PAYER EXCHANGE SUMMIT
ONCOLOGY PAYMENT REFORM

SUMMIT SUMMARY

Prepared by the Community Oncology Alliance

Summary Overview

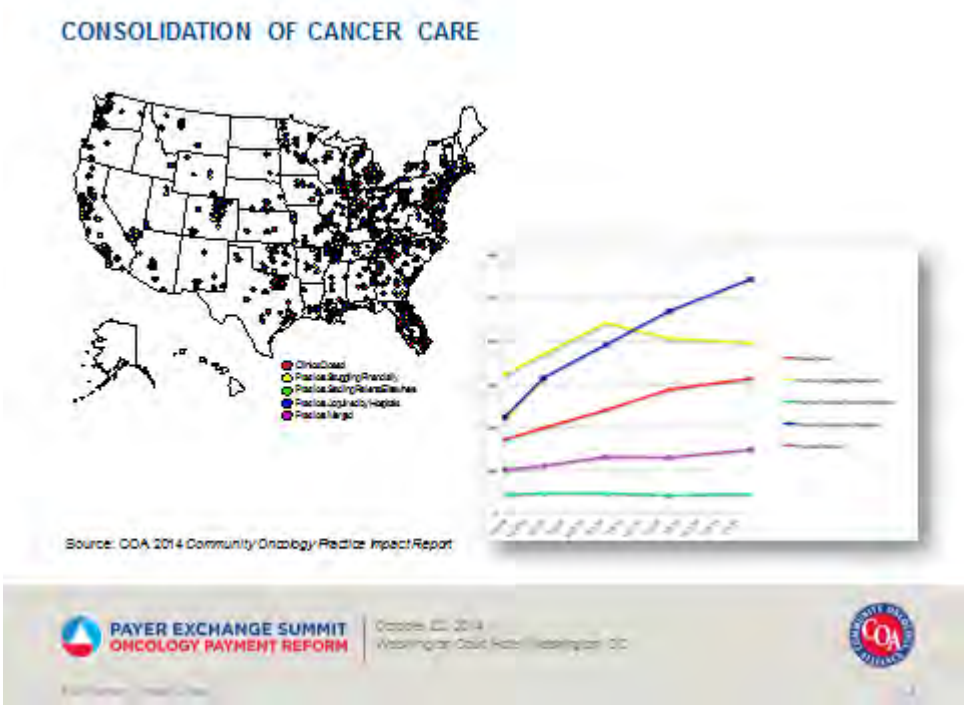
This is a detailed summary according to the agenda for the *Payer Exchange Summit on Oncology Payment Reform* held on October 22, 2014 in Washington, DC. Please note that the contents of the presentations are the property of the authors/presenters and should not be used without permission.

Summit Opening Remarks
Speaker: Bruce Gould, MD, COA president

Bruce Gould, MD, COA president, opened the Summit with a brief overview of why the Summit and payment reform are necessary.

The current payment system is not sustainable. New ways of delivering cancer care and paying for that care are necessary in the future. Dr. Gould discussed the newly released COA 2014 *Community Oncology Practice Impact Report*, which showed the continuing trend towards consolidation. Specifically, over the last eight years:

