The State of Cancer Care in America: 2015

www.ASCO.org/StateofCancerCare
Key Progress Against Cancer

- FDA approved 10 new cancer drugs and 9 new uses of existing drugs
- >800 therapies in the pipeline
- Immune-boosting therapy approved after 3.5 years development time
Cancer Survivorship on the Rise

- Cancer survival increasing & overall mortality decreasing
  - More than 2/3 patients live 5 years beyond diagnosis
  - 14.5 million cancer survivors today
Yet Challenges Persist

- Increasing demand for cancer services
  - Growth in elderly and new public health concerns (e.g., obesity)
  - People living longer after treatment
- Deaths are down, but still too high
- Unprecedented new technologies and scientific advances not yet reaching patients

![Graph showing new cancer cases and cancer survivors](image-url)
Disparities a Major and Persistent Problem

• African Americans
  – 2.5 times more likely to develop cancer than whites
  – Men 27% & Women 11% more likely to die from cancer than white men and women

• Asians more likely to develop and die from liver cancer
More Oncologists Over 64 Than Under 40

Oncologists Experiencing Burnout

• Nearly 50% of oncologists experience burnout
• 80% would choose to be oncologist again
• 34% of fellows reported high levels of burnout
• New oncologists desire to work fewer hours than current oncologists
Practice Pressures

- Payer pressures
- Cost pressures
- Competitive pressures
- Drug pricing
- Staffing issues
- Clinical research issues
- Local economic pressures
- Other
- Drug shortages
- Access to genomic testing

Source: ASCO Annual Practice Census 2014
Rough Waters for Practices

- Implementing evidence-based medicine
  - Often not sufficient evidence, but increasing desire for precision medicine
  - Lack of uniform standards for quality & performance

- Economic pressures
- Increasing administrative requirements
- Adjusting to new payment models
  - Greater financial risk
Smaller Community Practices at Risk

- Backbone of U.S. cancer care delivery system
- Serve more than one-third of all new patients, especially in the South
- Smaller practices more likely to merge, sell, or close in the next year
  - 16% (71) Merge
  - 12% (53) Sell
  - 10% (45) Close
Unequal Access to Care

Oncologists Per 100,000 Residents 55 and Older

Sources: CMS Physician Compare and Census Tiger Shapefiles
Especially for Rural America

- 18% of US residents live in rural areas
- 5.5% of oncologists practice in rural areas
- 75% of rural oncology practices are single-site practices

Sources: CMS Physician Compare and Census Tiger Shapefiles
PHYSICIAN PAYMENT REFORM
SGR Rollercoaster

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>Dec 2009:</td>
<td>Congress freezes rates for two months</td>
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<tr>
<td>Mar 2010:</td>
<td>CMS holds claims</td>
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<tr>
<td>Apr 2010:</td>
<td>CMS advises physicians to hold claims</td>
</tr>
<tr>
<td>Jun 2010:</td>
<td>Congress delays cut until November 30</td>
</tr>
<tr>
<td>Nov 2010:</td>
<td>Congress freezes rates for one month</td>
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<tr>
<td>Dec 2010:</td>
<td>Congress delays cut for one year</td>
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<tr>
<td>Feb 2011:</td>
<td>Congress delays cut with 10-month patch</td>
</tr>
<tr>
<td>Feb 2012:</td>
<td>Congress delays cut until Jan 2013</td>
</tr>
<tr>
<td>Jan 2013:</td>
<td>Congress delays cut for one year</td>
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<tr>
<td>Dec 2013:</td>
<td>Congress delays cut until April 1, 2014</td>
</tr>
<tr>
<td>Mar 2014:</td>
<td>Congress delays cut until March 31, 2015</td>
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</tbody>
</table>

**Cumulative cut now ~20%**
Repeal SGR Formula

SGR Repeal and Medicare Provider Payment Modernization Act of 2014

• Bi-partisan, bicameral support of policy
• Supported by physician community
• No agreement on how to pay for it
Ongoing Efforts for SGR Reform

- Current patch expires on March 31, 2015

- House passes H.R. 2 to repeal SGR!!

- Senate action expected next week!

