Title Slide: Healthcare Reform and Multilevel Interventions and Research: Big Changes Go Hand-in-Hand with Big Science

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Slide 2: Purpose

To identify, describe, and discuss:

- Some key provisions of the Affordable Care Act (ACA) and federal stimulus bill (ARRA HITECH)
    - New care delivery models
    - New provider payment models
    - Health information technology
- Their impact on cancer care
- Their implications for research

Slide 3: Major Themes and Take-Aways

- Big changes are underway
    - Influencing multiple levels of the health system
    - In fundamental areas
- They will impact cancer care in significant but unpredictable ways
    - Health system is particularly complex and dynamic
    - Unintended responses and consequences likely
- These times, and changes, require "big science"
    - Innovative approaches to and investment in:
        - Multi-level theory, data, methods, and measures
        - Larger, longitudinal studies
        - Mixed methods, not quantitative or qualitative alone
        - Multi-disciplinary research teams

Slide 4: What is a PCMH?

- Purpose is to support and improve primary care, particularly access, patient-centeredness, care coordination and management
- Dozens of specific PCMH definitions and numerous assessment instruments, such as NCQA's
- But, share seven common principles
    - Personal relationships; whole person orientation; team delivery of care; care coordination across specialties, care settings, and time; quality and safety improvement; enhanced access; and, adequate and/or new payment models.

Slide 5: PCMH Activity

- CMS recently announced its support for the Advanced Primary Care demonstration
    - Medicare is joining multi-payer medical home efforts in eight states
- Multi-stakeholder pilots are already underway
    - 27 initiatives in 18 states
- Currently 39 Medicaid-associated PCMH initiatives underway
    - Some Medicaid only and others part of multi-payer efforts

Slide 6: Impact on Cancer Care

- Are primary care providers well suited to serve as a medical home for cancer patients and to coordinate cancer care?
- Can oncology practices and oncologists be a medical home?
    - How do we encourage and support positive aspects of medical homes in oncology practice?
        - E.g., Patient-centered, shared decision-making, care integration and coordination
- How might medical homes effect multi-disciplinary care (MDC) cancer teams?

Slide 7: What is an ACO?

- Couples provider payment and delivery system reforms
    - Attempt to solve "chicken and egg problem"
    - Form of direct contracting between Medicare (or purchasers) and providers, cutting out Medicare plans!
- Purposely designed to be flexible, recognizing:
    - Variation in local markets, such as provider organization and willingness and ability to accept non-FFS payment arrangements

    - Need to experiment with new payment methods
- Broadly defined as a group of providers—primary care, specialists, hospital--that can be *jointly* held accountable for the quality and cost of care for a defined population
    - E.g., Traditional Medicare beneficiaries (Parts A and B)

Slide 8: Possible A C O Configurations

Key points:
In theory, ACO's require a strong primary care base. In this way, some see PCMHs as the foundation of an ACO and/or part of a "medical neighborhood" with specialists and hospitals.
In some cases, primary care physicians could be leading an ACO, as in model 1.
In other cases, more specialist and hospital dominated organizations may lead the ACO, as in models 2-4.

People have hypotheses regarding which one of these models would add the most value—that is maintain or improve quality while reducing total costs.

Finally, no one expects all care to be provided by the ACO and policymakers don't want to prevent Medicare beneficiaries from going to regional tertiary or quaternary facilities, like AMCs or NCI-designated centers. But, if the ACO is being held accountable for the cost and quality of care, they may not want to refer when necessary.
In theory, in the ACO program, patient can go to any facility they want. But, is that as likely if their primary care physicians and specialists have incentives not to do so.

[image]

Figure 1: Possible A C O Configurations, Comprised of Different Provider Organizations in Local and Regional Geographic Areas

Tertiary or Quaternary Care Facility and Associated Specialty Physicians*

*Most care provided by single A C O, but some care will be delivered by other A C Os or regional referral centers like tertiary or quaternary hospitals and their associated specialist, unless strict beneficiary lock-in is utilized.

Four A C O models:

- A C O Model 1
    - Independent Practice Association (I P A) or Primary Care Physician Groups
    - Specialty Groups
    - Hospital
- A C O Model 2
    - Multispecialty Group
    - Hospital
- A C O Model 3

    - Hospital Medical Staff Organization (M S O) or Physician-Hospital Organization (P H O)
- A C O Model 4
    - Organized Delivery System
        - Hospital
        - Employed and Affiliated Physicians
        - Possibly Other Providers, like Post-Acute Care

[End image]

Slide 9: ACO Activity

- First key step for ACO pilot is well underway
    - Notice of Proposed Rule Making (NPRM) for the ACO pilot will be released soon
    - NPRM describes decisions about all aspects of the ACO pilot program, including areas where CMS is still seeking public input
- Great interest in ACO pilot from providers, as well as public and private purchasers

(Section 3022- Shared Savings Program)

Slide 10: Impact on Cancer Care

- More incentive to reduce total cost of care
    - Strength of incentive varies with specific payment model
    - May alter referral patterns within local areas from community hospitals to academic medical centers (AMCs) and NCI- designated cancer centers
- More incentive to meet quality targets
    - Greater need for, and emphasis on risk-adjusted quality measures, to protect against stinting on care
- To what extent will AMCs and NCI-designated cancer centers lead or participate in ACOs?
- Where and how do hospice, nursing homes, and other services and providers fit in?

Slide 11: No Title

[image]

Title: The Debate Over Episode-Based Payments In Oncology
Sub-Title: Can this system replace buy and bill?
Author: By Paul Watson

The New England Journal of Medicine
Health Policy Report
Limits on Medicare's Ability to Control Rising Spending on Cancer Drugs
Peter B Bach, M.D., M.A.P.P.
The Urban Institute

[End image]

Slide 12: Electronic Health Records (EHRs) and Health Information Exchange (HIE)

- Largest investment by federal government in history--approximately $30 billion--to facilitate:
    - EHR adoption, upgrade, and meaningful use (MU) by Medicare and Medicaid providers
    - HIE among providers, patients, and other groups
    - Ultimately aims to increase quality, efficiency, and patient-centered care in a secure environment

Slide 13: Impact on Cancer Care

- Many oncology practices will be implementing, upgrading, and trying to meet MU requirements
    - Very challenging and in the short term may be disruptive to practices or have unintended impacts on quality, safety, and efficiency
- HIE provides new opportunities to share information among oncologists, hospitals, and researchers
    - But, also many technical challenges and concerns about security, privacy, and related legal matters

Slide 14: Implications for Research

- Are PCMH's and ACO's complementary or conflicting? What is their impact on integration, care coordination across the continuum, and outcomes?
    - Patient and community centeredness and engagement
    - Primary care—oncologist—hospital relationships
        - Multi-disciplinary care teams
    - Cancer programs, including linkages between community hospital based programs and AMCs and NCI-designated cancer centers
    - Access, quality, and cost of cancer care

- How do EHRs and HIE fit into PCMHs and ACOs?
    - How important are these components for achieving the aims of PCMHs /ACOs or can their contributions even be separated out?

Slide 15: Implications for Research

- Major delivery system and payment reforms underway are complex, multi-component, multi-level interventions!
    - Methods must match the times
    - Current multi-component, multi-level research tool-kit
        - Some areas of strength and progress, but also serious gaps
    - Need a comprehensive approach
        - Work in one area, or incremental change, is not likely to meet the needs of the field and researchers, OR
        - Diverse policymakers, payers, providers, patients, and the local communities in which they live

Slide 16: Big Changes Go Hand-in-Hand with the Need for Big Science!!

[End Presentation]