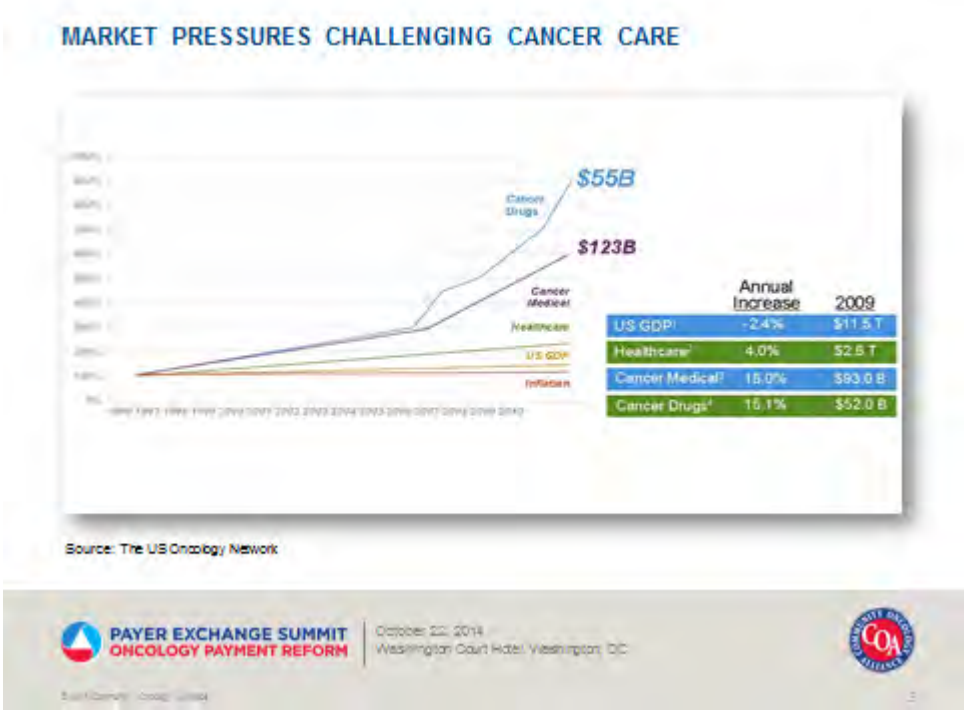
- 313 cancer treatment facilities have closed
- 544 community cancer practices have been acquired by or affiliated with hospitals



Payment reform is necessary because of the rising cost of cancer care.

- Costs are rising at about 15% per year

- Costs are rising, in part, because there is a larger at-risk population and oncologists are doing a better job of caring for patients who are living longer and/or at risk of getting a 2nd cancer



Dr. Gould emphasized that the tone of Summit would be collaborative and bridge building amongst those present, all of whom are at the forefront of cancer care payment reform.

Private Payer — Established Projects in the Field

A panel of provider/payer teams reviewed oncology payment reform projects already functioning in the field.

Payer: **Aetna, Michael Kolodziej, MD**
Provider: **Texas Oncology/US Oncology, Russell Hoverman, MD**

Because cancer is the most costly medical item and increasing at 2-3x the rate of other costs, a payment reform program must both:

- Improve quality
- Reduce cost

The focal points of Aetna's first payment reform program were:

- Pathways
  - Reduce variability in treatment patterns
  - Reduce costs of drugs and medication errors
  - Improve clinical efficiency
  - Increase patient and caregiver satisfaction
- Care management
  - Reduce hospitalizations and ER visits
  - Increase patient compliance and self-management
  - Increase patient and caregiver satisfaction
- Advanced care/end-of-life planning
  - Reduce costs of treatment near end-of-life
  - Increase hospice utilization
  - Document patient's values and goals for treatment

The program worked and produced a savings of 10-12%.

Practice lessons learned were:

- Patient accrual was excellent
- Analytics are challenging
- Management fee model is difficult
- Superb communication and dialogue is required
  - Leads to better outcomes, increased use of hospice, better symptom control, more satisfied patient and family
- Excellent health outcomes present a research opportunity
- Value of individual care processes is unclear
  - Begins with "I would be most happy when . . . . . "
- This type of program may not be scalable

Dr. Hoverman cautioned that any program will require:

- Re-engineering of the practice, and funds for personnel and infrastructure
  - There will be start-up costs such as software, training, personnel salaries
  - May require adjustment of operational hours
  - Operational key is case management and triage
- Greater opportunity for savings with expanded program

Payer: **PriorityHealth, John Fox, MD, MHA**
Provider: **Cancer and Hematology Centers of Western Michigan (CHCMW), Stuart Genschaw**

Both Dr. Fox and Stuart Genshaw agreed that it is "hard to shake hands with a clenched fist," embraced this philosophy in developing their program, and jointly agreed to the following principles:

- Paying for drugs at acquisition cost

- A combined program of pathways, care management fee, end-of-life planning
- Working in a very close relationship to resolve other issues
- Use of pathways
    - Required and achieved an 80% compliance
- Employed an end-of-life "Making Choices" program utilizing social workers and a psychologist
    - 98% acceptance for advanced planning when offered by the physician
    - 65% acceptance when offered by other staff
    - 90% of all patients signed a DNR

Additionally both PriorityHealth and CHCMW agreed to performance metrics based on:

