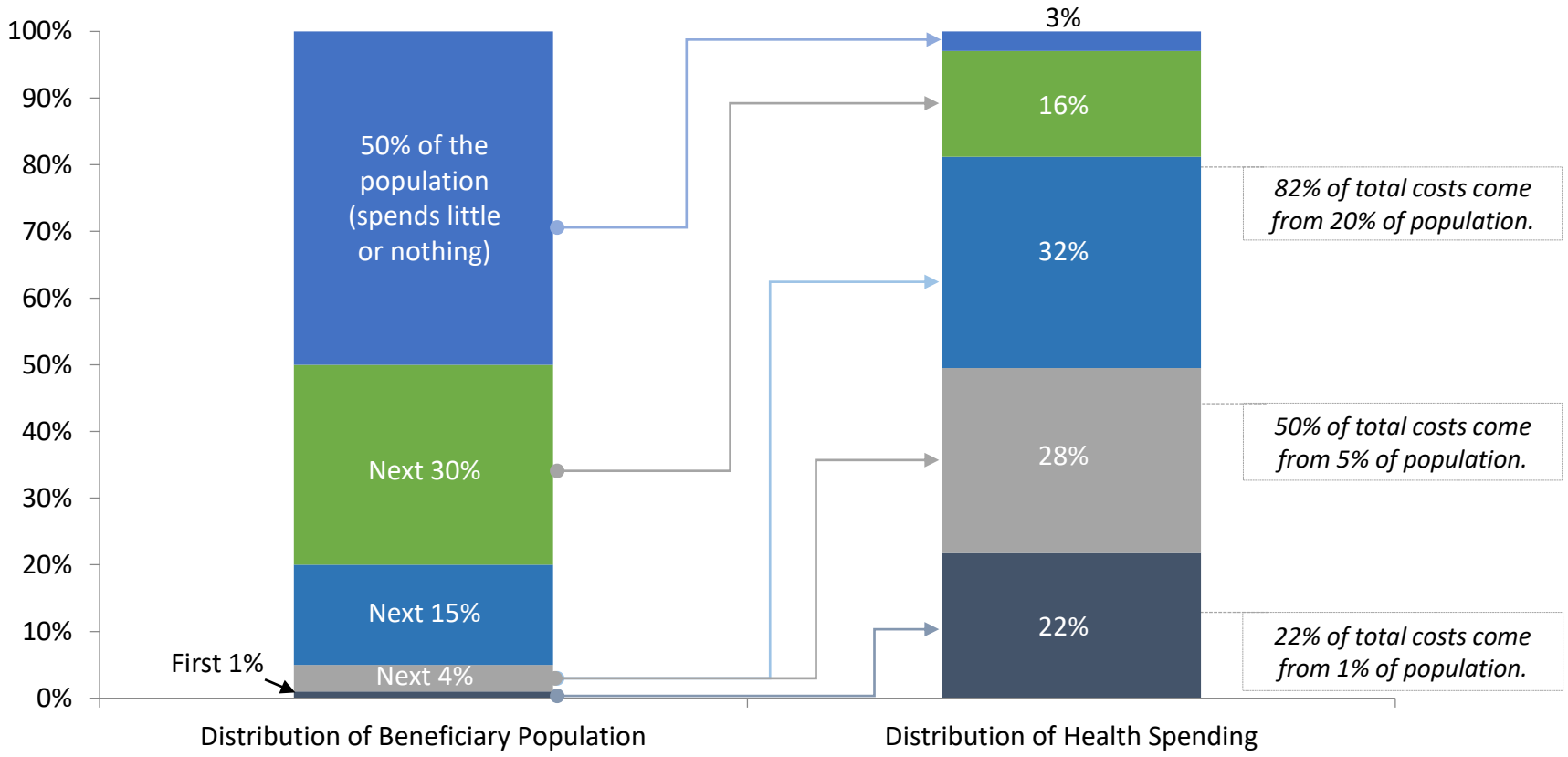


Source: Centers for Medicare & Medicaid Services (CMS), National Health Expenditure Data.

I. Background

5% of Patients Responsible for 50% of Costs

In a fee-for-service (FFS) world, the top 5% of patients (by usage) drive margins; in a value-based world, the top 5% pose a financial challenge that must be well-managed.



Note: Figures may not be exact due to rounding.

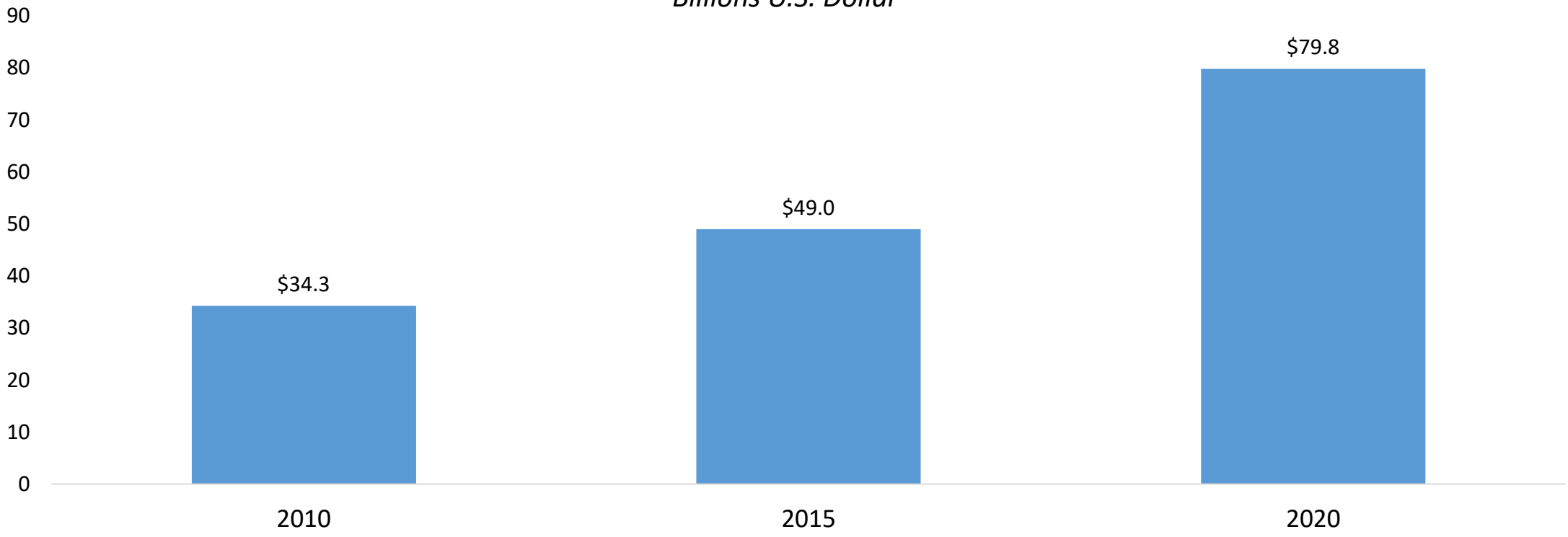
I. Background

U.S. Spending on Oncology

U.S. spending on oncology care is projected to grow rapidly, reaching nearly $80 billion by 2020.

Estimated Annual U.S. Spending on Oncology

Billions U.S. Dollar[1]



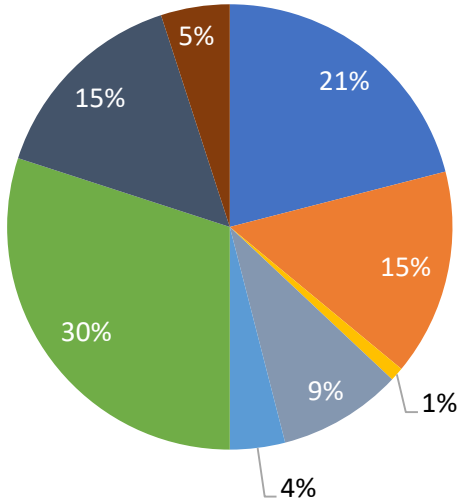
[1] Includes diagnosis, surgery, hospitalization, and palliative and end-of-life care. Source: "Global Oncology Trend Report: A Review of 2015 and Outlook to 2020," IMS Institute for Healthcare Informatics, June 2016.

I. Background

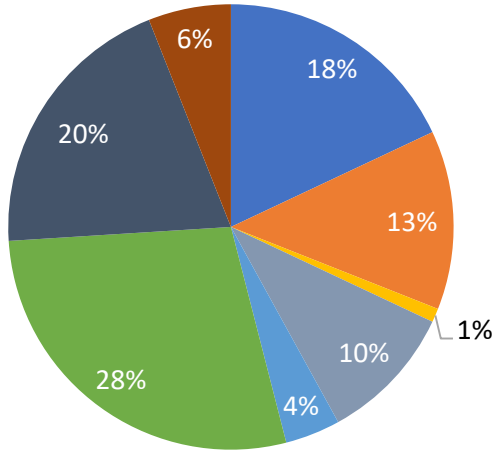
U.S. Spending on Oncology *(continued)*

Average spending per commercial patient increased by 62% from 2004 to 2014. Chemotherapy[1] is a key cost driver and represents a growing share of total expenditures.

Commercial Spending by Service, 2004 ($55,789 per Patient)



Commercial Spending by Service, 2014 ($90,656 per Patient)



Hospital Inpatient Admissions | Cancer Surgeries | ER | Radiology (Other)
Radiation Oncology | Other Outpatient Services | Chemotherapy | Other Services

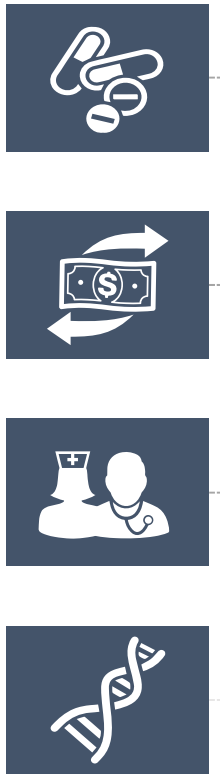
Source: "The Evolution of Oncology Payment Models: What Can We Learn from Early Experiments?," Deloitte Center for Health Solutions.

[1] Chemotherapy includes cytotoxic chemotherapy, other chemo and cancer drugs, and biologic chemotherapy.

I. Background

ACCC Trends in Cancer Programs: Top Challenges and Concerns

ACCC members are well aware of cost and spending issues, with a large majority citing drug costs and reimbursement factors as challenges and concerns.



1	The cost of cancer care drugs	83%
2	Reimbursement of non-revenue producing services that improve patient care (e.g., financial advocacy, navigation, survivorship)	66%
3	Transparency in commercial insurance policies so patients know exactly what plans do—and do not—cover	65%
4	The need for physicians and midlevel providers to focus on direct patient care—not paperwork	55%
5	Increased funding for cancer research and clinical trials	53%

Source: ACCC 2016 Trends in Cancer Programs Survey. n=166

II. 340B Drug Discount Program

II. 340B Drug Discount Program

Overview

Savings from the 340B Drug Discount Program are used by participating hospitals to subsidize charity care or to offer nonreimbursable services such as cancer navigators, nutrition, and social support services to patients.

