REDESIGNING HEALTH CARE FROM THE BOTTOM UP INSTEAD OF FROM THE TOP DOWN
How Physicians Can be a Disruptive Force for Better Care and Lower Spending

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

www.CHQPR.org
Healthcare Spending is the Biggest Driver of Federal Deficit

- **Debt Interest**: 94% Increase ($1 Trillion)
- **Medicaid**: 85% Increase ($770 Billion)
- **Medicare**: 25% Increase ($400 Billion)

*Projected Federal Budget Spending, 2016-2027 (Billions)*
Premiums Have Increased 73% More Than Inflation Since 2002

Average Family Premiums, Employer-Sponsored Insurance

Source: Medical Expenditure Panel Survey & Bureau of Labor Statistics

Family Premiums $6,164 Higher Than Inflation
Premiums Have Grown Faster Than Worker Earnings

Source: Medical Expenditure Panel Survey & Bureau of Labor Statistics
Family Premiums Now Equal to One-Third of Worker Pay

Source: Medical Expenditure Panel Survey & Bureau of Labor Statistics
How Do You Control Growing Healthcare Spending?

TOTAL HEALTHCARE SPENDING

TOTAL HEALTHCARE SPENDING

TOTAL HEALTHCARE SPENDING

TOTAL HEALTHCARE SPENDING

$ TIME
Typical Strategy #1: Cut Provider Fees for Services

- **TOTAL HEALTH CARE SPENDING**
- **TOTAL HEALTH CARE SPENDING**
- **TOTAL HEALTH CARE SPENDING**
- **SAVINGS**

Savings: Cut Provider Fees

**Typical Strategy #1:**
Cut Provider Fees for Services
Typical Strategy #2: Shift Costs to Patients

Typical Strategy #2:
Shift Costs to Patients

Higher Cost-Share & Deductibles

Total Health Care Spending

Total Health Care Spending

Total Health Care Spending

Total Health Care Spending by Payers

$
Typical Strategy #3:
Delay or Deny Care to Patients

- Lack of Needed Care

Typical Strategy #3:
Delay or Deny Care to Patients

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

SAVINGS

Lack of Needed Care

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
Win-Lose Results of Typical Strategies

- Patients don’t get the care they need and costs increase in the future
- Small physician practices and hospitals are forced out of business
- Health insurance premiums continue to rise and access to insurance coverage decreases
Win-Lose Results of Typical Strategies

- Patients don’t get the care they need and costs increase in the future
- Small physician practices and hospitals are forced out of business
- Health insurance premiums continue to rise and access to insurance coverage decreases

IS THERE A BETTER WAY?
The Right Focus: Spending That is *Unnecessary* or *Avoidable*
Avoidable Spending Occurs In All Aspects of Healthcare
Avoidable Spending Occurs In All Aspects of Healthcare

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

AVOIDABLE SPENDING

NECESSARY SPENDING

$
Avoidable Spending Occurs In All Aspects of Healthcare

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

TESTING & PROCEDURES
- Overuse of high-tech diagnostic imaging
- Unnecessary surgery
- Use of unnecessarily-expensive implants
- Infections and complications of surgery
- Overuse of inpatient rehabilitation

AVOIDABLE SPENDING

NECESSARY SPENDING

$
Avoidable Spending Occurs In All Aspects of Healthcare

- **CHRONIC DISEASE MANAGEMENT**
  - ER visits for exacerbations
  - Hospital admissions and readmissions
  - Amputations, blindness

- **TESTING & PROCEDURES**
  - Overuse of high-tech diagnostic imaging
  - Unnecessary surgery
  - Use of unnecessarily-expensive implants
  - Infections and complications of surgery
  - Overuse of inpatient rehabilitation

- **CANCER TREATMENT**
  - Use of unnecessarily-expensive drugs & radiation treatments
  - Repeat surgeries for full resection
  - ER visits/hospital stays for dehydration and avoidable complications
  - Fruitless treatment at end of life
  - Late-stage cancers due to poor screening
Institute of Medicine Estimate: 30% of Spending is Avoidable

<table>
<thead>
<tr>
<th>Excess Cost Domain Estimates: Lower bound totals from workshop discussions*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UNNECESSARY SERVICES</strong></td>
</tr>
<tr>
<td>• Overuse: services beyond evidence-established levels</td>
</tr>
<tr>
<td>• Discretionary use beyond benchmarks</td>
</tr>
<tr>
<td>- Defensive medicine</td>
</tr>
<tr>
<td>• Unnecessary choice of higher cost services</td>
</tr>
<tr>
<td>Total excess = $210 B*</td>
</tr>
<tr>
<td><strong>INEFFICIENTLY DELIVERED SERVICES</strong></td>
</tr>
<tr>
<td>• Mistakes—medical errors, preventable complications</td>
</tr>
<tr>
<td>• Care fragmentation</td>
</tr>
<tr>
<td>• Unnecessary use of higher cost providers</td>
</tr>
<tr>
<td>• Operational inefficiencies at care delivery sites</td>
</tr>
<tr>
<td>- Physician offices</td>
</tr>
<tr>
<td>- Hospitals</td>
</tr>
<tr>
<td>Total excess = $130 B*</td>
</tr>
<tr>
<td><strong>EXCESS ADMINISTRATIVE COSTS</strong></td>
</tr>
<tr>
<td>• Insurance-related administrative costs beyond benchmarks</td>
</tr>
<tr>
<td>- Insurers</td>
</tr>
<tr>
<td>- Physician offices</td>
</tr>
<tr>
<td>- Hospitals</td>
</tr>
<tr>
<td>- Other providers</td>
</tr>
<tr>
<td>• Insurer administrative inefficiencies</td>
</tr>
<tr>
<td>• Care documentation requirement inefficiencies</td>
</tr>
<tr>
<td>Total excess = $190 B*</td>
</tr>
<tr>
<td><strong>PRICES THAT ARE TOO HIGH</strong></td>
</tr>
<tr>
<td>• Service prices beyond competitive benchmarks</td>
</tr>
<tr>
<td>- Physician services</td>
</tr>
<tr>
<td>i. Specialists</td>
</tr>
<tr>
<td>ii. Generalists</td>
</tr>
<tr>
<td>- Hospital services</td>
</tr>
<tr>
<td>• Product prices beyond competitive benchmarks</td>
</tr>
<tr>
<td>- Pharmaceuticals</td>
</tr>
<tr>
<td>- Medical devices</td>
</tr>
<tr>
<td>- Durable medical equipment</td>
</tr>
<tr>
<td>Total excess = $105 B*</td>
</tr>
<tr>
<td><strong>MISSED PREVENTION OPPORTUNITIES</strong></td>
</tr>
<tr>
<td>• Primary prevention</td>
</tr>
<tr>
<td>• Secondary prevention</td>
</tr>
<tr>
<td>• Tertiary prevention</td>
</tr>
<tr>
<td>Total excess = $55 B*</td>
</tr>
<tr>
<td><strong>FRAUD</strong></td>
</tr>
<tr>
<td>• All sources—payer, clinician, patient</td>
</tr>
<tr>
<td>Total excess = $75 B*</td>
</tr>
</tbody>
</table>

*Lower bound totals of various estimates, adjusted to 2009 total expenditure level.
The Right Goal: Less Avoidable $,
The Right Goal: Less Avoidable $, More Necessary $
Win-Win for Patients & Payers

NECESSARY SPENDING

AVOIDABLE SPENDING

SAVINGS

NECESSARY SPENDING

AVOIDABLE SPENDING

SAVINGS

NECESSARY SPENDING

AVOIDABLE SPENDING

SAVINGS

NECESSARY SPENDING

AVOIDABLE SPENDING

SAVINGS

Lower Spending for Payers

Better Care for Patients

TIME

$
Barriers in the Payment System Create a Win-Lose for Providers

- Necessary Spending
- Avoidable Spending
- Barriers in the Current Payment System
- Savings

$
Barrier #1: No $ or Inadequate $ for High-Value 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.
- Communication between physicians to ensure accurate diagnosis & coordinate care
- Non-medical services, e.g., transportation
- Palliative care for patients at end of life
Barrier #2: Avoidable Spending May Be Revenue for Providers…

- Avoidable Spending
- Necessary Spending
- Provider Revenue
- Cost of Service Delivery
- Margin

$
...And When Avoidable Services Aren’t Delivered...
...Providers’ Revenue May Decrease...
…But Fixed Costs Don’t Vanish

Many Fixed Costs of Services Remain When Volume Decreases
- Leases & staff in physician practice
- Costs of hospital emergency room and other standby services

Diagram showing the relationship between necessary spending, avoidable spending, provider revenue, cost of service delivery, and margin.
...But Fixed Costs Don’t Vanish and New Costs May Be Added...

Many Fixed Costs of Services Remain When Volume Decreases And New Costs May Be Incurred

- Costs of nurse care managers
- Costs of unpaid physician services
- Costs of collecting quality data
Many Fixed Costs of Services Remain When Volume Decreases And New Costs May Be Incurred, Potentially Causing Financial Losses

LEAVING PROVIDERS WITH LOSSES
(or Bigger Losses Than Today)
A Payment *Change* isn’t *Reform* Unless It *Removes the Barriers*

**BARRIER #1**

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.
- Communication between physicians to ensure accurate diagnosis & coordinate care
- Non-medical services, e.g., transportation
- Palliative care for patients at end of life

**BARRIER #2**

Many Fixed Costs of Services Remain When Volume Decreases And New Costs May Be Incurred, Potentially Causing Financial Losses That Aren’t Offset by Small Bonuses
So Why Haven’t We Fixed This??
In Healthcare, Payers Are From Mars, Providers Are From Venus
Provider Approach: Pay Us More…

AVOIDABLE SPENDING

NECESSARY SPENDING

NECESSARY SPENDING

NEWLY PAID SERVICES

UNPAID SERVICES

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
Provider Approach: Pay Us More…
…and “Trust Us” on Savings

PROVIDER SOLUTION:

Provider to Payer:
“Paying for the services saved money in a demonstration project, so you can safely assume that you will also save money if you pay all providers to deliver the services for all patients”
Payer Concern: No Accountability to Reduce Avoidable Spending

NECESSARY SPENDING

AVOIDABLE SPENDING

NEWLY PAID SERVICES

SAVINGS

PROVIDER SOLUTION:

AVOIDABLE SPENDING

NECESSARY SPENDING

PAYER FEAR:

AVOIDABLE SPENDING

NEWLY PAID SERVICES

NECESSARY SPENDING

UNPAID SERVICES
Example: Accreditation Programs

• Physician practices and health systems want to be paid more if they are certified as delivering care the right way by an accrediting agency
Does Accreditation Assure High-Value Care?

