

Bundling of Payments

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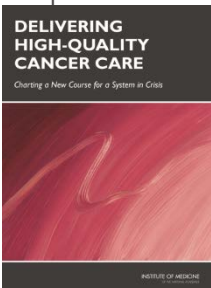
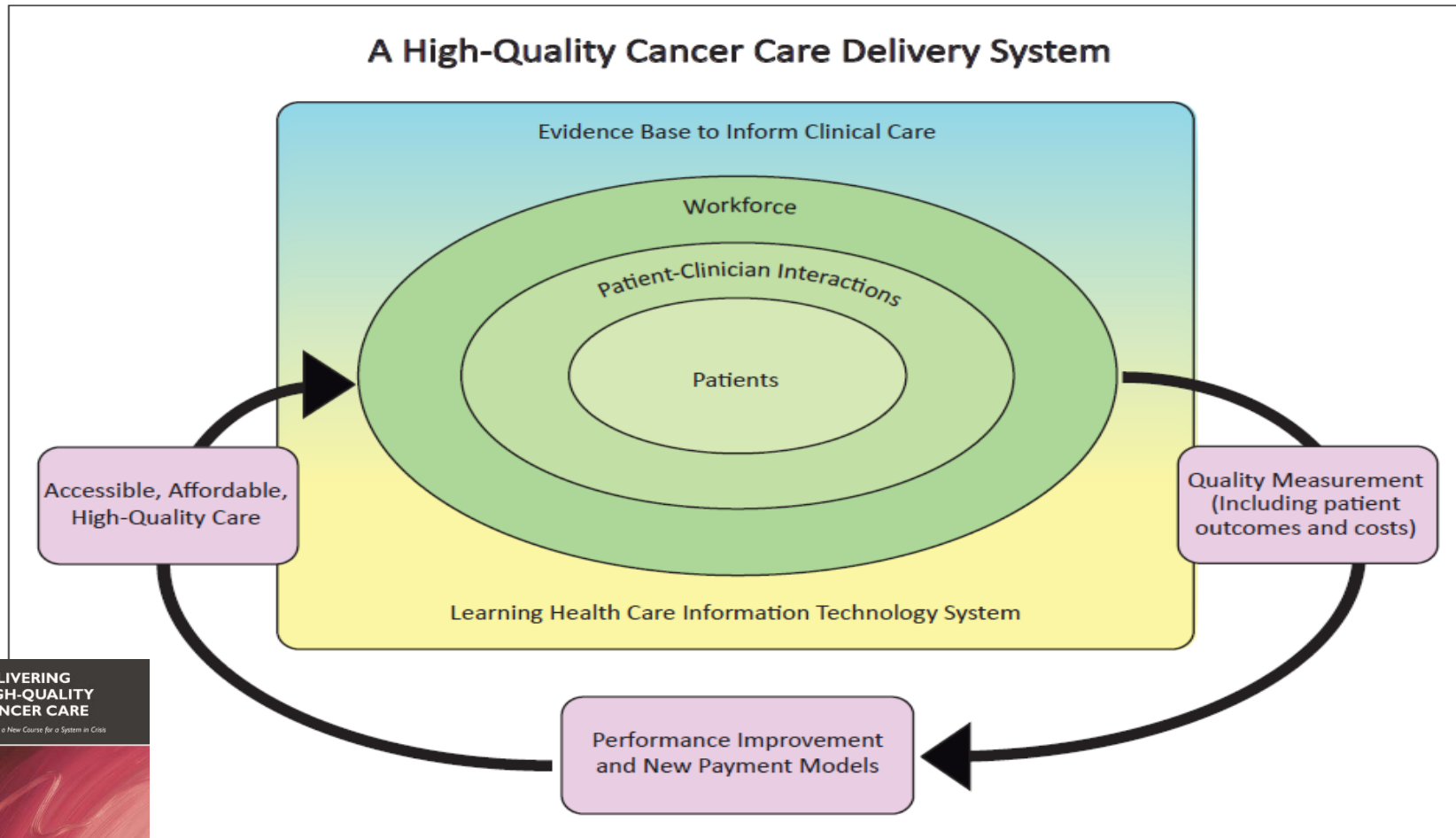
Agenda

- 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

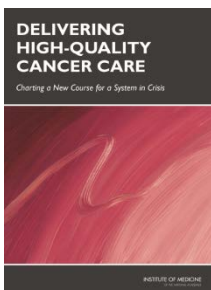
Conceptual Framework



SOURCE IOM (Institute of Medicine). 2013. Delivering high-quality cancer care: Charting a new course for a system in crisis. Washington, DC: The National Academies Press.

