PAYER EXCHANGE SUMMIT VII
ONCOLOGY PAYMENT REFORM

PAYER EXCHANGE SUMMIT VII
ONCOLOGY PAYMENT REFORM

October 23-24, 2017
Hyatt Regency Tysons Corner Center, Virginia

Perspectives on Value-Based Oncology

Stakeholder Experiences with the Oncology Care Model

Basit Chaudhry, MD, PhD
basitchaudhry@tuplehealth.com
Celeste Roschuni, PhD
celesteroschuni@tuplehealth.com

TUPLE | HEALTH

Purpose and Methodology

The Center for Medicaid Services' Oncology Care Model (OCM) pilot program has introduced notable challenges to community oncology practices.

Engaged by COA, Tuple Health explored stakeholder perspectives on OCM and other value based programs through a series of 35 qualitative interviews with practices in and out of OCM, payers, pharma and other stakeholders in the oncology space.

Agenda

SECTION HEADING

Practice variability & the OCM

Practice variation affects needs in new payment models

Factors from practice size and scope to geography and patient population greatly **influenced structural capacity and self-perceived ability** to be successful in OCM.

However, **no factor had a greater influence than a practice's previous experience in value-based programs and practice transformation**.

"We've been doing things like advanced care planning and survivorship and palliative care and a lot of stuff like that for probably three or four years or so now. So ***where a lot of practices are trying to figure out how to implement these things we're in the process now of refining that."***

— Administrator, OCM practice

Experience is more important than size

There's a general sense that the program is designed for **larger, more advanced** practices and health systems. However, even these practices may be struggling.

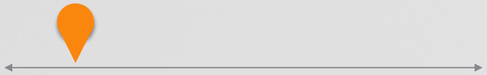
> *"You would think **it would be easier because we're larger.** **Some things are harder**... big practices like mine struggle with **optimal communication**, and we may be great at strategy, but that **implementation piece down at the local level** always is a challenge."* - Clinician, OCM practice

Given the **struggles across the spectrum**, it seems that Medicare designed for what they saw as the "average" practice. **There is no one "average" practice.**

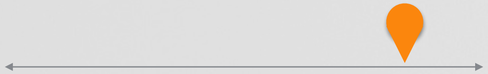
We found four types of practices engaged in OCM. Their qualitative experience was predicated on their expectations.

The Dubious Participant

Prevailing Mindset



Motivation



*"The management fees for the OCM patients helps a little bit, but when you have to go to the next step, it's basically **free services.**"*

*"Personally I don't trust anybody's two-sided risk. I look at OCM as **a way to figure out how to pay me less**. That's basically how I feel. So they're going to get this data, and decide oh well you can do it for 4% less, so we're going to pay you 4% less. **I don't look at it as a way to help me.**"*

Reason for joining OCM

*This practice wasn't considering OCM until a colleague at COA told them "**you have to do it otherwise you'll be left out in the cold and the payments will be bad**." So, they filled out the application to stay out of MIPS, but no one at the practice really wanted to do it.*

*"**OCM [is] the gateway** for practices to get into alternative payment models. It's **to get away from MIPS.**"*

Experience in VBP prior to OCM

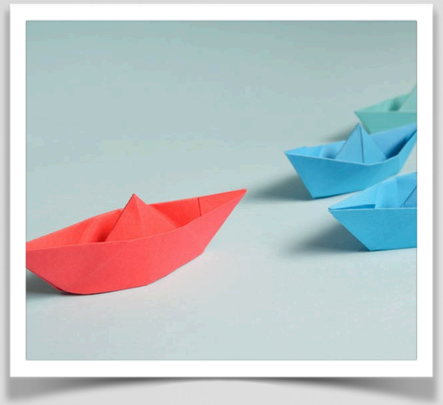
*With **no experience** in Value Based programs, this practice is figuring it all out as they go. Essentially, they feel they've been shoved into VBP all at once.*

Expectations & Experience

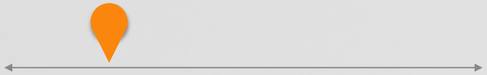
*Not having any experience, this practice didn't really know what to expect. They don't really trust the government programs anyway, and were thus skeptical from the outset. Even so, the program has been overwhelming in a number of ways, and **feels unfair** - they see it as a way to deprive them of funds, while forcing them to take on risk for **things that are out of their control**. In their mind, costs in healthcare live in other places, and they should only be held accountable for standard of care.*