- ASCO will continue efforts to repeal SGR, support the consensus bill and achieve broader reform in Medicare payments
Why Fee For Service Doesn’t Work

- **Low or no payment** for:
  - Patient education
  - Nursing evaluation & care coordination
  - Social work, financial counseling, nutrition
  - Survivorship & palliative care
  - Cost and use of innovative technology

- **Loss of revenue** if fewer or lower cost treatments are given or oral drugs used

- **No payment** for work outside of face to face encounters
On top of that…

The President proposed a **50% cut** in services payment (from ASP+6% to ASP+3%) or 30% (from 4.3%).
Continued Shift From Fee For Service

"...moving away from the old way of doing things, which amounted to 'the more you do, the more you get paid.'"

-Sylvia M. Burwell
HHS Secretary

- 70% Fee-For-Service
- 30% Medicare Advantage

- 70% in 2018
- 30% Medicare Advantage
- 65% in various APMS

*30% of Medicare beneficiaries currently choose MA. Since it has been growing at 10% per year (about 3 percentage points), it's likely to be greater than 30% in 2018. "Virtually all of this "traditional FFS" payment will be tied to quality in some way in 2018." ©2015 Avalere Health, LLC
Will HHS Reforms Make Sense in Oncology?

The Oncology Care Model

- Relies on broken fee for service
- Oncologists cannot control all aspects of spending
- Cancer care does not fit into 6-month episodes
- Seems designed only for large practices
- Only 100 practices can participate
Payment Reform Models Should…

• Be designed by practicing physicians in the field

• Pay fairly for services provided

• Test multiple options so practices can engage in alternative payment models appropriate for their circumstances

• Provide up-front investment to put practices on the path to transformation
CONSOLIDATED PAYMENTS FOR ONCOLOGY CARE

Payment Reform to Support Patient-Centered Care for Cancer

May 2014
Payment Reform Principles

• Multiple, flexible models
• Allow practice evolution
• Facilitate care delivery innovation
• Emphasize comprehensive patient care
• Reward outcomes (over process)
• Reward cost containment
Consolidated Payments for Oncology Care (CPOC)

- Flexible payment
  - Patient centered
  - Better match to services we provide/patients need

- Simpler billing structure

- More predictable revenue

- Incentivize high quality, high-value care

- Support coordinated, patient-centered care
Current vs. Proposed Payments

E&M (new patient)
E&M (established patient)
Consultations
Chemotherapy administration / therapeutic injections / hydration

New patient payment
Treatment month payment
Transition of treatment payment
Active monitoring month payment

6% of ASP+6% could be folded into treatment month payments once an alternative to buy and bill is developed and sufficiently tested.
Continued FFS Payments

- Laboratory tests
- Bone marrow biopsies
- Portable pumps
- Blood transfusions
- (list not all inclusive)
Additional Payment Adjustments

• Quality measures phased in over time

• Pathways, two stages:
  – Adherence
  – Use of certified pathways

• Resource utilization
  – OMH
  – ER and hospital admissions

• Clinical Trials
  – Higher Treatment Month and Non-Treatment Month payments for enrolled patients
Based on Your Feedback: 3 Options

*Payment for Rational Oncology Improvement*

- **Add new codes** to existing E&M codes to cover cost of services
- **Replace E&M codes with monthly payment codes** that provide flexibility in how care is delivered
- **Bundled monthly payments** that include both oncology practice costs and other costs such as tests, avoidable hospitalizations, and/or drugs

Accountability in all three—*but for things oncologists can control*
A Continuum for Practice Transformation

New E&M Codes

Monthly Payments

Bundled Monthly Payments
Status

• Collecting/analyzing clinical/administrative data to better define payment amounts, risk corridors, unpaid services

• Pursuing pilots
  – With multiple practices, diverse settings
  – Outreach to payers (CMS and commercial)

• Pursuing standard performance measures/programs
  – Clinical performance (overuse, underuse)
  – Care processes/management (hospitalizations, ER visits)
  – Outreach to AHIP, NBGH, employers, payers, CMS
We Hear You…and Feel Your Pain

• Rapid escalation in scope of issues

• Volatile practice environment
  – Economic pressures
  – Consolidations, mergers
  – Focus on value
  – Shifting care models
  – Growing administrative burden

• Practices need help
New Department of Clinical Affairs

Helping practices survive and thrive…today AND in the future

• Will be led by a practicing oncologist—priorities, programs to be driven by you

• Hands on help
  – Practice efficiency
  – Staffing models/work flow
  – Quality reporting/QI projects
  – Learning networks
  – Template contracts/agreements

