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

Projected Federal Budget Spending, 2016-2027 (Billions)

- Debt Interest: 94% Increase ($1 Trillion)
- Medicaid: 85% Increase ($770 Billion)
- Medicare: 25% Increase ($400 Billion)
- Social Security
- Other Mandatory
- Discretionary Spending

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Premiums Have Increased 73% More Than Inflation Since 2002

Source: Medical Expenditure Panel Survey & Bureau of Labor Statistics
Premiums Have Grown Faster Than Worker Earnings

Growth in Family Insurance Premiums, Annual Earnings, and Inflation

Source: Medical Expenditure Panel Survey & Bureau of Labor Statistics

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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 HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

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Typical Strategy #1: Cut Provider Fees for Services

Cut Provider Fees

SAVINGS

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING BY PAYERS
Typical Strategy #2: Shift Costs to Patients

Typical Strategy #2:
Shift Costs to Patients

TOTAL HEALTH CARE SPENDING
TOTAL HEALTH CARE SPENDING
TOTAL HEALTH CARE SPENDING
SAVINGS
TOTAL HEALTH CARE SPENDING BY PAYERS

Higher Cost-Share & Deductibles

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Typical Strategy #3: Delay or Deny Care to Patients

- Total Health Care Spending
- Total Health Care Spending
- Total Health Care Spending
- Savings
- 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
- Savings
- Lack of Needed Care
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

- NECESSARY SPENDING
- AVOIDABLE SPENDING
Avoidable Spending Occurs In All Aspects of Healthcare

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

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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 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
The Right Goal: Less Avoidable $,

- NECESSARY SPENDING
- AVOIDABLE SPENDING

$ / TIME
The Right Goal: Less Avoidable $, More Necessary $
Win-Win for Patients & Payers

Lower Spending for Payers
Better Care for Patients

NECESSARY SPENDING
AVOIDABLE SPENDING
SAVINGS

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

NECESSARY SPENDING

AVOIDABLE SPENDING

BARRIERS IN THE CURRENT PAYMENT SYSTEM

SAVINGS

NECESSARY SPENDING

AVOIDABLE SPENDING
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…

- NECESSARY SPENDING
- AVOIDABLE 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
…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
...Leaving Providers With Losses (or Bigger Losses Than Today)

Many Fixed Costs of Services Remain When Volume Decreases And New Costs May Be Incurred, Potentially Causing Financial Losses
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…

PROVIDER SOLUTION:

- NECESSARY SPENDING
- AVOIDABLE SPENDING
- NEWLY PAID SERVICES
- UNPAID SERVICES
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

== PROVIDER SOLUTION: ==

[Diagram showing the comparison of necessary spending, avoidable spending, and savings]

== PAYER FEAR: ==

[Diagram showing the fear of avoidable spending and newly paid services]

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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
How Do You Define Value?
How Do You Define Value?

VALUE = \frac{QUALITY}{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**
- 7 Year Survival
- $5,000/patient
- 0.51 days of life per dollar

**ONCOLOGIST #2**
- 10 Year Survival
- $10,000/patient
- 0.37 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
- $11,000/patient

**ONCOLOGIST #2**
- 10 Year Survival
- 50% Grade 3+ Toxicity
- $10,000/patient

?
Assessing Value is a Lot Harder Than This

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

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Payer Approach: Save Us Money…

$  

PAYER SOLUTION:

YEAR 1

NECESSARY SPENDING
AVOIDABLE SPENDING

UNPAID SERVICES
SAVINGS
LOSS OF REVENUE

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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

NECESSARY SPENDING

AVOIDABLE SPENDING

SAVINGS

YEAR 2

NECESSARY SPENDING

AVOIDABLE SPENDING

SAVINGS

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?

PATIENTS
- Heart Disease
- Cancer
- Back Pain
- Pregnancy

ACO

Primary Care  Cardiology  Oncology  Neurosurgery  OB/GYN
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…

MEDICARE

ACO

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

PATIENTS
- Heart Disease
- Cancer
- Back Pain
- Pregnancy

Primary Care
Cardiology
Oncology
Neurosurgery
OB/GYN

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…With Only the Potential for Receiving Future “Shared Savings”

MEDICARE

Shared Savings Payment Next Year???

