AMA
AMERICAN MEDICAL ASSOCIATION

MEMBERSHIP MOVES MEDICINE™

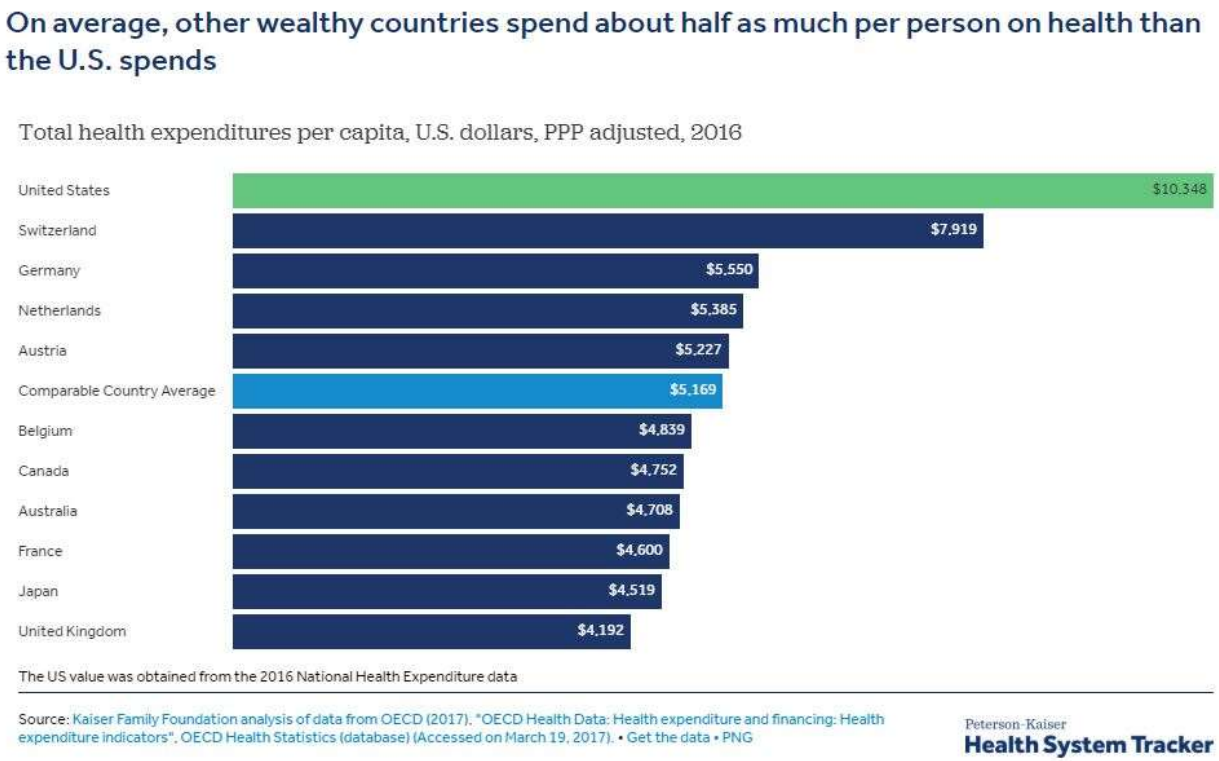
Physician Leadership and the Urgency of the Moment in Medicine

Barbara L. McAneny, MD, MACP, FASCO
Immediate Past President
American Medical Association
July 2019

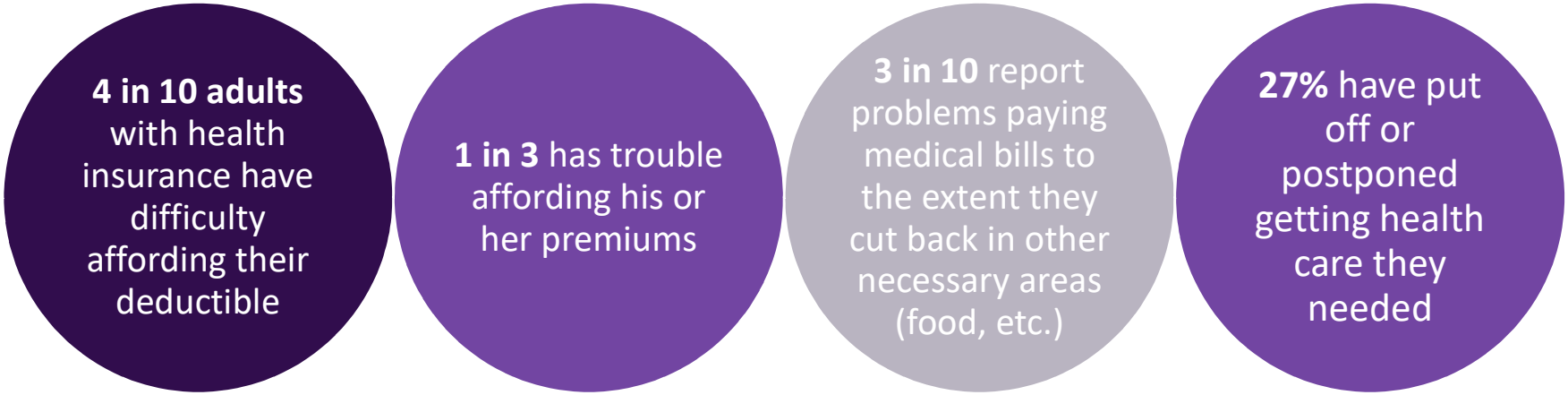
(Some of) the issues defining health care today

- Patients' access to care
- The high cost of care
- Regulatory burdens on physicians
- Increased health care sector consolidation
- The opioid epidemic
- A technology revolution

