



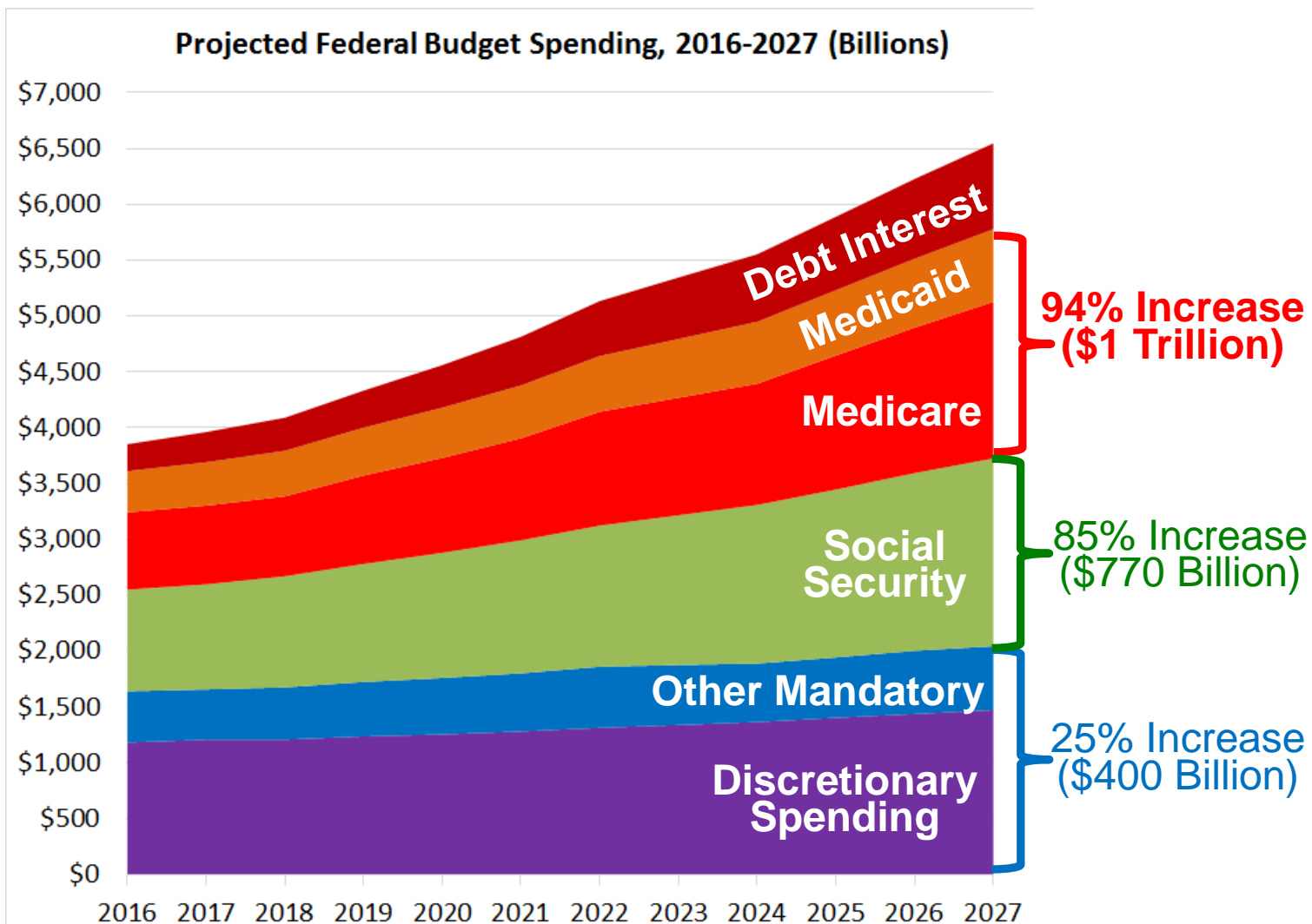
CENTER FOR
HEALTHCARE
QUALITY &
PAYMENT REFORM

**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**

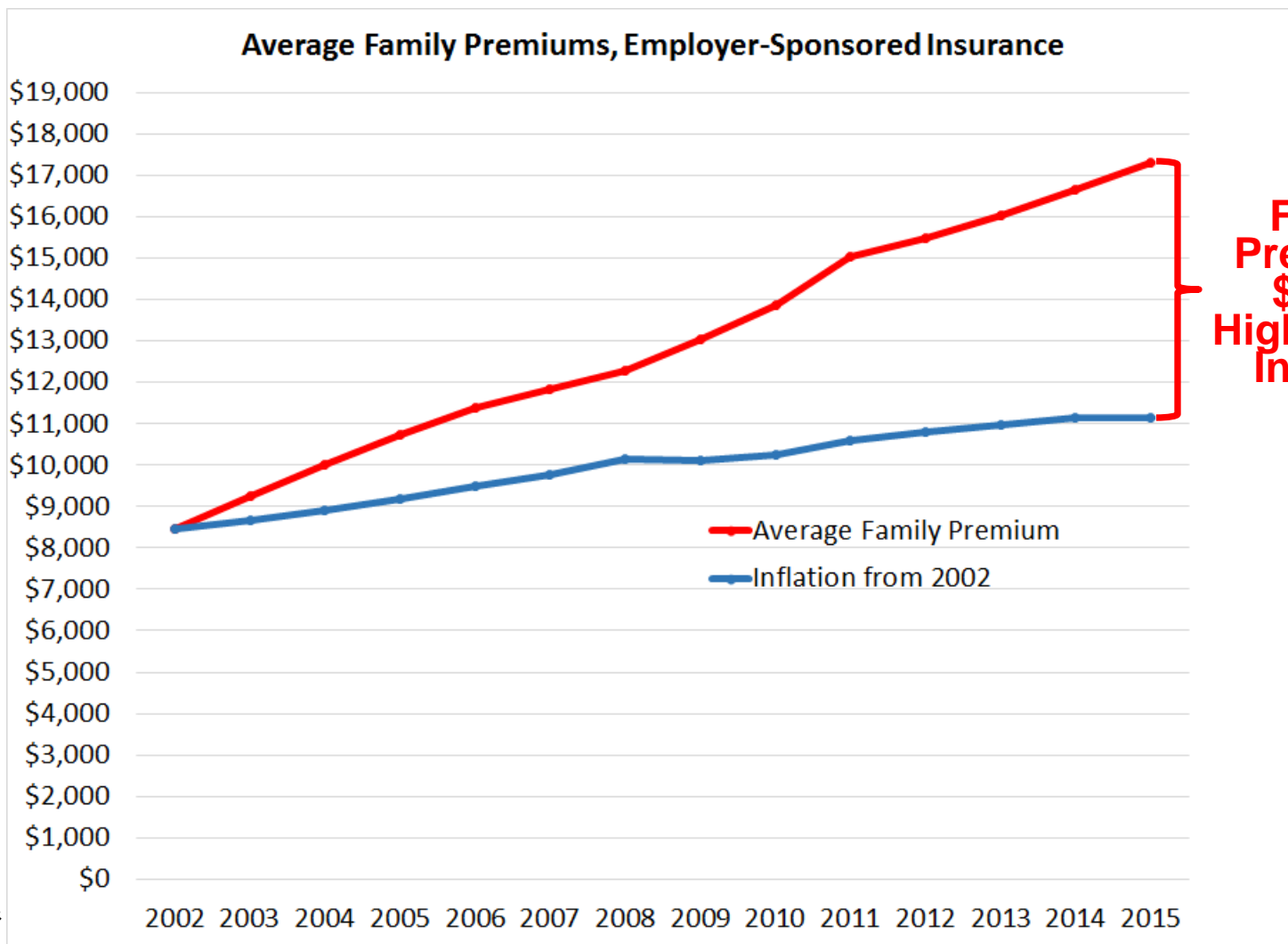
Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform

www.CHQPR.org

Healthcare Spending is the Biggest Driver of Federal Deficit

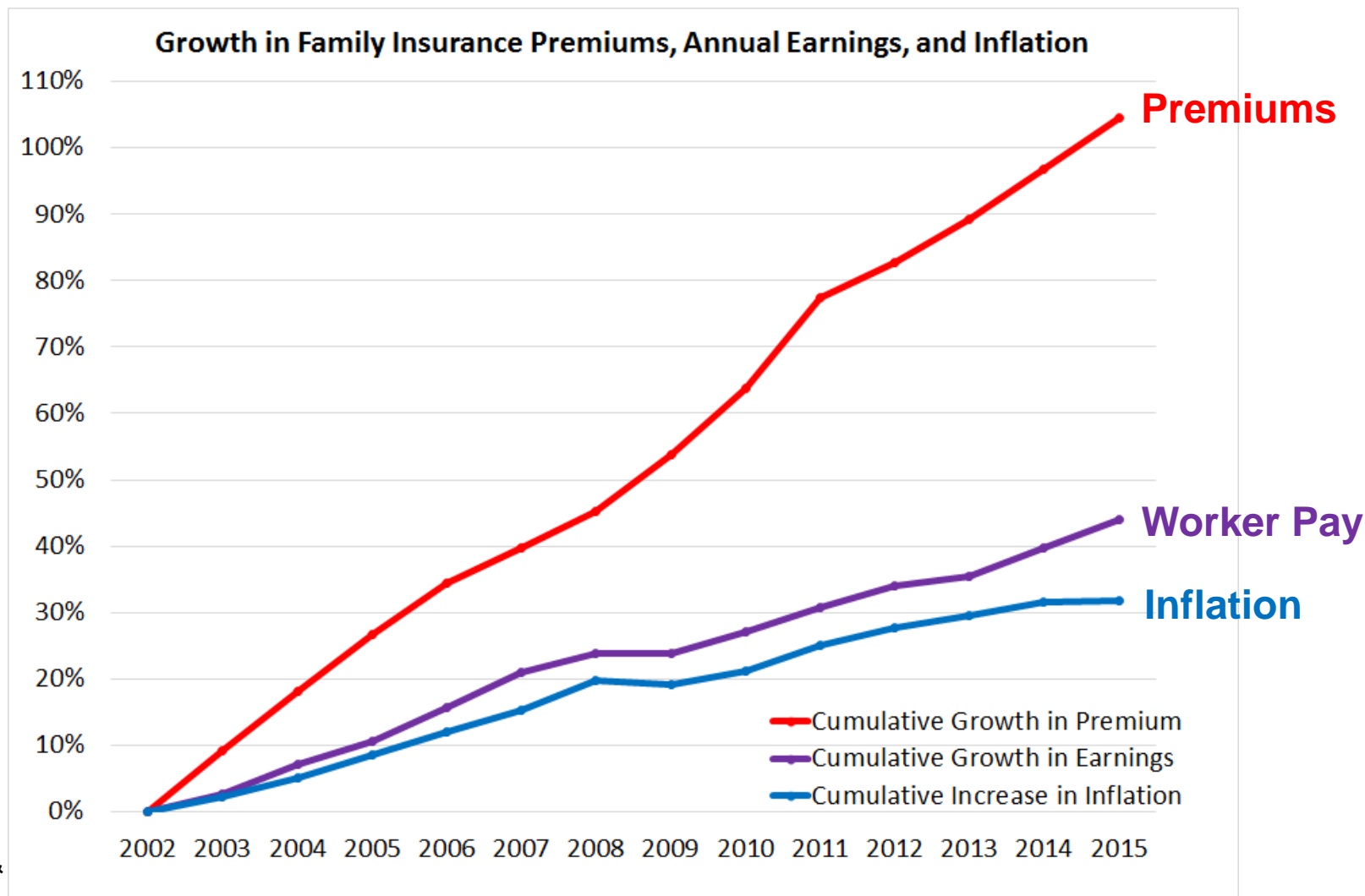


Premiums Have Increased 73% More Than Inflation Since 2002



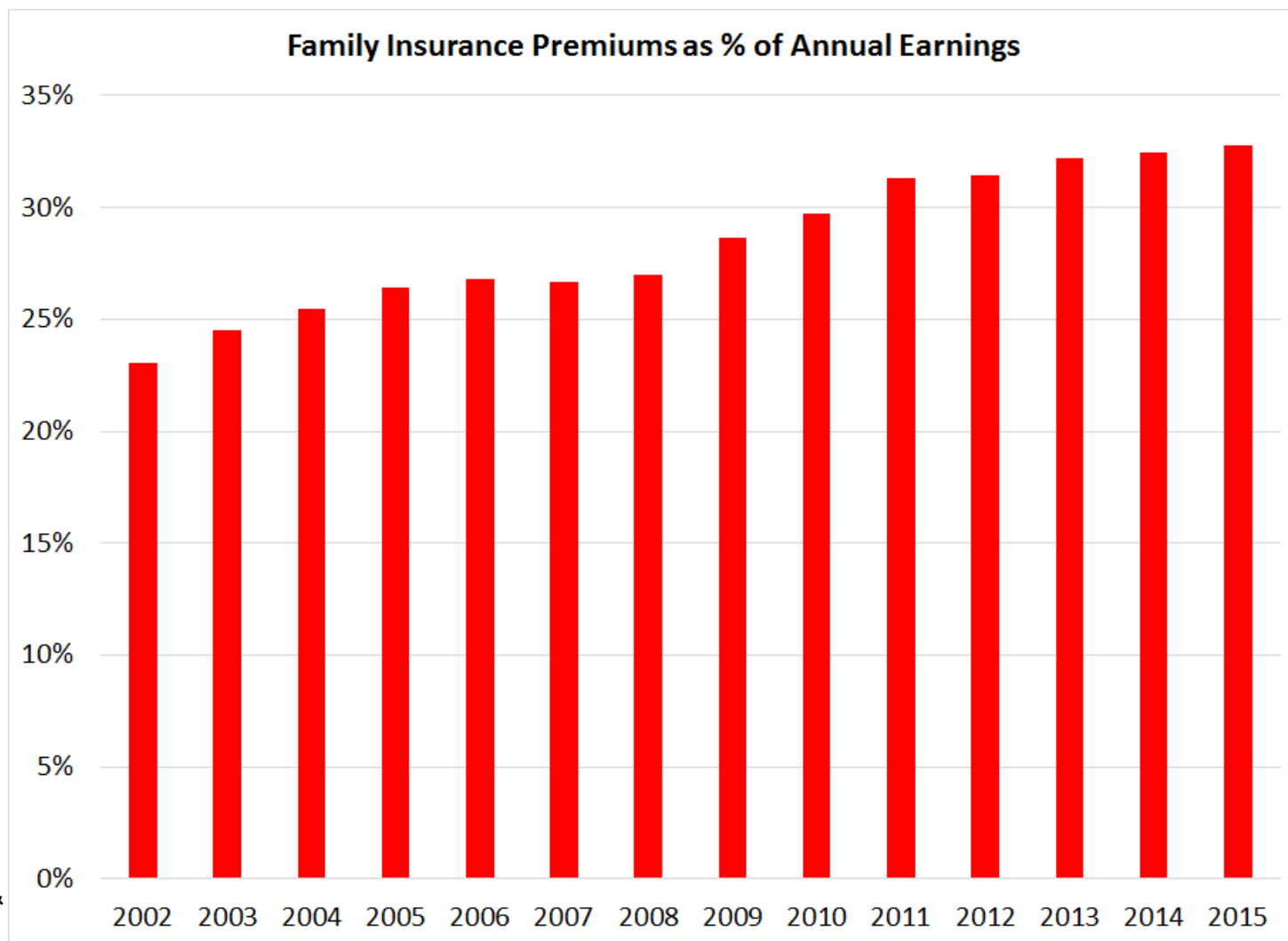
Source:
 Medical
 Expenditure
 Panel Survey &
 Bureau of
 Labor Statistics

Premiums Have Grown Faster Than Worker Earnings



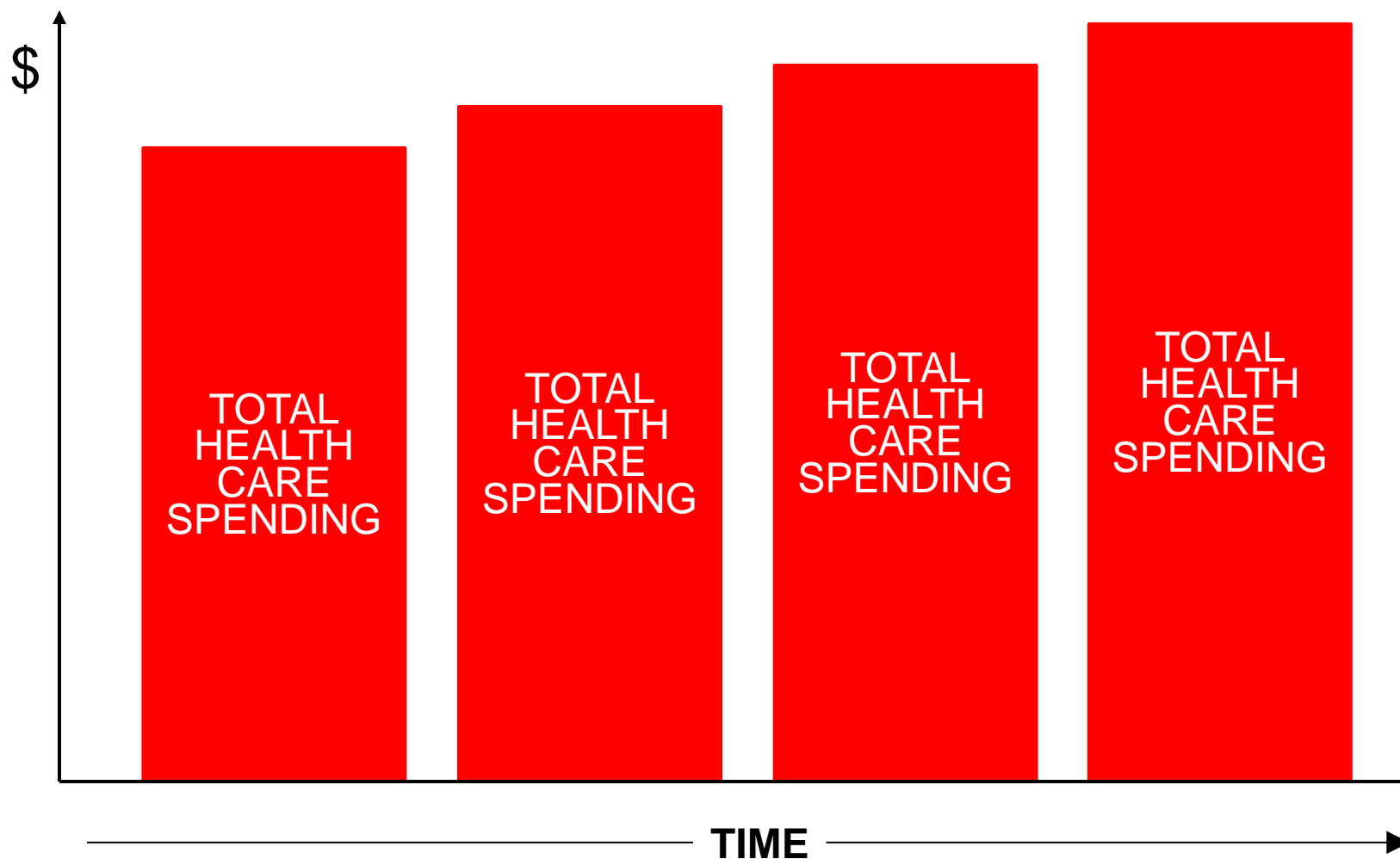
Source:
 Medical
 Expenditure
 Panel Survey &
 Bureau of
 Labor Statistics

Family Premiums Now Equal to One-Third of Worker Pay

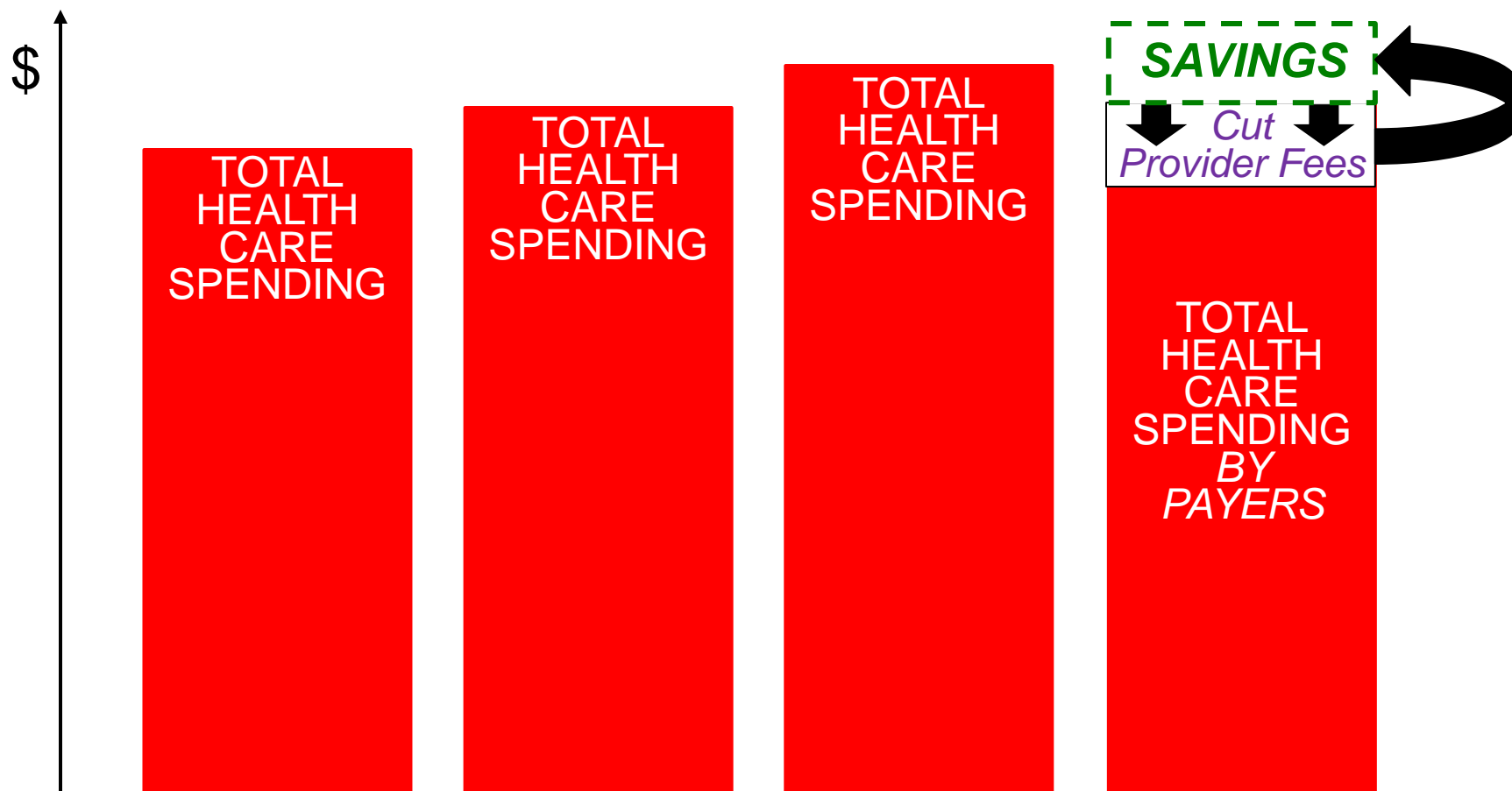


Source:
Medical
Expenditure
Panel Survey &
Bureau of
Labor Statistics

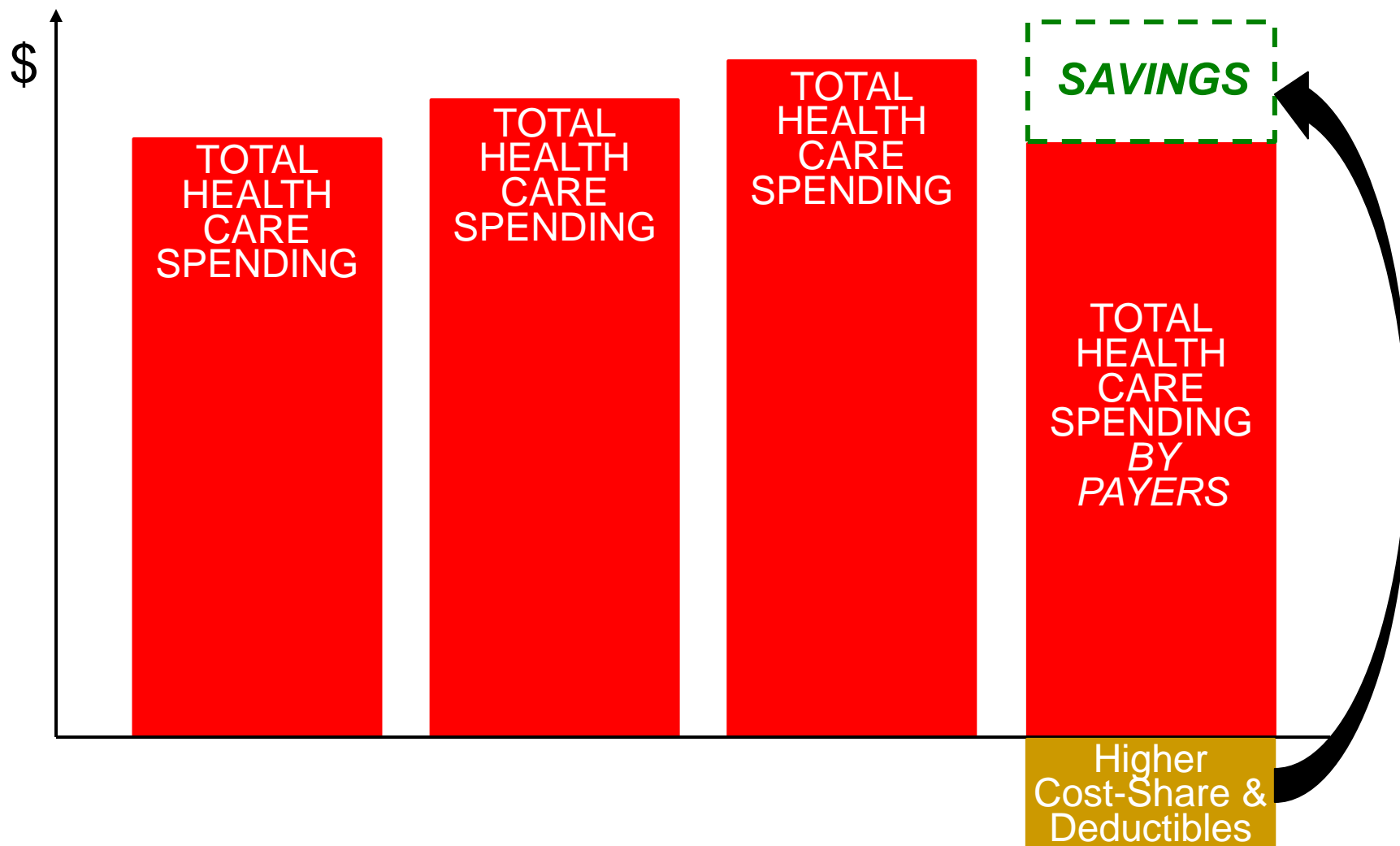
How Do You Control Growing Healthcare Spending?