• Information and analysis
  – Practice trends
  – Economic analysis
  – Performance measurement
  – Should I participate in CMMI demo?
• A rapid learning network for oncology practice knowledge – benchmarking and best practices
  – Initial focus on administrative, operational, financial and quality improvement activities
• Peer to peer interactive collaboration for knowledge sharing
• Quarterly benchmarks produced by practice and by physician, compared against national database of similar practices
  – Segmentation across types of practices, cohorts of physicians
• Annual “state of your practice” assessment for key production and cost measurements
• Networking opportunities
  – Peer to peer meetings
    • Optional, not required
    • Agenda driven by practice needs
  – Moderated listserv

• First report and meeting, fall 2015
US Health Spending at 17.7% of GDP is ~50% Greater than Others (and Still Rising)

Projected US Health Spending 2020 → 20% GDP

Higher Spending Does Not Increase Life Expectancy

Health Care Expenditures and Life Expectancy (2005)
Cost of Cancer Care is Rising

→ $125 billion in 2010

→ $175 billion in 2020

Cost estimates expressed in 2010 dollars using CMS cost adjusters and adjusted for out-of-pocket expenditures, including co-payments and deductibles.
Estimates for the population younger than 65 were developed using ratios of cost in the younger than 65 and older 65 populations from studies conducted in managed care populations.
Cancer Care Costs Rising Faster than Overall Healthcare

Source: Blue Cross Blue Shield Association
National Health Expenditures, 2010

Total - $2.594 trillion


Hospitals and Providers a large fraction
Monthly and Median Costs of Cancer Drugs at the Time of FDA Approval
1965 - 2013

- **X-axis**: Year of FDA Approval
- **Y-axis**: Monthly Price of Treatment (2013 Dollars)

Legend:
- **Blue Circle**: Individual Drugs
- **Orange Line**: Median Monthly Price (per 5 year period)
Patients are Bearing More of the Costs

Projected family health insurance premium costs and average household income

- Household Income
- 50 of Household Income
- Family Health Insurance Premiums
- Family Premium + OOP Costs

ASCO’s Efforts to Lower Costs, Increase Value

- Promoting adherence to evidence-based medicine: ASCO Guidelines
- Participating in and promoting “Choosing Wisely”
- Commitment to quality improvement: QOPI
- Working with payers: Integration of quality measures into reimbursement decision-making
- Cultivating a learning healthcare system: CancerLinQ
- Establishing clinically meaningful outcomes in cancer research
- Payment reform
- The Value in Cancer Care Task Force
What is “Value”?

“the regard that something is held to deserve; the importance, worth, or usefulness of something.”

Benefit(s)

Value = (Financial Cost + Non-financial Cost)
ASCO’s Value Initiative

Increasingly cancer care will be assessed on VALUE rather than COST. Yet ASCO has not taken the lead in defining value nor indicated how it should be integrated into treatment decisions.

Desired Outcomes

• There exists a transparent, clinically driven, methodologically sound method for defining and assessing relative value of cancer care options that influences treatment choices, insurance benefits, and research priorities.
• Oncology providers have the skills and tools assess relative value of therapies and use these in discussing treatment options with their patients.
• Patients have ready access to information to help them understand the relative value of treatment options that meet their unique needs.

Value Task Force Charge

• To develop an ASCO framework for comparing the value of various cancer treatments and interventions
ASCO’s Value Framework

- **Focus** is to support informed, shared decision making between doctor and patient.
- **Three primary parameters**: Clinical Benefit, Toxicity, and Cost.
- **Goal** is to develop tool that can customize information for each patient (e.g., importance of side effects vs. clinical benefit, out of pocket cost and other individual considerations).

**Guiding Principles**

- The physician-patient relationship is of central importance in defining management options for the patient.
- To ensure informed decision-making, patients need access to both clinical and cost information about their treatment options.
- As a physician performs his or her primary role as a patient’s trusted advocate, he or she also has a responsibility to be a good steward of healthcare resources.
ASC0’s 2012 Top Five List for Oncology

Question these things before doing them:

1. Use of chemotherapy for patients with advanced cancers who are unlikely to benefit, and who would gain more from a focus on palliative care and symptom management.

2. For early breast cancer, use of advanced imaging technologies (i.e., CT, PET and radionuclide bone scans) in cancer staging.

3. For early prostate cancer, use of advanced imaging technologies (i.e., CT, PET and radionuclide bone scans) in cancer staging.