ACO

Fee-for-Service Payment

PATIENTS
- Heart Disease
- Cancer
- Back Pain
- Pregnancy

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

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

**MEDICARE**

**ACO**

- Expensive IT Systems
- Care Coordinators

• 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**

**Shared Savings Payment Next Year??**
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

Fee-for-Service Payment

PATIENTS
- Heart Disease
- Cancer
- Back Pain
- Pregnancy

Primary Care
Cardiology
Oncology
Neurosurgery
OB/GYN

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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

Fee-for-Service Payment

More Downside Risk

Expensive IT Systems

Care Coordinators

Primary Care
Cardiology
Oncology
Neurosurgery
OB/GYN

MEDICARE

PATIENTS
Heart Disease
Cancer
Back Pain
Pregnancy

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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

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Value-Based Payment Is Being Designed the Wrong Way Today

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
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

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
- 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
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

American Society of Nephrology
American Academy of Allergy, Asthma & Immunology
American Society for Radiation Oncology
American Academy of Family Physicians
American Society of Clinical Oncology

5 Things Physicians and Patients Should Question

1. Don’t provide IG tests.
2. Don’t use dual-energy x-ray for osteoporosis in women under 70 who are no-risk factors.
3. Don’t use PET, CT, or radionuclide bone scans for patients with the following characteristics:
   - Low risk of metastases
   - No history of cancer
   - No known risk factors
   - No previous treatment for cancer
4. Don’t perform surveillance testing (biomarkers or imaging) for asymptomatic individuals who have been treated for prostate cancer.
5. Don’t use white cell stimulating factors for primary prevention of febrile neutropenia for patients with less than 20% risk for this complication.

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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

- Unpaid Services
- Loss of Revenue
- Necessary Spending
- Avoidable Spending

FEE FOR SERVICE

$
Step #3: Remove the FFS Barriers

- Unpaid Services
- Adequate, Flexible Payment for High-Value Services

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

- **Avoidable Spending**
- **Necessary Spending**
- **Unpaid Services**
- **Loss of Revenue**

**Fee for Service vs. 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

Fee for Service vs. Alternative Payment Model

- Avoidable Spending
- Necessary Spending
- Unpaid Services
- Loss of Revenue
- Lower Avoidable Spending
- Adequate, Flexible Payment for High-Value Services

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Most Healthcare Spending Doesn’t Go to Physicians

- **FEE FOR SERVICE**
  - **NECESSARY SPENDING**
    - Physicin Payment
  - **AVOIDABLE SPENDING**

- **Medicare Part A/B/D Spending FFY 2016**
  - Hospitals: 38%
  - Part D Drugs: 22%
  - SNF/HH/Hospice: 14%
  - DME/Labs/Meds: 12%
  - Physicians: 15%

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

- NECESSARY SPENDING
  - NEEDED AND NEEDED
  - Physician Payment

- AVOIDABLE SPENDING
  - AVOID AND AVOID
  - Physician Payment
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

www.PaymentReform.org

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
Option 1: Add New Payment(s) to Overcome Current Barriers

- CURRENT FFS
- APM #1

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

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Option 1, Part 2: Add in an Accountability Component

- **CURRENT FFS**
  - Necessary Spending
  - Physician Payment
  - Unpaid Service Revenue Loss

- **APM #1**
  - Necessary Spending
  - New Payment
  - Current Payment
  - Avoidable Spending

**SAVINGS**
Adjustment to New Payment Based on Control of Avoidable Spending
Accountability Component Could Utilize a P4P Approach

CURRENT FFS

Avoidable Spending
Physician Can Control

Necessary Spending

Unpaid Service
Revenue Loss

New Payment

APM #1

Avoidable Spending

Necessary Spending

New 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

New Payment
Current Payment

Unpaid Service
Revenue Loss

Bundled Payment for Physician Services

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Option 2, Part 2: Add an Accountability Component

CURRENT FFS

$ Avoidable Spending Physician Can Control

Necessary Spending

Physician Payment

Unpaid Service
Revenue Loss

APM #1

SAVINGS
Avoidable Spending

Necessary Spending

New Payment

APMs #2-3

SAVINGS
Avoidable Spending

Necessary Spending

Bundled Payment for Physician Services

Adjustment to New Payment Based on Control of Avoidable Spending
Option 3: Full Bundle Covering Necessary & Avoidable Costs