• Thanks to Joint Commission hospital accreditation, there are no longer any infections or patient safety problems in hospitals.

• Thanks to the Certification Commission for Health Information Technology (CCHIT), every EHR works effectively to support good patient care.

• Thanks to college accreditation organizations, every parent who sends their child to college knows they will get a good education and a good job after graduation.

“NOT”
In Healthcare, Payers Are From Mars, Providers Are From Venus
Payer Approach: “Value-Based” Pay for Performance

PAYER SOLUTION:

Physicians/Hospitals have to justify a portion of what they would have otherwise received based on performance on quality/cost measures.

- Fee for service payments
- Unpaid services
- Value-based P4P
How Do You Define Value?
How Do You Define Value?

\[
\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}
\]
Which Oncologist Would You Use to Treat Your Cancer?

\[
\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}
\]

**ONCOLOGIST #1**
- 7 Year Survival
- $5,000/patient

**ONCOLOGIST #2**
- 10 Year Survival
- $10,000/patient
Oncologist #2 Rates Worse on the Standard Measure of “Value”

\[
\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}
\]

**ONCOLOGIST #1**

\[
\frac{7 \text{ Year Survival}}{\$5,000/\text{patient}} = 0.51 \text{ days of life per dollar}
\]

**ONCOLOGIST #2**

\[
\frac{10 \text{ Year Survival}}{\$10,000/\text{patient}} = 0.37 \text{ days of life per dollar}
\]
Multiple Aspects of “Value”

\[
\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}
\]

ONCOLOGIST #1
8 Year Survival
20% Grade 3+ Toxicity
\[\frac{\$11,000/\text{patient}}{\text{?}}\]

ONCOLOGIST #2
10 Year Survival
50% Grade 3+ Toxicity
\[\frac{\$10,000/\text{patient}}{\text{?}}\]
Assessing Value is a Lot Harder Than This

VALUE ≠ QUALITY \overline{COST}
Do Physicians Need “Incentives” or True Solutions to FFS Barriers?

PAYER SOLUTION:

- P4P may not be enough to pay for delivering a high-value service or for the added costs of improving quality.
- P4P may not be enough to offset the costs of collecting and reporting the quality data.
- P4P may be less than the loss of fee-for-service revenue from healthier patients or lower utilization.

Value-Based P4P
Payer Approach: Save Us Money…

PAYER SOLUTION:

YEAR 1

$NECESSARY SPENDING

AVOIDABLE SPENDING

SAVINGS

UNPAID SERVICES

UNPAID SERVICES

LOSS OF REVENUE
Payer Approach: Save Us Money & (Maybe) We’ll Pay More Next Year

PAYER SOLUTION:

YEAR 1

YEAR 2

$
Provider Concern: Shared Savings is Too Little, Too Late

PAYER SOLUTION:

YEAR 1

YEAR 2

How does provider cover upfront costs of additional services and loss of revenue?

Shared savings, if received, may not cover costs & losses
Medicare’s Shared Savings ACO Program Isn’t Succeeding

2013 Results for Medicare Shared Savings ACOs
• 46% of ACOs (102/220) increased Medicare spending
• Only 24% (52/220) received shared savings payments
• After making shared savings payments, Medicare spent more than it saved
• Net loss to Medicare: $78 million

2014 Results for Medicare Shared Savings ACOs
• 45% of ACOs (152/333) increased Medicare spending
• Only 26% (86/333) received shared savings payments
• After making shared savings payments, Medicare spent more than it saved
• Net loss to Medicare: $50 million

2015 Results for Medicare Shared Savings ACOs
• 48% of ACOs (189/392) increased Medicare spending
• Only 30% (119/392) received shared savings payments
• After making shared savings payments, Medicare spent more than it saved
• Net loss to Medicare: $216 million
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 Aren’t ACOs Succeeding?

ACO

PATIENTS
- Heart Disease
- Cancer
- Back Pain
- Pregnancy

Primary Care Cardiology Oncology Neurosurgery OB/GYN

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
No Change in the Way Physicians or Hospitals Are Paid

MEDICARE

ACO

Fee-for-Service Payment

PATIENTS
- Heart Disease
- Cancer
- Back Pain
- Pregnancy

Primary Care
Cardiology
Oncology
Neurosurgery
OB/GYN
Providers Still Face All the Barriers in the Current Payment System…

- No payment for high-value services
- Inadequate revenues to cover costs when fewer services are delivered

PATIENTS
- Heart Disease
- Cancer
- Back Pain
- Pregnancy

ACO

<table>
<thead>
<tr>
<th>Fee-for-Service Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
</tr>
</tbody>
</table>

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
...With Only the Potential for Receiving Future “Shared Savings”

MEDICARE

Shared Savings Payment Next Year??

ACO

PATIENTS
- Heart Disease
- Cancer
- Back Pain
- Pregnancy

Fee-for-Service Payment

• No payment for high-value services
• Inadequate revenues to cover costs when fewer services are delivered

Primary Care Cardsiology Oncology Neurosurgery OB/GYN
ACOs Try to “Coordinate Care” Without Fixing Payment Barriers

PATIENTS
- Heart Disease
- Cancer
- Back Pain
- Pregnancy

MEDICARE

ACO

Fee-for-Service Payment

Expensive IT Systems
Care Coordinators

Shared Savings Payment Next Year???

• No payment for high-value services
• Inadequate revenues to cover costs when fewer services are delivered

Primary Care
Cardiology
Oncology
Neurosurgery
OB/GYN
Possibility of Future Bonuses Doesn’t Overcome Current Barriers

MEDICARE

Shared Savings Payment??

ACO

Expensive IT Systems

Care Coordinators

Part of Shared Savings??

• No payment for high-value services
• Inadequate revenues to cover costs when fewer services are delivered

PATIENTS
Heart Disease
Cancer
Back Pain
Pregnancy

Fee-for-Service Payment

Primary Care
Cardiology
Oncology
Neurosurgery
OB/GYN

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
Creating More “Risk” Won’t Solve the Problems with Payment Either

- No payment for high-value services
- Inadequate revenues to cover costs when fewer services are delivered

Patients:
- Heart Disease
- Cancer
- Back Pain
- Pregnancy

Fee-for-Service Payment

Expensive IT Systems
Care Coordinators

Medicare

More Downside Risk

Primary Care Cardiology Oncology Neurosurgery OB/GYN
Value-Based Payment Is Being Designed the *Wrong* Way Today
Value-Based Payment Is Being Designed the *Wrong* Way Today

**TOP-DOWN PAYMENT REFORM**

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems
Value-Based Payment Is Being Designed the *Wrong* Way Today

**TOP-DOWN PAYMENT REFORM**

- Medicare and Health Plans Define Payment Systems
- Physicians and Hospitals Have To Change Care to Align With Payment Systems
- Both Patients and Providers May Lose
Physicians Need to Design Payments to Support Good Care

TOP-DOWN PAYMENT REFORM

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems

Both Patients and Providers May Lose

BOTTOM-UP PAYMENT REFORM

Physicians Redesign Care and Identify Payment Barriers
Physicians Need to Design Payments to Support Good Care

TOP-DOWN PAYMENT REFORM

Medicare and Health Plans Define Payment Systems

Both Patients and Providers May Lose

Physicians and Hospitals Have To Change Care to Align With Payment Systems

BOTTOM-UP PAYMENT REFORM

Payers Change Payment to Support Redesigned Care

Physicians Redesign Care and Identify Payment Barriers

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
Physicians Need to Design Payments to Support Good Care

**TOP-DOWN PAYMENT REFORM**

- Medicare and Health Plans Define Payment Systems
- Physicians and Hospitals Have To Change Care to Align With Payment Systems
- Both Patients and Providers May Lose

**BOTTOM-UP PAYMENT REFORM**

- Payers Change Payment to Support Redesigned Care
- Physicians Redesign Care and Identify Payment Barriers
- Patients Get Better Care and Providers Stay Financially Viable
Step #1: Identify Avoidable Spending in FFS

**OPPORTUNITIES TO REDUCE TOTAL SPENDING**
- Avoidable Hospital Admissions/Readmissions
- Unnecessary Tests and Procedures
- Use of Lower-Cost Settings
- Use of Lower-Cost Treatments
- Preventable Complications of Treatment
- Prevention & Early Identification of Disease
Most Specialties Have Identified Areas of Avoidable Spending
Step #2: Identify Barriers in FFS

BARRIERS IN CURRENT FFS SYSTEM

- No payment for high-value services
  - Phone calls, e-mails with physicians
  - Services delivered by nurses, community workers
  - Communication/coordination among physicians
  - Non-medical services, e.g., transportation
  - Palliative care for patients at end of life

- Inadequate payment for patients who need more time or resources

- Inadequate revenue to cover fixed costs when utilization of services is reduced
You Can’t Reduce Spending if You Don’t Remove the Barriers

- **NECESSARY SPENDING**
- **AVOIDABLE SPENDING**
- **UNPAID SERVICES**
- **LOSS OF REVENUE**
Step #3: Remove the FFS Barriers

- **Fee for Service**: AVOIDABLE SPENDING
- **Alternative Payment Model**: ADEQUATE, FLEXIBLE PAYMENT FOR HIGH-VALUE SERVICES

Upfront payment to support improved delivery of care.
Step 4: Build in Accountability for Results

- **UNPAID SERVICES**
  - **AVOIDABLE SPENDING**
  - **NECESSARY SPENDING**
  - **LOSS OF REVENUE**

- **ALTERNATIVE PAYMENT MODEL**
  - **LOWER AVOIDABLE SPENDING**
  - **ADEQUATE, FLEXIBLE PAYMENT FOR HIGH-VALUE SERVICES**

Accountability for reducing avoidable spending

Upfront payment to support improved delivery of care
True Alternative Payment Models Can Be Win-Win-Wins

Win for Payer: Lower Total Spending (and Lower Premiums)
Win for Patient: Better Care Without Unnecessary Services
Win for Providers: Adequate Payment for High-Value Services
Most Healthcare Spending Doesn’t Go to Physicians

Most of the Spending (and Most of the Avoidable Spending) Isn’t Going to Physicians
But Individual Physicians Can’t Control All Avoidable Spending

- PCPs can’t reduce surgical site infections
- Surgeons can’t prevent diabetic foot ulcers
- Oncologists can’t prevent cancer