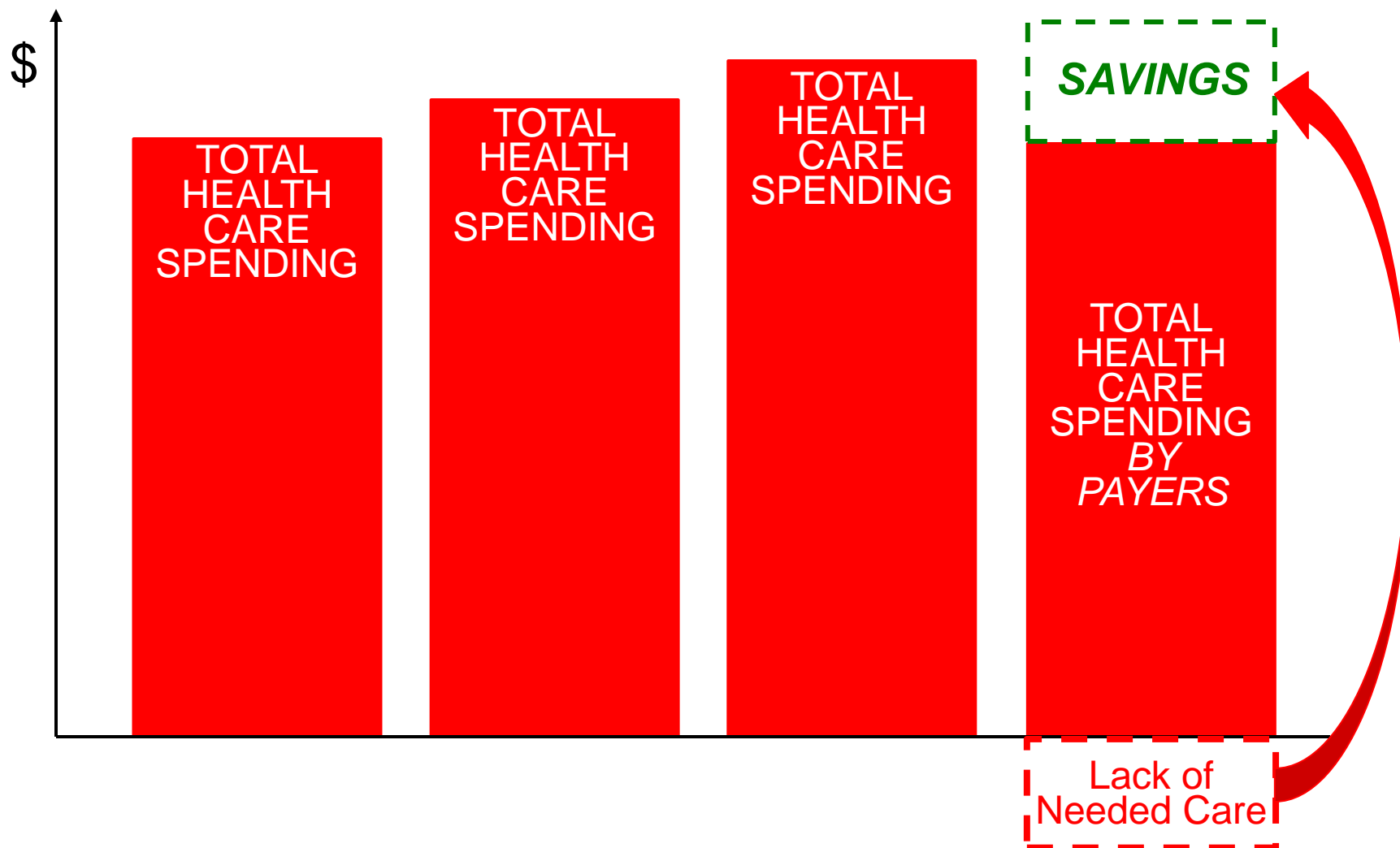
Typical Strategy #1: Cut Provider Fees for Services



Typical Strategy #2: Shift Costs to Patients



Typical Strategy #3: Delay or Deny Care to Patients



Win-Lose Results of Typical Strategies

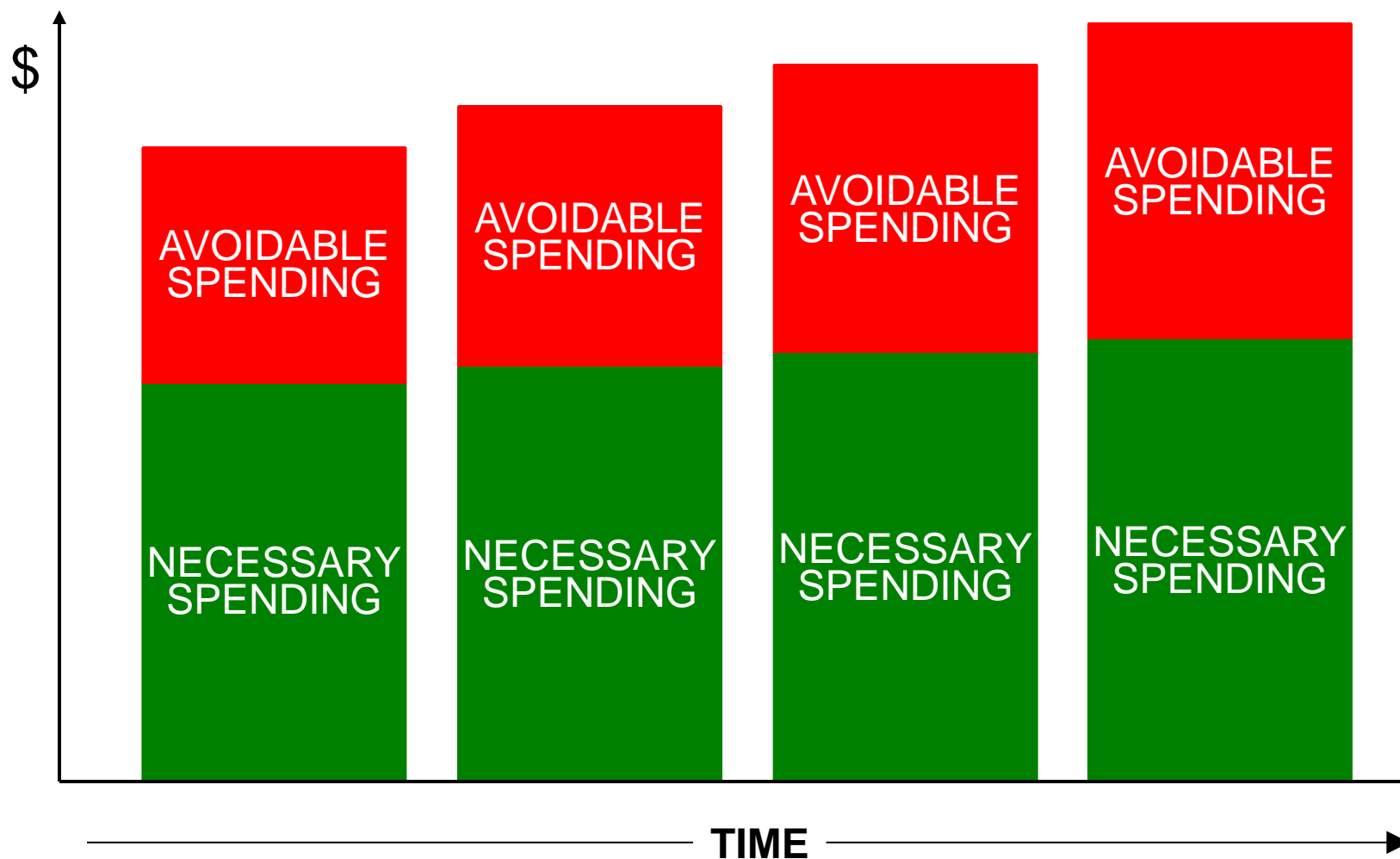
- Patients don't get the care they need and costs increase in the future
- Small physician practices and hospitals are forced out of business
- Health insurance premiums continue to rise and access to insurance coverage decreases

Win-Lose Results of Typical Strategies

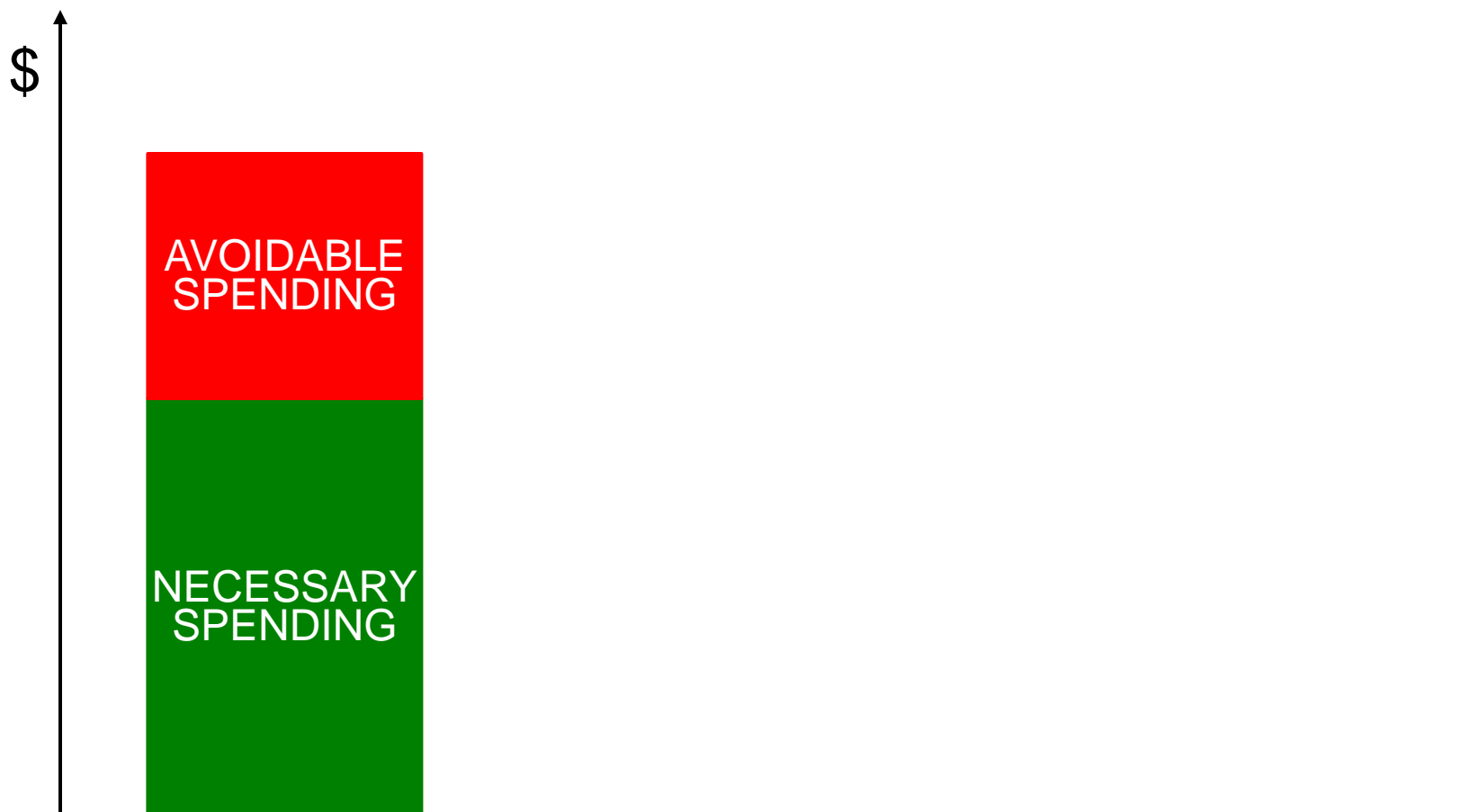
- Patients don't get the care they need and costs increase in the future
- Small physician practices and hospitals are forced out of business
- Health insurance premiums continue to rise and access to insurance coverage decreases

IS THERE A BETTER WAY?

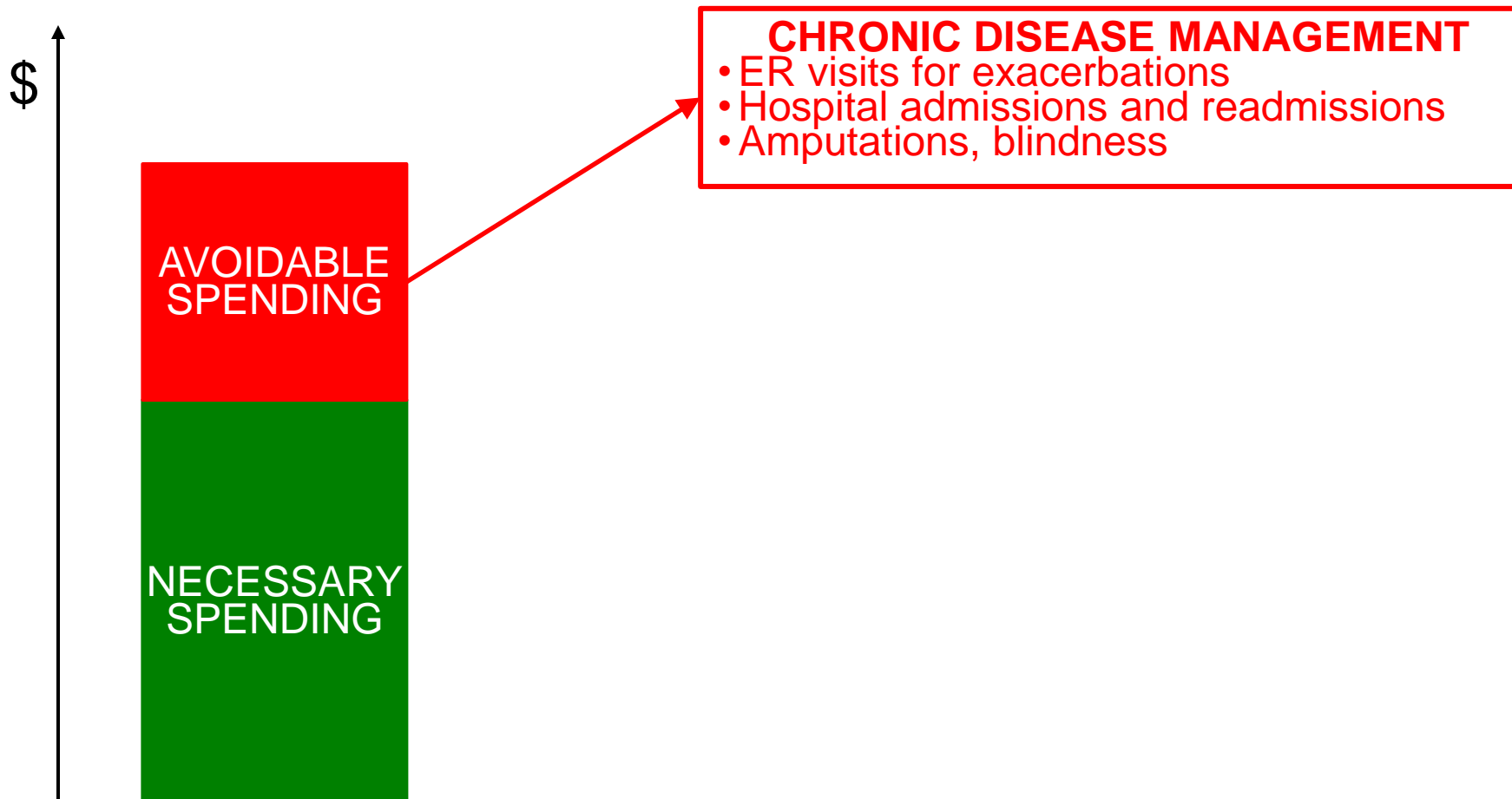
The Right Focus: Spending That is *Unnecessary* or *Avoidable*



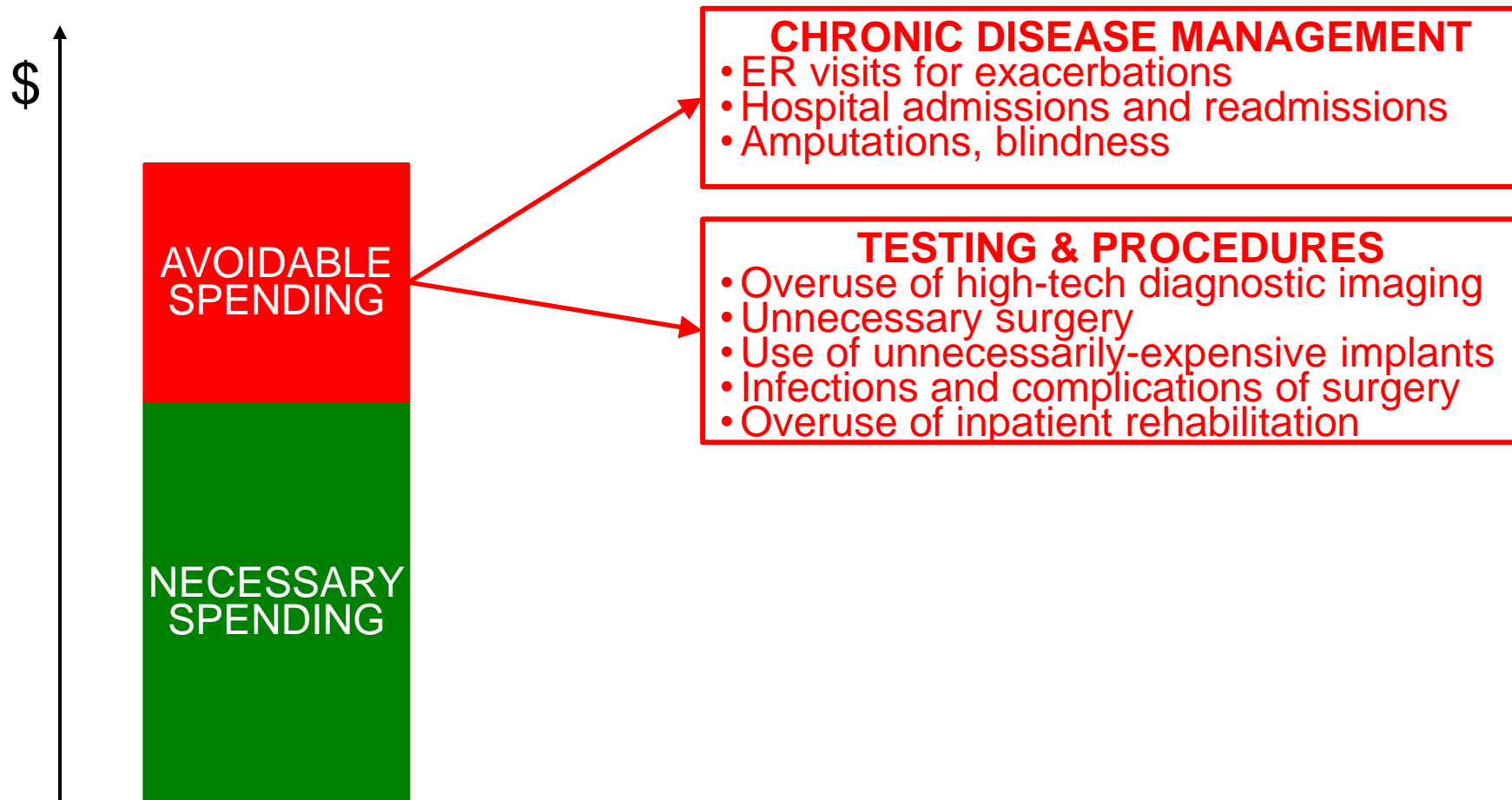
Avoidable Spending Occurs In All Aspects of Healthcare



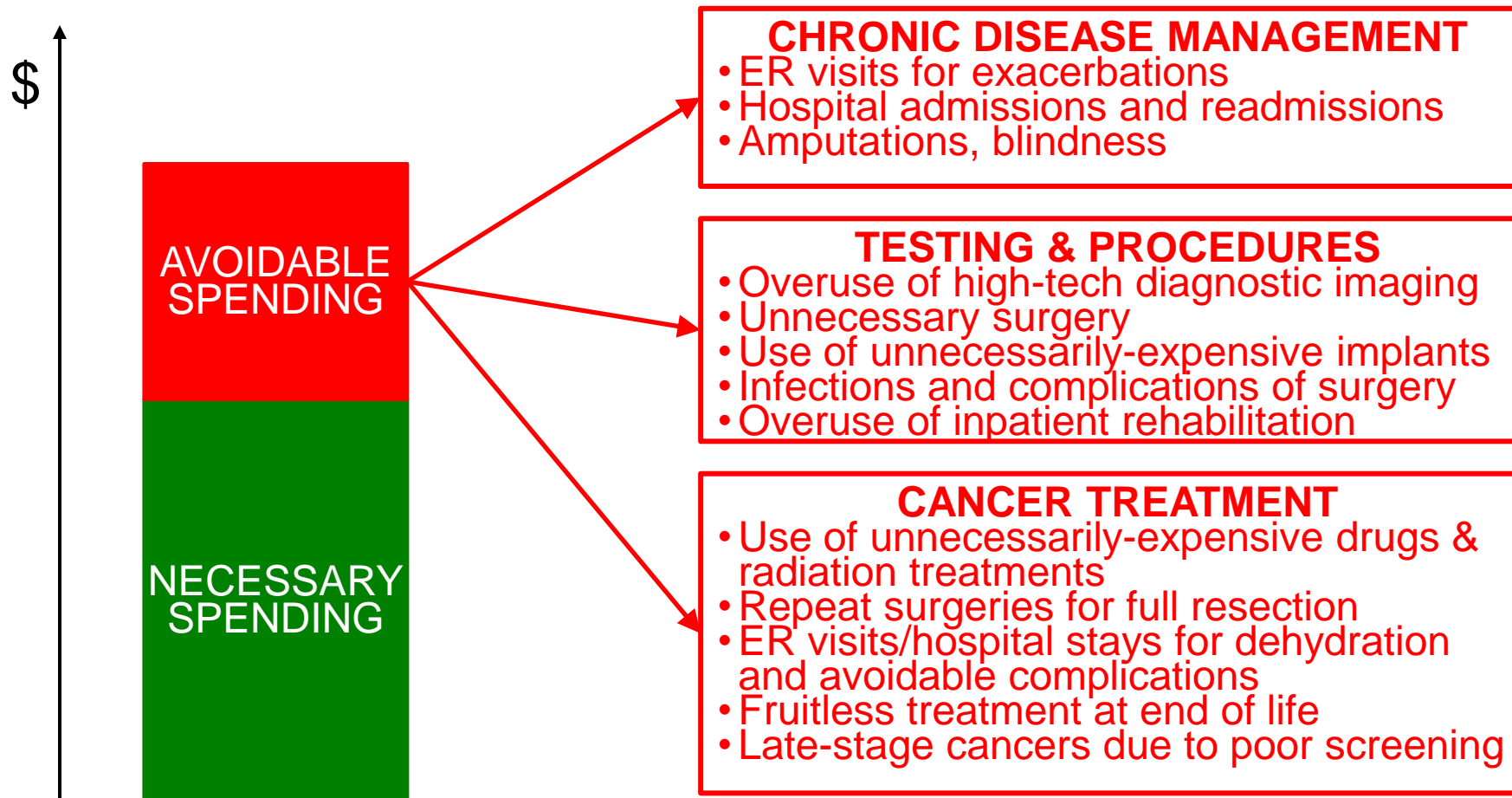
Avoidable Spending Occurs In All Aspects of Healthcare



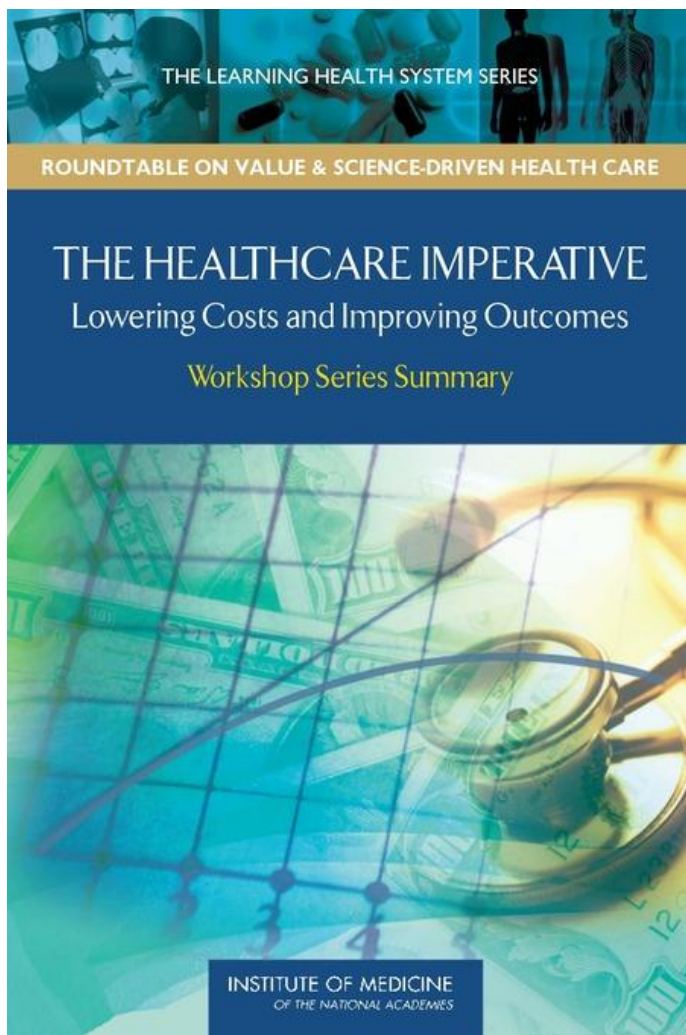
Avoidable Spending Occurs In All Aspects of Healthcare



