

Alternative Models of Payment

Greater Philadelphia Business Coalition on Health

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Alternative Models of Payment

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Growth of Alternative Payment Models in Oncology

A Framework for Alternative Payment Models



Category 1
Fee for Service –
No Link to Quality & Value



Category 2
Fee for Service –
Link to Quality & Value



Category 3
APMs Built on
Fee-for-Service Architecture



Category 4
Population-Based
Payment

Health Care Payment
Learning & Action
Network (HCP-LAN)

A

Foundation Payments
for Infrastructure
& Operations

B

Pay for Reporting

C

Pay for Performance

A

APMs with
Shared Savings

B

APMs with Shared Savings &
Downside Risk

A

Condition-Specific
Population-Based Payment

B

Comprehensive
Population-Based Payment

C

Integrated Finance &
Delivery System

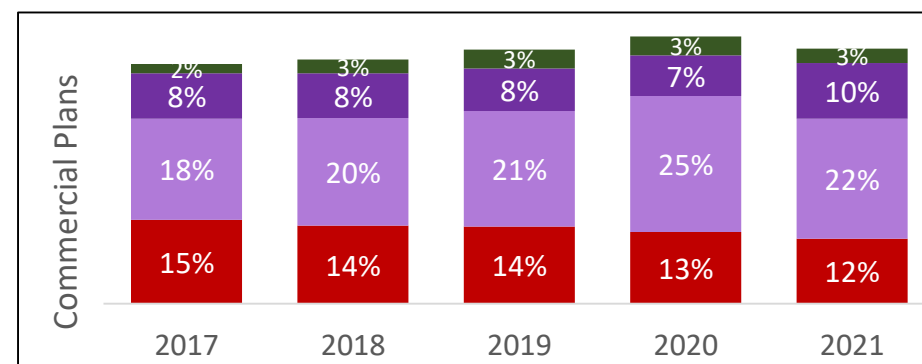
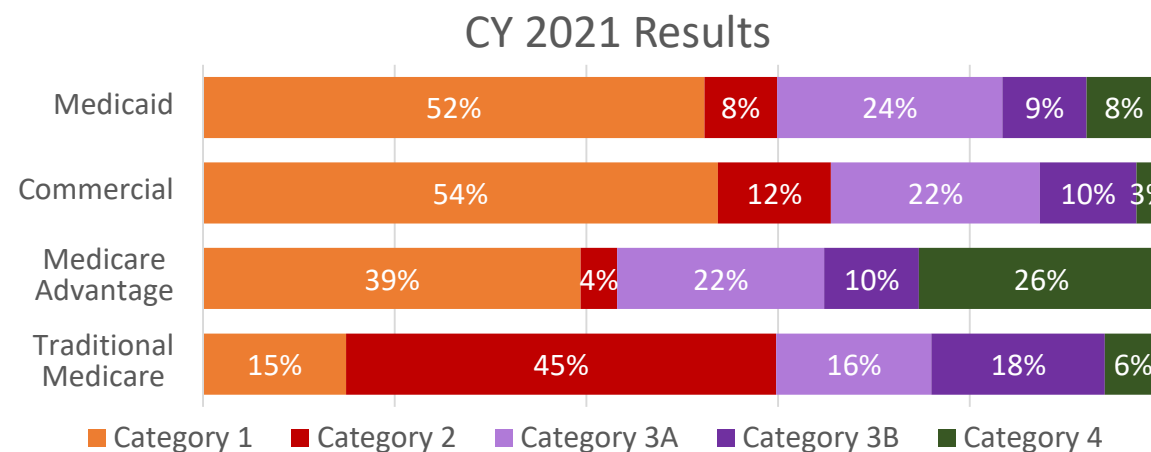


A Journey Towards Alternative Payment Models

HCP-LAN's target:

Adoption of two-sided risk alternative payment models (3B & 4), with the percentage of payments in such models meeting or exceeding the following:

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2020	15%	15%	30%	30%
2022	25%	25%	50%	50%
2025	50%	50%	100%	100%



