

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

C.J. Stimson, MD, JD

Disclosures

- None

Disclosures

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

Agenda

- What is 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.
- 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?

Paying for health care that works

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Paying for health care that works

What is value-based care?

$$/ˈvæljuːbəl/ = \frac{\text{Outcomes}}{\text{Spend}}$$

What is value-based care?

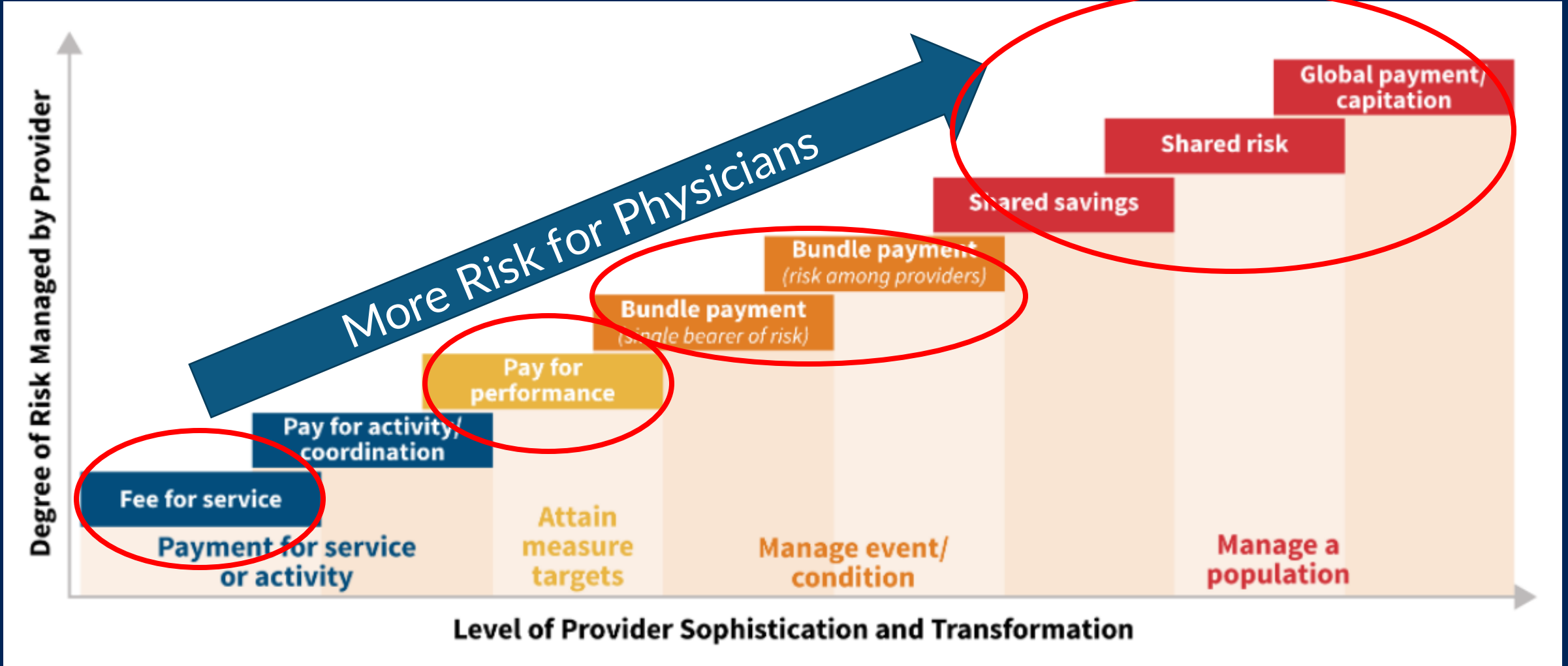
How do we encourage value-based care?

What is value-based care?

Deploy risk.

What is value-based care?

Bet on yourself.



