WIN-WIN-WIN APPROACHES TO ACCOUNTABLE CARE Engaging All Physicians to Reduce the Total Cost of Care in Oregon

Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform

www.CHQPR.org
Healthcare Costs Are Too High and Outpace Inflation

Employer-Sponsored Family Insurance Premiums, 2002-2013

- U.S. Premiums
- Inflation

Premiums $4,100 Higher Than Inflation
($24,000 extra over 10 years)
Oregon Costs Are Only Marginally Better Than U.S.
How Do You Reduce/Control Total Spending on Healthcare?

TODAY

Payer Spending

Total Spending for a Group of Patients

FUTURE

Payer Savings

Total Spending for a Group of Patients

NOTE: Graph is not drawn to scale
Create an ACO!
(or a CCO, or a CIN, or…)

TODAY

Total Spending for a Group of Patients

Payer Spending

FUTURE

Payer Savings

Total Spending for a Group of Patients

Payer Spending

Accountable Care Organization (ACO)

Coordinated Care Organization (CCO)

Clinically Integrated Network (CIN)

NOTE: Graph is not drawn to scale
But What Will The ACO/CCO/CIN Actually *DO* to Reduce Spending?

**TODAY**

- Total Spending for a Group of Patients

**FUTURE**

- Payer Savings

**Accountable Care Organization (ACO)**

- Which services will be reduced or eliminated?
- Will cutting services harm patients?
- Will physicians cooperate or are new forms of prior authorization needed?

**NOTE:** Graph is not drawn to scale

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Traditional Actuarial Breakdowns of Spending Aren’t Very Helpful

NOTE: Graph is not drawn to scale

Which categories can be reduced?
And how would that be done?

TODAY

FUTURE

Payer Savings

Spending Per Patient

Total Spending for a Group of Patients

Payer Spending

Other
Drugs
Physicians
Hospitals

Total Spending for a Group of Patients
More Detailed Breakdowns By Type of Service Don’t Help Much

Which categories can be reduced?
And how would that be done?

NOTE: Graph is not drawn to scale

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The Key Information Needed: Where is the Avoidable Spending?

TODAY

Avoidable Spending

Total Spending for a Group of Patients

Necessary and Appropriate Services

FUTURE

Payer Savings

Total Spending for a Group of Patients

Payer Spending

Payer Spending

NOTE: Graph is not drawn to scale

Necessary and Appropriate Services

Avoidable Spending

• Non-urgent ER visits
• Avoidable admissions for chronic disease
• Unnecessary tests
• Unnecessary surgeries
• Preventable infections and complications
Reducing Avoidable Spending Saves $ Without Hurting Patients

**TODAY**

- **Avoidable Spending**
  - Non-urgent ER visits
  - Avoidable admissions for chronic disease
  - Unnecessary tests
  - Unnecessary surgeries
  - Preventable infections and complications

- **Payer Spending**

**FUTURE**

- **Payer Savings**
- **Avoidable Spending**
  - Lower Spending Without Rationing
  - Necessary and Appropriate Services

**Spending Per Patient**

- **Total Spending for a Group of Patients**
  - Necessary and Appropriate Services
  - Avoidable Spending

**NOTE:** Graph is not drawn to scale

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Reducing Avoidable Spending Can Allow More of the Good Services

- Non-urgent ER visits
- Avoidable admissions for chronic disease
- Unnecessary tests
- Unnecessary surgeries
- Preventable infections and complications

NOTE: Graph is not drawn to scale

TODAY

Avoidable Spending

Necessary and Appropriate Services

FUTURE

Avoidable Spending

Necessary and Appropriate Services

Payer Savings

Lower Spending Without Rationing

Payer Spending

Spending Per Patient

Total Spending for a Group of Patients

Payer Spending

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Reducing Avoidable Spending Can Allow More of the Good Services

TODAY

<table>
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FUTURE

<table>
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<tr>
<td>Avoidable ER visits</td>
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How Do You Find Avoidable Spending to Reduce?

- Non-urgent ER visits
- Avoidable admissions for chronic disease
- Unnecessary tests
- Unnecessary surgeries
- Preventable infections and complications

Payer Spending

Necessary and Appropriate Services

Rationing

Appropriate Services

NOTE: Graph is not drawn to scale
Start by Looking at the Health Conditions Affecting Patients…

TODAY

Total Spending for a Group of Patients

- Chronic Diseases (Diabetes, Heart Failure, COPD)
- Back/Joint Pain
- Cancer
- Maternity
- Other

Payer Spending

Spending Per Patient

NOTE: Graph is not drawn to scale
Identify the *Avoidable* Spending Within Each Condition

NOTE: Graph is not drawn to scale

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Avoidable Spending:
- Back/Joint Pain
- Chronic Diseases
- Cancer
- Maternity
- Other
Example: Avoidable Costs for Chronic Disease Patients

- ER visits for exacerbations
- Hospital admissions and readmissions
- Amputations, blindness

NOTE: Graph is not drawn to scale.
Example: Avoidable Costs for Back, Knee, and Hip Pain

TODAY

Spending Per Patient

Total Spending for a Group of Patients

Payer Spending

Avoidable $
Other

Avoidable $
Maternity

Avoidable $
Cancer

Avoidable $
Back/Joint Pain

Avoidable $
Chronic Diseases

• Unnecessary surgery
• Use of unnecessarily-expensive implants
• Infections and complications of surgery
• ER visits for exacerbations
• Hospital admissions and readmissions
• Amputations, blindness

NOTE: Graph is not drawn to scale
Example: Avoidable Costs in Cancer Care

- Use of unnecessarily-expensive drugs
- ER visits/hospital stays for dehydration and avoidable complications
- Fruitless treatment at end of life
- Late-stage cancers due to poor screening
- Unnecessary surgery
- Use of unnecessarily-expensive implants
- Infections and complications of surgery
- ER visits for exacerbations
- Hospital admissions and readmissions
- Amputations, blindness
Example: Avoidable Costs for Maternity Care

NOTE: Graph is not drawn to scale

- Overuse of C-Sections
- Early elective deliveries
- Low birthweight due to poor prenatal care
- Use of hospitals instead of birth centers
- Use of unnecessarily-expensive drugs
- ER visits/hospital stays for dehydration and avoidable complications
- Fruitless treatment at end of life
- Late-stage cancers due to poor screening
- Unnecessary surgery
- Use of unnecessarily-expensive implants
- Infections and complications of surgery
- ER visits for exacerbations
- Hospital admissions and readmissions
- Amputations, blindness
And Many Other Opportunities

NOTE: Graph is not drawn to scale

Spending Per Patient

Total Spending for a Group of Patients

Avoidable $
Other
Avoidable $
Maternity
Avoidable $
Cancer
Avoidable $
Back/Joint Pain
Avoidable $
Chronic Diseases

Payer Spending

TODAY

- Unnecessary/avoidable services
- Overuse of C-Sections
- Early elective deliveries
- Low birthweight due to poor prenatal care
- Use of hospitals instead of birth centers
- Use of unnecessarily-expensive drugs
- ER visits/hospital stays for dehydration and avoidable complications
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- Late-stage cancers due to poor screening
- Unnecessary surgery
- Use of unnecessarily-expensive implants
- Infections and complications of surgery
- ER visits for exacerbations
- Hospital admissions and readmissions
- Amputations, blindness

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Lower Avoidable Spending Saves Money Without Hurting Patients

NOTE: Graph is not drawn to scale.
How Do You Reduce Avoidable Spending?

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FUTURE

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Payer Savings

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NOTE: Graph is not drawn to scale.
Only Physicians Know How to Change Care to Reduce Costs

NOTE: Graph is not drawn to scale

TODAY

Total Spending for a Group of Patients

Spending Per Patient

Avoidable $

Other

Avoidable $

Maternity

Avoidable $

Cancer

Avoidable $

Back/Joint Pain

Avoidable $

Chronic Diseases

FUTURE

Physicians

Avoidable $

Other

Physicians

Avoidable $

Maternity

Physicians

Avoidable $

Cancer

Physicians

Avoidable $

Back/Joint Pain

Physicians

Avoidable $

Chronic Diseases

Payer Savings

Payer Spending

Payer Spending

Back/Joint Pain

Chronic Diseases

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Primary Care Can’t Do It Alone

NOTE: Graph is not drawn to scale

Payer Spending

TODAY

Total Spending for a Group of Patients

Avoidable $ Other

Avoidable $ Maternity

Avoidable $ Cancer

Avoidable $ Back/Joint Pain

Avoidable $ Chronic Diseases

Primary Care?

