CREATING PHYSICIAN-FOCUSED ALTERNATIVE PAYMENT MODELS
Better Care for Patients, Lower Cost for Payers, and Financially Viable Physician Practices

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

www.CHQPR.org
Three Doors to the Future Under MACRA

- MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)
- ALTERNATIVE PAYMENT MODELS (APMs)
- PHYSICIAN-FOCUSED PAYMENT MODELS
Door #1: MIPS (Pay for Performance)

MIPS = PAY FOR PERFORMANCE

SGR Repeal
The Problem That P4P Was Supposed to Solve

PROBLEM

Physicians are paid the same amount under fee-for-service regardless of the quality of care they deliver
Most P4P “Solutions” Have Been Worse Than the Problem

PROBLEM

Physicians are paid the same amount under fee-for-service regardless of the quality of care they deliver

BAD “P4P”

Requiring physicians to deliver high-quality care regardless of whether they are paid adequately to do so

Penalizing physicians for quality problems they did not cause and cannot control

Penalizing physicians when patients don’t receive services they don’t need or want
Do Physicians Need “Incentives” to Deliver Higher Value Care?

Bonus

Penalty

P4P Based on Quality and Cost Measures

FFS
The Problem Isn’t “Incentives” But *Barriers* in FFS Payment

- A small bonus may not be enough to pay for delivering a high-value service or for the added costs of improving quality.
- A small bonus may not be enough to offset the costs of collecting and reporting the quality data.
- A small penalty may be less than the loss of fee-for-service revenue from healthier patients or lower utilization.
Door #2: Alternative Payment Models

MACRA → ALTERNATIVE PAYMENT MODELS (APMs)
MACRA Encourages Use of APMs Instead of MIPS

- Physicians who participate in approved Alternative Payment Models (APMs) at more than a minimum level:
  - are exempt from MIPS
  - receive a 5% lump sum bonus
  - receive a higher annual update (increase) in their FFS revenues
  - receive the benefits of participating in the APM
The Need for “Alternative Payment Models”

PROBLEM

Barriers in fee-for-service prevent physicians from delivering higher-quality care at lower total cost
The Need for “Alternative Payment Models”

PROBLEM

Barriers in fee-for-service prevent physicians from delivering higher-quality care at lower total cost

BARRIER #1
No payment or inadequate payment for many high-value services, e.g.,
- Responding to patient phone calls that can avoid office or ER visits
- Calls among physicians to determine a diagnosis or coordinate care delivery
- Hiring nurses to help chronic disease patient avoid exacerbations
- Providing palliative care, not just hospice

BARRIER #2
Loss of revenue when patients stay healthy and don’t need procedures
Most APMs Are “Shared Savings” Programs

**PROBLEM**

Barriers in fee-for-service prevent physicians from delivering higher-quality care at lower total cost

**“ALTERNATIVE” PAYMENT MODELS**

“Shared Savings”
- If the physician or health system can reduce spending below expected levels, the provider receives a share of the payer’s savings
Is Shared Savings Better Than MIPS?
Is Shared Savings Better Than MIPS?

MIPS/P4P

• Continue to pay only for what is billable under the Physician Fee Schedule at standard payment rates
Is Shared Savings Better Than MIPS?

MIPS/P4P

• Continue to pay only for what is billable under the Physician Fee Schedule at standard payment rates

• Provide a bonus if
  – quality is higher than average
  and
  spending is lower than average

• Impose a penalty if:
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  and
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Is Shared Savings Better Than MIPS?

**MIPS/P4P**
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**SHARED SAVINGS**
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**SHARED SAVINGS**
- Continue to pay only for what is billable under the Physician Fee Schedule at standard payment rates
- Provide a bonus if:
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- (“Track 2”) Impose a penalty if:
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SHARED SAVINGS IS JUST A DIFFERENT FORM OF P4P
Medicare ACOs Aren’t Succeeding Due to Flaws in Payment Model

2013 Results for Medicare Shared Savings ACOs
• 46% of ACOs (102/220) increased Medicare spending
• Only one-fourth (52/220) received shared savings payments
• After making shared savings payments, Medicare spent more than it saved

2014 Results for Medicare Shared Savings ACOs
• 45% of ACOs (152/333) increased Medicare spending
• Only one-fourth (86/333) received shared savings payments
• After making shared savings payments, Medicare spent more than it saved
Private Shared Savings ACOs Are Also Floundering

Many private-payer ACOs fail to yield lower costs, better quality

By Bob Herman  |  October 15, 2015

CHICAGO—Medicare’s investment in accountable care organizations has inspired hospitals and doctors to create their own versions of ACOs with private insurers. But as with Medicare, not all private ACOs are achieving lower costs and higher quality.

Providers and insurers need to do a better job of reaching patients and employers, according to physician executives at four large health insurance companies. They gave their take on the private ACO movement at an event held by America’s Health Insurance Plans, the industry’s trade group.

Their experiences reflect that ACOs are still a new structure, and building a new payment and care model as complex as an ACO is not easy to roll out.

“Our alternative payment models are succeeding at a much lower rate than they should be,” said Dr. Stephen Ondra, chief medical officer at Health Care Service Corp., the Blue Cross and Blue Shield insurer for five states. “In the ACO, the consumer engagement is very, very low.”
Why?? No Change in the Way Physicians Are Paid

MEDICARE, MEDICAID HEALTH PLAN

Fee-for-Service Payment

ACO

PATIENTS
- Heart Disease
- Cancer & Blood Disorders
- Back Pain
- Pregnancy

Primary Care  Cardiology  Hematology Oncology  Neurosurgery  OB/GYN
Most ACOs Spend a Lot on IT and Nurse Care Managers

MEDICARE, MEDICAID HEALTH PLAN

Fee-for-Service Payment

ACO

Expensive IT Systems
Nurse Care Managers

PATIENTS
Heart Disease
Cancer & Blood Disorders
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Primary Care
Cardiology
Hematology Oncology
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OB/GYN
Possible Future “Shared Savings” Doesn’t Support Better Care Today

MEDICARE, MEDICAID HEALTH PLAN

Fee-for-Service Payment → Shared Savings Payment??

ACO

Expensive IT Systems → Nurse Care Managers

Share of Shared Savings Payment??

PATIENTS
- Heart Disease
- Cancer & Blood Disorders
- Back Pain
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Primary Care → Cardiology → Hematology Oncology → Neurosurgery → OB/GYN
Most ACOs Today Aren’t Truly Redesigning Care

MEDICARE, MEDICAID HEALTH PLAN

Fee-for-Service Payment

Shared Savings Payment??

PATIENTS
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ACO

- Expensive IT Systems
- Nurse Care Managers

Share of Shared Savings Payment??