- Patient satisfaction
    - As determined by using the COA Oncology Medical Home (OMH) survey
- End-of-life care
    - Discovered that the amount of chemotherapy in the last weeks of life decreased
- Improved access to care and care triage
    - Required operational changes to have RN's take calls
    - Hospitalizations decreased from the Milliman average of 1/year/patient to .65/year/patient

The lessons learned by CHCMW were:

- Hard to sustain change without internal structural support
- Payment reform is critical if the practice is to offer services such as triage and end-of-life planning

Payer: **UnitedHealthcare, Lee Newcomer, MD**
Provider: **The Center for Cancer and Blood Disorders (CCBD), Ray Page, MD, Tammy Chambers**

Involvement in a payment reform program is indicated because:

- 50% of household income will be spent on healthcare
- Median income is not rising
- Healthcare is not affordable by the average household

UnitedHealthcare launched this episode payment pilot in 2009:

- Rewards physicians for improved quality and reduction in total cost of care
- Separates oncologist's income from drug revenue
- Builds a learning system to identify best practices for cost control and quality

Participating pilot practices were:

- The West Clinic, Memphis, TN

- Northwest Georgia Oncology Centers, P.C., Marietta, GA
- Center for Cancer and Blood Disorders, Fort Worth, TX
- Advanced Medical Specialties, Miami, FL
- Dayton Physicians LLC, Dayton, OH

The method of the pilot was:

- Identification of 19 clinical episodes in breast, colon, and lung cancer
- Selection of preferred chemotherapy regimen for these cancers
- Calculation of drug profits from those margins
- Payment fee-for-service
    - Drugs paid at average sales price
    - Episode payments unchanged with drug changes
- Measure performance annually
- Increase episode payment only if improved outcomes or lower total costs

The results were:

- 810 patients participated in the program
- 34% reduction ($33,000) of total medical costs
- 179% ($13,000) increase in chemotherapy drug costs

Dr. Newcomer stated:

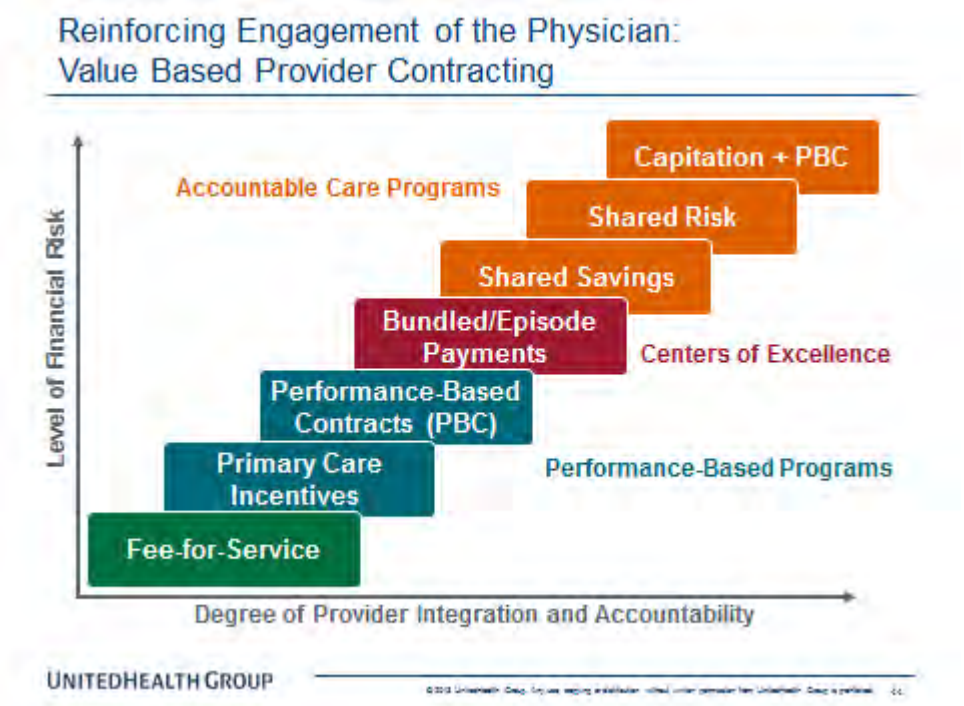
- "The results of the study, which has its imperfections, create a fantastic foundation for moving forward with ideas and concepts."
- "All of these programs require relationships, data is essential, and everybody has to withstand access."