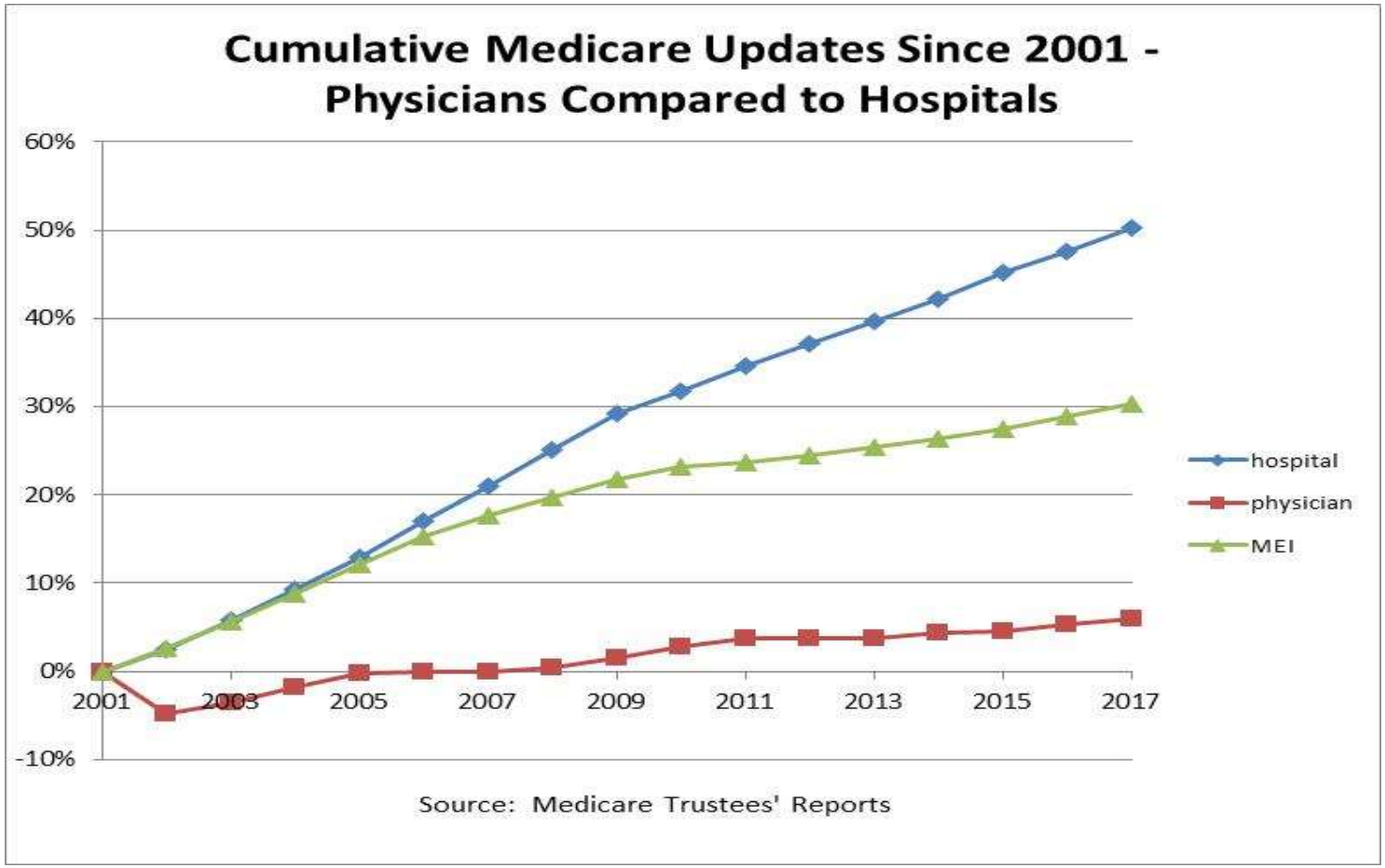
U.S. health care by far most expensive on Earth



Too many priced out of health care in U.S.



AMA | MEMBERSHIP MOVES MEDICINE



Patients often face steep costs for cancer care in hospital settings

- Timely access to affordable, high-quality cancer care is essential.
- Studies indicate increased costs to patients treated at hospital-based clinics compared to community-based clinics.
  - ➢ Some estimates show 20%-39% cost increase regardless of cancer type.
- If this trend continues, it will result in higher costs for patients and payers.

Table 2. Mean PPPM Medical Cost Components in All Matched Patients

	Cost PPPM ($)				
	Community Practice		Hospital-Based Practice		
Cost by patient group	Mean	SD	Mean	SD	*P*
All matched patients	n = 4,450		n = 2,225		
Mean total costs	12,548	10,507	20,060	16,555	< .001
Total medical costs	12,103	10,504	19,471	16,476	< .001
Chemotherapy	4,933	4,983	8,443	10,391	< .001
Branded agents only	6,674	5,046	10,900	10,712	< .001
Generic agents only	2,936	2,585	5,134	6,306	< .001
Combination regimen*	11,080	5,889	19,412	13,869	< .001
Physician visits	765	1,607	3,316	4,399	< .001
Radiation	1,095	4,153	1,430	4,904	< .001
Inpatient	1,178	6,229	1,498	7,193	.0095
ED visits	121	501	168	620	< .001
Outpatient	3,838	3,681	3,912	5,698	< .001
Other	174	2,405	704	3,353	< .001
Total pharmacy costs	445	1,239	589	1,934	.2708
Patients with breast cancer	n = 2,996		n = 1,498		
Mean total costs	11,599	8,129	19,279	14,358	< .001
Total medical costs	11,139	8,139	18,667	14,403	< .001
Chemotherapy	4,671	4,577	8,206	9,719	< .001
Branded agents only	5,608	4,273	9,279	7,805	< .001
Generic agents only	2,982	2,275	5,084	5,591	< .001
Combination regimen*	11,511	5,647	21,240	13,356	< .001
Physician visits	820	1,813	3,499	4,564	< .001
Radiation	378	1,305	440	1,493	.0561
Inpatient	735	4,230	874	3,804	.0415
ED visits	120	516	162	638	.0045
Outpatient	4,318	3,835	4,735	6,322	.2696
Other	97	718	752	3,461	< .001
Total pharmacy costs	461	1,361	612	1,699	.1084
Patients with lung cancer	n = 952		n = 476		
Mean total costs	17,566	17,436	26,980	25,386	< .001
Total medical costs	17,168	17,380	26,389	25,090	< .001
Chemotherapy	5,095	5,916	8,430	11,143	< .001
Branded agents only	7,969	4,967	7,881	5,974	.8408
Generic agents only	1,856	1,829	3,964	5,248	< .001
Combination regimen*	10,937	6,422	16,938	14,378	< .001
Physician visits	709	1,130	3,015	4,217	< .001
Radiation	3,255	7,845	4,343	8,798	< .001
Inpatient	2,767	10,612	3,413	12,982	.4836
ED visits	140	509	219	670	.0026
Outpatient	3,137	3,155	2,404	3,538	< .001
Other	133	947	506	2,120	< .001
Total pharmacy costs	398	950	591	2,828	.7058

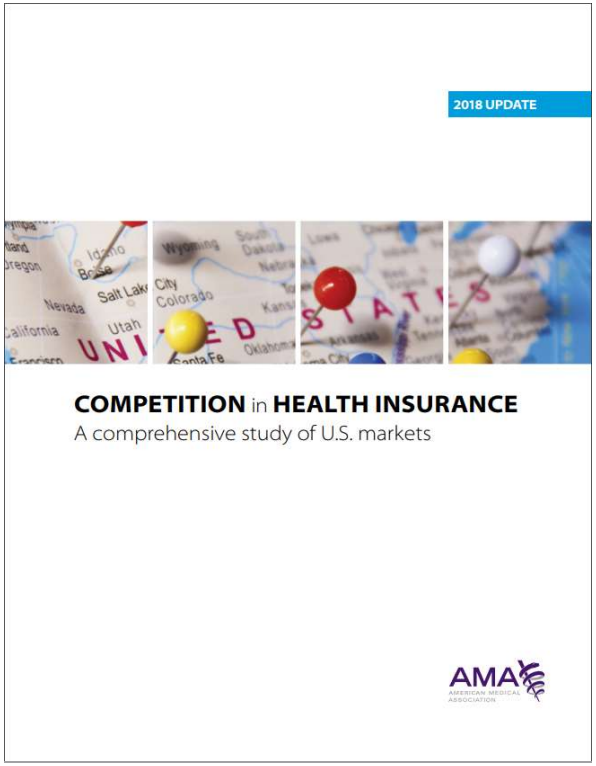
Source: 2018 report by the American Society of Clinical Oncology

The Site of Service Dilemma

- AMA longstanding policy supports equitable payments across outpatient sites of service.
- AMA policy urges private payers to implement coverage policies that do not unfairly discriminate between hospitals and private outpatient facilities.
- AMA advocates for reforms that promote improved patient access to high-quality and cost-effective care based on payment rates sufficient to cover the cost of sustainable medical practices.

