Value-Based Care in Cancer: Where will we go from here?

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Vanderbilt University Medical Center

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Disclosures

None

Disclosures

These are not new ideas, but new facts and faces.

Agenda

What is value-based care?

Why value-based care?

How value-based care?

Value-based care and cancer

Where will we go from here?

Conclusions

What is value-based care? Paying for health care that works.

Why value-based care? We deserve better.

How value-based care? Deploy risk.

Value-based care and cancer. There are value opportunities.

Where will we go from here? Risk is coming.

What is value-based care?

What is value-based care?

A different way of paying for health care.

What is value-based care?

Paying for health care that works.

What is value-based care?

Paying for health care that works.

What is value-based care?

/’valyo͞o/ = $\frac{\textit{Outcomes}}{\textit{Spend}}$

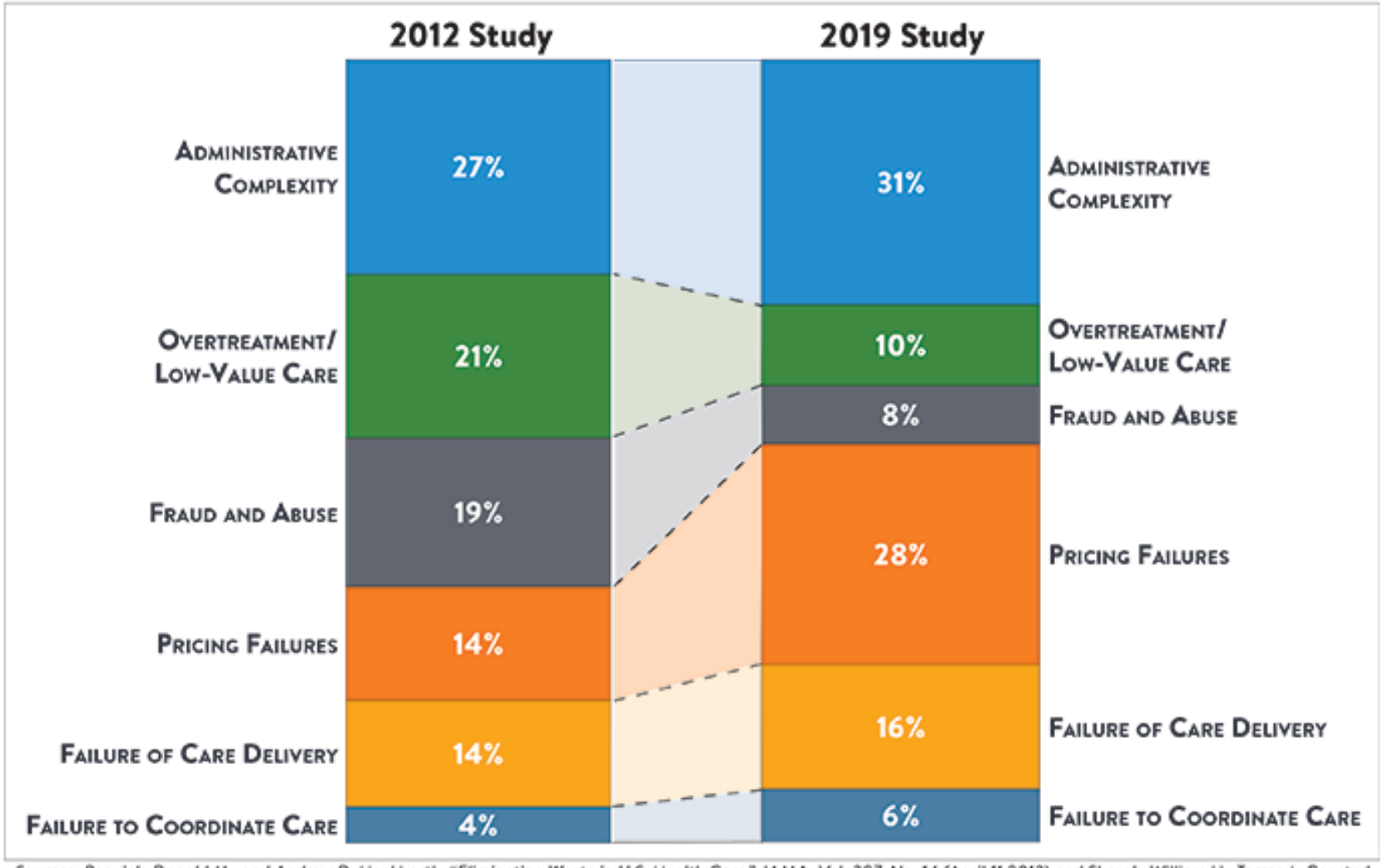
Why value-based care?