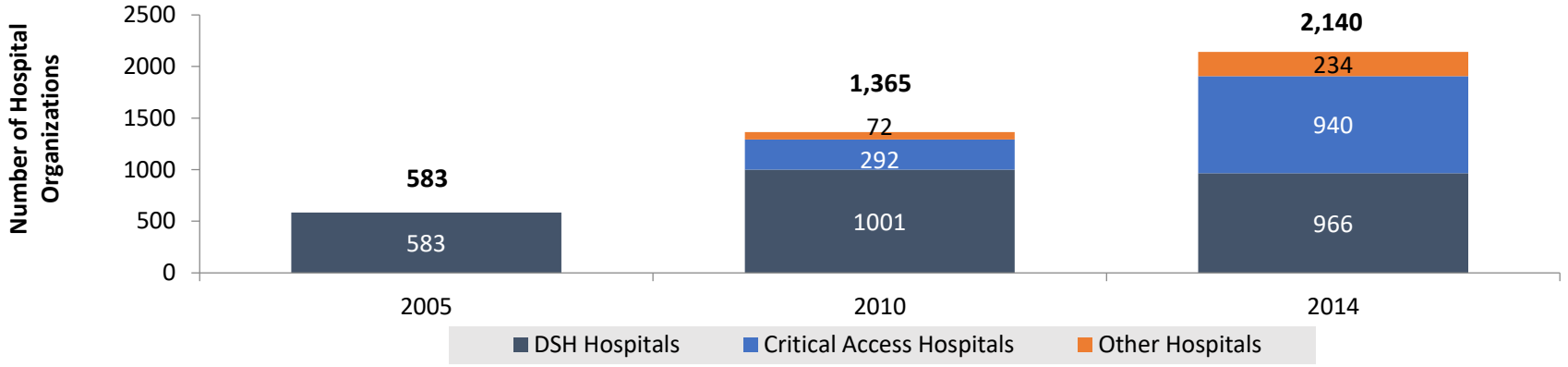
- Since 1992, the program allows covered entities to purchase separately payable outpatient prescription drugs and biologicals at significantly discounted prices.
- Drug manufacturers that participate in Medicaid are required to participate in the 340B program.
- The mission of the program is to support participating hospitals' abilities to provide services to disadvantaged and underserved patients.
- Proponents claim that without 340B operating margins, they would not be able to invest in capital improvements or offer critical nonreimbursable support services.
- Opponents of 340B claim that the program lacks oversight and that many participating hospitals do not return the funds to the community as they should.

Notes: http://www.medpac.gov/docs/default-source/reports/may-2015-report-to-the-congress-overview-of-the-340b-drug-pricing-program.pdf?sfvrsn=0.
https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-23932.pdf.

II. 340B Drug Discount Program

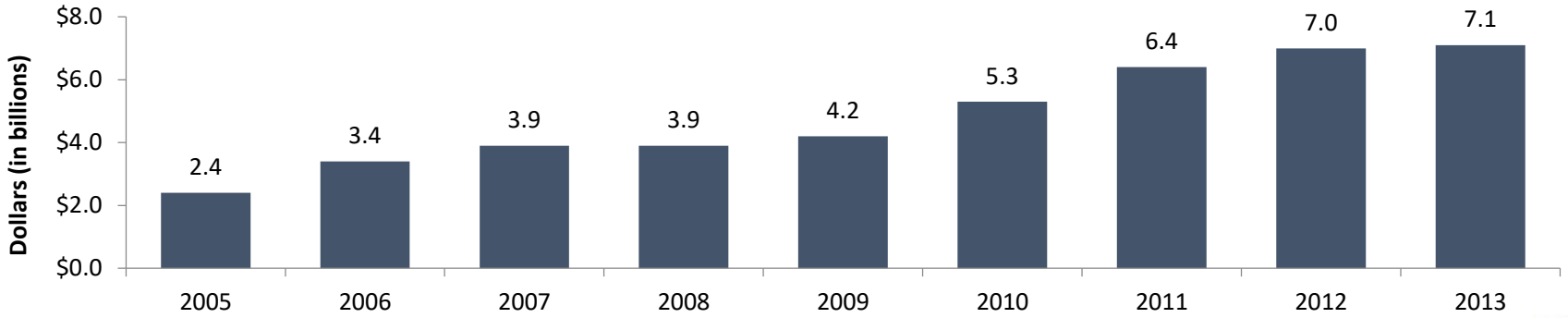
MedPAC Targets 340B Hospitals for Reductions

As the number of organizations participating in 340B and expenditures on the program have grown, MedPAC has focused on reducing spending.



The number of hospital organizations participating in the 340B program more than tripled between 2005 and 2014.

The amount spent by covered entities on 340B drugs tripled from 2005 to 2013.



Source: MedPAC *Report to the Congress: Overview of the 340B Drug Pricing Program*, May 2015.

II. 340B Drug Discount Program

340B Reimbursement Changes

CMS modified 340B funding for 2018. Medicare payments to hospitals for most separately payable drugs acquired through the 340B program will be subject to a payment reduction of approximately 30%.

Overview of the Payment Cut

- Payment reduction is only applicable to payments made under the Medicare hospital OPPS.
- Payment rate is reduced from ASP plus 6% to ASP minus 22.5%.
- "Savings" generated from the payment cuts are redistributed across all hospitals/services paid under OPPS.
  - Therefore, it is possible that some 340B hospitals could see a net gain from the payment cuts.
  - All non-340B hospitals will see a payment increase.

II. 340B Drug Discount Program

Effects on Non-340B Hospitals

All hospitals participating in 340B except Critical Access Hospitals and Maryland waiver hospitals will need to use new claim modifiers to ensure the proper reimbursement. Hospitals are responsible for indicating when they are owed the non-340B reimbursement rate, which is still ASP plus 6%.

Increased Administrative Burden

- Hospitals billing Part B must add a modifier to claims indicating a drug was ***not*** purchased at 340B prices.
- Without the modifier, CMS will assume the drug was purchased at 340B prices and therefore reimburse at the reduced rate of ASP minus 22.5%.

Source: https://www.advisory.com/research/care-transformation-center/care-transformation-center-blog/2017/07/pef-6-things-340b-and-non-340b.

II. 340B Drug Discount Program

Exclusions

Several exclusions were included in the new rule, as listed below.

Exclusions
• Does not apply to most contract pharmacy arrangements • Does not apply to Critical Access Hospitals • Does not apply to Maryland waiver hospitals • Does not apply to hospital departments excluded from OPPS under the 2015 Section 603 Site-Neutral Payments Provision (at least for now…) • Currently excludes rural sole community hospitals (disproportionate share hospitals [DSHs]), IPPS-exempt cancer hospitals, and children's hospitals, but that may change in the future

II. 340B Drug Discount Program

Litigation Activities

> Although the reimbursement changes have gone into effect, legal activities are underway to contract the scope of the regulation.

Litigation

- Litigation to stop payment cuts was filed by hospital associations and 340B hospitals.
  - Case was dismissed on December 29, 2017.
  - Judge ruled that plaintiffs did not have standing to file the suit.
  - Judge did not rule on the merits of the case.
  - Appeal was filed in early January 2018.
- Expect continued litigation following payment of a claim at the reduced rate.
- Underlying legal issues are related to administrative law as well as the intent of the 340B program.

Recent Developments: March 2018

- Plaintiffs filed court papers detailing the significant impact of the 340B cuts.
- HHS filed a brief defending the cuts on March 20.
- The plaintiffs' response is due April 2 and oral arguments in the case are scheduled for May 4.

In Court Papers, 340B Hospitals Tell How Massive CMS Cuts Are Causing Irreparable Injury

II. 340B Drug Discount Program

Legislative Activities

> Several legislative activities aimed at eliminating or slowing down Medicare cuts to 340B are also under development.

Legislation

- Multiple legislative efforts are in process, including the following:
  - HR 4392: This would prevent CMS from implementing the payment cuts; it has significant bipartisan support.
  - HR 4710 (340B PAUSE Act): This would impose a two-year moratorium on new 340B DSHs and locations and would also require for DSHs, cancer hospitals, and children's hospitals: (1) additional data reporting, (2) OIG study on charity care, and (3) GAO report on hospital/government contracts and 340B revenue.
  - S 2312 (HELP Act): It would also impose a two-year (possibly longer) moratorium on new 340B DSHs and locations. This law is similar to but more comprehensive than HR 4710.
- Areas of focus for new legislation include:
  - Strong focus on 340B-participating hospitals (not on grantees) and limitations on patient eligibility.
  - Limits on amounts that could be charged for 340B drugs.
  - Limits on contract pharmacies by number and location.
  - Required reporting of amount and use of 340B savings.

The uncertainty and risk currently associated with the 340B program is likely to continue in the foreseeable future.

III. OPPS Rule and PFS

III. OPPS Rule and PFS

CY 2018 Changes

Hospital Payment Rates

- Hospitals will see a 1.35% increase in Medicare reimbursement rates in 2018.
- Medicare Part B reimbursements will significantly change for facilities participating in the 340B Drug Discount Program.

Site-of-Service Transparency

- CMS intends to create a searchable website with the estimated payment amount for items and services under the OPPS and ASC payment system.
- The goal is to facilitate price transparency for hospital outpatient department and ASC services.

Payment for Biosimilar Biological Products Under Part B

- Each individual biosimilar product will now have separate HCPCS coding and payments. This differs from the current policy, wherein all biosimilar products with a common reference product are subject to the same payment calculation.
- CMS hopes to encourage innovation needed to bring more biosimilar products to market, and to facilitate drug access and physician/patient choice.

Sources: http://www.klgates.com/cms-finalizes-changes-in-cy-2018-opps-and-pfs-final-rules-11-07-2017/ and https://revcycleintelligence.com/news/cms-finalizes-2018-hospital-physician-medicare-reimbursement.

III. OPPS Rule and PFS

CY 2018 Changes *(continued)*

Site-Neutral Payment Rule

- Off-campus outpatient provider-based departments (PBDs) that began furnishing services on or after November 2, 2015, are no longer paid under the OPPS.
- These "nonexcepted" locations receive a reduced site-neutral payment, which has generally been 50% of the OPPS rate.
- CMS refers to this 50% adjustment as the "PFS Relativity Adjuster."
- For CY 2018, CMS has reduced the PFS Relativity Adjuster to 40%.
  - The new rate is based on a comparison of the payment rate for a hospital outpatient clinic visit to the payment rates for similar outpatient visit services.
- CMS is aiming to ensure that Medicare payments to hospitals billing for nonexcepted items and services furnished by nonexcepted off-campus PBDs under the PFS reflect the relative resources used in furnishing the items and services relative to other PFS services.