Commercial health insurance market is becoming less competitive

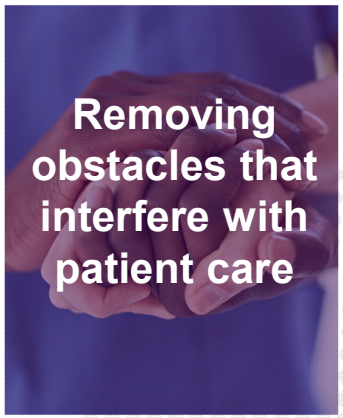
- Anthem is the dominant player, with the top market share in 75 MSAs
- Health Care Service Corp. ranks second, with a market share lead in 40 MSAs, followed by UnitedHealth Group (27 MSAs)
- North Dakota, Alaska, Louisiana, Indiana and Utah lost the most competition between 2016 and 2017



AMA | MEMBERSHIP MOVES MEDICINE

History in the making at the AMA

AMA: The physician's powerful ally in patient care



AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Efforts to protect patient access to care

Texas v. Azar:

What's at stake:

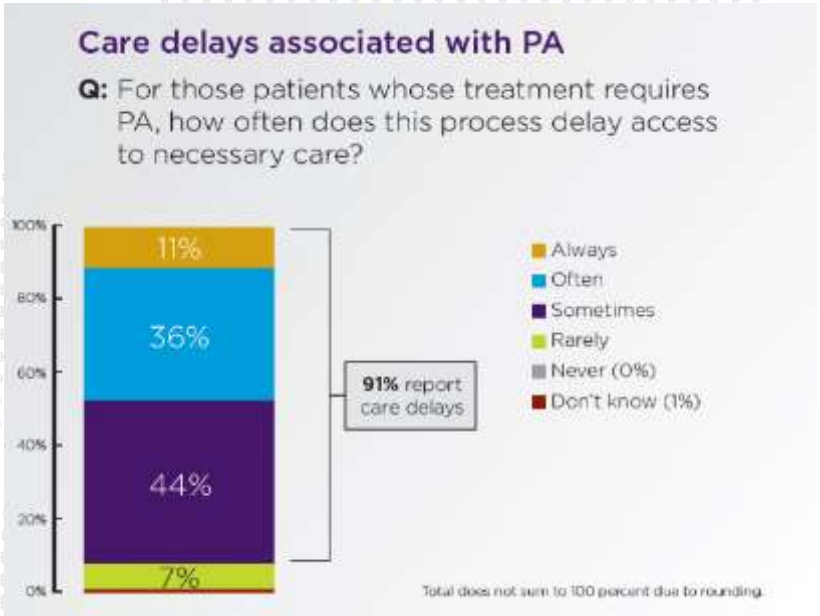
- Pre-existing condition protections
- Coverage for children until age 26
- Insurers no longer held to 85% medical loss ratio
- 100% coverage for certain preventive services would cease
- Annual and life-time dollar limits could be reinstated, leading to more bankruptcies

AMA filed an amicus brief in opposition to plaintiff arguments and is working to reverse the December 2018 district court decision.

Prior authorization

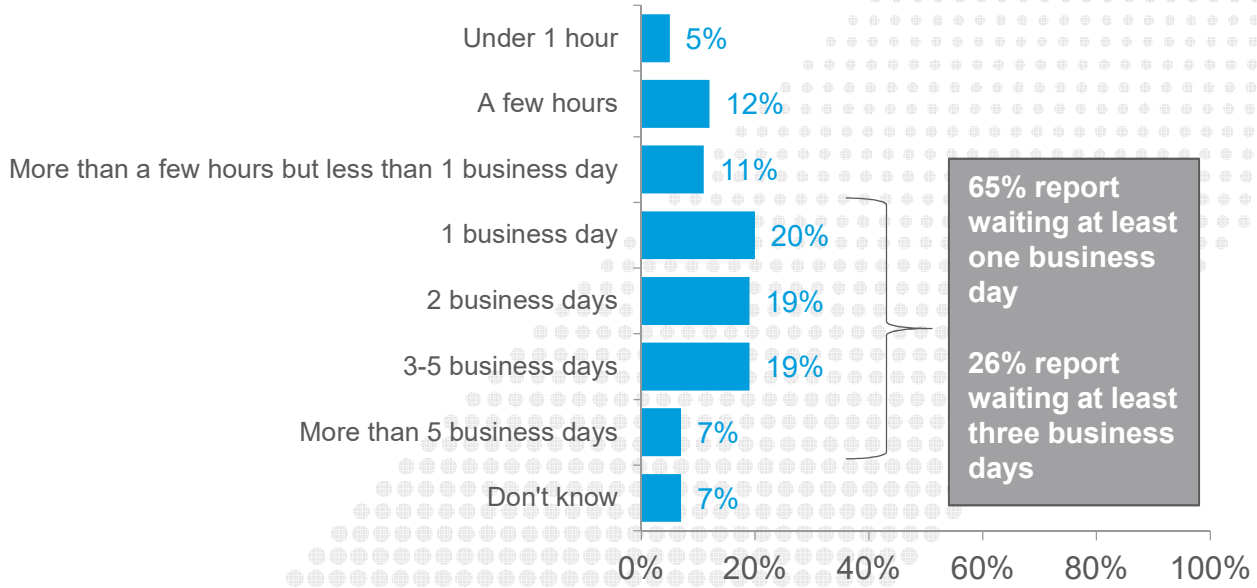
What we're doing about it:

- Working directly with national partners and the insurance industry to "right-size" prior authorization
- Pushing state legislation to address prior authorization and step therapy and advocating to national policymaking organizations for regulation of these programs and entities
- Creating new resources to help practices streamline prior authorization
- Increasing awareness of the issue – fixpriorauth.org



Average prior authorization response wait time

Question: In the last week, how long on average did you and your staff need to wait for a PA decision from health plans?