Why value-based care?

Health care is wasteful.

25%-33% of health care spending does not improve outcomes.

Six Categories of Healthcare Waste: New Data Updates Previous Findings



Sources: Berwick, Donald M., and Andrew D. Hackbarth, "Eliminating Waste in U.S. Health Care," JAMA, Vol. 307, No. 14 (April 11 2012) and Shrank, William H., Teresa L. Rogstad, and Natasha Parekh, "Waste in the US Health Care System: Estimated Costs and Potential for Savings," JAMA, Vol. 322, No. 15 (Oct. 15, 2019).
Note: Figure uses mid-point estimates to contrast the contribution of each category of waste.

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Wasteful health care spending poses an insolvency risk.

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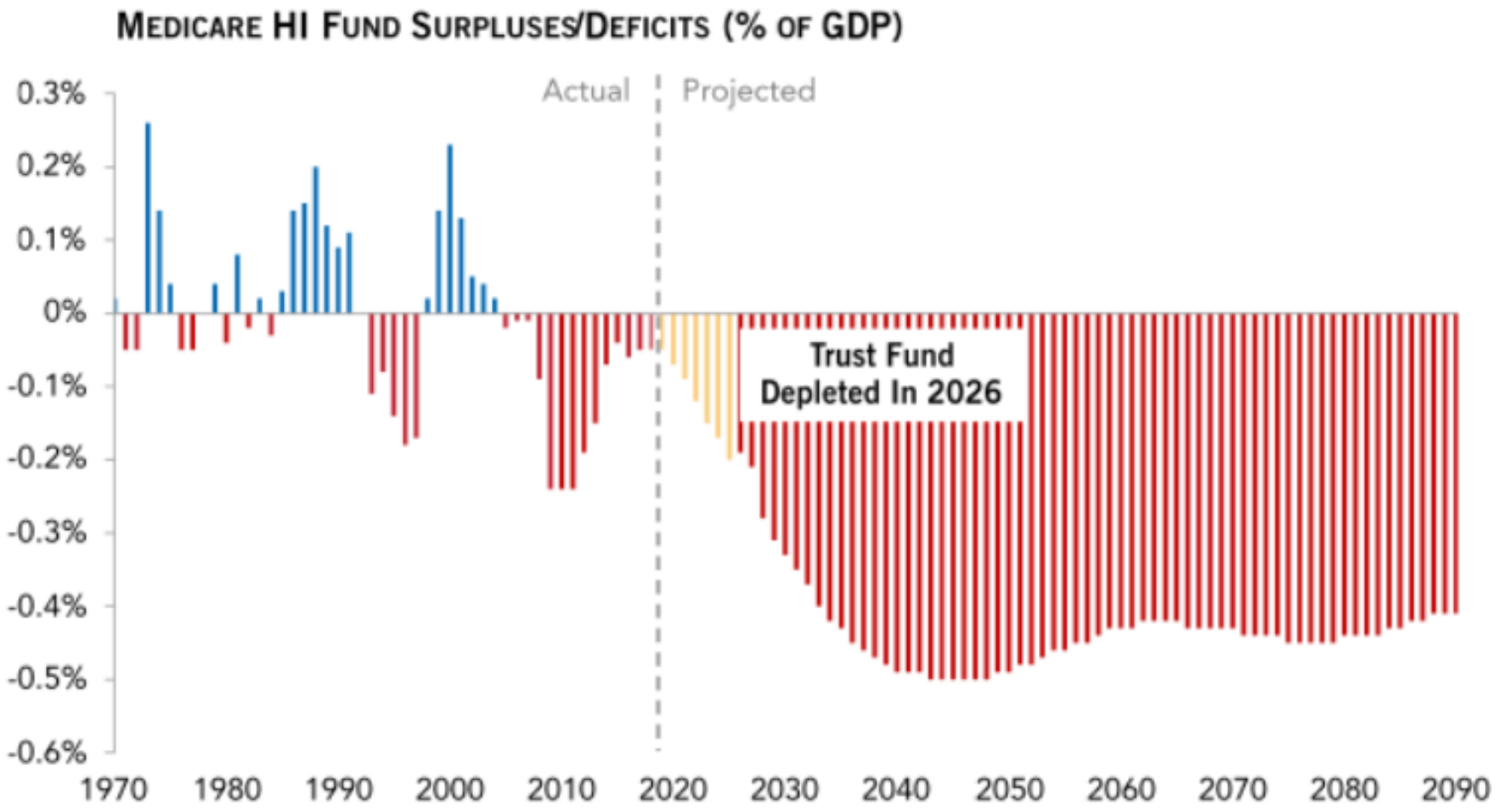
Medicare's Hospital Insurance trust fund will be depleted in 2026