Sources: http://www.klgates.com/cms-finalizes-changes-in-cy-2018-opps-and-pfs-final-rules-11-07-2017/ and https://www.aha.org/system/files/2018-01/17-factsheet-site-neutral.pdf

III. OPPS Rule and PFS

Proposed Oncology-Specific Outpatient Quality Reporting Measure

> CMS is proposing tracking inpatient admissions and ED visits, beginning in 2020, for beneficiaries who receive hospital-based outpatient chemotherapy as part of the Hospital Outpatient Quality Reporting program.

- The new measure, OP-35: Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy, would track patients for what CMS considers preventable admissions and visits.
- The measure would be risk-adjusted for various factors (e.g., demographics, comorbidities).
- Inpatient admissions and ED visits would be counted for any hospital a beneficiary receives care from within the allotted time period, not just the one providing outpatient chemotherapy.

Included Conditions	Time Period	New Reporting Requirements
• Anemia • Dehydration • Diarrhea • Emesis • Fever • Nausea • Neutropenia • Pain • Pneumonia • Sepsis	30 days after receiving chemotherapy	None (claims-based measure)

IV. MIPS

IV. MIPS

Overview of the Final Rule

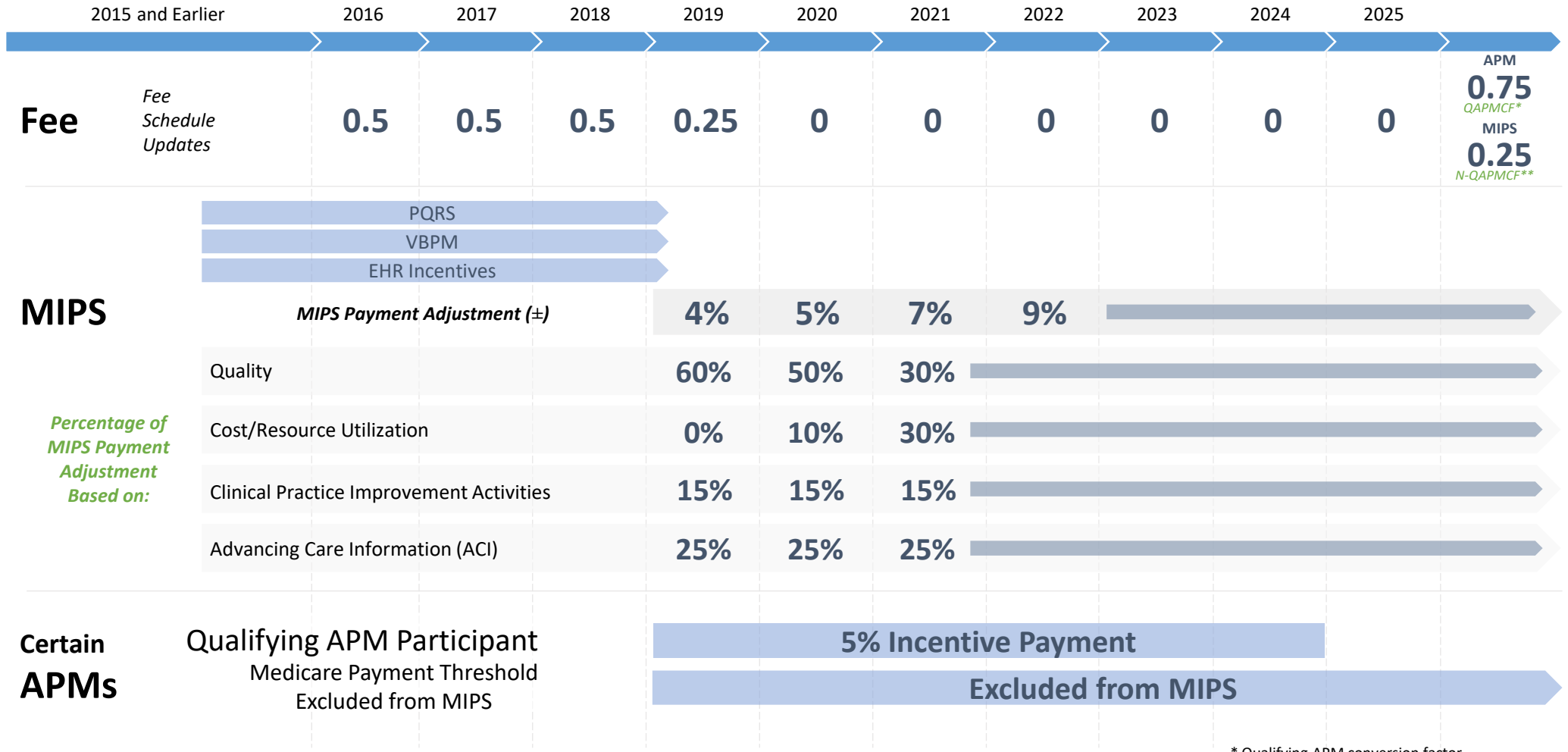
MACRA institutes a new payment structure that will place most providers accepting Medicare beneficiaries at risk for their value-based performance.

Key Provisions

Two-Track System	• Merit-Based Incentive Payment System (MIPS) • Advanced Alternative Payment Models (APMs)
More Consistent Rate Increases	• Rate increases have been standardized at 0.5% for 2016-2018 and 0.25% for 2019. • Rates will remain constant from 2020 through 2025. • Beginning in 2026, rate increases will be dependent on an eligible clinician's designated track (MIPS at 0.25% and APMs at 0.75%).
Integrated Quality Payment Program	• The MIPS track combines the historical Physician Quality Reporting System (PQRS), meaningful use, and the VBPM program. • The APM track includes similar performance categories, and metrics already incorporate value-based payment programs.

IV. MIPS

Payment Adjustments Summary



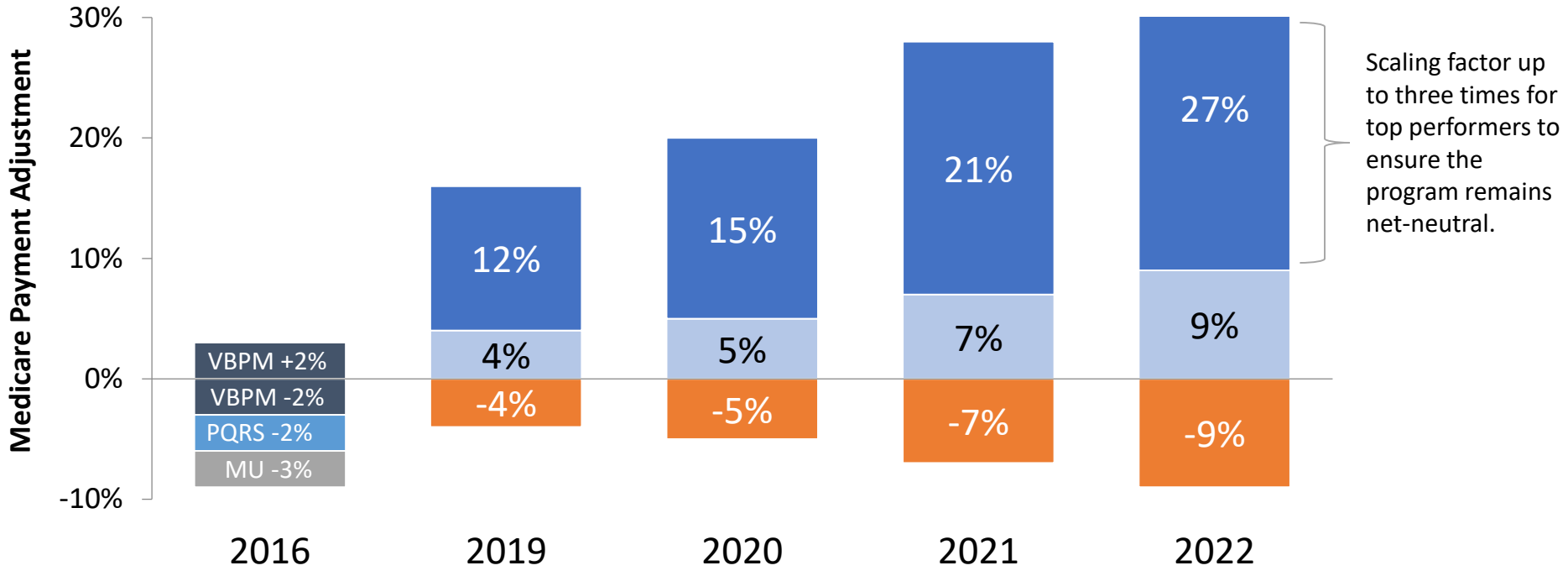
Source: CMS, "The Medicare Access and CHIP Reauthorization Act of 2015: Path to Value."

* Qualifying APM conversion factor.
** Nonqualifying APM conversion factor.

IV. MIPS

Comparison to Existing Incentives

Under MIPS, the range of upside/downside potential is substantially greater than it is for the existing programs MIPS replaces.



Performance Scoring

1 Providers will be assigned a score of 0 to 100 based on their performance across the four categories.

2 Reporting providers will be compared to the CMS-determined performance threshold.

3 Scores above the performance threshold result in an upward adjustment, while scores below the performance threshold will result in a downward adjustment, where all adjustments are net-neutral.

2018

IV. MIPS

Summary of 2018 Final Rule and MIPS Changes

> The 2018 final rule extends and expands upon many of the transition features from the 2017 final rule.

- Setting the performance threshold at 15
- Changing quality measures:
  - Less credit given for quality measures with incomplete data
  - Data completion standard increased to 60%
- Changing performance period:
  - 12-month calendar year for quality and cost measures
  - 90 days for ACI and improvement activities
- Beginning assessment of cost measures in 2018, weighted at 10% of the MIPS final score in 2018
- Introducing improvement scoring
- Continuing to allow the use of 2014 CEHRT certification
- Increasing the low-volume threshold

IV. MIPS

BBA Update

On February 9, 2018, the Bipartisan Budget Act of 2018 was enacted. It included a number of revisions to MIPS.

- **Reduction in Physician Fee Schedule Update:** Reduces the 2019 update from 0.50% to 0.25%.
- **Repeal of MIPS Payment Adjustment to Part B Drugs:** MIPS payment adjustment was limited to professional services only.
- **Slowing the Implementation of the Cost Performance Category in MIPS:** For the second through fifth years of the program (2020 through 2023), the cost performance category "shall be not less than 10% and not more than 30% of the MIPS score."
- **Continued Incremental Transition of the MIPS Adjustment:** The new law continues the gradual transition of the MIPS program by requiring the HHS secretary to increase the performance threshold from the third through the fifth years of MIPS.

Source: Eric Zimmerman and Piper Su, McDermott+Consulting LLC, "Bipartisan Budget Act of 2018 Includes Significant Changes in Medicare, Other Federal Health Programs."

IV. MIPS

How to Avoid a Penalty in 2020

For performance year 2018/payment year 2020, the threshold has increased to 15 points; however, it is still possible to avoid a penalty based on performance in a single performance category.