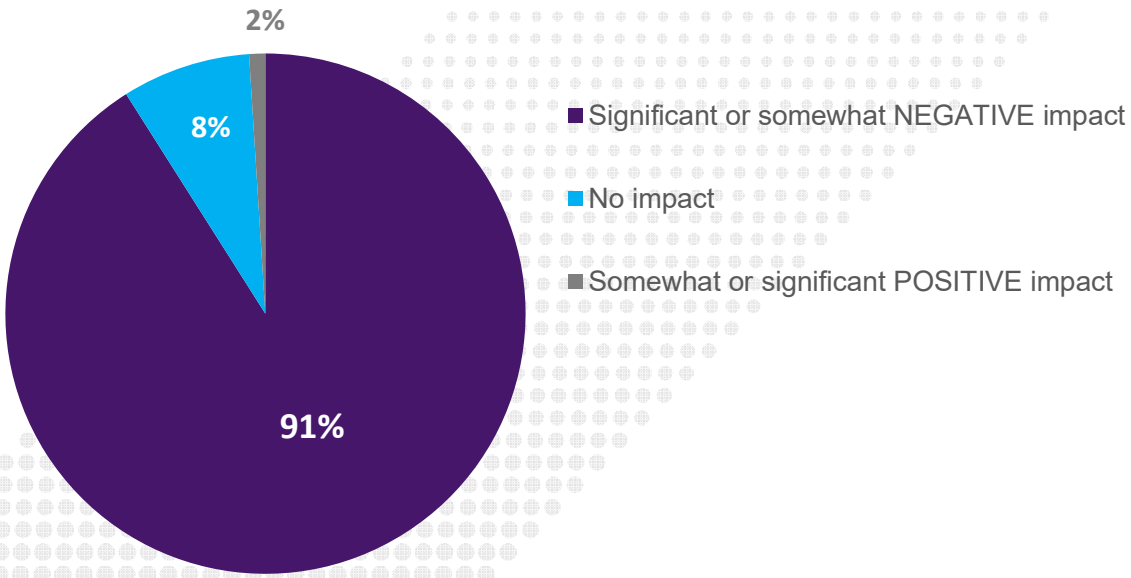


Source: 2018 AMA Prior Authorization Physician Survey

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Impact of prior authorization on clinical outcomes

Question: For those patients whose treatment requires PA, what is your perception of the overall impact of this process on patient clinical outcomes?



Source: 2018 AMA Prior Authorization Physician Survey

Total does not equal 100% due to rounding.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Consensus statement on improving prior authorization

- Released in **January 2018** by the AMA, American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group Management Association
- Five "buckets" addressed:
  - Selective application of PA
  - PA program review and volume adjustment
  - Transparency and communication regarding PA
  - Continuity of patient care
  - Automation to improve transparency and efficiency
- **GOAL**: Promote safe, timely, and affordable access to evidence-based care for patients; enhance efficiency; and reduce administrative burdens

Consensus Statement on Improving the Prior Authorization Process

Our organizations represent health care providers (physicians, pharmacists, medical groups, and hospitals) and health plans. We have partnered to identify opportunities to improve the prior authorization process, with the goals of promoting safe, timely, and affordable access to evidence-based care for patients; enhancing efficiency; and reducing administrative burdens. The prior authorization process can be burdensome for all involved—health care providers, health plans, and patients. Yet, there is wide variation in medical practice and adherence to evidence-based treatment. Communication and collaboration can improve stakeholder understanding of the functions and challenges associated with prior authorization and lead to opportunities to improve the process, promote quality and affordable health care, and reduce unnecessary burdens.

The following five areas offer opportunities for improvement in prior authorization programs and processes that, once implemented, can achieve meaningful reform.

1. **Selective Application of Prior Authorization.** Differentiating the application of prior authorization based on provider performance on quality measures and adherence to evidence-based medicine or other contractual agreements (i.e., risk-sharing arrangements) can be helpful in targeting prior authorization requirements where they are needed most and reducing the administrative burden on health care providers. Criteria for selective application of prior authorization requirements may include, for example, ordering/prescribing patterns that align with evidence-based guidelines and historically high prior authorization approval rates.

   We agree to:

   - *Encourage the use of programs that selectively implement prior authorization requirements based on stratification of health care providers' performance and adherence to evidence-based medicine*
   - *Encourage (1) the development of criteria to select and maintain health care providers in these selective prior authorization programs with the input of contracted health care providers and/or provider organizations; and (2) making these criteria transparent and easily accessible to contracted providers*

1

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

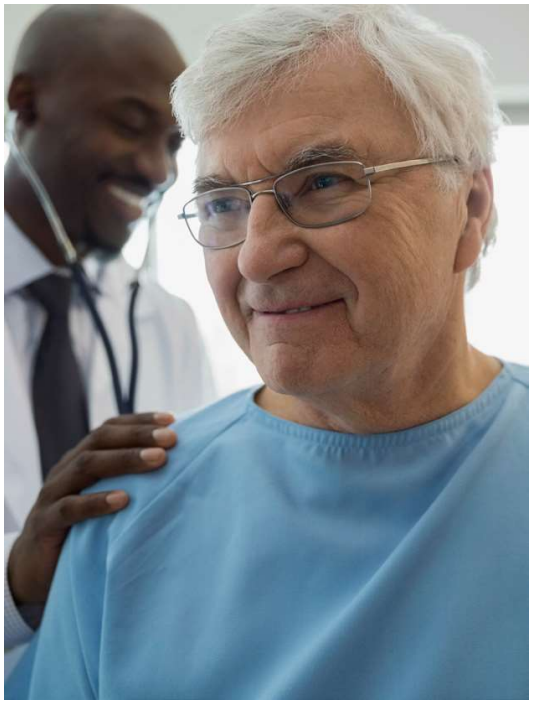
Opportunities for prior authorization reform

- Regulation of pharmacy benefit managers
- Health insurance transparency efforts
- Movement toward value-based purchasing
- Access to treatment for opioid use disorder
- Enforcement of mental health parity
- CMS activity/interest

