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APMs in Cancer Care: The Patient-Centered Oncology Payment Model

Narrator:

You're listening to ReachMD, and this is Inside Medicare's New Payment System, produced in partnership with the American Medical Association. This podcast was produced before final regulations for the quality payment program created by the Medicare Access and CHIP Reauthorization Act (MACRA) were released. Visit the AMA website for the latest news and more details on Medicare's new quality payment program.

Dr. Birnholz:

Value-based, patient-centered care, has become the destination for all branches of medicine and is the philosophy driving moderate payment reform initiatives like MACRA, but the unique care delivery needs in each specialty challenge the notion that one payment model can serve everyone. Nowhere has this become more relevant than in the field of oncology, which will be the focus of discussion today. This is ReachMD and I'm Dr. Matt Birnholz. I'm joined by Dr. Robin Zon, practicing oncologist and Vice-President and Senior Partner at Michiana Hematology Oncology in South Bend, Indiana. Dr. Zon is past Chair of ASCO's Clinical Practice Committee and now serves as Chair Elect of the Government Relations Committee which, alongside other stakeholders at ASCO, helped develop a patient-centered oncology payment model, or PCOP. Dr. Zon, welcome to the program.

Dr. Zon:

Thank you so much for having me this afternoon.

Dr. Birnholz:

It's great to have you with us. So, on this patient-centered oncology payment model, you helped design what appears to be a three-phased approach to reforming oncology care payments and it starts with a new way of looking at care management fees. Tell us about that.

Dr. Zon:

So, ASCO convened a group of volunteers to help design a new payment reform model, understanding that the oncology costs were a very large and growing percent of healthcare spending and, as providers and as volunteers within ASCO which is the largest professional society of oncologists worldwide, we felt that we could be part of the solution, especially since there had already been some projects that demonstrated that there are methods, in fact, to reduce oncology costs while promoting quality care. Relevant to MACRA, as you well understand, is that our payments are being directed away from volume and fee-for-service and are being directed more toward value care. So, we identified potential model opportunities where we could look at chemotherapy episodes of care and try to develop a system, develop a mechanism, in which we would have three different ways of paying for oncology care to provide the services that our patients need and want. Specifically, as you understand, we're being paid a fee-for-service, a face-to-face, but yet a lot of the work that the oncology provider does is behind the scene. So, for example, for a new patient consultation, it's not just seeing the patient face-to-face, it's all the staff and the work and the cost associated with that in getting your source documentation, talking to the pathologist, talking to radiologists, other specialty doctors that are required for the care of that patient in developing a treatment plan, and that all happens behind the scenes for which many specialty doctors are not being reimbursed. Then, as we proceed and care for a patient for the treatment, it goes beyond just face-to-face when we're treating our patient, but it's all the supportive care and the care management to help minimize complications related to therapy. So, we felt that it would be important to develop options that would transition away from fee-for-service and the three options include a first phase where there are actually new codes that are added to

existing E/M codes to try to cover the costs of services and primarily what that covers is care management including triage and rapid response, to concerns and issues the patient may be having, so we could try to reduce complications. A second phase replaces the E/M codes entirely with a monthly payment code that provides flexibility from the provider's standpoint and how the care is actually delivered. And a third phase would be a bundled monthly payment that would include not only the oncology practice costs but other costs involved in the care of our patient, such as testing, hospitalization, and/or drugs. Now, this particular approach doesn't necessarily mean that folks who would be interested in this alternative payment model would all start with adding new codes. There may be some that are very comfortable in looking at monthly payments, either by replacing E/M codes, or monthly bundled payments. So we felt, with this type of a model, that there were opportunities for practices, regardless of their level of sophistication and regardless of where they were in terms of development, oncology medical homes, or developing the infrastructure to support alternative payment models that they would have an opportunity to come into this particular alternative payment model.

Dr. Birnholz:

Now Dr. Zon, you're obviously looking at this from an oncology point of view, but just seeing this from a 30,000-foot view, as a three-phased approach from overhauling the care management fees to looking at consolidating the codes, to moving in on bundled-payments, do you see this as applicable beyond oncology as well?