Avoidable Spending Occurs In All Aspects of Healthcare



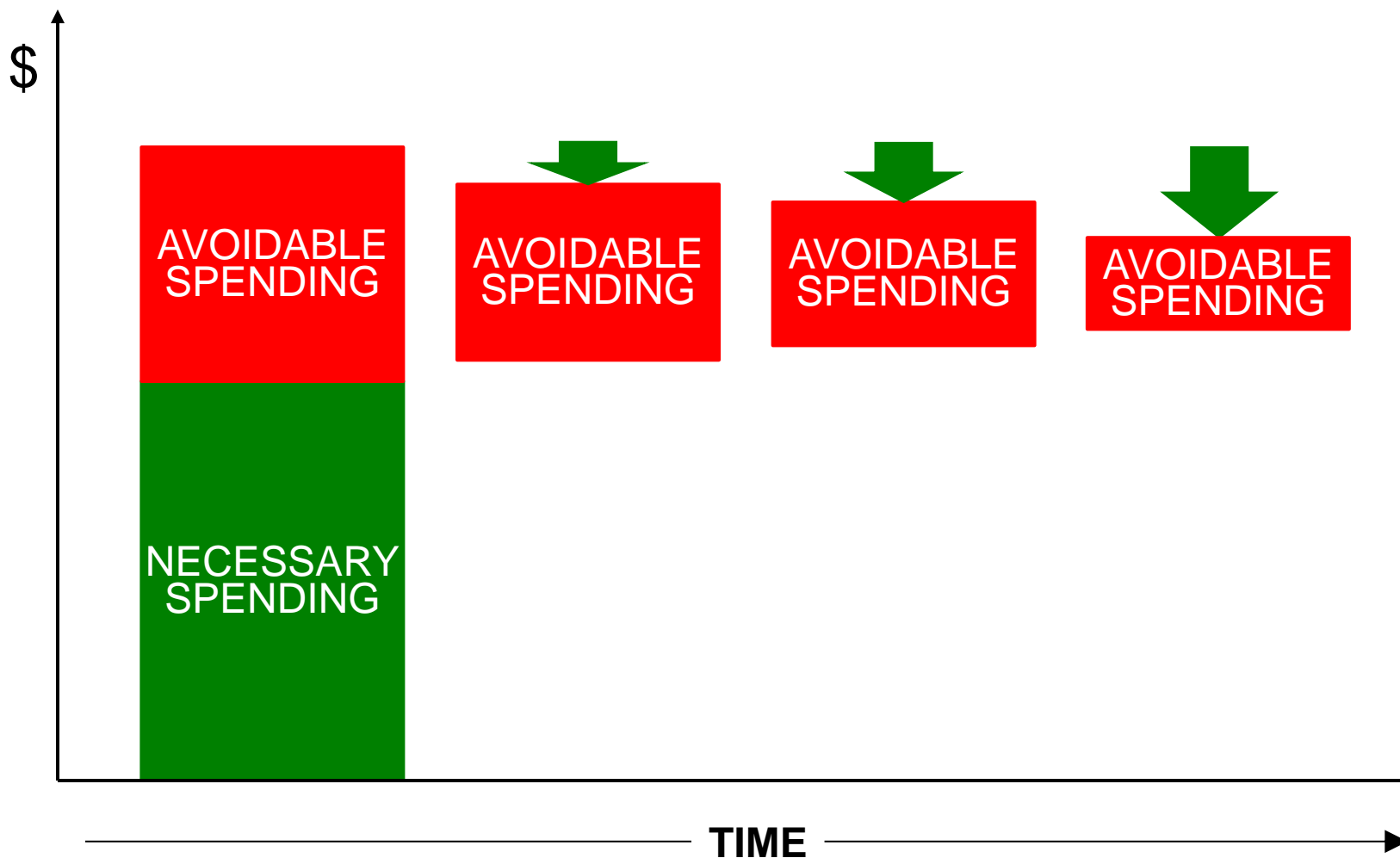
Institute of Medicine Estimate: 30% of Spending is Avoidable



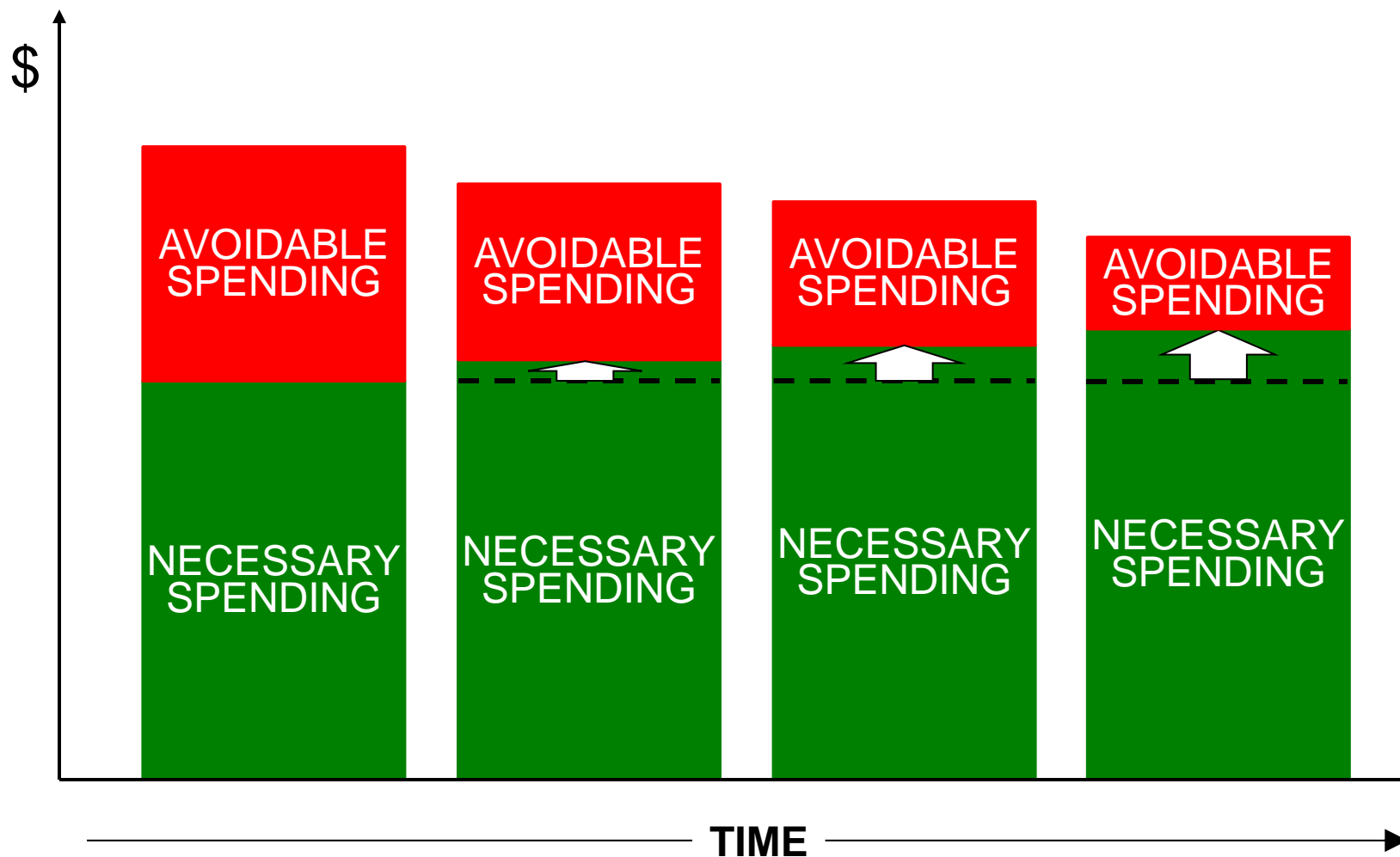
Excess Cost Domain Estimates:	
<i>Lower bound totals from workshop discussions*</i>	
UNNECESSARY SERVICES <ul style="list-style-type: none"> • Overuse: services beyond evidence-established levels • Discretionary use beyond benchmarks <ul style="list-style-type: none"> – Defensive medicine • Unnecessary choice of higher cost services 	Total excess = \$210 B*
INEFFICIENTLY DELIVERED SERVICES <ul style="list-style-type: none"> • Mistakes—medical errors, preventable complications • Care fragmentation • Unnecessary use of higher cost providers • Operational inefficiencies at care delivery sites <ul style="list-style-type: none"> – Physician offices – Hospitals 	Total excess = \$130 B*
EXCESS ADMINISTRATIVE COSTS <ul style="list-style-type: none"> • Insurance-related administrative costs beyond benchmarks <ul style="list-style-type: none"> – Insurers – Physician offices – Hospitals – Other providers • Insurer administrative inefficiencies • Care documentation requirement inefficiencies 	Total excess = \$190 B*
PRICES THAT ARE TOO HIGH <ul style="list-style-type: none"> • Service prices beyond competitive benchmarks <ul style="list-style-type: none"> – Physician services <ul style="list-style-type: none"> i. Specialists ii. Generalists – Hospital services • Product prices beyond competitive benchmarks <ul style="list-style-type: none"> – Pharmaceuticals – Medical devices – Durable medical equipment 	Total excess = \$105 B*
MISSED PREVENTION OPPORTUNITIES <ul style="list-style-type: none"> • Primary prevention • Secondary prevention • Tertiary prevention 	Total excess = \$55 B*
FRAUD <ul style="list-style-type: none"> • All sources—payer, clinician, patient 	Total excess = \$75 B*

*Lower bound totals of various estimates, adjusted to 2009 total expenditure level.

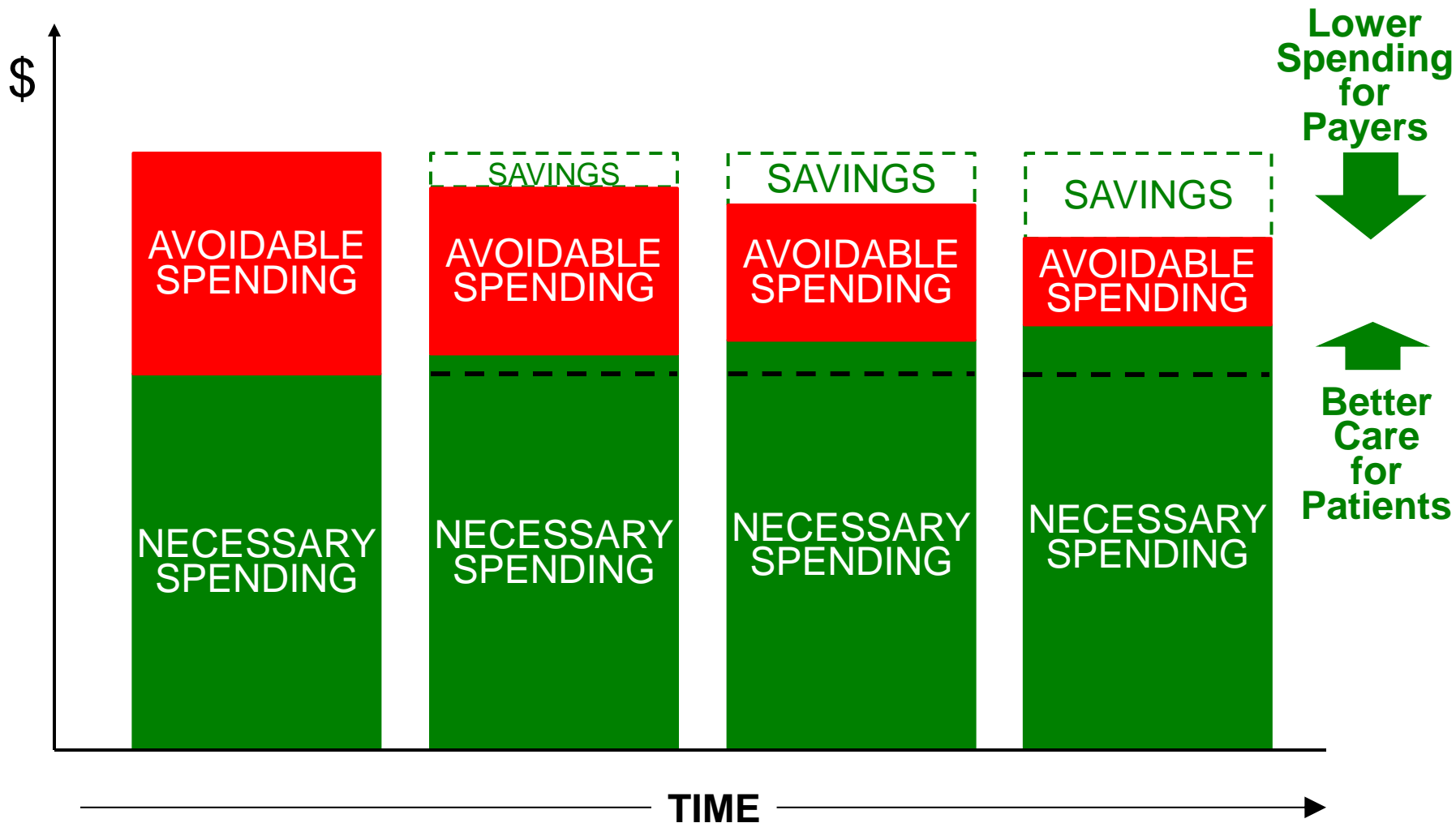
The Right Goal: Less Avoidable \$,



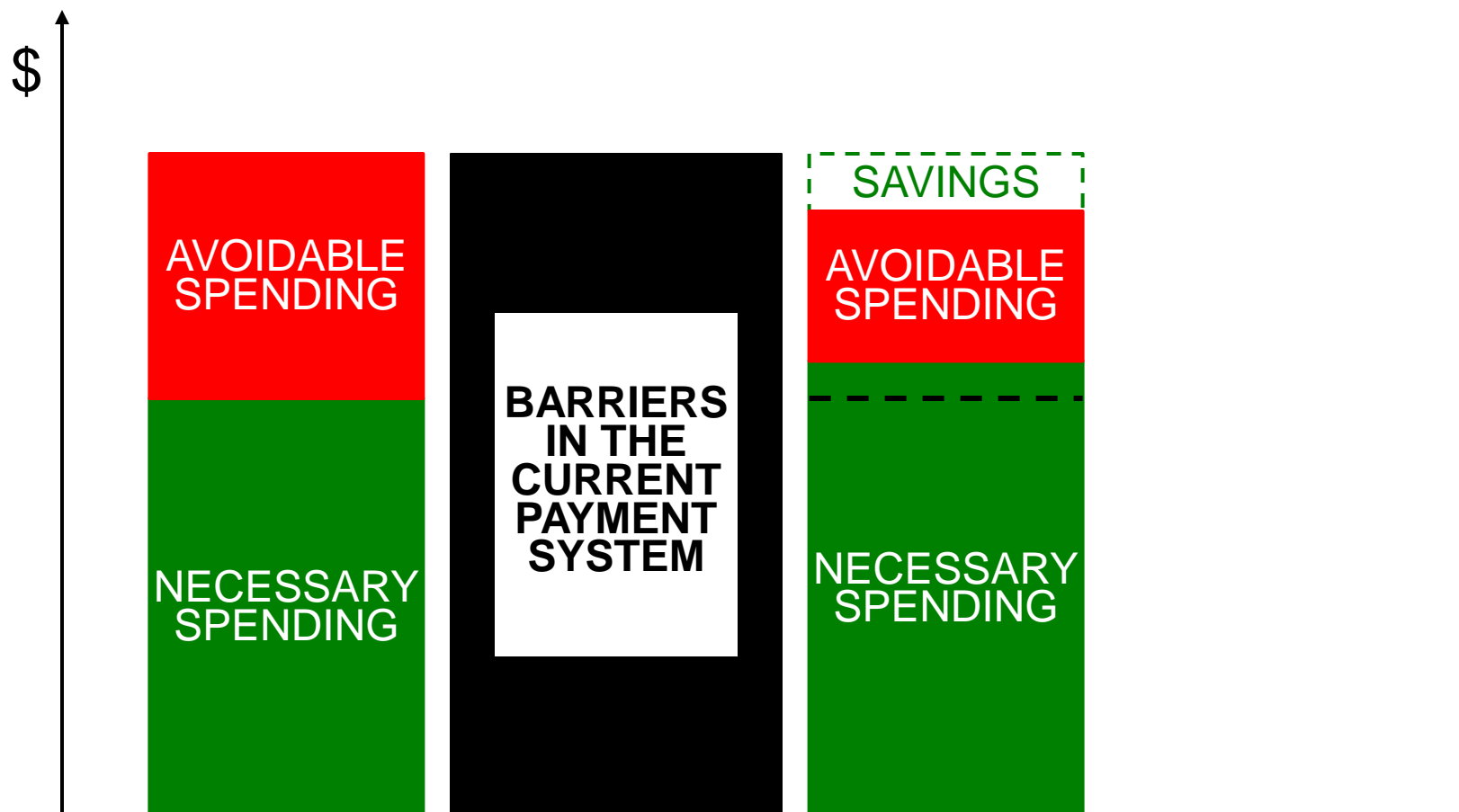
The Right Goal: Less Avoidable \$, More Necessary \$



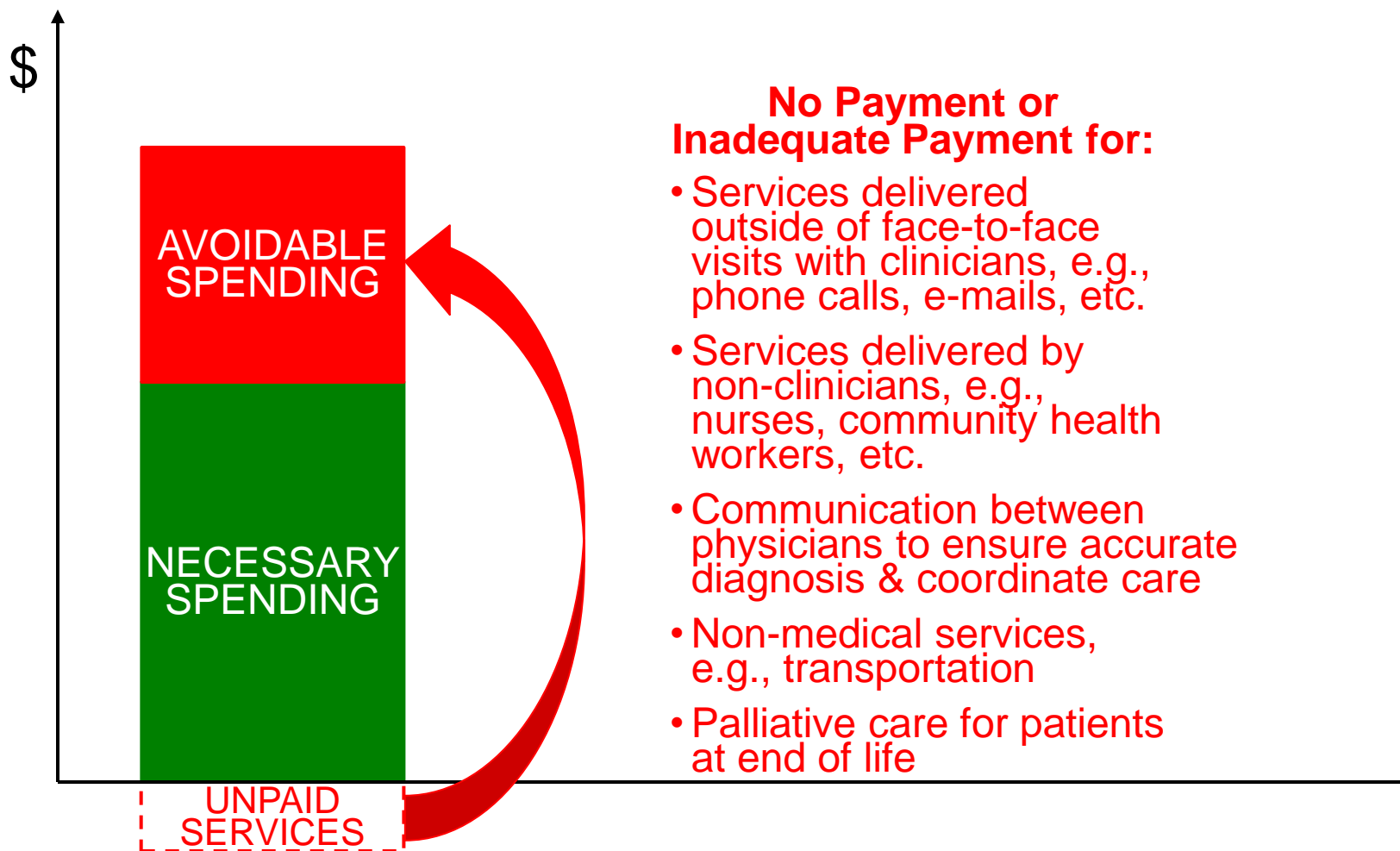
Win-Win for Patients & Payers



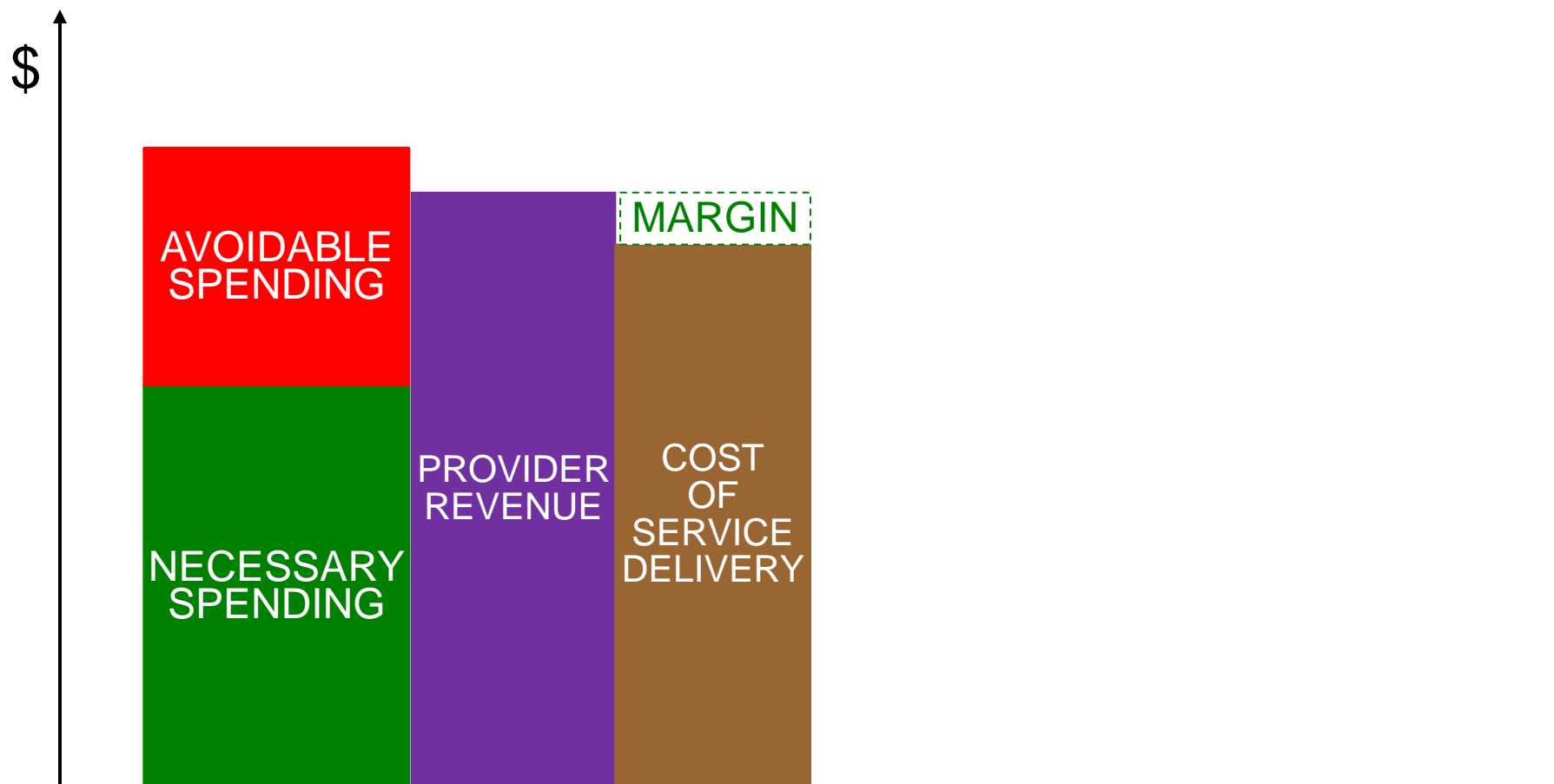
Barriers in the Payment System Create a Win-Lose for Providers



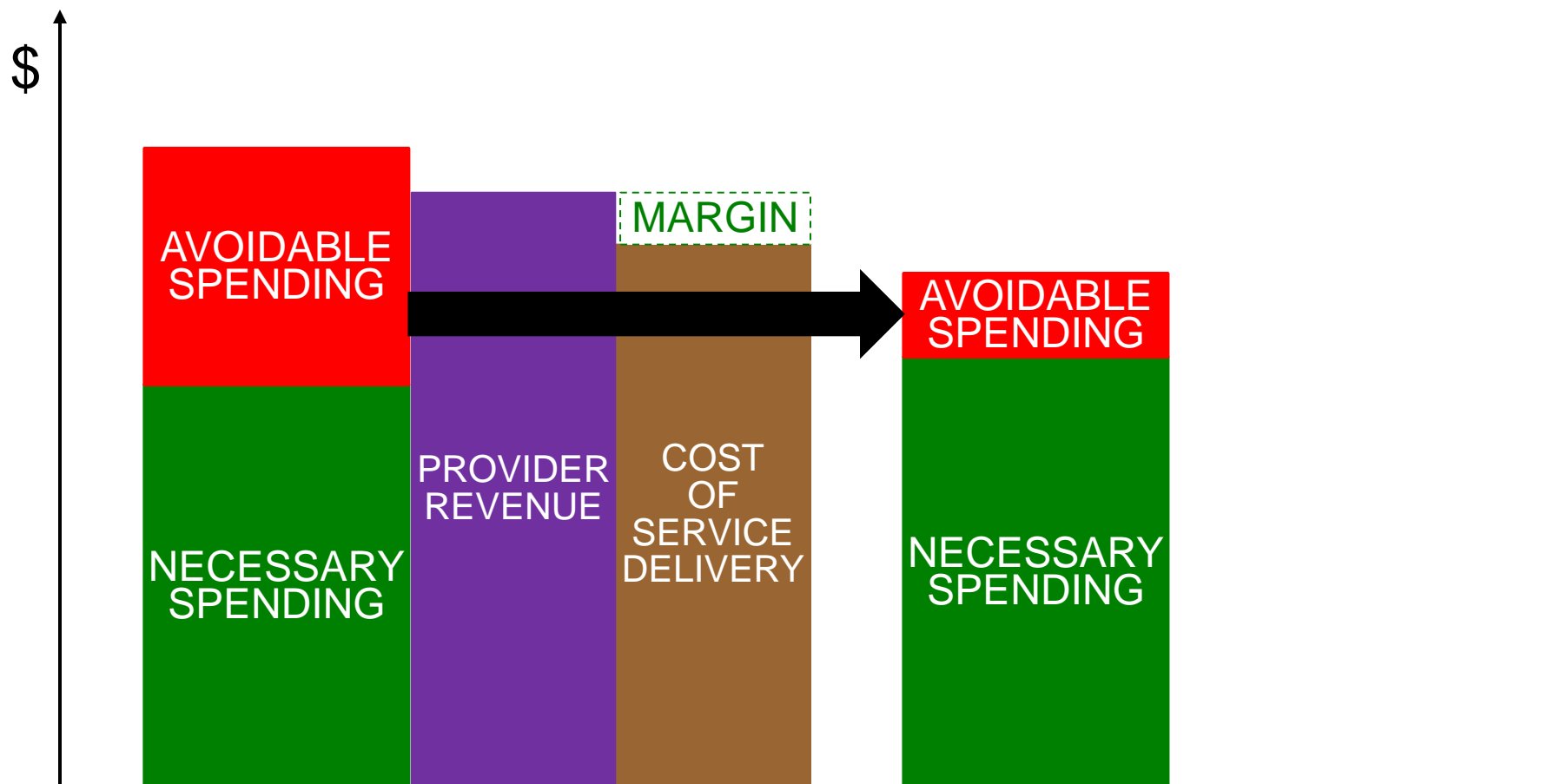
Barrier #1: No \$ or Inadequate \$ for High-Value Services