Oncologists Participation in Medicare Accountable Care Organizations (ACOs) and Specialist Models

Model / Track	2017	2018	2019	2020	2021	2022
Medicare Shared Savings Program (ACO) Participants (2-sided risk)	1,243	3,052	3,877	4,093	4,184	5,989
Medicare Shared Savings Program Participants (1-sided or limited risk)	6,856	7,047	7,247	7,082	7,019	5,727
Oncology Care Model Participants (2-sided risk)			1	2,146	1,940	1,886
Oncology Care Model Participants (1-sided risk)	4,009	4,053	4,079	1,294	1,374	1,349

Gynecologic Oncology, Hematology/Oncology, Radiation Oncology, Surgical Oncology
 Accessed 8/8/22 from qpp.cms.gov. 2022 includes July snapshot.
 Manuscript in writing.

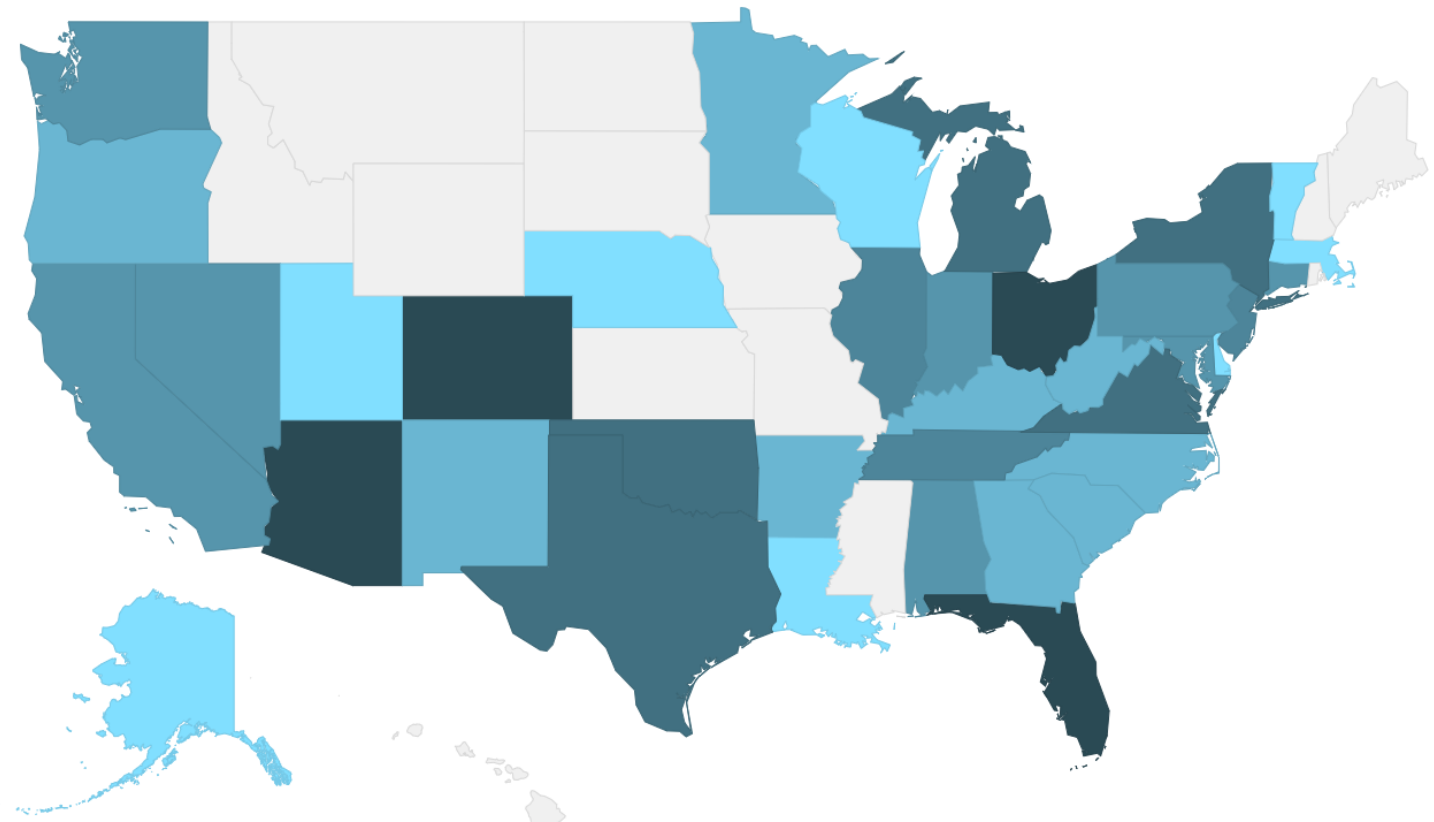


Interest in improvements is growing

- 2005 – Value-based Insurance Design Center (VBID) conceptualized
- 2009 – United Insurance launched NEW Episodes (6 months of care) Cancer Care model
- 2010 – John Sprandio MD, Oncology Patient Centered Medical Home
- 2010 – Medicare launched the Center for Medicare and Medicaid Innovation – CMMI
- 2011 – Priority Insurance launched NEW model for cancer care in Michigan
- 2011 – Aetna Insurance launched NEW model for cancer care
- 2012 – COME HOME physician driven oncology model – Medicare grant
- 2016 – Medicare’s Oncology Care Model – 6-year model
- 2019 – COA counted 22 models for cancer care
- 2020 – COA counted 35 models for cancer care
- 2022 – COA counted 30 models for cancer care
- 2023 – Expected launch of Medicare’s Enhancing Oncology Model



2020 National Inventory of Reform Models



2022
 30 Models
 141 Occurrences
 No Medicare model
 ➤ Standardization
 ➤ Regional models
 ➤ Employer arrangements



Reform Components

- Recognized quality
- Pay for reporting
- Payment for performance improvements
- Patient incentives for their care at your cancer center
- Payment for certification by another entity
- Incentive payment for adherence to specific treatment guidelines *
- Benchmarking against past performance for the cancer care team
- Benchmarking against other cancer care teams
- Shared savings only when savings are realized
- Shared savings or refunds back to payer
- Per member per month additional payment