Primary Care
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Problems With “Shared Savings”

• Already efficient providers receive little or no additional revenue and may be forced out of business

• Physicians who have been practicing inefficiently or inappropriately are paid more than conservative physicians

• Physicians could be rewarded for denying needed care as well as by reducing overuse

• Physicians are placed at risk for costs they cannot control and random variation in spending

• Shared savings bonuses are temporary and when there are no more savings to be generated, physicians are underpaid
The Problem With ACO Payment
Is It Doesn’t Solve Barriers in FFS

MIPS/P4P
• Continue to pay only for what is billable under the Physician Fee Schedule at standard payment rates
• Provide a bonus if:
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• Impose a penalty if:
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APM
• Continue to pay only for what is billable under the Physician Fee Schedule at standard payment rates
• Provide a bonus if:
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  quality has improved
• (“Track 2”) Impose a penalty if:
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The Obvious Solution: Improve Physician Payment

**MIPS/P4P**
- Continue to pay only for what is billable under the Physician Fee Schedule at standard payment rates
- Provide a bonus if:
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**APM**
- Continue to pay only for what is billable under the Physician Fee Schedule at standard payment rates
- Change the way physicians are paid to address FFS barriers
- Provide a bonus if:
  - spending is lower than expected and
  - quality has improved
- (“Track 2”) Impose a penalty if:
  - spending is higher than expected
Instead, Everyone Thinks the Answer is “More Risk”

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**APM**
- Continue to pay only for what is billable under the Physician Fee Schedule at standard payment rates
- Provide a bonus if:
  - spending is lower than expected and
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- ("Track 2") Impose a penalty if:
  - spending is higher than expected
Or Only Pay Physicians Differently If They Accept *Significant* Risk

### MIPS/P4P
- Continue to pay only for what is billable under the Physician Fee Schedule at standard payment rates
- Provide a bonus if:
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- Impose a penalty if:
  - quality is lower than average and
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### APM
- Add additional payments beyond what is billable under the Physician Fee Schedule
- Provide a bonus if:
  - spending is lower than expected and
  - quality has improved
- (*“Track 2”) Impose a LARGE financial penalty if:
  - spending is higher than expected
Requirements for Financial Risk in APMs

What MACRA Says

- The APM Entity must
  - “bear financial risk for monetary losses under such alternative payment model that are in excess of a nominal amount;” or
  - be a medical home expanded by the Innovation Center
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What MACRA Says

• The APM Entity must
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What Proposed Regs Say

• The APM Entity is required to repay Medicare when spending on patients exceeds expected amounts, up to:
  – 4% of total Medicare spending (except for PCP practices with <50 clinicians)
Only 16% of Medicare Spending Goes to *Physicians*
4% of Medicare Spending = Huge Risk for Average Physician

Physicians: 16%

25% of Physician Revenues

4% of Total Medicare Spending

What CMS Definition of “More Than Nominal Risk” Means for Oncology

• Hypothetical oncology practice
  – 500 new Medicare patients each year
  – Average Medicare payments to the practice: $4,000/patient
  – Projected total Medicare spending on the patients: $50,000/patient
  – Target Medicare spending under APM: $48,000/patient (-4%)
  – Actual Medicare spending under APM: $55,000/patient (+10%)
What CMS Definition of “More Than Nominal Risk” Means for Oncology

**Hypothetical oncology practice**
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- Target Medicare spending under APM: $48,000/patient (-4%)
- Actual Medicare spending under APM: $55,000/patient (+10%)

**Impact of CMS APM financial risk standards on the practice**
- Current *practice revenue* from Medicare: $2 million (500 x $4,000)
- Total *Medicare spending* on patients: $27.5 million (500 x $55,000)
- Medicare spending above target: $3.5 million (500 x $7,000)
- 4% of Medicare spending = $1.1 million (500 x $55,000 x 4%)
- Risk: 55% of practice revenue ($1.1 million/$2 million)
Current CMS Alternative Payment Models

- Bundled Payments for Care Improvement (BPCI)
- Comprehensive Care for Joint Replacement (CJR)
- Comprehensive ESRD Care – Large Dialysis Organization
- Comprehensive ESRD Care – Small Dialysis Organization
- Comprehensive Primary Care Plus
- Frontier Community Health Integration Program
- Home Health Value Based Purchasing Model
- Independence at Home Demonstration
- Medicare Value-Based Insurance Design Model
- Part D Enhanced Medication Therapy Management Model
- Reducing Hospitalizations Among Nursing Home Residents
- Intravenous Immune Globulin Demonstration
- Maryland All-Payer Hospital Model
- Medicare Part B Drug Payment Model
- Medicare Care Choices Model
- Medicare Shared Savings Program (ACO) – Track 1
- Medicare Shared Savings Program (ACO) – Track 2
- Medicare Shared Savings Program (ACO) – Track 3
- Million Hearts Cardiovascular Risk Reduction Model
- Next Generation ACO Model
- Oncology Care Model – Track 1
- Oncology Care Model – Track 2
APMs Meeting the Risk Standards Under Proposed Rule

- Bundled Payments for Care Improvement (BPCI)
- Comprehensive Care for Joint Replacement (CJR)
- Comprehensive ESRD Care – Large Dialysis Organization
- Comprehensive ESRD Care – Small Dialysis Organization
- Comprehensive Primary Care Plus (Only for Small Practices)
- Frontier Community Health Integration Program
- Home Health Value Based Purchasing Model
- Independence at Home Demonstration
- Medicare Value-Based Insurance Design Model
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A Better Way to Define “More Than Nominal Financial Risk”

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<td>– 5% of the entity’s total revenue…</td>
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More Reasonable Risk Standard Should Be Used for All Practices

What MACRA Says

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What Proposed Regs Say

- The APM Entity is required to repay Medicare when spending on patients exceeds expected amounts, up to:
  - 4% of total Medicare spending (except for PCP practices with <50 clinicians)
  - 5% of the entity’s total revenue, if the entity is a primary care practice with 50 or fewer clinicians (2.5% of revenue in 2017, 3% in 2018, 4% in 2019)
Excessive Risk Is Not the Only Problem with CMS APMs
Excessive Risk Is Not the Only Problem with CMS APMs

Oncology Care Model
Starting with Current Payments for an Oncology Practice…

HOW ONCOLOGY PRACTICE IS PAID TODAY

<table>
<thead>
<tr>
<th>TREATMENT MONTHS</th>
<th>POST-TREATMENT CARE</th>
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<tbody>
<tr>
<td>$0</td>
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0 Dx

$0  $300  $600  $900  $1200

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

Infusion  Infusion  Infusion  Infusion  Infusion  Infusion  Infusion

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How Does the CMS Oncology Care Model Improve Payments?

