

The Oncology Care Model, Care Delivery & Payment Reform: A Riddle Wrapped in Risk, Culture, & Opportunity

perspectives of a frustrated, optimistic, liberal, red state oncologist facing High Noon

John V. Cox, DO, MBA, FACP, FASCO

Hematology / Medical Oncology

UTSW / Parkland Health System

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Name: John V. Cox, DO, MBA, FACP, FASCO
Academic Rank: Professor
Division: Hematology Oncology

Biosketch:

John V. Cox, DO, MBA, FACP, FASCO is a practicing oncologist in Dallas, Texas. In 2015 he joined UT Southwestern / Parkland as Medical Director of Oncology Services @ Parkland Health System. He completed a fellowship in medical oncology and hematology at the University of Texas Southwestern Medical School and after a stint on the faculty at Southwestern, he entered private practice in Dallas – practicing for over 25 years, most of that interval with Texas Oncology, P.A.. His interests focus on GI oncology and the delivery of care. He did return to school, and completed an MBA, with a certificate in medical management from University of Texas Dallas in 2008. He was an active leader in his hospital medical staff at Methodist Hospitals of Dallas and his group practice. He is active in the Texas Society of Medical Oncology (past President, current board member), and is the state of Texas oncology representative to the Texas Carrier Advisory Committee of Novitas. He also served as a member of CMS' Medicare Evidence Development & Coverage Advisory Committee from 2006 to 2010. Dr. Cox is an active volunteer in ASCO and is a liaison member of the Clinical Practice Committee, which he chaired, 2005-2006. He has served on ASCO's HIT Workgroup since its formation in 2005 - 13, and is a past-Chair. He has been a liaison of ASCO to the American College of Physicians' Council of Sub-Specialty Societies (CSS) and represents ASCO on the CSS workgroup on the patient centered medical home / Neighbor. He is a member of ASCO's payment reform workgroup, and active in ASCO's efforts to evaluate / codify new practice models. He was the Education Chair for ASCO's 2015 annual meeting. He has served as a member of the editorial board of the Journal of Clinical Oncology (JCO); and beginning in January of 2009, he became the editor of the Journal of Oncology Practice (JOP).

Purpose and Overview:

Advances in basic science are transforming the clinical practice of medicine at a rapid pace. Despite these wondrous transitions in our science, we have not effectively tackled the task of our time – how do we deliver health care to maximize benefit & avoid toxicity to patients AND do so in an effective and efficient manner AND pay for it? Indeed, healthcare delivery is the thorniest issue that we face as a society and as a profession. The demand that healthcare be of high quality, be delivered in a cost efficient and highly coordinated manner is driving change in care delivery. Private and government payers have set in motion an array of market pressures and regulatory demands to press change in practice. This talk will address these demands and provide an overview of the most challenging regulatory issues affecting care delivery. Highlighted will be a recently initiated alternative payment model for oncology by CMS – the oncology care model – as a template for change.

Educational Objectives:

Post talk attendees should be able to:

- Describe the intersect of care delivery reform with the systems of healthcare reimbursement.
- Explain the mandates of MACRA and MIPS. (Medicare Access & CHIP Reauthorization Act of 2015 // Merit-Based Incentive Payment System)
- Determine steps that can be taken to prepare for a change to a reimbursement system that focuses on outcomes.

Care Delivery

Better understandings of the basic steps / drivers of neoplasia and the arbiters of host immune defense characterize a remarkable transformation of the science of oncology. After years of anticipation, futurists can see medical oncology transformed from a barbarous age of broad, poison based cytotoxic strategies to an era of targeted, specific therapies – minimizing toxicities, simplifying care and improving outcomes.

Though better science will help change some mechanisms of delivering care – key questions still vex us: how to deliver care to provide maximum benefit with least toxicity to our patients AND do so in a cost effective and efficient manner? Indeed, healthcare delivery is the thorniest issue that faces us as a society and as a profession. Balancing consciousness of cost with the challenges of coordinating new therapies AND articulating the value of care to individual patients and to society at large is proving to be a very difficult task.

Problems

When any two or more physicians are gathered together, it is easy to spark a conversation regarding the problems in care delivery.

Physician or patient centered? Medicine's culture has classically been dominated by a physician / provider centric view. Our systems of care are described and structured, in large part, around the convenience of those who deliver care - rather than being sensitive to what a patient or caregiver sees. The structures of medicine are very specialty specific & siloed – with poor information sharing. Often the only person keeping track of and coordinating care is the patient or caregiver. Within healthcare systems' organizational structures – whether medicine or surgery or radiology, etc. - often do not share common goals or focus on common patient oriented outcomes.

The tools that we use fragment us. Electronic health records often define our processes of care – and few would argue that the tool has provided the mechanisms to better care continuity or driven efficiency in care delivery. Indeed, these systems have largely simply 'machined' the structures we had on paper – with a design focused on the documentation and regulatory requirements required for reimbursement.