Category	Activity	Category Points	Weight	Overall Points
Quality	Report on five or six quality measures. • Data completeness standards ***do*** need to be met. • Benchmarks ***do not*** need to exist. • Case minimum requirements ***do not*** need to be met.	30	60%	18
— OR —				
ACI	Attest to the base measures plus: • A maximum score on one performance measure. ***OR*** • A less-than-maximum score on two or more performance measures.	60	25%	15
— OR —				
Clinical Practice Improvement	Attest to the maximum number of improvement activities (varies by group size and other criteria).	100	15%	15

IV. MIPS

Example: Achieving Exceptional Performer Status

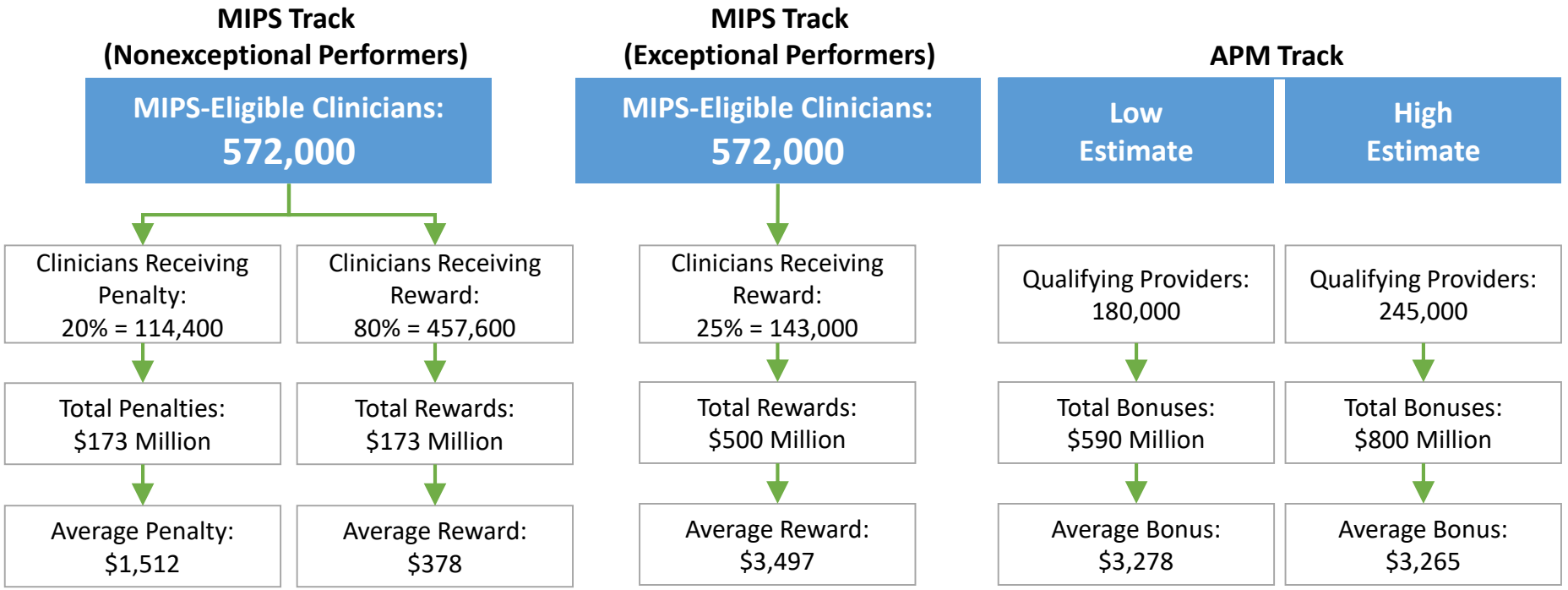
The following is an example of how to earn the requisite 70 points for exceptional performer status through a combination of performance categories.

Category	Activity	Category Points	Weight	Overall Points
Quality	Perform, on average, at the seventh decile on quality measures plus all-cause hospital readmissions rate: • Data completeness standards must be met. • Benchmarks must exist. • Case minimum requirements must be met.	70	60%	42
— AND —				
ACI	Attest to the base measures plus: • Maximum score on one performance measure. ***OR*** • Less than maximum score on more than one performance measure.	60	25%	15
— AND —				
Clinical Practice Improvement	Attest to a the maximum number of improvement activities (varies by group size and other criteria).	100	15%	15

IV. MIPS

Some Rough Numbers

While it is not possible to estimate MACRA's penalties and rewards with accuracy, we can make reasonable estimates based on information provided by CMS.[1]



[1] Number of participants and aggregate bonuses/penalties provided by CMS in the 2018 proposed rule.

CMS's information collection cost totals $869 million.

2018

IV. MIPS

Decision-Making Framework and Key Decision Points

There are three major categories of decisions that must be made: (1) at which level to report, (2) which measures to report, and (3) through which means to submit the data.

Eligible clinicians have a choice of reporting as individuals or as groups.

Data submission mechanisms vary based on the types of data that can be used and whether they are available for providers reporting as individuals or as groups.

The reporting requirements for 2017 quality measures vary based on which type of submission mechanism is selected.

This is not an entirely linear decision-making process, as these decisions are interrelated.

V. ACA Rollback

V. ACA Rollback

Legislative Action

> The Trump administration efforts over the past year to roll back the ACA have focused on weakening the law's provisions as opposed to fully repealing the law.

December 2017

- Eliminated the individual mandate by reducing the penalty to zero.

February 2018

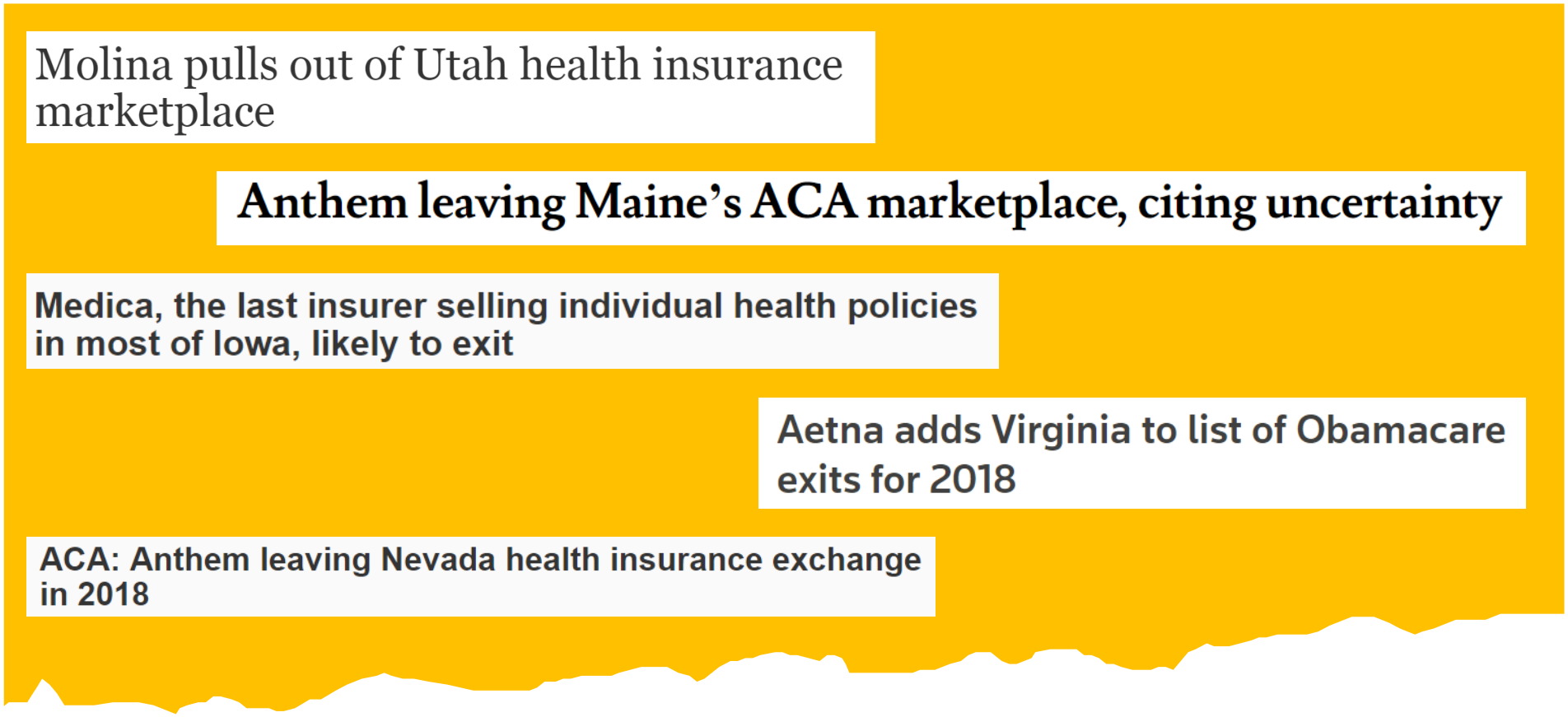
- Proposed regulations making it easier for health insurers to sell short-term coverage policies, which are generally cheaper because they exclude key benefits mandated by the ACA. Under the regulations, short-term plans:
  - Do not have to cover mental health and other "essential benefits."
  - Can have annual or lifetime limits on the bills the insurance company will pay.
  - Are available only to individuals with good health status.
- The proposal is currently in the midst of a 60-day comment period prior to being finalized.

Source: https://www.huffingtonpost.com/entry/trump-obamacare-insurance-rules_us_5a3d3cb5e4b06d1621b42a1b.

V. ACA Rollback

Insurer Participation on ACA Marketplaces

News of insurers exiting ACA health insurance marketplaces made headlines across the country through the latter half of 2017, and the trend is likely to continue as legislation rolling back Obamacare goes into effect.