Dr. Zon:

So, that's a great question and I would envision the answer to that would be yes. I think there may be portions of these options, for example, adding new codes that could be applicable to other disciplines and other specialties. There may be others, in fact, there is already work, as you well know, in the orthopedic world, looking at the bundled-payments. So, that may be an area where bundled monthly payments would be appropriate. Similarly, we are aware of the alternative payment model concept, if you will, and the bundled-payments for endstage renal disease and for dialysis. So, there are actually already some models out there that are showing that the concept of one of these three options, looking at bundled-payments, is actually quite effective.

Dr. Birnholz:

And it looks, then, like this approach, via the PCOP model, would require putting in more money upfront for total patient care, so as to then save cost of care down the road. Am I understanding that correctly?

Dr. Zon:

You're absolutely right and the issue is, is that for the past couple of decades, at least for the time that I have been practicing in a community setting, most of the services that we are providing for a patient, which happens after the face-to-face encounter, has actually been paid for by profit margins that we gain from a number of other activities that we're involved in, including the usage of chemotherapy drugs. And, of course, with reimbursement changing in all ways, in all manners, our margin to be able to support those services as a specialty field has remarkably decreased, but nobody is paying us for the services that we're providing our patients outside of the face-to-face model. So, in our initial modeling, we looked at the potential for net savings and we actually did an illustrative analysis looking at 2012 Medicare data and looked at 500 new medical oncology patients to the system, and we looked at the current average spending per beneficiary, as it would stand in 2012, but then looked at the proposed new payments and estimated savings, and what we discovered is that even though, to your point, that there is money being put in for care management fees and to allow the physician group to provide the services for the patient, there ended up being a 4% savings. In this particular illustrative analysis, what we discovered is for 500 new Medicare patients that are coming to the practice with a new diagnosis of cancer that requires some type of treatment, either IV or oral chemotherapy that, although the additional practice revenue would be about a million dollars, the net payer savings, in this case, Medicare net payer savings was also approximately one million dollars.

Dr. Birnholz:

I'm sure that's turning heads across the board for a number of our listening audience. Did you find that those responding or reviewing those numbers, from the CMS or MACRAside, if anybody has reviewed that, also had their head turned a little bit?

Dr. Zon:

Right. So, that's a great question. I'm sure that CMS is aware of the PCOP. ASCO leadership has been in conversation with CMS regarding this particular proposed alternative payment model and, in fact, ASCO plans on submitting this PCOP model to the PTAC which is the committee that is looking at alternate payment model submissions from a number of specialties and then making advisement to CMS as to whether or not those particular APMs submitted should be endorsed by CMS.

Dr. Birnholz:

Now, let me ask you one more question that gets back to that comparison of oncology with the broader field of medicine. Oncology is special in many respects with regards to payment because of the very high cost of care with chemotherapy and radiation therapy, do you find that the potential savings here could apply to other fields that might have different types of costs related to the care?

Dr. Zon:

Yes, certainly, and my answer to that would be yes. Certainly there are other fields now that are using some of the very same drugs that we use. So, for example, ophthalmology uses bevacizumab, otherwise known as Avastin for macular degeneration. You have other specialty fields such as those who are treating rheumatoid arthritis that are using monoclonal antibodies that we use for treatment of lymphoma, and so on, and so forth. So you can see that from the drug spend in other specialties where they're also using very high-cost drugs, that there could be some benefit. But I'd like to mention, however, that in oncology care, although 10% of the dollar, if you will, actually goes to the provider, the rest of it, the 90% goes not only to drug costs, but also to testing and imaging and other services the patient may need. So I could envision that going forward there could also be a reduction, not only in efficiently using drugs, but also in efficiently using other services such as imaging and diagnostic testing. And specifically for oncology, is the increased utilization of what we refer to as molecular testing, where we're actually doing genomic analysis of the cancer cells themselves and then using that to help direct therapy, but I would venture to say that genomic analysis extends beyond oncology, and it could be used in other specialties. For example, there is work that is being done in the anesthesia world where they're looking at potential for pain control based on genomic analysis of a particular person's pain receptors and metabolism, as well as types of anesthesia that they may be using for folks. So, I can envision that this type of model would be extremely appropriate in being able to reduce costs across a number of fields.

Dr. Birnholz:

Excellent. And while we're on that subject of envisioning, I want to take an opportunity to think about a day-to-day view of the model's impact on care pathways. I understand that you have spoken at length about looking at how perspective oncology patients' courses of care could play out differently from the fee-for-service model versus this PCOP model. Can you talk a little bit about how a sample patient might experience that care differently between the two?