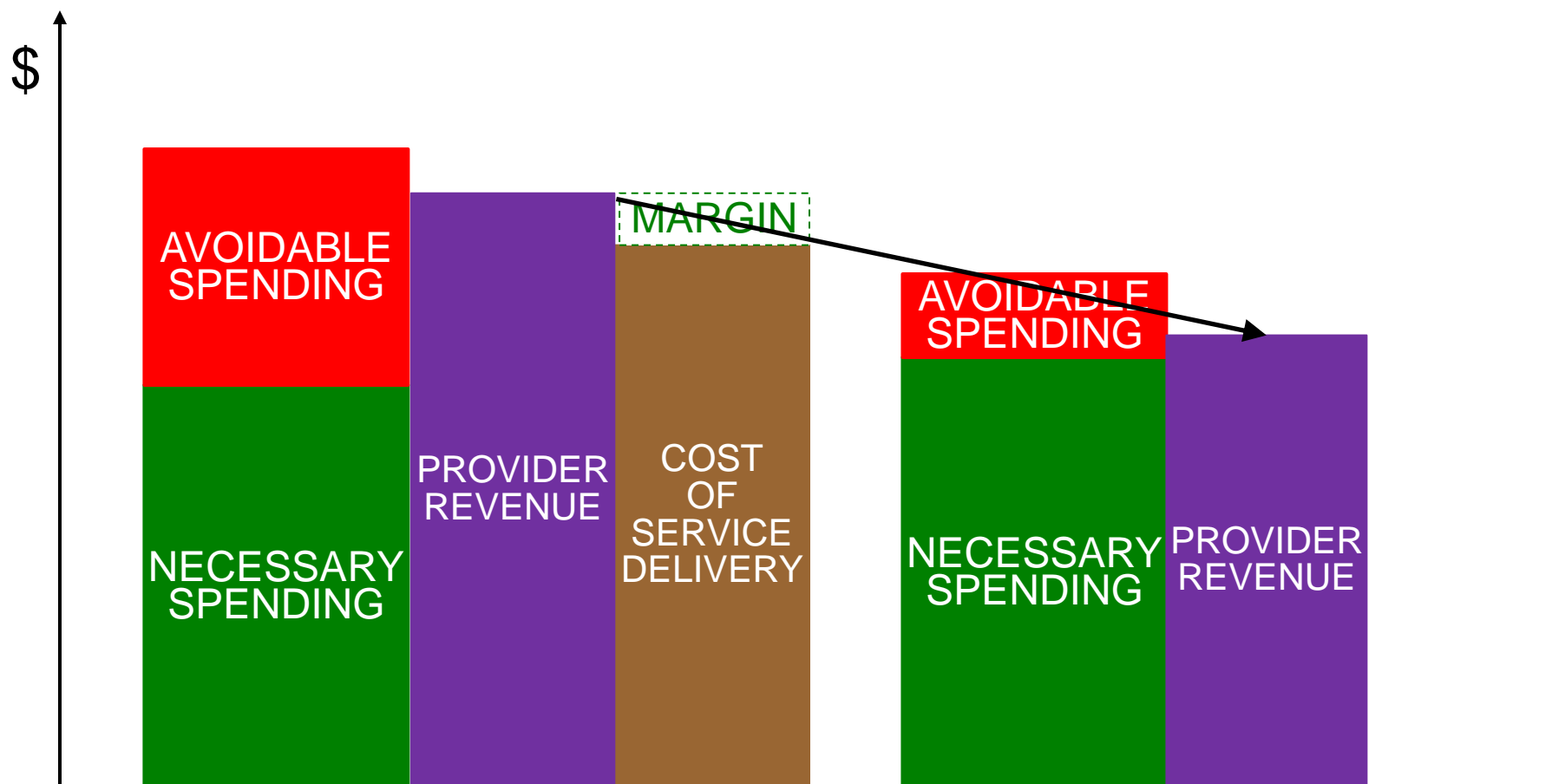
Barrier #2: Avoidable Spending May Be Revenue for Providers...



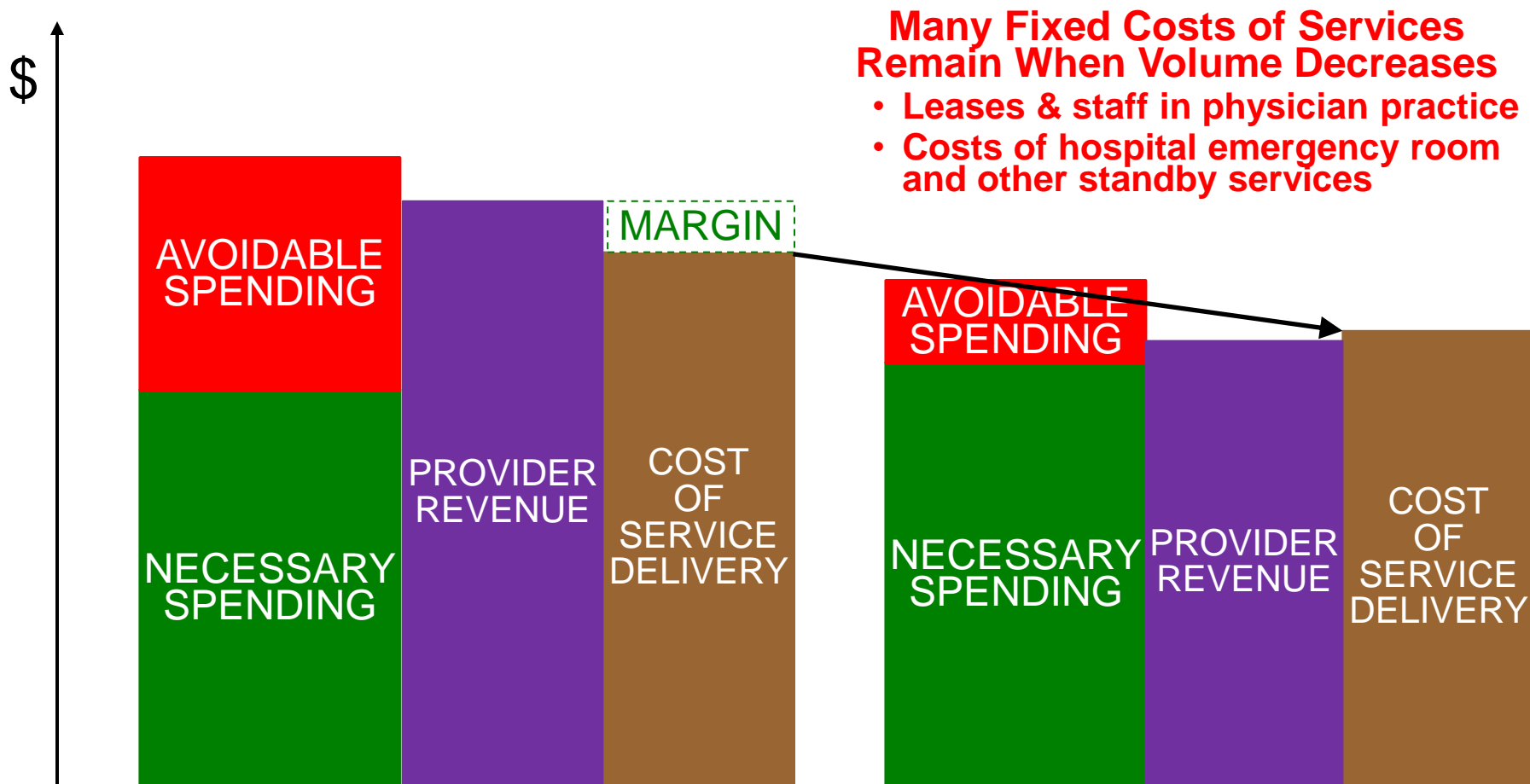
...And When Avoidable Services Aren't Delivered...



...Providers' Revenue May Decrease...



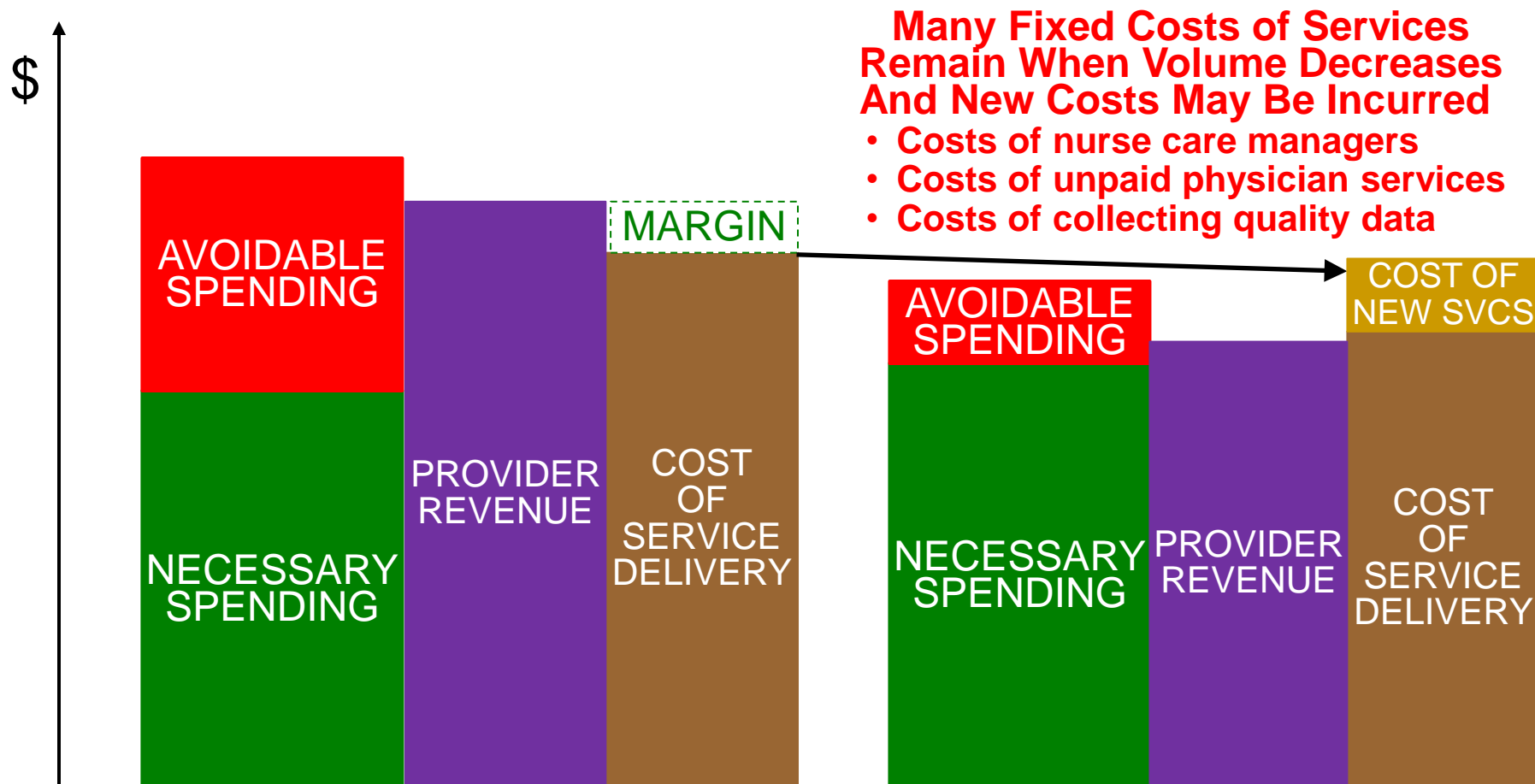
...But Fixed Costs Don't Vanish



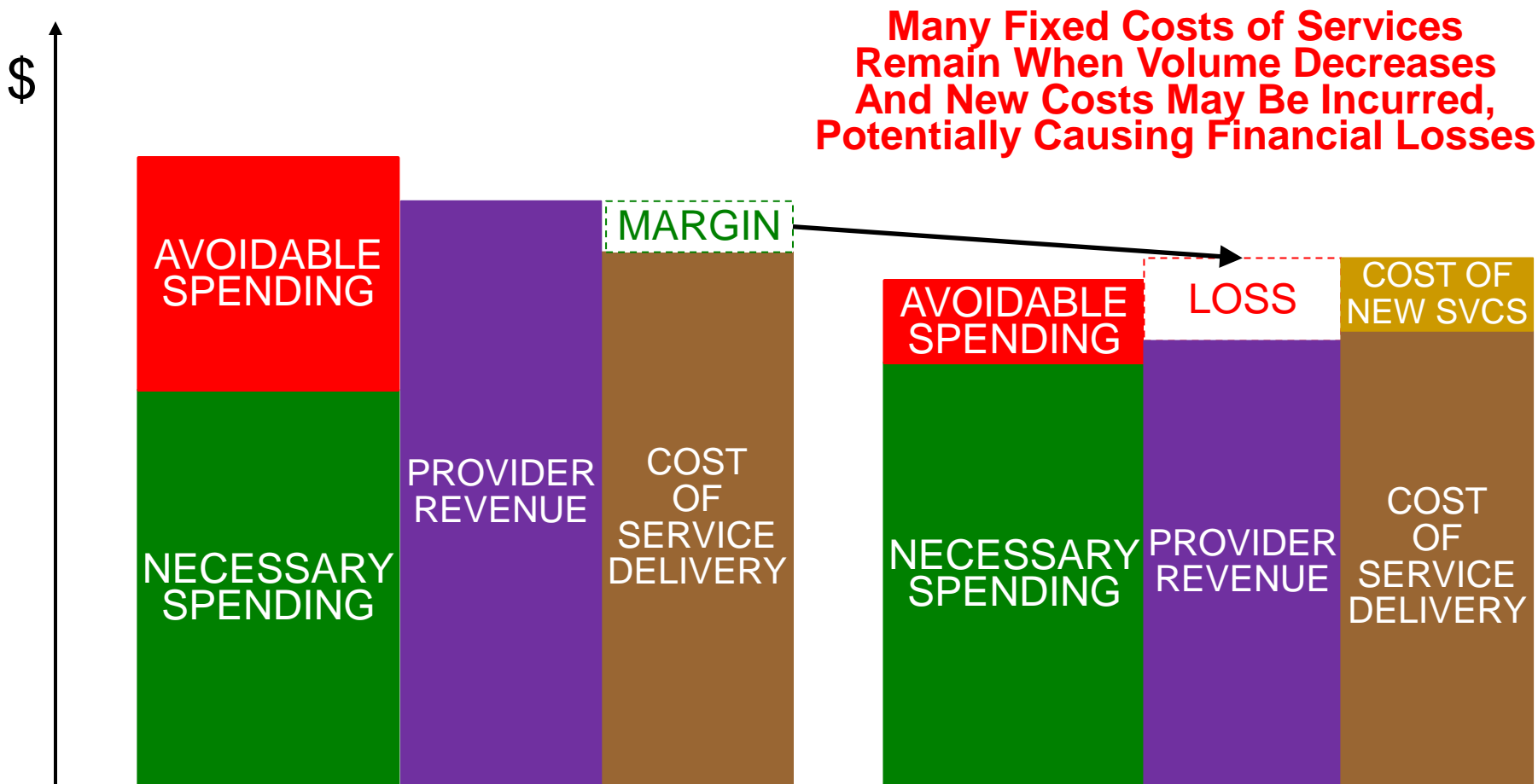
Many Fixed Costs of Services Remain When Volume Decreases

- 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...

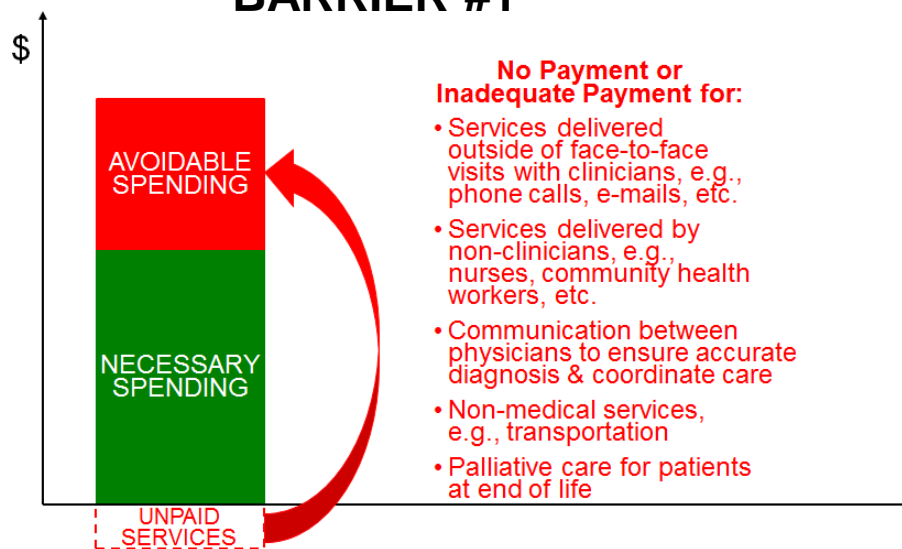


...Leaving Providers With Losses (or Bigger Losses Than Today)

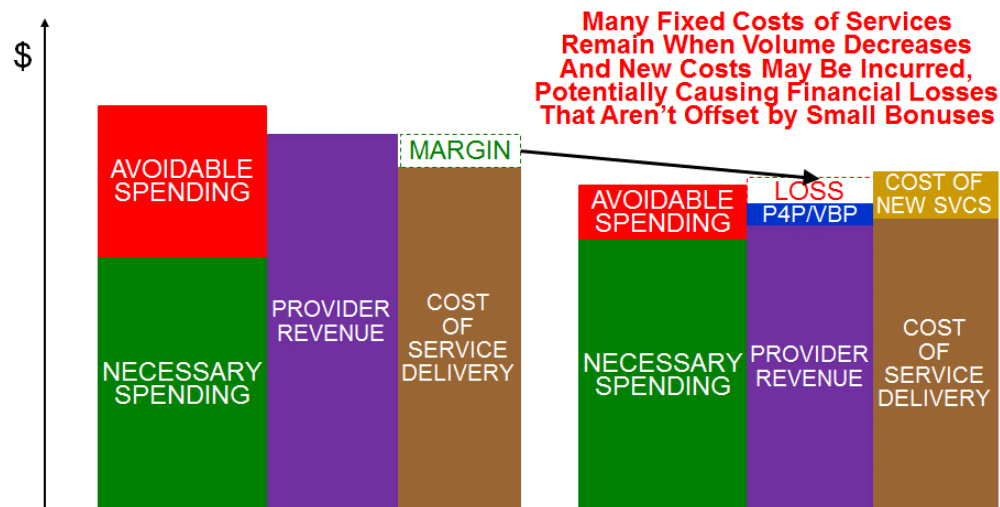


A Payment *Change* isn't *Reform* Unless It *Removes the Barriers*

BARRIER #1



BARRIER #2



So Why Haven't We Fixed This??

John Gray, Ph.D.

With a New Introduction by the Author

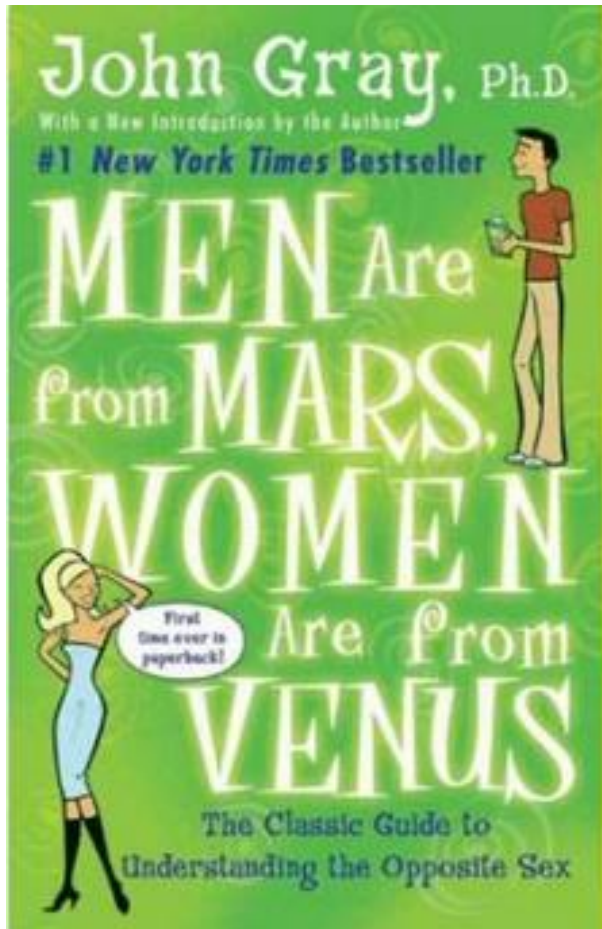
#1 *New York Times* Bestseller

MEN Are
from MARS.
WOMEN
Are from
VENUS



First
time ever in
paperback!

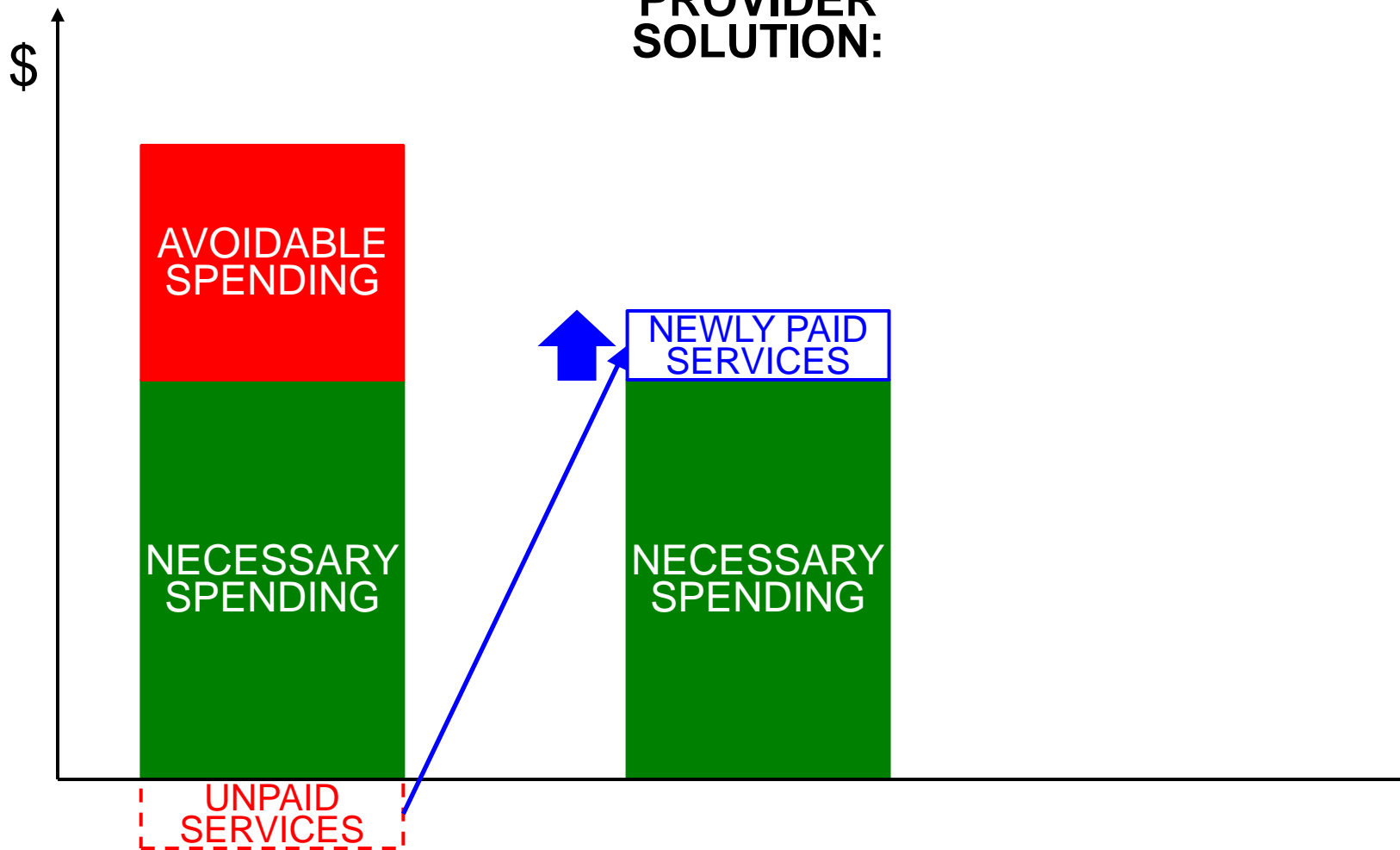
The Classic Guide to
Understanding the Opposite Sex



In Healthcare,
Payers Are From Mars,
Providers Are From Venus

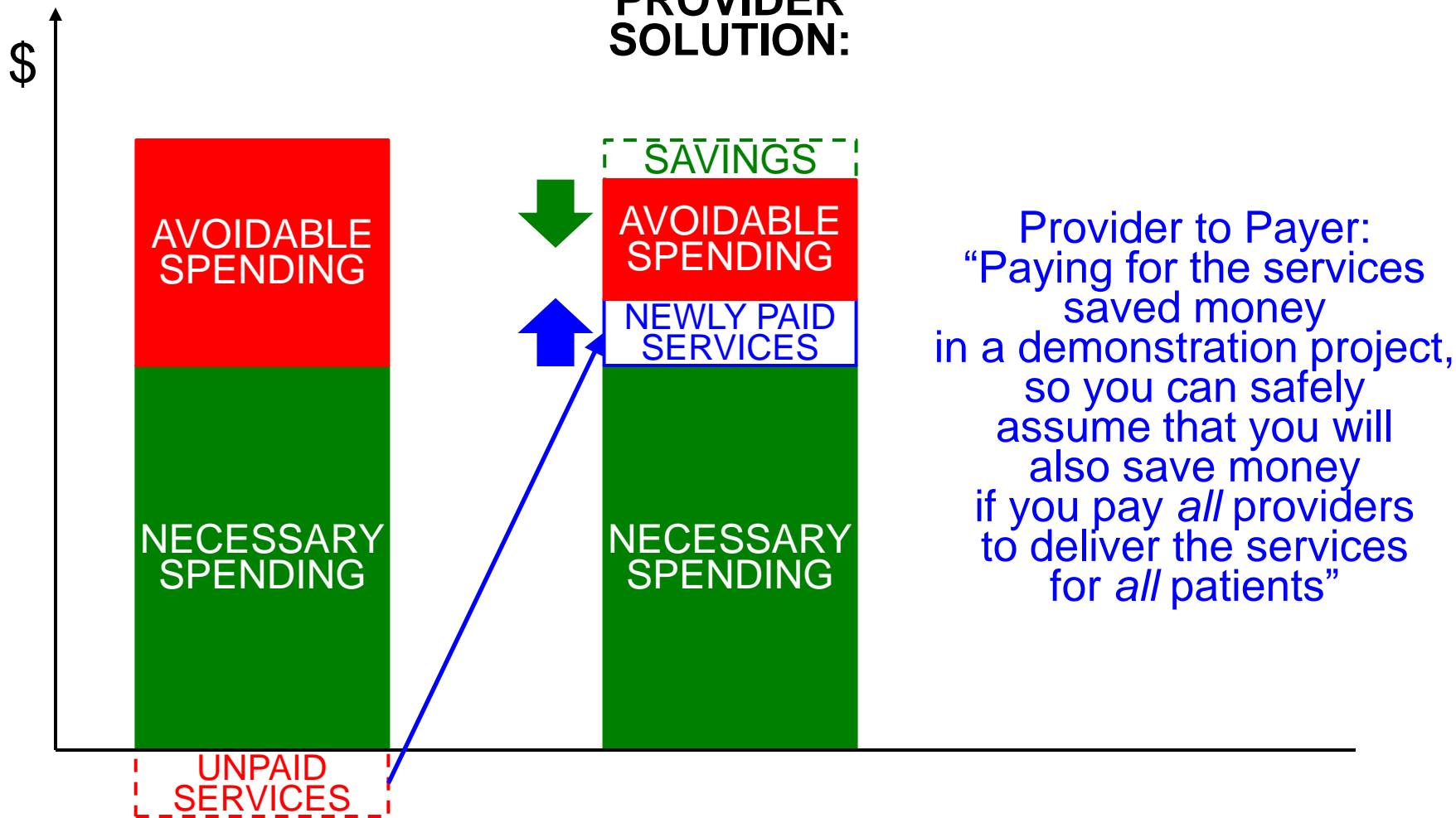
Provider Approach: Pay Us More...