- PCPs can help diabetics avoid amputations
- Surgeons can reduce surgical site infections
- Oncologists can reduce complications of cancer treatment
APM Design Must Focus on What Physician *Can* Control

**CURRENT FFS**

- Spending the Physician Cannot Control
  - Avoidable Spending Physician Can Control
  - Necessary Spending
  - Physician Payment
  - Unpaid Service Revenue Loss

**ALTERNATIVE PAYMENT MODEL**

- Savings
  - Spending the Physician Cannot Control
  - Avoidable Spending
  - Adequate, Flexible Payment for High-Value Services
Multiple APMs Needed for Different Opportunities & Barriers

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

www.PaymentReform.org
Option 1: Add New Payment(s) to Overcome Current Barriers

- **CURRENT FFS**
  - Spending the Physician Cannot Control
  - Avoidable Spending Physician Can Control
  - Necessary Spending

- **APM #1**
  - New Payment
  - Current Payment

Necessary Spending

Unpaid Service Revenue Loss
Option 1, Part 2: Add in an Accountability Component

CURRENT FFS

AVOIDABLE SPENDING
- Physician Can Control

NECESSARY SPENDING

PAYMENT
- Physician

APM #1

SAVINGS

AVOIDABLE SPENDING

NECESSARY SPENDING

PAYMENT
- New

ADJUSTMENT TO NEW PAYMENT BASED ON CONTROL OF AVOIDABLE SPENDING

UNPAID SERVICE REVENUE LOSS
Accountability Component Could Utilize a P4P Approach

CURRENT FFS

Avoidable Spending
Physician Can Control

Necessary Spending

Physician Payment

Unpaid Service Revenue Loss

APM #1

Avoidable Spending

Necessary Spending

Necessary Spending

Physician Payment

New Payment

Current Payment

SAVINGS

Adjustment to New Payment Based on Control of Avoidable Spending

P4P Adjustments To Amount(s)
Option 2: Bundle New Payment with Existing Payments

CURRENT  FFS  APM #1  APMs #2-3

$  

Avoidable Spending  Physician Can Control

Necessary Spending  

Physician Payment  

Unpaid Service  Revenue Loss

Avoidable Spending  

Necessary Spending  

New Payment  Current Payment  Bundled Payment for Physician Services

SAVINGS
Option 2, Part 2: Add an Accountability Component

CURRENT FFS

APM #1

APMs #2-3

Avoidable Spending Physician Can Control

Necessary Spending

Unpaid Service Revenue Loss

New Payment

Current Payment

SAVINGS

Adjustment to New Payment Based on Control of Avoidable Spending

Bundled Payment for Physician Services
Option 3: Full Bundle Covering Necessary & Avoidable Costs

CURRENT
FFS

APM #1

APMs #2-3

APMs #4-7

Avoidable Spending Physician Can Control

Necessary Spending

Unpaid Service Revenue Loss

SAVINGS

SAVINGS

SAVINGS

Bundled Payment for Physician Services

Costs of Other Related Services

Costs of Physician Services

BUNDLED PAYMENT
If Patients Differ in the Services They Need…

- **Lower Need Patients**
- **Medium Need Patients**
- **Higher Need Patients**

- **Physician Services**
  - Unpaid Svc
  - $ Loss

- **Physician Services**
  - Unpaid Svc
  - $ Loss
…Or if Patients Differ in Risks & Opportunities for Better Care

Lower Need Patients

Medium Need Patients

Higher Need Patients

Avoidable Spending

Necessary Spending

Physician Services

Unpaid Svc

$ Loss

Lower Need Patients

Medium Need Patients

Higher Need Patients

Avoidable Spending

Necessary Spending

Physician Services

Unpaid Svc

$ Loss
APM $ Will Have to Be Adjusted for Differences in Need

- Lower Need Patients
- Medium Need Patients
- Higher Need Patients

- Avoidable Spending
- Necessary Spending

- Level 1 APM $
- Level 2 APM $
- Level 3 APM $

- Unpaid Svc
- $ Loss
Accountability Targets Need to Be Adjusted for Patient Differences

Lower Need Patients

Lower Need Patients

Medium Need Patients

Medium Need Patients

Higher Need Patients

Higher Need Patients

Avoidable Spending

Necessary Spending

Savings

UnpaidSvc $ Loss

Physician Services

Unpaid Svc

Level 1 APM $

Level 2 APM $

Level 3 APM $
How Does All of This Apply to Oncology?
Cancer Care is a Big Part of Healthcare Spending

% of Total Healthcare Spending, 2014

Medicare

Private Insurance

- Normal birth/live born
- Back problems
- Hypertension
- Mental disorders
- Diabetes mellitus
- Cancer
- Trauma-related disorders
- Osteoarthritis/joint disorders
- COPD, asthma
- Heart conditions

Cancer #5
Cancer #2
Spending on Cancer Care Has Grown Rapidly

[Bar chart showing spending on cancer care in the U.S. 2004-2020]
Where Does Spending on Medical Oncology Go?

Analysis of total spending in 2012 for commercially insured patients during an “episode” of chemotherapy treatment (all treatment months plus two months after treatment ends)
<10% of Spending Pays Oncology Practices for Services

Analysis of total spending in 2012 for commercially insured patients during an “episode” of chemotherapy treatment (treatment months through the second month after treatment ends).

Fees for oncology practice services represent less than 10% of spending for cancer patients during episodes of chemotherapy treatment.

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
Half of the Spending Goes to Drugs

Analysis of total spending in 2012 for commercially insured patients during an “episode” of chemotherapy treatment (treatment months through the second month after treatment ends)
8% of Spending Goes to Laboratory Tests and Imaging

Analysis of total spending in 2012 for commercially insured patients during an “episode” of chemotherapy treatment (treatment months through the second month after treatment ends)
20% Goes to Radiation Therapy, Procedures, and Other Services

Analysis of total spending in 2012 for commercially insured patients during an “episode” of chemotherapy treatment (treatment months through the second month after treatment ends)
11% of Spending is for ED Visits & Hospital Admissions

Analysis of total spending in 2012 for commercially insured patients during an “episode” of chemotherapy treatment (treatment months through the second month after treatment ends)
Most $$ Go to Drugs, Tests, and Admissions, Not Oncology Practices

Analysis of total spending in 2012 for commercially insured patients during an “episode” of chemotherapy treatment (treatment months through the second month after treatment ends)

- 90%+ of spending pays for drugs, laboratory tests, imaging studies, surgical procedures, emergency room visits, and hospitalizations
- Fees for oncology practice services represent less than 10% of spending for cancer patients during episodes of chemotherapy treatment
Most $$ Go to Drugs, Tests, and Admissions, Not Oncology Practices

Analysis of total spending in 2012 for commercially insured patients during an “episode” of chemotherapy treatment (treatment months through the second month after treatment ends)

Fees for oncology practice services represent less than 10% of spending for cancer patients during episodes of chemotherapy treatment

Where Are the Opportunities to Reduce Spending Without Harming Patients?
Opportunity 1: Reducing Avoidable ED Visits and Hospitalizations

- 40%+ of ED visits and hospital admissions are for chemotherapy-related complications

<table>
<thead>
<tr>
<th>Total Spending Per Patient</th>
<th>$0</th>
<th>$5,000</th>
<th>$10,000</th>
<th>$15,000</th>
<th>$20,000</th>
<th>$25,000</th>
<th>$30,000</th>
<th>$35,000</th>
<th>$40,000</th>
<th>$45,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER/Hospital Admissions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M Infusions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Large Reductions in Avoidable ED Visits & Hospitalizations

Oncology patient-centered medical home and accountable cancer care

John D. Spradlin, MD
Consultant in Medical Oncology and Hematology, PC, Drexel Hill, PA

With the passage of healthcare reform and the call for improved quality, value, and demonstration of results, the primary care patient-centered medical home (PCMH) concept has gained considerable traction across the United States. In 2004, we began implementing our processes of cancer care delivery to our medical oncology practice concurrently with the implementation of an oncology-specific electronic medical record and the development of customized software to better suit practice/patient needs and to facilitate data collection. These custom software applications were designed to support comprehensive processes of care that were also required for level III medical home recognition by the National Committee for Quality Assurance (NCQA). We have been tracking our data for the past 5 years, documenting improvements in disease management—resulting in the reduction in emergency room utilization and hospital admissions. We have engaged local and national payers with the goal of developing collaborative pilot programs. Furthermore, we are establishing formalized relationships with other like-minded medical oncology and primary care PCMH practices, as we continue to refine our delivery of cancer care within an oncology PCMH model.

Medical oncology is planning an overview of all patients toward the delivery of cancer care. The current and future challenges they face in their efforts to deliver effective, efficient, and appropriate cancer care are broad, and solutions to the rising costs of cancer care continue to be sought. The patient-centered medical home (PCMH) model has emerged as a partial solution to the fragmentation of delivery of primary care. In many instances, the delivery of cancer care is also fragmented and fraught with deficiencies in communication, coordination, and accountability. The oncology PCMH (OPCMH) model of cancer care may potentially serve as a practice framework for oncology care. The OPCMH model aims to provide a value-based approach that facilitates physician accountability, encourage clinical integration between medical oncology groups, enhance communication and coordination of care with primary care, facilitate care for patients across the continuum, improve the coordination of care, establish a standard medical record and medical home recognition by the National Committee for Quality Assurance (NCQA).

A backward glance at the PCMH model

A combination of factors lead to the rapid acceptance of the PCMH model in the delivery of primary care (1) physicians and patient recognition of the PCMH model as a partial solution to the unacceptable fragmentation of healthcare delivery, (2) the availability of electronic medical records (EMRs) and the accountable information that can be mined from these databases (3) the alignment of incentives among stakeholders, including the largest employers in the United States, medical professional societies, government, insurance companies, academic institutions, patient advocacy groups, state Medical agencies, and the Centers for Medicare & Medicaid Services; and (4) early results from medical home demonstration projects, suggesting that elements of the model may have a positive effect on quality, cost, and satisfaction of the patient and the clinical team.