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.**



SOURCE IOM (Institute of Medicine). 2013. Delivering high-quality cancer care: Charting a new course for a system in crisis. Washington, DC: The National Academies Press.

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**

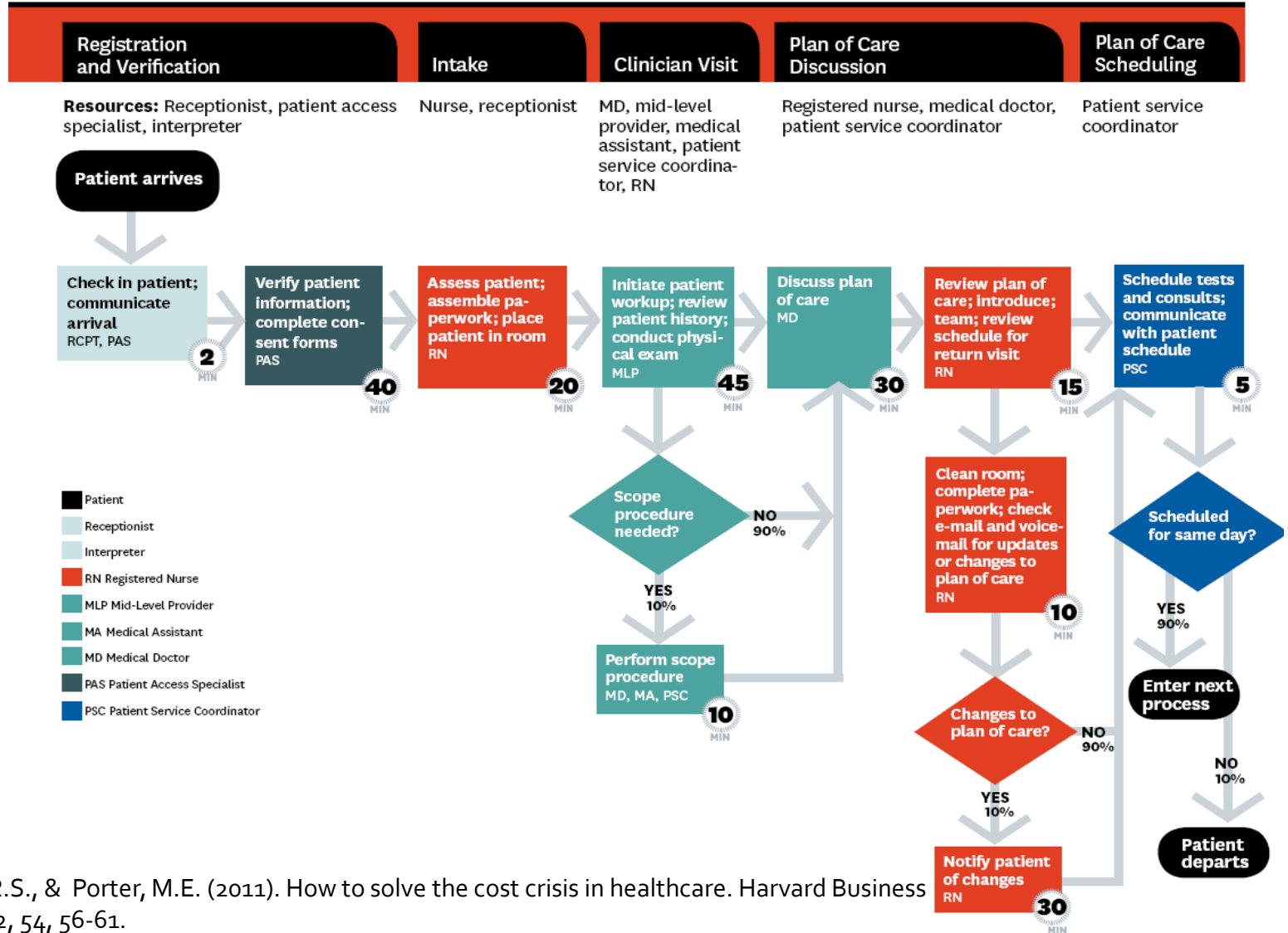
Measuring MD Anderson Costs

- 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.