PROVIDER SOLUTION:



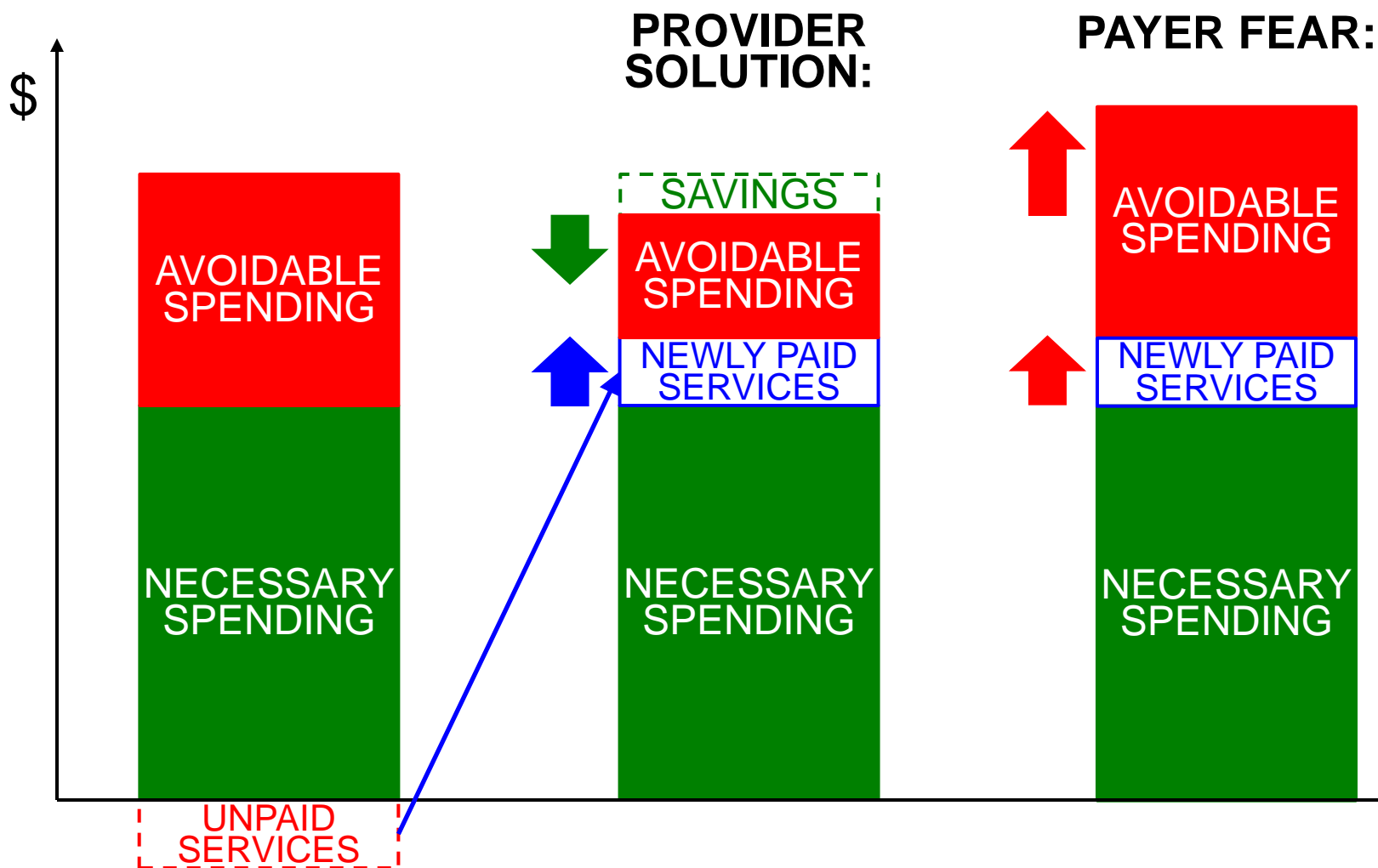
Provider Approach: Pay Us More... ...and “Trust Us” on Savings

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



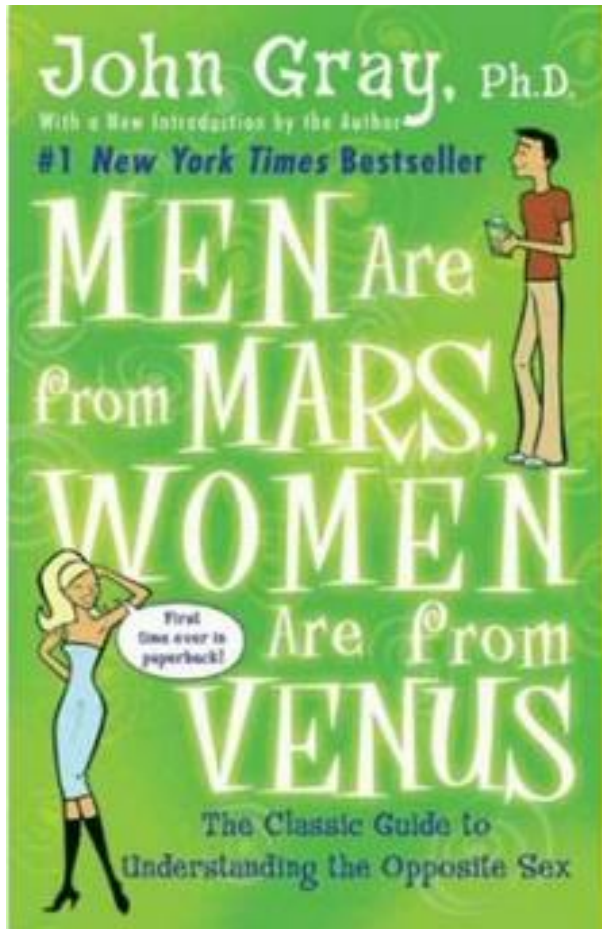
Example: Accreditation Programs

- 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

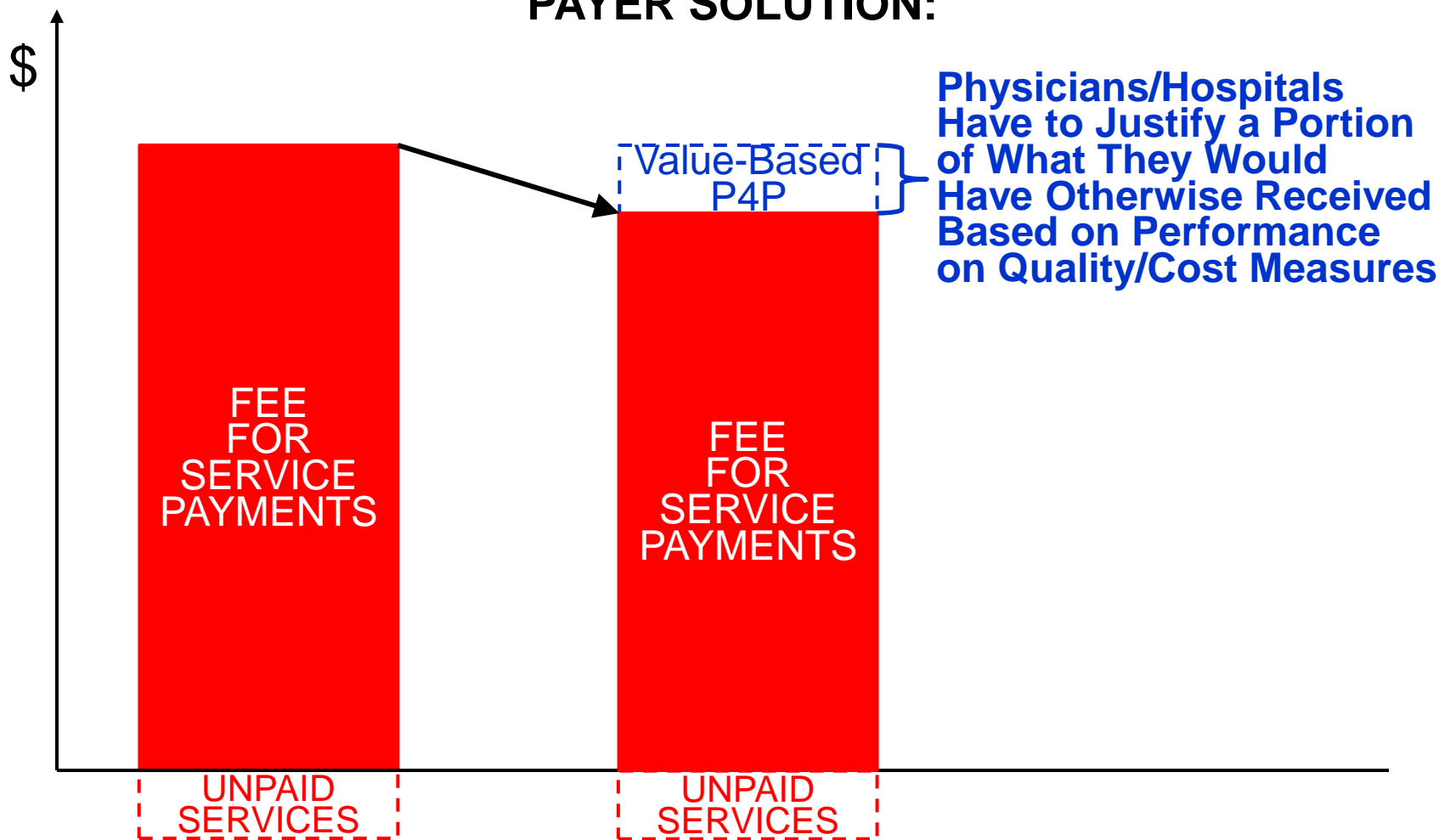
“NOT”



In Healthcare,
Payers Are From Mars,
Providers Are From Venus

Payer Approach: “Value-Based” Pay for Performance

PAYER SOLUTION:



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
days of life
per dollar

ONCOLOGIST #2

$$\frac{10 \text{ Year Survival}}{\$10,000/\text{patient}}$$

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

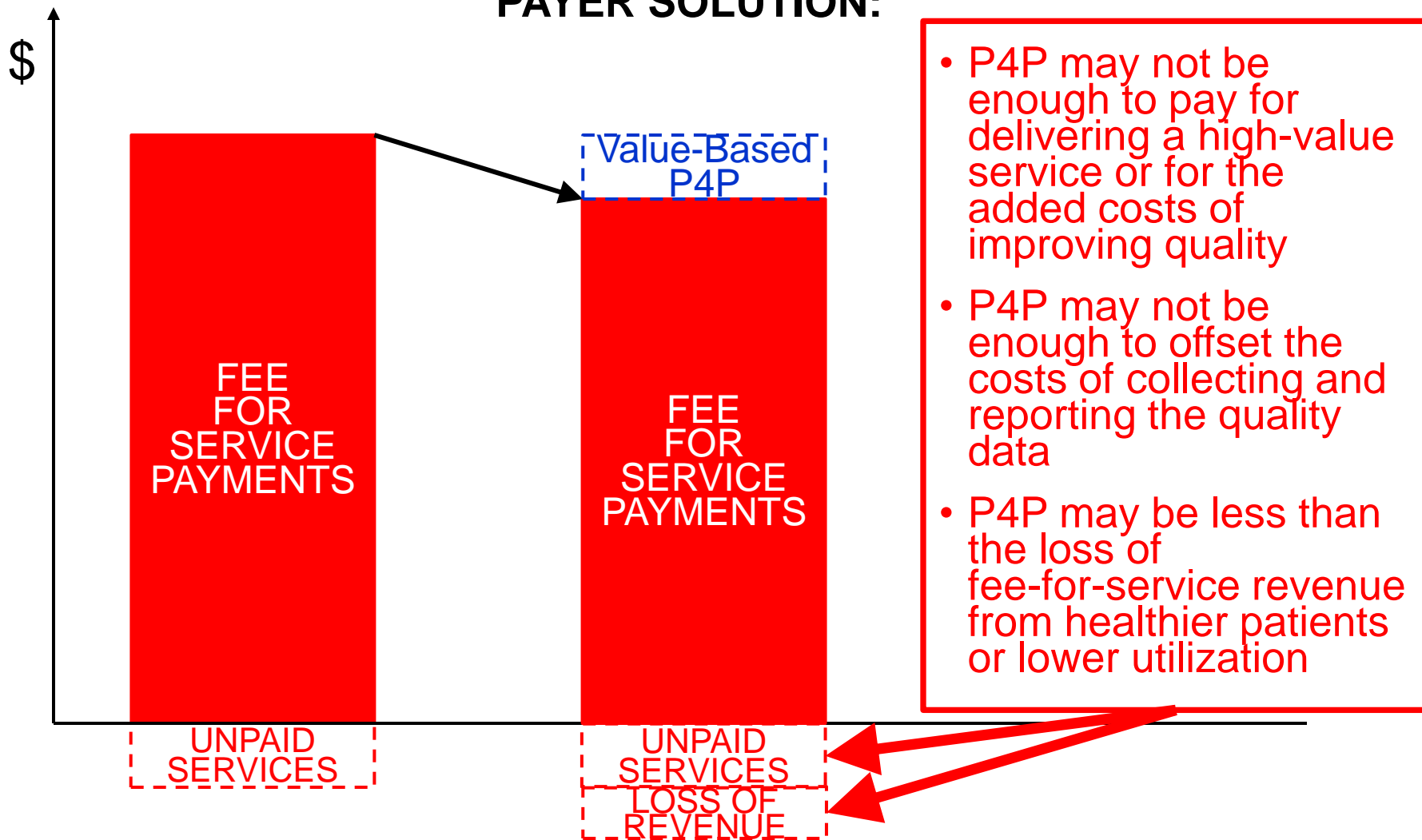
?

Assessing Value is a Lot Harder Than This

$$\del{VALUE = \frac{QUALITY}{COST}}$$

Do Physicians Need “Incentives” or True Solutions to FFS Barriers?

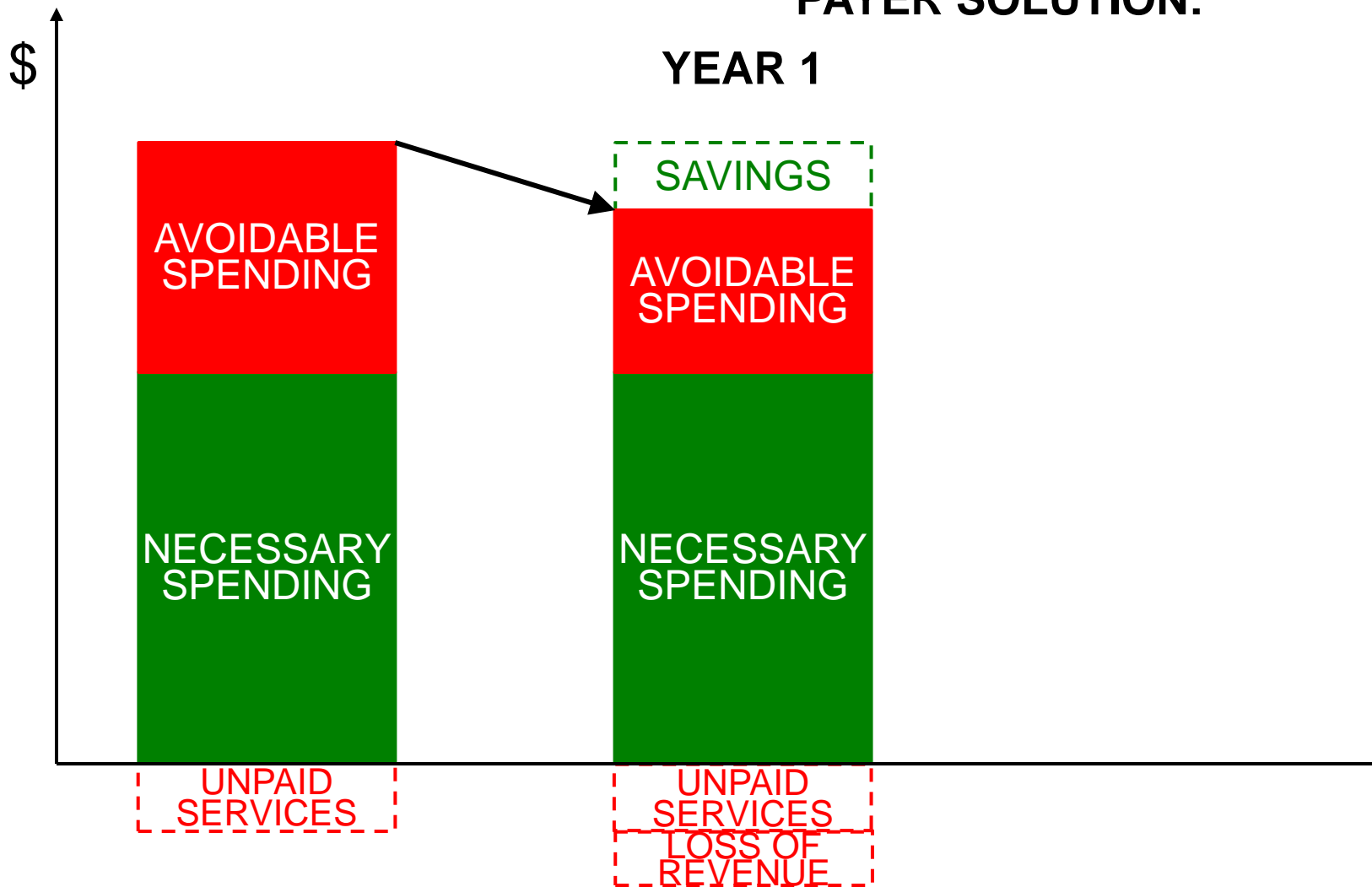
PAYER SOLUTION:



Payer Approach: Save Us Money...

PAYER SOLUTION:

YEAR 1

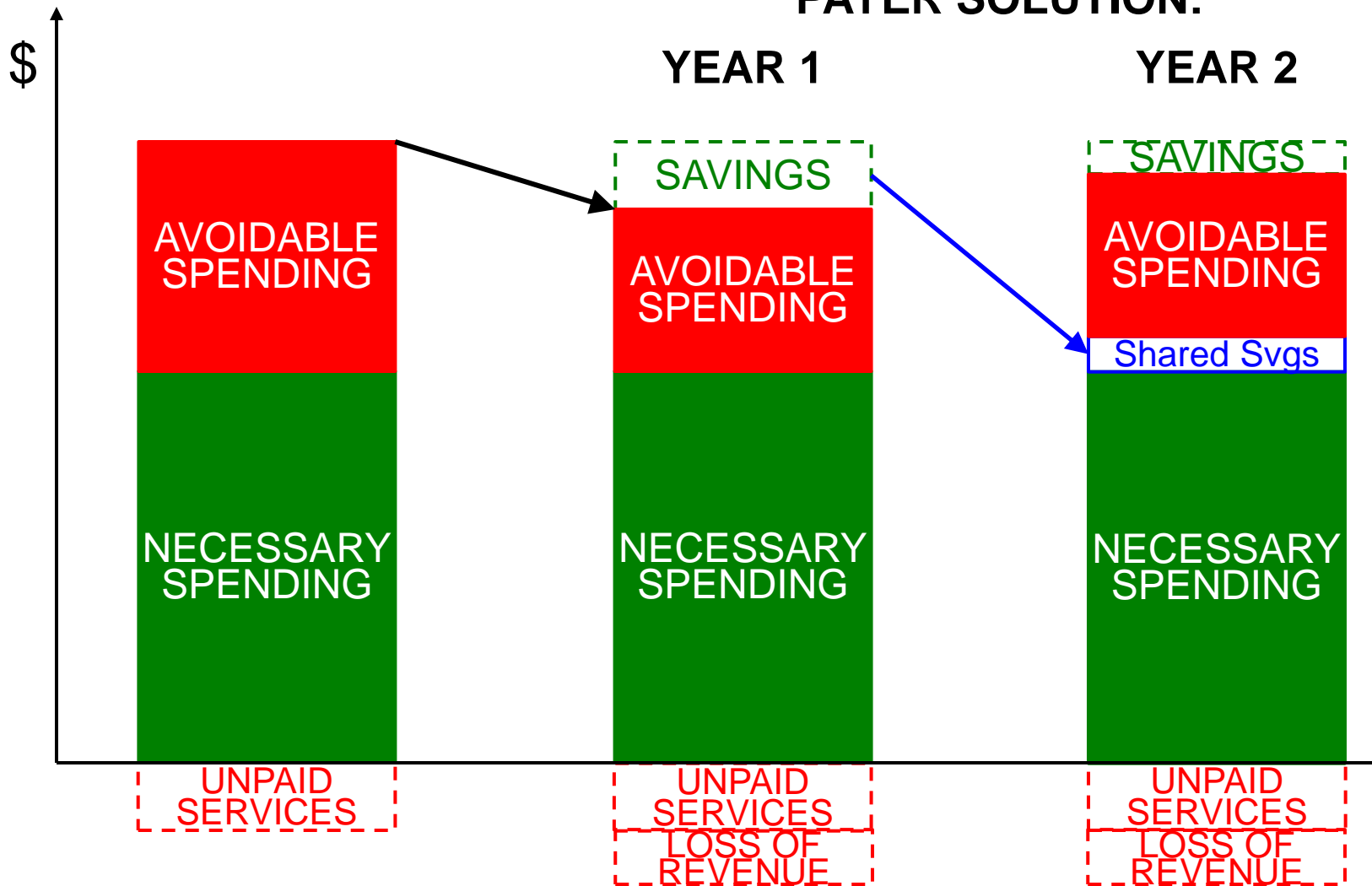


Payer Approach: Save Us Money & (Maybe) We'll Pay More Next Year

PAYER SOLUTION:

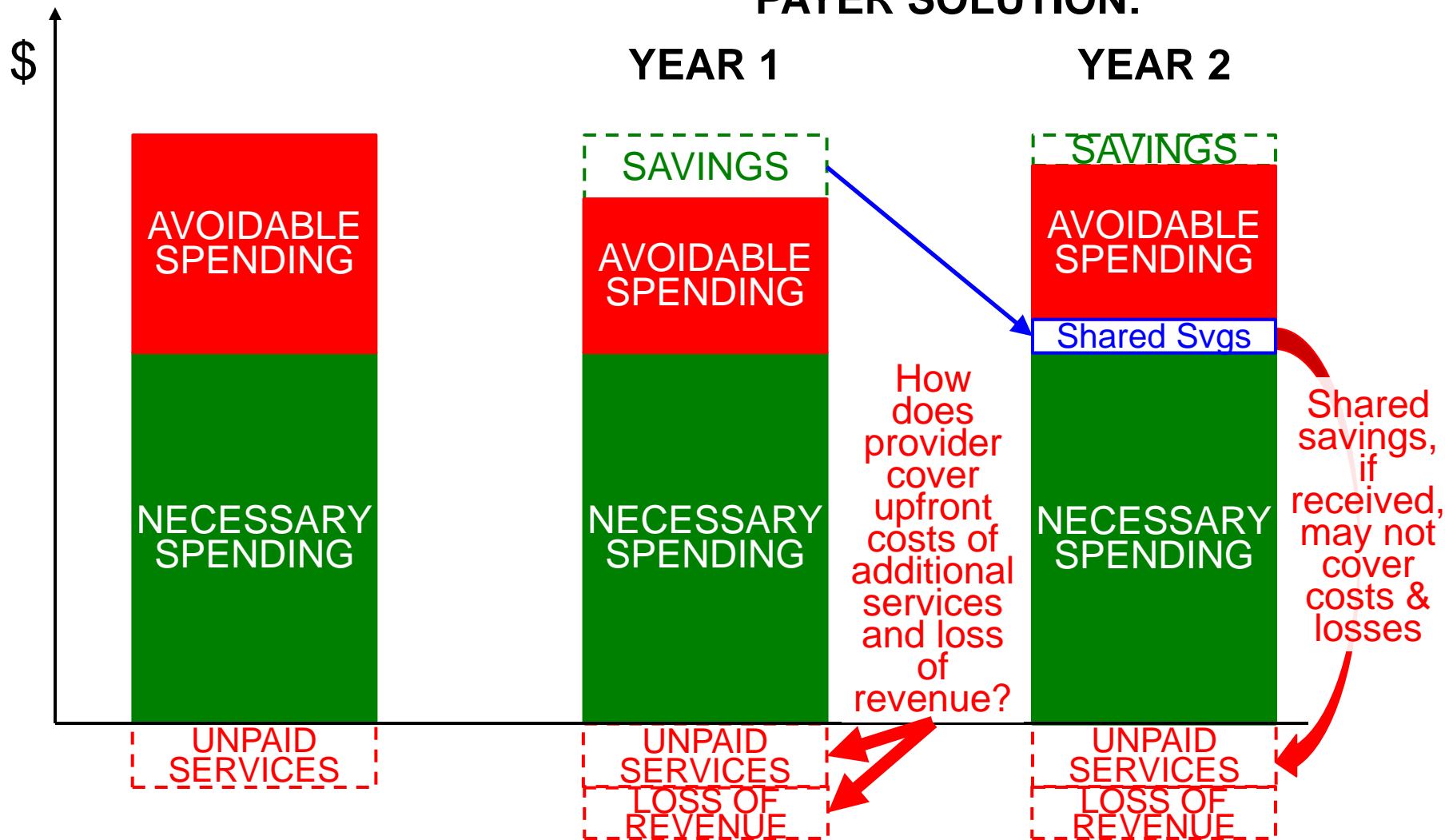
YEAR 1

YEAR 2



Provider Concern: Shared Savings is Too Little, Too Late

PAYER SOLUTION:



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

Modern Healthcare

The leader in healthcare business news, research & data

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

By [Bob Herman](#) | October 15, 2015

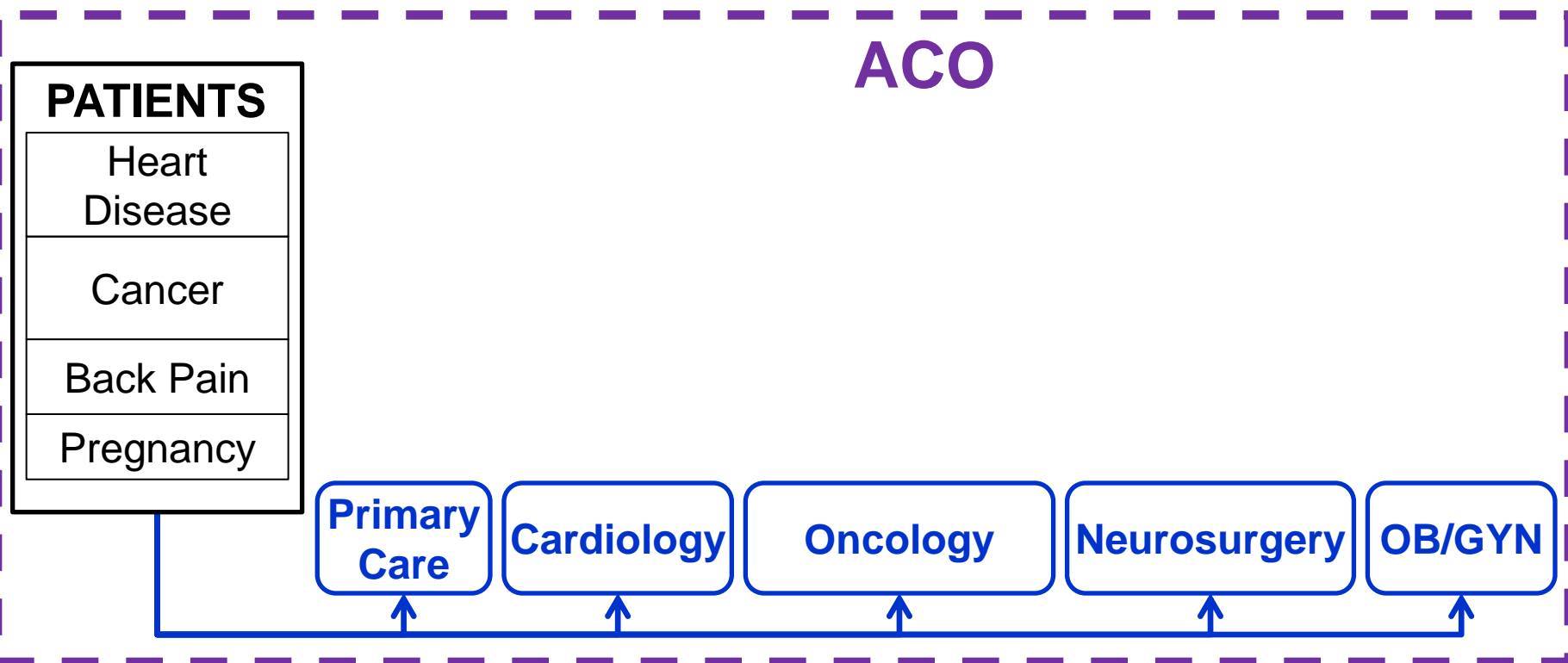
CHICAGO—Medicare's investment in accountable care organizations has inspired hospitals and doctors to create their own versions of ACOs with private insurers. But as with Medicare, not all private ACOs are achieving lower costs and higher quality.