MACRA/QPP: An opportunity for more personalized care for patients

AMA | MEMBERSHIP MOVES MEDICINE

Medicare physician payment reform



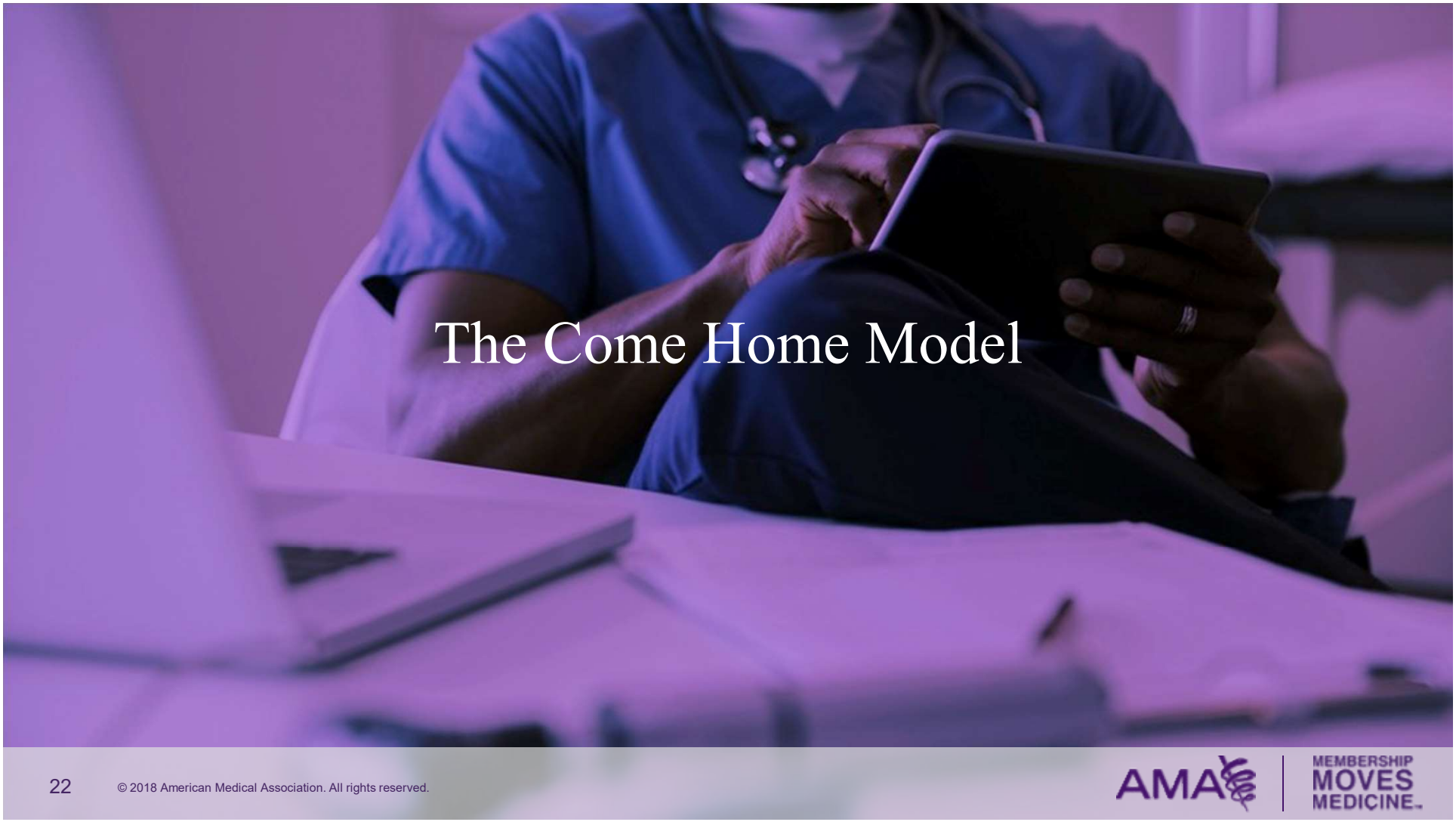
What we're doing about it:

- Advocating for payment system changes that support improvements in care rather than simply add new administrative burdens.
- Working to simplify administrative requirements in payment models to improve professional satisfaction.
- Expanding payment model options for physicians in all specialties.
- Developing simple, straightforward educational material to help physicians succeed under new payment models.

Analysis of 2017 Medicare Shared Savings Program (MSSP)

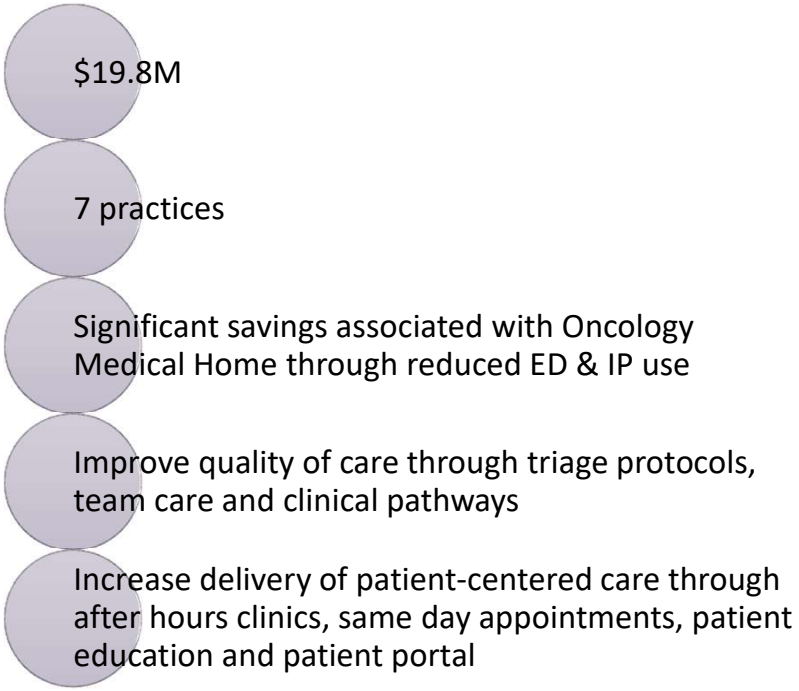
- 472 ACOs in the MSSP spent nearly $1.1 billion less than “benchmark” spending levels.
- $799 million given back to 162 of ACOs in shared savings bonuses.
- 16 Track 2 & 3 ACOs paid penalties to CMS totaling $57 million.
- Net savings for CMS: **$313.7 million on the MSSP**
- **Is this a lot of savings?**
  - Just **$36** for each of nearly 9 million ACO beneficiaries
  - Only **.33%** of total ACO spending ($95 billion)
- Downside risk: ACOs spent **$254 more** per beneficiary than upside ACOs even after "saving" money for Medicare

Source: Harold D. Miller, Center For Healthcare Quality & Payment Reform



AMA | MEMBERSHIP MOVES MEDICINE

CMS/CMMI Grant



Summary of Findings

NMCC Post-COME HOME compared with NMCC in the Pre-COME HOME period:

- 35.9% drop in % of patients with ED Visits
- 43.1% drop in % of patients with IP Admissions
- 23.8% drop in inpatient days
- $4,784.08 (22.4%) drop in six month total cost of care

NMCC Post-COME HOME compared with contemporaneous data from the Albuquerque MSA:

- COME HOME patients are 50.2% as likely to have an ED Visit
- COME HOME patients are 43.6% as likely to have an IP Admission
- COME HOME patients spend 2.71 fewer days in the hospital
- COME HOME patients cost Medicare $2,149.28 (11.5%) less

COME HOME results: avoided ED visits and IP admissions

- 1,223 same day visits (SDAs) per month
  - Of those, 245 (20%) would have gone to the ED
  - Of those, 152 (62.3%) would have been admitted
- Average encounter costs (CH data):
  - SDA: $108
  - ED encounter: $1,034
  - IP Admission: $9,878
- Total monthly savings (estimate): $1.6M
  - Approximately $175K per practice per month

NORC 3rd Annual Report Outcomes

Overall Impact of COME HOME (all on per quarter basis)

- ED visits reduced by 13 per 1,000 patients
- Ambulatory Care Sensitive (ACS) hospitalizations reduced by 3 per 1000
- Average Cost lowered by $612 per patient
- Significant decreases in costs of care in last 30-180 days of life: $959 lower in last 30 days, $3346 in last 90 days, $5790 in last 180 days of life

By Cancer Type (per quarter basis)