Dr. Zon:

So, first I think it's important to appreciate that not all oncology practices are the same in terms of what they're able to provide and in terms of services because they're partners may vary. There are some oncology practices that are partnering with hospitals. They're often owned by hospitals, so they're able to offer one set of services. But then there's a wide breadth of independent community practices ranging from the doctors who are still single doctors, or one or two-person groups, to groups that are larger, like mine, where we have 15. So, you can see that there could be then, obviously, a different budget that is available to support patient needs and services. So, what I could envision is, for example, let's look at a small practice that's in a rural community, and by the way, much of oncology care is delivered in rural community, because there's a significant number of patients diagnosed with cancer that live in rural America. So, having said that, you may only have one or two medical oncologists, and if they're independent they only have so much of a budget to be able to support all the services that we provide that we're currently not reimbursed for. So, the example that I'd like to use is a gentleman name John who comes in and he gets a round of chemotherapy and, very appropriately so, he gets very good education, is given a number of prescriptions to use at home as needed to help control any symptoms that he may experience from the therapy and, sometimes, but not always, many times he's also given a number that he can call, 24 hours a day, 7 days a week, in case there are any questions or concerns. Well, John goes home and he's an older gentleman and he's fairly stoic and he says to himself, "Yeah, I'm not feeling all that well." The next day he wakes up, "I'm feeling a little worse, but I don't want to bother the doctor." Okay? He goes on and the next day he tries to remember what was told to him, he's kind of forgotten, and he's embarrassed, he doesn't really want to call anybody, and the following day his family members come to visit him and John is now quite ill. He's dehydrated and, in fact, he's been having some side effects, including some nausea and vomiting, and perhaps a little bit of loose bowels, and now he has to go to the emergency room where he then is hospitalized for a multi-day treatment of supportive care. So, that may be a situation that occurs now. Now, how would this change with the PCOP model? Well, what would change is that that very same group, the one or two-person group is now being given additional money, additional code reimbursement, that allows them now to be able to hire a nurse who's, what we call an outbound triage nurse, and the outbound triage nurse now is able to contact these patients for one or two or three days, as necessary, after the chemotherapy is delivered. So, let's replay the situation. John gets his chemotherapy, he gets the education, and he gets the prescriptions from his doctor and nurses, just like he did in the other situation. He goes home and he wakes up the next day and he says, "You know, I'm not feeling so well." The phone rings and it's the outbound triage nurse from John's doctor's office, asking how he's doing. John explains to the nurse exactly what the symptoms are. The nurse then talks with the doctor and comes back and reeducates John on how to use his supportive medications, as well as what to do to try to hydrate himself, and

says to John, “I’m going to call you tomorrow and I’m going to make sure you’re doing okay, but please call me if you have any questions or concerns.” John doesn’t call that day, but she then calls back the following day. John’s feeling a little better, but he’s not quite perfect, so the nurse goes back and talks to the doctor again and then comes back to the patient and states, “You know, we’ve been discussing some things and you may want to try this and this is one option to help hydrate yourself and you may want to try this in terms of how you’re using the supportive care medicine. And by the end of three days, John is feeling much better, he avoids an emergency room and he avoids a hospitalization. So, by offering the funding, by offering the monies for care management and to transform the practice infrastructure so it can, in fact, support what’s needed by the patient’s needs and what they want, they’re able to actually affect the outcome of that particular patient in reducing emergency room and acute hospitalization visits.

Dr. Birnholz:

That’s excellent. I’m marveling because, from what I’ve heard, it sounds like the care could not be more divergent and the meaningful applications of this potential model could have huge ramifications for care, especially between visits, as you were talking about.

For those of you who are just joining us, this is ReachMD and I’m Dr. Matt Birnholz. I’m speaking with Dr. Robin Zon, practicing oncologist from Michiana Hematology Oncology in South Bend, Indiana, past Chair of ASCO’s Clinical Practice Committee, and Chair Elect of the Government Relations Committee.

So, Dr. Zon, from what I’ve gathered, this model is one of the most developed APMs put forward by any specialty group. Now, how did the oncology field move so far in front of this and where would you say other providers are right now with respect to MACRA?