4. Routine use of advanced imaging and blood biomarker tests for women treated with curative therapy for breast cancer and who have no symptoms of recurrence.

5. Use of white cell stimulating factors for patients who are at low risk for febrile neutropenia.
Choosing Wisely: 2013 Top Five

1. Don't give patients starting on a chemotherapy regimen that has a low or moderate risk of causing nausea and vomiting antiemetic drugs intended for use with a regimen that has a high risk for this effect.

2. Don’t use combination chemotherapy (multiple drugs) instead of single-drug chemotherapy when treating an individual for metastatic breast cancer unless the patient needs urgent symptom relief.
Choosing Wisely: 2013 Top Five

3. Avoid using advanced imaging technologies -- positron emission tomography (PET), CT and radionuclide bone scans -- to monitor for a cancer recurrence in patients who have finished initial treatment and have no signs or symptoms of cancer.
Choosing Wisely: 2013 Top Five

4. Don’t perform PSA testing for prostate cancer screening in men with no symptoms of the disease when they are expected to live less than 10 years.

5. Don’t use a targeted therapy intended for use against a specific genetic abnormality unless a patient’s tumor cells have a specific biomarker that predicts a favorable response to the targeted therapy.
More than two decades ago, the Institute of Medicine defined quality care as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”16 In a subsequent report, “Ensuring Quality Cancer Care,” the IOM further refined the definition to mean care that is delivered in a technically competent manner with strong communication, cultural sensitivity, and shared decision making.17 Advancing access to high-quality, evidence-based care is the fundamental goal of oncology and has been core to ASCO’s mission since the Society first formed in 1964.

Many organizations, including ASCO, have dedicated resources to improved measurement of the quality of care that patients receive, and to improving the quality, consistency, and value of that care. Though these efforts are not new to oncology, they are taking on increased urgency in an environment of practice and payment reform. With the United States now projected to spend $709 billion on cancer care in 2020,18 diverse stakeholders are seeking ways to control spending while preserving or enhancing quality. Oncology professionals play a key role in controlling the costs of cancer care, and the profession has actively engaged in a variety of efforts to manage this growing issue. Further, concerns about cost is driving demand from purchasers, payers and policymakers for clear evidence of value. Performance measurement and improvement programs are necessary components for demonstrating value and, even more importantly, driving forces toward the best possible outcomes for patients facing the life-altering diagnosis of cancer.

This chapter provides insight into the current quality of oncology care, highlights a number of recent efforts to improve quality and cost effectiveness, and describes the potential for “big data” to enhance quality and value in cancer care.

Quality Measurement: Insights from ASCO’s Quality Oncology Practice Initiative

ASCO’s Quality Oncology Practice Initiative (QOPI) was launched in 2006 to promote excellence in cancer care by helping practices create a culture of self-examination and improvement. Offered as a free program to ASCO members, QOPI is an unparalleled opportunity to improve patient care.
What is Quality Cancer Care?

- Patients undergoing technically complex procedures receive care in highly experienced centers.
- Care guided by systematically developed guidelines based on best available evidence.
- Efforts to measure and monitor the quality of care delivered using a core set of quality measures.
- Healthcare systems and physicians accountable for delivering high quality care.

National Cancer Policy Board, 1999
What is Quality Cancer Care?

• Cancer patients receive:
• A care plan that clearly outlines the goals of care;
• Access to clinical trials;
• Care coordination among necessary medical specialists;
• Psychosocial and other supportive care services – particularly timely referral to palliative care specialists and hospice services.

National Cancer Policy Board, 1999
Patients and families receive information about prognosis, treatment goals, palliative care, psychosocial support, and costs.

Patients receive end-of-life care that meets their needs, values, and preferences.

Coordinated and comprehensive patient-centered care.

All individuals caring for cancer patients have core competencies.

Expand the breadth of data collected about older adults.
IOM Report on Quality Cancer Care

• Expand the data collected in research by capture of patient-reported outcomes and health behaviors.
• Develop a learning health care information technology system that enables real-time analysis of data from cancer patients.
• Develop a national quality reporting program for cancer care as part of a learning health care system.
• Implement a national strategy to reduce disparities in access to cancer care for underserved populations.
• Improve the affordability of cancer care by reforming payment and eliminating waste.
Why the Focus on Quality?