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Why value-based care?

We deserve better.


FENWAY PARK

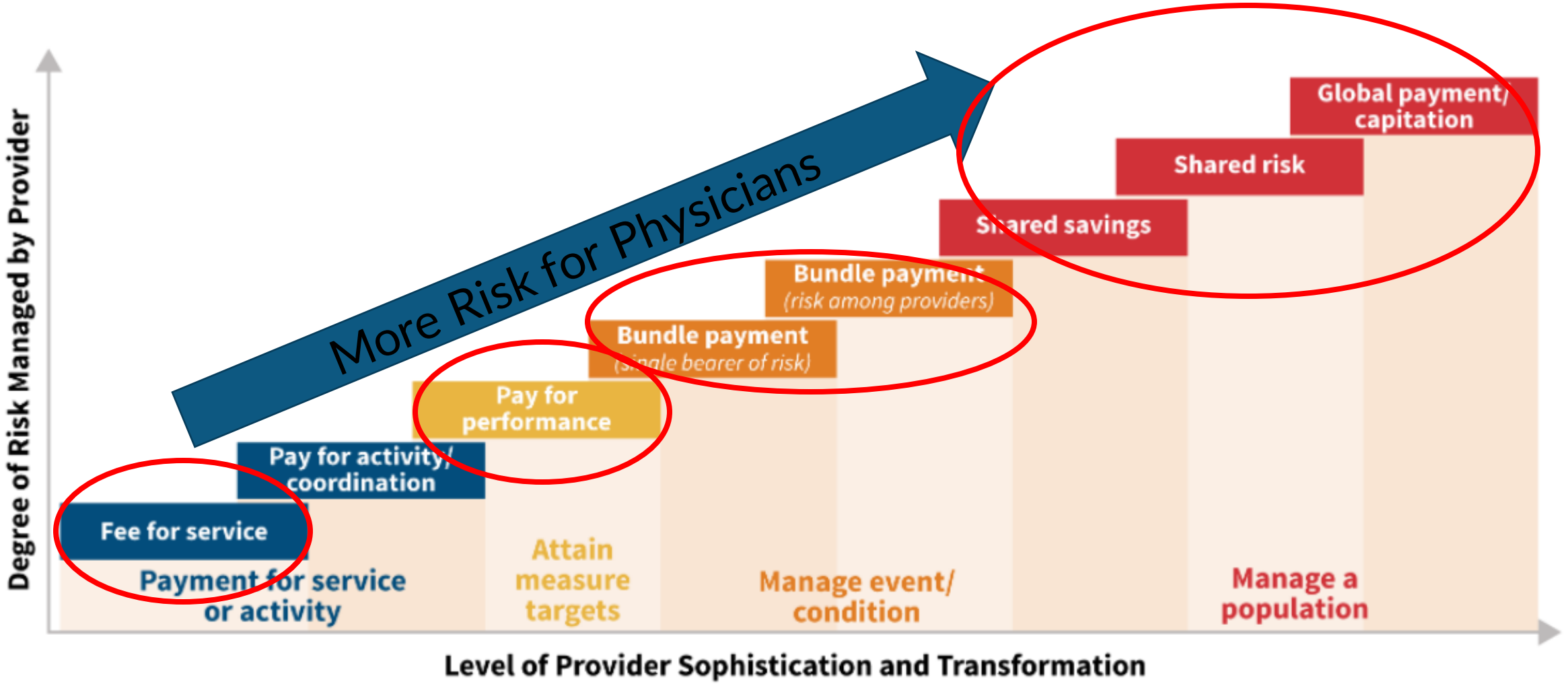
How value-based care?

How value-based care?

Deploy risk.