"Follow the money". Ultimately our system of care is defined by the reimbursement scheme that underpins it. Many have observed that our system is the 'best' designed system to take advantage of the nuance of fee for service. Arguably the fact that undermines care innovation the most is that every reimbursement event requires a 'face to face' encounter with a provider. The greater number of services provided (& documented) is linked to more reimbursement realized. Care innovation incorporating services provided by nursing or other 'non-billing-providers' or 'non-face to face' encounters is not feasible due to the restrictions of FFS.

Healthcare Reform

It is generally understood that the current systems are broken. The ACA began to address the issues of insurance reform and 'access to care' for citizens – yet there is great need for reform of how we deliver care.

Growing recognition of the need to transform our health care system from FFS to one based on outcomes is at hand. Private and government payers are rapidly experimenting and adopting a host of systems aimed at transitioning reimbursement to value based schemes.

This shift to payment for value provides many stresses to current systems, but also defines many opportunities. Indeed, one can envision what our future system might look like if completely transformed to one where payment is pegged to meaningful outcomes.

One can imagine designing systems for the care of cancer patients that would hold all caregivers accountable to a common set of measurable outcomes that are important to the patient (survival, recovery to work & family, lessened morbidities, etc.) and for cost efficiencies. Such accountability would force reorganization of care delivery and break down silos of care. Linked to global mechanisms of payment, care delivery can be structured to be inclusive of the key roles of nurses, navigators and advanced practice providers – such as are not recognized under our current FFS systems. Innovation around the extent of global payments that are tied to outcomes, could both improve cost and increase the value to the patient.

Transitions

Private Payers. Over the last decade private payers have tinkered with different payment models. In oncology many of these experiments have focused on drug reimbursement – looking at schemes to reward or penalize practices that adopt defined clinical pathways and hold physicians accountable for compliance. Another focus has been on bundling multiple services into episodes of care and paying for such with a bundled, ‘global’ payment.

Payers have also focused on processes of care with schemes to prompt oncology practices to undergo significant self-examination and ‘transform’ care processes to focus on patient engagement and ready access to care in lower cost, ambulatory sites of service. The focus of these efforts has been to keep patients out of hospitals and emergency rooms AND to improve end of life care. Many of these principles have been drawn from the patient centered medical home movement. Indeed, oncology medical home principles have been codified by several private payers and independent certifying organizations.

However, most of the efforts by private payers have been limited to innovative health systems or private practices. As most healthcare in this country is paid for by the public payers, more universal transition from FFS to alternate payment models will occur only when the government weighs in.

Government. In a contentious political environment, one might expect there to be deep disagreement around broad reform in care delivery, yet there is actually broad agreement by both branches of government – the executive and legislative – that these transitions are necessary. The executive branch, through HHS/CMS, declared that at least 30% of the government dollars paid by Medicare will be paid under alternative payment mechanisms by the end of this year (2016) (they met this goal 10 months early). By 2018 over 50% of federal Medicare dollars will be paid through alternative payment schemes and by the early 2020s, 80% of care will be paid under alternative payment means. Clearly a rapid shift to new models of care is upon us.

As well, within the legislative branch there is broad, bipartisan agreement with the move to alternative payment models. After 16 years of annual fights around Medicare payment for physician services (driven by a formula designed in the 1990s to control the cost of healthcare – the sustainable growth rate, SGR) – a bipartisan bill was passed (& signed into law) that will press physicians to transform their practices to adopt alternative payment models. The

Medicare Access and CHIP Reauthorization Act (MACRA) rescinds SGR, consolidates a patchwork of reporting mandates (Meaningful Use, PQRS and the Value Based Modifier), and provides for the development of multiple alternative payment models – including models that are specialty specific. The law provides a blueprint to transform healthcare reimbursement AND will push providers of all stripes - whether in academia, private institutions or private practice - into alternative payment models. MACRA also includes mechanisms to make the cost of care that we provide and the outcomes that we achieve more transparent. There is controversy about the implementing rules, but many mark 2019 – the year MACRA mandates come to full force – as a watershed year moving away from a pure FFS reimbursement system.

Grappling with the Opportunity of Change

Embrace risk and experiment with practice structure. To be able to innovate in care delivery, it will be important to develop the structure and framework to assess the impact of any change. Michael Porter – a business guru and harsh critic of healthcare structures – has advocated key principles that healthcare systems need to adopt to embrace the shift to value based reimbursement.

Better cost accounting. He argues that current mechanisms of cost accounting in healthcare systems do not allow us to understand what it cost to care for an individual patient. If our future is going to be built around episode of care payments and tied to given outcomes; then systems will need to parse the cost of care for each individual patient. Doing so will open up the opportunity to identify areas of potential improvement both in the quality of care delivered as well as managing variations in cost.

Measure meaningful outcomes. Porter presses us to describe outcomes in terms that are meaningful to patients. Many current ‘measures’ of quality are focused on processes of care. Systems do not capture broad outcomes that patients may find valuable – in oncology, beyond quantifying how often one survives, we should be able to describe what is the expected quality of life or morbidities that are seen after a course of therapy? Porter presses us to measure such outcomes with the same vigor we measure cost – and to do so for every patient. The quest for a defined, comprehensive set of outcome measures for a given condition has prompted the organization of the International Consortium for Health Outcomes Measurement (ICHOM) – with the hope of codifying universal language around outcome reporting.