After the first phase, the program was modified as follows:

- Modify payment for original groups
    - Case management fee replaced episode payment
- Expansion to new groups to confirm results
- Pilot is a true bundled case
- Find small group solution

The continuum of financial risk and provider involvement is as follows:

[Note: Chart on next page.]



The next steps are:

- Expansion of reference database
- Benefit differentials for patients
  - Site of care
  - Regimen value
- Patient information on cost

A summary of the program indicates:

- It is possible to reduce costs and improve quality
- Physicians must manage that change
- Incentives can be realigned for change
- These changes must occur immediately

Private Payer – New Projects

A panel of provider/payer teams reviewed oncology payment reform projects newly established in the field.

Payer: **AvMed, Michael Sheehan, MD**
Provider: **Miami Cancer Institute of Baptist Health So. Florida, Leonard Kalman, MD**

In 2012 three parties came together to discuss oncology payment reform:

- AvMed Health plans
  - Large regional health plan whose highest spend was/is cancer costs
- Baptist Health South Florida (BHSF)
- Advanced Medical Specialties (AMS)

The participants chose to form an oncology specific Accountable Care Organization (ACO):

- Pursuing the triple aim for cancer patients
  - Pathways
  - Care management
  - Advanced care/end of life planning
- Focused on population management/total cost of care rather than bundles/episode
  - No RA, few excluded DRG's, $500,000 cap
  - Commercial patients viewed separately from Medicare patients
- Targeted the six most common cancer types
- Chose a workable attribution methodology
- Providers were paid fee-for-service
- Established baselines per year, population, expenditure
- Three year arrangement with annual reconciliation
- Measurement against past performance
- Shared savings arrangement if certain quality metrics were met
  - "Shared savings" was not the goal
  - Real goal was population management

Program baseline is:

- Patient mix
  - 250 commercial members
  - 324 Medicare members
- Total cost of care
  - $17,412, 881 - commercial members
  - $12,426,778 - Medicare members
- Average annual cost of care per member
  - $69,652 - commercial member
  - $38,354 - Medicare member

This program launched in October 2013 with:

- Chemotherapy pathway regimens embedded in the practice EHRs
- Semi-coordinated outpatient triage, inpatient and transition of care efforts
- Uncoordinated third party efforts in imaging and radiation
- Continuing communication to doctors and staff

Despite the programs relatively short duration, participants are learning:

- Despite small numbers are able to see big concepts
- Payment reform is more difficult than expected
- To achieve sustainable success and ultimate scalability will require
    - Thought, commitment, time, effort, people, cooperation, money and an analytical strategy
    - Provider drive, hospital cooperation, patient support
- Now is the time to develop the skills to manage a cancer population
- ACO concept is here to stay
    - Bundles and episodes are flawed
    - Will not achieve the triple aim
    - Very few new models of care show credible savings
    - Mostly show quality metric gains
- Now is the time to demonstrate value and strike strategic partnerships
    - Specialty deals that drive better pricing, access, and steerage are likely
- Cost savings, patient satisfaction, and access are most important to insurers

There are issues with measuring performance; no approach is ideal. This means there must be a balancing of trade-offs. There will be issues and implications such as the following:

Issues	**Implications**
Oncology is a very complex condition with many different types and patient trajectories	Metrics can quickly lose power if they are too complex
In addition to all the other changes in healthcare (e.g., reform), oncology sees rapid advances in technology which can have impact on both outcomes and cost	Past performance is not a reliable benchmark for comparison
Costs of cancer care can vary significantly across markets because of local pricing dynamics	"Simple" comparisons of cost across markets not meaningful
Patient mix can vary significantly from year to year and can result in a very different risk profile	Evaluating performance across larger patient panels will offer a more robust view

The participants consider this program worthwhile and have mapped a specific strategy through 2017 to continue the program.