Payer Savings

FUTURE

Payer Spending

Avoidable $ Other

Primary Care?

Avoidable $ Maternity

Primary Care?

Avoidable $ Cancer

Primary Care?

Avoidable $ Back/Joint Pain

Primary Care?

Avoidable $ Chronic Diseases

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Specialists Must Also Be Included

NOTE: Graph is not drawn to scale

Spending Per Patient

Total Spending for a Group of Patients

TODAY

Avoidable $

Other

Avoidable $

Maternity

Avoidable $

Cancer

Avoidable $

Back/Joint Pain

Avoidable $

Chronic Diseases

FUTURE

Payer Savings

Avoidable $

Other

Avoidable $

Maternity

Avoidable $

Cancer

Avoidable $

Back/Joint Pain

Avoidable $

Chronic Diseases

• Other Specialties
  • Primary Care

• OB-GYN
  • Primary Care

• Oncology
  • Gastroenterology
  • Primary Care

• Orthopedics
  • Neurosurgery
  • Primary Care

• Endocrinology
  • Cardiology
  • Pulmonology
  • Primary Care

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An ACO/CCO Could Facilitate These Changes…

TODAY

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ACO/CCO/CIN

Avoidable $

Other

Avoidable $

Maternity

Avoidable $

Cancer

Avoidable $

Back/Joint Pain

Avoidable $

Chronic Diseases

FUTURE

<table>
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Avoidable $

Other

Avoidable $

Maternity

Avoidable $

Cancer

Avoidable $

Back/Joint Pain

Avoidable $

Chronic Diseases

NOTE: Graph is not drawn to scale

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But They Can Also Be Pursued Separately for Many Conditions

NOTE: Graph is not drawn to scale

- Back/Joint Pain
  - Orthopedics
  - Neurosurgery
  - Primary Care
  - Avoidable $

- Chronic Diseases
  - Endocrinology
  - Cardiology
  - Pulmonology
  - Primary Care
  - Avoidable $

- Cancer
  - Oncology
  - Gastroenterology
  - Primary Care
  - Avoidable $

- Maternity
  - OB-GYN
  - Primary Care
  - Avoidable $

- Other Specialties
  - Primary Care
  - Other
  - Avoidable $

- Other
The Problem:
The Current Payment System

NOTE: Graph is not drawn to scale

- Back/Joint Pain
- Chronic Diseases
- Cancer
- Maternity
- Other

Avoidable $ for:

- Back/Joint Pain
- Chronic Diseases
- Cancer
- Maternity
- Other

Payer Spending

FEE FOR SERVICE PAYMENT

Payer Savings

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It’s Not a Lack of “Incentives,” But *Barriers* in Fee-for-Service

$\begin{array}{c}
\text{AVOIDABLE SPENDING} \\
\text{DESIRABLE SPENDING} \\
\text{FEE FOR SERVICE PAYMENT} \\
\text{AVOIDABLE SPENDING} \\
\text{DESIRABLE SPENDING} \\
\text{SAVINGS}
\end{array}$
Barrier #1: No $ or Inadequate $ for High-Value Services

No Payment or Inadequate Payment for:
- Physical examination, diagnosis, and evaluation of test results
- Services delivered outside of face-to-face visits with clinicians, e.g., phone calls, e-mails, etc.
- Services delivered by non-clinicians, e.g., nurses, community health workers, etc.
- Consultation and coordination with other physicians/providers
- Additional time for patients with complex needs or language barriers

DESIRABLE SPENDING
AVOIDABLE SPENDING
UNPAID SERVICES
SAVINGS
Paying for Unpaid Services Could Still Reduce Total Spending

- Desirable Spending
- Avoidable Spending

$ For Unpaid Services

Savings

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Barrier #2: Avoidable Spending is *Revenue* for the Providers…
…Currently Generating a (Small) Profit Margin

$\text{AVOIDABLE SPENDING}$

$\text{REVENUE}$

$\text{COST OF SERVICE DELIVERY}$

$\text{PROFIT}$

$\text{DESIRABLE SPENDING}$
When Avoidable Services Aren’t Delivered…

AVOIDABLE SPENDING

PROFIT

COST OF SERVICE DELIVERY

SAVEINGS

AVOIDABLE SPENDING

REVENUE

DESIRABLE SPENDING

DESIRABLE SPENDING

REVENUE
Revenues Decline…

![Diagram showing the relationship between revenues, avoidable spending, desirable spending, profit, and savings.](image-url)
…But Providers’ Costs Don’t Decrease Proportionately…

![Bar Chart Diagram](Image)

- Desirable Spending
- Avoidable Spending
- Revenue
- Cost of Service Delivery
- Profit
- Savings
...Because Fixed Costs Remain Even with Fewer Services...

Many Fixed Costs of Services Remain When Volume Decreases
...Leaving Providers With Losses

![Graph showing the relationship between desirable spending, avoidable spending, revenue, and costs.](chart.png)
That’s a Win-Lose Approach

AVOIDABLE SPENDING

DESIRABLE SPENDING

REVENUE

PROFIT

VARIABLE COST OF SERVICE

SAVINGS

LOSS

WIN-LOSE

AVOIDABLE SPENDING

VARIABLE COST OF SERVICE

DESIRABLE SPENDING

REVENUE

FIXED COST OF SERVICE

VARIABLE COST OF SERVICE

FIXED COST OF SERVICE

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By Adjusting Payment to Adequately Cover (Lower) Costs..

- Desirable Spending
- Avoidable Spending
- Revenue
- Variable Cost of Service
- Fixed Cost of Service Delivery
- Profit
- Savings
- Adjusted Payment
- Desirable Spending
- Revenue
- Variable Cost of Service
- Fixed Cost of Service Delivery

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…Win-Wins Are Possible for Payers and Providers
A Payment *Change* isn’t *Reform* Unless It *Removes the Barriers*

**PAYMENT BARRIERS**

- **Avoidable Spending**
  - Desirable Spending
  - Unpaid Services

**PAYMENT SOLUTIONS**

- **Avoidable Spending**
  - Desirable Spending
  - Unpaid Services

No Payment or Inadequate Payment for:
- Services delivered outside of face-to-face visits with clinicians, e.g., phone calls, e-mails, etc.
- Services delivered by non-clinicians, e.g., nurses, community health workers, etc.
- Non-medical services, e.g., transportation
- Services “covered” by a bundled or global payment for patients with higher intensity needs

---

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Most “Payment Reform” Has Been Small Bonuses/Penalties on FFS

“Value-Based Purchasing”

- PCP Quality Incentives
- Physician Value-Based Modifier
- Hospital Quality Incentives
- Hospital Readmission Penalties
- Hospital-Acquired Condition Penalties
Do Physicians Need “Incentives” to Deliver Higher Quality Care?

Payer’s View of “Value-Based Payment”

FFS Payment

FFS Payment + Quality Measures

P4P
The Payer Only Sees Payment, But The Provider Also Sees Cost

**Payer’s View of “Value-Based Payment”**
- FFS Payment
- FFS Payment + Quality Measures
- P4P

**Provider’s View of “Value-Based Payment”**
If the Provider Has Managed to Make FFS Payment Cover Costs…

**Payer’s View of “Value-Based Payment”**

- FFS Payment
- FFS Payment + Quality Measures
- P4P

**Provider’s View of “Value-Based Payment”**

- FFS Payment for Current Services
- Costs of Current Services
- Margin
Higher Quality/Lower Spending May Mean Lower FFS Revenues...

**Payer’s View of “Value-Based Payment”**

- FFS Payment
- FFS Payment + Quality Measures
- P4P

**Provider’s View of “Value-Based Payment”**

- FFS Payment for Current Services
- Costs of Current Services
- Margin
- Lower FFS Payment for Fewer Current Services

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...And Added Costs to Achieve the Higher Quality

**Payer’s View of “Value-Based Payment”**

- $FFS$ Payment
- $FFS$ Payment + Quality Measures
- P4P

**Provider’s View of “Value-Based Payment”**

- Lower $FFS$ Payment for Fewer Current Services
- Costs of Current Services
- Added Costs of New Services
- Costs of (Fewer) Current Services

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Even With the Payer’s “Incentive” Payment...