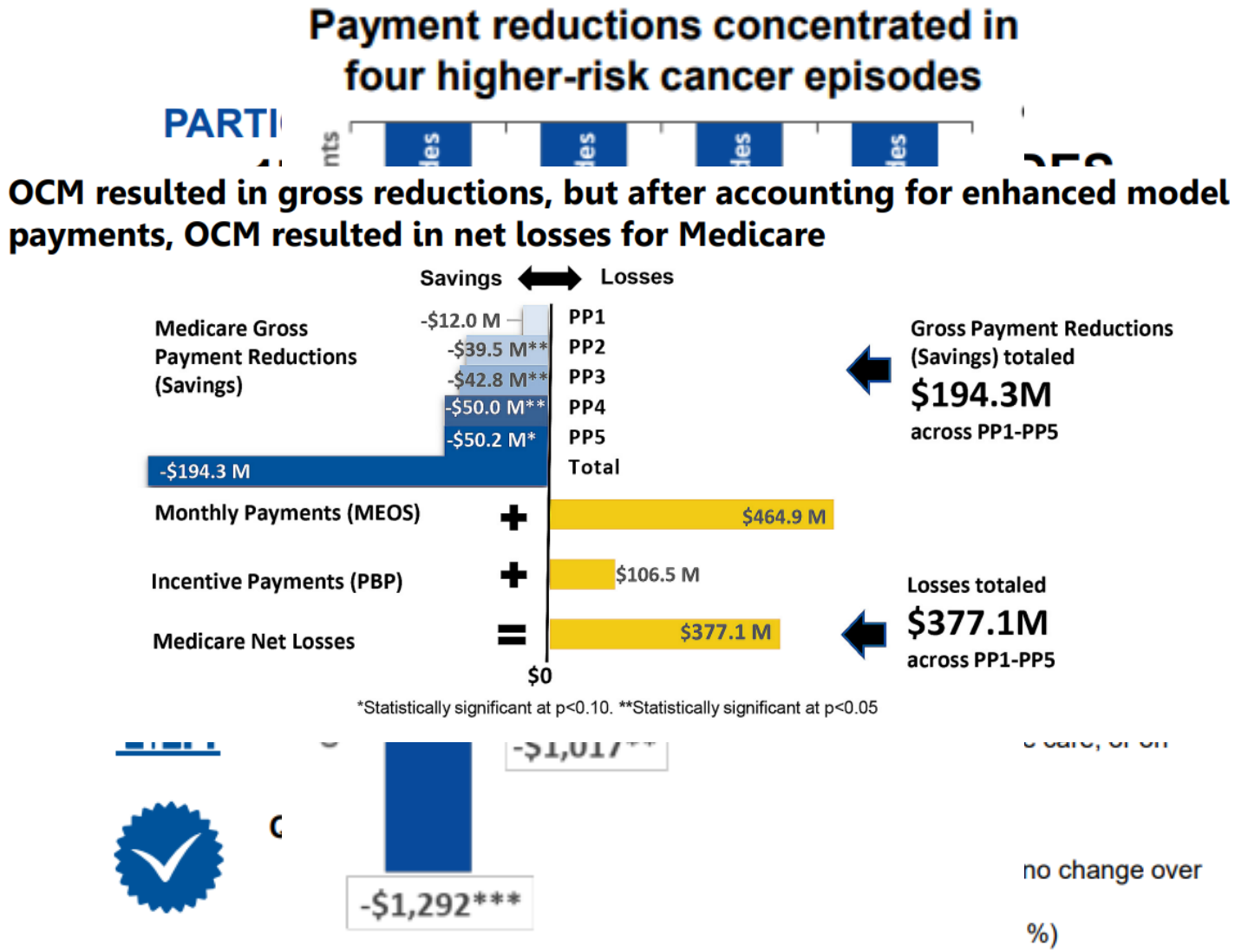
How value-based care?

Bet on yourself.