Value-Based Care and Cancer

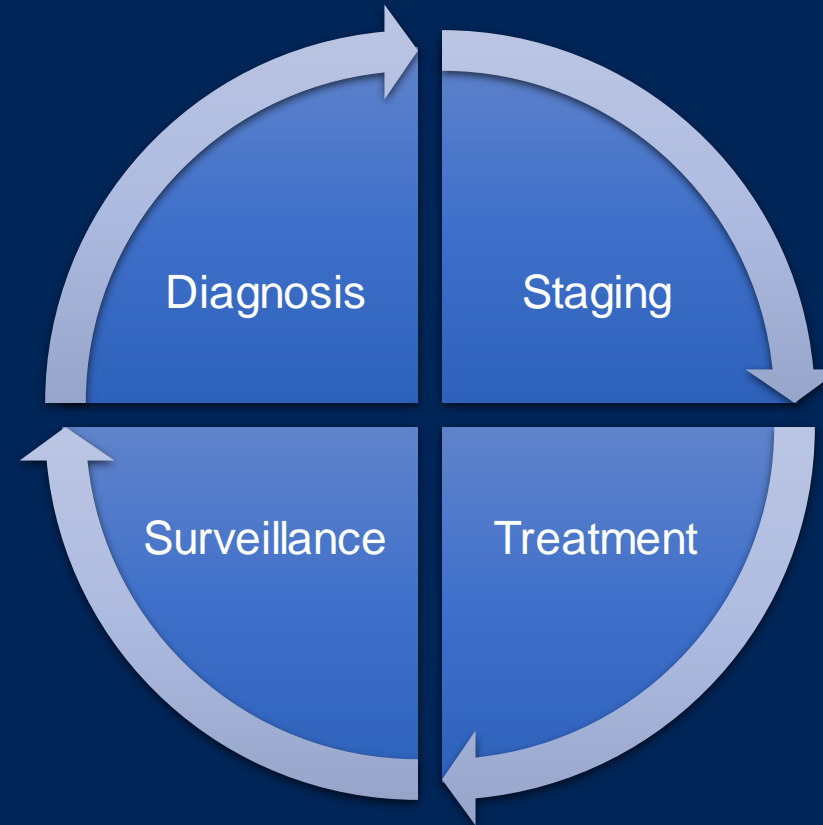
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Paying for health care that works

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What cancer care is high or low value?

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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, Paramanathan 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.

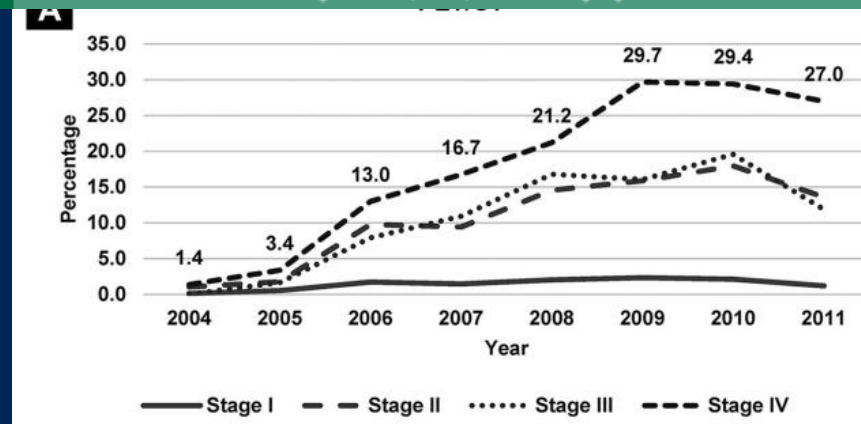
Value-Based Care and Cancer



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. Williams⁸

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

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.

No. of years	Total median costs	Median, \$								Hodges-lehmann estimate (95% CI) ^a
		Radical cystectomy				Trimodal therapy				
		Total	IQR	Inpatient	Outpatient	Total	IQR	Inpatient	Outpatient	
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.

^aHodges-Lehmann median difference in total costs (trimodal therapy minus radical cystectomy).

^bRadical 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

Value-Based Care and Cancer



Treatment

Alvimopan Accelerates Gastrointestinal Recovery After Radical Cystectomy: A Multicenter Randomized Placebo-Controlled Trial

Cheryl T. Lee^{a,*}, Sam S. Chang^b, Ashish M. Kamat^c, Gilad Amiel^d, Timothy L. Beard^e, Amr Fergany^f, R. Jeffrey Karnes^g, Andrea Kurz^f, Venu Menon^f, Wade J. Sexton^h, Joel W. Slatonⁱ, Robert S. Svatek^j, Shandra S. Wilson^k, Lee Techner^l, Richard Bihrlé^m, Gary D. Steinbergⁿ, Michael Koch^m

Table 2 – Primary and key secondary end-point results in patients who underwent radical cystectomy and received alvimopan or placebo (modified intention-to-treat population)