**Payer’s View of “Value-Based Payment”**
- FFS Payment
- FFS Payment + Quality Measures
- P4P

**Provider’s View of “Value-Based Payment”**
- Costs of Current Services
- Costs of (Fewer) Current Services
- Added Costs of New Services
- Lower FFS Payment for Fewer Current Services

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P4P May Not Offset Provider’s Added Costs & Revenue Losses

**Payer’s View of “Value-Based Payment”**

- FFS Payment
- FFS Payment + Quality Measures
- P4P

**Provider’s View of “Value-Based Payment”**

- Costs of Current Services
- Lower FFS Payment for Fewer Current Services
- Added Costs of New Services
- Margin
- Loss
- P4P

FFS = Fee-For-Service
More Measures Every Year, With the Same Small Bonuses

- Mammograms
- Colon Cancer Screening
- HbA1c Control
- LDL

P4P Bonus

- Mammograms
- Colon Cancer Screening
- Flu Vaccine
- Tobacco Counseling
- Hypertension Control
- HbA1c Control
- LDL
- Eye Exams
- Aspirin Use

P4P Bonus

- Mammograms
- Colon Cancer Screening
- Flu Vaccine
- BMI Screens
- Tobacco Counseling
- Fall Risk Assessment
- Hypertension Control
- HbA1c Control
- LDL
- Eye Exams
- Aspirin Use
- Beta Blockers for CHF

P4P Bonus

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The End of Collaboration?

- In the CMS Value-Based Payment Modifier, bonuses are *only* paid to physicians who have above average quality *if* penalties are assessed on other physicians with below average quality.
- To maintain budget neutrality, the size of bonuses depends on the size of penalties.
- Under this system, why would high-performing physicians want to help under-performing physicians to improve?
Over-Emphasis on Narrow Quality Measures Can Harm Patients

Hypoglycemia
1 Yr Mortality: 19.9%
30 Day Readmits: 16.3%

Hyperglycemia
1 Yr Mortality: 17.1%
30 Day Readmits: 15.3%

Source: National Trends in US Hospital Admissions for Hyperglycemia and Hypoglycemia Among Medicare Beneficiaries, 1999 to 2011  JAMA Internal Medicine May 17, 2014
HHS Announced Goal to Move Away From VBP & FFS+P4P

“Value-Based Purchasing”

FFS
• No payment for services that will benefit patients
• Lower revenues from reducing avoidable costs

P4P
• No payment for services that will benefit patients
• Lower revenues from reducing avoidable costs

HHS Goal for 2018

“Alternative Payment Models Built on a FFS Architecture”

FFS

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HHS Announced Goal to Move Away From VBP & FFS+P4P

"Value-Based Purchasing"

FFS
• No payment for services that will benefit patients
• Lower revenues from reducing avoidable costs

P4P

FFS
• No payment for services that will benefit patients
• Lower revenues from reducing avoidable costs

HHS Goal for 2018

"Alternative Payment Models Built on a FFS Architecture"

P4P

FFS

What the heck is an “Alternative Payment Model Built on FFS Architecture?”

And is that better than FFS+P4P?
# CMS “Alternative Payment Models” Built on FFS Architecture” To Date

<table>
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<td>Oncology Care Model</td>
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<td>Bundled Payments for Care Improvement Initiative</td>
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## Mostly FFS With a New Add-On: PMPM + Shared Savings

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# The First Specialty Payment Model: Oncology

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**Oncology Care Model**

**Overview and Application Process**

Centers for Medicare & Medicaid Services Innovation Center (CMMI)

*February 19, 2015*
Problems With Current Payments For Oncology Practices
Today: Many Hours in Diagnosis, Treatment Planning & Counseling

New Patient: Diagnosis, Choosing Therapy, Counseling

$2000
$1500
$1000
$500
$0

0
Dx
Today: Time to Deliver Treatment & Help Avoid Complications

New Patient: Diagnosis, Choosing Therapy, Counseling
Treatment: Therapy & Preventing Complications

$1000
$2000
$1500
$1000
$500
$0

Dx

0 1 2 3 4 5 6
TREATMENT MONTHS
Today: Many Months of Follow-Up Monitoring & Survivorship Care

- **New Patient:** Diagnosis, Choosing Therapy, Counseling
- **Treatment:** Therapy & Preventing Complications
- **Post-Treatment:** Monitoring & Support

<table>
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How is an Oncology Practice Paid for All of These Services?

PHYSICIAN/STAFF TIME FOR CANCER CARE

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<tr>
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</table>
$200-300 for the Most Critical Phase: Diagnosis & Planning

Physician/staff time for cancer care

How oncology practice is paid

New Patient: Small Payment for 1-2 Face-to-Face Visits With Oncologist; No Payment for Education and Support Services from Staff of Oncology Practice
Little Payment for Managing Treatment Using Oral Therapy

Physician/staff time for cancer care

How oncology practice is paid

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Most Revenue is Dependent on Use of Expensive, Infused Drugs

Large Payments for Infused Chemotherapy, Higher Payments for Use of More Expensive Drugs

PHYSICIAN/STAFF TIME FOR CANCER CARE

TREATMENT MONTHS POST-TREATMENT CARE

0 Dx 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

$0 $500 $1000 $1500 $2000

EM E&M E&M E&M E&M E&M Infusion Infusion Infusion Infusion Infusion Infusion

Drug Margin Drug Margin Drug Margin Drug Margin Drug Margin Drug Margin

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Little Payment for Patient Care After Treatment Ends

PHYSICIAN/STAFF TIME FOR CANCER CARE

HOW ONCOLOGY PRACTICE IS PAID

Payment for Occasional Face-to-Face Visits With Oncologist; No Payment for Support Services from Staff

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Significant Mismatch Between Payment and Patient Needs

Physician/Staff Time for Cancer Care

How Oncology Practice is Paid

Drug Margin
Infusion
E&M
0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
Dx
TREATMENT MONTHS
POST-TREATMENT CARE

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Does the CMMI Oncology Model Fix the Payment System?

PHYSICIAN/STAFF TIME FOR CANCER CARE

HOW ONCOLOGY PRACTICE IS PAID

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
Dx TREATMENT MONTHS POST-TREATMENT CARE

0 $0 $500 $1000 $1500 $2000

0 $0 $500 $1000 $1500 $2000

0 1 2 3 4 5 6
TREATMENT MONTHS

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More Money During Treatment

PHYSICIAN/STAFF TIME FOR CANCER CARE

HOW ONCOLOGY PRACTICE IS PAID IN CMMI OCM PROGRAM

$960 in New Payment (6 x $160)
More Money During Treatment + Shared Savings on Total Spending

PHYSICIAN/STAFF TIME FOR CANCER CARE

HOW ONCOLOGY PRACTICE IS PAID IN CMMI OCM PROGRAM

Shared Savings on Total Cost

$960 in New Payment (6 x $160)
Extra Payments Are Made for **Fixed 6 Month Episodes**

An “episode” starts when chemotherapy starts and lasts 6 months even if chemotherapy ends sooner.
What Happens If One of the Patient’s Treatments is Delayed?

Many Patients Have to Delay a Treatment Because of Side Effects
Logic Would Say That It’s Now a Longer (7 Month) Episode
But CMMI Says It’s a New Episode With $960 More in Payments

A new “episode” starts if chemotherapy continues more than 6 months after it starts, even for a very short time.
And Shared Savings Is More Likely With Same Spending in 2 Episodes

Penalty for Helping Patients Avoid Side Effects?