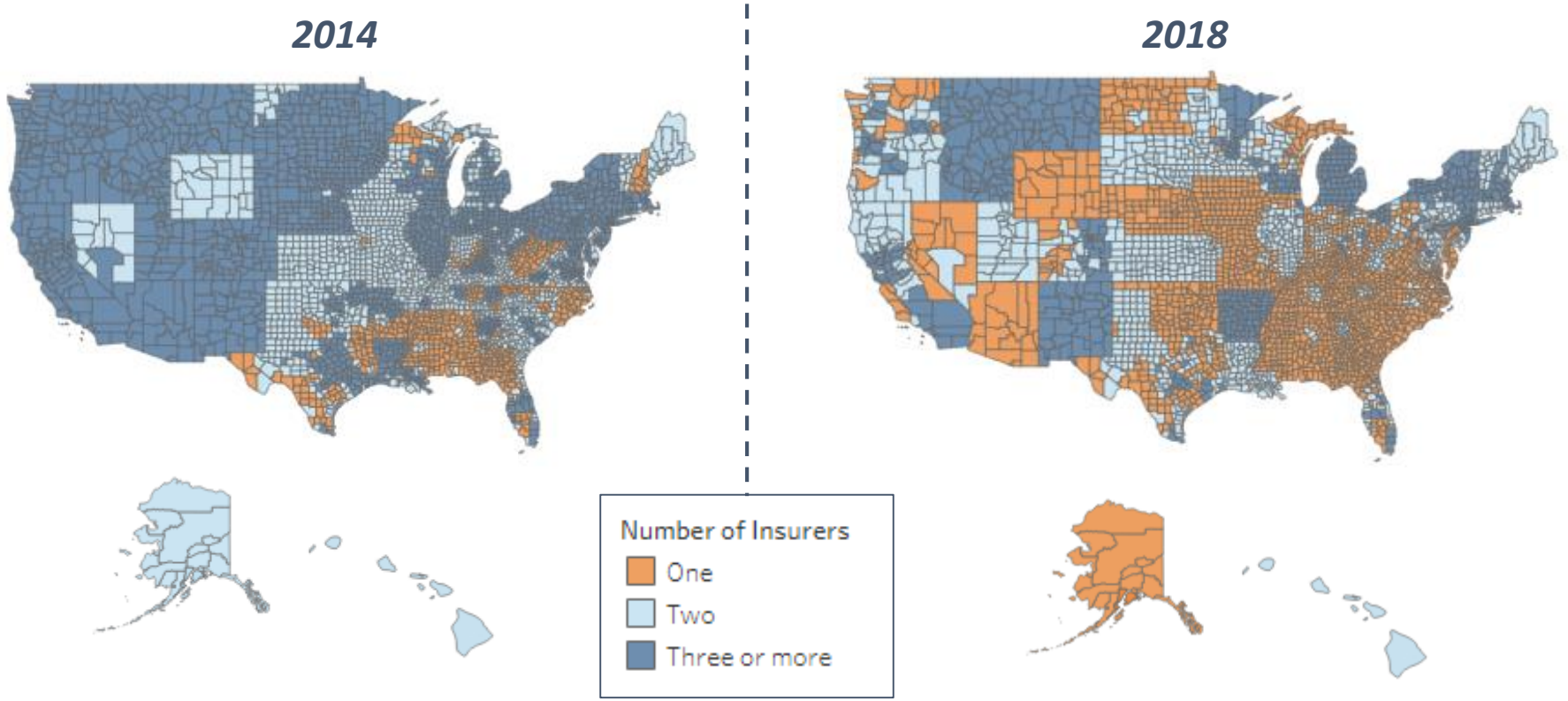


V. ACA Rollback

Insurer Participation on ACA Marketplaces *(continued)*

In 2018, 48% of enrollees (living in about 18% of counties) have a choice of three or more insurers, down from 58% in 2017 and 85% in 2016.

Insurer Participation on ACA Marketplaces: 2014 versus 2018



Source: https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces/.

V. ACA Rollback

Expected Impacts

Eliminating the individual mandate is estimated to leave 4 million fewer people without insurance over the course of one year. Other anticipated impacts are listed below.

The insurance market is expected to continue to erode, as enrollment continues to drop and insurers exit ACA marketplaces.

Re-emergence of short-term coverage policies will increase financial risk for consumers over the long term.

The higher risk profile of enrollees who remain on ACA exchange products will drive up insurance premiums.

Hospitals will see increases in bad debt due to growth of the uninsured population.

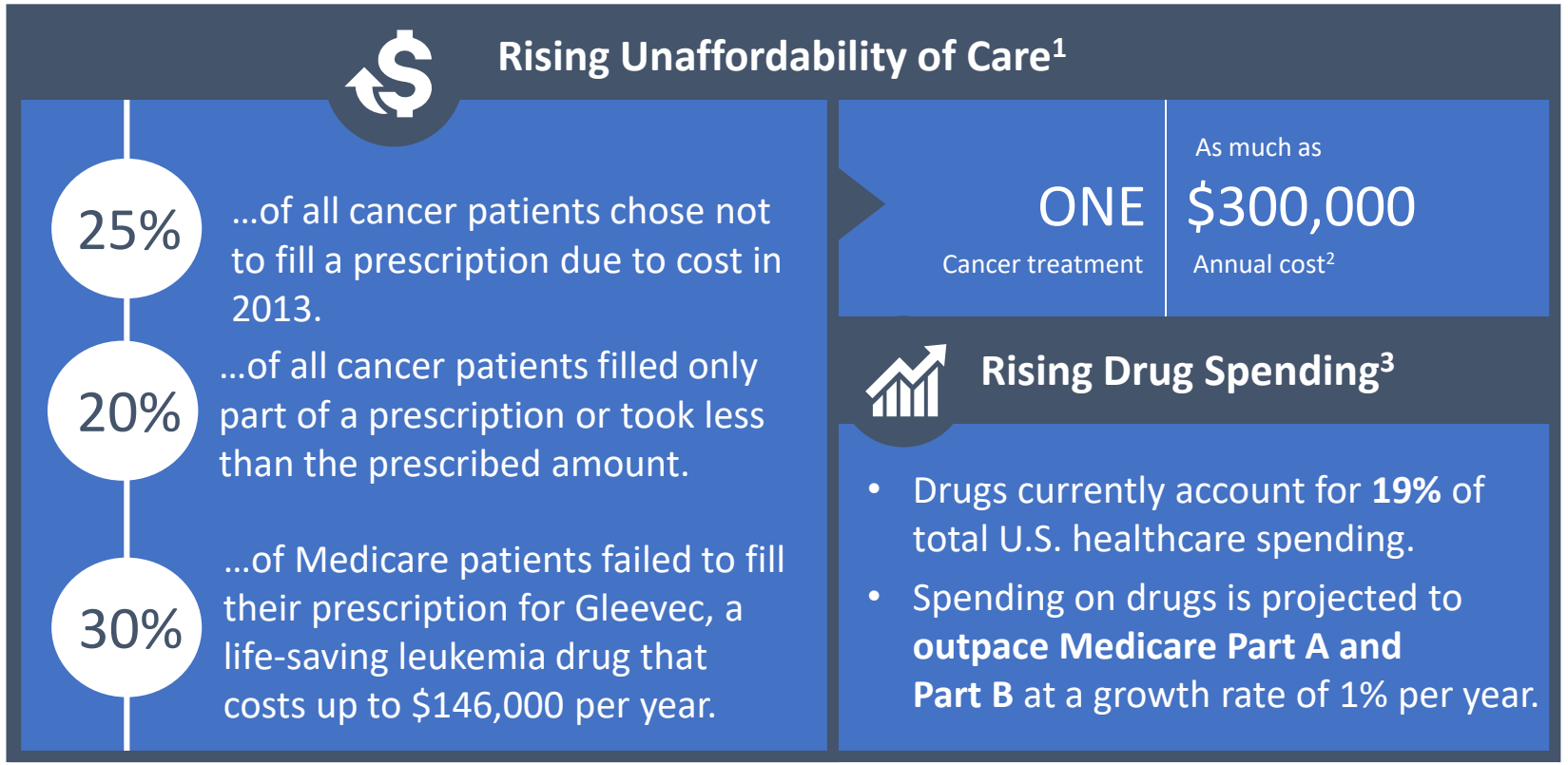
Note: Estimated increase of 10% according to *Health Affairs*: "Eliminating the Individual Mandate Penalty in California: Harmful but Non-Fatal Changes In Enrollment and Premiums." https://www.healthaffairs.org/do/10.1377/hblog20180223.551552/full/.

VI. Drug Pricing Trends

VI. Drug Pricing Trends

Rising Costs

Patients, providers, and payors alike are experiencing significant financial pressures due to the cost of cancer care drugs. The sustained increases in costs over recent years have accelerated interest in industry-wide drug pricing reform.



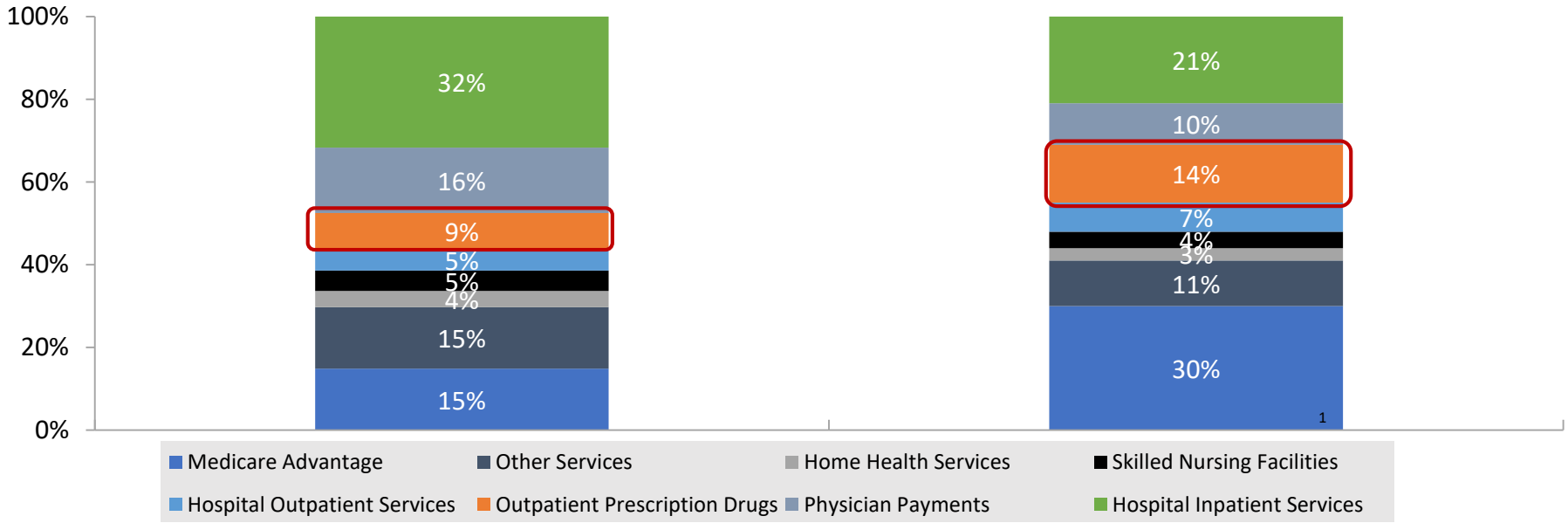
1 http://www.npr.org/sections/health-shots/2017/03/15/520110742/as-drug-costs-soar-people-delay-or-skip-cancer-treatments.
2 ASCO *State of Cancer Care in America* reports for 2016 and 2017.
3 http://www.ascopost.com/issues/march-10-2017/value-based-approaches-to-the-rising-costs-of-cancer-drugs/.

VI. Drug Pricing Trends

Pressure to Reduce Costs

CMS is exploring a number of strategies to reduce overall costs. Drug reimbursement methodology is under particular scrutiny because drugs represent such a significant portion of Medicare's annual benefit payments.