End point	Alvimopan 12 mg (n = 143)	Placebo (n = 134)	Difference (95% CI)	p value
Time to GI-2 recovery				
HR (95% CI)	1.8 (1.4, 2.3)	–	–	<0.0001*
KM, d, median (IQR)	4.9 (4.0, 5.8)	6.1 (4.7, 8.9)	–1.2	–
KM, d, mean (SE)	5.5 (0.18)	6.8 (0.23)	–1.3 (–1.9 to –0.7)	–
Time to DOW				
HR (95% CI)	1.7 (1.3, 2.2)	–	–	0.0002*
KM, d median (IQR)	6.7 (5.7, 7.7)	7.5 (5.7, NC)	–0.8	–
KM, d mean (SE)	6.9 (0.2)	7.8 (0.2)	–0.9 (–1.5 to –0.4)	–
Postoperative LOS, d				
Median (range)	7.0 (4.0, 22.0)	8.0 (4.0, 77.0)	–1.0	–
Mean (SD)	7.44 (3.05)	10.07 (8.23)	–2.63	0.0051†
Prolonged LOS (>7 d), %	32.9	51.5	–18.6%	<0.010†
POI-related morbidity, %	8.4	29.1	–20.7%	<0.001†

Takeaway

Alvimopan shortens time to GI recovery and LOS

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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

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B. Sander RN MBA MEcDev PhD,†§|| and K.K.W. Chan MD MSc PhD*†#

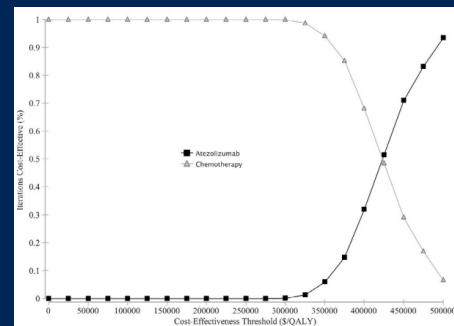


FIGURE 2 Cost-effectiveness acceptability curve for the base-case analysis. QALY = quality-adjusted life-year.

Takeaway

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

Value-Based Care and Cancer



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Article

ARTICLE

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

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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

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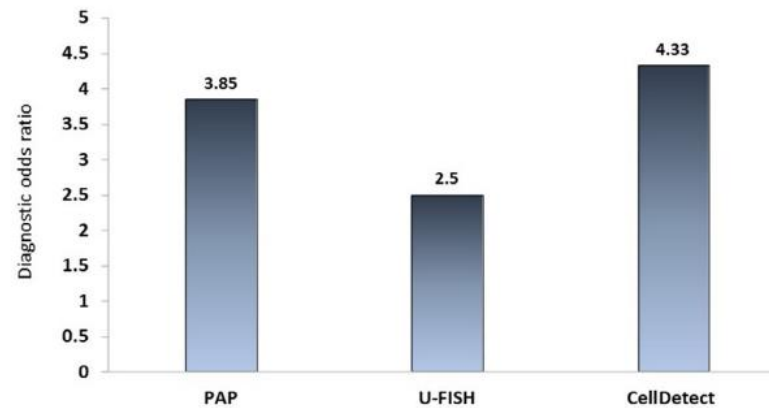