Incentive to Stretch Out Treatment?
Problems with CMMI “Oncology Care Model”

- What’s Good: $160/month extra payment for practices

- What’s Bad:
  - Could encourage delaying treatments in order to receive more PMPM payments & shared savings
  - Could penalize practices who have patients who respond better to treatment
  - No change to underlying FFS structure, so some savings will also reduce practice revenues
  - Oncology practice is accountable for all spending on their patients, even for health problems unrelated to cancer
  - Target spending level is based on historical spending for the practice’s own patients, so it rewards practices that are currently overusing and managing patient care poorly
  - Methodology for adjusting spending targets to deal with new drugs, new evidence about effectiveness of treatments, etc. has not been defined.
The Right Way and Wrong Way To Define Better Payment Models

THE WRONG WAY
(BUT THE DOMINANT MODE TODAY)

Medicare and Health Plans Define Payment Systems

Physicians Have To Change Care to Align With Payment Systems

Patients and Physicians May Not Come Out Ahead
The Right Way and Wrong Way
To Define Better Payment Models

THE WRONG WAY
(BUT THE DOMINANT MODE TODAY)

- Medicare and Health Plans Define Payment Systems
- Physicians Have To Change Care to Align With Payment Systems
- Patients and Physicians May Not Come Out Ahead

THE RIGHT WAY

- Physicians Redesign Care and Identify Payment Barriers
- Payers Change Payment to Support Redesigned Care
- Patients Get Better Care and Physicians Stay Financially Viable
Oncologists Have Developed a Better Approach to Payment
A Better Way: Monthly Payments Instead of Current FFS Payments

- Treatment Month Payments
- Active Monitoring Month Payments
- E&M and Infusion Codes
Dramatic Simplification of Coding and Billing

50+ Current Billing Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>99211</td>
<td>Established Patient Office Visit – Level 1</td>
</tr>
<tr>
<td>99212</td>
<td>Established Patient Office Visit – Level 2</td>
</tr>
<tr>
<td>99213</td>
<td>Established Patient Office Visit – Level 3</td>
</tr>
<tr>
<td>99214</td>
<td>Established Patient Office Visit – Level 4</td>
</tr>
<tr>
<td>99215</td>
<td>Established Patient Office Visit – Level 5</td>
</tr>
<tr>
<td>99231</td>
<td>Subsequent Hospital Care – Level 1</td>
</tr>
<tr>
<td>99232</td>
<td>Subsequent Hospital Care – Level 2</td>
</tr>
<tr>
<td>99233</td>
<td>Subsequent Hospital Care – Level 3</td>
</tr>
<tr>
<td>96401</td>
<td>Subcutaneous chemotherapy administration</td>
</tr>
<tr>
<td>96402</td>
<td>Subcutaneous chemotherapy administration</td>
</tr>
<tr>
<td>96405</td>
<td>Intralesional chemotherapy administration</td>
</tr>
<tr>
<td>96406</td>
<td>Intralesional chemotherapy administration</td>
</tr>
<tr>
<td>96409</td>
<td>Push chemotherapy administration</td>
</tr>
<tr>
<td>96411</td>
<td>Push chemotherapy administration</td>
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<tr>
<td>96413</td>
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<tr>
<td>96417</td>
<td>Infusion chemotherapy administration</td>
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<td>96420</td>
<td>Intra-arterial push chemotherapy</td>
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<td>96422</td>
<td>Intra-arterial infusion chemotherapy</td>
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<td>Intra-arterial infusion chemotherapy</td>
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<td>96425</td>
<td>Intra-arterial infusion chemotherapy</td>
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<td>96440</td>
<td>Pleural cavity chemotherapy</td>
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<td>96446</td>
<td>Peritoneal cavity chemotherapy</td>
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<td>96450</td>
<td>CNS chemotherapy</td>
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<table>
<thead>
<tr>
<th>Code</th>
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</thead>
<tbody>
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<tr>
<td>96522</td>
<td>Refilling and maintenance of implantable pump</td>
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<tr>
<td>96523</td>
<td>Irrigation of implanted venous access device</td>
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<td>96542</td>
<td>Chemotherapy injection via subcutaneous reservoir</td>
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<td>79005</td>
<td>Oral radiopharmaceutical therapy</td>
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<td>79101</td>
<td>Radiopharmaceutical infusion</td>
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<td>Radiopharmaceutical intracavitary administration</td>
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<tr>
<td>79300</td>
<td>Radiopharmaceutical therapy</td>
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<td>96366</td>
<td>Intravenous infusion, non-chemotherapy</td>
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<td>96367</td>
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<tr>
<td>96368</td>
<td>Intravenous infusion, non-chemotherapy</td>
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<tr>
<td>96369</td>
<td>Subcutaneous infusion, non-chemotherapy</td>
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<td>96370</td>
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<td>96371</td>
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</tr>
<tr>
<td>96372</td>
<td>Injection, non-chemotherapy</td>
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<tr>
<td>96373</td>
<td>Intra-arterial injection, non-chemotherapy</td>
</tr>
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<td>96374</td>
<td>Intravenous push, non-chemotherapy</td>
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<td>96375</td>
<td>Intravenous push, non-chemotherapy</td>
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<td>96376</td>
<td>Intravenous push, non-chemotherapy</td>
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<tr>
<td>96379</td>
<td>Unlisted injection or infusion, non-chemotherapy</td>
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<tr>
<td>96360</td>
<td>Intravenous infusion, hydration</td>
</tr>
<tr>
<td>96361</td>
<td>Intravenous infusion, hydration</td>
</tr>
</tbody>
</table>

< 10 New Codes

- New Patient Payment
- Treatment Month (4-6 Levels)
  - Patient characteristics
  - Treatment characteristics
  - Transitions
  - Clinical Trials
- Active Monitoring Month (2 Levels)
Better Payment for Practices...

NOTE: Chart not drawn to scale
Better Payment for Practices…
But Higher Spending for Payers

NOTE: Chart not drawn to scale
Part 2 of Better Oncology Pmt: Accountability for Reducing Costs

CURRENT

- Lower Total Oncology Spending

PROPOSED

- Savings
  - Lower Total Oncology Spending

- More $
  - Monitoring
  - Treatment
  - New Patient

Bundled Payments Enabling Better Care Management

NOTE: Chart not drawn to scale
Step 1: Identify Potentially Avoidable Costs

CURRENT

$ 

Hospital Admits
ED Visits
Testing

Drug Costs

PROPOSED

More $

Practice Expense
Rx Margin
Monitoring
New Patient
Treatment
Monitoring

Practice Expense
Infusion

COSTS
SPENDING
COSTS

Bundled Payments Enabling Better Care Management

NOTE: Chart not drawn to scale
Step 2: Accountability for Drug/Test Costs

**CURRENT**
- Hospital Admits
- ED Visits
- Testing
- Drug Costs

**PROPOSED**
- Testing
- Drug Costs
- ASCO Appropriate Use Criteria (Pathways)

- Monitoring
- Treatment
- New Patient

Accountability for Following ASCO-Developed Appropriate Use Criteria for Drugs, Laboratory Tests, and Imaging and End-of-Life Treatment

Bundled Payments Enabling Better Care Management

**NOTE:** Chart not drawn to scale
Starting Point for Appropriate Use:
ASCO Guidelines

1. Don’t use cancer-directed therapy for solid tumor patients with the following characteristics: low performance status (3 or 4), no benefit from prior evidence-based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anti-cancer treatment.
   - Studies show that cancer-directed treatments are likely to be ineffective for solid tumor patients who meet the above stated criteria.
   - Exceptions include patients with functional limitations due to other conditions resulting in a low performance status or those with disease characteristics (e.g., mutations) that suggest a high likelihood of response to therapy.
   - Implementation of this approach should be accompanied with appropriate palliative and supportive care.

2. Don’t perform PET, CT, and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis.
   - Imaging with PET, CT, or radionuclide bone scans can be useful in the staging of specific cancer types. However, these tests are often used in the staging evaluation of high-risk cancers, despite a lack of evidence suggesting they improve detection of metastatic disease or survival.
   - Endpoints do not support the use of these scans for staging of newly diagnosed low-risk patients of the prostate (Stage T1a/T1b, prostate-specific antigen [PSA] <10 ng/mL, Gleason score ≤6 or equal to 6 with low risk of distant metastases).
   - Unnecessary imaging can lead to harm through unnecessary invasive procedures, overtreatment, unnecessary radiation exposure, and misdiagnosis.