CURRENT FFS

- Necessary Spending
  - Physician Payment
  - Unpaid Service
  - Revenue Loss

APM #1

- Necessary Spending
  - New Payment

APMs #2-3

- Necessary Spending
  - Bundled Payment for Physician Services
  - SAVINGS

APMs #4-7

- Costs of Other Related Services
  - Costs of Physician Services
  - SAVINGS

SAVINGS

- Avoidable Spending
  - Physician Can Control

- Avoidable Spending

- Avoidable Spending
If Patients Differ in the Services They Need…

- **Lower Need Patients**
  - Physician Services: Unpaid Svc
  - $ Loss

- **Medium Need Patients**
  - Physician Services: Unpaid Svc
  - $ Loss

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

![Chart showing different levels of need for patients and corresponding spending categories: Avoidable Spending, Necessary Spending, Physician Services.](chart.png)
APM $ Will Have to Be Adjusted for Differences in Need

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

- Avoidable Spending
- Necessary Spending

$ Loss

Unpaid Svc

Level 1 APM $

Level 2 APM $

Level 3 APM $

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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

$ Physician Services

Level 1 APM $

Level 2 APM $

Level 3 APM $

$ Unpaid Svc

$ Loss

$ Savings

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

% of Total Healthcare Spending, 2014

Cancer is a significant part of healthcare spending, accounting for 5% of total healthcare spending under Medicare and 2% under private insurance. This is represented in the bar chart, with Cancer ranked #5 under Medicare and #2 under private insurance.
Spending on Cancer Care Has Grown Rapidly

Spending on Cancer Care in U.S. 2004-2020

- $175,000,000,000
- $150,000,000,000
- $125,000,000,000
- $100,000,000,000
- $75,000,000,000
- $50,000,000,000
- $25,000,000,000
- $0

- 2004
- 2010
- 2020 Projected
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).

Current Spending Per Patient

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

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

90%+ of spending pays for drugs, laboratory tests, imaging studies, surgical procedures, emergency room visits, and hospitalizations
Most $$ Go to Drugs, Tests, and Admissions, Not Oncology Practices

Where Are the Opportunities to Reduce Spending Without Harming Patients?

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

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).
Opportunity 1: Reducing Avoidable ED Visits and Hospitalizations

• 40%+ of ED visits and hospital admissions are for chemotherapy-related complications
Large Reductions in Avoidable ED Visits & Hospitalizations

How We Do It

Oncology patient-centered medical home and accountable cancer care

John D. Spraulio, MD
Consultants 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 transforming our processes of cancer care delivery in our medical oncology practice concurrently with the implementation of an oncology-specific electronic medical record and the development of customized software to better meet 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 II 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.

M</ref>

ER evaluations per patient per year

![Graph showing ER evaluations per patient per year from 2004 to 2010.](image)

FIGURE 3 Average emergency room (ER) evaluations at Delaware County Memorial Hospital of the Drexel Hill office population per chemotherapy patient per year, 2004-2010 (YTD).

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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 $140,891 for those with breast cancer. These far exceed the average $38,797 per beneficiary Medicare spending in the last year of life.13 There were approximately 390,000 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. Total costs of cancer care in the last year of life amounted to $1.3 billion in 2010 and will approach $50 billion in 2020. Each 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.24 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.24

High utilization of cancer treatment at the end of life not only poses a burden to the health care system, but 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 supportive settings at the end of life.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 several measures as indicators of poor quality of care at the end of life, such as the use of chemotherapy in the last four 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.27

Though hospice is designed to facilitate patients’ end-of-life preferences, keeping patients at home or in a noninvasive environment while reducing pain and psychological stress and pro-
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.
Opportunity 2: Reducing Avoidable Use of Drugs, Tests, & Imaging

The image shows a bar chart with the y-axis labeled "Total Spending Per Patient" and the x-axis divided into categories such as "ER/Hospital Admissions," "Other Services," "Testing," and "E&M Infusions." Each category has a corresponding bar with a monetary value.