- Other – (Typically case rates for radiation therapy)



Expected in the Near Future

Understanding and agreement regarding quality in cancer care (Oncology Medical Home national program starts July 1, 2023)

More relationships and agreements between local employers and local cancer care teams.

Further growth in transparency and accountability.



Medicare's Enhancing Oncology Model

Enhancing Oncology Model

- July 2023 to June 2028
- Voluntary for physician groups and hospitals
- 9, six-month performance periods
- Medicare fee-for-service beneficiaries undergoing chemotherapy treatment
 - Other payers may elect to participate
- Quality measurement and data reporting
- Fee-for-service payment, plus
 - Additional per-beneficiary-per-month (PBPM) payments
 - Performance-based payments and recoupments
 - Based on total cost of care and quality measures

Cancer Types

- Breast Cancer
- Chronic leukemia
- Small intestine/colorectal cancer
- Lung cancer
- Lymphoma
- Multiple Myeloma
- Prostate cancer

Initiating Therapies

IV or Oral (if on Part D)

- Chemotherapies
- Immunotherapies
- (excludes some hormonal therapies that were included in OCM)



Participant Redesign Activities (PRAs)

Implementation of PRAs is required to comply with the program.

Patient navigation

Care plan documentation

Treatment consistent with nationally recognized guidelines

Identifying health-related social needs (HRSN)

Gradual implementation of electronic Patient Reported Outcomes (ePROs)

Data utilization for continuous quality improvement

Using Certified EHR Technology (CEHRT)



Quality Measures

1. Admissions and Emergency Department Visits for Patients Receiving Chemotherapy (National Quality Forum [NQF] 3490; claims-based)
2. Patients who Died who were Admitted to Hospice for 3+ Days (NQF 0215 & 0216; claims-based)
3. Patients who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (NQF 0210; claims-based)
4. Pain Intensity Quantified & Plan of Care for Pain (NQF 0384 & 0383; participant-reported)
5. Screening for Depression and Follow-up Plan (NQF 0418; participant-reported)
6. Patient-Reported Experience of Care Survey (patient-reported)