HOW ONCOLOGY PRACTICE IS PAID IN CMMI OCM PROGRAM

$1200

$900

$600

$300

$0

0
Dx

1
2
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4
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15

TREATMENT MONTHS

POST-TREATMENT CARE

HOW ONCOLOGY PRACTICE IS PAID IN CMMI OCM PROGRAM
Higher Payments When Chemotherapy is Given

HOW ONCOLOGY PRACTICE IS PAID IN CMMI OCM PROGRAM

$960 in New Payment (6 x $160) for each 6 Month “Episode”
Practice is at Risk for Total Spending on Patients

HOW ONCOLOGY PRACTICE IS PAID IN CMMI OCM PROGRAM

$960 in New Payment (6 x $160) for each 6 Month “Episode”

Risk-Sharing on Total Spending

“Performance-Based Payment”
Problems with OCM Structure

• **$160 Monthly Enhanced Oncology Services (MEOS)**
  – MEOS only paid if a patient receives chemotherapy, so it penalizes the practice even more than today for avoiding fruitless treatment
  – Practice is required to significantly increase services, and it’s not clear the payment is adequate to cover the higher costs of those services
  – The MEOS payment will be recouped if patient is not “attributed” to the practice later based on the number of face-to-face office visits in claims data, even though the payment doesn’t require face-to-face services
Problems with OCM Structure

• **$160 Monthly Enhanced Oncology Services (MEOS)**
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• **Performance-Based Payment (Risk-Sharing)**
  – Practices would receive bonuses for delivering cheaper, less effective treatments to patients and for avoiding important surveillance testing
  – Practices would be penalized for higher-cost types of cancer and for health problems the patient has that are unrelated to cancer
  – Practices that are currently overusing services could be rewarded because target spending is based on the practice’s own historical costs
  – Practices could be penalized for treating higher-risk patients because risk adjustment does not capture major factors affecting spending
OCM Also Blindly Uses “Episodes” Where They Don’t Make Sense

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
And Shared Savings Is More Likely With Same Spending in 2 Episodes
Undesirable New Incentives for Oncology Practices

Penalty for Helping Patients Avoid Side Effects?

Incentive to Stretch Out Treatment?
**THE RIGHT WAY TO DESIGN PAYMENT REFORMS**

- **Physicians** Redesign Care and Identify Payment Barriers
- **Payers Change** Payment to Support Redesigned Care
- **Patients Get** Better Care and Physicians Stay Financially Viable
The Third Door Under MACRA

MACRA

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

ALTERNATIVE PAYMENT MODELS (APMs)

PHYSICIAN-FOCUSED PAYMENT MODELS
How Do You Define a Physician-Focused Alternative Payment Model?
Step 1: Identify Opportunities to Reduce Related Spending

**Fee-for-Service Payment (FFS)**

<table>
<thead>
<tr>
<th>Payments to Other Providers for Related Services</th>
<th>Avoidable Spending</th>
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<td>FFS Payments to Physician Practice</td>
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**Total Spending Relevant to the Physician’s Services**

**OPPORTUNITIES TO REDUCE SPENDING THAT PHYSICIANS CAN CONTROL**
- Reduce Avoidable Hospital Admissions
- Reduce Unnecessary Tests and Treatments
- Use Lower-Cost Tests and Treatments
- Deliver Services More Efficiently
- Use Lower-Cost Sites of Service
- Reduce Preventable Complications
- Prevent Serious Conditions From Occurring
Step 2: Identify Barriers in Current Payments That Need to Be Fixed

BARRIERS IN CURRENT FFS SYSTEM
• No Payment for Many High-Value Services
• Insufficient Revenue to Cover Costs When Using Fewer or Lower-Cost Services

OPPORTUNITIES TO REDUCE SPENDING THAT PHYSICIANS CAN CONTROL
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• Reduce Unnecessary Tests and Treatments
• Use Lower-Cost Tests and Treatments
• Deliver Services More Efficiently
• Use Lower-Cost Sites of Service
• Reduce Preventable Complications
• Prevent Serious Conditions From Occurring

Fee-for-Service Payment (FFS)

Avoidable Spending

Payments to Other Providers for Related Services

FFS Payments to Physician Practice

Unpaid Services

Total Spending Relevant to the Physician’s Services

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Step 3: Design an APM That Removes the Payment Barriers

Fee-for-Service Payment (FFS)

Physician Practice Revenue

Physician-Focused Alternative Payment Model

Total Spending Relevant to the Physician’s Services

Avoidable Spending

Payments to Other Providers for Related Services

FFS Payments to Physician Practice

Flexible, Adequate Payment for Physician’s Services

Unpaid Services
Step 4: Include Provisions to Assure Control of Cost & Quality

- Fee-for-Service Payment (FFS)
- Physician-Focused Alternative Payment Model

- Avoidable Spending
  - Payments to Other Providers for Related Services
  - FFS Payments to Physician Practice
  - Unpaid Services

- Savings
  - Payments to Other Providers for Related Services
  - Flexible, Adequate Payment for Physician’s Services

- Total Spending Relevant to the Physician’s Services

Accountability for Controlling Avoidable Spending
The CMS Models Are NOT the Only Way to Define APMs

- Primary Care Medical Home
- Episode Payment to Hospital
- Upside-Only Only Shared Savings
- “Two-Sided Risk” Shared Savings
- Full-Risk Capitation
There are More & Better Ways to Create *Physician-Focused* APMs

Primary Care Medical Home
Episode Payment to Hospital
Upside-Only Shared Savings
“Two-Sided Risk” Shared Savings
Full-Risk Capitation

APM #1: Payment for a High-Value Service
APM #2: Condition-Based Payment for a Physician’s Services
APM #3: Multi-Physician Bundled Payment
APM #4: Physician-Facility Procedure Bundle
APM #5: Warrantied Payment for Physician Services
APM #6: Episode Payment for a Procedure
APM #7: Condition-Based Payment
How Would You Design APMs for Hematology/Oncology?
Look at Each Condition Separately

<table>
<thead>
<tr>
<th>Conditions Treated</th>
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<tbody>
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<td>Sickle Cell Disease</td>
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## Step 2: Identify the Barriers in the Current Payment System

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<td>• Reduce avoidable ED visits, admits</td>
<td>• Inadequate payment for diagnosis &amp; treatment planning</td>
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<td>• Reduce avoidable spending on drugs</td>
<td>• Most revenues come from treatment</td>
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### Step 3: Design Solutions to Overcome the Barriers

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<th>Solutions via Alternative Payment Models</th>
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<td>• Inadequate payment for diagnosis &amp; treatment planning&lt;br&gt;• Most revenues come from treatment&lt;br&gt;• No payment for care management svcs</td>
<td>• Additional payment for tx planning and care management with accountability for utilization&lt;br&gt;• Condition-based payment for controllable spending</td>
</tr>
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<td>Sickle Cell Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemophilia</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other Conditions &amp; Procedures</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Opportunities, Barriers, and Solutions Will Differ by Condition

<table>
<thead>
<tr>
<th>Conditions Treated</th>
<th>Opportunities to Improve Care and Reduce Cost</th>
<th>Barriers in Current Payment System</th>
<th>Solutions via Alternative Payment Models</th>
</tr>
</thead>
</table>
| Cancer             | • Reduce avoidable ED visits, admits  
|                    | • Reduce avoidable spending on drugs  
|                    | • Reduce avoidable testing/imaging  
|                    | • Reduce fruitless end-of-life care  
|                    | • Inadequate payment for diagnosis & treatment planning  
|                    | • Most revenues come from treatment  
|                    | • No payment for care management svcs  
|                    | • Additional payment for tx planning and care management with accountability for utilization  
|                    | • Condition-based payment for controllable spending  |
| Sickle Cell Disease| • Reduce ED visits and hospitalizations due to pain and other complications  
|                    | • Reduce unnecessary transfusions  
|                    | • No payment for care management  
|                    | • No payment for phone & email consultations with specialists  
|                    | • Care management payment with accountability for utilization  
|                    | • Specialty medical home payment  |
| Hemophilia         |                                              |                                   |                                          |
| Other Conditions & Procedures |                                             |                                   |                                          |
## Different Payment Models for Different Hem/Onc Conditions