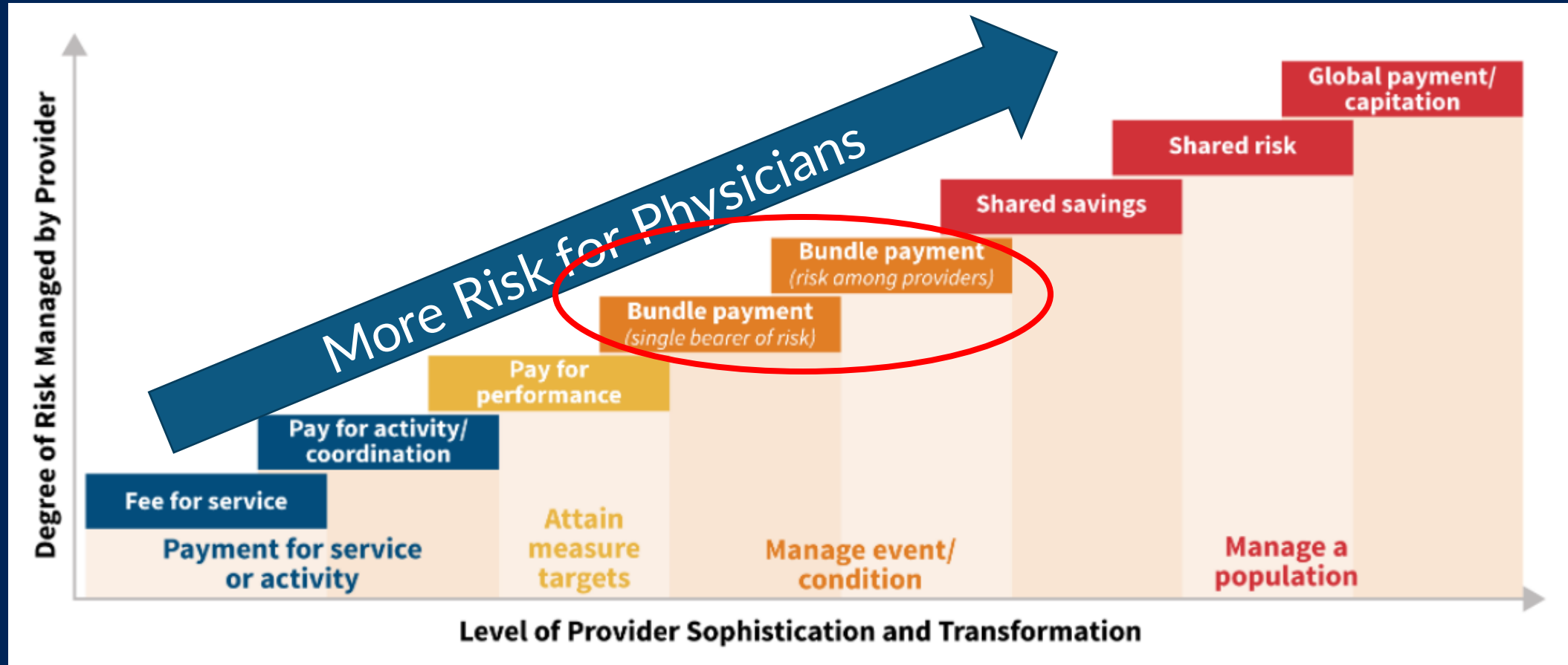
Fig. 3. Comparative effectiveness of the studied tests using diagnostic odds ratio for 93 patients with suspected bladder cancer.

Takeaway

CellDetect has higher sensitivity and NPV compared to cytology and UroVysion

The Future of VBC and Cancer

The Future of VBC in Cancer



The Future of VBC in Cancer

OVERVIEW OF ONCOLOGY CARE MODEL (OCM)

OCM provides a strong foundation for EOM design.

FOCUS

▶ Six-year, **voluntary payment and delivery model** running from July 1, 2016-June 30, 2022, that focuses on innovative payment strategies that promote high-quality and high-value cancer care in Medicare FFS beneficiaries with a cancer diagnosis who are undergoing **chemotherapy treatment**

SCOPE

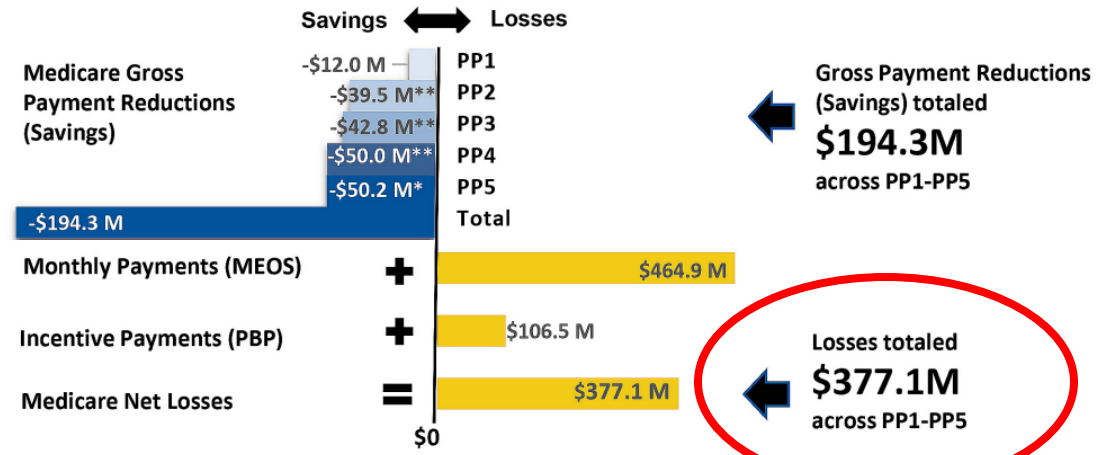
▶ **126 oncology practices and 5 payers** that account for about **25% of the chemotherapy-related care** for Medicare FFS beneficiaries in the US

