Improving the efficiency of oncology services in FFS Medicare

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Background

- Part B Medicare spending for anticancer drugs administered in offices and HOPD is substantial
- Prior exploratory data analysis found that oncology drugs & administration account for nearly half of total six-month episode spending
- In MedPAC's June 2015 report, we began to examine approaches for bundling oncology services including Part B oncology drugs and biologics

Today's session

- Two case studies on narrower approaches
  - *Risk-sharing agreements* attempt to get a better price for drugs
  - *Clinical pathways* attempt to make providers more sensitive to the cost of anticancer drugs
- Two case studies on broader approaches
  - *Oncology care medical homes* attempt to redesign care delivery and implemented by CMS
  - *Episodes-of-care* hold providers financially accountable for anticancer drugs and other outpatient and inpatient services

Risk-sharing agreements

- Goal: improve the value of drug spending
- Agreements between payers and product developers that link a drug's payment to patient outcomes
- Under an agreement with United Kingdom's National Institute for Health and Care Excellence, the product developer assumes cost of bortezomib for patients who do not respond to therapy
- The product developer provides a refund to the payer for nonresponders
- Patient response is based on a biomarker for disease progression

Issues in implementing risk-sharing agreements in Medicare

- Administrative burden and time and cost investment (e.g., to develop and adjudicate the agreement)
- Define and measure clinically relevant outcomes that are measurable in a reasonable time period
- Availability of data infrastructure to track patients' outcomes
- Define the financial arrangement
- The Secretary would need statutory authority to implement risk-sharing under Part B and would need to create the necessary infrastructure to implement such approaches

Clinical pathways

- Goal: reduce prescribing variability, improve quality of care, and reduce costs of care
- Pathways are evidence-based treatment protocols used by commercial payers and providers that identify specific treatment options based on clinical benefit, minimizing toxicity risk, strength of national guideline recommendations, and cost
- Some providers have developed their own pathways while others use pathways developed by third-party vendors
- Limited evidence showing effect of pathways on patient outcomes and costs of care

Issues in implementing clinical pathways in Medicare

- Develop and update pathways
  - Medicare could invest resources for pathway development or could evaluate existing pathways
  - Transparency: some existing pathways used by providers and commercial payers are proprietary
- Link financial incentives to the use of pathways
  - Adjust payment for adhering to pathway
- The Secretary would need statutory authority to implement pathways under Part B
- Participants of CMMI Oncology Care Model required to report if care is consistent with national guidelines or clinical pathway if it is based on national guideline

CMS oncology medical home

- Goal: improve health outcomes, enhance patient care experiences, improve timeliness and coordination of care, and reduce costs of care
- COME HOME model
  - CMS awarded grant to seven medical oncology practices to implement and test a medical home model of care delivery for Medicare FFS, MA, Medicaid, and commercially insured patients with seven cancer types
  - Practices' capabilities included: Triage pathways, same-day appointments, extended and weekend hours, clinical pathways, and patient education
  - Three-year grant ended in 2015

Issues in implementing oncology medical homes in Medicare

- Define trigger event and patient population
- Determine practice requirements
- How to pay providers participating in oncology medical home
- Risk-sharing opportunities
- Using CMMI authority, Medicare could implement oncology medical home

UnitedHealthcare oncology episode-of-care

- Goal: remove revenue incentive to prescribe one drug over another, strengthen incentive to prescribe on quality basis
- Most services still paid under FFS
  - Drugs are paid ASP + 0%
  - Flat episode fee instead of drug add-on
- A further incentive to reduce overall spending was the potential for shared savings, if groups:
  - Lowered the total cost of care
  - Improved the survival rate for the episode
- Between 2009 and 2012, reduction in total spending, but increase in drug spending

Issues in implementing oncology episodes and bundles in Medicare

- The services included in the episode
- The duration of the episode: short vs. longer time frame
- The trigger event: diagnosis vs. initiation of a treatment regimen
- Type of payment: prospective vs. retrospective
- Adjusting for risk
- Risk sharing
- Countering the incentive to stint
- Using CMMI authority, Medicare could implement oncology episode-of-care

For Commissioner discussion

- Narrower approaches attempt to improve the value of drug spending while broader approaches attempt to improve healthcare delivery
- Providers would have greater flexibility under broader approaches than under narrower approaches
- We welcome Commissioner feedback on opportunities to improve the efficiency of oncology care in FFS Medicare