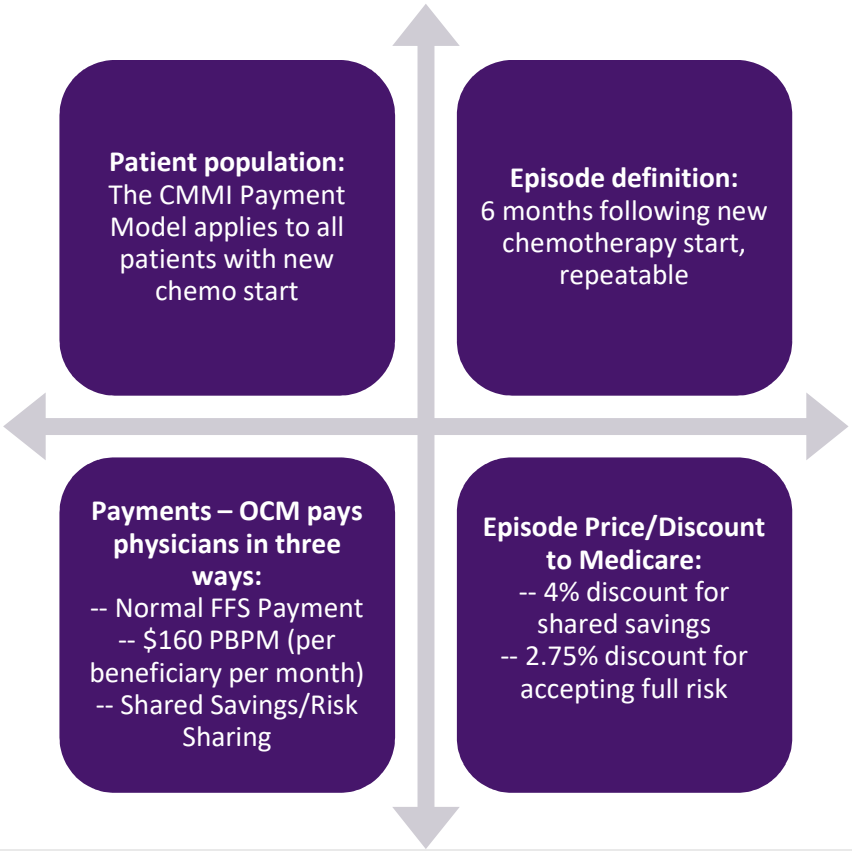
Most differences no longer significant because of smaller sample size and high variation

- ED Visits lower: breast (23 per 1,000)
- Average Cost of Care lower: breast ($717)
- IP stays higher: Colon (28 per 1,000)

Published March 2017

AMA | MEMBERSHIP MOVES MEDICINE

The Oncology Care Model (OCM)



OCM: At a glance

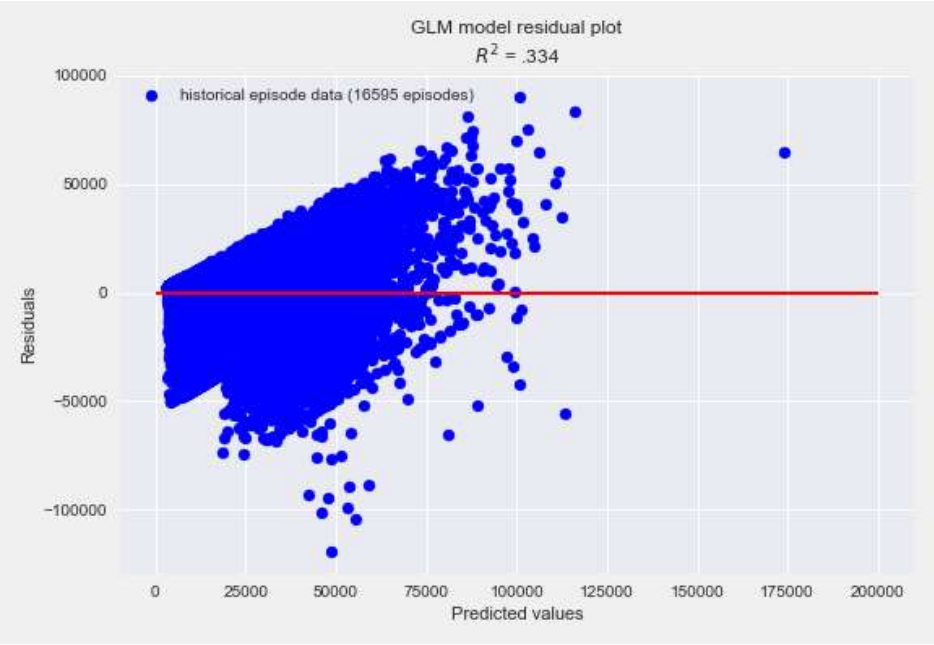
The Good

- Improved patient care
- Earlier Intervention
- Fewer hospital/emergency department visits

The Bad

- Documentation burdens
- EHRs lack sufficient care coordination
- Inadequate payment rates
- Lack of support for patient education, counseling, support services
- Access inequalities
- Chemo drugs inadequately reimbursed

What's Problematic About the OCM: Target Calculation



- 16K historical episode data (2012-2015) from CMS
- Residual Value : OCM model predicted value - actual values for each historical episode
- Residual Plot: Scatter Plot of Residual vs Predicted Value
- If the points are not randomly dispersed across the red line, than a linear regression model is inappropriate. R-squared =0.334
- Time and Clinical data are not included in the model -> Residual plot not randomly dispersed around the red line.

Community Oncology Alliance survey

Findings and updates since Performance Period 1

- Change in trend factor
- HRR relative cost could lead to rebasing of target prices
- COA letter proposed alternative solution to avoid the risk of rebasing; adopted by Medicare

Significant methodology changes implemented in OCM for first true up are favorable

- Proportion of spend on novel therapies increased
- Changes to geographic adjustment
- Adjustments for bone marrow transplant, cancer related surgery, clinical trials

Performance Period 2

Attribution – 7 responses

- Averaged 79% more patients than CMMI
- Highest = 364% more than CMMI
- Lowest = <1% less than CMMI\

Biggest issues so far:

- Patient attributed to different care team
- Part D

Performance Based Payment

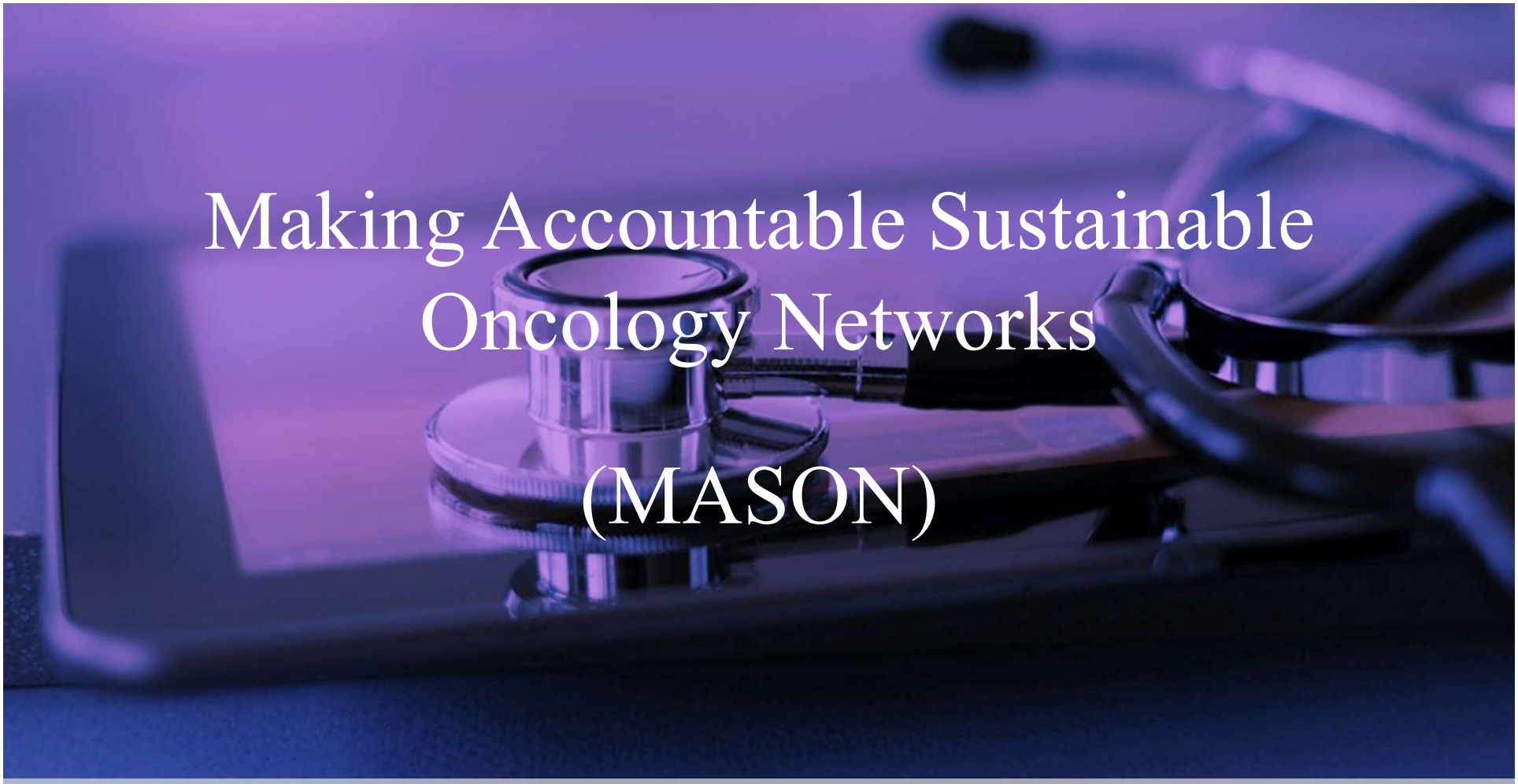
- 42 survey responses
- 31% received PBP
- 69% did not receive PBP

Amounts – average per MD

- $14,797 + PBP

New findings since PP2

- **Per CMMI, shared savings increased: 25% in PP1 -> 33% in PP2**
  - Anecdotally, seeing improvements in practices relative to benchmark
- **Trend factor: medical cost inflation continues, trend factor increased in PP2**
- **Novel therapy spend increased in non-OCM comparison group to 17.8%**
- **Moving forward, significant structural changes when implanted in novel therapy list**
  - Specifically to account for doublets and complex I/O regimens
  - Following more granular, complex, clinical logic per FDA indication



Making Accountable Sustainable Oncology Networks

(MASON)

AMA | MEMBERSHIP MOVES MEDICINE

MASON

Transition from volume to value

Builds on COME HOME, OCM, FFS, APC, and DRGs

Oncology Payment Category (OPC)-Accurate Cost Target modeled on above methodology

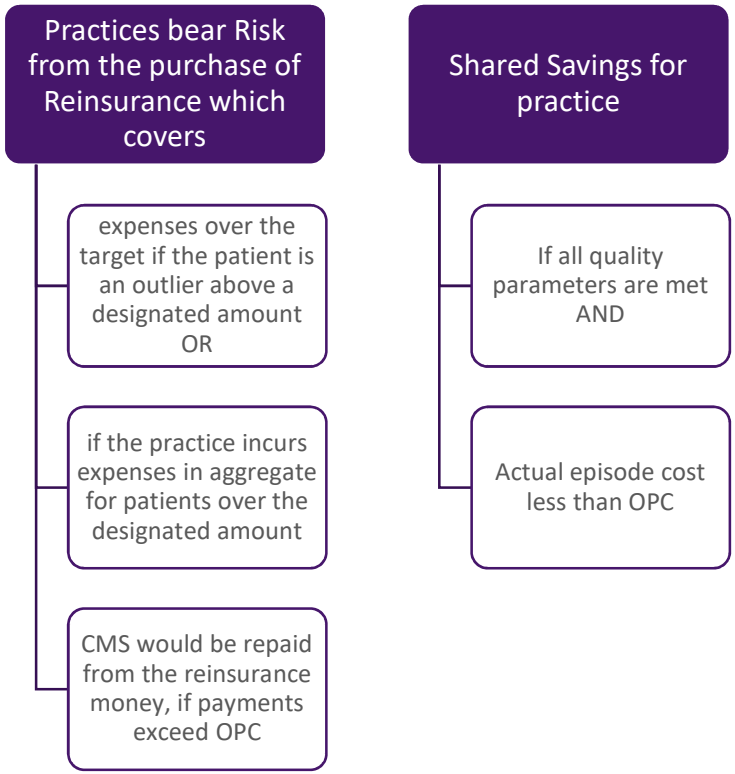
Tight-knit relationship between Patient ,Care team- (physicians, caregivers and family)