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<td>Hemophilia</td>
<td>• Manage clotting factor doses &lt;br&gt;• Prevent &amp; managing joint bleeding</td>
<td>• Inadequate payment for management of drug administration &lt;br&gt;• No payment for care management svcs</td>
<td>• Additional payment for enhanced svcs &lt;br&gt;• Condition-based payment for management</td>
</tr>
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Not Every Condition Needs an Alternative Payment Model

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<td>• FFS&lt;br&gt;• APM</td>
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Creating a Better Oncology APM
Opportunities to Reduce Cancer Spending w/o Harming Patients

- ED visits and hospital admissions for chemotherapy-related complications
- Unnecessarily expensive tests
- Unnecessary testing
- Unnecessarily expensive drugs
- Unnecessary drugs
- Unnecessary end-of-life treatment

Current Spending Per Patient

- ER/Hospital Admissions
- Other Services
- Testing
- Drugs
- E&M Infusions

Avoidable $
ASCO Choosing Wisely List
Targets Areas of High Spending

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 anticancer 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 or lesions 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.
   - Evidence does not support the use of these scans for staging of newly diagnosed low grade carcinomas of the prostate (Stage T1a/T2a, prostate-specific antigen (PSA) <10 ng/ml, Gleason score less than 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 no evidence demonstrating a benefit for the use of PET, CT, or radionuclide bone scans in asymptomatic individuals with newly diagnosed early 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., colorectal). 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 lead to 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 equally effective treatment programs 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).
20-50% Non-Adherence to Choosing Wisely Criteria

Rate of Non-Adherence to Choosing Wisely Guidelines

Do not use routine biomarker tests and advanced imaging to screen for recurrence in asymptomatic breast cancer patients...

Avoid anticancer therapy in patients with advanced solid tumors who are unlikely to benefit

Do not use white-cell stimulating factors for patients undergoing chemotherapy with less than 20% risk of febrile neutropenia

Do not use PET, CT and radionuclide bone scans in staging early prostate cancer at low risk of spreading

Do not use PET, CT and radionuclide bone scans in staging early breast cancer at low risk of spreading

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No Payment For Many Services Essential to Quality Cancer Care

- No payment for physician time outside of face-to-face visits with patients
- No payment for time spent with patients by non-physician staff (nurses, social workers, financial counselors, etc.)
Inadequate Time for Effective Diagnosis & Treatment Planning

With inadequate time:
- Easier to order multiple tests than to figure out which ones are most appropriate
- Easier to order the “usual” drugs rather than determine what’s exactly right for this patient
- Easier to order drugs that patients want than to help them understand the tradeoffs between length of life and quality of life
- Easier to continue treatment than to have a difficult end-of-life discussion

- No payment for physician time outside of face-to-face visits with patients
- No payment for time spent with patients by non-physician staff (nurses, social workers, financial counselors, etc.)
No Payment For Services Needed to Improve Outcomes of Care

Current Spending Per Patient

- ER/Hospital Admissions
- Other Services
- Testing
- Avoidable $
- Drugs
- E&M Infusions
- Non-E&M

• ED visits and hospital admissions for chemotherapy-related complications
No payment for services needed to improve outcomes of care.

Current spending per patient:

- ER/Hospital Admissions
- Other Services
- Testing
- Avoidable $ (Drugs)
- E&M Infusions
- Non-E&M Care Mgt

- No payment for 24/7 hotline and triage services needed by patients experiencing complications
- No payment for extended hours or open schedule slots for urgent care
Inability to Address Problems in the Practice → High Use of ED

Lack of practice resources to help patients:
- No choice for patients but to visit ED
- Delay in seeking treatment may cause more severe complications requiring hospitalization

- No payment for 24/7 hotline and triage services needed by patients experiencing complications
- No payment for extended hours or open schedule slots for urgent care
Large Reductions in Avoidable Hospitalizations Are Possible

Source: Sprandio JD. “Oncology patient-centered medical home and accountable cancer care.” Community Oncology, December 2010

**FIGURE 3** Average emergency room (ER) evaluations at Delaware County Memorial Hospital of the Drexel Hill office population per chemotherapy patient per year, 2004–2010 (YTD).
Failure to Pay for Good Care… Leads to Costly, Low-Value Services

Current Spending Per Patient

- ED visits and hospital admissions for chemotherapy-related complications
- Unnecessarily expensive tests
- Unnecessary testing
- Unnecessarily expensive drugs
- Unnecessary drugs
- Unnecessary end-of-life treatment

Avoidable $:
- No payment for physician time outside of face-to-face visits with patients
- No payment for time spent with patients by non-physician staff (nurses, social workers, financial counselors, etc.)
- No payment for 24/7 hotline and triage services needed by patients experiencing complications
- No payment for extended hours or open schedule slots for urgent care

Drug Margin

Drugs

Testing

Other Services

ER/Hospital Admissions

- $45,000
- $40,000
- $35,000
- $30,000
- $25,000
- $20,000
- $15,000
- $10,000
- $5,000
- $0

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ASCO Payment Reform Developed by Oncologists & Practice Managers

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- Dan Zuckerman, MD, Mountain States Tumor Institute
- Tammy Chambers, Center for Cancer and Blood Disorders
- James Frame, MD, CAMC Cancer Center
- Bruce Gould, MD, Northwest Georgia Oncology Center
- Ann Kaley, Mountain States Tumor Institute
- Justin Klamerus, MD, Karmanos Cancer Institute
- Lauren Lawrence, Karmanos Cancer Institute
- Barbara McAneny, MD, New Mexico Cancer Center
- Roscoe Morton, MD, Cancer Center of Iowa
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- Scott Parker, Northwest Georgia Oncology Center
- Charles Penley, MD, Tennessee Oncology
- Gabrielle Rocque, MD, University of Alabama at Birmingham
- Barry Russo, Center for Cancer and Blood Disorders
- Joel Saltzman, MD, Seidman Cancer Center
- Laura Stevens, Innovative Oncology Business Solutions
- Jeffery Ward, MD, Swedish Cancer Institute
- Kim Woofter, Michiana Hematology Oncology
- Robin Zon, MD, Michiana Hematology Oncology

www.asco.org/paymentreform
PCOP Part 1: More Payment to Practices Where It’s Needed

Current FFS Payment vs. Patient-Centered Oncology Payment

- Drug Margin
- E&M Infusions
- Non-E&M Care Mgt
- Better Payment for Practices

Oncology Practice Receives Higher Payments Than Today
PCOP Part 2: Implement ASCO Guidelines & Control Hospital Use

Current FFS Payment

- ER/Hospital Admissions
- Other Services
- Testing
- Drugs
  - Drug Margin
  - E&M Infusions
  - Non-E&M Care Mgt