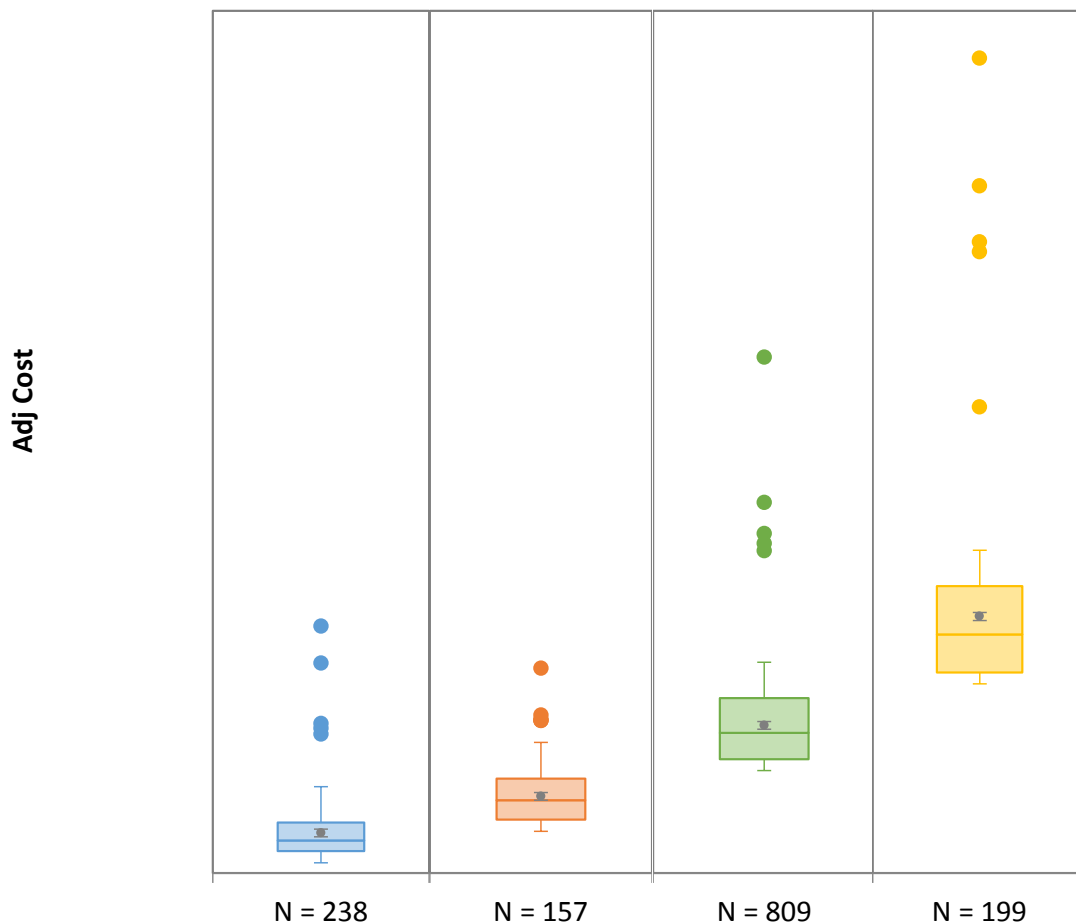


SOURCE: Kaplan, R.S., & Porter, M.E. (2011). How to solve the cost crisis in healthcare. Harvard Business Review, 89(9), 46-52, 54, 56-61.