Unacceptable fragmentation of care

In 2004, the average emergency room (ER) evaluations at Delaware County Memorial Hospital of the Drexel Hill office population per chemotherapy patient per year, 2004-2010 (YTD).
Better Care and Lower Spending Possible For End-of-Life Patients

Innovative Oncology Care Models Improve End-Of-Life Quality, Reduce Utilization And Spending

ABSTRACT Three models that received Health Care Innovation Awards from the Centers for Medicare and Medicaid Services (CMS) aimed to reduce the cost and use of health care services and improve the quality of care for Medicare beneficiaries with cancer. Each emphasized a different principle: the oncology medical home, patient navigation, or palliative care. Comparing participants in each model who died during the study period to matched comparators, we found that the oncology medical home and patient navigation models were associated with decreased costs in the last ninety days of life ($3,346 and $5,424 per person, respectively) and fewer hospitalizations in the last thirty days of life (fifty-seven and forty per 1,000 people, respectively). The patient navigation model was also associated with fewer emergency department visits in the last thirty days of life and increased hospice enrollment in the last two weeks of life. These promising results can inform new initiatives for cancer patients, such as the CMS Oncology Care Model.

Medicare expenditures in the last year of life for beneficiaries with cancer range from $56,764 for those with melanoma to $104,891 for those with brain cancer. These far exceed the average $8,975 per beneficiary Medicare spending in the last year of life. 8,9 There were approximately 903,000 Medicare beneficiaries with cancer in the last year of life in 2010, and that number is expected to increase to 1.2 million in 2020. Costs of cancer care in the last year of life amounted to $3.5 billion in 2010 and will approach $50 billion in 2020. Much end-of-life spending results from high rates of hospitalizations, emergency department (ED) visits, and stays in the intensive care unit in patients’ last months.10 A substantial proportion of hospitalizations and ED visits at the end of life are avoidable and thus represent an area for improved quality of care and patient satisfaction and for reduced utilization.11

High utilization of cancer treatment at the end of life not only poses a burden to the health care system, but it also may represent poor outcomes from the perspective of patients. Previous studies suggest that patients with advanced cancer prefer to have less aggressive treatment and more spiritual support and palliative care, and to avoid intensive inpatient settings at the end of life.12,13 In fact, the National Quality Forum has recognized the need to emphasize the importance of palliative options for cancer care at the end of life. It has endorsed the use of screening instruments to identify patients in the last sixteen days of life, multiple ED visits and stays in the intensive care unit in the last thirty days of life, and enrollment in hospice for fewer than three days.14

Although hospitalization is a frequent condition in patients’ end-of-life preferences, keeping patients at home or in a noninvasive environment while reducing pain and psychological stress and pro-

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
No Payment For Services Needed to Improve Outcomes of Care

- 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

Total Spending Per Patient:

- ER/Hospital Admissions
- Other Services
- Testing
- Drugs

Costs:

- $45,000
- $40,000
- $35,000
- $30,000
- $25,000
- $20,000
- $15,000
- $10,000
- $5,000
- $0
Opportunity 2: Reducing Avoidable Use of Drugs, Tests, & Imaging

- Unnecessarily expensive tests
- Unnecessary testing
- Unnecessarily expensive drugs
- Unnecessary drugs
- Unnecessary end-of-life treatment
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 anti-cancer treatment.

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 in low-risk prostate cancer (Stage T1c/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 a lack of evidence demonstrating a benefit for the use of PET/CT or radionuclide bone scans in asymptomatic individuals with newly diagnosed ductal carcinoma 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 higher 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).
22%-47% 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...

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
27%-40% Non-Adherence to Choosing Wisely Criteria

Rate of Non-Adherence to Choosing Wisely Guidelines

1. Do not use combination chemotherapy when treating metastatic breast cancer unless the patient needs rapid response...

2. Do not routinely use extended fractionation schemes for palliation of bone metastases

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

4. Do not perform surveillance testing or imaging for asymptomatic individuals treated for breast cancer with curative...

5. Do not give patients starting a chemotherapy regimen with low or moderate risk of nausea an antiemetic...

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
30% of Patients Are Receiving CSFs Outside of Guidelines

Rate of Non-Adherence to Choosing Wisely Guidelines

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

Do not use white-cell stimulating factors for patients undergoing chemotherapy with less than 20% risk of febrile neutropenia
Neulasta is the #3 Part B Drug: $1.2 Billion in Medicare Spending

8 Drugs Account for 40% of Medicare Part B Spending
CMS Spends More on Neulasta Than on Patient Visits w/ Oncologists
14% of Drug Spend & 7% of Total During Chemo is Pegfilgrastim

2/3 of Spending Due to 5 Drugs
Elimination of 30% Overuse Reduces Total Drug Spend by 4%

Total Spending Per Patient

- Drugs
- Testing
- Other Services
- ER/Hospital Admissions

Pegfilgrastim 14%

30% Reduction

4% Savings
Inadequate Resources for Effective Planning & Monitoring of 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.)
- 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
Inadequate Resources for Effective Planning & Monitoring of Care

With inadequate time and care management support:

- Easier to order the “usual” drugs rather than determine what’s exactly right for this patient
- Safer to order high-powered drugs if the practice can’t monitor and intervene quickly when the patient has a problem

- 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
17% of Drug Spend & 8% of Total Spending is Bevacizumab

- Total Spending Per Patient
- ER/Hospital Admissions
- Other Services
- Testing
- Drugs
  - Bevacizumab 17%
  - E&M
  - Infusions

<table>
<thead>
<tr>
<th>Spending Per Patient</th>
<th>$45,000</th>
<th>$40,000</th>
<th>$35,000</th>
<th>$30,000</th>
<th>$25,000</th>
<th>$20,000</th>
<th>$15,000</th>
<th>$10,000</th>
<th>$5,000</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER/Hospital Admissions</td>
<td>$22,000</td>
<td>$18,000</td>
<td>$14,000</td>
<td>$10,000</td>
<td>$6,000</td>
<td>$2,000</td>
<td>$0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Services</td>
<td>$12,000</td>
<td>$8,000</td>
<td>$4,000</td>
<td>$2,000</td>
<td>$0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testing</td>
<td>$8,000</td>
<td>$4,000</td>
<td>$2,000</td>
<td>$0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>$15,000</td>
<td>$10,000</td>
<td>$5,000</td>
<td>$0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bevacizumab 17%</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
Alternative Regimens Have Similar Efficacy But Much Lower Cost

<table>
<thead>
<tr>
<th>Regimen</th>
<th>Median Overall Survival (months)</th>
<th>Median Progression-Free Survival</th>
<th>Grade 3+ Adverse Event</th>
<th>Cost Difference (6 cycles)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carboplatin + Paclitaxel</td>
<td>10.3</td>
<td>4.5</td>
<td>24%</td>
<td></td>
</tr>
<tr>
<td>Carboplatin + Paclitaxel + Bevacizumab</td>
<td>12.3</td>
<td>6.3</td>
<td>61%</td>
<td>+~$30,000</td>
</tr>
<tr>
<td>Cisplatin + Gemcitabine</td>
<td>13.1</td>
<td>6.1</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Cisplatin + Gemcitabine + Bevacizumab</td>
<td>13.6</td>
<td>6.7</td>
<td>76%</td>
<td>+~$30,000</td>
</tr>
</tbody>
</table>


Reck, M et al.  Annals of Oncology 2010
Failure to Pay for Good Care… Leads to Costly, Low-Value Services

- ED visits and hospital admissions for chemotherapy-related complications
- Unnecessarily expensive tests
- Unnecessary testing
- Unnecessarily expensive drugs
- Unnecessary drugs
- Unnecessary end-of-life treatment
- 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
ASCO Payment Reform Developed by Oncologists & Practice Managers

- Christian Thomas, MD, New England Cancer Specialists
- 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
- Julie Moran, Seidman Cancer Center
- Ray Page, DO, PhD, Center for Cancer and Blood Disorders
- 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

Patient-Centered Oncology Payment

Better Payment for Practices

Oncology Practice Receives Higher Payments Than Today

Drug Margin

E&M Infusions

Non-E&M Care Mgt

Drug Margin

PCOP Pmts

E&M Infusions
PCOP Part 2: Implement ASCO Guidelines & Avoid ED Visits

Current FFS Payment

- ER/Hospital Admissions
- Other Services
- Testing
- Drugs
  - Avoidable $

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
Payment Based on Adherence to Appropriate Use Criteria

Rate of Adherence to Appropriate Use Criteria

100%  
80%  
Min%  

HIGH  

LOW  

New PCOP Payment  
E&M and Infusion  

$  

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.

- Patients who are unlikely to benefit from standard therapy
- Patients with limited life expectancy
- Patients with serious comorbidities
- Patients with specific genetic mutations

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 not usually performed in the staging evaluation of low-risk cancer, despite a lack of evidence supporting they improve detection of metastatic disease or survival.

- Evidence does not support the use of these scans for staging or monitoring disease progression.

Choosing Wisely

American Society of Clinical Oncology

Five Things Physicians and Patients Should Question

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.

2. Don’t perform PET, CT, and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis.

3. Don’t perform PET, CT, and radionuclide bone scans in the staging of early breast cancer at low risk for metastasis.

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.

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.

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
PCOP Result: Better Care, Better Payment, Payer Savings

Current FFS Payment
- ER/Hospital Admissions
- Other Services
- Testing
- Avoidable $
- Drugs
- Drug Margin
- E&M Infusions
- Non-E&M Care Mgt

Patient-Centered Oncology Payment
- SAVINGS
  - ER/Admissions
  - Other Services
  - Testing
  - Drugs
  - Drug Margin
  - PCOP Pmts
  - E&M Infusions

Payer Spends Less in Total
- 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

Better Payment for Practices
- Lower Spending without Rationing
## Analysis of PCOP Shows Large Net Savings from Better Payment

<table>
<thead>
<tr>
<th>Costs and Savings from Patient-Centered Oncology Payment</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></td>
</tr>
<tr>
<td>PCOP</td>
<td></td>
<td>$750</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></td>
</tr>
<tr>
<td>Infusion Services</td>
<td>$1,904</td>
<td>$1,904</td>
<td></td>
</tr>
<tr>
<td>PCOP</td>
<td></td>
<td>$1,190</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>-5%</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></td>
</tr>
<tr>
<td>PCOP</td>
<td></td>
<td>$220</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$50,048</td>
<td>$48,089</td>
<td>-3.9%</td>
</tr>
</tbody>
</table>

### For 500 New Patients:

- **Additional Practice Revenues**: $1,080,000
- **Net Payer Savings**: $979,802

---

**THE AMERICAN SOCIETY OF CLINICAL ONCOLOGY**

**PATIENT-CENTERED ONCOLOGY PAYMENT**

Payment Reform to Support Higher Quality, More Affordable Cancer Care

May 2015

www.asco.org/paymentreform
# Potentially Large Win-Win-Win for Payers, Patients & Practices