Payer: **Aetna, Michael Kolodziej, MD**
Provider: **Northwest Georgia Oncology Centers (NGOC), Bruce Gould, MD**

Aetna recognizes that when it comes to cancer care most people do not understand:

- What providers do

- Why they do it
- Why it costs so much to do it

Payers and providers must be willing to question every single process when seeking to enhance clinical services by providing the following:

- Evidence-based medicine
- Enhanced access
- Shared decision making
- Coordination of care
- Quality reporting
- Payment reform

A review of this program revealed the following differences between the pre-pilot and pilot groups in adherence to evidence-based care:

- 43% relative improvement in adherence to evidence based treatment selection
- Peer-reviewed, published evidence-based treatment options were selected for 25 more patients for every 100 cancer patients in our study

The use of pathways requires:

- Evidentiary and operational process
- Measurement and reporting

Payment reform is a never-ending cycle of:

- Define
- Measure
- Explore
- Develop
- Implement

In analyzing patient care it was discovered that:

- Expensive end-of-life care is not due to chemotherapy or chemotherapy-related issues but to hospitalization to manage symptoms
    - Estimate that this represents half of all admissions

NGOC has learned that:

- Physician and management buy-in is critical
- Pathways goal should be a single pathway for each cancer
- Feedback from payer is key to a successful project
    - Previous difficulty has been that feedback was not timely
    - Claims-based evaluation is 1980's based data idea and a much more contemporary data idea is necessary
- Providers and payers are learning together; there is a lot to learn
- The ACO model is not universal but can be scaled

- In an ACO it is vital to bridge to episode-based reimbursement
- Despite an agreed upon desire for change, change is difficult

Payer: **Blue Cross/Blue Shield of South Carolina, Laura Long, MD**
Provider: **Carolina Blood and Cancer Care (CBCC), Kashyap Patel, MD**

This pilot program assessed performance based on the following four criteria:

- Resource utilization
  - Number of ER visits per patient per cycle
  - Number of hospitalizations per chemo per patient
- Patient care measures
  - Staging
  - Treatment plan
  - Confirmation of pathology
  - Palliative versus curative chemotherapy
- End-of-life care
  - Percent of Stage IV patients with an end-of-life discussion
  - Percent of patients who die in an acute facility
  - Percent of patients receiving chemo near end-of-life
- Survivorship
  - Percent of patients with survivorship plans within 60 days
  - Percent of patients making lifestyle modifications

The pilot revealed possible areas of cost savings without compromising quality:

- Patients on chemotherapy being managed in a physician-based office setting have lower per-member, per-month cost versus those treated in a hospital outpatient department (HOPD)
- In the first 30 days, in-office treatment costs $4,300 less than patients receiving similar care in an HOPD
- Office-based patients cost approximately $29,000 less than HOPD-based patients
- Office-managed patients remain less costly after controlling for patient characteristics
- There are savings based on site of service care
- There are savings from reduced hospitalization and ER visits and with end of life care planning

In a payment reform program the following are the provider's responsibility:

- Care management
  - To reduce side effects, reduce admissions, readmissions, and improve adherence
- Patient engagement programs that provide after hours and weekend services
- Advance care planning programs
- Survivorship programs

- Primary and secondary prevention programs
- Palliative care programs
- End-of-life care

The successful program has four requisite components:

- The patient is at the center of what is done
- We will have to pay for what we want
- There must be transparency in all directions amongst payers, providers, patients
- There must be collaboration in all directions amongst payers, providers, patients

Payer: **WellPoint, Jennifer Malin, MD**
Provider: **Dayton Physicians Network (DPN), Charles Bane, MD**

Optimal health reform is based on collaboration and the seminal question is how to evolve the system so it works for big practices and the solo-practitioner.

WellPoint's pilot *Cancer Care Quality Program* was designed to:

- Provide a framework for rewarding high quality cancer care
- Oncologists participating in the *Cancer Care Quality Program* will receive additional payment for treatment planning and care coordination when they select a treatment regimen that is on pathway
- Provide a web-based platform with decision-support that improves efficiency of review and decreases administrative burden for practices

By Feb 2015, this program will include pathways for cancers contributing to 90% of chemotherapy expenditures. The WellPoint approach to pathway development is to:

- Extract, review, and analyze data from trials, publications, and compendia
- Synthesize medical evidence into clinical guidelines
- Use evidence to develop medical policies and utilization management guidelines when making benefit coverage determinations
- Pathways are a subset of regimens supported by evidence and clinical guidelines and aligned with health plan medical policies intended to be applicable for 80%-90% of patients and are selected based on:
    - Clinical benefit
    - Side effects/toxicities especially those leading to hospitalizations and/or that impact quality of life
    - Strength of national guideline recommendations
    - Cost of regimens