Patient-Centered Oncology Payment

- ER/Admissions
- Other Services
- Testing
- Drugs
  - Drug Margin
  - PCOP Pmts
  - E&M Infusions

Oncology Practice Helps Patients Avoid Use of ED/Hospital for Complications of Treatment

Oncology Practice Follows ASCO Guidelines for Use of Chemotherapy, Supportive Drugs, Testing/Imaging, and End-of-Life Care

Oncology Practice Receives Higher Payments Than Today

Lower Spending without Rationing
Better Payment for Practices
PCOP Result: Better Care, Better Payment, Payer Savings

Greater Payer Savings with Better Care

- **Better Payment for Practices**
  - Drug Margin
  - E&M Infusions
  - Non-E&M Care Mgt

- **Lower Spending without Rationing**
  - ER/Hospital Admissions
  - Other Services
  - Testing

- **Avoidable $**

Greater Payer Savings with Better Care

- **Oncology Practice Helps Patients Avoid Use of ED/Hospital for Complications of Treatment**
- **Oncology Practice Follows ASCO Guidelines for Use of Chemotherapy, Supportive Drugs, Testing/Imaging, and End-of-Life Care**
- **Oncology Practice Receives Higher Payments Than Today**

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Analysis of PCOP Shows Large Net Savings from Better Payment

### Costs and Savings from Patient-Centered Oncology Payment

<table>
<thead>
<tr>
<th></th>
<th>Current Average Spending Per Beneficiary</th>
<th>With Proposed New Payments and Estimated Savings</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Month Prior to Treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M Services</td>
<td>$296</td>
<td>$296</td>
<td>0%</td>
</tr>
<tr>
<td>PCOP</td>
<td>$750</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>During and 2 Months After Treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M Services</td>
<td>$2,071</td>
<td>$2,071</td>
<td>0%</td>
</tr>
<tr>
<td>Infusion Services</td>
<td>$1,904</td>
<td>$1,904</td>
<td>0%</td>
</tr>
<tr>
<td>PCOP</td>
<td>$1,190</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy/Drugs</td>
<td>$25,131</td>
<td>$23,372</td>
<td>-7%</td>
</tr>
<tr>
<td>Lab Tests</td>
<td>$583</td>
<td>$553</td>
<td>-5%</td>
</tr>
<tr>
<td>Imaging</td>
<td>$1,503</td>
<td>$1,428</td>
<td>-30%</td>
</tr>
<tr>
<td>ED/Ambulance</td>
<td>$421</td>
<td>$295</td>
<td>-30%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$7,100</td>
<td>$4,970</td>
<td>-30%</td>
</tr>
<tr>
<td>Other</td>
<td>$10,920</td>
<td>$10,920</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Months 3-6 After Treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M Services</td>
<td>$120</td>
<td>$120</td>
<td>0%</td>
</tr>
<tr>
<td>PCOP</td>
<td>$220</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$50,048</strong></td>
<td><strong>$48,089</strong></td>
<td>-3.9%</td>
</tr>
</tbody>
</table>

For 500 New Patients:

- Additional Practice Revenues: $1,080,000
- Net Payer Savings: $979,802
New Billing Codes Will Be Easy for Payers & Practices to Implement

• **New Billing Code for New Patient Treatment Planning**
  The oncology practice would bill the payer for a $750 payment for each new oncology patient who begins treatment or active management with the practice.

• **New Billing Code for Care Management During Treatment**
  The oncology practice would bill the payer for a $200 payment for each month in which an oncology patient is receiving parenteral or oral anti-cancer treatment prescribed by the practice. This payment would also be made for patients who are in hospice if the oncologist is the hospice physician.

• **New Billing Code for Care Management During Active Monitoring**
  The oncology practice would bill the payer for a $50 per month payment when an oncology patient was not receiving anti-cancer treatment but was being actively monitored by the practice. This would include any months in which treatment was not received before a treatment regimen was completed and up to six months after the completion of treatment.

• **Continuation of Current Billing Codes for Services**
  The practice would continue to bill the payer for all existing CPT and HCPCS codes (e.g., E&M services, infusions, drugs administered in the practice, etc.)
What Do Payers Need to Know and Do to Implement APMs?
## Five Key Elements of an APM

<table>
<thead>
<tr>
<th>Key Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trigger for Payment of Service?</td>
<td>Submission of claim with CPT and ICD codes or bundled service or condition mgmt code.</td>
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<tr>
<td>Services Included In a Single Payment?</td>
<td>Services defined by a CPT code or a bundled service code; coding rules avoid double billing.</td>
</tr>
<tr>
<td>Amount of Payment for Service?</td>
<td>Payment defined in advance by standard RVU weight and annual conversion factor or based on expected cost.</td>
</tr>
<tr>
<td>Adjustment for Differences in Patient Needs?</td>
<td>Payment adjusted post-delivery by comparison to FFS billings by non-bundled providers + discount.</td>
</tr>
<tr>
<td>Physician Who Is Accountable for Cost &amp; Quality?</td>
<td>Physician billed using the CPT code or as the manager of the bundle of services.</td>
</tr>
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## Implementation of These Elements in the Physician Fee Schedule

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<th>Current RBRVS</th>
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<tr>
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<td>More billable services delivered to higher-need pts</td>
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<tr>
<td><strong>Physician Who Is Accountable for Cost &amp; Quality?</strong></td>
<td>Physician who bills using the CPT code</td>
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# How Do You “Build an APM on the FFS Architecture?”

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<th><strong>Payer-Administered APMs</strong></th>
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<td>Trigger formula based on retrospective pattern of CPT and ICD codes</td>
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<td>Claims retrospectively “grouped” into bundle using formula based on CPT and ICD codes</td>
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<td>Adjusted using risk score based on (some) prior ICD codes</td>
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<td>Physician is “attributed” responsibility after care is delivered using CPTs</td>
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Physicians Find Out What They’ll Be Paid After Care is Delivered

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## Payments Are Tied to What Is Coded Using CPT & ICD Codes

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Example #1 of Problems w/ APMs Built on (Current) FFS Structure

Patient-Centered Medical Home (PCMH) programs (e.g., CMS Comprehensive Primary Care Initiative and private health plan programs) pay PCPs a monthly payment per patient (PMPM) in addition to E&M payments for face-to-face visits

- **Good**: PMPM gives PCP flexibility to deliver a wide range of services beyond what is possible through E&M visits; PMPM provides resources to manage patient care without the need for face-to-face visits

- **Bad**: PMPM is only paid for patients “attributed” to the PCP, and the attribution formula is based on the number of E&M visits the physician had with the patient, so if the physician doesn’t bring the patient in for office visits, they could lose the payment needed to support the non-office-visit-based care

- **What’s Missing**: A way for the physician to indicate that they are managing the patient’s care for one or more conditions during the month
CMS and private health plans are using “episode groupers” to determine which services are related to a patient’s condition or treatment and they are using episode attribution rules to determine which physician is responsible for the episode