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

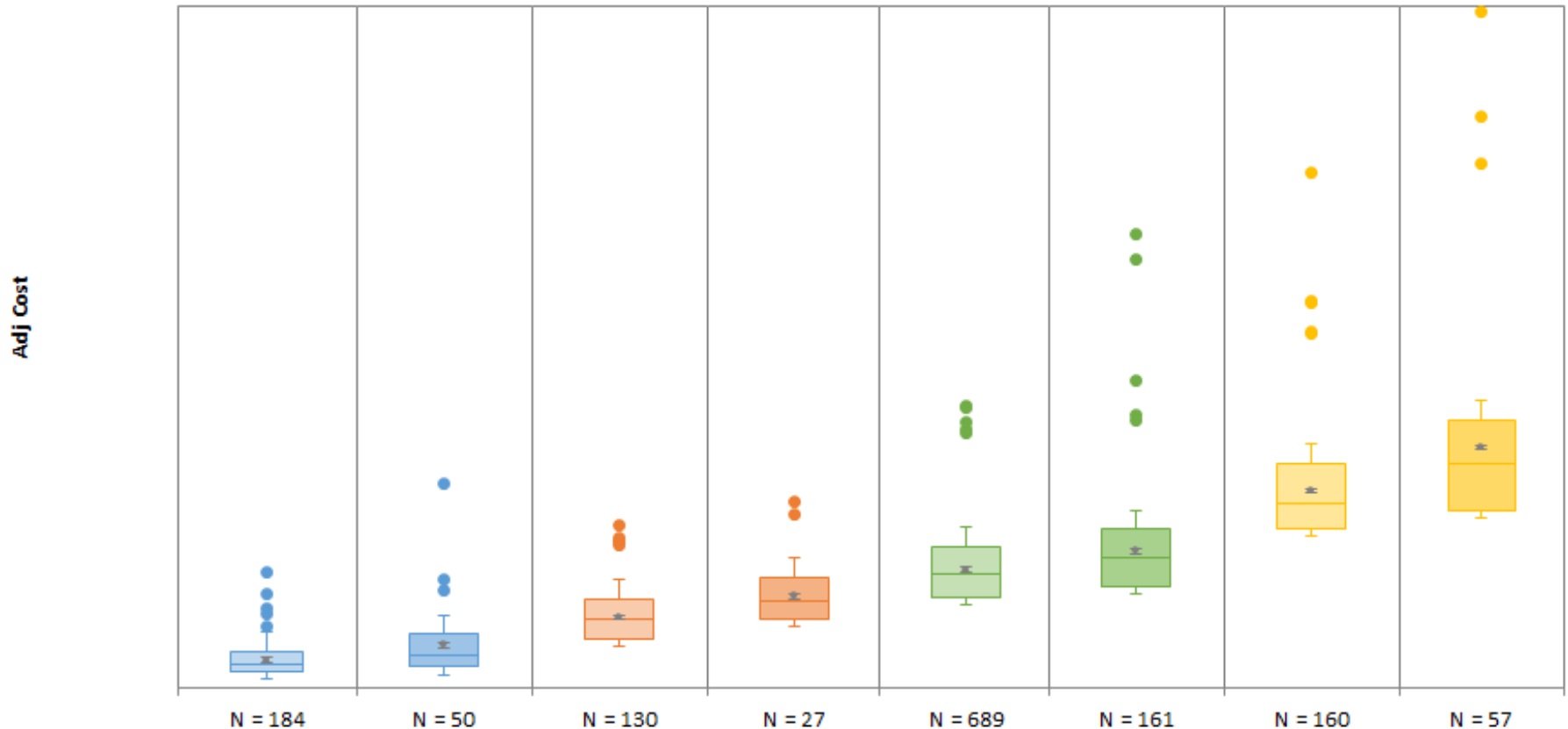


Legend

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

Pilot Concept

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

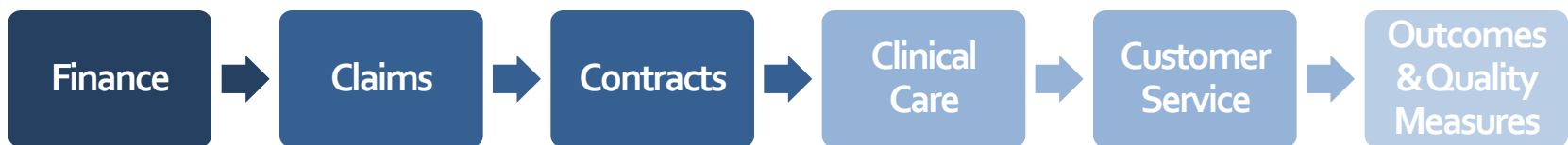
Patients and Services



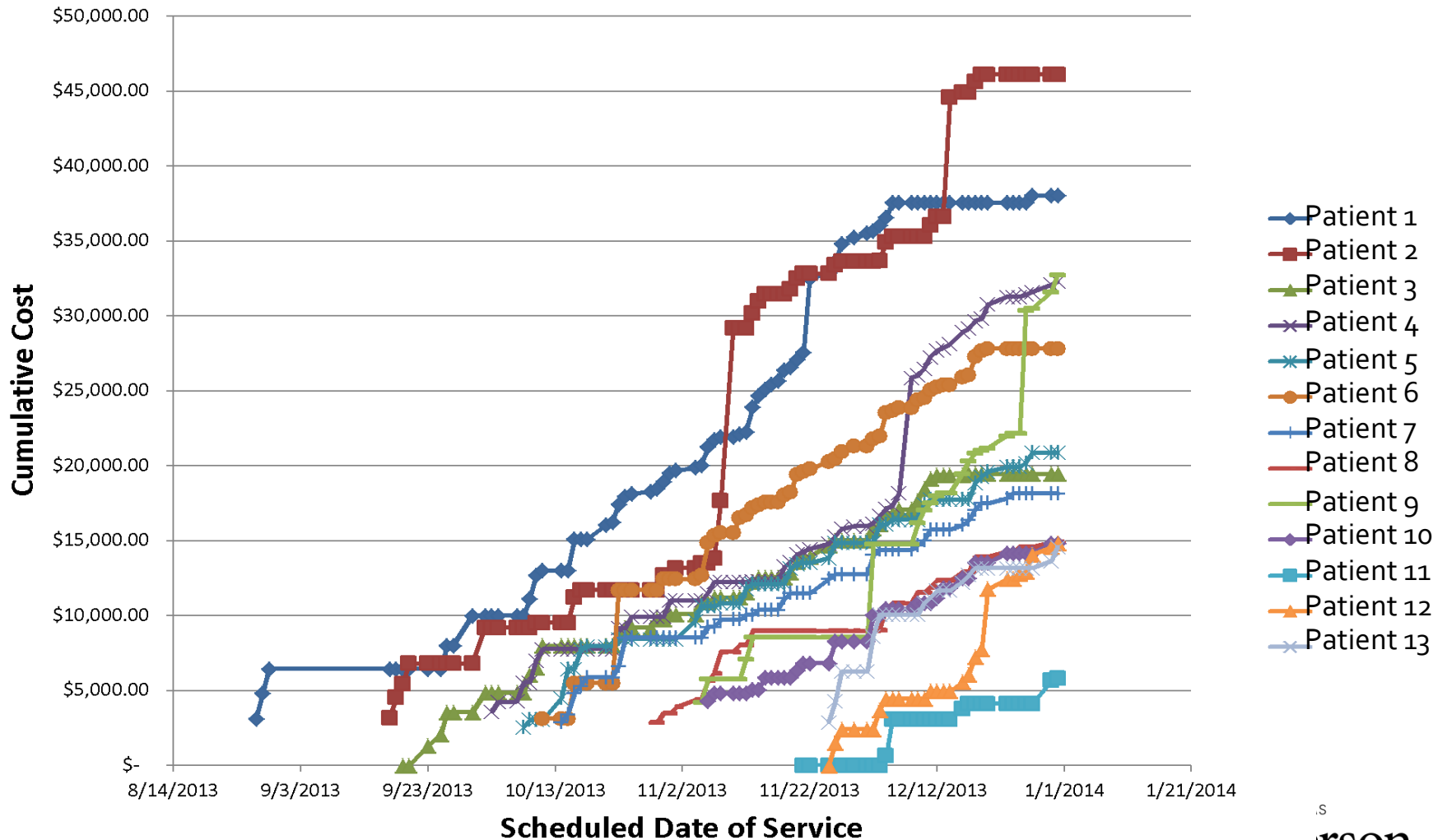
- **Newly-diagnosed**, untreated lip & oral cavity, laryngeal, salivary gland and oropharyngeal cancers