Other components of the program are:

- Pathways are selected by the practice versus a broad consensus
- Treatment planning payments will support cost-effective care

- Enhanced reimbursement for treatment planning and care coordination will be provided when patient is registered with the *Cancer Care Quality Program* and treatment regimen is on pathway

DPN is involved in payment reform initiatives with:

- UHC Episode Fee Payment Pilot
  - Payer driven/collaborative effort
    - Single regimen, practice selected for quality (not cost)
    - No reduction in care
    - Clinical trial participation encouraged
    - Management fee, treatment reimbursed at cost
    - Objectives and data collection clear from outset
    - Opportunity for shared savings
  - Results
    - Increase in drug costs
    - Substantial decrease in overall cost of care
    - Measurable quality outcomes equal or improved
- IOBS Oncology Medical Home
  - Provider driven/collaborative effort
    - CMS funded
    - Provider generated pathways
      - Clinical trial participation encouraged
    - Expansion of care
      - Nurse triage, acute appointments and expanded hours
    - Objectives
      - Enhanced patient experience, improved quality outcomes
      - Reduced cost – decreased ER visits and hospitalizations
- Anthem/WellPoint *Cancer Care Quality Program*
  - Payer driven/Non-collaborative
    - Payer determined pathways
      - Reduce variability
      - Based on efficacy, toxicity, and cost
    - Management payment
      - Incentive to participate
      - Non-pathway treatment (clinical trial) = no management fee
      - No opportunity for shared savings
    - Objectives
      - Reduced drug costs
      - Data collection and use not stated
- Aetna/Via Pathways

Oncology Medical Home Accreditation
Speaker: Daniel McKellar, MD, Commission on Cancer

Accreditation of an OMH:

- Is important for validation of compliance of standards
- Assures appropriate structures and processes in place
- Provides accountability
- Promotes best practices
- Improves patient and other stakeholder confidence in the quality of care
- Identifies areas needing improvement
- Decreases variations in care
- Improves efficiency of care

COA sought accreditation from the Commission on Cancer (COC) because of:

- 80 years of experience accrediting cancer programs
    - Comprehensive patient-centered standards
    - Leader in quality metric development and implementation
- Significant infrastructure in place
    - Well trained knowledgeable staff
    - Trained and experienced surveyor team
    - Experience with data on cancer patients (NCDB)
    - Numerous educational programs for cancer programs
- National recognition for accrediting cancer programs

The COC is a consortium of 54 professional organizations dedicated to improving survival and quality of life for cancer patients through standard setting, prevention, research, education, and the monitoring of comprehensive quality care.

The OMH accreditation program progress to date includes:

- Standards workgroup meetings for last 12 months
- Standards finalized
- Proposed quality measures developed
- Draft of standards manual completed
- Pilot practices educated on standards

The next steps are as follows:

- Pilot surveys in 10 practices
    - Assessment of ability to meet standards
    - Feedback on applicability of standards
    - Abstraction of quality measure data
- Review findings from pilot surveys and finalize standards
- Recruit and train additional surveyors
- Develop resources to assist practices in meeting standards
    - Best practices

    - Educational programs such as webinars
- Expand accreditation of oncology practices

The proposed standards will be similar to the COC criteria for hospital-based cancer programs:

- Patient engagement
- Expanded access
- Evidence-based medicine
- Comprehensive team-based care
- Quality improvement

The eligibility requirements for an OMH program are:

- OMH leadership within the practice
- Established use of a certified EHR
- Financial counselors, patient access to patient data, and a patient portal
- Established and new patient access to the OMH
- Use of recognized treatment guidelines for treatment planning
- Participation in clinical trials
- Comprehensive team-based care
- Data collection to verify compliance with quality measures
- Patient satisfaction evaluation
- Data collection and analysis for all agreed upon quality measures

The COC proposed survey process is:

- Each practice to be evaluated on-site every 3 years
- Prior to survey practice will submit the survey application
- Record (SAR)
- Surveyor will review SAR and all accompanying documentation prior to on-site visit
- Surveyor will perform record review
    - Verify compliance with standards
    - Verify compliance with quality measures
- Surveyor will meet with physicians in the practice
- Surveyor will meet with key practice employees