3. Don’t perform PET, CT, and radionuclide bone scans in the staging of early breast cancer at low risk for metastasis.
   - Imaging with PET, CT, or radionuclide bone scans can be useful in the staging of specific cancer types. However, these tests are often used in the staging evaluation of breast cancers, despite a lack of evidence suggesting they improve detection of metastatic disease or survival.
   - In breast cancer, for example, there is a lack of evidence demonstrating a benefit for the use of PET, CT, or radionuclide bone scans in asymptomatic individuals with newly diagnosed breast cancer in situ (DCIS) or clinical stage I or II disease.
   - Unnecessary imaging can lead to harm through unnecessary invasive procedures, overtreatment, unnecessary radiation exposure, and misdiagnosis.

4. Don’t perform surveillance testing (biomarkers) or imaging (PET, CT, and radionuclide bone scans) for asymptomatic individuals who have been treated for breast cancer with curative intent.
   - Surveillance testing with serum tumor markers or imaging has been shown to have clinical value for certain cancers (e.g., colon). However, for breast cancer that has been treated with curative intent, several studies have shown there is no benefit from routine imaging or serial measurement of serum tumor markers in asymptomatic patients.
   - False-positive tests can harm through unnecessary invasive procedures, overtreatment, unnecessary radiation exposure, and misdiagnosis.

5. Don’t use white cell stimulating factors for primary prevention of febrile neutropenia for patients with less than 20 percent risk for this complication.
   - ASCO guidelines recommend using white cell stimulating factors when the risk of febrile neutropenia, secondary to a recommended chemotherapy regimen, is approximately 20 percent and to use alternative regimens that do not require white cell stimulating factors are unavailable.
   - Exceptions should be made when using regimens that have a lower chance of causing febrile neutropenia if it is determined that the patient is at high risk for this complication (due to age, medical history, or disease characteristics).
### Commercial Spending on Oncology Drugs Under Medical Benefits
for Breast, Colon and Lung Cancer Patients in Maine, 2012

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Drug Description</th>
<th>Pre/Auth</th>
<th>Unit Cost</th>
<th>Anthem</th>
<th>Total Spending</th>
<th>Cumulative</th>
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<td>INJECTION, BEVACIZUMAB, 10 MG</td>
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<td>$5,074</td>
<td>$5,728,632</td>
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<td>INJECTION, OXALIPLATIN, 0.5 MG</td>
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<td>$2,999</td>
<td>$4,000,865</td>
<td>12%</td>
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<tr>
<td>5</td>
<td>INJECTION, PEMETREXED, 10 MG</td>
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<td>INJECTION, PACLITAXEL, 30 MG</td>
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<td>INJECTION, PACLITAXEL PROTEIN-</td>
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<td>$2,725</td>
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<td></td>
<td>ALL OTHERS</td>
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<td>ALL DRUGS</td>
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Significant savings possible through more appropriate use.
Step 3: Accountability for ER/Hospital Use

CURRENT

- Hospital Admits
- ED Visits
- Testing
- Drug Costs

PROPOSED

- Hospital Admits
- ED Visits
- Testing
- Drug Costs

Accountability for Managing Complications of Treatment to Avoid Patient Need to Use Emergency Department and Hospital

Accountability for Following ASCO-Developed Appropriate Use Criteria for Drugs, Laboratory Tests, and Imaging and End-of-Life Treatment

Bundled Payments Enabling Better Care Management

NOTE: Chart not drawn to scale
Result: Win-Win-Win for Payers, Patients, Physicians

**CURRENT**

- Hospital Admits
- ED Visits
- Testing
- Drug Costs

**PROPOSED**

- Improved Management of Complications
- ASCO Appropriate Use Criteria (Pathways)

**Savings**

- Hospital Admits
- ED Visits
- Testing

**Savings Achieved in Ways That Don’t Harm Patients**

- ASCO Appropriate Use Criteria (Pathways)

**Practice Follows Clinical Guidelines and Achieves Pre-Defined Targets on Avoidable Services**

- Practice Receives Higher, More Flexible Payments Than Today

**NOTE:** Chart not drawn to scale
Will It Actually Save Money?

You Need Data on the Total Cost of Care to Figure That Out
Data on Actual Oncology Spending from an RHIC

<table>
<thead>
<tr>
<th>Service Type</th>
<th>% of Total</th>
<th>Average Per Total Patient</th>
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<tr>
<td>E&amp;M</td>
<td>3%</td>
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<tr>
<td>Infusion</td>
<td>7%</td>
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<tr>
<td>New Payments</td>
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</tr>
<tr>
<td>New Patient ($250)</td>
<td>8%</td>
<td>$3,857</td>
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<tr>
<td>Care Management ($225 x 9)</td>
<td>50%</td>
<td>$22,586</td>
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<tr>
<td>Testing</td>
<td>20%</td>
<td>$9,279</td>
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<tr>
<td>Drugs</td>
<td>10%</td>
<td>$435</td>
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<tr>
<td>Emergency Room</td>
<td>10%</td>
<td>$4,751</td>
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<tr>
<td>Inpatient Hospital Stays</td>
<td>10%</td>
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<tr>
<td>Total</td>
<td>100%</td>
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</tbody>
</table>

Only 10% of Spending Goes to E&M/Infusion
Large New Practice Payments = High Cost to Payers

### Commercial Spending on Healthcare Services During Treatment for Breast, Colon and Lung Cancer Patients in Maine, 2012

<table>
<thead>
<tr>
<th>Service Type</th>
<th>% of Total</th>
<th>Average Per Total Patient</th>
<th>Revised</th>
<th>% Chg</th>
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<tbody>
<tr>
<td>E&amp;M</td>
<td>3%</td>
<td>$1,417</td>
<td>$1,417</td>
<td>0%</td>
</tr>
<tr>
<td>Infusion</td>
<td>7%</td>
<td>$3,132</td>
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<td>0%</td>
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<td>New Payments</td>
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<tr>
<td>New Patient ($250)</td>
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<tr>
<td>Care Management ($225 x 9)</td>
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<td>Testing</td>
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<td>Drugs</td>
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<td>Other</td>
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<td>$9,279</td>
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<td>10%</td>
<td>$4,751</td>
<td>$4,751</td>
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</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>$45,456</td>
<td>$47,731</td>
<td>5.0%</td>
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Increase in Practice $: $3,517,150
Net Payer Savings: $(3,517,150)

New Payments to Practice
Large Cost to Payer
Reductions in 3 Overused Drugs Would More Than Cover New $
25%+ of Admissions Are Likely Complications of Treatment

<table>
<thead>
<tr>
<th>Diagnosis Group</th>
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<th>Admits</th>
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<td>Diseases of Blood and Blood-Forming Organs</td>
<td>29</td>
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<tr>
<td>Injury and Poisoning</td>
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<td>6%</td>
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<tr>
<td>Symptoms, Signs and Ill-Defined Conditions</td>
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<td>V-Codes</td>
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<td>Diseases of Nervous System and Sense Organs</td>
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<tr>
<td>Endocrine, Nutrition and Metabolic Disorders, and Immuno</td>
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<tr>
<td>Diseases of the Genitourinary System</td>
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<tr>
<td>Infectious and Parasitic Diseases</td>
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<tr>
<td>Congenital Abnormalities</td>
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<tr>
<td>Complications of Pregnancy and Childbirth</td>
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<tr>
<td>Conditions Originating in the Perinatal Period</td>
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<tr>
<td>TOTAL</td>
<td>347</td>
<td>100%</td>
<td>27%</td>
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</table>
Big Opportunities for Savings Through Changes in Several Areas

### Commercial Spending on Healthcare Services During Treatment for Breast, Colon and Lung Cancer Patients in Maine, 2012

1,546 Patients with Breast, Lung or Colon cancer receiving Chemotherapy

<table>
<thead>
<tr>
<th>Service Type</th>
<th>% of Total</th>
<th>Average Per Total Patient</th>
<th>Revised</th>
<th>% Chg</th>
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<tr>
<td>E&amp;M</td>
<td>3%</td>
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<td>7%</td>
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<tr>
<td>New Patient ($250)</td>
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<td>$250</td>
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<tr>
<td>Care Management ($225 x 9)</td>
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<tr>
<td>Testing</td>
<td>8%</td>
<td>$3,857</td>
<td>$3,664</td>
<td>-5%</td>
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<tr>
<td>Drugs</td>
<td>50%</td>
<td>$22,586</td>
<td>$20,328</td>
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<tr>
<td>Other</td>
<td>20%</td>
<td>$9,279</td>
<td>$9,279</td>
<td>0%</td>
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<tr>
<td>Emergency Room</td>
<td>1%</td>
<td>$435</td>
<td>$326</td>
<td>-25%</td>
</tr>
<tr>
<td>Inpatient Hospital Stays</td>
<td>10%</td>
<td>$4,751</td>
<td>$3,563</td>
<td>-25%</td>
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<tr>
<td>Total</td>
<td>100%</td>
<td>$45,456</td>
<td>$43,984</td>
<td>-3.2%</td>
</tr>
</tbody>
</table>

| Increase in Practice $:       | $3,517,150 |
| Net Payer Savings:            | $2,277,053 |

**New Payments to Practice**

Offset by Savings in Testing and Drugs...