More Risk for Physicians
Degree of Risk Managed by Provider
Fee for service
Pay for activity/ coordination
Pay for performance
Bundle payment (risk among providers)
Bundle payment (single bearer of risk)
Shared savings
Shared risk
Global payment/ capitation
Payment for service or activity
Attain measure targets
Manage event/ condition
Manage a population
Level of Provider Sophistication and Transformation

ONCOLOGY CARE MODEL

- Voluntary
- 24 cancer types
- 6-month chemo episodes
- Total cost of care
- Care coordination payment
- Quality bonus



Value-Based Care and Cancer

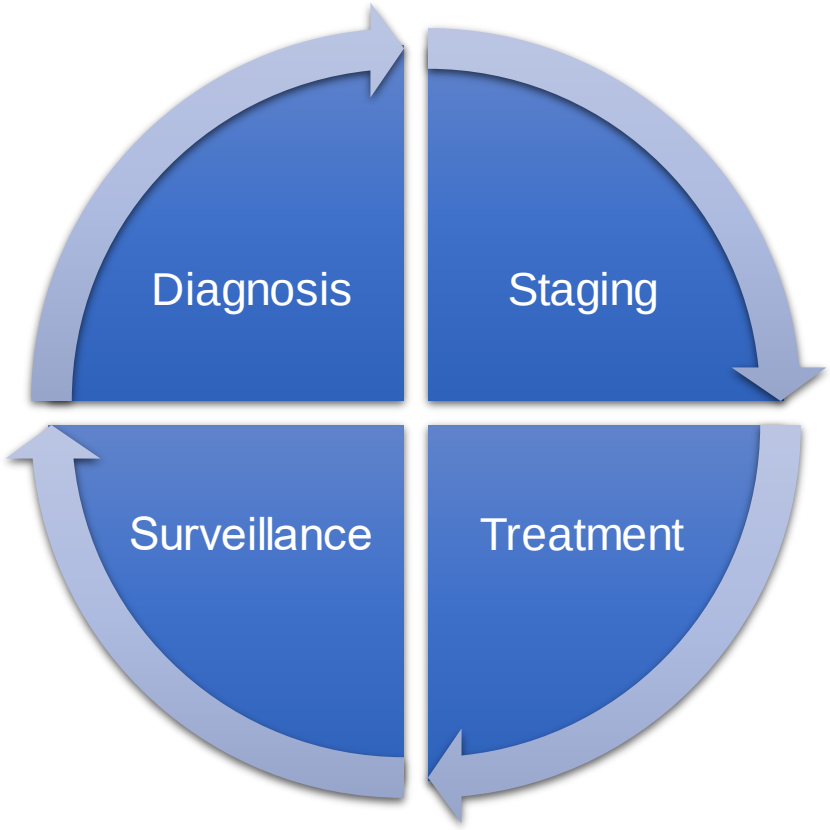
Value-Based Care and Cancer

Paying for health care that works.

Value-Based Care and Cancer

What cancer care is high or low value?

Value-Based Care and Cancer



Value-Based Care and Cancer

NIHR | National Institute for Health and Care Research

Journals Library

Check for updates

Health Technology Assessment

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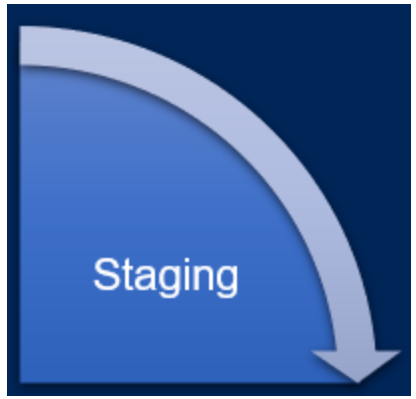
Photodynamic versus white-light-guided resection of first-diagnosis non-muscle-invasive bladder cancer: PHOTO RCT

Rakesh Heer, Rebecca Lewis, Anne Duncan, Steven Penegar, Thenmalar Vadiveloo, Emma Clark, Ge Yu, Paramananthan Mariappan, Joanne Cresswell, John McGrath, James N'Dow, Ghulam Nabi, Hugh Mostafid, John Kelly, Craig Ramsay, Henry Lazarowicz, Angela Allan, Matthew Breckons, Karen Campbell, Louise Campbell, Andy Feber, Alison McDonald, John Norrie, Giovany Orozco-Leal, Stephen Rice, Zafer Tandogdu, Ernest Taylor, Laura Wilson, Luke Vale, Graeme MacLennan and Emma Hall

Takeaway

Photodynamic TURBT did not reduce recurrence and was not cost effective compared with white light at 3 years.