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.

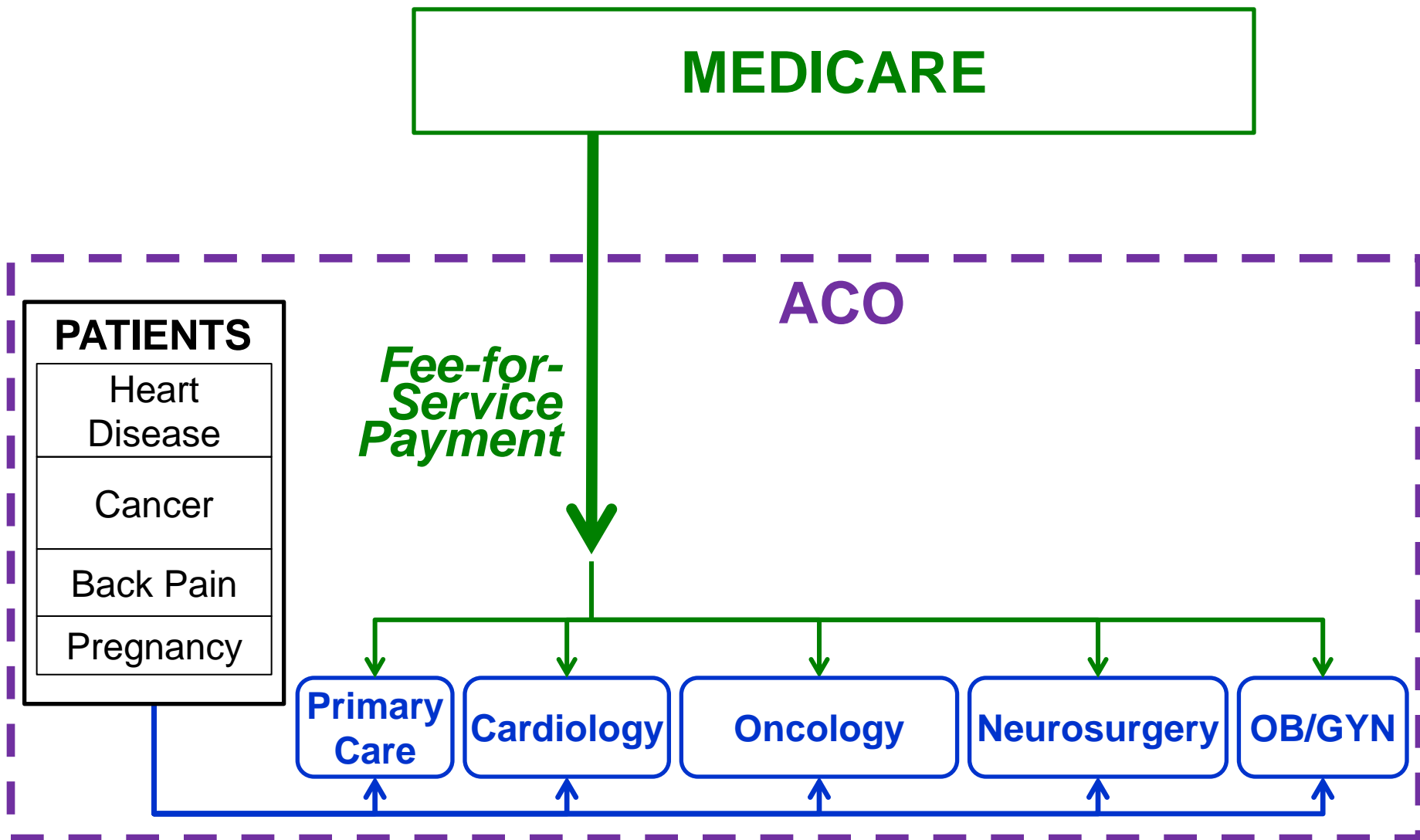
Their experiences reflect that ACOs are still a new structure, and building a new payment and care model as complex as an ACO is not easy to roll out.

"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."

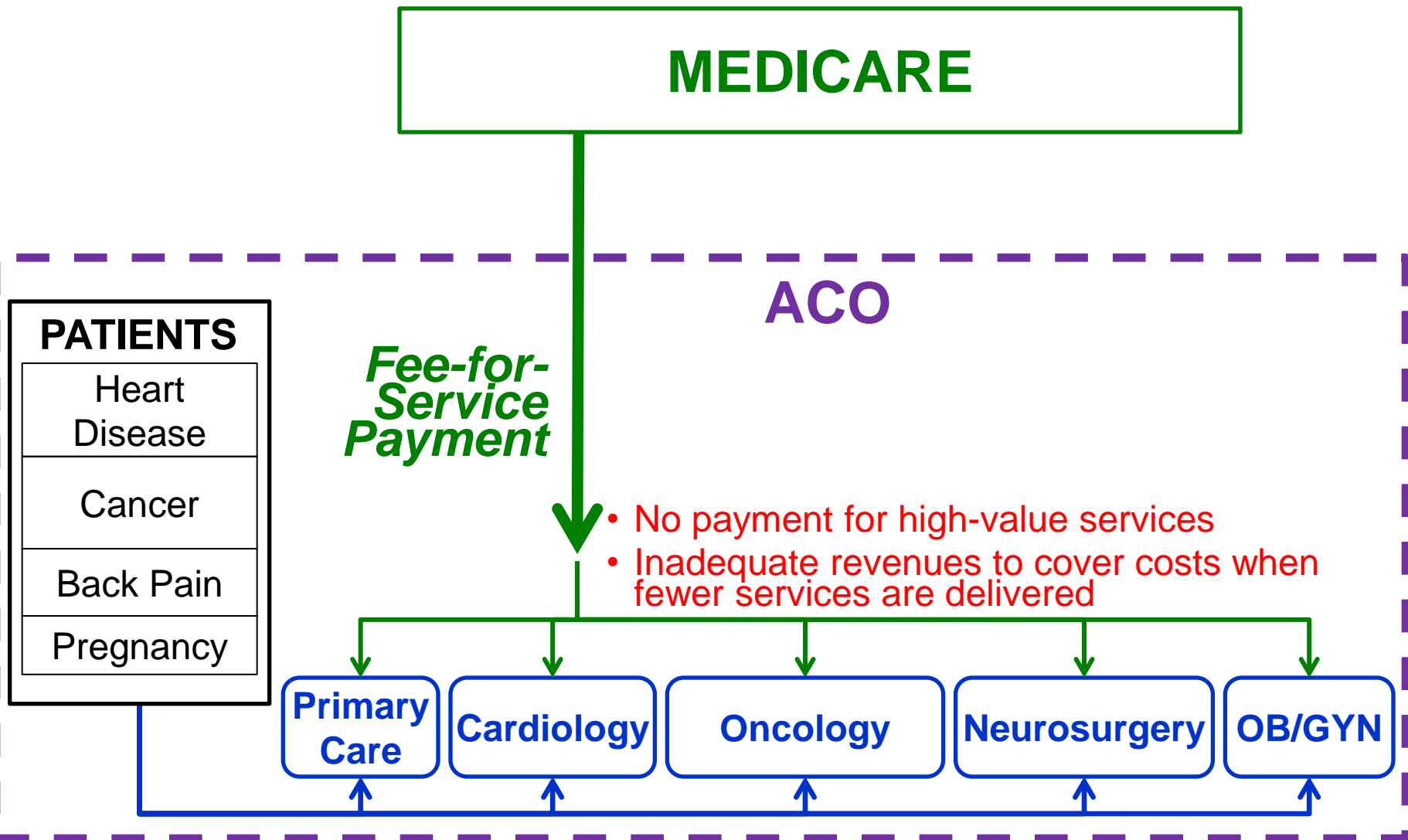
Why Aren't ACOs Succeeding?



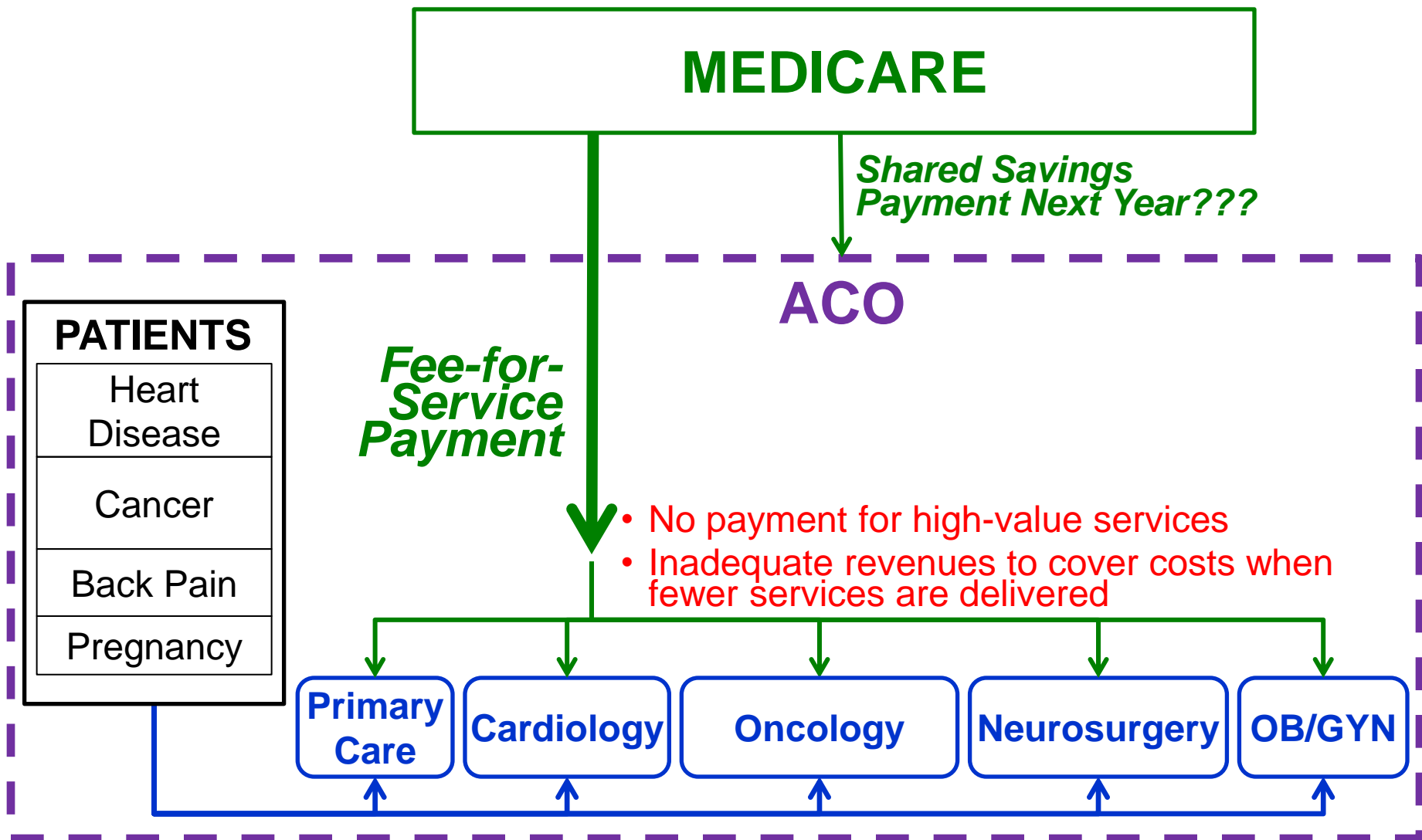
No Change in the Way Physicians or Hospitals Are Paid



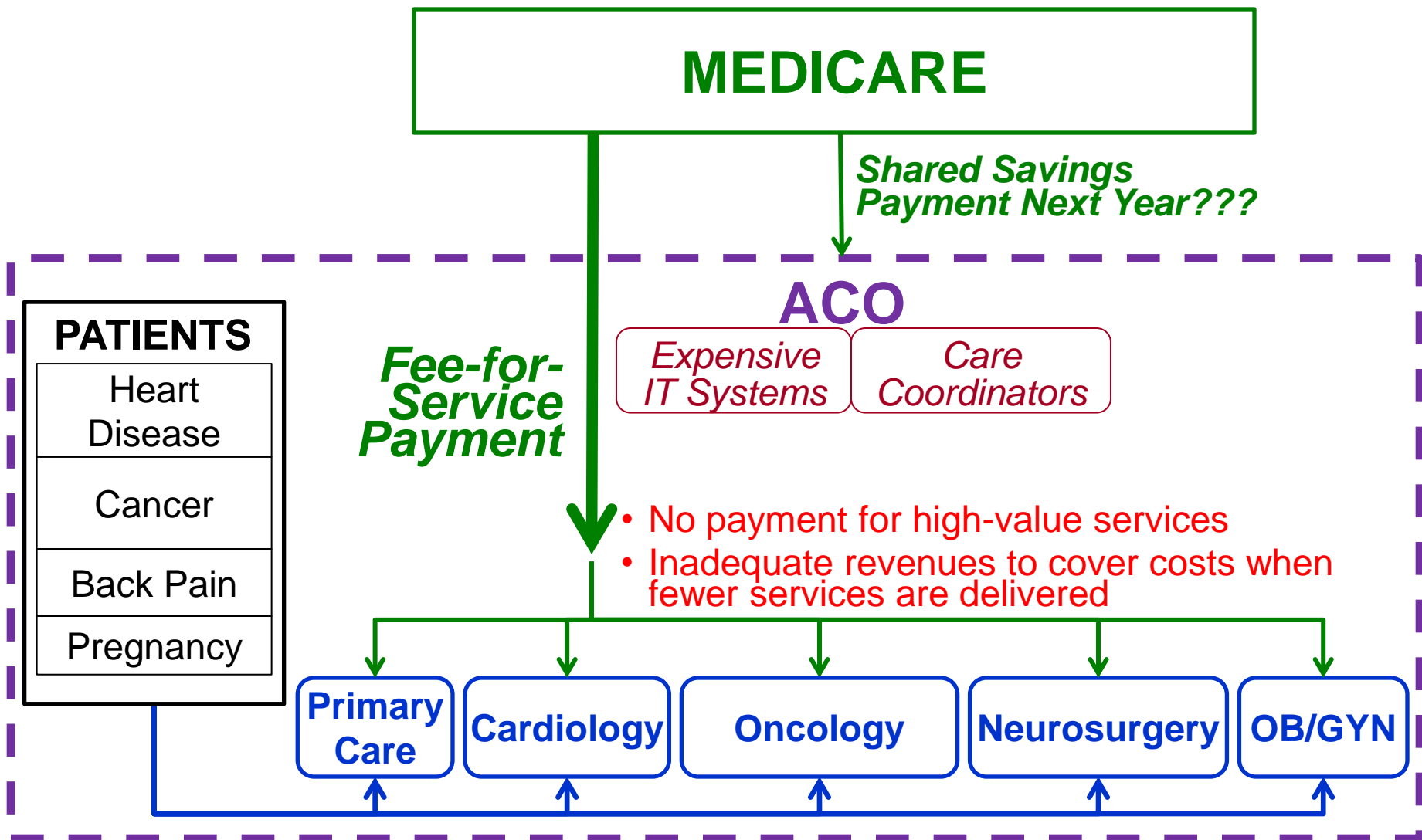
Providers Still Face All the Barriers in the Current Payment System...



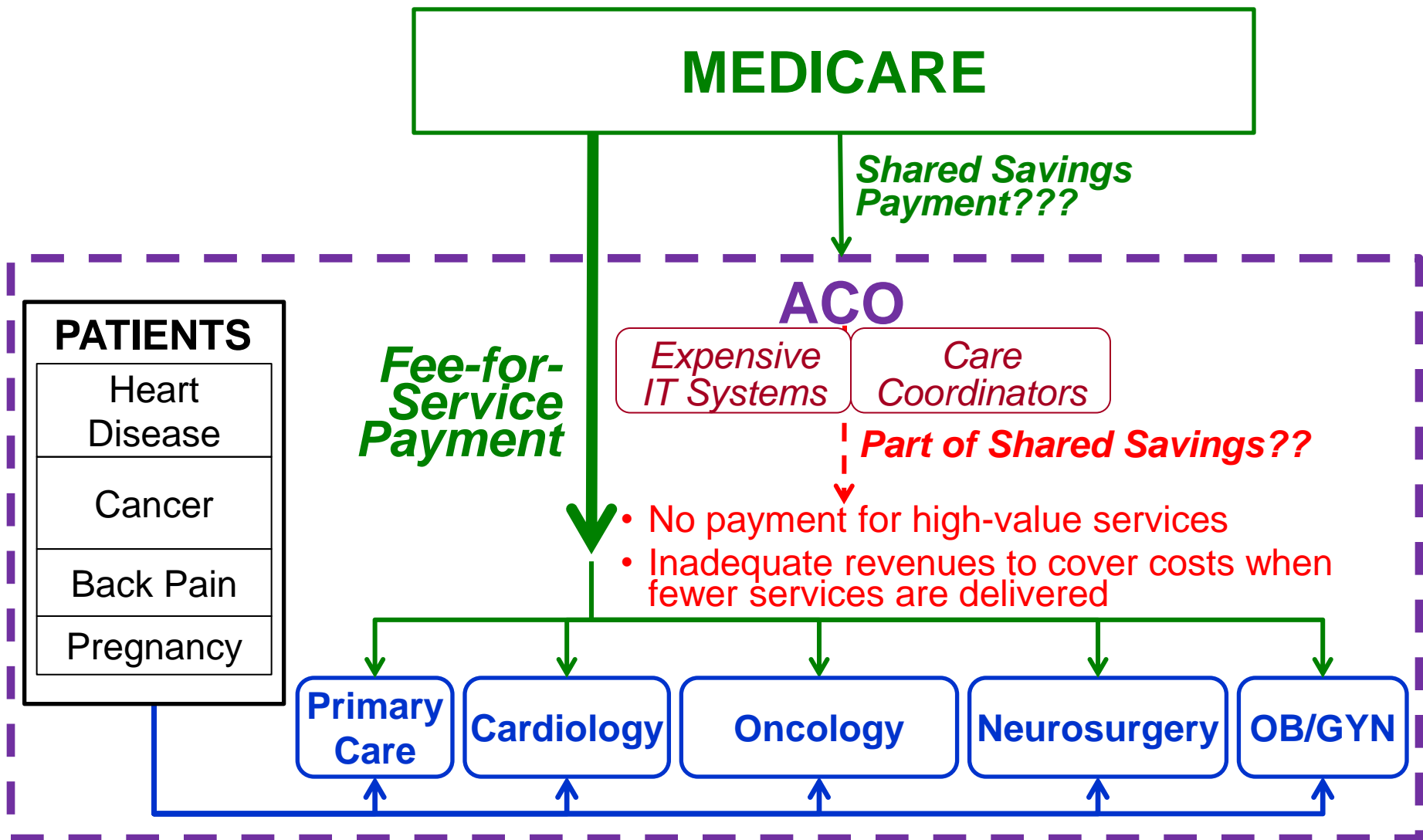
...With Only the Potential for Receiving Future “Shared Savings”



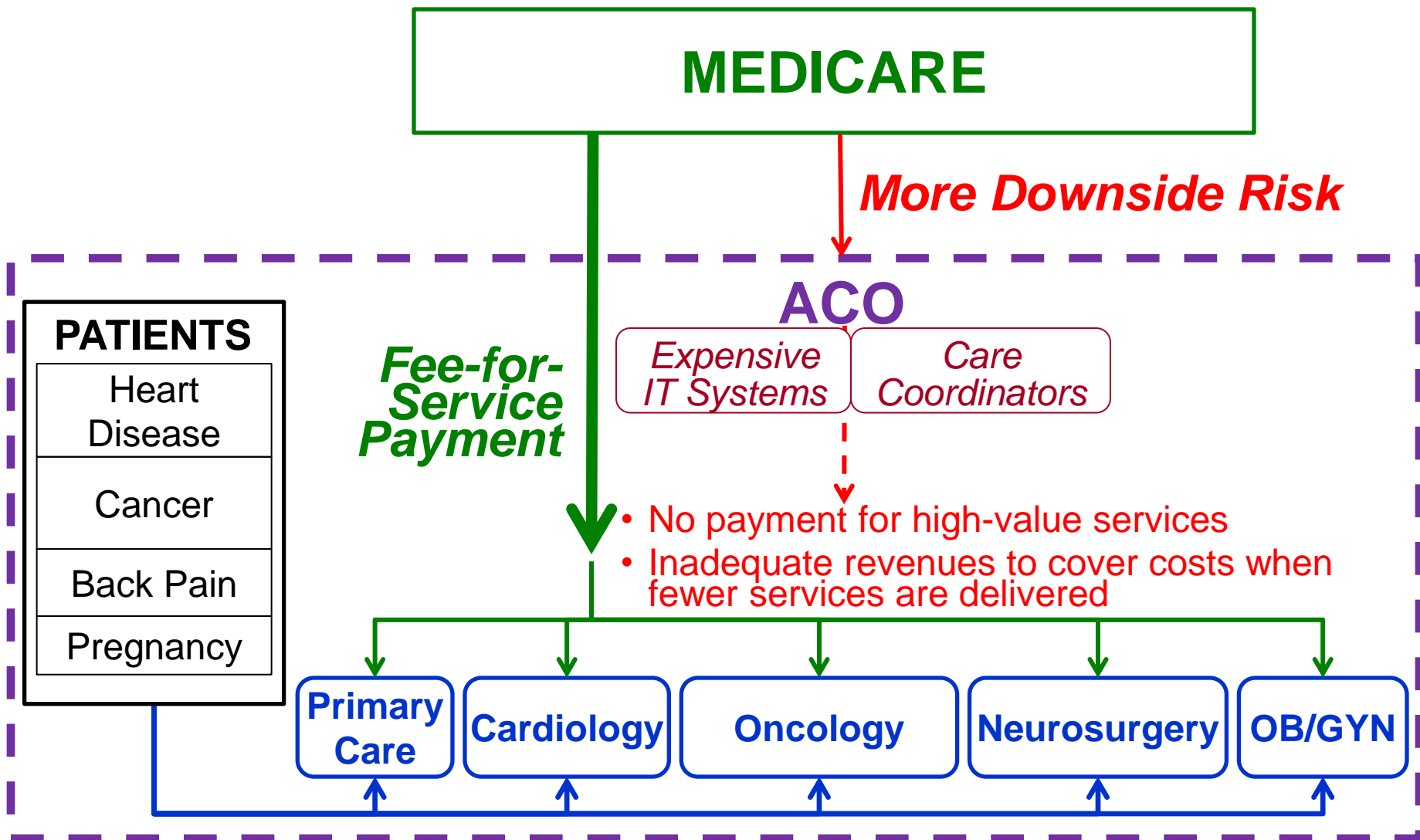
ACOs Try to “Coordinate Care” Without Fixing Payment Barriers