Dr. Zon:

Well, as I mentioned, ASCO approximately, I guess it’s been three years ago now, had recognized that there is escalating cost in oncology care and we really need to be part of the solution in gaining control. And there were projects that were being done by our own oncology providers actually, looking at what’s called Oncology Medical Home Centers as well as other demonstration projects, to show how we might be able to reduce the cost of care for our patients. So, having said that, there’s been over three years of work that’s been done, primarily by volunteers from a number of different settings including not only the community setting, but also the academic, and over a period of two years we developed this model and have continued to work and refine it and, in fact, have currently the PCOP being demonstrated, in one particular instance, with a practice and a payer, and are currently expanding that so we could provide that information to the PTAC as they review it in the future. So, with regards to your question about other practices, I am not aware that other specialty practices are as far along as we may be in terms of APM development. Now, I’m not familiar with all the specialties and what they’re doing specifically for alternative payment models but, both by your comments and by other comments shared with me, our model seems to be one of the more advanced.

Dr. Birnholz:

But as far advanced as it’s come, I imaging it’s still going to take some steps for this model to become a set alternative payment model under MACRA. What is it going to take to get there?

Dr. Zon:

Right. So, under the MACRA statute, Congress actually is encouraging that CMS invite alternative payment models as an option of payment for providers. As you are aware, there are two options for payment, or two paths, if you will. One is the MIPS and the other is the APMs or the Advanced Alternative Payment Model system. So, oncology’s PCOP model, the P-C-O-P model will apply. They will take their model and submit it to the PTAC and then the PTAC will analyze our model, hopefully will have some more financial information that would support what are claims are for cost savings. Reducing costs while saving money, improving quality of care, and then submit that to the CMS. So, what it’s going to take is a review and then CMS will need to review the review by the PTACcommittee, take their recommendations under consideration, and then determine as to whether or not they would allow PCOP to be another possible Advanced Alternative Payment Model for the oncology world. Currently there’s only one Alternative Payment Model for oncology and that is through the CMMI oncology care model, and that particular Alternative Payment Model will become an Advanced Alternative Payment Model in 2018. And I think it’s important to take a moment to explain the difference between an Alternative Payment Model and an Advanced Alternative Payment Model. The main difference is that an Alternative Payment Model, such as this, talks about ways in which you take payment away from fee-for-service and face-to-face and payment that focuses on value and quality. What happens with an Advanced Alternative Payment Model is that there’s a two-sided risk. So those individuals, those providers that are participating in an Advanced Alternative Payment Model are at risk for loss, just as they’re at risk for gain and increase in revenue. So, in order to be an Advanced Alternative Payment Model, which is where CMS and the statute would like to see providers go, you have to have a two-sided risk.

Dr. Birnholz:

So, let's speculate for a moment, in the last couple of minutes that we have, assuming that this model moves to become an advanced APM, under MACRA, where do you see oncology, the field, headed from there?

Dr. Zon:

So, with regards to the future of oncologists, just like many other specialists, they'll have to choose for their Medicare patients whether or not they're going to follow the MIPS path, or whether they're going to follow the Alternative Payment Model path. Ultimately, my sense is, is that the statute, Congress, and MACRA ultimately would like to see all providers go into Alternative Payment Model. The advantage of oncology, having an Alternative Payment Model early on, is being able to learn how to use it, implement it, to be able to help grow the Alternative Payment Model as time goes on, and structure it such that it can help transform the practice which is trying to be funded, solely by fee-for-service right now, to a practice that is being funded based on value and quality of care. So, from an oncology perspective, we are ahead of many fields, I believe, in terms of specialty organizations and perhaps other specialty organizations can learn from our experiences. But I also can see going forward that along with Alternative Payment Models there may be some possibility for integration with another area that oncology is very interested in, and that's pathways. And pathways is a sequenced event of interventions that can be used for the diagnosis, the treatment, and the care of patients, survivors or end of life, who have cancer. And so, I could actually see that as the PCOP and Alternative Payment Model for oncology evolves, it may be able to integrate other types of interventions. In this particularly case, pathways, to improve the care such that, no matter where you are in this U.S., wherever you are in this country, if you're a breast cancer patient in rural America or a breast cancer patient in an urban environment, that you're care will be standardized and you know that you're getting the best care possible and it will be equal to the care that anybody else is receiving across this U.S.

Dr. Birnholz:

Well, with those forward-looking thoughts, I very much want to thank my guest, Dr. Robin Zon, for updating our audience on the evolution of this patient-centered oncology payment model. Dr. Zon, it was so nice to have you on the program today.

Dr. Zon:

Thank you so very much for this opportunity.

Dr. Birnholz:

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