## 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></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></td>
</tr>
<tr>
<td>Infusion Services</td>
<td>$1,904</td>
<td>$1,904</td>
<td></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>-5%</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></td>
</tr>
<tr>
<td>PCOP</td>
<td>$220</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$50,048</td>
<td>$48,089</td>
<td>-3.9%</td>
</tr>
</tbody>
</table>

**For 500 New Patients:**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Practice Revenues</td>
<td>$1,080,000</td>
</tr>
<tr>
<td>Net Payer Savings</td>
<td>$979,802</td>
</tr>
</tbody>
</table>

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
What About the CMMI Oncology Care Model?
The Oncology Care Model Doesn’t Eliminate Current FFS…

HOW ONCOLOGY PRACTICE IS PAID TODAY

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Dx</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
</tbody>
</table>

$0  $300  $600  $900  $1200
It Adds New Monthly Payments…

HOW ONCOLOGY PRACTICE IS PAID IN CMMI OCM PROGRAM

$960 in New Payment (6 x $160) for each 6 Month “Episode”
It Adds New Monthly Payments…
But Only If Chemotherapy is Given

HOW ONCOLOGY PRACTICE IS PAID
IN CMMI OCM PROGRAM

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

Under OCM, the financial penalty to the oncology practice
for not treating the patient is even higher than it is today,
with no extra support for time needed for end-of-life discussions
and no extra support for palliative care
OCM Then Puts Practice at Risk for Total Spending on Patients

HOW ONCOLOGY PRACTICE IS PAID IN CMMI OCM PROGRAM

“Performance-Based Payment”

Risk-Sharing on Total Spending

$960 in New Payment (6 x $160) for each 6 Month “Episode”
Problems with Risk Under OCM

- 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 treating 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 Uses an “Episode” Model to Pay for Oncology Care

An “episode” starts when chemotherapy starts and lasts 6 months even if chemotherapy ends sooner.
OCM Uses an “Episode” Model to Pay for Oncology Care

An “episode” starts when chemotherapy starts and lasts 6 months even if chemotherapy ends sooner.

How did CMS decide on a 6 month episode?
Monthly Spending on Cancer Patients

Figure 4.1. Average Monthly Total Medicare Payments for Beneficiaries Initiating Chemotherapy in 2010

[Graph showing average monthly Medicare payments for various types of cancer, with the X-axis representing months relative to chemo initiation and the Y-axis representing average Medicare payments in dollars.]
Monthly Spending
In First Six Months vs. Later

Figure 4.1. Average Monthly Total Medicare Payments for Beneficiaries Initiating Chemotherapy in 2010
Cumulative Spending By Month

Figure 4.2. Cumulative Proportion of Total 24-Month Medicare Payments Occurring in Each Month Relative to Chemotherapy Initiation

Specialty Payment Model Opportunities and Assessment
Oncology Model Design Report

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
6 Month Episodes?

Figure 4.2. Cumulative Proportion of Total 24-Month Medicare Payments Occurring in Each Month Relative to Chemotherapy Initiation

6 month “episode”
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

**“6 MONTH EPISODE”**

- No Shared Savings Payment

<table>
<thead>
<tr>
<th>Dx</th>
<th>Treatment Months</th>
<th>Post-Treatment Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>E&amp;M</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Infusion</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Infusion</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Infusion</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Infusion</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Infusion</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>E&amp;M</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>E&amp;M</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>E&amp;M</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>E&amp;M</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>E&amp;M</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>E&amp;M</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>E&amp;M</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>E&amp;M</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>E&amp;M</td>
<td></td>
</tr>
</tbody>
</table>

**Penalty for Helping Patients Avoid Side Effects?**

**Incentive to Stretch Out Treatment?**
Top-Down vs. Bottom-Up Design of Care & Payment

CMS ONCOLOGY CARE MODEL

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems

Both Patients and Providers May Lose
Top-Down vs. Bottom-Up Design of Care & Payment

**CMS ONCOLOGY CARE MODEL**

- Medicare and Health Plans Define Payment Systems
  - Physicians and Hospitals Have To Change Care to Align With Payment Systems
  - Both Patients and Providers May Lose

**ASCO PATIENT-CENTERED ONCOLOGY PAYMENT**

- Payers Change Payment to Support Redesigned Care
  - Physicians Redesign Care and Identify Payment Barriers
  - Patients Get Better Care and Providers Stay Financially Viable

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
APM for Medical Oncology Could Improve Care, Lower Cost

**PATIENT**

**Alternative Payment Model for Medical Oncology**

**Improvements in Value**
- Reduce ED visits and hospital admissions for toxicity-related complications of treatment
- Reduce unnecessary use of expensive tests and treatments
- Provide better support to patients in transition to survivorship or end-of-life care
What About Other Oncology Sub-Specialties?

**Alternative Payment Model for Medical Oncology**

**Improvements in Value**
- Reduce ED visits and hospital admissions for toxicity-related complications of treatment
- Reduce unnecessary use of expensive tests and treatments
- Provide better support to patients in transition to survivorship or end-of-life care

**Surgical Oncology?**

**Radiation Oncology?**
Many Types of Avoidable Spending Already Identified
Opportunities to Improve Value in Surgical Oncology

PATIENT

Alternative Payment Model for Medical Oncology

Bundled/Warrantied Payment for Surgical Oncology

Improvements in Value
- Reduce repeat surgeries to assure successful resections of tumors
- Use most efficient imaging, localization, and pathology approaches for successful resection
- Minimize need for reconstructive surgery and perform resection and reconstruction at same time when possible
- Reduce infections/complications from surgery
Opportunities to Improve Value in Radiation Oncology

- Alternative Payment Model for Medical Oncology
- Bundled/Warrantied Payment for Surgical Oncology
- Bundled/Warrantied Payment for Radiation Oncology

**Improvements in Value**
- Reduce overuse of expensive treatments
- More predictable payments for payers/patients
- Predictable revenues to cover practice cost
21st Century Oncology
Rad Onc Bundled Payments

- Payment based on type of cancer, not based on type of radiation therapy used
- Payment based on weighted average of available therapies, with discount over past spending
- Payments adjusted as technology and evidence changes
- Warranty for repeat treatments within 90 days
- Predictable spending for payers and patients
- Predictable revenues to oncology practice to cover fixed costs of expensive equipment without the need or incentive to overuse services with high average cost/payment
Supporting Coordinated Care from All Oncology Specialties

Condition-Based Payment for Patient’s Cancer

PATIENT

Monthly Condition-Based Payments for Medical Oncology

Bundled/Warrantied Payment for Surgical Oncology

Bundled/Warrantied Payment for Radiation Oncology
Should Providers Fear the Risks of Alternative Payment Models?

Risks Under APMs

• Will the amount of payment be adequate to cover the services patients need?
• Will risk adjustment be adequate to control for differences in need?
• How will you control the costs of other providers involved in the care in the alternative payment model?
• What portion of payments will be withheld based on quality measures?
• Will you have enough patients to cover the costs of managing the new payment?
### Risk Is Not New to Providers, It’s Just *Different* Risk in APMs

<table>
<thead>
<tr>
<th>Risks Under FFS</th>
<th>Risks Under APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Will fee levels from payers be adequate to cover the costs of delivering services?</td>
<td>• Will the amount of payment be adequate to cover the services patients need?</td>
</tr>
<tr>
<td>• What utilization controls will payers impose on your services?</td>
<td>• Will risk adjustment be adequate to control for differences in need?</td>
</tr>
<tr>
<td>• What “value-based” reductions will be made in your payments based on “efficiency” measures?</td>
<td>• How will you control the costs of other providers involved in the care in the alternative payment model?</td>
</tr>
<tr>
<td>• What “value-based” reductions will be made in your fees based on quality measures?</td>
<td>• What portion of payments will be withheld based on quality measures?</td>
</tr>
<tr>
<td>• Will you have enough patients to cover your practice or hospital expenses?</td>
<td>• Will you have enough patients to cover the costs of managing the new payment?</td>
</tr>
</tbody>
</table>
Will Payers Implement Physician-Focused Payments?

**Higher Value Care:**
- Better Quality
- Lower Spending
Most Health Plans Resist True Payment Reforms

“Value-Based Purchasing”
- FFS + P4P
- Shared Savings
- Narrow Network Discounts

Low Value Care:
- Poor Quality
- High Avoidable Spending
For Most Workers, *Employers are the Insurer, Not a Health Plan*

60% of Workers Are Now in Self-Insured Plans

Source: Employer Health Benefits 2012 Annual Survey. The Kaiser Family Foundation and Health Research and Educational Trust.
For Self-Funded Employers, The Health Plan is Just a Pass Through
Little Incentive for Health Plans to Support Payment Reforms

True Payment Reform Means:

- Health plan incurs the costs of implementing new payment models
- Purchaser gains all the savings from reduced utilization and spending (because all claims are passed through)
2nd Biggest Source of Spending Growth is Insurance Administration

Sources of Private Insurance Spending Increase, 2009-2015

- **Insurance Admin**: 30% Increase, 12% of Total
- **Physician & Clinical Services**: 19% Increase
- **Hospital Svcs**: 41% Increase
- **Drugs**: 20% Increase
- **Other Svcs**: 24% Increase

Change 2009-2015
25% of Avoidable Spending is Excess Administrative Costs

**EXCESS ADMINISTRATIVE COSTS**
- Insurance-related administrative costs beyond benchmarks
  - Insurers
  - Physician offices
  - Hospitals
  - Other providers
- Insurer administrative inefficiencies
- Care documentation requirement inefficiencies

**Excess Cost Domain Estimates:**
- **UNNECESSARY SERVICES**
  - Total excess = $210 B
    - Overuse: services beyond evidence-established levels
    - Discretionary use beyond benchmarks
    - Defensive medicine
    - Unnecessary choice of higher cost services
- **INEFFICIENTLY DELIVERED SERVICES**
  - Total excess = $130 B
    - Mistakes—medical errors, preventable complications
    - Care fragmentation
    - Unnecessary use of higher cost providers
    - Operational inefficiencies at care delivery sites
    - Physician offices
- **PRODUCT PRICES**
  - Total excess = $190 B
    - Product prices beyond competitive benchmarks
    - Pharmaceuticals
    - Medical devices
    - Durable medical equipment
- **MISSED PREVENTION OPPORTUNITIES**
  - Total excess = $55 B
    - Primary prevention
    - Secondary prevention
    - Tertiary prevention
- **FRAUD**
  - Total excess = $75 B
    - All sources—payer, clinician, patient