Break down silos. Organize care teams around the patient’s condition / episodes of care / patients’ care experience. Current care systems are often fragmented by departmental structures, siloed budgets and reimbursement schemes. This can lead to differing goals of care and differing priorities. Holding care teams accountable to common outcome measures and organizing care teams around episodes of care for a given condition will prompt discussions regarding how providers are paid and teams incentivized. Alternative payment schemes need to be reflected to the care team. This will require more than an informal realignment of physicians / care teams.

Risk & Experimentation

Just as laboratory experimentation leads to new understandings, we need to embrace experimentation in care delivery – including financial structures. Participation in CMMI’s Oncology Care Model will challenge the UTSW oncology practice & its care partner Parkland

to transform how we deliver oncology care. The relationship between UTSW and Parkland may offer a perfect lab for such experimentation. It would be possible to trial differing cross departmental care teams (potentially inclusive of clinic teams) accountable to common measures and cost targets. Arguably Parkland's financial structure is everyone's future – Parkland has a global, fixed budget to deliver care to a population of patients. Global budgets and population health are already aspects of every health systems' vocabulary. The Parkland relationship could experiment with movement away from RVU based reimbursement (FFS) and explore unique reimbursement schemes structured around patient & cost outcome measures. The opportunity to innovate care delivery is clear – yet such schemes could also provide the opportunity for both organizations to experiment with concepts of risk.

Incorporating financial risks into healthcare systems is often seen as an anathema. Entrepreneurial systems thrive on the opportunity that risk provides and lever against the downsides that can occur. Embracing risk in healthcare systems can be a 'good'. Conceivably shared risk will force the breaking down of care silos, and generate conversations that physicians will lead – to ensure good care for our patients AND to be informed of choices that are tied to costs. No health care system will be able to be successful at managing risk without the leadership of physicians – yet to be effective leaders, physicians are going to need to learn the levers of risk.

A colleague of mine, who leads an innovative practice, often highlights the roles of pioneers and settlers. He strives to position his practice as “an innovative early settler” – noting that the pioneers ‘catch’ all the arrows, and then the settlers who follow reap the benefits. In a way he was describing aspects of experimentation and risk. Healthcare organizations have classically enjoyed a very ‘settled’ experience -- that said, is there a special responsibility of a university and public hospital relationship to be more inventive? Should this practice setting be a sentinel of learning and experimentation – maybe a bit of a pioneer? Classically universities have provided innovative thinking and provided insights that lead us to new understandings. Should inquiry into mechanisms of care delivery and reimbursement be any different?

References and Links

Health care imperatives

Kaiser Health: <http://kff.org/>

Families USA: <http://familiesusa.org/>

Quality Payment Program ((MACRA)) - MIPS and APMs

CMS: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html>

AMA: <http://www.ama-assn.org/ama/pub/advocacy/topics/medicare-physician-payment-reform.page>

ACP: <https://www.acponline.org/practice-resources/business-resources/payment/medicare/macra>

TMA: <https://www.texmed.org/macra/>

CMMI / CMS Specialty Specific Alternative Payment Models

Oncology Care Model: <https://innovation.cms.gov/initiatives/oncology-care/>

Comprehensive Listing of Models – existing / development:

<https://innovation.cms.gov/initiatives/index.html#views=models>

Specialty and Oncology Medical Home

Oncology Medical Home. Srandio, J. et al. Commun Oncol 2010; 7(12):565, JOP May 1, 2013:130-132

ACP – PCMH Neighbor Policy paper:

https://www.acponline.org/advocacy/current_policy_papers/assets/pcmh_neighbors.pdf

Criteria developed NCQA Patient Centered Specialty Practice:

<http://www.ncqa.org/programs/recognition/practices/patient-centered-specialty-practice-pcsp>

Oncology Clinical Pathways / Risk in Bundling in Oncology

Development and Implementation of Oncology Care Pathways in an Integrated Care Network: The Via Oncology Pathways Experience. Ellis PG. JOP May 1, 2013:171-173

Refining the Standard of Care: How Oncology Treatment Pathways Can Make a Difference. Page RD. JOP Feb 1, 2016:143-144

A Pathway Through the Bundle Jungle. Polite B, Ward JC, Cox JV, et al. JOP June 2016 vol. 12 no. 6 504-509.

Michael Porter

The Strategy that will fix health care. Porter. <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>

What Is Value in Health Care? Michael E. Porter, Ph.D. N Engl J Med 2010; 363:2477-2481 (Two framework papers that develop the concepts outlined in this article, “[Value in Health Care](#)” and “[Measuring Health Outcomes](#),” are available as Supplementary Appendixes.)

International Consortium for Health Outcomes Measurement (ICHOM) - <http://www.ichom.org/>

High Noon

Many references / including IMBD & Wikipedia pages.

<https://anthonyhutson.wordpress.com/2015/03/02/high-noon-1952-a-brief-analysis-of-structure-content-meaning/>

Hooked? Grace Kelly? Watch Hitchcock’s Rear Window.