*Nevertheless, they're finding **they appreciate the aspects of OCM that have enhanced patient care**, whether it's better record keeping or, especially, nurse navigators who not only support patients, but may hear things patients don't want to tell doctors.*

The Reluctant Participant



Prevailing Mindset



Motivation

*"You feel like you almost just want to carry a hammer and just beat people on the head. It's like, **we have got to do this or we're going to be way behind**. They **want you to be forward thinking**, but yet they **don't give you the manpower or the tools** to do that, so it can be kind of frustrating... "*

"I could not possibly bite all that off and do it in one swoop, because it was overwhelming to me. So I've taken off little chunks and I keep going, day by day,"

Reason for joining OCM

*This practice joined at the behest of **one value-based champion**. Most of the practice is more skeptical, but has bought into the idea that this is the way the future seems to be shaking out.*

*"Some of them will be very excited with you and **some of them look at you like you have two heads**. They don't get it...the physicians are going to drive it, so that's who I really work at the hardest."*

Experience in VBP prior to OCM

*These practices have **little or no experience** in Value Based programs prior to OCM, so much of the practice still thinks in Fee-for-service ways.*

Expectations & Experience

These practices are somewhere between cautious and straight-up afraid of the future, but are spurred on by their champion to get out ahead of it, who has been trying to get into VBP for a while to that end. This is their first opportunity to really jump in and start to make changes, but they didn't really know what to expect.

*Even so, OCM has required more than they anticipated - a "slap in the face" to do so much at once. Eventually, they realized they'd need to dedicate a whole person just to leading the effort, not to mention the additional people they need to do the reporting. The champion **has faith things will get better in time**.*

*"**It will come to fruition** where we don't manually enter all that stuff so it always happens. It's just you've got to cry and gripe and complain to get there."*

The High Expectations Participant

Prevailing Mindset

Fee-for-Service ↔ Value-based/ population health

Motivation

Internal ↔ External

*"We've been **a value-based practice for a decade** ...we're a good value-based provider, and so there's a lot of uncertainty in what that means in the risk sharing agreements that we'll likely enter into in 2019"*

*"We had a **very different view of the practice redesign activities prior to July** than we do now...They're so prescriptive, that something originally we had said, 'oh this is a good thing to have included in the model, this is something we already do,' **we find we don't do it the way that these FAQs specify CMMI thinks it should be done.**"*

Reason for joining OCM

These practices joined OCM thinking it would primarily acknowledge what they were already doing as a high quality provider, while helping them expand further into value-based payment and practice transformation.

*"We think of ourselves as a high quality provider, so **any model that rewards quality, we think we would shake out ahead.**"*

Experience in VBP prior to OCM

*These practices have **some experience** in Value Based programs prior to OCM, including multiple private payer demo projects and the Oncology Medical Home.*

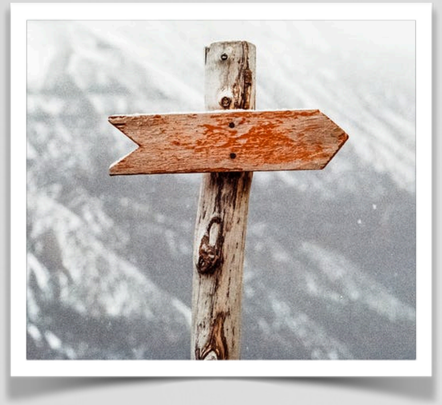
Expectations & Experience

Experience in prior models level-set expectations for what OCM would be and their experience in the model. Participation in OCM itself is frequently refracted back against those prior experiences. They then expected OCM to validate that they are low-cost and high quality.

*Their prior experiences also gave them a sense of **high perceived self-efficacy.** This made the complexities of OCM particularly difficult to understand and come to terms with.*

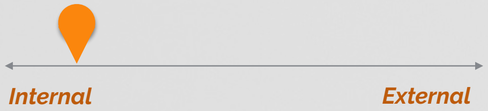
More practices will move into this group after OCM, as practices will now have experience in OCM.

The Pathway Participant



Prevailing Mindset

Motivation



*"I even had one hospital tell me yeah, we admit our patients because we get more money if we admit them. I mean I couldn't believe they actually said that to me, so **we're still bumping up against a fee-for-service world when we're trying to reduce costs**."*

*"There are some **common themes throughout these programs** so we had a pretty good idea of what we were in for."*

Reason for joining OCM

The goal of improving patient experience is the key driver of this practice, and OCM was an opportunity to make changes in that direction.