QUALITY & PAYMENT*

▶ Model participants are paid FFS with the addition of **two** financial incentives to **improve quality and reduce cost**:

- Additional \$160 per-beneficiary-per-month **Monthly Enhanced Oncology Services (MEOS)** payment to support care transformation; OCM practices furnished **Enhanced Services** (e.g., patient navigation, documenting a care plan) to OCM beneficiaries
- Potential **performance-based payment (PBP)** based on the total cost of care (including drugs) and quality performance during 6-month episodes that begin with the receipt of chemotherapy

OCM resulted in gross reductions, but after accounting for enhanced model payments, OCM resulted in net losses for Medicare



*Statistically significant at p<0.10. **Statistically significant at p<0.05

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

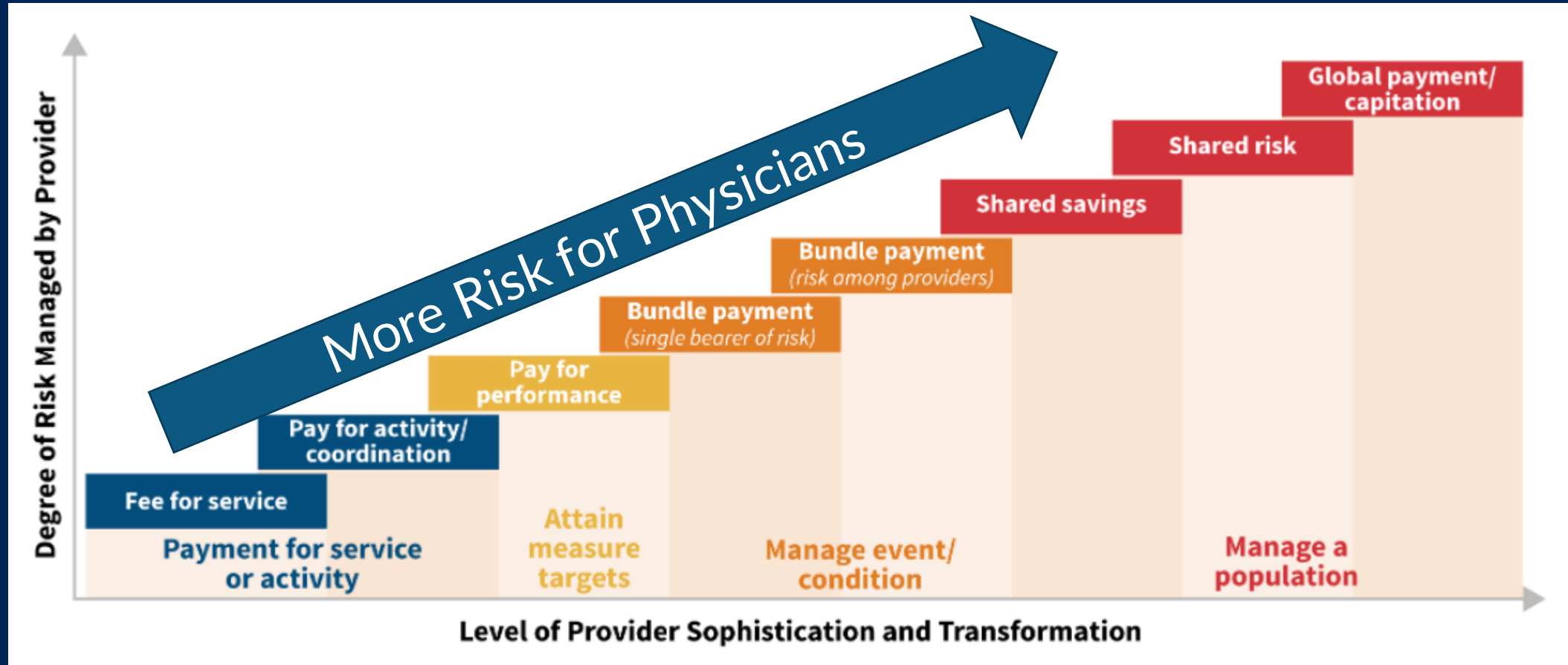
EOM participants are paid FFS with the addition of **two** financial incentives to **improve quality** and **reduce cost**:

- 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...but not in bladder cancer

The Future of VBC in Cancer



Conclusions

- What is value-based care? Paying for health care that works.
- Value-based care and cancer There are value opportunities.
- Where will we go from here? Risk is coming.