*Lower bound totals of various estimates, adjusted to 2009 total expenditure level.*
A Better Approach: Purchaser/Provider Partnerships

**Self-Funded Purchasers**

- Better Payment and Benefit Structure
- Lower Cost, Higher Quality Care

**Providers Willing to Manage Costs**

- **Purchasers and Patients “win” if:**
  - Providers reduce purchasers’ costs
  - Patients stay healthy and have lower cost-sharing

- **Provider “wins” if:**
  - Patients stay healthy and need less care
  - Purchaser pays provider adequately to manage care efficiently
Purchasers and Physicians Have Common Interests, But Don’t Know It

“We’ve started talking directly to physicians, and we’ve discovered that what they want to sell is what we want to buy…”

Cheryl DeMars
CEO, The Alliance
(Employer Coalition in Wisconsin)
Purchasers Have Total Risk Today

TOTAL COST OF HEALTH CARE

Self-Funded Purchasers, Medicare, Medicaid

Providers
The Goal Should Not Be to Shift Total Risk to Physicians

TOTAL COST OF HEALTH CARE

Self-Funded Purchasers, Medicare, Medicaid

TOTAL COST OF HEALTH CARE

Physicians
Physicians Should be Accountable for *Costs They Can Control*

**Performance Risk** (Cost/Illness)

**Bottom-Up Payment Reform**

Physicians

**Insurance Risk** (Risk of Illness)

Self-Funded Purchasers, Medicare, Medicaid

Payers change payment to support redesigned care

Patients get better care and providers stay financially viable

Physicians redesign care and identify payment barriers
Health Plan Implements Changes Purchasers/Providers Agree On

- Better Payment and Benefit Structure
- Lower Cost, Higher Quality Care

Health Plans

Purchasers

Implementation

Physicians & Hospitals
Facilitator Needed to Provide Data and Technical Assistance

Better Payment and Benefit Structure

Lower Cost, Higher Quality Care

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
Regional Multi-Stakeholder Groups Facilitate Win-Win-Win Solutions

Regional Health Improvement Collaboratives (RHICS)

Network for Regional Healthcare Improvement
www.NRHI.org
Florida Needs a Mechanism for Multi-Stakeholder Collaboration

Regional Health Improvement Collaboratives (RHICS)

Network for Regional Healthcare Improvement
www.NRHI.org
There Are NOT (Just) Two Choices Under MACRA

#1
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

#2
ALTERNATIVE PAYMENT MODELS (APMs)
There are 3 Paths to the Future: Which Will Oncologists Choose?

Macra

#1 Merit-Based Incentive Payment System (MIPS)

#2 Alternative Payment Models (APMs)

#3 Physician-Focused Payment Models
If You Don’t Like Doors 1 & 2, What Should You Do?
If You Don’t Like Doors 1 & 2, What Should You Do?

1. Continue listening to Powerpoint presentations at the FLASCO Meeting, go back home, continue business as usual, and hope somebody else figures this out.
If You Don’t Like Doors 1 & 2, What Should You Do?

1. Continue listening to Powerpoint presentations at the FLASCO Meeting, go back home, continue business as usual, and hope somebody else figures this out

2. Plan to retire before 2019
If You Don’t Like Doors 1 & 2, What Should You Do?

1. Continue listening to Powerpoint presentations at the FLASCO Meeting, go back home, continue business as usual, and hope somebody else figures this out

2. Plan to retire before 2019

3. Design/implement physician-led APMs for oncology
If You Don’t Like Doors 1 & 2, What Should You Do?

1. Continue listening to Powerpoint presentations at the FLASCO Meeting, go back home, continue business as usual, and hope somebody else figures this out.


3. Design/implement physician-led APMs for oncology.
   - Look at your own patient population and identify opportunities to reduce spending without harming patients.
   - Talk to the purchasers in your community about the opportunities to improve care and reduce spending and how to create a collaborative regional partnership to implement them.
   - Demand that health plans and Medicare implement good alternative payment models to enable you to deliver more affordable, high-quality care in your community.
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

Example of Win-Win-Win Approach for Physicians, Hospitals, and Payers Using Condition-Based Payment
Example: Reducing Preventable Admits During Cancer Treatment

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td>Oncology Pract.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
<td>$4,500,000</td>
</tr>
</tbody>
</table>

Patients Receiving Chemotherapy Treatment for Cancer

- 1,000 patients treated by oncology practice in a year
- Oncology practice receives $4,500 per patient in total fees for E&M services and infusion services (excluding cost of drugs)
Example: Reducing Preventable Admits During Cancer Treatment

<table>
<thead>
<tr>
<th>CURRENT</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncology Pract.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
<td>$4,500,000</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions</td>
<td>$15,000</td>
<td>350</td>
<td>$5,250,000</td>
</tr>
</tbody>
</table>

**Patients Receiving Chemotherapy Treatment for Cancer**

- 1,000 patients treated by oncology practice in a year
- Oncology practice receives $4,500 per patient in total fees for E&M services and infusion services (excluding cost of drugs)
- 35% of patients are hospitalized during the year for complications related to chemotherapy treatment ($15,000 payment to hospital per admission)
## Patients Receiving Chemotherapy Treatment for Cancer

- 1,000 patients treated by oncology practice in a year
- Oncology practice receives $4,500 per patient in total fees for E&M services and infusion services (excluding cost of drugs)
- 35% of patients are hospitalized during the year for complications related to chemotherapy treatment ($15,000 payment to hospital per admission)

### Example: Reducing Preventable Admits During Cancer Treatment

<table>
<thead>
<tr>
<th>Patients Receiving Chemotherapy Treatment for Cancer</th>
<th>CURRENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncology Pract.</td>
<td>$4,500</td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>1000</td>
</tr>
<tr>
<td>Total Spending</td>
<td>1000</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>$15,000</td>
</tr>
<tr>
<td>Admissions</td>
<td>350</td>
</tr>
<tr>
<td>Total Spending</td>
<td>1000</td>
</tr>
</tbody>
</table>

- **Oncology Pract.**  
  - E&M/Infusions: $4,500 per patient, 1000 patients = $4,500,000
  - Hospitalizations: 35% of 1000 patients hospitalized, $15,000 payment per admission = $5,250,000
  - **Total Spending**: 1000 patients * $9,750,000 = $9,750,000
How Would You Improve Payment and Lower Total Spending?

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td>Oncology Pract.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
<td>$4,500,000</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions</td>
<td>$15,000</td>
<td>350</td>
<td>$5,250,000</td>
</tr>
<tr>
<td>Total Spending</td>
<td></td>
<td>1000</td>
<td>$9,750,000</td>
</tr>
</tbody>
</table>
Improve Care for Patients By Paying for Triage/Response

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td>Oncology Pract.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
<td>$4,500,000</td>
</tr>
<tr>
<td>Triage/Respond</td>
<td>$200</td>
<td>1000</td>
<td>$200,000</td>
</tr>
<tr>
<td>Total Practice</td>
<td>1000</td>
<td></td>
<td>$4,500,000</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions</td>
<td>$15,000</td>
<td>350</td>
<td>$5,250,000</td>
</tr>
<tr>
<td>Total Spending</td>
<td>1000</td>
<td></td>
<td>$9,750,000</td>
</tr>
</tbody>
</table>

Better Payment for Cancer Treatment Management

- Oncology practice paid additional $200,000 ($200/patient) to set up a triage system and provide rapid treatment in the office for complications of treatment (nausea, fever, etc.)
A Reduction in Hospital Admissions Would More Than Pay for Costs

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th></th>
<th>FUTURE</th>
<th></th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
<td>$/Pt</td>
<td># Pts</td>
</tr>
<tr>
<td><strong>Oncology Pract.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
<td>$4,500,000</td>
<td>$4,500</td>
<td>1000</td>
</tr>
<tr>
<td>Triage/Respond</td>
<td>$200</td>
<td>1000</td>
<td>$200,000</td>
<td>$200</td>
<td>1000</td>
</tr>
<tr>
<td>Total Practice</td>
<td>1000</td>
<td></td>
<td>$4,500,000</td>
<td>1000</td>
<td></td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions</td>
<td>$15,000</td>
<td>350</td>
<td>$5,250,000</td>
<td>$15,000</td>
<td>245</td>
</tr>
<tr>
<td>Total Spending</td>
<td>1000</td>
<td></td>
<td>$9,750,000</td>
<td>1000</td>
<td></td>
</tr>
</tbody>
</table>

Better Payment for Cancer Treatment Management

- Oncology practice paid additional $200,000 ($200/patient) to set up a triage system and provide rapid treatment in the office for complications of treatment (nausea, fever, etc.)
- Result is a 30% reduction in preventable hospital admissions
Wins for Patients, Docs, & Payers

### Better Payment for Cancer Treatment Management

- Oncology practice paid additional $200,000 ($200/patient) to set up a triage system and provide rapid treatment in the office for complications of treatment (nausea, fever, etc.).
- Result is a 30% reduction in preventable hospital admissions.