*"We don't look at it as a revenue source or a financial gain. It's really, **we're going to get to transform the practice** and Medicare is going to pay for it"*

Experience in VBP prior to OCM

*These practices have **relatively more experience** in Value Based programs, and a strong focus on patient experience. They've participated in at least one private payer program.*

Expectations & Experience

*The pathway participant has prior experience in multiple previous private payer models sees OCM as a way-point on a larger journey, and made changes to transform their practice before OCM. They are able to **drag payers into value-based discussions and contracts**.*

For them, this has been great - they approached the project as an opportunity to make the changes to continue on their transformation journey, and are adaptable to the program as long as it progresses their vision. Their flexibility has helped them shift mindsets.

*"Everybody's complaining about putting all the co-morbidities and codes and stuff. Well, you know, **it made me a better doctor.** I really feel that understanding that piece and putting those codes down makes me think twice about what I'm doing to the patient."*

Perceptions of Value & Risk

Perceptions of the value of a practice vary enormously across stakeholder groups

- **Community practices** perceive their value to be **convenient**, **quick**, and **low-cost quality care**, with perceptions of risk tied to things "beyond my control," like the cost of pharmaceuticals
- **Patients** see value as a combination of **convenient location**, **coordination of services**, and **competence of their physicians**
- **Payers** view **site of service cost savings** positively, but **within the context of medical inflation** in specialty pharmaceuticals; timeliness and convenience are not reflected in VBP models
- **Pharma** perceptions of value focus on **innovativeness**, and they often sees themselves as **outside the discussion of VBP**

Perceptions of risk are tied to type and severity of disease

> *"How can you mitigate for a patient that has a tumor that lies right next to, and is eating into their esophagus? How can you help if they get admitted to the hospital? You can't.*
>
> *— Clinician, OCM practice*

> *"Say the average cost of treating a breast cancer patient is $50,000, right, across all of them, but* ***you've got a stage IV person come walk through your door, if you're the provider, what's your incentive to keep and treat this patient really well?*** *I mean, how do you stop the reaction of, oh my goodness, this person is going to bust our budget. So that's something we think about."*
>
> *— Pharma Stakeholder*

Risk is compounded by the rising cost of pharmaceuticals

> *The pharmacies will dispense large supplies, whether that be 30 days, 90 days with lots of refills because they generate profit by dispensing medication … In a total cost of care model all that stuff is charged against us. Not to mention it's horrific waste, but* ***you can't expect doctors to be at risk without giving them control over those very expensive medications.***
>
> *— CEO, OCM practice*

> *[Another issue is] around* ***financial risk*** *and what's included in the financial risk model and what's not… the* ***rate at which new therapies are coming to market and the growth in costs*** *has not been linear,* ***it's exponential****…* ***I'm not convinced anyone has figured out how to model that yet, and how to account for that yet.***
>
> *— Administrator, OCM practice*

Most payers have not developed significant risk adjustment methodologies for their models, leaving practices open to adverse selection.

Meanwhile, OCM is deemed as making the models “too complex” to implement

As with value and risk, mental models around pathways and quality metrics vary between practices and payers.

- **Practices** view pathways and quality metrics **as ways to show their ability to deliver quality care.**
  - Practices see pathways as a way to show they are doing what they can on quality & utilization, and see it as a way to reduce their administrative burden.
  - Practices see their ability to hit quality metrics as evidence that they provide high quality care.
- However, **payers** perceive pathways and quality metrics **as ways to mitigate their risk**
  - Pathways are seen as *minimal* levels of quality and value for a practice to meet.
  - Quality metrics are used as a way to prevent practices from skimping on care.

Transformation is a Journey

Practice transformation isn’t an event, it's a spectrum of activity

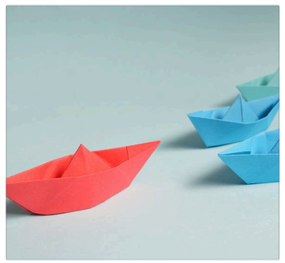
- **Internal transformation** in culture and mindset; new services and abilities
- **Extending influence** through network development and scope of service
- **Expanding payer programs** to all patients in the practice

The Dubious Participant

The High-expectations Participant

Fee for service based — *Integrated care*

The Reluctant Participant



The Pathway Participant

Transformation begins and ends within a practice's walls

Beyond adding new staff, programs, and services, transformation **requires a challenging cultural and mindset shift** away from fee-for-service norms. These shifts may be driven by **administrators**, but require the buy-in of **physician leaders.**

*“**We just wanted them to think differently, and so we did a tremendous amount of one-on-one training**...we **meet every week** to talk about how we’re performing, what we can do to improve patient care, improve physician engagement, improve patient engagement...reduce hospital utilization, and **it takes a lot of commitment. None of this happens by itself**.”*

— Administrator, non-OCM practice

Extending influence requires network development and potentially expanded scope

Total cost of care models require practices (especially small ones) to expand their influence outside their walls. Network development is the simpler, but not always successful, path.