Health Equity within EOM

Incentivize care for underserved communities

- + \$30 PBPM for dual eligible beneficiaries

Collect beneficiary-level sociodemographic data

- Reported to CMS for monitoring and evaluation

Identify and address health-related social needs (HRSN)

- Screening tools for transportation, food insecurity, and housing instability
- Collect electronic Patient Reported Outcomes, including HRSN needs

Improved shared decision-making

- See Care Plan documentation

Continuous Quality Improvement

- Participants required to develop a health equity plan



Data Reported to CMS



Quality Measures: Patient experience, avoidable acute care utilization, management of symptoms of toxicity, management of psychosocial health, and end-of-life care.



Clinical Data: Collection and reporting of clinical data elements not available in claims or captured in the quality measures for the purposes of monitoring, evaluation, and payment.



Sociodemographic Data: Collection and reporting of sociodemographic data used for monitoring and evaluation. HRSN data may be added in future performance periods.

Data Shared with EOM Participants

Quarterly
feedback
reports

Semiannual
reconciliation
reports

Attribution
lists

Episode level
files

Monthly
claims data



Payments and Financial Incentives

Current or Non-EOM	EOM
Fee for Service (FFS) Payments	Fee for Service (FFS) Payments
	+ \$70 Monthly Enhanced Oncology Services (MEOS) Payment
	+ \$30 MEOS for Dual-Eligible (Medicare & Medicaid)
	+/- Potential Performance Based Payment (PBP) or Performance Based Recoupment (PBR)



Predicted Expenditures



Episodes from 7/1/16-6/30/20 are used to establish predicted expenditures, accounting for historical variation.

Experience Adjuster



Considering national, regional, and participant-specific variation in historical costs.

Clinical Adjusters



Metastatic disease and HER-2 status.

Trend Factor



Cancer-specific differences in cost of care between the final baseline period and a performance period.

Novel Therapy Adjustment



Accounts for above average costs for newly approved drugs.



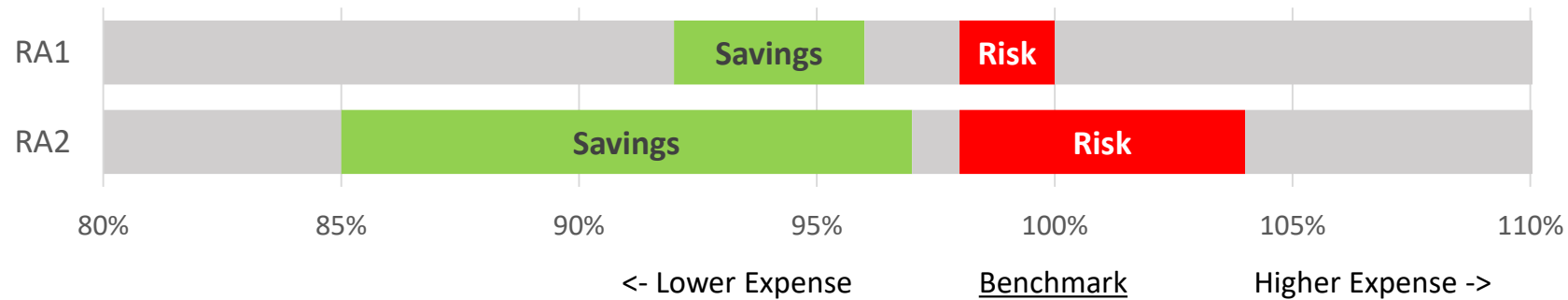
Benchmark Amount



Risk Arrangement Options

Participants select one of two risk arrangement options

	RA1 (Default)	RA2
EOM Discount	4%	3%
Target amount	96%	97%
Downside risk (stop-loss)	2%	6%
Upside risk (stop-gain)	4%	12%
Threshold for recoupment	98%	98%



Questions / Discussion