...and Savings in ED Visits & Admits

Win-Win
Instead of Trying to Put More Band-aids on a Broken System…

- **FFS**
  - No payment for services that will benefit patients
  - Lower revenues from reducing avoidable costs

“Value-Based Purchasing”
- P4P
  - No payment for services that will benefit patients
  - Lower revenues from reducing avoidable costs

“APMs Built on FFS Architecture”
- Shared Savings: P4P
- Shared Savings: PMPM
  - No payment for services that will benefit patients
  - Lower revenues from reducing avoidable costs

“Value-Based Purchasing”
- “APMs Built on FFS Architecture”
We Need *True* Payment Reforms: Accountable Payment Models

‘Value-Based Purchasing’

- P4P
  - No payment for services that will benefit patients
  - Lower revenues from reducing avoidable costs

‘APMs Built on FFS Architecture’

- Shared Savings
  - PMPM
  - Flexibility to deliver services patients need
  - Accountability for costs the provider can control
  - Accountability for quality the provider can control
  - Adequate payment for high-quality care

FFS

- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs
Other Specialties/Conditions Face Similar Kinds of Barriers

• Heart Failure
  – Inadequate payment for time needed for diagnosis and treatment planning
  – Inadequate payment for shared decision-making with patients about appropriate treatment
  – Inadequate payment for patient education and medical management of cardiac conditions
  – No payment for phone/email consultation with PCPs
  – Dependence on testing and procedures to subsidize other services
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• Musculoskeletal Pain/Arthritis
  – Inadequate payment for time needed for diagnosis and treatment planning
  – Inadequate payment for shared decision-making with patients about appropriate treatment
  – Inadequate payment for non-surgical management of joint and back pain
  – Dependence on surgery to pay for practice costs
Physicians in Oregon Working to Design Solutions

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  – Inadequate payment for non-surgical management of joint and back pain
  – Dependence on surgery to pay for practice costs
Barrier #2: Losses From Using Lower Cost Procedures & Settings

- Maternity Care
  - Vaginal delivery instead of C-Section
  - Term delivery instead of early elective delivery
  - Delivery in birth center instead of hospital

- Chest Pain
  - Lower cost imaging
  - Non-invasive imaging instead of invasive imaging
  - Medical management instead of invasive treatment

- Back Pain and Knee Pain
  - Less radical surgery
  - Physical therapy instead of surgery
Example: Reducing Avoidable Surgeries for Knee Osteoarthritis

<table>
<thead>
<tr>
<th>Physician Svcs</th>
<th>TODAY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient</td>
</tr>
<tr>
<td>Evaluations</td>
<td>$160</td>
</tr>
<tr>
<td>Management</td>
<td>$250</td>
</tr>
<tr>
<td>Surgery</td>
<td>$850</td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Phys. Therapy</td>
<td>$500</td>
</tr>
<tr>
<td>Hospital Pmt</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>$11,000</td>
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</tr>
</tbody>
</table>

Treatment of Knee Osteoarthritis

- Surgery performed procedure on 50% of evaluated patients
- Physical therapy used for remaining 50%
- 20% of surgeries avoidable with better outpatient management
Physicians Only Receive 11% of the Total Spending

<table>
<thead>
<tr>
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<th>Total $</th>
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<tr>
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<td>$11,000</td>
<td>150</td>
<td>$1,650,000</td>
</tr>
<tr>
<td><strong>Total Pmt/Cost</strong></td>
<td>$6,460</td>
<td>300</td>
<td><strong>$1,938,000</strong></td>
</tr>
</tbody>
</table>

Physician payments are 11% of total spending
Under FFS, Fewer Surgeries = Losses for Physicians & Hospitals

<table>
<thead>
<tr>
<th></th>
<th>TODAY</th>
<th>TOMORROW</th>
<th>Chg</th>
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<tbody>
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<td></td>
<td>$1,938,000</td>
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</tbody>
</table>
# You Can’t Solve This Problem
With Small P4P/VBP Bonuses

<table>
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<th>TOMORROW</th>
<th>Chg</th>
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<td>$1,938,000</td>
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</table>

4% "Incentive" for Reducing Avoidable Procedures
## Is There a Better Way?

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<tr>
<td>Total Pmt/Cost</td>
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</table>

Better Payment for Condition Management

- Physician paid adequately to engage in shared decision-making process with patients and to manage non-surgical care
Physicians Could Be Paid *More* While Still Reducing Total $ 

<table>
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<tr>
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</table>
### Do Hospitals Have to Lose In Order for Other Providers & Payers To Win?

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<td>300</td>
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</tbody>
</table>
What Should Matter to Hospitals is *Margin*, Not Revenues (Volume)
We Need to Understand the Hospital’s Cost Structure

<table>
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Adequacy of Payment Depends On Fixed/Variable Costs & Margins

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Now, if the Number of Procedures is Reduced...

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…Fixed Costs Will Remain the Same (in the Short Run)…

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…Variable Costs Will Go Down in Proportion to Procedures…

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...And Even With a Higher Margin for the Hospital...

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...The Hospital Gets Less *Total Revenue* But Higher Margin

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| Phys. Therapy  | $500     | 150    | $75,000 | $500     | 180    | $90,000 | +20% |

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| Total Pmt/Cost | 300    | $1,938,000 |  |     |
…And The Payer Still Saves Money

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I.e., Win-Win-Win for Providers, Hospital, and Payer

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What Payment Model Supports This Win-Win-Win Approach?

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Renegotiating Individual Fees is Impractical

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### Pay Based on the Patient’s Condition, Not on the Procedure

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Plan to Offer Care of the Condition at a Lower Cost Per Patient

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Use the Payment as a Budget to Redesign Care…

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|                |            |             |       |
|                | $6,259      | 300         | $1,877,626 |
| **Chg**        |            |             | -3%   |

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...And Let Providers & Hospitals Decide How They Should Be Paid

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Opportunities for Reducing Spending Exist in Every Specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Opportunities to Improve Care and Reduce Cost</th>
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</thead>
</table>
| Neurology    | • Avoid unnecessary hospitalizations for epilepsy patients  
               • Reduce strokes and heart attacks after TIA |
| Gastroenterology | • Reduce unnecessary colonoscopies and colon cancer  
                       • Reduce ER/admits for inflammatory bowel d. |
| Psychiatry   | • Reduce ER visits and admissions for patients with depression and chronic disease |
| Radiology    | • Reduce use of high-cost imaging  
                       • Improve diagnostic speed & accuracy |
Fee-for-Service Creates **Barriers** to Redesigning Care

<table>
<thead>
<tr>
<th>Opportunities to Improve Care and Reduce Cost</th>
<th>Barriers in Current Payment System</th>
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</thead>
<tbody>
<tr>
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<td></td>
</tr>
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<td>• Avoid unnecessary hospitalizations for epilepsy patients</td>
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<td>• No payment to coordinate w/ cardio</td>
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<tr>
<td><strong>Psychiatry</strong></td>
<td></td>
</tr>
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<td>• Reduce ER visits and admissions for patients with depression and chronic disease</td>
<td>• No payment for phone consults with PCPs</td>
</tr>
<tr>
<td>• No payment for RN care managers</td>
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<tr>
<td><strong>Radiology</strong></td>
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</tr>
<tr>
<td>• Reduce use of high-cost imaging</td>
<td>• Low payment for reading images &amp; penalty for 2x</td>
</tr>
<tr>
<td>• Improve diagnostic speed &amp; accuracy</td>
<td>• Inability to change inapprop. orders</td>
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# There Are Win-Win-Win Solutions Through Better Payment Systems