- **ER/Hospital Admissions** includes:
  - Unnecessarily expensive tests
  - Unnecessary testing

- **Other Services** includes:
  - Unnecessarily expensive drugs
  - Unnecessary drugs

- **Testing** includes:
  - Unnecessary end-of-life treatment

- **E&M Infusions**

The chart highlights the significant portion of avoidable spending, particularly in the categories of unnecessarily expensive drugs and unnecessary end-of-life treatment. The total spending per patient is visualized across different price ranges, emphasizing the potential savings from reducing avoidable use.
ASCO Choosing Wisely List
Targets Areas of High Spending
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

0% 10% 20% 30% 40% 50%
# 27%-40% Non-Adherence to Choosing Wisely Criteria

## Rate of Non-Adherence to Choosing Wisely Guidelines

- **Do not use combination chemotherapy when treating metastatic breast cancer unless the patient needs rapid response.**
- **Do not use white-cell stimulating factors for patients undergoing chemotherapy with less than 20% risk of febrile...**
- **Do not perform surveillance testing or imaging for asymptomatic individuals treated for breast cancer with curative...**
- **Do not give patients starting a chemotherapy regimen with low or moderate risk of nausea an antiemetic...**

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Rate of Non-Adherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
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<tr>
<td>10%</td>
<td></td>
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<tr>
<td>20%</td>
<td></td>
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<tr>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>50%</td>
<td></td>
</tr>
</tbody>
</table>
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 Pegfilgrastim Than on Patient Visits w/ Oncologists

2014 Medicare Part B Spending on Pegfilgrastim and Oncologist E&M

- Pegfilgrastim
- Oncologist E&M

- Other Visits/E&M Svcs
- Hospital Visits
- Established Patient Office Visits
- New Patient Office Visits
- Pegfilgrastim
14% of Drug Spend & 7% of Total During Chemo is Pegfilgrastim

- Bevacizumab: 17%
- Pegfilgrastim: 14%
- Oxaliplatin: 13%
- Trastuzumab: 12%
- Pemetrexed: 7%

All Other: 37%

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


<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>Cisplatin + Gemcitabine</td>
<td>13.1</td>
<td>6.1</td>
<td>75%</td>
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</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

Total Spending Per Patient

<table>
<thead>
<tr>
<th>Service</th>
<th>Avoidable $</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER/Hospital Admissions</td>
<td>$45,000</td>
</tr>
<tr>
<td>Other Services</td>
<td>$40,000</td>
</tr>
<tr>
<td>Testing</td>
<td>$35,000</td>
</tr>
<tr>
<td>Drugs</td>
<td>$30,000</td>
</tr>
<tr>
<td>Drug Margin</td>
<td>$25,000</td>
</tr>
<tr>
<td>E&amp;M Infusions</td>
<td>$20,000</td>
</tr>
<tr>
<td>Non-E&amp;M Care Mgt</td>
<td>$15,000</td>
</tr>
<tr>
<td>Drug Margin</td>
<td>$10,000</td>
</tr>
<tr>
<td>E&amp;M Infusions</td>
<td>$5,000</td>
</tr>
<tr>
<td>Non-E&amp;M Care Mgt</td>
<td>$0</td>
</tr>
</tbody>
</table>

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ASCO Payment Reform Developed by Oncologists & Practice Managers

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- Laura Stevens, Innovative Oncology Business Solutions
- Jeffery Ward, MD, Swedish Cancer Institute
- Kim Woofter, Michiana Hematology Oncology
- Robin Zon, MD, Michiana Hematology Oncology
PCOP Part 1: More Payment to Practices Where It’s Needed

Current FFS Payment

Patient-Centered Oncology Payment

Drug Margin

E&M Infusions

Better Payment for Practices

PCOP Pmts

E&M Infusions

Drug Margin

Oncology Practice Receives Higher Payments Than Today

Non-E&M Care Mgt
PCOP Part 2: Implement ASCO Guidelines & Avoid ED Visits

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

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

Lower Spending without Rationing
Better Payment for Practices
Avoidable $

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

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Payment Based on Adherence to Appropriate Use Criteria

<table>
<thead>
<tr>
<th>100%</th>
<th>80%</th>
<th>Min%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HIGH</strong></td>
<td><strong>LOW</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Rate of Adherence to Appropriate Use Criteria**

$\$ 

**New PCOP Payment**

**E&M and Infusion**

Choosing Wisely

Five Things Physicians and Patients Should Question

- 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.
- Don’t perform PET, CT, and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis.
- Don’t perform PET, CT, and radionuclide bone scans in the staging of early breast cancer at low risk for metastasis.
- 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.
- Don’t use white cell stimulating factors for primary prevention of febrile neutropenia for patients with less than 20% risk for this complication.