 - Stages I-IVB at diagnosis (excludes patients with concurrent or recurrent cancer or cancer treatment within the preceding 12 months)
- **Treatment-related** services delivered within a **one-year** 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



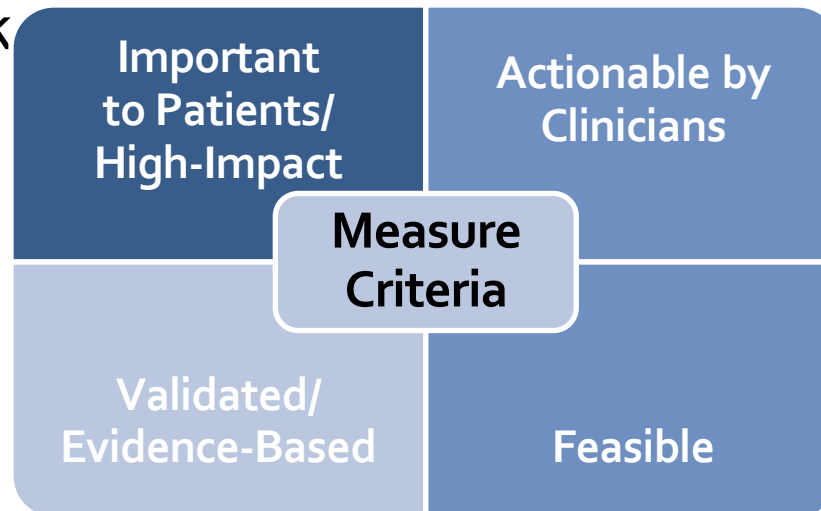
Sample Patient Tracking



**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



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