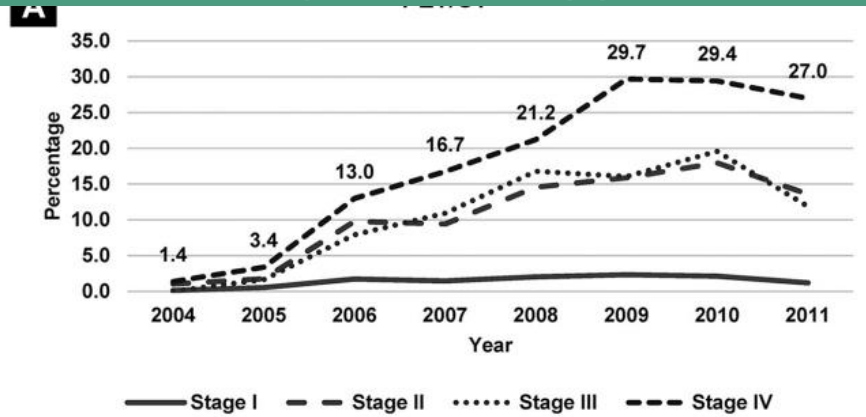
Value-Based Care and Cancer



Increased Utilization of Positron Emission Tomography/Computed Tomography (PET/CT) Imaging and Its Economic Impact for Patients Diagnosed With Bladder Cancer

Jinhai Huo,[1] Yiyi Chu,[2] Karim Chamie,[3] Marc C. Smaldone,[4] Stephen A. Boorjian,[5] Jacques G. Baillargeon,[6] Yong-Fang Kuo,[7] Preston Kerr,[8] Padraic O'Malley,[9] Eduardo Orihuela,[8] Douglas S. Tyler,[10] Stephen J. Freedland,[11] Sharon H. Giordano,[2] Raghu Vikram,[12] Ashish M. Kamat,[13] Stephen B. Williams[8]

Figure 2 Percent of Patients Receiving PET/CT, MRI, or CT Imaging After a Bladder Cancer Diagnosis.



Takeaway

Sharp increase in PET/CT utilization; $12m in excess spending based on PET/CT imaging

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Value-Based Care and Cancer

Clinical-Bladder cancer

Long term cost comparisons of radical cystectomy versus trimodal therapy for muscle-invasive bladder cancer

Vishnukamal Golla, M.D., M.P.H.[a,i], Yong Shan, Ph.D.[b], Elias J. Farran, M.D.[b], Courtney A. Stewart, B.S.[b], Kevin Vu, M.D.[b], Alexander Yu, B.S.[b], Ali Raza Khaki, M.D.[c], Divya Ahuja Parikh, M.D.[c], Todd A. Swanson, M.D., Ph.D.[d], Kirk A. Keegan, M.D.[e], Ashish M. Kamat, M.D.[f], Douglas S. Tyler, M.D.[g], Stephen J. Freedland, M.D.[h,i], Stephen B. Williams, M.D., M.S.[b,*]

Table 2
Medicare costs (USD) associated with RC and TMT following bladder cancer diagnosis.

		Median, $								
		Radical cystectomy				Trimodal therapy				
No. of years	Total median costs	Total	IQR	Inpatient	Outpatient	Total	IQR	Inpatient	Outpatient	Hodges-lehmann estimate (95% CI)[a]
2 y[b]	276,274	191,363	227,296	62,240	100,900	372,839	324,125	33,631	318,221	127,815 (112,663–142,966)
5 y[b]	339,101	253,651	288,475	75,499	146,561	424,570	390,798	45,223	367,092	124,466 (105,711–143,221)

Abbreviations: CI = confidence interval; IQR = interquartile range; RC = radical cystectomy; TMT = trimodal therapy; USD = US dollar.
[a] Hodges-Lehmann median difference in total costs (trimodal therapy minus radical cystectomy).
[b] Radical cystectomy vs. trimodal therapy total; inpatient and outpatient. *P* values all <0.001.

Takeaway

Costs for TMT are greater than RC at 2y and 5y

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CURRENT ONCOLOGY
A Canadian Cancer Research Journal

ORIGINAL

A cost–utility analysis of atezolizumab in the second-line treatment of patients with metastatic bladder cancer

A. Parmar MD,*† M. Richardson MSc,† P.C. Coyte MA PhD,†‡ S. Cheng MD,*
B. Sander RN MBA MEcDev PhD,†‡§|| and K.K.W. Chan MD MSc PhD*†#

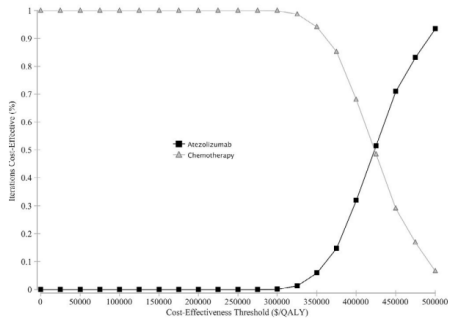

FIGURE 2 Cost-effectiveness acceptability curve for the base-case analysis. QALY = quality-adjusted life-year.