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PCOP Result: Better Care, Better Payment, Payer Savings

Current FFS Payment vs. Patient-Centered Oncology Payment

- **Lower Spending without Rationing**
- **Better Payment for Practices**
- **Avoidable $**
- **Drug Margin**
- **E&M Infusions**
- **Non-E&M Care Mgt**
- **ER/Hospital Admissions**
- **Other Services**
- **Testing**
- **Drugs**

**SAVINGS**
- **ER/Admissions**
- **Other Services**
- **Testing**
- **Drugs**

**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

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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>
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<tr>
<td>Other</td>
<td>$10,920</td>
<td>$10,920</td>
<td>0%</td>
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<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
# Potentially Large Win-Win-Win-Win for Payers, Patients & Practices

## Patient-Centered Oncology Payment

Payment Reform to Support Higher Quality, More Affordable Cancer Care  
May 2015

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

<table>
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### For 500 New Patients:

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

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www.asco.org/paymentreform
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>TREATMENT MONTHS</th>
<th>0 Dx</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<td>$900</td>
<td>$1200</td>
<td>$600</td>
<td>$900</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

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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

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

Risk-Sharing on Total Spending

“Performance-Based Payment”
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
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
6 Month Episodes?

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

Cumulative proportion of payments

Months relative to chemo 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

![Diagram showing the difference between a 6-month episode for treatment and post-treatment care.](image)
And Shared Savings Is More Likely With Same Spending in 2 Episodes
Undesirable New Incentives for Oncology Practices

Penalty for Helping Patients Avoid Side Effects?

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

CMS ONCOLOGY CARE MODEL

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
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
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

PATIENT

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

### Risks Under FFS
- Will fee levels from payers be adequate to cover the costs of delivering services?
- What utilization controls will payers impose on your services?
- What “value-based” reductions will be made in your payments based on “efficiency” measures?
- What “value-based” reductions will be made in your fees based on quality measures?
- Will you have enough patients to cover your practice or hospital expenses?

### Risks Under APMs
- Will the amount of payment be adequate to cover the services patients need?
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- How will you control the costs of other providers involved in the care in the alternative payment model?
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Will Payers Implement Physician-Focused Payments?

Physician-Focused Payment Models

Higher Value Care:

- Better Quality
- Lower Spending

Health Plans

Physician Practice
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*

**Source:** Employer Health Benefits 2012 Annual Survey. The Kaiser Family Foundation and Health Research and Educational Trust

60% of Workers Are Now in Self-Insured Plans
For Self-Funded Employers, The Health Plan is Just a Pass Through

Self-Funded Purchasers → Purchaser Payment → Physician Practice

ASO Health Plan (No Risk) → Provider Claims
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

- Hospital Svcs: 41% Increase
- Physician & Clinical Services: 19% Increase
- Drugs: 20% Increase
- Other Svcs: 24% Increase
- Insurance Admin: 30% Increase

12% of Total
25% of Avoidable Spending is Excess Administrative Costs
A Better Approach: Purchaser/Provider Partnerships

Self-Funded Purchasers → Better Payment and Benefit Structure → 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

Insurance Risk (Risk of Illness)
Self-Funded Purchasers, Medicare, Medicaid

Bottom-up Payment Reform
Payers Change Payment to Support Redesigned Care
Physicians Redesign Care and Identify Payment Barriers

Performance Risk (Cost/Illness)
Physicians

Patients Get Better Care and Providers Stay Financially Viable
Health Plan Implements Changes Purchasers/Providers Agree On

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

Purchasers

Health Plans

Implementation

Physicians & Hospitals
Facilitator Needed to Provide Data and Technical Assistance

Health Plans

Purchasers

Physicians & Hospitals

Neutral Community Facilitator

Technical Assistance

Data

Better Payment and Benefit Structure

Lower Cost, Higher Quality Care

Implementation
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)

Physicians & Hospitals

Payers

Purchasers

Consumers

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

MACRA

#1
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

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

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

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How Would You Improve Payment and Lower Total Spending?

