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

<table>
<thead>
<tr>
<th></th>
<th>Cross-cutting</th>
<th>Disease-specific</th>
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<tbody>
<tr>
<td>Adjuvant disease</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Metastatic disease</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>End of life</td>
<td>10</td>
<td>0</td>
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</table>
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)*
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