- Good: Most physicians can only influence the services patients receive for the conditions they are treating, not the total cost of care for all of the patient’s health problems
- Bad: Episode groupers “guess” at which services are inter-related based on their proximity in time and based on the presence or absence of diagnosis codes, and the groupers make a lot of mistakes
- Bad: Attribution rules assign episodes to physicians based on who had the most expensive services or who saw the patient the most, not based on who was actually in charge, and the attribution formula can make mistakes
- What’s Missing: A way for a physician to indicate that they are managing the patient’s care during an episode and a way to determine the clinical rationale for a service and whether it’s related to previous services
Example #3 of Problems w/ APMs
Built on (Current) FFS Structure

CMS uses the Hierarchical Condition Category (HCC) system to risk adjust payments to physicians under various APMs

- **Good**: Risk adjustment is needed to ensure that physicians receive higher payments for patients who have more health problems that require more services and increase the likelihood of poor outcomes
- **Bad**: HCCs were designed to predict total spending by Medicare Advantage plans (and do not do that very well), they were not designed to predict patient needs for services related to specific health problems
- **Bad**: HCCs are based on ICD diagnosis codes, and even ICD-10 codes do not capture many important differences in disease severity or other patient characteristics that can significantly affect service needs and outcomes
- **Bad**: HCCs weight diagnoses codes the same way for all patients, even though different diagnoses have different impacts on the types of care delivered by different physicians
- **What’s Missing**: A way for the physician to indicate that a patient has the specific characteristics that affect their need for the services delivered by that physician and/or their risk of complications and poor outcomes
## A Better Way to Define APMs: An Expanded FFS Architecture

<table>
<thead>
<tr>
<th></th>
<th>Current RBRVS</th>
<th>Physician-Focused APMs</th>
<th>Payer-Administered APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trigger for Payment of Service</strong></td>
<td>Submission of claim with CPT and ICD codes</td>
<td>Submission of claim with bundled service or condition mgt code</td>
<td>Trigger formula based on retrospective pattern of CPT and ICD codes</td>
</tr>
<tr>
<td><strong>Services Included In Single Payment</strong></td>
<td>CPT code defines services included; coding rules avoid double billing</td>
<td>Bundled service code defines services included and excluded &amp; time period involved</td>
<td>Claims retrospectively “grouped” into bundle using formula based on CPT and ICD codes</td>
</tr>
<tr>
<td><strong>Amount of Payment for Service</strong></td>
<td>Defined in advance by standard RVU weight and annual conversion factor</td>
<td>Defined in advance based on expected cost of delivering services in bundle</td>
<td>Determined after services delivered by comparison to FFS billings by non-bundled providers + discount</td>
</tr>
<tr>
<td><strong>Adjustment for Differences in Patient Needs</strong></td>
<td>More billable services delivered to higher-need pts</td>
<td>Multiple levels defined based on patient characteristics</td>
<td>Adjusted using risk score based on (some) prior ICD codes</td>
</tr>
<tr>
<td><strong>Physician Accountable for Cost &amp; Quality</strong></td>
<td>Physician who bills using the CPT code</td>
<td>Physician who bills as the manager of the bundle of services</td>
<td>Physician is “attributed” responsibility after care is delivered using CPTs</td>
</tr>
</tbody>
</table>
MACRA Requires Development of Three New Types of Codes

- Care Episode Groups (and associated codes)
- Patient Condition Groups (and associated codes)
- Patient Relationship Categories (and associated codes)
Care Episode & Patient Condition Groups Under MACRA

DEVELOPMENT OF CARE EPISODE AND PATIENT CONDITION GROUPS

The Secretary shall establish care episode groups and patient condition groups, which account for a target of an estimated 1/2 of expenditures under parts A and B (with such target increasing over time as appropriate); and assign codes to such groups.

CARE EPISODE GROUPS.—In establishing care episode groups, the Secretary shall take into account the patient’s clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization occurs, and the principal procedures or services furnished; and other factors determined appropriate by the Secretary.

PATIENT CONDITION GROUPS.—In establishing patient condition groups, the Secretary shall take into account the patient’s clinical history at the time of a medical visit, such as the patient’s combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period, such as 3 months); and other factors determined appropriate by the Secretary.
DEVELOPMENT OF PATIENT RELATIONSHIP CATEGORIES AND CODES

The Secretary shall develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service.

Patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes may reflect combinations of such categories), such as a physician or applicable practitioner who—

(i) considers themself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;

(ii) considers themself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

(iii) furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;

(iv) furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or

(v) furnishes items and services only as ordered by another physician or practitioner.
## Timetable for CMS Adoption and Use of New Codes Under MACRA

<table>
<thead>
<tr>
<th>Estimated Date</th>
<th>Care Episode Groups and Codes</th>
<th>Patient Condition Groups and Codes</th>
<th>Patient Relationship Categories &amp; Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 16, 2016</td>
<td>Draft list of care episode codes</td>
<td>Draft list of patient condition codes</td>
<td>Draft patient relationship categories and codes</td>
</tr>
<tr>
<td>November 25, 2016</td>
<td>Draft list of care episode codes</td>
<td>Draft list of patient condition codes</td>
<td></td>
</tr>
<tr>
<td>April 20, 2017</td>
<td>Operational list of care episode codes</td>
<td>Operational list of patient condition codes</td>
<td>Operational list of patient relationship categories and codes</td>
</tr>
<tr>
<td>December 20, 2017</td>
<td>Operational list of care episode codes</td>
<td>Operational list of patient condition codes</td>
<td></td>
</tr>
<tr>
<td>January 1, 2018</td>
<td>Include care episode codes on claim forms</td>
<td>Include patient condition codes on claim forms</td>
<td>Include patient relationship category codes on claim forms</td>
</tr>
</tbody>
</table>
Potential Patient Characteristics for Stratifying Chemo Payment Amounts

1. Comorbidities, measured using the Charlson Comorbidity Scale but with no points assigned to cancer diagnoses

2. Performance status, measured using the ECOG scale

3. Toxicity of the patient’s drug regimen

4. Complexity of administration of the drug regimen for both the practice and patient
# Examples of a Stratification Structure

<table>
<thead>
<tr>
<th>Points</th>
<th>Hospitalization Risk (risk-grade III/IV-toxicity)</th>
<th>Impact on QOL and ADLs (risk-grade I/II-toxicity)</th>
<th>Risk of Toxic Death (risk)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>&lt;20%</td>
<td>&lt;50%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>2</td>
<td>20%–35%</td>
<td>50%–75%</td>
<td>1%–9%</td>
</tr>
<tr>
<td>4</td>
<td>&gt;35%</td>
<td>&gt;75%</td>
<td>&lt;10%</td>
</tr>
</tbody>
</table>