Medicare Benefit Payments by Type of Service, 2006 and 2016



Sources: Kaiser Family Foundation, "The Facts On Medicare Spending and Financing," 2016 (https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing); in 2016 Medicare represented 15% and Medicaid 10% of the total federal budget. Congressional Budget Office, June 2017, Medicare Baseline.

Notes: Consists of Medicare benefits spending on hospice, durable medical equipment, Part B drugs, outpatient dialysis, ambulance, lab services, and other Part B services. Figures may not be exact due to rounding.

With pressures such as the projected depletion of the Medicare Part A trust fund by 2027, CMS has renewed its focus on reducing costs across the system.

VI. Drug Pricing Trends

Approaches to Reform: Challenges for Drug Price Reforms

Despite President Trump's outreach to industry leaders and declarations of support for reducing drug prices, any attempt at price reform will be hard fought.

Very strong opposition from the pharmaceutical lobby

Bipartisan support required—yet hard to achieve

Trump's contradiction of GOP stances and flip-flopping on issues

Besides the challenge in crafting and implementing drug pricing reforms, there is much speculation about the actual impact any reforms may have.

VI. Drug Pricing Trends

Potential Drug Reforms

Several approaches for lowering drug costs have been discussed and may be included in reforms aimed at lowering costs.

Potential Approaches to Drug Reform

- Import cheaper drugs.
- Increase availability of generic drugs.
- Allow Medicare to negotiate drug prices.
- Increase use of value-based drug purchasing.
- Establish reference pricing.
- Reform the 340B Drug Discount Program.

VI. Drug Pricing Trends

Impact on Providers

Absent broader payment reform, any efforts to reduce drug acquisition costs will have a direct and negative impact on the bottom line for oncology providers.

- Most of the proposals discussed in this section target the supply cost of drugs.
- In the current environment, providers are paid a “commission” for administering drugs to patients.
- If the underlying cost basis decreases, all other factors being the same, the provider’s margin will also decrease.

VII. Oncology Care Model

VII. Oncology Care Model

Overview

> This five-year CMS Medicare demonstration project is designed to improve care coordination, access, and appropriateness while lowering the total cost for Medicare beneficiaries receiving cancer treatment.

Program Aim

Promote whole practice transformation through the use of aligned financial incentives, including performance-based payments to improve care coordination, appropriateness of care, and access for FFS Medicare beneficiaries undergoing chemotherapy.

Program Participation

187 practices and 14 payors are currently participating in OCM.

Current OCM Participating Practices

Source: CMS.

VII. Oncology Care Model

Episode Definition

> Care episodes are six months in length and include all Medicare Part A and B services received by beneficiaries.

Episode Definition

- An episode is initiated when a beneficiary receives a qualifying chemotherapy drug (first Part B/D chemotherapy claim).
- Each episode lasts for six months.
- If a patient requires chemotherapy beyond those six months, they begin a new episode.
- Beneficiaries may initiate multiple episodes during the five-year model.

Included Services

- All Medicare Part A and B services received by Medicare FFS beneficiaries during the episode.
- Certain Part D expenditures: the Low-Income Cost-Sharing Subsidy (LICS) amount and 80% of the Gross Drug Cost above the Catastrophic (GDCA) threshold.

Source: CMS.

Although the OCM does not change *how* drugs are reimbursed, it incentivizes practices to select high-value options.

VII. Oncology Care Model

Payment Methodology

During OCM episodes, providers continue to bill for standard Medicare FFS payments. OCM incorporates two additional payment mechanisms: a Monthly Enhanced Oncology Services (MEOS) payment and retrospective Performance-Based Payment (PBP).

MEOS

- The MEOS payment provides OCM practices with financial resources to aid in effectively managing and coordinating care for Medicare FFS beneficiaries.
- The $160 per member per month (PMPM) payment can be billed for OCM FFS beneficiaries for each month of their six-month episodes.

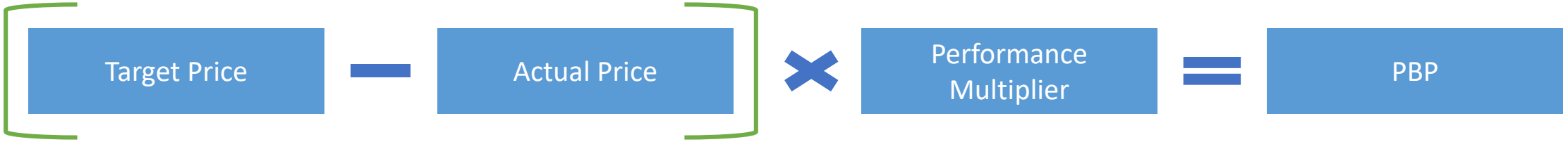
PBP

- PBP encourages OCM practices to improve care for beneficiaries and lower the total cost of care during the six-month episodes.
- PBP is calculated retrospectively on a semiannual basis based on the practice's achievement on quality measures and reductions in Medicare expenditures below a target price.

Source: CMS.

VII. Oncology Care Model

Performance-Based Payment Methodology



1 Calculate Benchmark

CMS calculates benchmark episode expenditures for OCM practices.

- Based on historical data
- Risk-adjusted (including for geographic variation)
- Trended to applicable performance period
- Includes a novel therapies adjustment

2 Determine Target Price

Discount is applied to the benchmark to determine a target price for OCM-FFS episodes.

Example:

- Benchmark = $30,000
- Discount = 4%
- Target Price = $28,800

3 Compare Actual to Target

If actual OCM-FFS episode expenditures are below target, the practice could receive a PBP.

Example:

- Target Price = $28,800
- Actual = $25,000
- PBP = up to $3,800

Note: Actual expenditures include both FFS and MEOS payments.

4 Adjust Based on Performance

The PBP amount is adjusted based on the participant's achievement across five quality domains.

- Communications and care coordination
- Person- and caregiver-centered outcomes
- Clinical quality of care
- Patient safety
- Clinical data

Source: CMS.

Payments are calculated for the total cost for the episode of care (includes Part A, B, and D payments).

VII. Oncology Care Model

Lessons for Every Practice

> While the OCM pilot includes only a small subset of U.S. oncology practices, the pilot is generating important information regarding opportunities to reduce the cost of cancer care.

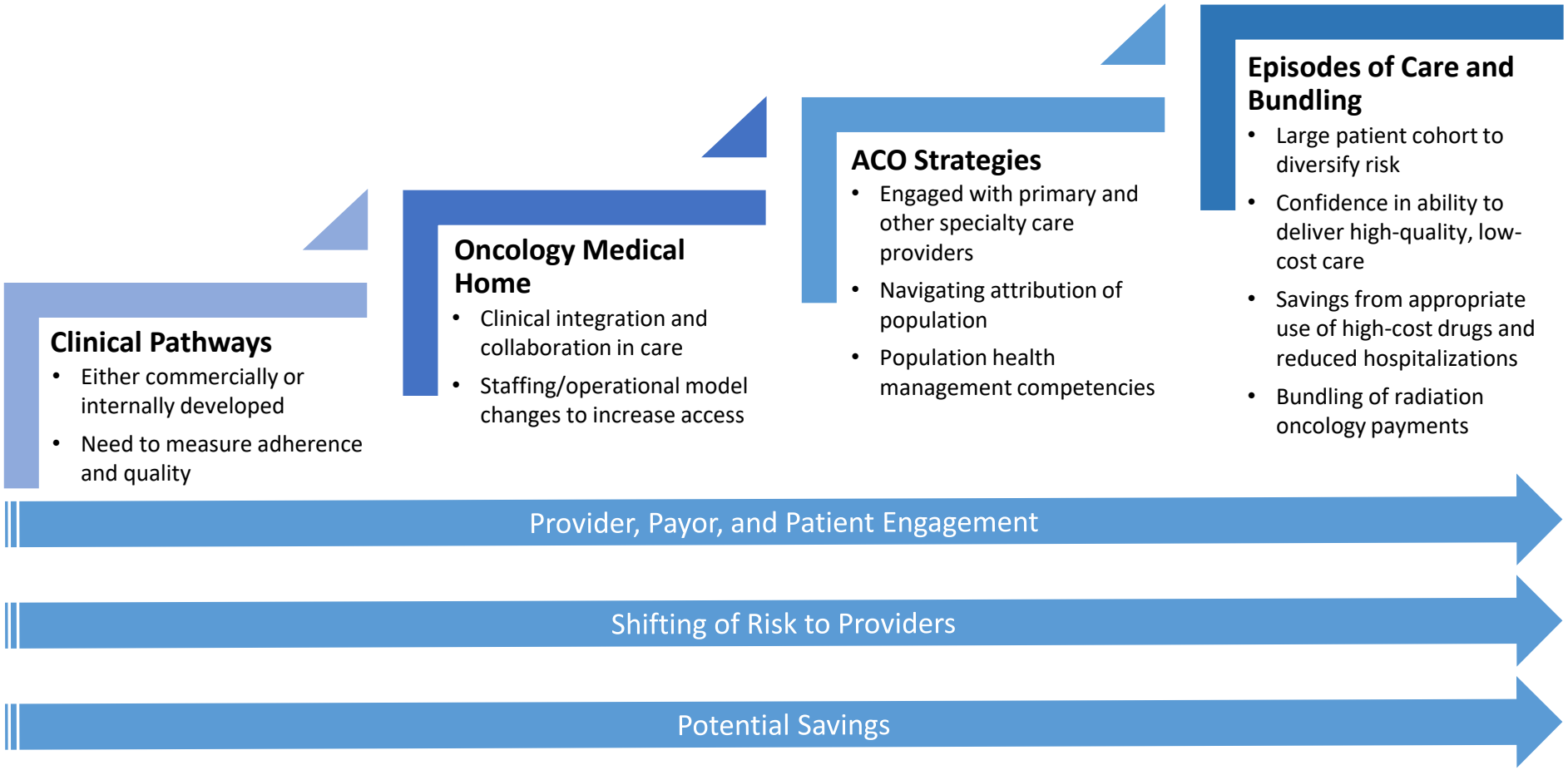
- Active case management is needed.
- Utilization of standardized pathways is critical.
- Without data and analytics, it is impossible to manage or improve performance.
- Narrow networks are essential to ensure pathway compliance and cost management.
- Look for areas of innovation to drive cost reduction all over the practice.
- Provider engagement is critical; without it, change will be nearly impossible.
- Coding and documentation (HCCs) are critical to getting credit for the complexity of your patient population.
- Infrastructure, infrastructure, infrastructure: people, processes, technology, and so forth are vital to generating and managing the information needed to manage change.
- Patient retention is important in a risk-based environment.