Takeaway

Atezo is not cost-effective compared to cytotoxic chemotx as 2nd line for M+ bladder cancer

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OXFORD

JNCI J Natl Cancer Inst (2017) 109(11): djx063

doi: 10.1093/jnci/djx063
First published online June 3, 2017
Article

ARTICLE

A Phamacoeconomic Analysis of Personalized Dosing vs Fixed Dosing of Pembrolizumab in Firstline PD-L1-Positive Non–Small Cell Lung Cancer

Daniel A. Goldstein, Noa Gordon, Michal Davidescu, Moshe Leshno, Conor E. Steuer, Nikita Patel, Salomon M. Stemmer, Alona Zer

Affiliations of authors: Davidoff Cancer Center, Rabin Medical Center, Petach Tikvah, Israel (DAG, NG, SMS, AZ); Winship Cancer Institute, Emory University, Atlanta, GA (DAG, CES, NP); Ben Gurion University of the Negev, Beer Sheva, Israel (NG); Clalit Health Services Headquarters, Tel Aviv, Israel (MD); Sackler Faculty of Medicine (ML, SMS, AZ) and Faculty of Management (ML), Tel Aviv University, Tel Aviv, Israel

Correspondence to: Daniel A. Goldstein, MD, Davidoff Cancer Center, Rabin Medical Center, Ze'ev Jabotinsky Rd 39, Petah Tikva, 4941492, Israel (e-mail: dgolds8@emory.edu).

Takeaway

Pembro dosing at 2mg/kg (vs. 200mg) could save $800m annually in US

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Value-Based Care and Cancer

Clinical-bladder cancer

Performance of CellDetect for detection of bladder cancer: Comparison with urine cytology and UroVysion

Hila Kreizman Shefer, Ph.D.[a], Ismael Masarwe, M.D.[b], Jacob Bejar, M.D.[a], Luna Hijazi Naamnih, M.Sc.[a], Keren Gueta-Milshtein, M.Sc.[c], Adel Shalata, M.D.[d], Yarin Hadid[d], Omri Nativ, M.D.[e,*], Ofer Nativ, M.D.[b]

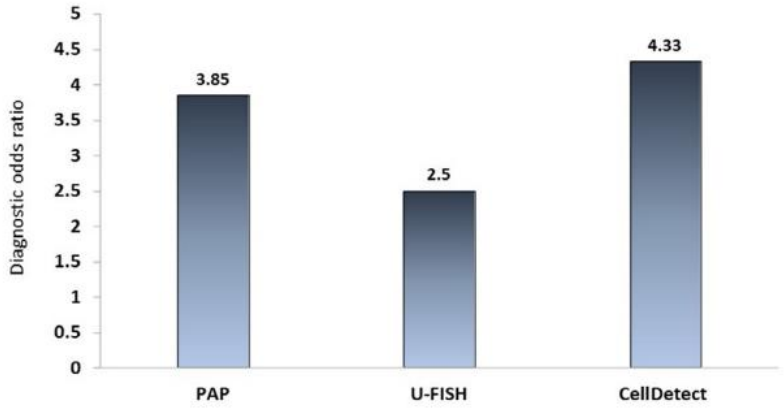

Fig. 3. Comparative effectiveness of the studied tests using diagnostic odds ratio for 93 patients with suspected bladder cancer.

Takeaway

CellDetect has higher sensitivity and NPV compared to cytology and UroVysion

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The Future of VBC and Cancer

The Future of VBC and Cancer

Risk is coming.