## Toxicity of Drugs Factor

<table>
<thead>
<tr>
<th>Points</th>
<th>Infusions/Injections (including combo-infusion/oral)</th>
<th>Multiple Infusions/ Month</th>
<th>Oral Drugs Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Any injection (subcutaneous or IM), +</td>
<td>Single Drug +</td>
<td>(2nd and subsequent months)</td>
</tr>
<tr>
<td></td>
<td>Port flush, +</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>D/C SFU pump, +</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Central line maintenance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Less than one hour of nursing care, +</td>
<td>2+ treatments per month at level 1a</td>
<td>Single Drug (initial month) or Single Drug with on-off pattern (2nd and subsequent months)</td>
</tr>
<tr>
<td></td>
<td>Monoclonal therapy with low incidence of adverse event, +</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chemo infused in less than 15 minutes or IVR, +</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uncomplicated hydration, +</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bisphosphonate therapy, +</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Iron replacement therapy, +</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2-3 hours of nursing care, +</td>
<td>2+ treatments per month at level 2a</td>
<td>Multiple Drugs + every day or Single Drug with on-off pattern (initial month)</td>
</tr>
<tr>
<td></td>
<td>Single agent chemotherapy, +</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Single agent chemo + bisphosphonate, +</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Single agent chemo + monoclonal (other than Rituxan), +</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Side effect management requiring supportive drugs, +</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Subsequent day chemotherapy less than 3 hours, +</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Single agent Rituxan, +</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weekly combo therapy:2-3 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>4-5 hours of nursing care, +</td>
<td></td>
<td>Multiple Drugs w/ long-term pattern (2nd and subsequent months)</td>
</tr>
<tr>
<td></td>
<td>Combination therapy, +</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any level-3 regimen or research protocol that requires VS monitoring, +</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weekly combination regimen with a monoclonal, +</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>6-8 hours of nursing care, +</td>
<td>2+ treatments per month at level 3a</td>
<td>Multiple Drugs w/ on-off pattern (initial month)</td>
</tr>
<tr>
<td></td>
<td>Combination therapy lasting more than 6 hours, +</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chemo regimens requiring an advanced procedure, +</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient at lower acuity but requires full care, +</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Stem cell transplant, +</td>
<td>2+ treatments per month at level 4a</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Stem cell transplant, +</td>
<td>2+ treatments per month at level 4a</td>
<td></td>
</tr>
</tbody>
</table>
What Happens to ACOs with Physician-Focused APMs?
Each Patient Should Have a Good Primary Care Practice…
…With Payment That Enables Delivery of Good Primary Care…

**MEDICARE, MEDICAID HEALTH PLAN**

**PATIENTS**
- Heart Disease
- Cancer & Blood Disorders
- Back Pain

Payment That Supports Good Primary Care

**Primary Care Practice**
...And PCPs Take Accountability for Costs They Can Control/Influence

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS
Heart Disease
Cancer & Blood Disorders
Back Pain

Primary Care Practice

Payment That Supports Good Primary Care

Accountability for:
• Avoidable ER Visits
• Avoidable Hospitalizations
• Unnecessary Tests
• Unnecessary Referrals
• Adequate Preventive Care
Give PCPs a Medical Neighborhood to Consult With on Difficult Cases

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS
- Heart Disease
- Cancer & Blood Disorders
- Back Pain

Primary Care Practice

Cardiology, Hem/Onc, Physiatry

Payment That Supports Good Primary Care
Pay the Medical Neighbors to Support the PCPs

**MEDICARE, MEDICAID HEALTH PLAN**

**PATIENTS**
- Heart Disease
- Cancer & Blood Disorders
- Back Pain

Primary Care Practice

Cardiology, Hem/Onc, Physiatry

Payment That Supports Good Primary Care

Payment That Supports Diagnostic & Care Management Help From Specialists
Ask the Medical Neighbors to Be Accountable for Costs They Control

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS
- Heart Disease
- Cancer & Blood Disorders
- Back Pain

Primary Care Practice
- Payment That Supports Good Primary Care
- Accountability for:
  - Appropriate Use of Testing and Interventions
  - Improving Chronic Disease Management

Cardiology, Hem/Onc, Physiatry
- Payment That Supports Diagnostic & Care Management Help From Specialists

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Have Good Specialists Ready to Manage Serious Conditions…

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS

| Heart Disease | Cancer & Blood Disorders | Back Pain |

Primary Care Practice

Cardiology Group

Neurosurg. Group

Hem/Onc Group

Cardiology, Hem/Onc, Physiatry

Payment That Supports Good Primary Care

Payment That Supports Diagnostic & Care Management Help From Specialists

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Pay Them To Deliver Quality Care at the Most Affordable Cost

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS
- Heart Disease
- Cancer & Blood Disorders
- Back Pain

Primary Care Practice

Payment That Supports Good Primary Care

Cardiology Group

Neurosurg. Group

Hem/Onc Group

Cardiology, Hem/Onc, Physiatry

Payment That Supports Diagnostic & Care Management Help From Specialists

Payment That Supports Good Management of Heart Disease

Payment That Supports Good Care for Back Pain

Payment That Supports Good Care for Cancer & Blood Disorders
Ask Specialists to Be Accountable for Costs They Can Control

Accountability for:
• Using Appropriate Procedures
• Avoiding Complications of Procedures

PATIENTS
- Heart Disease
- Cancer & Blood Disorders
- Back Pain

Primary Care Practice
- Payment That Supports Good Primary Care

Cardiology, Hem/Onc, Physiatry
- Payment That Supports Diagnostic & Care Management Help From Specialists

Cardiology Group
- Payment That Supports Good Management of Heart Disease

Neurosurg. Group
- Payment That Supports Good Care for Back Pain

Hem/Onc Group
- Payment That Supports Good Care for Cancer & Blood Disorders
That’s an “ACO,” But Built from the Bottom Up, Not the Top Down

MEDICARE, MEDICAID HEALTH PLAN

Alternative Payment Models

PATIENTS

Heart Disease
Cancer & Blood Disorders
Back Pain

Payment That Supports Good Primary Care
Primary Care Practice
Cardiology, Hem/Onc, Physiatry

Cardiology Group
Neurosurg. Group
Hem/Onc Group

Payment That Supports Good Management of Heart Disease
Payment That Supports Good Care for Back Pain
Payment That Supports Good Care for Cancer & Blood Disorders

“ACO”
A True ACO Can Take a Global Payment And Make It Work

**MEDICARE, MEDICAID**
**HEALTH PLAN, EMPLOYER**

Risk-Adjusted Global Payment

**ACO**

- **Cardiology Group**
- **Neurosurg. Group**
- **Hem/Onc Group**

Payment That Supports Good Management of Heart Disease
Payment That Supports Good Care for Back Pain
Payment That Supports Good Care for Cancer & Blood Disorders

- **Primary Care Practice**
- **Cardiology, Hem/Onc, Physiatry**

Payment That Supports Good Primary Care
Payment That Supports Diagnostic & Care Management Help From Specialists

**PATIENTS**
- Heart Disease
- Cancer & Blood Disorders
- Back Pain
Instead of a Vision That Won’t Work and Patients Don’t Want…
Instead of a Vision That Won’t Work and Patients Don’t Want…

Primary Care from a Medical Home

PATIENT
Instead of a Vision That Won’t Work and Patients Don’t Want…

PATIENT

Primary Care from a Medical Home

Joint Replacement from a Hospital
Instead of a Vision That Won’t Work and Patients Don’t Want…

