

# AHCCCS Payment Modernization

## Blog # 8

### Value Based Cancer Care

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April 30, 2015

In the U.S., approximately 14 million people have had cancer, with 1.6 million new cases diagnosed each year. According to the [Institute of Medicine](#) (IOM) the cost of cancer care is increasing faster than many other health care sectors and with the aging of the population, a 45% increase in the number of people developing cancer is expected over the next 15 years.

[Researchers](#) have identified significant payment variation for cancer care among oncology practices even when clinical guidelines are available. The **value** of cancer care in the U.S. is receiving increased attention. According to a [recent study](#), compared to Western Europe, costs for treating cancer here have risen much more steeply over the past 45 years, but U.S. cancer rates have decreased only modestly. To illustrate, in the U.S.,

*...lost quality-adjusted life-years despite additional spending for lung cancer: –\$19,000 per quality-adjusted life-year saved. Our results suggest that cancer care in the United States may provide less value than corresponding cancer care in Western Europe for many leading cancers.*

Clouding the picture, there are differing views on how to calculate cancer treatment outcomes. [Researchers](#) using different measures concluded higher rates of U.S. spending were in fact worth the higher cost. It comes down to the difference between using mortality rates versus survival rates, which is explained really well [here](#).

Cancer care is complicated, and value based delivery and payment models are not as widespread as with many other types of care. However, that may be changing. UnitedHealth in conjunction with MD Anderson recently announced a [bundled payment pilot](#) for head and neck cancer including surgery, radiation, and chemotherapy. Cancer care represents 11 percent of United's commercial plan spending.

*...the pre-priced payment will give patients and their doctors a better idea upfront what the care costs. UnitedHealth also said MD Anderson doctors will get paid more because they are eliminating various inefficiencies by taking on more risk that they can streamline the care, improve quality and eliminate bureaucratic inefficiencies.*

Risk models will not be common until cancer care cost and quality measurement challenges are addressed. Even experts' recommendations such as those from a 2013 [IOM report](#) on cancer reflect these challenges and uncertainties.

*If evaluations of specific payment models demonstrate increased quality and affordability, the Centers for Medicare & Medicaid Services and other payers should rapidly transition from traditional fee-for-service reimbursements to new payment models.*

Despite the challenges, in order to continue to move this very significant component of health care toward value, cancer care payment and delivery arrangements which move away from fee for service will be pursued. Bundled payments seem to be the most popular pathway, as was advocated in a recent [think tank report](#)

*Cancer is well suited for bundled payments because there are well-defined episodes of care; extensive, evidence-based, professional guidelines; and clear process and outcomes measures of the quality of care. Evidence suggests that cancer-payment bundling could produce substantial savings*

According to the [Association for Value-Based Cancer Care](#), another possible route to value based care is the increased use of clinical guidelines and pathways, although the pathways may not include the most high value alternative.

*“To the extent that things are really interchangeable, it’s highly efficient to have pathways that incentivize doctors to use the cheaper of the available interchangeable regimens.”*

But

*Because physicians are largely not equipped to speak about costs, costs rarely direct a shared decision about cancer treatment... Instead, clinical practice may be influenced by the ownership of technology (i.e., radiation machines) that needs to be paid for. “In the case of radiation doubling the cost of care for prostate cancer, the insurers all know that,” he said. “They have the data, yet they have been unwilling to go to case rates or restrain practice.”*

## The Promise of ACOs

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*April 30, 2015*

CMS recently announced the “[Next Generation ACO Model](#)”, which will have higher levels of risk than MSSP and Pioneer models

*The goal of the Model is to test whether strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management, can improve health outcomes and lower expenditures for Original Medicare fee-for-service (FFS) beneficiaries.*

ACOs are widely regarded as a key reform strategy and clearly CMS is committed to ACOs. As the various ACO models evolve, factors important to successful and unsuccessful implementation are being identified. [Examples include](#) methodology for setting of benchmarks, means of recoupment of start-up costs, and [conflicting incentives](#) for different payers.

In a recent [HBR article](#) the author warned that simply integrating providers in an ACO does not necessarily result in efficiencies, although ACOs still offer great potential to reduce fragmentation and reduce costs.

Early Medicare ACO results are mostly positive. Among the research findings on Pioneer ACO savings published in [the NEJM](#):

*Savings were similar in ACOs with financial integration between hospitals and physician groups and those without*

However, it has been a challenge for Medicare ACOs to [contract with other payers](#) for a variety of reasons and as ACOs assume more risk, this can strain the viability of the organization.

Despite these challenges ACOs continue to demonstrate [positive results for Medicaid](#) populations in several states. As the AHCCCS VBP Initiative evolves, **Arizona ACOs** are an increasingly significant part of the value based strategies being implemented by AHCCCS contracted managed care organizations. AHCCCS is developing systems which accommodate the role of ACOs in moving toward value based payment and delivery arrangements.

## Miscellaneous

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[Surgical checklists—high hopes and dashed expectations](#) Researchers looked at whether implementation of a checklist-based quality improvement program called Keystone Surgery was associated with improved 30-day mortality rates, and lower surgical site infection, and wound and other complications rates. Alas, it was not.

[More consumers enrolling in narrow health insurance networks](#) Consumers who bought narrowed-network plans in 2014 reported less satisfaction with their payers than purchasers of broad-network plans did. Few of them switched to broad-network plans, though. Choice has increased, but many consumers remain unaware of network types.

[How Severe is the Shortage of Substance Abuse Specialists?](#) The shortage of specialists threatens to stall a national movement to bring the prevention and treatment of SUD into the mainstream of American medicine at a time when millions of people with addictions have a greater ability to pay for treatment thanks to insurance.