## Opportunities to Improve Care and Reduce Cost

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## Barriers in Current Payment System

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## Solutions via Accountable Payment Models

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<tbody>
<tr>
<td>• Condition-based payment for epilepsy</td>
<td>• Population-based payment for colon cancer screening</td>
<td>• Joint condition-based payment to PCP and psychiatrist</td>
</tr>
<tr>
<td></td>
<td>• Condition-based pmt for IBD</td>
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## Neurology

- Avoid unnecessary hospitalizations for epilepsy patients
- Reduce strokes and heart attacks after TIA

## Gastroenterology

- Reduce unnecessary colonoscopies and colon cancer
- Reduce ER/admits for inflammatory bowel disease

## Psychiatry

- Reduce ER visits and admissions for patients with depression and chronic disease

## Radiology

- Reduce use of high-cost imaging
- Reduce strokes and heart attacks after TIA
We Need *True* Payment Reforms: Accountable Payment Models

**“Value-Based Purchasing”**
- P4P

**“APMs Built on FFS Architecture”**
- Shared Savings
- PMPM

**FFS**
- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

"Value-Based Purchasing"

"APMs Built on FFS Architecture"

**Accountable Payment Models**
- Flexibility to deliver services patients need
- Accountability for costs the provider can control
- Accountability for quality the provider can control
- Adequate payment for high-quality care
We Know How to Design Win-Win-Win Payment Models

- Flexibility to deliver services patients need
- Accountability for costs the provider can control
- Accountability for quality the provider can control
- Adequate payment for high-quality care

www.PaymentReform.org
The Biggest Challenge Has Been Getting Payers to Use Them

**FFS**
- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

**P4P**
- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

**Accountable Payment Models**
- Flexibility to deliver services patients need
- Accountability for costs the provider can control
- Accountability for quality the provider can control
- Adequate payment for high-quality care

**Payer-Designed Payment Systems**

**Provider-Designed Payment Systems**
Instead of Win-Lose Approaches That Ultimately Harm Patients…

- CMS
  - Cost-Shifting Through Underpayment
  - Inability to Provide Coverage

- Employers
  - Inability to Provide Coverage

- Hospitals
  - Hospitals Acquiring MDs
  - Battle Over RVUs
  - Inadequate # of PCPs

- Specialists
  - Battle Over RVUs

- PCPs
  - Inadequate # of PCPs

- Patients
  - Fragmented, Expensive Poor Quality Care
...We Need Collaboration That Benefits All Stakeholders

- Employers
  - Savings for Employers

- CMS
  - Savings for Medicare
  - Adequate Margins to Support Quality Care

- Patients
  - Better Care for Patients

- Hospitals

- PCPs
  - High Quality, Financially Viable Primary Care Practices

- Specialists
  - High Quality, Financially Viable Specialty Practices

WIN-WIN-WIN
How Could Oregon Get to a Win-Win-Win-Win Approach?
Step 1: Agree on a Truly Multi-Stakeholder Vision

**SHARED COMMUNITY VISION AND GOALS**

- Better health for residents
- Lower spending for payers
- Financially viable physician practices and hospitals
Step 2: Support a Mechanism for Collaboration Toward the Vision

**Shared Community Vision and Goals**

- Better health for residents
- Lower spending for payers
- Financially viable physician practices and hospitals

**Regional Health Improvement Collaborative (RHIC) (Q-Corp)**
Facilitation and analysis so all stakeholders can work together in a win-win-win way to achieve the vision
Step 3: Convert Vision Into Action: Business Plans for Win-Wins

**SHARED COMMUNITY VISION AND GOALS**
- Better health for residents
- Lower spending for payers
- Financially viable physician practices and hospitals

**REGIONAL HEALTH IMPROVEMENT COLLABORATIVE (RHIC) (Q-Corp)**
Facilitation and analysis so all stakeholders can work together in a win-win-win way to achieve the vision

**BUSINESS PLAN FOR HIGHER-VALUE CARE**
- Specific initiatives to achieve the vision
- Priorities to achieve early successes
- Financial and operational plan for each initiative
Step 4: Help Providers Organize for Better Care & Accountability

**SHARED COMMUNITY VISION AND GOALS**
- Better health for residents
- Lower spending for payers
- Financially viable physician practices and hospitals

**REGIONAL HEALTH IMPROVEMENT COLLABORATIVE (RHIC) (Q-Corp)**
Facilitation and analysis so all stakeholders can work together in a win-win-win way to achieve the vision

**BUSINESS PLAN FOR HIGHER-VALUE CARE**
- Specific initiatives to achieve the vision
- Priorities to achieve early successes
- Financial and operational plan for each initiative

**CARE REDESIGN IPAs/ACOs/CCOs/IDNs**
Providers organized to deliver higher-value care and take accountability for quality and costs
Step 5: Pay Providers Appropriately to Allow Success

**Step 5: Pay Providers Appropriately to Allow Success**

**Shared Community Vision and Goals**
- Better health for residents
- Lower spending for payers
- Financially viable physician practices and hospitals

**Regional Health Improvement Collaborative (RHIC) (Q-Corp)**
Facilitation and analysis so all stakeholders can work together in a win-win-win way to achieve the vision

**Business Plan for Higher-Value Care**
- Specific initiatives to achieve the vision
- Priorities to achieve early successes
- Financial and operational plan for each initiative

**Accountable Payment Systems**
Flexible, adequate payment with appropriate accountability to enable higher quality and lower costs

**CARE Redesign**
IPAs/ACOs/CCOs/IDNs
Providers organized to deliver higher-value care and take accountability for quality and costs

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A Win-Win-Win Strategy for Higher-Value Care in Oregon

**SHARED COMMUNITY VISION AND GOALS**
- Better health for residents
- Lower spending for payers
- Financially viable physician practices and hospitals

**REGIONAL HEALTH IMPROVEMENT COLLABORATIVE (RHIC) (Q-Corp)**
Facilitation and analysis so all stakeholders can work together in a win-win-win way to achieve the vision

**BUSINESS PLAN FOR HIGHER-VALUE CARE**
- Specific initiatives to achieve the vision
- Priorities to achieve early successes
- Financial and operational plan for each initiative

**ACCOUNTABLE PAYMENT SYSTEMS**
Flexible, adequate payment with appropriate accountability to enable higher quality and lower costs

**CARE REDESIGN IPAs/ACOs/CCOs/IDNs**
Providers organized to deliver higher-value care and take accountability for quality and costs
Learn More About Win-Win-Win Payment and Delivery Reform

Center for Healthcare Quality and Payment Reform
www.PaymentReform.org
For More Information:

Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform

Miller.Harold@GMail.com
(412) 803-3650

www.CHQPR.org
www.PaymentReform.org
APPENDIX

Payment Reform and ACOs
How Does This All Fit Into ACOs?

<table>
<thead>
<tr>
<th>PATIENTS</th>
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<tr>
<td>Diabetes</td>
</tr>
<tr>
<td>Back Pain</td>
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<tr>
<td>Pregnancy</td>
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Each Patient Should Choose & Use a Primary Care Practice…

**PATIENTS**

- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

Primary Care Practice
...Which Takes Accountability for What PCPs Can Control/Influence

**ACCOUNTABILITY for:**
- Avoidable ER Visits
- Avoidable Hospitalizations
- Unnecessary Tests
- Unnecessary Referrals

**PATIENTS**
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

**Primary Care Practice**

**Accountable Medical Home**

**MEDICARE/HEALTH PLAN**
…With a Medical Neighborhood to Consult With on Complex Cases

MEDICARE/HEALTH PLAN

PATIENTS

- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

Primary Care Practice

Endocrinology, Cardiology, Pulmonology

Accountable Medical Neighborhood

Accountability for:
- Unnecessary Tests
- Unnecessary Referrals
- Co-Managed Outcomes
..And Specialists Accountable for the Conditions They Manage

Accountability for:
- Unnecessary Tests
- Unnecessary Procedures
- Infections, Complications

Patients
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

Primary Care Practice

Cardiology Group
Orthopedic Group
OB/GYN Group

Endocrinology, Cardiology, Pulmonology

Heart Episode/Condition Pmt
Back Episode/Condition Pmt
Pregnancy Condition Pmt

Accountable Medical Home
That’s Building the ACO from the Bottom Up

MEDICARE/HEALTH PLAN

Accountable Payment Models

ACO

Heart Episode/Condition Pmt
Back Episode/Condition Pmt
Pregnancy Condition Pmt

PATIENTS
Heart Disease
Diabetes
Back Pain
Pregnancy

Primary Care Practice

Endocrinology, Cardiology, Pulmonology

Cardiology Group
Orthopedic Group
OB/GYN Group

Accountable Medical Neighborhood

Accountable Medical Home
Most ACOs Today Aren’t Truly Reinventing Care

Fee-for-Service Payment

MEDICARE/HEALTH PLAN

Shared Savings Payment

ACO

Expensive IT Systems

Nurse Care Managers

Share of Shared Savings Payment??