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## Improve Care for Patients By Paying for Triage/Response

### Table: Oncology Practice Costs

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### 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

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**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

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

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

Cost & Revenue Changes With Fewer Patients

- 7% reduction in cost
- 20% reduction in volume

#Patients

Costs

$000

$1,000
$980
$960
$940
$920
$900
$880
$860
$840
$820
$800
Reductions in Utilization Reduce Revenues More Than Costs

Cost & Revenue Changes With Fewer Patients

- 20% reduction in volume
- 7% reduction in cost
- 20% reduction in revenue

#Patients

$000

Revenues
Costs
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

![Graph showing cost and revenue changes with fewer patients](image_url)
We Need to Understand the Hospital’s Cost Structure

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<td>Fixed (65%)</td>
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<td>Variable (30%)</td>
<td>$4,500</td>
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<td>Margin (5%)</td>
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...Fixed Costs Will Remain the Same (in the Short Run)...

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…Variable Costs Will Decrease in Proportion to Admissions…

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...And Even With a Higher Margin…

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…The Hospital Comes Out Ahead With Significantly Lower Revenue

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And the Payer Still Saves Money

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| Hospitalizations | | |
| **$/Pt** | **# Pts** | **Total $** | **$/Pt** | **# Pts** | **Total $** | **Chg** |
| Fixed (65%) | $9,750 | | $3,412,500 | $3,412,500 | 0% |
| Variable (30%) | $4,500 | | $1,575,000 | $1,102,500 | -30% |
| Margin (5%) | $750 | | $262,500 | $273,000 | +4% |
| Total Hospital | $15,000 | 350 | $5,250,000 | 245 | $4,788,000 | -9% |

**Total Spending** | | |
| **$/Pt** | **# Pts** | **Total $** | **$/Pt** | **# Pts** | **Total $** | **Chg** |
| 1000 | | $9,750,000 | | | $9,488,000 | -3% |
### I.e., a Win-Win-Win-Win for Patient, Practice, Hospital, & Payer

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- **Oncology Practice Wins**: +4%
- **Hospital Wins**: -3%
- **Payer Wins**: -9%

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

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## Trying to Renegotiate Individual Fees Is Impractical

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...Use the Payment as a Budget to Redesign Care...

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...And Let Physicians and Hospitals Decide How They Should Be Paid

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<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>1000</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>
# Condition-Based Payment Provides Flexibility to Redesign Care & Pmt

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
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<th>CONDITION-BASED PMT</th>
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<th>Chg</th>
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<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
<td>$/Pt</td>
<td># Pts</td>
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<tr>
<td><strong>Oncology Pract.</strong></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>E&amp;M/Infusions</td>
<td>$4,500</td>
<td>1000</td>
<td>$4,500,000</td>
<td>$4,500,000</td>
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<tr>
<td>Triage/Respond</td>
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<tr>
<td>Total Practice</td>
<td>1000</td>
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<td>$4,500,000</td>
<td>$4,700</td>
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<tr>
<td><strong>Hospitalizations</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (65%)</td>
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<td>$3,412,500</td>
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<tr>
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<td>Margin (5%)</td>
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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>HIGHER RISK PATIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td># Pts</td>
<td># Pts</td>
</tr>
<tr>
<td>Oncology Pract.</td>
<td></td>
</tr>
<tr>
<td>Total Practice</td>
<td>500</td>
</tr>
<tr>
<td></td>
<td>500</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
</tr>
<tr>
<td>Total Hospital</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>183</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>LOWER RISK PATIENTS</th>
<th>HIGHER RISK PATIENTS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td>Oncology Pract.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E&amp;M/Infusion</td>
<td>$4,500</td>
<td>500</td>
</tr>
<tr>
<td>Triage/Intervene</td>
<td>$100</td>
<td>500</td>
</tr>
<tr>
<td>Total Practice</td>
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<td>500</td>
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<tr>
<td>Hospitalizations</td>
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<tr>
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<tr>
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<td>Total Spending</td>
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</table>

Lower Payment For Lower-Risk Patients
Higher Payment For Higher-Risk Patients
Still Lower Total Spending