Possibility of Future Bonuses Doesn't Overcome Current Barriers



Creating More “Risk” Won’t Solve the Problems with Payment Either



Value-Based Payment Is Being Designed the *Wrong Way* Today

Value-Based Payment Is Being Designed the *Wrong Way* Today

TOP-DOWN PAYMENT REFORM

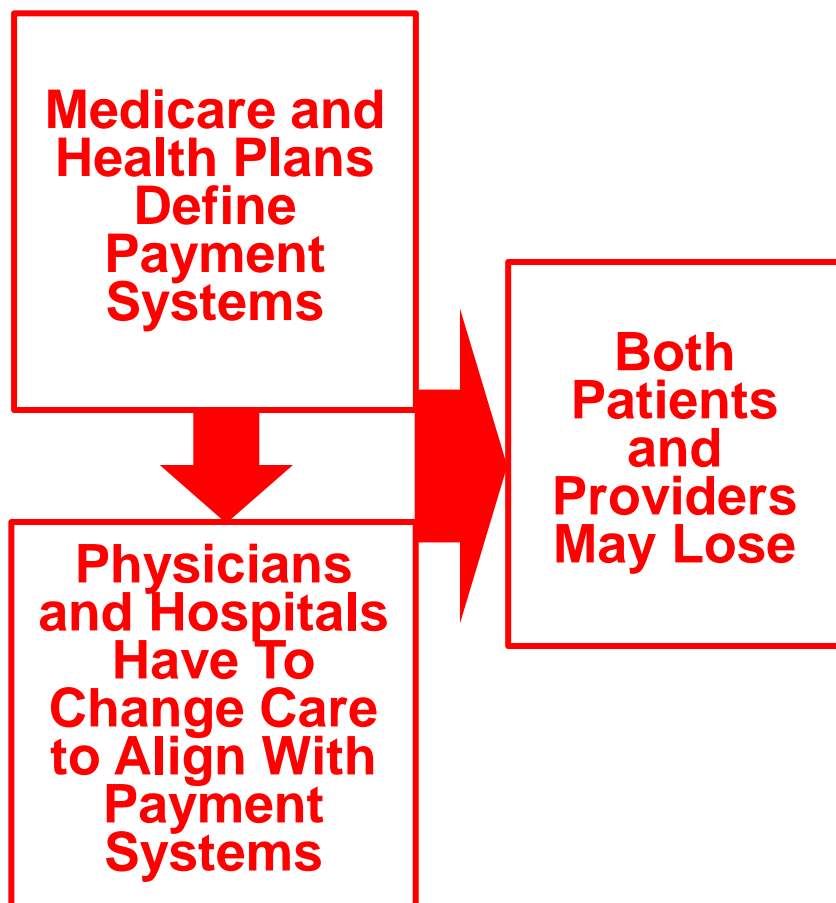
Medicare and
Health Plans
Define
Payment
Systems



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

Value-Based Payment Is Being Designed the *Wrong Way* Today

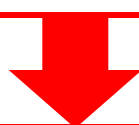
TOP-DOWN PAYMENT REFORM



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
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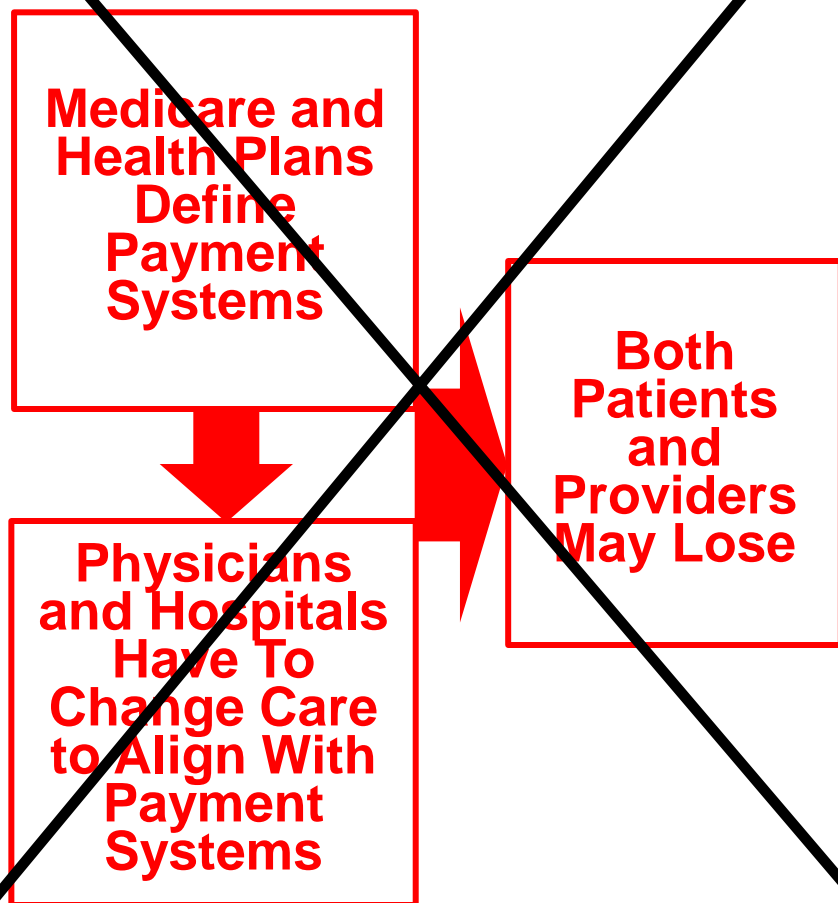
**Both
Patients
and
Providers
May Lose**

BOTTOM-UP PAYMENT REFORM

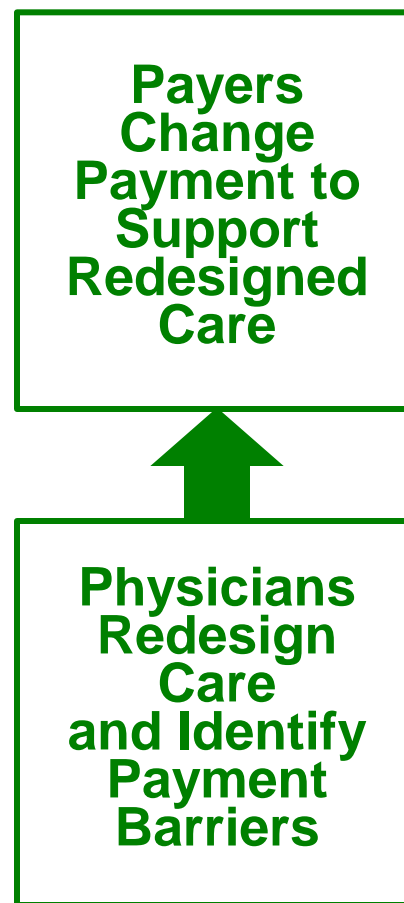
**Physicians
Redesign
Care
and Identify
Payment
Barriers**

Physicians Need to Design Payments to Support Good Care

TOP-DOWN PAYMENT REFORM

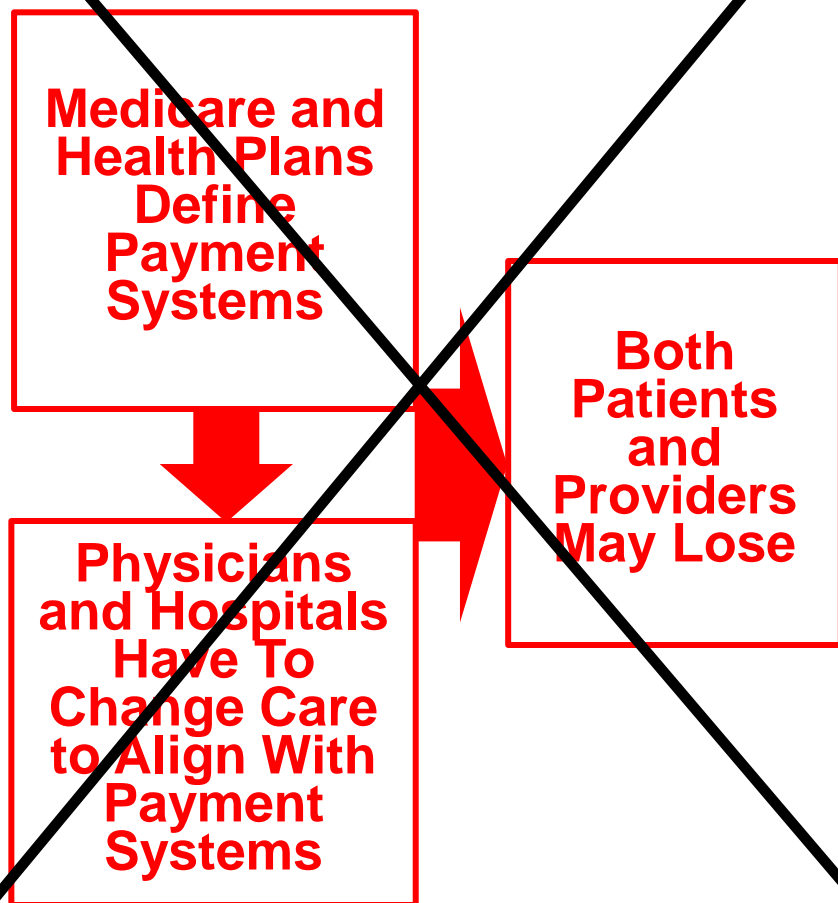


BOTTOM-UP PAYMENT REFORM

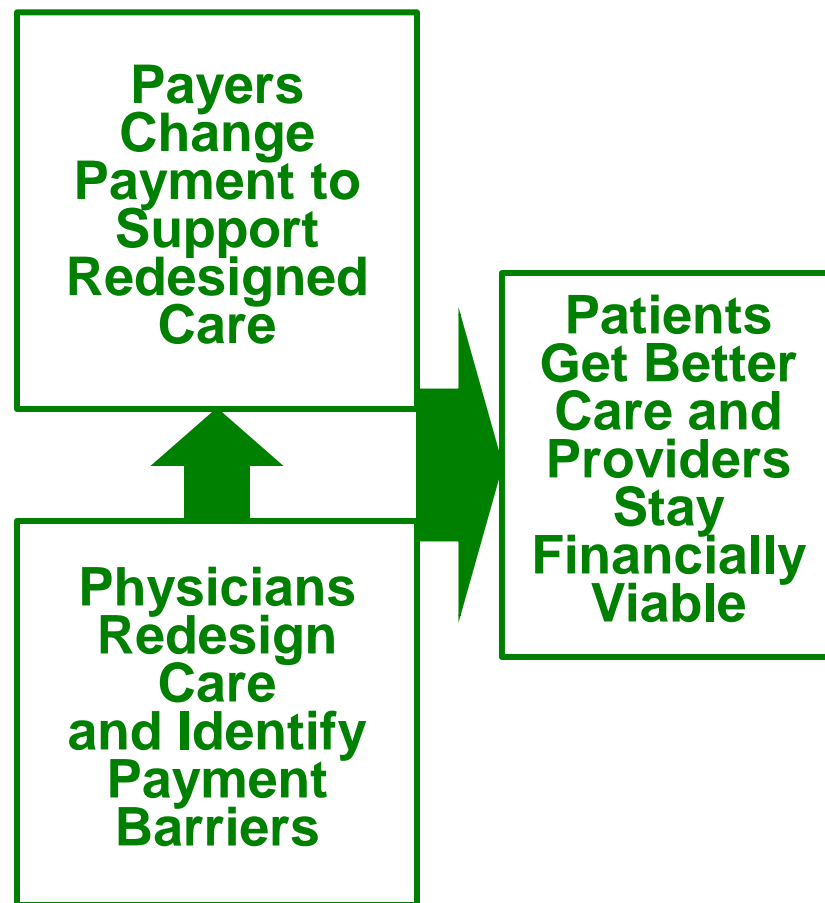


Physicians Need to Design Payments to Support Good Care

TOP-DOWN PAYMENT REFORM

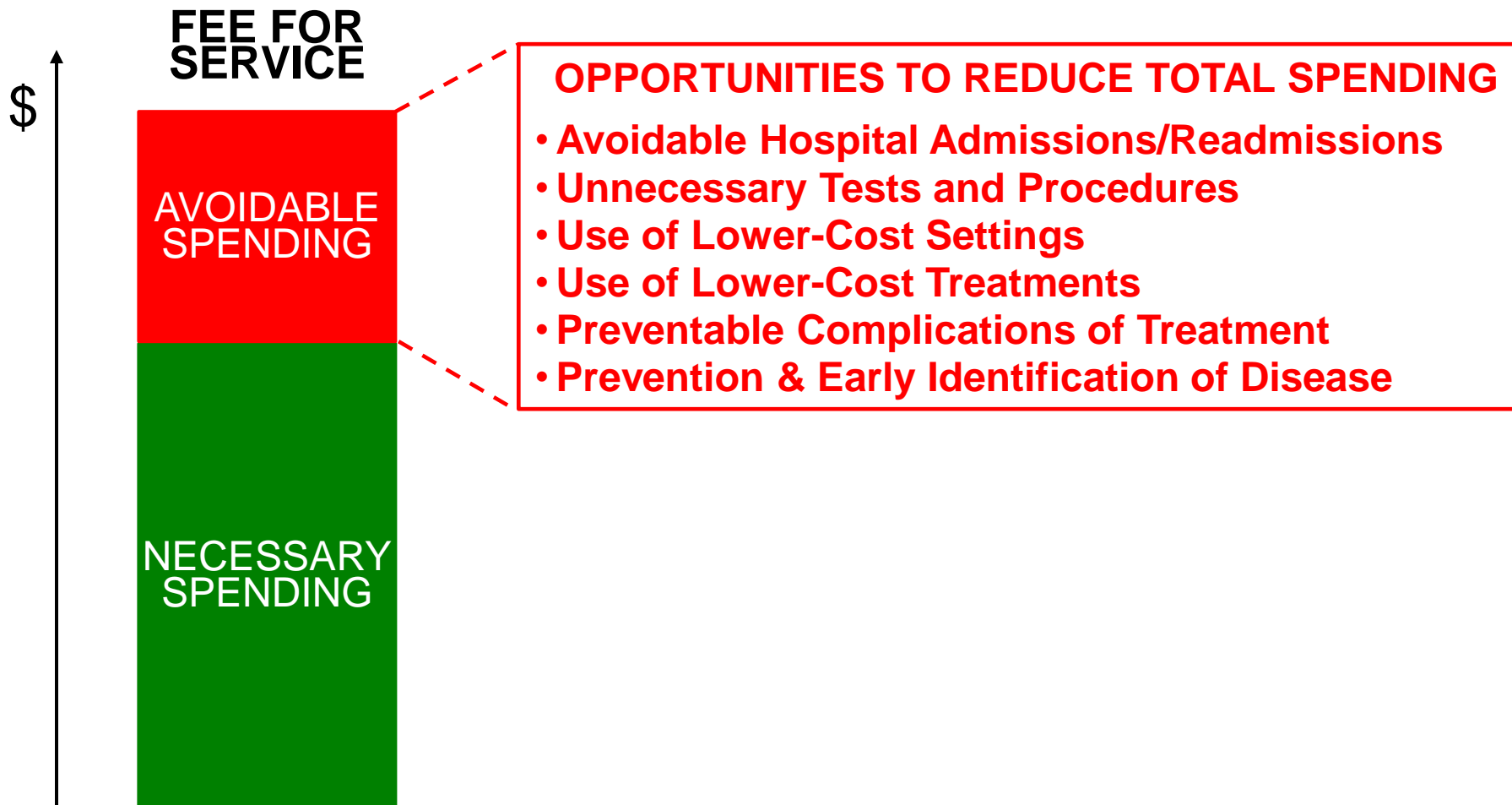


BOTTOM-UP PAYMENT REFORM



Step #1:

Identify Avoidable Spending in FFS



Most Specialties Have Identified Areas of Avoidable Spending

Choosing Wisely
An initiative of the American Society of Clinical Oncology

Five Things Physicians and Patients Should Question

- Don't do imaging for low back red flags are present.**
Red flags include, but are not limited to, severe or progressive neurologic deficits, saddle anesthesia, bowel or bladder dysfunction, or significant weight loss. Imaging of the lower spine before six weeks is not indicated.
- Don't routinely prescribe antibiotics for acute sinusitis unless symptoms have worsened after initial clinical management.**
Symptoms must include discolored nasal secretions and facial pain or pressure. Most acute sinusitis is self-limiting and will resolve on its own. Despite costs, the use of antibiotics for acute sinusitis is not supported by available evidence. Testing for viral infection is not indicated.
- Don't use dual-energy x-ray absorptiometry (DEXA) for osteoporosis in women younger than 70 with no risk factors.**
DEXA is not cost effective in younger, low-risk patients, but may be useful in older patients with risk factors.
- Don't order annual electrocardiogram (ECG) screening for low-risk patients.**
There is little evidence that detection of coronary artery disease in asymptomatic patients leads to improved outcomes. False-positive tests are likely to lead to harm from further testing and treatment.
- Don't perform Pap smears or have a hysterectomy for non-cervical cancer.**
Most observed abnormalities in adolescents regress spontaneously and do not require additional testing and cost. Pap smears are not helpful in women with a history of abnormal Pap smears.

Don't use cancer-directed therapy for solid tumor patients with the following characteristics: low performance status (3 or 4), no benefit from prior evidence-based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anti-cancer treatment.

- Studies show that cancer directed treatments are likely to be ineffective for solid tumor patients who meet the above stated criteria.
- Exceptions include patients with functional limitations due to other conditions (resulting in a low performance status) or those with disease characteristics (e.g., mutations) that suggest a high likelihood of response to therapy.
- Implementation of this approach should be accompanied with appropriate palliative and supportive care.

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 of low-risk cancers, despite a lack of evidence suggesting they improve detection of metastatic disease or survival.
- Evidence does not support the use of these scans for staging of newly diagnosed low grade carcinoma of the prostate (Stage 11c/72a, prostate-specific antigen (PSA) <10 ng/ml, Gleason score less than or equal to 6) with low risk of distant metastasis.
- Unnecessary imaging can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.

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 of low-risk 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 identified ductal carcinoma in situ (DCIS), or clinical stage I or II disease.
- Unnecessary imaging can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.

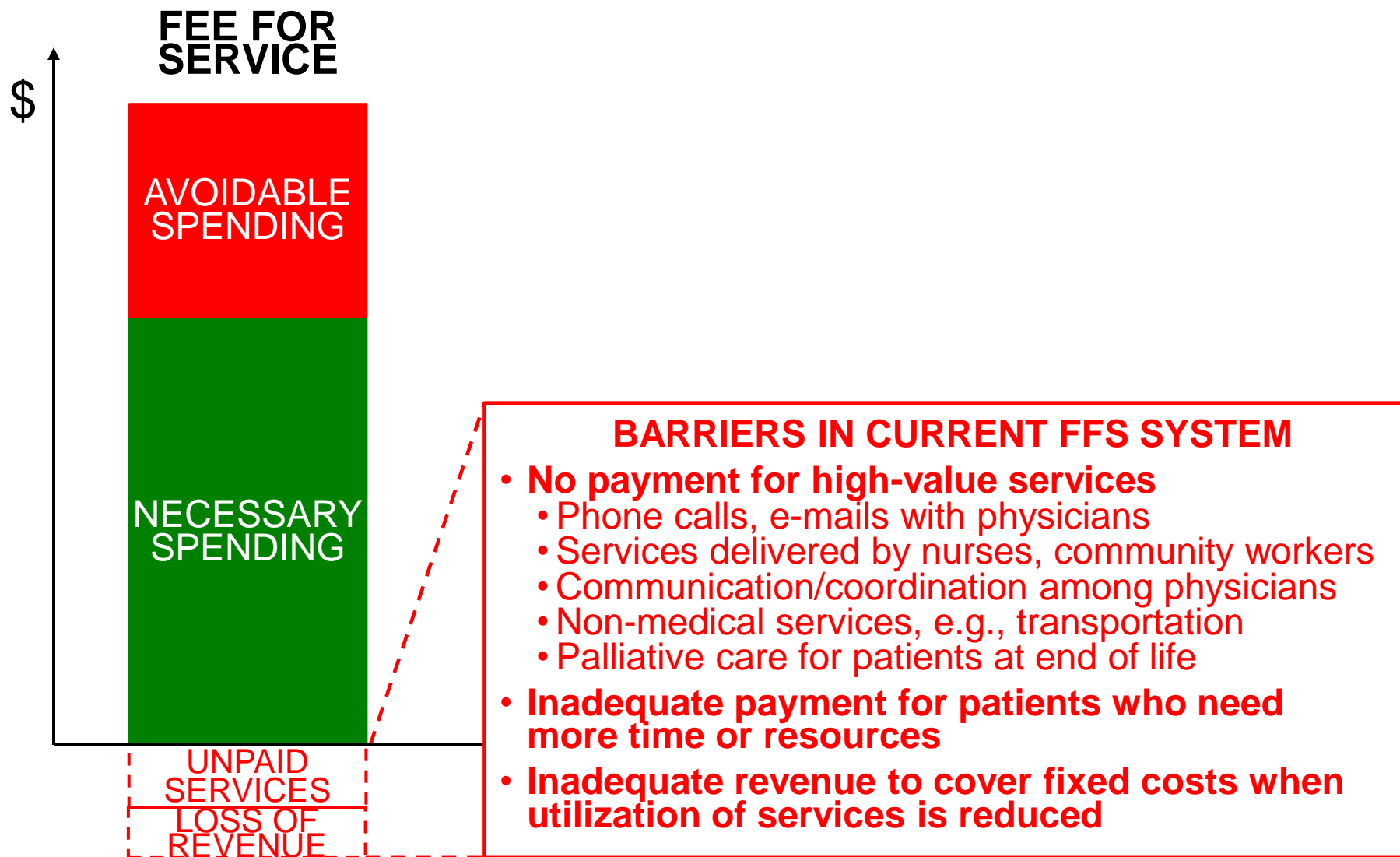
Don't perform surveillance testing (biomarkers) or imaging (PET, CT, and radionuclide bone scans) for asymptomatic individuals who have been treated for breast cancer with curative intent.

- 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 serum measurement of serum tumor markers in asymptomatic patients.
- False-positive tests can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.

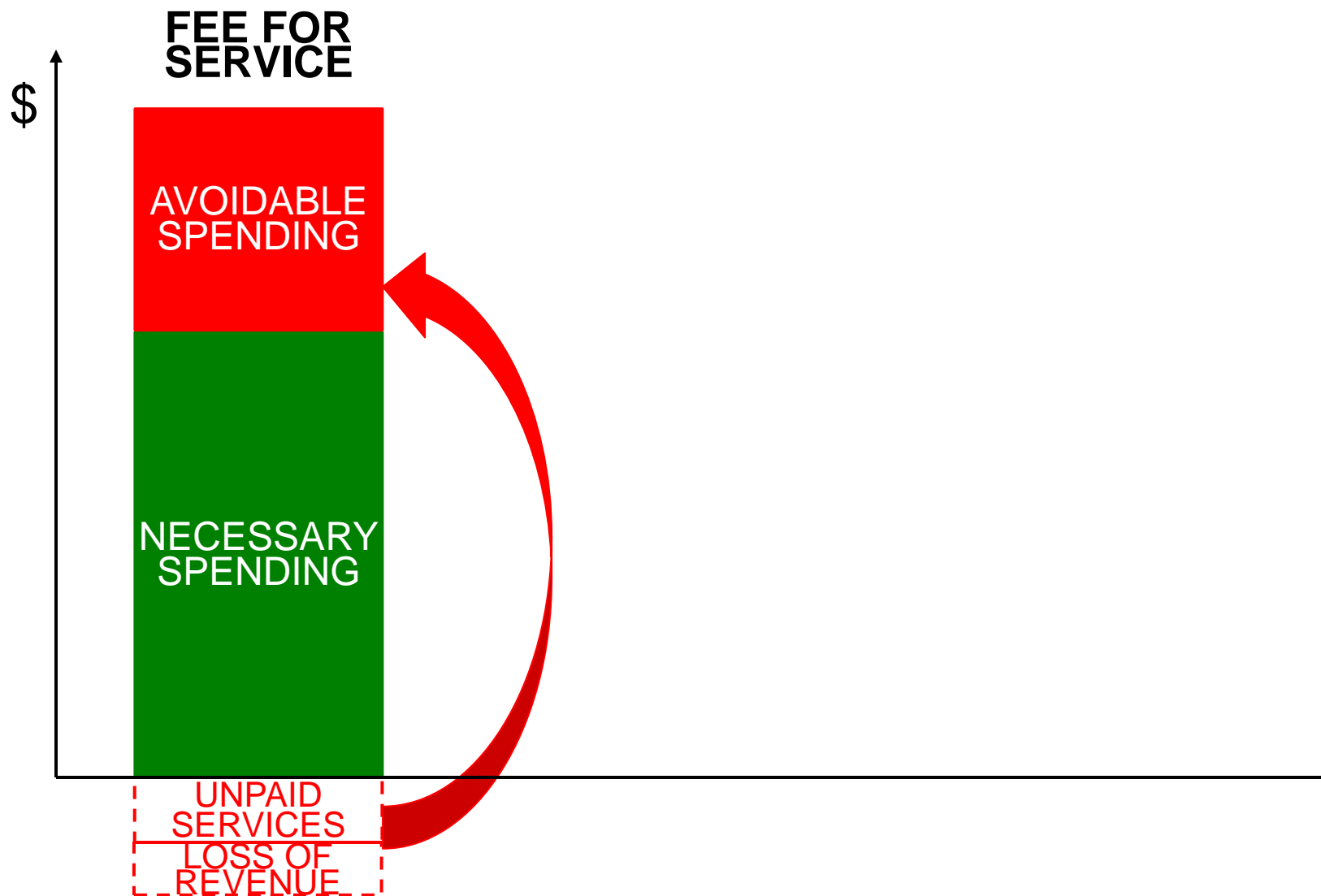
Don't use white cell stimulating factors for primary prevention of febrile neutropenia for patients with less than 20 percent risk for this complication.

- ASCO guidelines recommend using white cell stimulating factors when the risk of febrile neutropenia, secondary to a recommended chemotherapy regimen, is approximately 20 percent and equally effective treatment programs that do not require white cell stimulating factors are unavailable.
- Exceptions should be made when using regimens that have a lower chance of causing febrile neutropenia if it is determined that the patient is at high risk for this complication (due to age, medical history, or disease characteristics).