- Primary Care from a Medical Home
- Everything Else from an ACO
- Joint Replacement from a Hospital

“Coordinated” Low Quality High-Priced Health Care
Pursue a Vision That Will Benefit Patients, Providers & Payers
Pursue a Vision That Will Benefit Patients, Providers & Payers

A Better Vision

HEALTHY PATIENTS → Primary Care from a Medical Home → Accountable Medical Home Payment
Pursue a Vision That Will Benefit Patients, Providers & Payers

A Better Vision

Healthy Patients

Primary Care from a Medical Home

Accountable Medical Home Payment

Patients with a Health Problem

PCP

Condition-Based Payment

Specialist
Pursue a Vision That Will Benefit Patients, Providers & Payers

A Better Vision

- **HEALTHY PATIENTS**
  - Primary Care from a Medical Home
  - Accountable Medical Home Payment

- **PATIENTS WITH A HEALTH PROBLEM**
  - PCP
  - Specialist
  - Condition-Based Payment

- **PATIENTS WITH A SERIOUS CONDITION**
  - Treatment & Management by a Specialist
  - Specialty Medical Home Payment

HEALTHY PATIENTS

PATIENTS WITH A HEALTH PROBLEM

PATIENTS WITH A SERIOUS CONDITION

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Pursue a Vision That Will Benefit Patients, Providers & Payers

A Better Vision

HEALTHY PATIENTS

Primary Care from a Medical Home

Accountable Medical Home Payment

PATIENTS WITH A HEALTH PROBLEM

PCP

Condition-Based Payment

Specialist

PATIENTS WITH A SERIOUS CONDITION

Treatment & Management by a Specialist

Specialty Medical Home Payment

PATIENTS WITH MULTIPLE HEALTH PROBLEMS

Accountable Care Team

PCP

Multi-Condition Payment or Risk-Adjusted Global Payment

Specialist

Specialist

Specialist
Physician-Focused APMs Can Create Win-Win-Win Solutions

MACRA

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

ALTERNATIVE PAYMENT MODELS (APMs)

PHYSICIAN-FOCUSED PAYMENT MODELS
Learn More About Win-Win-Win Payment and Delivery Reform

www.PaymentReform.org
For More Information:

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

Miller.Harold@CHQPR.org
(412) 803-3650

www.CHQPR.org
www.PaymentReform.org
APPENDIX:
Improving Payment for Part B Drugs
Current Method of Paying for Oncology Drugs

- **PAYMENT**
  - ASP from 2 quarters earlier
  - + x%

- **COSTS**
Current Payments May or May Not Cover the Cost of Drugs

PAYMENT

COSTS

ASP from 2 quarters earlier + x%  

Drug Acquisition Cost  

Drug Acquisition Cost
The Cost of Administering Drugs Is Not Just the Cost of the Drugs

PAYMENT

COSTS

- ASP from 2 quarters earlier
- Drug Acquisition Cost
- Bad Debt
- Wastage
- Pharmacy Operating Cost
- x%

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Oncology Practices Are at Significant Financial Risk

PAYMENT

COSTS

ASP from 2 quarters earlier + x%
Goal for Reform: Pay Practice for What It Costs to Buy & Use Drugs

COSTS

Drug Acquisition Cost

Profit

Bad Debt

Wastage

Pharmacy Operating Cost

Drug Acquisition Cost

Bad Debt

Wastage

Pharmacy Operating Cost

Loss

FUTURE PAYMENT

Pharmacy Operation Cost

Drug Acquisition Cost

Drug Acquisition Cost

Pharmacy Operation Cost

Drug Acquisition Cost

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Starting With the Current System…

**CURRENT**

- ASP from 2 quarters earlier + x%
- Margin to Cover Losses on Patient Care
  - Bad Debt
  - Wastage
  - Pharmacy Operating Cost
  - Drug Acquisition Cost
Component #1: Pay for Drug Acquisition Cost

CURRENT

- Margin to Cover Losses on Patient Care
- Bad Debt
- Wastage
- Pharmacy Operating Cost

FUTURE

- Payment for Average Drug Acquisition Cost in Current Quarter

Drug Acquisition Cost

ASP from 2 quarters earlier + x%

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Component #2: Pay for Costs of Operating Pharmacy

CURRENT

- ASP from 2 quarters earlier + x%
- Drug Acquisition Cost
- Bad Debt
- Wastage
- Pharmacy Operating Cost

FUTURE

- y%
- $x
- Payment for Average Drug Acquisition Cost in Current Quarter
- Bad Debt
- Wastage
- Pharmacy Operating Cost
- Drug Acquisition Cost
Component #3: Transfer Any Remaining Margin to Other Pmts

CURRENT

- Margin to Cover Losses on Patient Care
- Bad Debt
- Wastage
- Pharmacy Operating Cost
- Drug Acquisition Cost

FUTURE

- Oral Rx Pmt
- CareMgt Pmt
- New Pt Pmt
- Costs Not Covered by E&M and Infusion Codes
  - Bad Debt
  - Wastage
  - Pharmacy Operating Cost
- Payment for Average Drug Acquisition Cost in Current Quarter
- Drug Acquisition Cost

ASP from 2 quarters earlier + x%
Margin to Cover Losses on Patient Care

CURRENT

- Bad Debt
- Wastage
- Pharmacy Operating Cost

Drug Acquisition Cost

FUTURE

- Oral Rx Pmt
- CareMgt Pmt
- New Pt Pmt

Oral Rx Pmt

+$x$

Costs Not Covered by E&M and Infusion Codes

- Bad Debt
- Wastage
- Pharmacy Operating Cost

Payment for Average Drug Acquisition Cost in Current Quarter

We don’t have a good alternative way of controlling drug prices if oncologists aren’t at partial risk for drug prices

ASP from 2 quarters earlier + x%
Challenge #2 in Replacing Buy and Bill

CURRENT

- ASP + x%
- Drug Acquisition Cost
- Margin to Cover Losses on Patient Care

FUTURE

- Drug Acquisition Cost
- Oral Rx Pmt
- CareMgt Pmt
- New Pt Pmt
- Costs Not Covered by E&M and Infusion Codes

We don’t know how much these costs are & practices don’t want bad debt.
Challenge #3 in Replacing Buy and Bill

Current:
- Margin to Cover Losses on Patient Care
- ASP + x%
- Drug Acquisition Cost
- Bad Debt
- Wastage
- Pharmacy Operating Cost

Future:
- Nobody believes the full margin will be converted to fees
- Oral Rx Pmt
- CareMgt Pmt
- New Pt Pmt
- +y%
- +$x
- Drug Acquisition Cost
- Costs Not Covered by E&M and Infusion Codes
- Bad Debt
- Wastage
- Pharmacy Operating Cost
- Drug Acquisition Cost

Nobody believes the full margin will be converted to fees.
Challenge #4 in Replacing Buy and Bill

Drug prices increase over time and Medicare physician fees don’t, so revenue increases more if part of payment is tied to drug prices.