VIII. New Reimbursement Models

VIII. New Reimbursement Models

Increasingly Coordinated Care Models and Incentive Structures

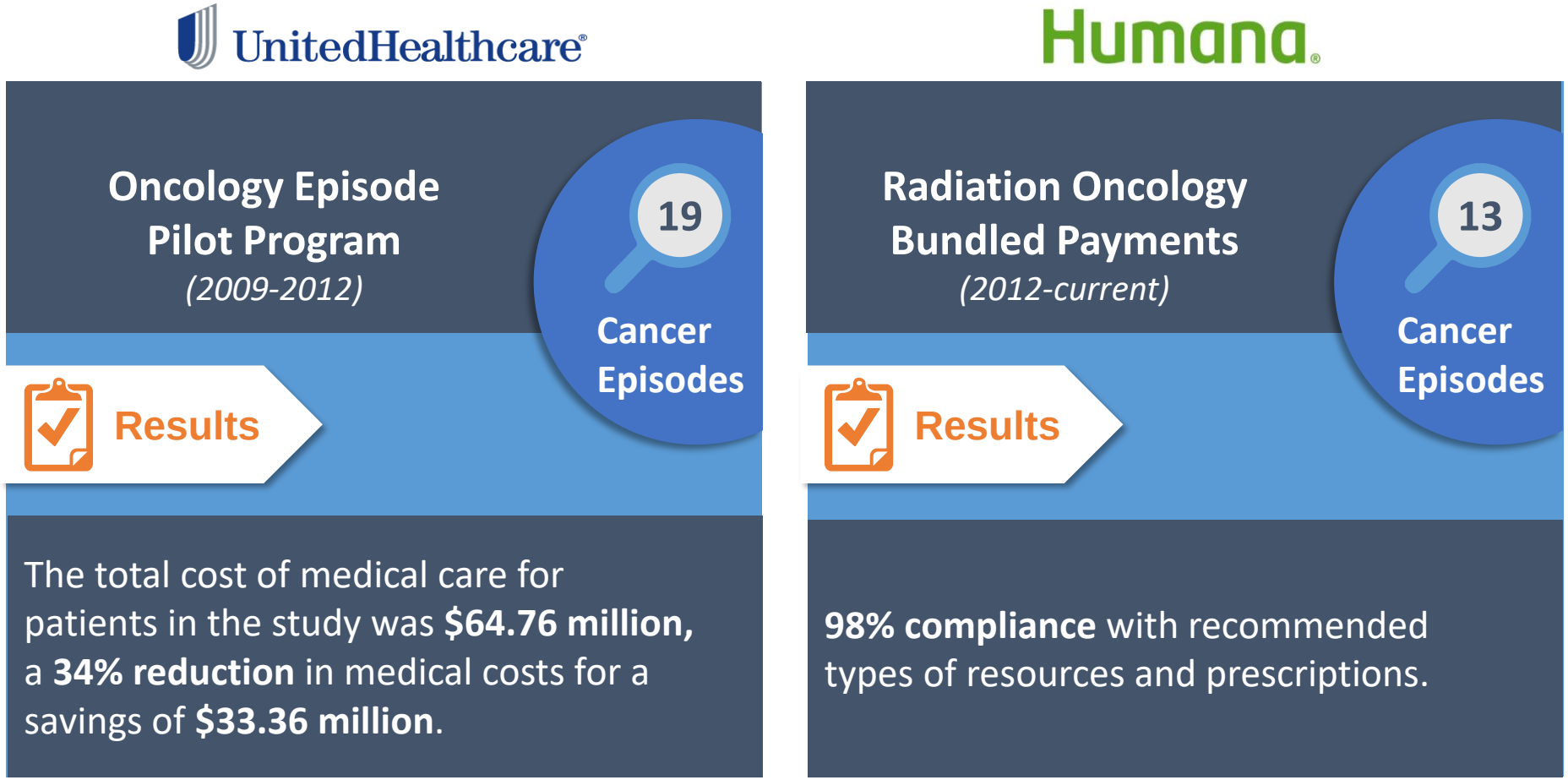
To provide optimal patient care and to align with changing reimbursement mechanisms, providers must assume an increasingly large role in managing overall cancer care, which is becoming more complicated and requires greater integration.



VIII. New Reimbursement Models

Commercial Bundled Payments

Commercial payors such as UnitedHealthcare and Humana are beginning to successfully experiment with new reimbursement models for oncology care.



2018

VIII. New Reimbursement Models

Case Study: MD Anderson and UnitedHealthcare Bundled Payment

MD Anderson and UnitedHealthcare entered into a pilot program to test an oncology-focused bundled payment.

THE UNIVERSITY OF TEXAS MD Anderson Cancer Center
Making Cancer History®

UnitedHealthcare®

Motivation

Voluntary experimentation with APMs.

Program

Three-year pilot (2013-2016) of a **one-year prospective bundled payment** for head and neck cancer.

Methodology

Four prospective, risk-adjusted, treatment-based bundles that **begin with treatment,** and payments are made at treatment start.

Results

One-year prospective bundled payment could be implemented, but **existing claims systems lacked flexibility** to automate bundled billings and payment.

Source: Spinks, et al., "Development and Feasibility of Bundled Payments for the Multidisciplinary Treatment of Head and Neck Cancer: A Pilot Program," *JOncPract,* December 2017.

VIII. New Reimbursement Models

Case Study: MD Anderson and UnitedHealthcare Bundled Payment *(continued)*

Feasibility

MD Anderson sees 2% of all U.S. head and neck cancers, giving it a **well-understood** patient population with **predictable treatment pathways**.

MD Anderson Resources

Dedicated project teams:

- Bundle design
- Contract negotiation
- Pilot implementation

Representing:

- Clinical operations
- Finance
- Legal
- Clinical support
- Compliance
- Institute of Cancer Care Innovation

UnitedHealthcare Resources

Dedicated project teams:

- Contracting
- Customer service
- Claims processing
- Claim configuration
- Oncology line of service representatives

Source: Spinks, et al., "Development and Feasibility of Bundled Payments for the Multidisciplinary Treatment of Head and Neck Cancer: A Pilot Program," *JOncPract,* December 2017.

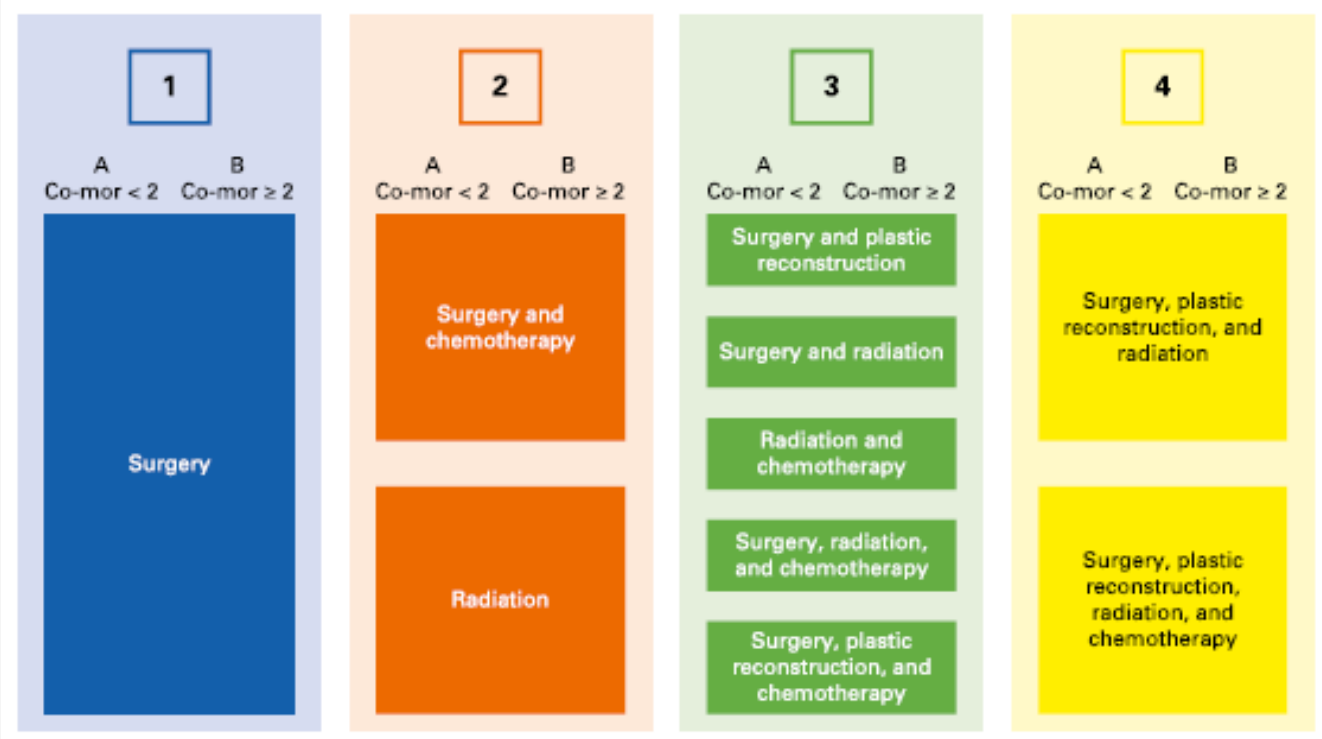
VIII. New Reimbursement Models

Case Study: MD Anderson and UnitedHealthcare Bundled Payment *(continued)*

Bundle Design

Primary cancer treatment (surgery, radiation therapy, chemotherapy) and **one year of care,** including:

- Inpatient care
- Surgical reconstruction
- Emergency visits
- Diagnostic imaging
- Internal medicine
- Preventive care



Note: Head and neck bundled payment pilot: four risk-adjusted bundles. The risk-adjusted payment bundles for head and neck cancer are shown with treatment plans included in each bundle. "Co-mor" stands for comorbidity (per the Charlson comorbidity index).

Source: Spinks, et al., "Development and Feasibility of Bundled Payments for the Multidisciplinary Treatment of Head and Neck Cancer: A Pilot Program," *JOncPract,* December 2017.

VIII. New Reimbursement Models

Case Study: MD Anderson and UnitedHealthcare Bundled Payment *(continued)*

MD Anderson and UnitedHealthcare's bundle was deemed feasible, but presented operational challenges. Cost and quality outcomes are not yet clear.

Outcome

- After a three-year pilot, it was determined that a single bundled payment for head and neck cancer patients was feasible.
- UnitedHealthcare has not yet expressed interest in expanding the program.[1]

Challenges

- Claims submissions were difficult to do and required manual workarounds. Many billing systems are not well-equipped for bundled payments.
- Payments for newer technology (e.g., proton therapy) were not included in the bundle.