*First we focused on radiology… **we ended up working with them to offer a reduced rate to our patients** because we're so focused on OCM… We really wanted to do that with radiation. The local group here is not receptive to that at all… But **we're not really satisfied with that. Basically what that's leading us to [look at having our] own radiation.***

— Administrator, OCM practice

Neither network development nor expanded scope are directly incentivized or accounted for in current models.

Expanding payer programs to all patients in a practice will be challenging

Many payers **don't see oncology as unique** in substantive ways. This means they see their experience in other VBP as **transferable, informative, and restrictive.**

> *"**I'm not convinced that they need to be that tailored to tell you the truth.** I mean I think there are some things that are different, like, maybe the drug use... Our [OHM] model is a little bit more scaled back from both the PCMH or the ACO, [and] we also have a total cost of care model, but it's not that significantly different."*
>
> *— Payer*

On top of this, many **VBP programs conflict with each other**.

> *"**It's hard when for OCM you're focusing on one thing, for QOPI you're focusing on something else**. It would just really be nice if they kind of walked hand in hand and said this is important for the next year, 18 months or whatever and then kind of had in line a schedule of what will happen down the road because **it's hard to be a clinician and constantly look at quality but constantly look at quality from several different groups.**"*
>
> *— Administrator, OCM practice*

Payers see data as a window into practices that they can use to teach practices

> *The purchasing sector somehow puts its fists on its hips and says* ***'Why aren't the doctors doing fill in the blank?' at the same time that they don't give them information…*** ***We don't have sufficient learning circles and sufficient attention to that difference in resource use.*** *Guys like me were trained that economics are immoral in health care. You don't treat to cost. That's just, frankly, silly."* — *Payer*

Practices must learn to use their data to inform their journey or be subject to what payers are willing to tell them.

Summary of Perspectives

- **Practice Variability Affected Success** in OCM. **OCM is designed for the average practice but there is no average practice** - practices of all sizes and health systems alike feel "OCM was not designed for us."
  - There are **four types** of practices engaged in OCM: **The Dubious Participant, The Reluctant Participant, The High-Expectations Participant,** and **The Pathway Participan**t (see slides 28-31).
- **Perceptions of Value and Risk vary enormously** - especially between stakeholder groups (pharma, payers, patients and practices)
  - Though practices see their value as providing convenient, timely, and low cost care, **timeliness and convenience are not reflected in existing VBP models**.
  - Perceptions of risk are tied to **type and severity of disease,** and compounded by rising **pharmaceutical costs**
  - While practices see **pathways and quality metrics** as a way to demonstrate their quality, payers see them as ways to mitigate risk
- **Practice Transformation is a Journey,** with three key types of challenges: ***Internal Transformation, Extending Influence & "Network"; and Expanding Payers Programs.*** Practices must learn to use their data to guide their journey.

Questions?

- **Practice Variability Affected Success** in OCM. **OCM is designed for the average practice but there is no average practice** - practices of all sizes and health systems alike feel "OCM was not designed for us."
  - There are **four types** of practices engaged in OCM: **The Dubious Participant, The Reluctant Participant, The High-Expectations Participant,** and **The Pathway Participan**t (see slides 28-31).
- **Perceptions of Value and Risk vary enormously** - especially between stakeholder groups (pharma, payers, patients and practices)
  - Though practices see their value as providing convenient, timely, and low cost care, **timeliness and convenience are not reflected in existing VBP models**.
  - Perceptions of risk are tied to **type and severity of disease,** and compounded by rising **pharmaceutical costs**
  - While practices see **pathways and quality metrics** as a way to demonstrate their quality, payers see them as ways to mitigate risk
- **Practice Transformation is a Journey,** with three key types of challenges: ***Internal Transformation, Extending Influence & "Network"; and Expanding Payers Programs.*** Practices must learn to use their data to guide their journey.

Thank you.

Basit Chaudhry, MD, PhD
basitchaudhry@tuplehealth.com
Celeste Roschuni, PhD
celesteroschuni@tuplehealth.com

PAYER EXCHANGE SUMMIT VII
ONCOLOGY PAYMENT REFORM

October 23-24, 2017
Hyatt Regency Tysons Corner Center, Virginia