PATIENTS

Heart Disease
Diabetes
Back Pain
Pregnancy

Primary Care
Psych., Neuro
Cardiology
Orthopedics
OB/GYN
It Hasn’t Been Working Too Well in Medicare So Far

- Of the 109 Track 1 (Upside Only) ACOs that started in 2012:
  - 57 (52%) Track 1 ACOs did not achieve savings in 2013
  - 25 (23%) Track 1 ACOs achieved savings, but not enough to receive shared savings payments
  - 27 (25%) Track 1 ACOs received shared savings payments

- Of the 5 Track 2 (Downside Risk) ACOs that started in 2012:
  - 2 (33%) Track 2 ACOs received shared savings payments
  - 3 (67%) Track 2 ACOs had to repay a share of losses to CMS
A True ACO Can Take a Global Payment And Make It Work

MEDICARE/HEALTH PLAN

Risk-Adjusted Global Payment

ACO

Cardiology Group
Orthopedic Group
OB/GYN Group

Heart Episode/Condition Pmt
Back Episode/Condition Pmt
Pregnancy Condition Pmt

Accountable Medical Neighborhood

Primary Care Practice

Endocrinology, Cardiology, Oncology

Accountable Medical Home

PATIENTS
Heart Disease
Diabetes
Back Pain
Pregnancy

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You Don’t Need a Big Health System to Manage Global Payment

• Independent PCPs & Specialists Managing Global Payments
  – Northwest Physicians Network (NPN) in Tacoma, WA is an IPA with 109 PCPs and 345 specialists in 165 practices (average size: 2.4 MDs/practice). NPN accepts full or partial risk capitation contracts, operates its own Medicare Advantage plan, and does third party administration for self-insured businesses. [www.npnwa.net](http://www.npnwa.net)
  – North Texas Specialty Physicians, a 600 physician multi-specialty IPA in Fort Worth, set up its own Medicare Advantage PPO plan and uses revenues from the health plan and capitation contracts to pay its PCPs 250% of Medicare rates and provides high quality, coordinated care to patients. [www.ntsp.com](http://www.ntsp.com)

• Joint Contracting by MDs & Hospitals for Global Payments
  – The Mount Auburn Cambridge IPA (MACIPA) and Mount Auburn Hospital jointly contract with three major Boston-area health plans for full-risk capitation. The IPA is independent of the hospital; they coordinate care with each other without any formal legal structure. [www.macipa.com](http://www.macipa.com)
APPENDIX:

Managing Risk
in Accountable Payment Models
The Goal: Slower *Growth* in Spending Than Under FFS
To Attract Payers, New Payment Must Be < \textit{Projected} FFS Spend

![Chart showing cost and time comparison between FFS payments, bundled or condition-based payment levels, and an alternative payment model.](chart.png)
…If All Goes Well, Provider’s Costs Are Lower Than the Payment…
...And Both the Payer and Provider Will “Win”

<table>
<thead>
<tr>
<th>COST</th>
<th>TIME</th>
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</thead>
<tbody>
<tr>
<td>Bundled or Condition-Based Payment Level</td>
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<tr>
<td>FFS Pmts</td>
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<tr>
<td>Costs of Svcs</td>
<td>Actual</td>
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Savings For Payer: Lower Pmt
WIN-WIN
Profit for Provider: Lower Costs

Actual
Proposed

COST
The Risk Physicians Fear: All Won’t Go Well (Costs Go Up)...

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- Lower Pmt
- Excess Cost
...Creating a Win-Lose Situation

COST

Bundled or Condition-Based Payment Level

FFS Pmts Actual

FFS Pmts Actual

Alt. Pmt Model $ Proposed

Costs of Svcs Actual

TIME

Savings For Payer

WIN-LOSE

Lower Pmt

Excess Cost

Loss for Provider

Actual

Proposed

WIN-LOSE

Many Different Reasons Costs May Increase Beyond Payment

- Unusually Costly Patient
- Overutilization of Services
- Large Random Variation
- New, High-Cost Treatment
- Unusually Costly Patient
- Higher-Severity Patients

Costs of Svcs

Excess Cost

Many Avoidable Complications

Failure to Follow Guidelines

Savings

Alt. Pmt Model $
Physicians CAN Control Many of the Factors Causing Higher Costs

- Many Avoidable Complications
- Failure to Follow Guidelines
- Overutilization of Services
- Large Random Variation
- New, High-Cost Treatment
- Unusually Costly Patient
- Higher-Severity Patients

What Physicians CAN Control (Performance Risk)

COST

Bundled or Condition-Based Payment Level

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Savings
But Other Causes of Higher Costs CANNOT Be Controlled by Doctors

- Unusually Costly Patient
- Overutilization of Services
- Large Random Variation
- New, High-Cost Treatment
- Unusually Costly Patient
- Higher-Severity Patients

What Physicians CAN Control (Performance Risk):
- Many Avoidable Complications
- Failure to Follow Guidelines

What Physicians CANNOT Control (Insurance Risk):
- Savings
- Costs of Svcs

Bundled or Condition-Based Payment Level

COST

TIME

Actual
Actual
Proposed
Actual

FFS Pmts
FFS Pmts
Alt. Pmt Model $

FFS Pmts

Bundled or Condition-Based Payment Level
Physicians Should NOT Be Expected To Take Insurance Risk

- Many Avoidable Complications
- Failure to Follow Guidelines
- Overutilization of Services
- Large Random Variation
- New, High-Cost Treatment
- Unusually Costly Patient
- Higher-Severity Patients

What Physicians CAN Control (Performance Risk)

What Physicians CANNOT Control (Insurance Risk)

- Bundled or Condition-Based Payment Level
- Savings
- Excess Cost
- Costs of Svcs

- FFS Pmts
- Alt. Pmt Model $
## Four Mechanisms for Separating Insurance and Performance Risk

### COST

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### TIME

- Many Avoidable Complications
- Failure to Follow Guidelines
- Overutilization of Services
- Large Random Variation
- New, High-Cost Treatment
- Unusually Costly Patient
- Higher-Severity Patients
- Risk Corridors
- Risk Exclusions
- Outlier Pmt/Stop-Loss
- Risk Adjustment

### Savings

- Excess Cost

### Costs

- Savings
Protections For Providers Against Taking Inappropriate Risk

- **Risk Adjustment:** The payment rates to the provider would be adjusted based on objective characteristics of the patient and treatment that would be expected to result in the need for more services or increase the risk of complications.

- **Outlier Payment or Individual Stop Loss Insurance:** The payment to the provider from the payer would be increased if spending on an individual patient exceeds a pre-defined threshold. An alternative would be for the provider to purchase individual stop loss insurance (sometimes referred to as reinsurance) and include the cost of the insurance in the payment bundle.

- **Risk Corridors or Aggregate Stop Loss Insurance:** The payment to the provider would be increased if spending on all patients exceeds a pre-defined percentage above the payments. An alternative would be for the provider to purchase aggregate stop loss insurance and include the cost of the insurance in the payment bundle.

- **Adjustment for External Price Changes:** The payment to the provider would be adjusted for changes in the prices of drugs or services from other providers that are beyond the control of the provider accepting the payment.

- **Excluded Services:** Services the provider does not deliver, or order, or otherwise have the ability to influence would not be included as part of accountability measures in the payment system.