Personalized care plan based on multiple factors

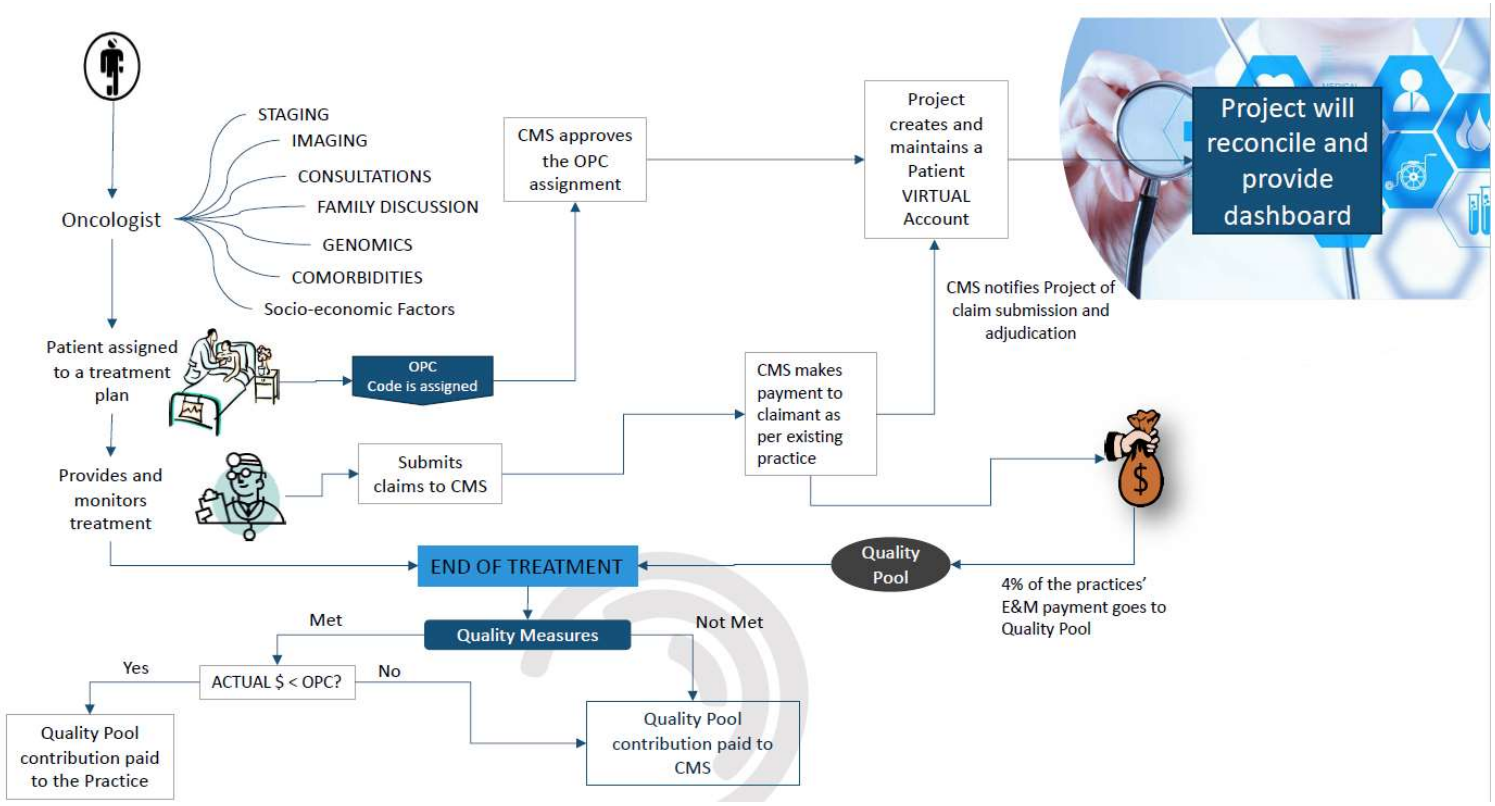
Uses Cognitive computing Platform (CCP) for best Diagnostic and Therapeutic Pathways (DTP)

2% of OPC is reserved for a quality pool

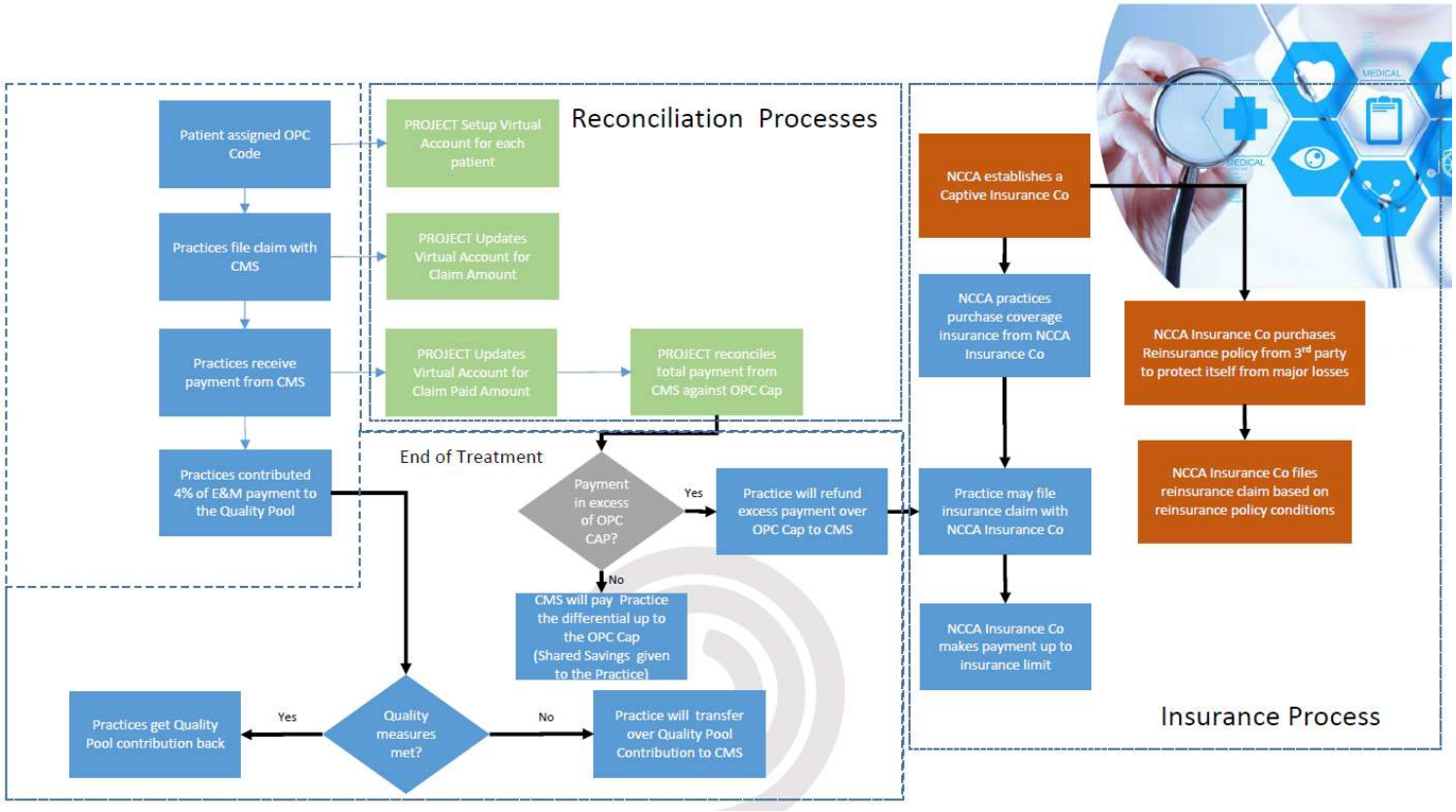
MASON: Practice Risks and Savings



The MASON model



MASON workflow



Frank Alexander Clark, MD
Member since 2003

How do YOU move medicine?

MembershipMovesMedicine.com
#MembersMoveMedicine

AMA | MEMBERSHIP MOVES MEDICINE


AMA
AMERICAN MEDICAL
ASSOCIATION