The Future of VBC in Cancer

OVERVIEW OF ENHANCING ONCOLOGY MODEL (EOM)

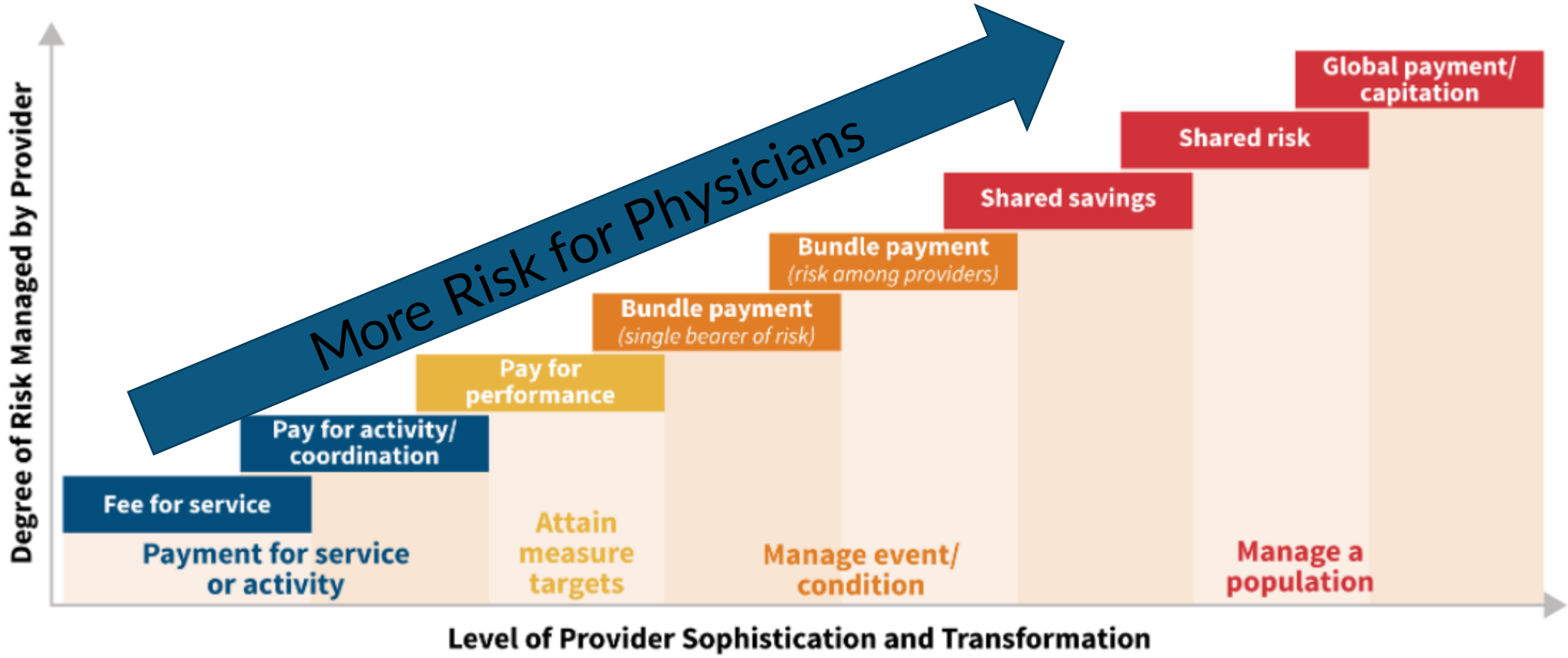
EOM will continue to drive care transformation and reduce Medicare costs

FOCUS	Five-year, **voluntary payment and delivery model** scheduled to begin July 2023 and conclude June 2028, that focuses on innovative payment strategies that promote high-quality, person-centered, equitable care to Medicare FFS beneficiaries with certain cancer diagnoses who are undergoing **chemotherapy treatment**
PARTICIPANTS	**Oncology Physician Group Practices (PGPs)** and **other payers** (e.g., commercial payers, state Medicaid agencies) through multi-payer alignment
QUALITY & PAYMENT	EOM participant are paid FFS with the addition of **two** financial incentives to **improve quality** and **reduce cost**: ▪ Additional payment to support care transformation in the form of a **$70** per-beneficiary-per-month **Monthly Enhanced Oncology Services (MEOS)** to support care transformation. Participants can bill an additional **$30** per-beneficiary-per-month MEOS for EOM beneficiaries that are dually eligible, this additional payment will be excluded from EOM participants' total cost of care (TCOC) responsibility. EOM participants would be eligible to receive MEOS for furnishing Enhanced Services ▪ Potential **performance-based payment (PBP)** or **performance-based recoupment (PBR)** based on the total cost of care (including drugs) and quality measures during 6-month episodes that begin with the receipt of chemotherapy

Takeaway

CMS is doubling-down on bundles in cancer care.

The Future of VBC in Cancer



Conclusions

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