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td><strong>Oncology Pract.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
<td>$4,500,000</td>
</tr>
<tr>
<td>Triage/Respond</td>
<td>$200</td>
<td>1000</td>
<td>$200,000</td>
</tr>
<tr>
<td><strong>Total Practice</strong></td>
<td>1000</td>
<td></td>
<td>$4,500,000</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions</td>
<td>$15,000</td>
<td>350</td>
<td>$5,250,000</td>
</tr>
<tr>
<td><strong>Total Spending</strong></td>
<td>1000</td>
<td></td>
<td>$9,750,000</td>
</tr>
</tbody>
</table>

**Payer Wins**

- **Payer Wins**

**Patient Wins**

**Oncology Practice Wins**
Wins for Patients, Docs, & Payers But What About Hospitals?

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th></th>
<th>FUTURE</th>
<th></th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
<td>$/Pt</td>
<td># Pts</td>
</tr>
<tr>
<td>Oncology Pract.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
<td>$4,500,000</td>
<td>$4,500,000</td>
<td></td>
</tr>
<tr>
<td>Triage/Respond</td>
<td>$200</td>
<td>1000</td>
<td>$200,000</td>
<td>$200,000</td>
<td></td>
</tr>
<tr>
<td>Total Practice</td>
<td></td>
<td>1000</td>
<td>$4,500,000</td>
<td>1000</td>
<td>$4,700,000</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions</td>
<td>$15,000</td>
<td>350</td>
<td>$5,250,000</td>
<td>$15,000,000</td>
<td>245</td>
</tr>
<tr>
<td>Total Spending</td>
<td></td>
<td>1000</td>
<td>$9,750,000</td>
<td>1000</td>
<td>$9,375,000</td>
</tr>
</tbody>
</table>

Better Payment for Cancer Treatment Management

- Oncology practice paid additional $200,000 ($200/patient) to set up a triage system and provide rapid treatment in the office for complications of treatment (nausea, fever, etc.)
- Result is a 30% reduction in preventable hospital admissions

Payer Wins
Hospital Loses
Oncology Practice Wins
What Should Matter to Hospitals is *Margin*, Not Revenues (Volume)
Hospital Costs Are Not Proportional to Utilization

Cost & Revenue Changes With Fewer Patients

- 20% reduction in volume
- 7% reduction in cost
Reductions in Utilization Reduce Revenues More Than Costs

Cost & Revenue Changes With Fewer Patients

<table>
<thead>
<tr>
<th>#Patients</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,000</td>
</tr>
<tr>
<td></td>
<td>$980</td>
</tr>
<tr>
<td></td>
<td>$960</td>
</tr>
<tr>
<td></td>
<td>$940</td>
</tr>
<tr>
<td></td>
<td>$920</td>
</tr>
<tr>
<td></td>
<td>$900</td>
</tr>
<tr>
<td></td>
<td>$880</td>
</tr>
<tr>
<td></td>
<td>$860</td>
</tr>
<tr>
<td></td>
<td>$840</td>
</tr>
<tr>
<td></td>
<td>$820</td>
</tr>
<tr>
<td></td>
<td>$800</td>
</tr>
</tbody>
</table>

- 7% reduction in cost
- 20% reduction in revenue
- 20% reduction in volume
Causing Negative Margins for Hospitals

Cost & Revenue Changes With Fewer Patients

Payers Will Be Underpaying For Care If Admissions, Readmissions, Etc. Are Reduced
But Spending Can Be Reduced Without Bankrupting Hospitals

Cost & Revenue Changes With Fewer Patients

Payers Can Still Save $ Without Causing Negative Margins for Hospital

Revenues
Costs

#Patients

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
We Need to Understand the Hospital’s Cost Structure

<table>
<thead>
<tr>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
</tr>
<tr>
<td>Oncology Pract.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
</tr>
<tr>
<td>Triage/Respond</td>
<td>$200</td>
<td>1000</td>
</tr>
<tr>
<td>Total Practice</td>
<td>1000</td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions</td>
<td>$15,000</td>
<td>350</td>
</tr>
<tr>
<td>Total Spending</td>
<td>1000</td>
<td></td>
</tr>
</tbody>
</table>
We Need to Understand the Hospital’s Cost Structure

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt        # Pts  Total $</td>
<td>$/Pt        # Pts  Total $</td>
<td></td>
</tr>
<tr>
<td>Oncology Pract.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500      1000  $4,500,000</td>
<td>$4,500      1000  $4,500,000</td>
<td></td>
</tr>
<tr>
<td>Triage/Respond</td>
<td>$200        1000  $200,000</td>
<td>$200        1000  $200,000</td>
<td></td>
</tr>
<tr>
<td>Total Practice</td>
<td>1000        1000  $4,500,000</td>
<td>1000        1000  $4,700,000</td>
<td>+4%</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (65%)</td>
<td>$9,750</td>
<td>$3,412,500</td>
<td></td>
</tr>
<tr>
<td>Variable (30%)</td>
<td>$4,500</td>
<td>$1,575,000</td>
<td></td>
</tr>
<tr>
<td>Margin (5%)</td>
<td>$750</td>
<td>$262,500</td>
<td></td>
</tr>
<tr>
<td>Total Hospital</td>
<td>$15,000</td>
<td>$5,250,000</td>
<td></td>
</tr>
<tr>
<td>Total Spending</td>
<td>1000</td>
<td>$9,750,000</td>
<td></td>
</tr>
</tbody>
</table>
Now, If the Number of Admissions is Reduced…

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th></th>
<th></th>
<th>FUTURE</th>
<th></th>
<th></th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
<td></td>
</tr>
<tr>
<td>Oncology Pract.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
<td>$4,500,000</td>
<td>$4,500</td>
<td>1000</td>
<td>$4,500,000</td>
<td></td>
</tr>
<tr>
<td>Triage/Respond</td>
<td>$200</td>
<td>1000</td>
<td>$200,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Practice</td>
<td></td>
<td>1000</td>
<td>$4,500,000</td>
<td></td>
<td>1000</td>
<td>$4,700,000</td>
<td>+4%</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (65%)</td>
<td>$9,750</td>
<td></td>
<td>$3,412,500</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variable (30%)</td>
<td>$4,500</td>
<td></td>
<td>$1,575,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Margin (5%)</td>
<td>$750</td>
<td></td>
<td>$262,500</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Hospital</td>
<td>$15,000</td>
<td>350</td>
<td>$2,450,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Spending</td>
<td></td>
<td>1000</td>
<td>$9,750,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
...Fixed Costs Will Remain the Same (in the Short Run)...

<table>
<thead>
<tr>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oncology Pract.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500 1000 $4,500,000</td>
<td>$4,500 1000 $4,500,000</td>
</tr>
<tr>
<td>Triage/Respond</td>
<td>$200 1000 $200,000</td>
<td>$200 1000 $200,000</td>
</tr>
<tr>
<td>Total Practice</td>
<td>1000 $4,500,000</td>
<td>1000 $4,700,000</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (65%)</td>
<td>$9,750</td>
<td>$3,412,500</td>
</tr>
<tr>
<td>Variable (30%)</td>
<td>$4,500</td>
<td>$1,575,000</td>
</tr>
<tr>
<td>Margin (5%)</td>
<td>$750</td>
<td>$262,500</td>
</tr>
<tr>
<td>Total Hospital</td>
<td>$15,000 350 $5,250,000</td>
<td></td>
</tr>
<tr>
<td>Total Spending</td>
<td>1000 $9,750,000</td>
<td></td>
</tr>
</tbody>
</table>
…Variable Costs Will Decrease in Proportion to Admissions…

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td><strong>Oncology Pract.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
<td>$4,500,000</td>
</tr>
<tr>
<td>Triage/Respond</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Practice</td>
<td>1000</td>
<td></td>
<td>$4,500,000</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (65%)</td>
<td>$9,750</td>
<td></td>
<td>$3,412,500</td>
</tr>
<tr>
<td>Variable (30%)</td>
<td>$4,500</td>
<td></td>
<td>$1,575,000</td>
</tr>
<tr>
<td>Margin ( 5%)</td>
<td>$750</td>
<td></td>
<td>$262,500</td>
</tr>
<tr>
<td>Total Hospital</td>
<td>$15,000</td>
<td>350</td>
<td>$5,250,000</td>
</tr>
<tr>
<td>Total Spending</td>
<td>1000</td>
<td></td>
<td>$9,750,000</td>
</tr>
</tbody>
</table>
...And Even With a Higher Margin...

<table>
<thead>
<tr>
<th>Current</th>
<th>Future</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncology Pract.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
</tr>
<tr>
<td>Triage/Respond</td>
<td>$200</td>
<td>1000</td>
</tr>
<tr>
<td>Total Practice</td>
<td>1000</td>
<td>$4,500,000</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (65%)</td>
<td>$9,750</td>
<td>$3,412,500</td>
</tr>
<tr>
<td>Variable (30%)</td>
<td>$4,500</td>
<td>$1,575,000</td>
</tr>
<tr>
<td>Margin (5%)</td>
<td>$750</td>
<td>$262,500</td>
</tr>
<tr>
<td>Total Hospital</td>
<td>$15,000</td>
<td>350</td>
</tr>
<tr>
<td>Total Spending</td>
<td>1000</td>
<td>$9,750,000</td>
</tr>
</tbody>
</table>

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
…The Hospital Comes Out Ahead With Significantly Lower Revenue

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td><strong>Oncology Pract.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
<td>$4,500,000</td>
</tr>
<tr>
<td>Triage/Respond</td>
<td></td>
<td>1000</td>
<td>$200,000</td>
</tr>
<tr>
<td><strong>Total Practice</strong></td>
<td>1000</td>
<td>$4,500,000</td>
<td></td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (65%)</td>
<td>$9,750</td>
<td></td>
<td>$3,412,500</td>
</tr>
<tr>
<td>Variable (30%)</td>
<td>$4,500</td>
<td></td>
<td>$1,575,000</td>
</tr>
<tr>
<td>Margin (5%)</td>
<td>$750</td>
<td></td>
<td>$262,500</td>
</tr>
<tr>
<td><strong>Total Hospital</strong></td>
<td>$15,000</td>
<td>350</td>
<td>$5,250,000</td>
</tr>
<tr>
<td><strong>Total Spending</strong></td>
<td>1000</td>
<td>$9,750,000</td>
<td></td>
</tr>
</tbody>
</table>

Total Spending: $9,750,000
And the Payer Still Saves Money

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt  # Pts Total $</td>
<td>$/Pt  # Pts Total $</td>
<td></td>
</tr>
<tr>
<td>Oncology Pract.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500 1000 $4,500,000</td>
<td>$4,500 1000 $4,500,000</td>
<td></td>
</tr>
<tr>
<td>Triage/Respond</td>
<td>$200 1000 $200,000</td>
<td>$200 1000 $200,000</td>
<td></td>
</tr>
<tr>
<td>Total Practice</td>
<td>1000 $4,500,000</td>
<td>1000 $4,700,000</td>
<td>+4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (65%)</td>
<td>$9,750 $3,412,500</td>
<td>$9,750 $3,412,500</td>
<td>0%</td>
</tr>
<tr>
<td>Variable (30%)</td>
<td>$4,500 $1,575,000</td>
<td>$4,500 $1,102,500</td>
<td>-30%</td>
</tr>
<tr>
<td>Margin (5%)</td>
<td>$750 $262,500</td>
<td>$750 $273,000</td>
<td>+4%</td>
</tr>
<tr>
<td>Total Hospital</td>
<td>$15,000 350 $5,250,000</td>
<td>245 $4,788,000</td>
<td>-9%</td>
</tr>
<tr>
<td><strong>Total Spending</strong></td>
<td>1000 $9,750,000</td>
<td><strong>$9,488,000</strong></td>
<td><strong>-3%</strong></td>
</tr>
</tbody>
</table>
I.e., a Win-Win-Win-Win for Patient, Practice, Hospital, & Payer