The potential benefits of OMH accreditation are:

- Improve patient access to care
- Decrease variations in care
- Improved outcomes
- Improved efficiency of care
- Sharing of best practices
- Expedite implementation of new treatments

Value Based Insurance Design in Oncology
Speaker: Jonas de Souza, MD, University of Chicago Medical Center

Since 1999 worker contribution to healthcare has increased almost 200%, cost of care has increased while earnings have remained flat. A study among 254 patients assessed at Duke/Healthway Foundation revealed:

- 42% had a significant or catastrophic subjective financial burden
- 46% used savings to defray out-of-pocket expenses
- 20% took less than the prescribed amount of the medication
- 19% partially filled prescriptions
- 24% avoided filling prescriptions altogether

This increased cost has resulted in:

- Cost of cancer care is impacting patients' well-being
- Cost-sharing is impacting compliance
- Cost-sharing is not related to value or efficacy of treatment

There are four options for value-based copayments:

- Value-based insurance design
- Value-based benefit design
- Evidence-based benefit design
- Clinically sensitive benefit design

Value-based insurance in oncology considers that:

- Clinical benefits differ quantitatively and qualitatively, depending on indication and clinical setting (e.g., adjuvant vs. palliative, or survival vs. symptom improvement)
- Levels of evidence supporting interventions differ, and although an intervention may have irrefutable survival benefit in a specific scenario, it may lack evidence for other indications
- Programs acknowledge patient population heterogeneity and promote personalized medicine, as the value of a specific intervention varies across patient groups, and biomarkers may identify those who would benefit most

Such programs could structure payments in one of two ways:

- High-value interventions: low co-payment
- Low-value interventions: high co-payment

The potentials for value-based insurance in oncology could be:

- A lower copay for the same drug depending on the type of cancer being treated
- A higher copay for off-label therapies
- A higher copay for screenings depending on certain indicators, like age

There has been experimentation with bundling on the premise that it eliminates the "perverse incentive." A recent study by UnitedHealthcare proved the opposite:

- Cost of chemotherapy was higher for episode group than for control group

If we fast-forward 1-2 years and presume:

- Value has been determined (ASCO initiative)
- Payers able to link reimbursement and evidence to value
- Oncology drugs are removed from the bundle

Then the effect of value-based insurance might be:

- Beneficiaries would receive credits based on the specific interventions they receive
- Each intervention would be assigned a tier level of credit, corresponding to the currency the beneficiaries will receive for enrolling in the plan
- The pair intervention-credit would be publicly available and mailed to beneficiaries and their providers
- Health outcomes/metrics would be measured
- A beneficiary could decide to a prior plan at any time, but credits would cease
- The rationale for offering credits is that patients would be incentivized to receive high-value care (by receiving higher credits), while decreasing low-value interventions (either explicitly not covered in the value-based plan or by receiving lower credits)

Medicare Pilots and Proposals

A panel reviewed oncology payment reform projects for Medicare currently being implementing or proposed.

COME HOME: Barbara McAneny, MD, New Mexico Oncology Hematology Consultants

Oncologists are becoming victims of unintended consequences as we see:

- More practices aggregated into hospitals
- Prices are rising
- Trying to design treatment for patients for whom a cancer diagnosis is a financial disaster

What we have designed is dependent on getting a payer participant because practices can no longer function on fee-for-service reimbursement:

- There are too many services for which there is no compensation
- Must have triage pathways for which there is no compensation

- We have to allow for scheduling access for triaged patients

The appropriate system would have:

- Every physician doing what only the physicians can do
- Use other staff to do other work
- This will improve job satisfaction because people want to work at the top of their license
- Must move people appropriately to high volume/high revenue and low volume/low revenue tasks

Quality care is two things:

- Knowing medically what to do
- Customer service for the patient

By 2030, 70% of all cancer patients will be of Medicare age. This will allow us to capitalize on the fact that the CMS can quickly and accurately process claims to allow a claims-based review of physician compensation.

Bryan Loy, MD, Humana, added, "We need to work together so the first domino can fall and payers join in and can share information in an actionable and accessible way."