- Demand for oncology services
- Workforce issues
- Access to care
- Fragmentation of care
- Cost of care
- Physician payment reform
Quality assessment and improvement program for outpatient hematology-oncology practices – to create a culture of self-examination and improvement

‘If you cannot measure it, you cannot improve it’

‘To measure is to KNOW’
Growth in QOPI Since 2006

QOPI Certification Program

QOPI Certified/Recertified Practices

280 Certifications
May 2014

1 - 2
3 - 4
5 - 6
7 - 8
9+

Hawaii 2
Puerto Rico 1
Alaska 1
Washington, DC 1
What’s In It for Institutions/Practices?

- **GOLD STANDARD** for oncology care
- Aligns with many TJC standards but more oncology relevant
- Ability to market your cancer center’s focus on quality & safety
- Demonstrates to payers adherence to national standards of care
Concordance with Recommendations for Adjuvant Chemotherapy
Chemotherapy in the Last Two Weeks of Life

[Graph showing concordance over collection rounds from Fall 08 to Fall 13.]
Other Areas for Improvement

- Cessation counseling
- Infertility risk
- Fertility preservation
Limitations of QOPI

- Manual
- Retrospective
- Incomplete
- Twice annually
- Incomplete adoption
- Assesses process not outcomes
Evolution to Meet Member Needs

QOPI Certification Program

Current QOPI®

Ability to manual abstract with flexibility of focus
Gateway to QOPI Certification

Improvement Training & Tools

QI Training Class
Virtual learning collaborative
QI Toolbox
PI-CME website

iQOPI

Pilot QOPI to international members in 2013

eQOPI®

Batch upload of data for QOPI reporting in 2014

Deeming

CMS reporting through QOPI in 2014/2015

CancerLinQ Development
CancerLinQ: The Vision

A system in which real-time clinical data is captured, analyzed, and used to enhance patient care and drive scientific discovery.
The treatment experience of 95% of people with cancer is isolated in their individual medical records.

CancerLinQ will collect data, analyze it, create knowledge then provide real-time access for doctors, researchers and patients.
The future of cancer care relies on evidence based, validated systems which enable system wide learning and rapid adoption.
The primary purpose of CancerLinQ is to improve the QUALITY of care and to enhance outcomes; additional benefits include:

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<thead>
<tr>
<th>For Patients:</th>
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<tbody>
<tr>
<td>✷ Improved outcomes</td>
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<tr>
<td>✷ Clinical Trial matching</td>
</tr>
<tr>
<td>✷ Safety Monitoring</td>
</tr>
<tr>
<td>✷ Real time side effect management</td>
</tr>
<tr>
<td>✷ Patient Reported Outcomes</td>
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<th>For Providers:</th>
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<tr>
<td>✷ Real time “second opinions”</td>
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<tr>
<td>✷ Observational and guideline-driven Clinical Decision Support</td>
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<td>✷ Real time access to resources at the point of care</td>
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<td>✷ Quality reporting and benchmarking</td>
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<td>✷ Mining “big data” for correlations</td>
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<tr>
<td>✷ Comparative Effectiveness Research</td>
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<tr>
<td>✷ Hypothesis generating exploration of data</td>
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<tr>
<td>✷ Identifying early signals for adverse events and effectiveness in “off label” use</td>
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Paradigm Shift in Providing Care

**TODAY’S CARE MODEL**

- Providers seek out content
- Care is fragmented and key information is missing
- Research requires years; real-world data are lacking

**TOMORROW’S CancerLinQ MODEL**

- Content comes to providers at point of care
- Complete Longitudinal Data flows between patients and providers
- Learning from every patient becomes a reality; cycle of EBM is dramatically hastened
Paradigm Shift in Technology

TRADITIONAL REGISTRY

Requires Query Writers & Analysts
Form the Query, Get the Data, Use the Data
Structured Data Only
Requires Special Skills

TOMORROW’S CancerLinQ MODEL

Ability to Explore Data Freely
Get ALL Data, Explore the Data, Apply the Data
Structured and Non-Structured Data
Familiar and Intuitive Tools Requiring Minimal Training
GRASSROOTS & STATE ACTIVITIES
State Affiliate Council
ASCO BOD Advisory Group

Requests from ASCO Board

Chair delivers Council recommendations to the Board

Issues Raised by Grassroots

Council members report back to their State Societies
State Efforts Matter

- Visit with members of Congress (home or DC)
- Share your stories
- Supportive letters/messages
- Stay in touch!

Rep. John Carney (DE), Dr. Sandra Swain, and Dr. Stephen Grubbs
Questions?