<table>
<thead>
<tr>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
</tr>
<tr>
<td>Oncology Pract.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
</tr>
<tr>
<td>Triage/Respond</td>
<td>$200</td>
<td>1000</td>
</tr>
<tr>
<td>Total Practice</td>
<td>1000</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (65%)</td>
<td>$9,750</td>
<td></td>
</tr>
<tr>
<td>Variable (30%)</td>
<td>$4,500</td>
<td></td>
</tr>
<tr>
<td>Margin ( 5%)</td>
<td>$750</td>
<td></td>
</tr>
<tr>
<td>Total Hospital</td>
<td>$15,000</td>
<td>350</td>
</tr>
<tr>
<td>Total Spending</td>
<td>1000</td>
<td></td>
</tr>
</tbody>
</table>

Oncology Practice Wins, Hospital Wins, Payer Wins
**What Payment Model Supports This Win-Win-Win Approach?**

<table>
<thead>
<tr>
<th></th>
<th><strong>CURRENT</strong></th>
<th></th>
<th><strong>FUTURE</strong></th>
<th></th>
<th><strong>Chg</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
<td>$/Pt</td>
<td># Pts</td>
</tr>
<tr>
<td><strong>Oncology Pract.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
<td>$4,500,000</td>
<td>$4,500</td>
<td>1000</td>
</tr>
<tr>
<td>Triage/Respond</td>
<td>$200</td>
<td>1000</td>
<td>$200,000</td>
<td>$200</td>
<td>1000</td>
</tr>
<tr>
<td>Total Practice</td>
<td>1000</td>
<td></td>
<td>$4,500,000</td>
<td>1000</td>
<td></td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (65%)</td>
<td>$9,750</td>
<td></td>
<td>$3,412,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variable (30%)</td>
<td>$4,500</td>
<td></td>
<td>$1,575,000</td>
<td>$4,500</td>
<td></td>
</tr>
<tr>
<td>Margin (5%)</td>
<td>$750</td>
<td></td>
<td>$262,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Hospital</td>
<td>$15,000</td>
<td>350</td>
<td>$5,250,000</td>
<td>245</td>
<td></td>
</tr>
<tr>
<td><strong>Total Spending</strong></td>
<td>1000</td>
<td></td>
<td>$9,750,000</td>
<td>1000</td>
<td></td>
</tr>
</tbody>
</table>
Trying to Renegotiate Individual Fees Is Impractical

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td><strong>Oncology Pract.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
<td>$4,500,000</td>
</tr>
<tr>
<td>Triage/Respond</td>
<td>$200</td>
<td>1000</td>
<td>$200,000</td>
</tr>
<tr>
<td>Total Practice</td>
<td>$4,500</td>
<td>1000</td>
<td>$4,500,000</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (65%)</td>
<td>$9,750</td>
<td></td>
<td>$3,412,500</td>
</tr>
<tr>
<td>Variable (30%)</td>
<td>$4,500</td>
<td></td>
<td>$1,575,000</td>
</tr>
<tr>
<td>Margin (5%)</td>
<td>$750</td>
<td></td>
<td>$262,500</td>
</tr>
<tr>
<td>Total Hospital</td>
<td>$15,000</td>
<td></td>
<td>$19,543</td>
</tr>
<tr>
<td>Total Spending</td>
<td>$9,750,000</td>
<td>1000</td>
<td>$9,488,000</td>
</tr>
<tr>
<td></td>
<td>CURRENT</td>
<td>FUTURE</td>
<td>Chg</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------</td>
<td>-----------------</td>
<td>------</td>
</tr>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td><strong>Oncology Pract.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
<td>$4,500,000</td>
</tr>
<tr>
<td>Triage/Respond</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Practice</strong></td>
<td></td>
<td>1000</td>
<td>$4,500,000</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (65%)</td>
<td>$9,750</td>
<td></td>
<td>$3,412,500</td>
</tr>
<tr>
<td>Variable (30%)</td>
<td>$4,500</td>
<td></td>
<td>$1,575,000</td>
</tr>
<tr>
<td>Margin (5%)</td>
<td>$750</td>
<td></td>
<td>$262,500</td>
</tr>
<tr>
<td><strong>Total Hospital</strong></td>
<td>$15,000</td>
<td>350</td>
<td>$5,250,000</td>
</tr>
<tr>
<td><strong>Total Spending</strong></td>
<td>$9,750</td>
<td>1000</td>
<td>$9,750,000</td>
</tr>
</tbody>
</table>
…Offer to Manage Care for a Lower, But More Flexible Payment

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td><strong>Oncology Pract.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
<td>$4,500,000</td>
</tr>
<tr>
<td>Triage/Respond</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Practice</td>
<td></td>
<td>1000</td>
<td>$4,500,000</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (65%)</td>
<td>$9,750</td>
<td></td>
<td>$3,412,500</td>
</tr>
<tr>
<td>Variable (30%)</td>
<td>$4,500</td>
<td></td>
<td>$1,575,000</td>
</tr>
<tr>
<td>Margin (5%)</td>
<td>$750</td>
<td></td>
<td>$262,500</td>
</tr>
<tr>
<td>Total Hospital</td>
<td>$15,000</td>
<td>350</td>
<td>$5,250,000</td>
</tr>
<tr>
<td><strong>Total Spending</strong></td>
<td>$9,750</td>
<td>1000</td>
<td>$9,750,000</td>
</tr>
</tbody>
</table>
...Use the Payment as a Budget to Redesign Care...

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>FUTURE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
</tr>
<tr>
<td>Oncology Pract.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
</tr>
<tr>
<td>Triage/Respond</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Practice</td>
<td>1000</td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (65%)</td>
<td>$9,750</td>
<td></td>
</tr>
<tr>
<td>Variable (30%)</td>
<td>$4,500</td>
<td></td>
</tr>
<tr>
<td>Margin (5%)</td>
<td>$750</td>
<td></td>
</tr>
<tr>
<td>Total Hospital</td>
<td>$15,000</td>
<td>350</td>
</tr>
<tr>
<td>Total Spending</td>
<td>$9,750</td>
<td>1000</td>
</tr>
</tbody>
</table>
...And Let Physicians and Hospitals Decide How They Should Be Paid

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td><strong>Oncology Pract.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
<td>$4,500,000</td>
</tr>
<tr>
<td>Triage/Respond</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Practice</td>
<td>1000</td>
<td></td>
<td>$4,500,000</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (65%)</td>
<td>$9,750</td>
<td></td>
<td>$3,412,500</td>
</tr>
<tr>
<td>Variable (30%)</td>
<td>$4,500</td>
<td></td>
<td>$1,575,000</td>
</tr>
<tr>
<td>Margin (5%)</td>
<td>$750</td>
<td></td>
<td>$262,500</td>
</tr>
<tr>
<td>Total Hospital</td>
<td>$15,000</td>
<td>350</td>
<td>$5,250,000</td>
</tr>
<tr>
<td><strong>Total Spending</strong></td>
<td>$9,750</td>
<td>1000</td>
<td>$9,750,000</td>
</tr>
</tbody>
</table>
## Condition-Based Payment Provides Flexibility to Redesign Care & Pmt

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>CONDITION-BASED PMT</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td>Oncology Pract.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
<td>$4,500,000</td>
</tr>
<tr>
<td>Triage/Respond</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Practice</td>
<td>1000</td>
<td></td>
<td>$4,500,000</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (65%)</td>
<td>$9,750</td>
<td></td>
<td>$3,412,500</td>
</tr>
<tr>
<td>Variable (30%)</td>
<td>$4,500</td>
<td></td>
<td>$1,575,000</td>
</tr>
<tr>
<td>Margin (5%)</td>
<td>$750</td>
<td></td>
<td>$262,500</td>
</tr>
<tr>
<td>Total Hospital</td>
<td>$15,000</td>
<td>350</td>
<td>$5,250,000</td>
</tr>
<tr>
<td>Total Spending</td>
<td>$9,750</td>
<td>1000</td>
<td>$9,750,000</td>
</tr>
</tbody>
</table>
Protections For Providers Against Taking Inappropriate Risk

- **Risk Adjustment/Stratification:** 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 Physician from the payer would be increased if spending on an individual patient exceeds a pre-defined threshold. An alternative would be for the physician 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 physician would be increased if spending on all patients exceeds a pre-defined percentage above the payments. An alternative would be for the physician 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 physician would be adjusted for changes in the prices of drugs or services from other physicians that are beyond the control of the physician accepting the payment.

- **Excluded Services:** Services the physician 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.
### Example of Risk-Stratified Condition-Based Payment

<table>
<thead>
<tr>
<th>LOWER RISK PATIENTS</th>
<th># Pts</th>
<th>HIGHER RISK PATIENTS</th>
<th># Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oncology Pract.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Practice</strong></td>
<td>500</td>
<td></td>
<td>500</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Hospital</strong></td>
<td>62</td>
<td>183</td>
<td>245</td>
</tr>
<tr>
<td></td>
<td>500</td>
<td>500</td>
<td>1000</td>
</tr>
</tbody>
</table>

**Lower-Risk (12%) of Hospital Admission**

**Higher-Risk (37%) of Hospital Admission**
### Example of Risk-Stratified Condition-Based Payment

<table>
<thead>
<tr>
<th></th>
<th>LOWER RISK PATIENTS</th>
<th>HIGHER RISK PATIENTS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total</td>
</tr>
<tr>
<td><strong>Oncology Pract.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusion</td>
<td>$4,500</td>
<td>500</td>
<td>$2,250,000</td>
</tr>
<tr>
<td>Triage/Intervene</td>
<td>$100</td>
<td>500</td>
<td>$50,000</td>
</tr>
<tr>
<td>Total Practice</td>
<td>$4,600</td>
<td>500</td>
<td>$2,300,000</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed</td>
<td></td>
<td></td>
<td>$853,125</td>
</tr>
<tr>
<td>Variable</td>
<td>$4,500</td>
<td></td>
<td>$279,000</td>
</tr>
<tr>
<td>Margin</td>
<td></td>
<td></td>
<td>$68,250</td>
</tr>
<tr>
<td>Total Hospital</td>
<td>$2,401</td>
<td>62</td>
<td>$1,200,375</td>
</tr>
<tr>
<td>Total Spending</td>
<td>$7,001</td>
<td>500</td>
<td>$3,500,375</td>
</tr>
</tbody>
</table>

- **Lower Payment for Lower-Risk Patients**
- **Higher Payment for Higher-Risk Patients**
- **Still Lower Total Spending**