Next Steps

- The bundle's performance on quality and cost is still under evaluation.
- UnitedHealthcare is testing other bundles, such as a program with community medical oncologists.[2]

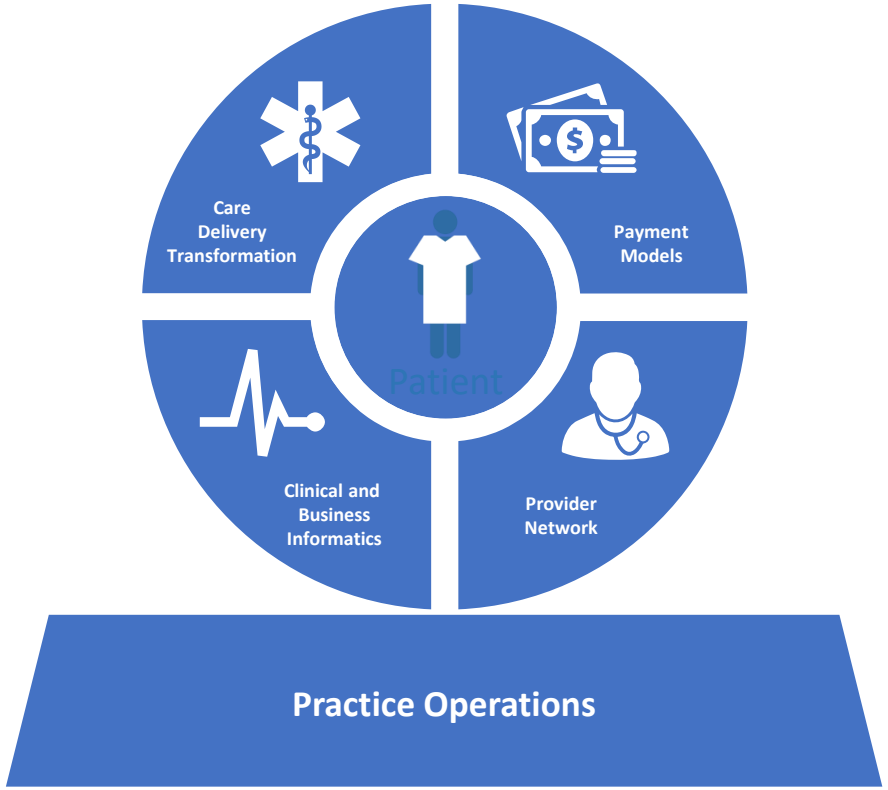
1 "In the End, It Will Be Episode Payment." *Managed Care,* May 1, 2017.
2 "Study: New Cancer Care Payment Model Reduced Health Care Costs, Maintained Outcomes." UnitedHealth Group, July 8, 2014.

IX. Takeaways

IX. Takeaways

Strategic Opportunities: Overview

To succeed in the changing healthcare environment, providers need to simultaneously evolve care delivery, align with new payment models, integrate across the care continuum, and improve technological capabilities while maintaining highly efficient operations.

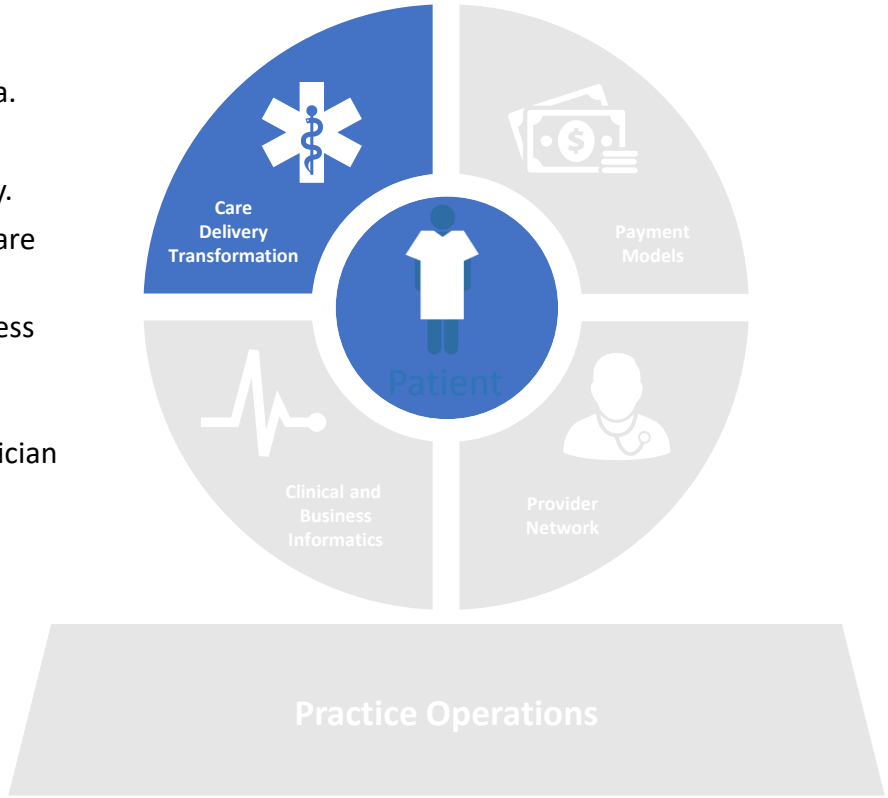


IX. Takeaways

Strategic Opportunities: Care Delivery Transformation

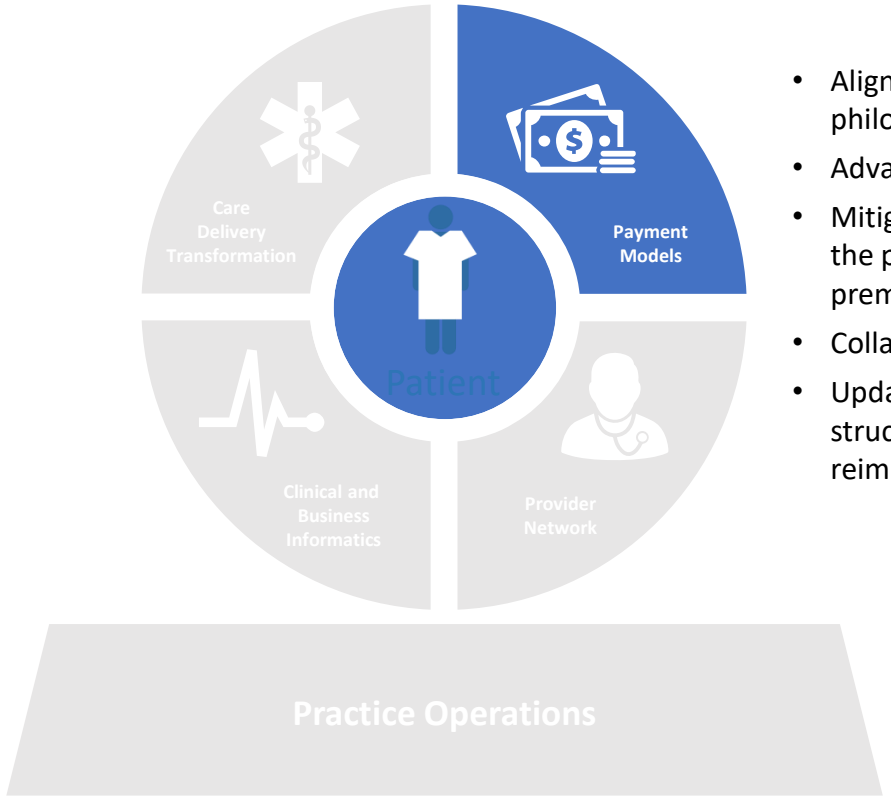
Care Delivery Transformation

- Analyze clinical and claims data.
- Develop protocols.
- Optimize the group's formulary.
- Outline and prioritize clinical care improvements.
- Oversee clinical teams to address variation and create tools for improvement.
- Evolve the framework for physician leadership, management, and accountability for protocol implementation.



IX. Takeaways

Strategic Opportunities: Payment Models



Payment Models

- Align the value-based reimbursement philosophy with clinical goals.
- Advance value payment models.
- Mitigate reliance on FFS by diversifying the portfolio and getting closer to the premium.
- Collaborate with payors.
- Update physician compensation structures to align with new methods of reimbursement.

IX. Takeaways

Strategic Opportunities: Provider Network

Provider Network

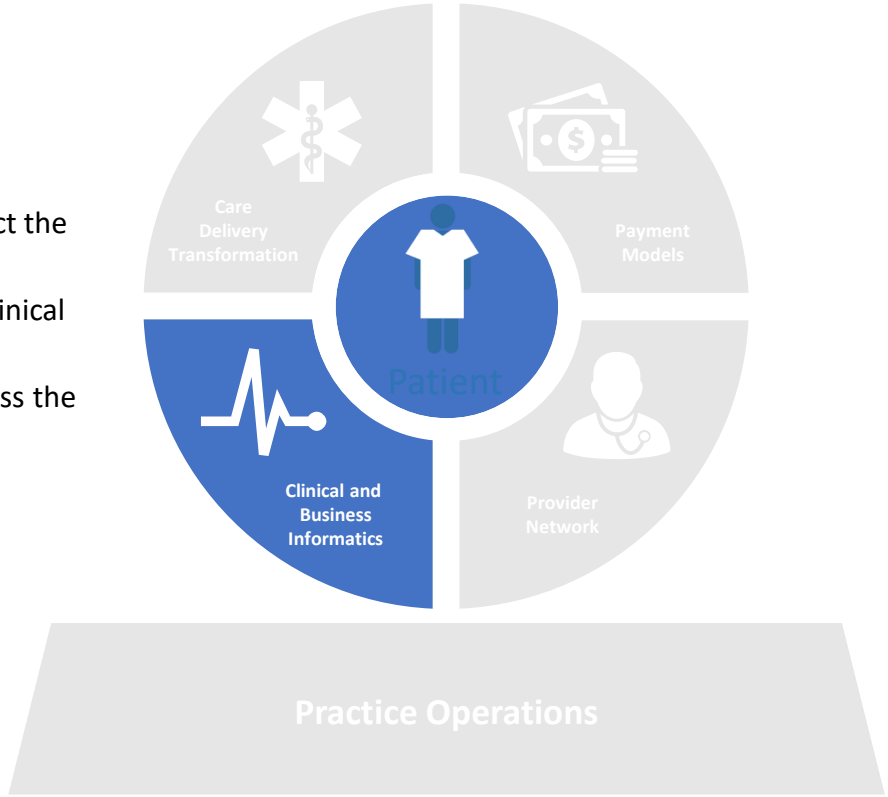
- Provide and coordinate the clinical scope across the care continuum.
- Align the network financially and clinically.
- Ensure that the network follows protocols and facilitates in-network referrals.

IX. Takeaways

Strategic Opportunities: Clinical and Business Informatics

Clinical and Business Informatics

- Develop reports of clinical and financial performance that reflect the priorities of value-based care.
- Incorporate tools that provide clinical decision support.
- Accomplish data exchanges across the care continuum.



IX. Takeaways

Strategic Opportunities: Practice Operations

Practice Operations

- Develop and adhere to clinical pathways.
- Develop a formulary and actively manage/enforce its use.
- Reduce waste associated with high-expense drugs.
- Ensure that overall ordering and inventorying of drug doses match the clinical requirements of the services offered.
- Ensure coding accuracy and compliance.
- Develop and optimize clinical care teams, ensuring all staff practice at the top of their licensees.
- Standardize processes, roles, and expectations across work areas.
- Eliminate non value-added operations.

Questions & Answers

Matt Sturm
MSturm@ecgmc.com
206.689.2243