SUMMARY
The US government and payer organizations are currently piloting new value-based payment models to reduce costs and improve the delivery of cancer care. Similar to other Alternative Payment Models (APMs), these approaches focus on realigning provider reimbursements with new clinical performance outcomes, quality of care metrics, and accountable spending. In turn, cancer care providers face several challenges in redesigning their practices to match the requirements of value-based APMs. Providers must develop new methods for data collection, adhere to the new standards of care, and optimize performance outcomes and resource use – all without negatively impacting the quality of care or exceeding cost targets.

BACKGROUND
The cost of cancer care is skyrocketing. By 2020, the National Cancer Institute estimates that the United States will spend $173 billion annually on cancer care – up from $125 billion in 2010. The increase in cost for cancer care is distinctly steeper than the cost trajectories of other medical specialties for a variety of reasons: the increased use of expensive drugs and chemotherapy treatments, the adoption of new and costly diagnostic tools, and the rising incidence of cancer among baby boomers. These unique factors, in conjunction with poor patient engagement, subpar care coordination and the inadequate use of palliative care in treatment plans, have all been drivers for payment reform in cancer care. In particular, providers have seen the gradual transition from the Fee-For-Service models (FFS) to value-based reimbursement models, such as:

- **Oncology Care Model (OCM):** developed by Centers for Medicare & Medicaid Services (CMS)
- **Patient-Centered Oncology Payment Model (PCOP):** developed by the American Society of Clinical Oncology (ASCO)
- **Independent Pilot Programs:** developed by private payers, such as Aetna and UnitedHealthcare

Although each model varies in its structure, scale, and phase, they share the goals of increasing access to higher quality care and better outcomes for cancer patients, while also lowering the financial burden on the individual and healthcare system. Like many APMs, these oncology-specific models aim to align financial payments with the quality of care and other performance outcomes, rather than with each billable service. By linking financial incentives to quality outcomes, providers have more flexibility in developing the most appropriate and cost-effective treatment plans for patients. Moreover, oncology practices are incentivized to pilot different care delivery models and select one that complements their specific practice. Such models can break down the adversarial relationship between payers and providers and promote a more collaborative approach to the cost-effective delivery of care.

Despite the push towards valued-based care, several of these models are still hinged on FFS principles. For example, the OCM is still structured around traditional Medicare reimbursements rates; however, it has two additional components that promote value-based care:
• **Case-Based Management Fee:** In addition to traditional Medicare payments, participating oncology practices will receive a ‘per member per month’ (PMPM) case management fee for each Medicare cancer patient. CMS will dispense the $160 monthly fee at the start of the patient’s treatment and will continue payment for six months, regardless of whether the patient actually receives face-to-face treatment during that period. If the patient is still receiving treatment after the initial six-month period, a new payment period will begin. The fee is designed to encourage providers to offer services that are typically not billable, such as care coordination, patient education, research and performance improvement, all of which are essential to the delivery of quality care.

• **Performance-Based Payments:** In addition to traditional Medicare payments and the Case-Based Management Fee, participating practices may also earn revenue through shared savings with CMS. However, to earn this revenue, practices must meet certain risk-adjusted performance and quality standards. These conditions of the OCM highlight the growing trend toward linking payment to performance and quality outcomes. Beyond meeting these standards, oncology practices are also becoming more accountable for healthcare expenditures. In particular, each practice must meet a preset cost reduction target to receive any shared savings. As a result, cancer centers and oncology providers must be more diligent about containing costs across the board, ranging from initial diagnostic tests to unplanned ER visits.

**KEY PRACTICE FACTORS & ACTION ITEMS**

With the rise in new value-based payment models, cancer centers and other oncology practices face the challenge of adapting their care delivery models to match new reimbursement metrics and guidelines. In specific, each practice will need to assess its performance in the six key practice factors and ability to accomplish the corresponding action points highlighted below. Although primarily focused on cancer care, most serve as the foundation for value-based care models in other chronic disease groups as well.

**Quality of Care & Performance Management**

- Establish patient/family orientation program to develop patient-centered care plans
- Standardize early treatment discussions, including treatment expectations, advanced care plans, psychosocial needs, and financial and legal concerns
- Record and manage key quality and performance metrics, such as ER visits, preventable complications, pain management, patient experience during end of life, and other cancer-specific measures
- Leverage an interdisciplinary team to administer performance improvement efforts
- Align policies and protocols with new value-based reimbursement programs

**Revenue & Cost Management**

- Create an effective dashboard to monitor and benchmark utilization of services and procedures (e.g., radiation treatment, imaging, therapy and home health care)
- Establish and track the most cost-effective treatment options through coordination with imaging and testing providers, drug providers, and payers
- Empower patients to choose their most appropriate treatment plan using the ASCO Value Framework, which allows patients and providers to compare treatment options, based on benefit, safety/toxicity, and cost
Guideline Adherence in Delivery of Care

- Optimize staffing model and triage protocols
- Develop phone tree system and establish digital chain of command
- Establish remote EHR access for providers
- Enhance patient literacy and education tools to reduce need for after-hour consultations

Robust EHR & IT System

- Identify important quality and performance metrics
- Develop system for data collection and PHI (personal health information) protection
- Analyze patient case mix to identify the potential risks associated with APMs
- Establish meaningful use and develop plans for process improvement
- Use findings to establish benchmarks and identify long-term patterns

Patient Navigation & Communication

- Standardize protocols to ensure patient understanding of treatment options
- Establish patient experience survey program and feedback mechanisms
- Develop follow-up communication strategies with patients and family members
- Provide patient access to community resources, clinical trials, and follow-up services

24/7 Access to Care

- Standardize treatment plans to optimize patient safety and care outcomes
- Develop protocols to incorporate guideline updates into care delivery
- Establish provider accountability for meeting practice standards

The decision to adopt a value-based payment model requires a comprehensive evaluation of the organization’s six practice factors as well as any associated risks, such as an unstable patient case mix, staff education and adoption costs, and state-level regulations. By accounting for these risks and incorporating the key practice factors into an implementation plan, cancer centers will be well prepared to adopt a new payment model, such as the OCM, PCOP, or other payer programs. Through the FTI Consulting Care Transformation in Oncology Program, healthcare experts assess the unique needs of each client organization and prepare the most appropriate plan for a value-based transition. FTI offers experience in transforming cancer care organizations and implementing enhanced models of care that will enable each client to mitigate the risks of new payment models, achieve financial opportunities, optimize resource use and improve quality of care and overall patient experience.

AUTHORS

FTI Health Solutions has collaborated with leading Cancer Centers to implement new care delivery models and to improve processes in areas such as Revenue Cycle, Clinical Operations, Tumor Registry, Quality and Labor Productivity. To learn more about FTI Health Solutions and our client services, please visit www.fticonsulting.com or contact one of our healthcare professionals listed on page 4.
References:


