Bundling of Payments

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Agenda

- Conceptual framework
- Current initiatives
- MD Anderson’s approach
- Challenges and barriers
Reasons for Episode Based Payment

• Fee for service system blamed for our national health care cost crisis
• Move away from paying for volume of care and procedures to paying true costs of care
• Incentivizes efficient care and good outcomes
• Reduces administrative costs of current claims process
• A better alternative to global budgeting and capitation
Recommendation 10

• Professional societies should identify and disseminate practices that are unnecessary or where the harm may outweigh the benefits.

• CMS and others should develop payment policies that reflect professional societies’ findings.

• CMS and others should design and evaluate new payment models.

• If evaluations of specific payment models demonstrate increased quality and affordability, CMS and others should rapidly transition from fee-for-service reimbursements to new payment models.

Cancer Bundling Initiatives

- Bundled payment for cancer **not addressed** in ACA
- IOM found **no current evidence of its effectiveness** in controlling costs of cancer treatment
- Evaluation by RAND and the Brookings Institute to look at alternative payment models including bundled payment
- **CMS/CMMI** have interest in new cancer reimbursement models in current calendar year
- Initiative from **Center for American Progress** initiated in September 2013 to develop models of EBP for cancer conditions – lung and colon
- **MD Anderson** has had a 4 year project leading to bundled pricing programs
- At least one other **major cancer provider network** in northeast developing cancer bundles with payer
- **AMA** and **ASCO** also have proposals
MDACC Considerations

Concepts

- We are fully integrated practice unit delivery system ideal modeling this type of payment – all providers, services, outpatient and inpatient care
- Move away from fee for service and pay for value – the balance between our outcomes and our costs
- Drive incentives to control costs to providers

Aims

- Bundle must reflect true cost of care delivery
- Bundle must capture the entire multidisciplinary care experience
- Must be tied to meaningful, measurable outcomes
Modeling for bundle needs to reflect true cost of care delivery
Measuring MD Anderson Costs

• We have a **charge based** system for Medicare cost report, treatment estimates, and product line decision support

• Partnered with Robert Kaplan from HBS (2010)
  -Introduced time-driven activity based costing (**TDABC**) to health care based on time spent by personnel – 65% of budget

• Questions:
  - Could we do TDABC in health care?
  - Could we use TDABC to price episodes of care?
  - Could TDABC help us understand cost savings of performance improvements?
How does TDABC Measure Costs?

New-Patient Process Map

This process map, developed by the project team at one of our pilot sites, describes a segment of the patient care cycle at MD Anderson Head and Neck Center.

Modeling and Risk

- Chose to model **head and neck cancers** and **early stage lung cancer** due to extensive work in cost analysis of those disease sites.
- Through modeling, the **biggest differentiator** in cost was the **treatment selected** by the multidisciplinary team (*not tumor type and/or stage*).
- **Simulated the impact of bundles** to determine expected financial performance as well as maximum exposure.
- **Provider financial risk** mitigated by the price point negotiated and inclusion of a factor for co-morbidities.
- Prices and stop-loss thresholds **influenced** by historical **financial performance**.
- Final prices and stop-loss thresholds **targeted** to provide an **adequate expected margin** and downside **protection** against severe outliers.
Treatments Define Episode

Legend
S: Surgery  C: Chemo  R: Radiation Therapy
SS: Surgery w/ Plastics
4 Primary Risk-Adjusted Bundles

Box & Whisker Plot Analysis

Each bundle modified if Charleston Co-Morbidity Score is 2 or greater
Pilot Development

• **Scope**
  - One large private payer
  - Head and neck cancer initially, others to follow
    - Pilot for both payer and provider

• **Objectives**
  - Can this be done in cancer care?

• **Patient Population**
  - Regional patients with established diagnosis
  - Increased numbers of patients – a benefit or a liability

• **Plan Deployment**
  - Work teams engaged – project management key
  - Critical to standardize practice
  - Aim to initiate September 2014
Payer will direct newly-diagnosed head and neck cancer patients in Texas and surrounding areas to MDA for workup and treatment.

MDA will deliver all services for a pre-determined price, regardless of the actual services utilized by the patient.
Patients and Services

- **Newly-diagnosed**, untreated lip & oral cavity, laryngeal, salivary gland and oropharyngeal cancers
  - Stages I-IVB at diagnosis (excludes patients with concurrent or recurrent cancer or cancer treatment within the preceding 12 months)
- **Treatment-related** services delivered within a one-year period, **plus radiation therapy workup**
  - Includes covered clinical trial costs
  - Does not include diagnosis
Project Organization

• Project management for provider and payer

• Claims teams for payer and provider have the largest challenges in terms of change management
Sample Patient Tracking
Bundle tied to meaningful, measurable, outcome metrics
Outcome Measure Considerations

• To pay for **value** one must measure **outcomes of care**
• Fewer, high-level measures allows for more targeted focus on quality – must include **underuse measures**
• Ideally, **5-10 outcome measures**, including **patient-reported outcomes**
• Ones for pilot being finalized – survival, qol, readmissions, return to work

**Measure Criteria**

- Important to Patients/High-Impact
- Actionable by Clinicians
- Validated/Evidence-Based
- Feasible
Challenges and Barriers to EBP

• Finance teams seem reluctant to change a reimbursement system that they know.

• We really do not have systems that tell us how much it costs to deliver our care.

• Since financial risk is shifted to provider how do we mitigate that risk?

• How is the payment distributed in practices that are not integrated like MDACC

• Will clinicians embrace this change?

• Can we demonstrate EBP improves quality and controls costs?
THANK YOU