CMS/CMMI: Erin Smith, JD

The CMS/CMMI payment model is a bundled payment five-year model focused around chemotherapy episodes of care.

The physician practice participants must meet some requirement such as:

- Must have patient navigators for every patient
- Must increase access to a real 24/7 triage
- Must have meaningful use of data
- Must move towards use of HIPAA compliant EHR

Bundling and episodic care will be featured:

- Episodes for bundles will likely be 6 months as shorter episodes do not make clinical sense
- Episodes will start with the first chemotherapy administration rather than diagnosis because physicians cannot control pre-chemo costs

There will be:

- Benchmarking against practice's historic performance
- Performance-based payment
- Comparison of historical expenditures versus episode performance

The program must address other issues around benchmarking such as risk assessment factors limited to use of claims data because that is all we have with which to work.

Participation and engagement will happen over time; the program will go live, followed by the distribution of:

- Details of the program
- Submission of a letter of intent
- Submission of an application

The CMMI program will be a gain-sharing program in which practices will be compared to themselves. This will allow practices at or above national averages an opportunity to improve and be rewarded.

Congress: Nick Magallenes, Office of Congresswoman Cathy McMorris Rodgers

We are confident that we are going to get rid of SGR in the very near future. We want to:

- Incentivize standards of care across the US
- Provide "comprehensive care that is patient centered and coordinated"
- Which will rapidly increase quality of care

Congresswoman McMorris Rodgers wants to learn how technology can be used to improve care. To date there has been minimal progress on reporting and benchmarking best practice. Practice rewards need to be standardized to quality care not the volume of care.

She believes such a model can work for cancer and other specialties and wants to work with all parties. At this time it is not possible to be more specific because details are still begin worked out.

Observations and Discussion
Speaker: Ira Klein, MD, Aetna

Dr. Klein highlighted some specific speaker statements in summarizing the Summit. He acknowledged those comments as follows:

Dr. Kolodziej:
We could either improve quality or reduce costs; hopefully we will do both. We have to work on OMH, triage reform, patient education, and very likely a change in practice hours.

Dr. Hoverman:
We must determine who will make decisions when patients cannot. Patients want to know when they are dying. Payment reform will require much re-engineering which is hard to do, will be costly, will require massive data collection over time, and ultimately result in the practice's reinvention.

Dr. Fox:
There must be dialogue if there is to be payment reform. We must change the manner in which practices are paid and in which they deliver care. Payment reform must include end-of-life care. Improvements in cost controls are hard to maintain without a complete practice restructuring.

Drs. Page and Newcomer
Healthcare costs will overrun Americans because their rise exceeds any increase in income. Case management fees should replace episode fees, or all practices will have to re-position, and reform would be very tough for the 2-4 physician practice.

Dr. Kalman:
You cannot implement payment reform if you do not know your local market.

Dr. Patel:
I agree that there have to be changes if one wants to be a physician for very long. We are going in the right direction but we cannot go off a cliff together; payers will have to say what they want but then will have to pay for the agreed upon care delivery design.

Drs. Bane and Malin:
We can transform cancer care but it is difficult to be collaborative when dealing with 600 payers. Multiple pathways are problematic.

Dr. McAneny:
Quality measures are vital — what is the right care and the best customer service?

Erin Smith:
CMS/CMMI is proposing a bundled model with some aspects of OMH. It will be voluntary and measure the total cost of care versus a baseline.

Nick Magallenes:
We are confident we will fix the SGR.

Comments and Questions from attendees:

Patrick Cobb, MD, St. Vincent Frontier Cancer Center
How do those of us already in a hospital affect payment reform? Our hospitals are addicted to the revenue stream; it will be hard to change them. We will need another way.

Ira Klein, MD:
Yes. I think we may see hospitals unhitch some PHAs/PHOs and send them back to community. As 340B drug money decreases, hospitals will begin to look at total cost of care.

Brian Bourbeau, Oncology Hematology Care, Inc.
How do you get physician buy-in to pathways?

Ira Klein, MD:
If everyone pursues the other aspects of payment reform, this will resolve itself.

Ted Okon, COA:
Today was not a single event but the beginning of a dialogue. We will be looking for feedback on what should be the next steps. This meeting will continue at the 2015 Community Oncology Conference on April 23-24 in Orlando, but we cannot stop working between now and then.