A Higher Value U.S. Cancer Care System:

The Opportunity for Bundled Payments

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Framing the conversation

- ***Issues with the current U.S. cancer care system***
- ***Is payment reform for cancer desirable?***
- ***If so, why bundles?***
- ***Are bundled payments for cancer doable?***

Issues with the current U.S. cancer care system

FFS misaligns incentives → High, unsustainable costs

•Direct medical costs of cancer = 5% of all health care spending
•Projected to reach **$184 B** by 2020

FFS misaligns incentives → Inappropriate use of services

•Some services overused (imaging, genetic testing, preventable ER use, aggressive chemo near EOL)
•Some services underused (genetic testing, care coordination, palliative care, shared decision making)

Inconsistent quality of care

Increasing disease prevalence

•Incidence of cancer expected to rise **45%** from 2010 – 2030

Is payment reform for cancer desirable?

YES.

- *Realign incentives and increase care efficiencies*
- *Improve care coordination & quality*
- *Chronic disease bundle paradigm*

Why bundles for oncology?

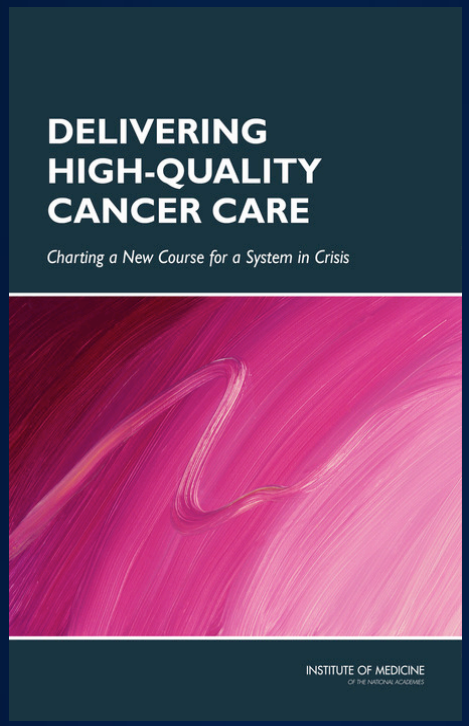
- ***Realign incentives***
- ***Available evidence-based guidelines***
- ***Flexibility in implementation***
  - *Opportunities for providers and plans of various sizes and capacities*

Are bundled payments for cancer doable?

YES.

Current bundled oncology payments: More data needed

A call to action



CAP Consortium

- Providers
- Patient groups
- Public & private payers
- Policy makers

CAP Consortium

- ***Begin with high prevalence cancers***
  - ***Metastatic NSCLC; Adjuvant & Metastatic Colon Cancer***
- ***Standardized set of meaningful quality measures across plans & providers***
- ***Assist in designing multi-payer demonstration***

Developing a framework

- ***What measures should define the bundle?***
- ***What services are included in each episode?***
- ***Who's included in the bundle?***
- ***Length of the episode***

Standardized quality measures

	Cross-cutting	Disease-specific
Adjuvant disease	11	1
Metastatic disease	9	2
End of life	10	0

Examples of standardized measures – adjuvant disease

- *OS (1, 3, 5 yrs) & DFS (1, 3, 5 yrs)*
- *Discuss chemo intent and patient's treatment goals before initiation of any new line of therapy*
  (also for metastatic patients)
- *Initiate chemo w/in 8 weeks of resection*
- *Delivered dose intensity*
- *% of patients with an inpatient admission associated w/treatment-related complications*
  (also for metastatic patients)

Examples of standardized measures – metastatic disease

- *% of patients who receive molecular testing prior to first-line treatment (lung cancer)*
- *Failure to provide genetic counseling for newly diagnosed patients (colon cancer)*
- *Chemotherapy for patients with ECOG ≤ 3 (lower is better)*
- *Systematic assessment of patient symptoms at each visit using PRO tool (also for adjuvant patients)*
- *% of patients with advanced care plan (also for adjuvant patients)*

Examples of standardized measures – end of life

- *Chemo within 30 days of death (lower is better)*
- *ICU admission, hospitalization within 30 days of death (lower is better)*
- *% of patients who died in hospital (lower is better)*
- *Systematic assessment of patient symptoms at each visit using PRO tool (also for adjuvant patients)*
- *% of patients with advanced care plan (also for adjuvant patients)*

Broad payment principles

- *Episode should be based on total cost of care*
- *Oncologist is the accountable provider*
- *Transition from retrospective to prospective payment with two-sided risk*

Next steps for consortium

- ***Publish recommended model and guiding principles***
- ***Encourage wide adoption of this model by public and private payers and providers***
- ***Track pilots and refine model as needed; disseminate best practices***