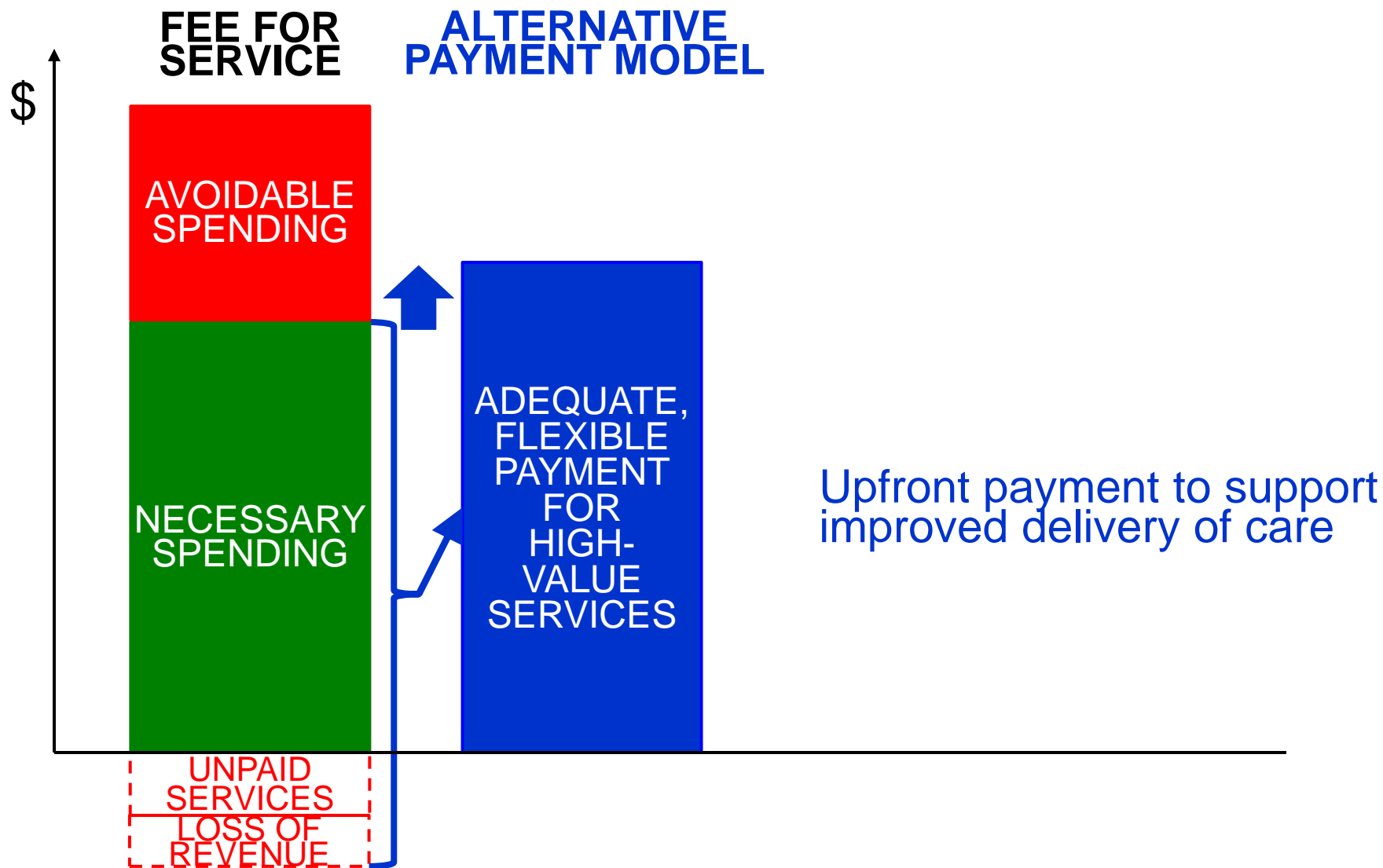
Step #2: Identify Barriers in FFS



You Can't Reduce Spending if You Don't Remove the Barriers

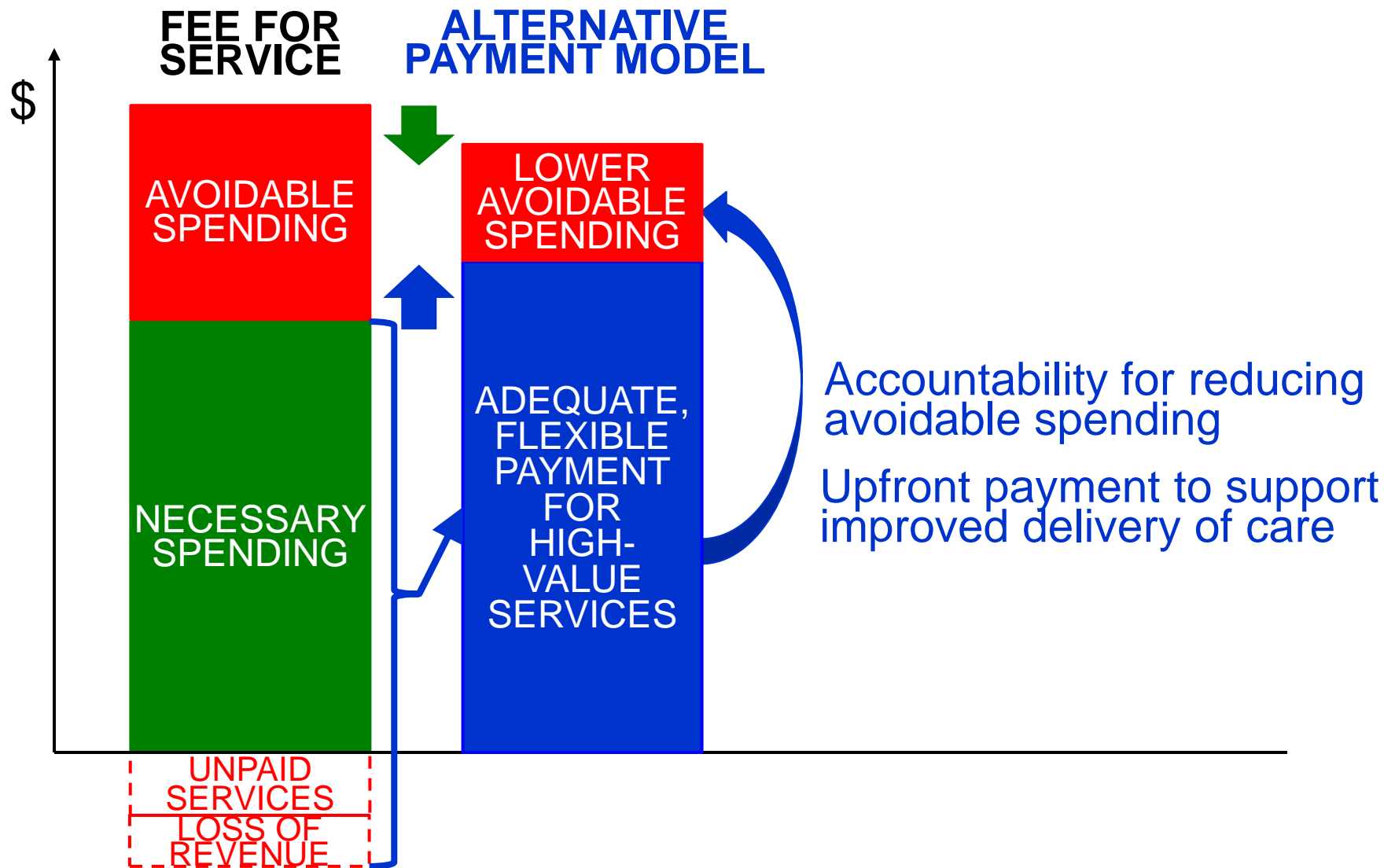


Step #3: Remove the FFS Barriers

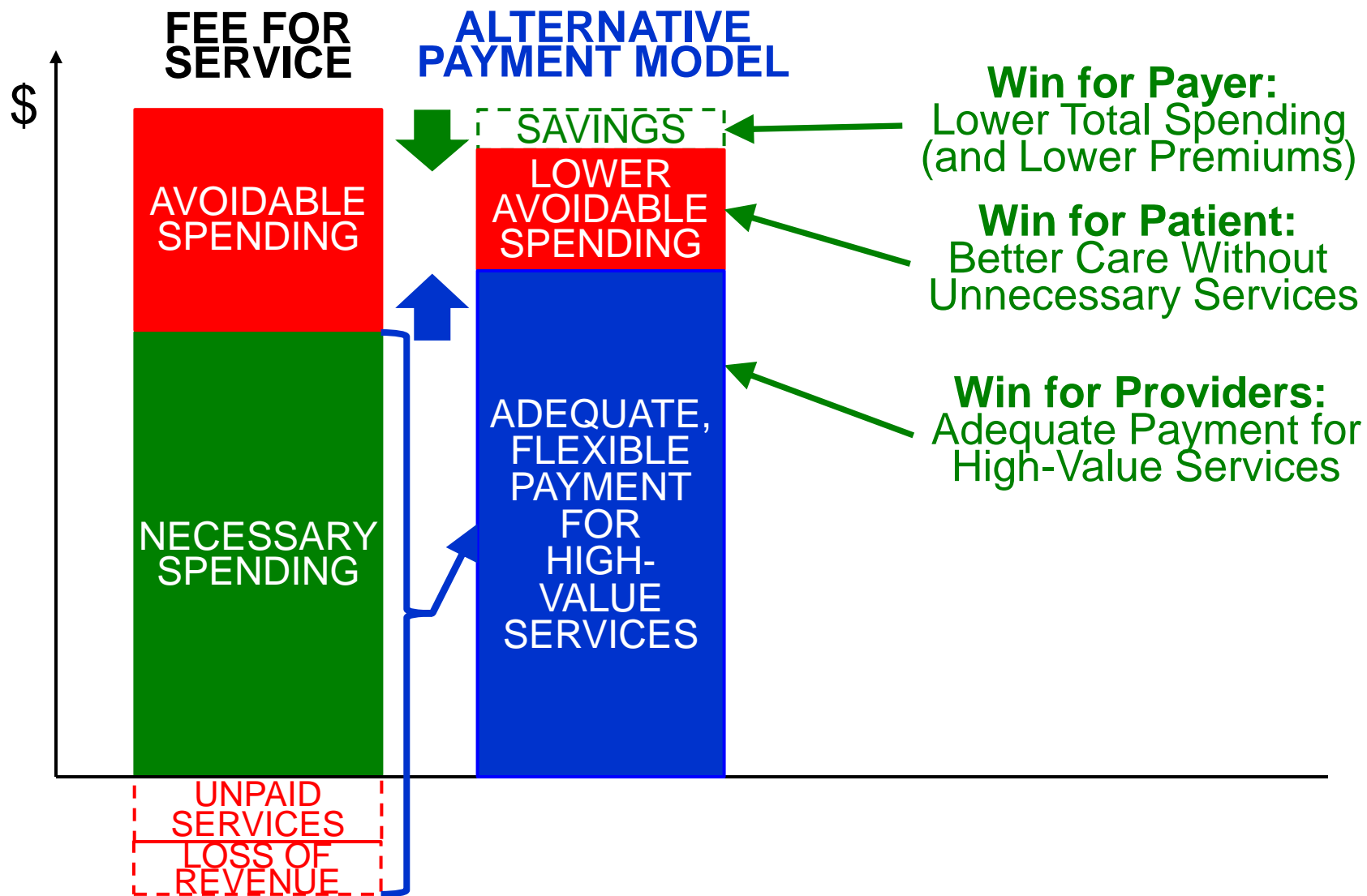


Step 4:

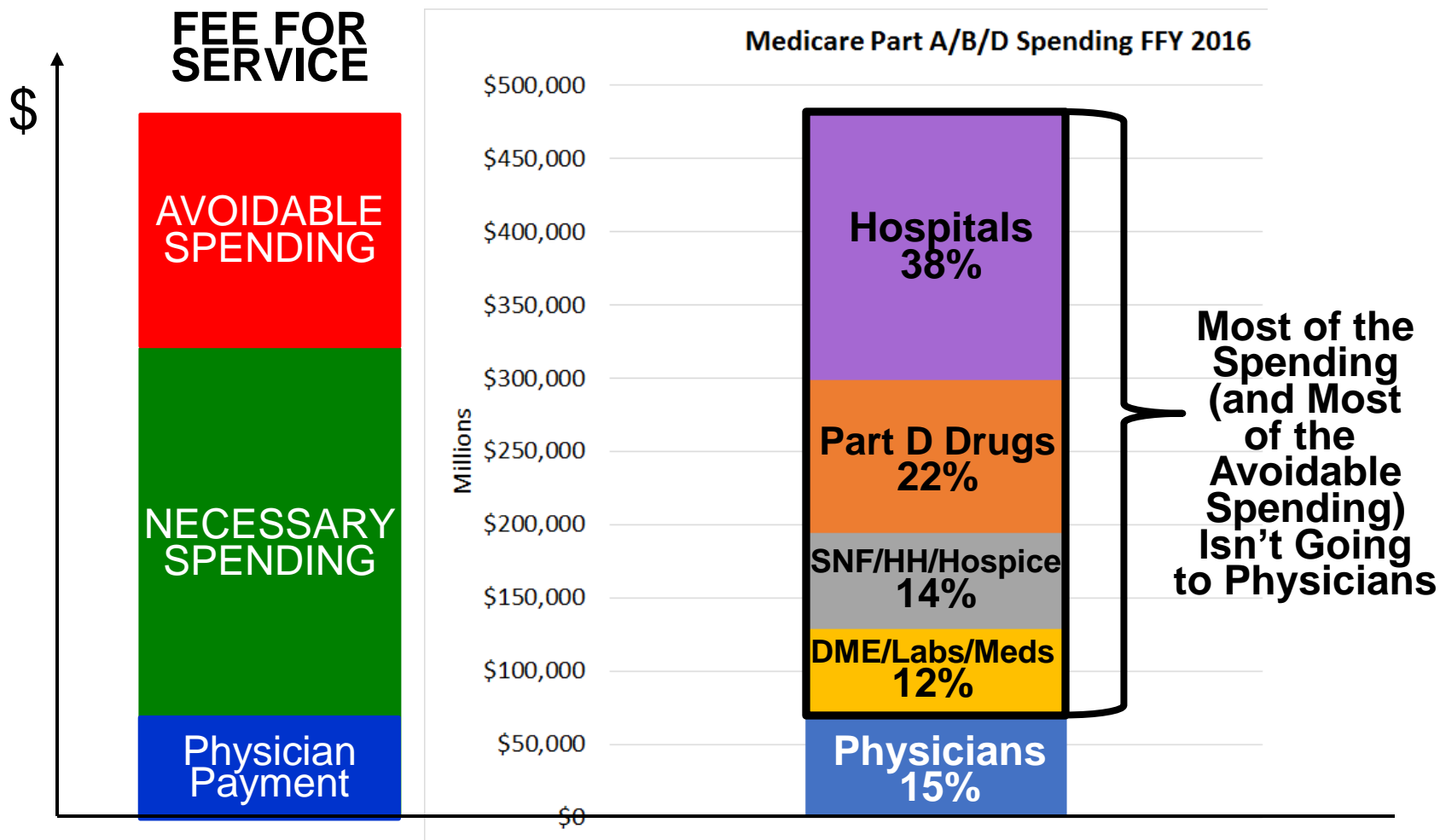
Build in Accountability for Results



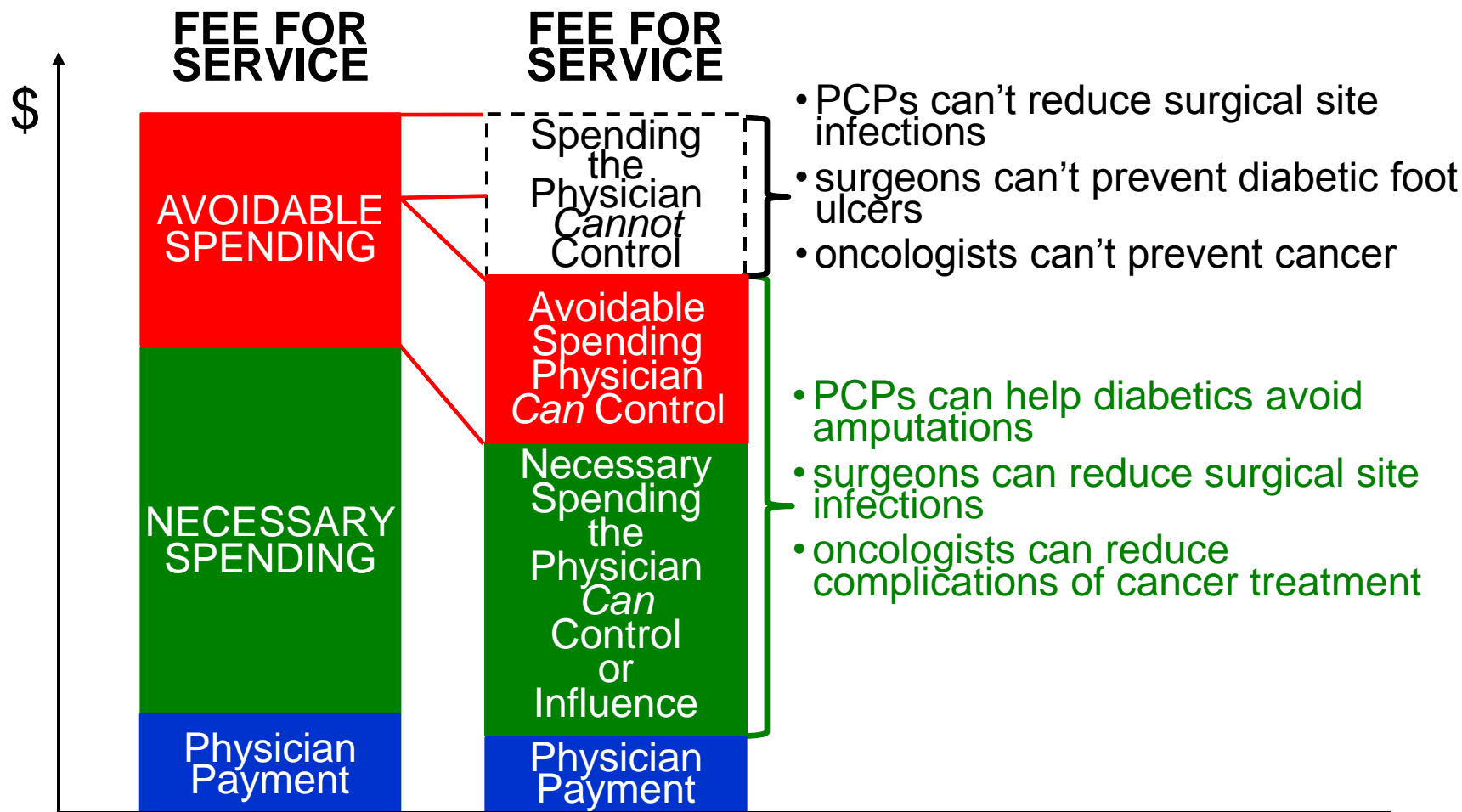
True Alternative Payment Models Can Be Win-Win-Wins



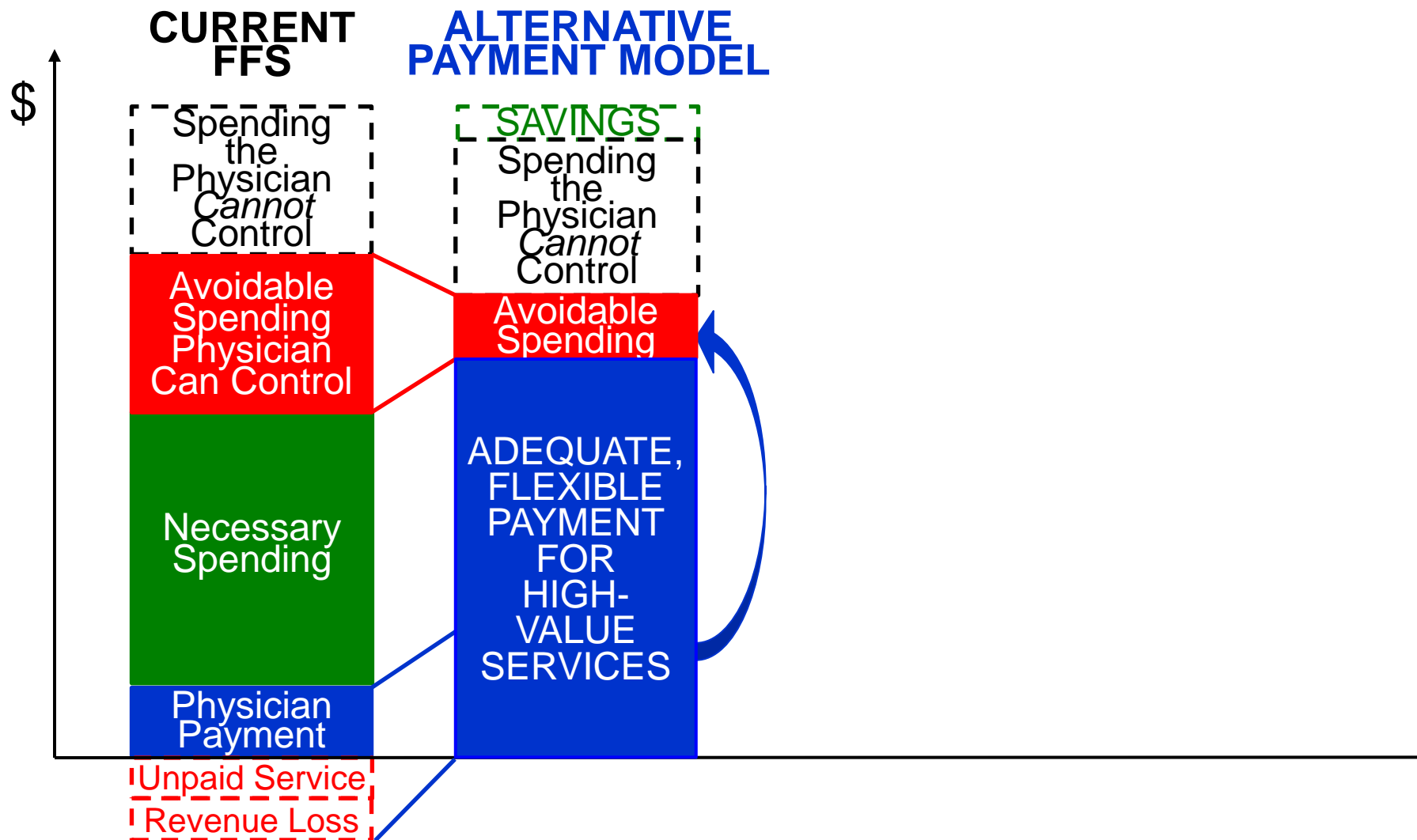
Most Healthcare Spending Doesn't Go to Physicians



But Individual Physicians Can't Control *All* Avoidable Spending

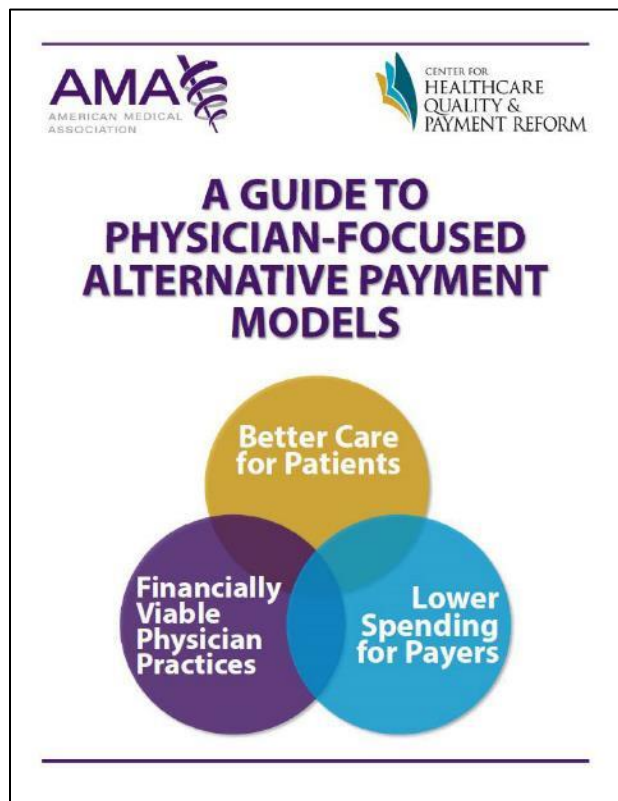


APM Design Must Focus on What Physician *Can* Control



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

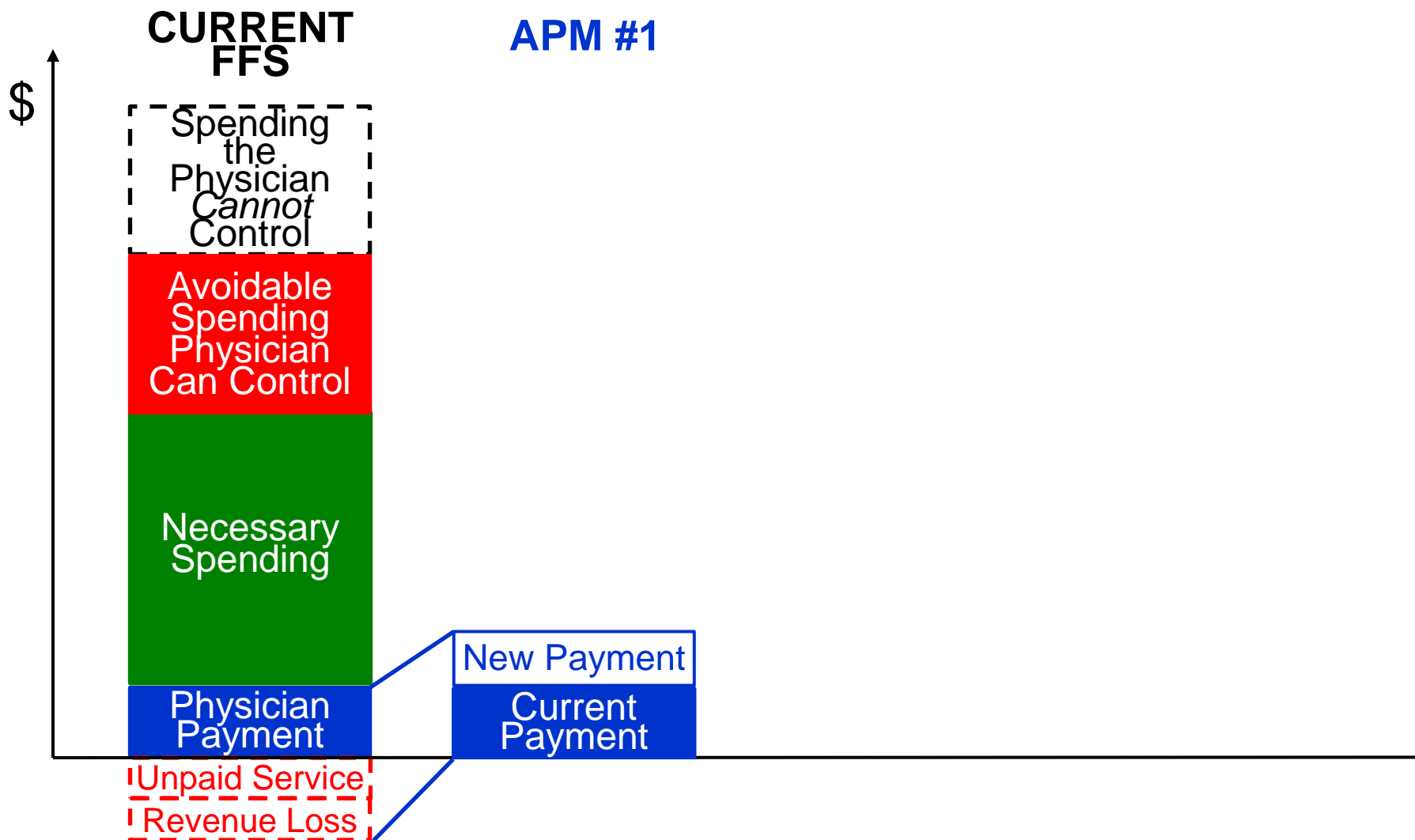
APM #4: Physician-Facility Procedure Bundle

APM #5: Warranted Payment for Physician Services

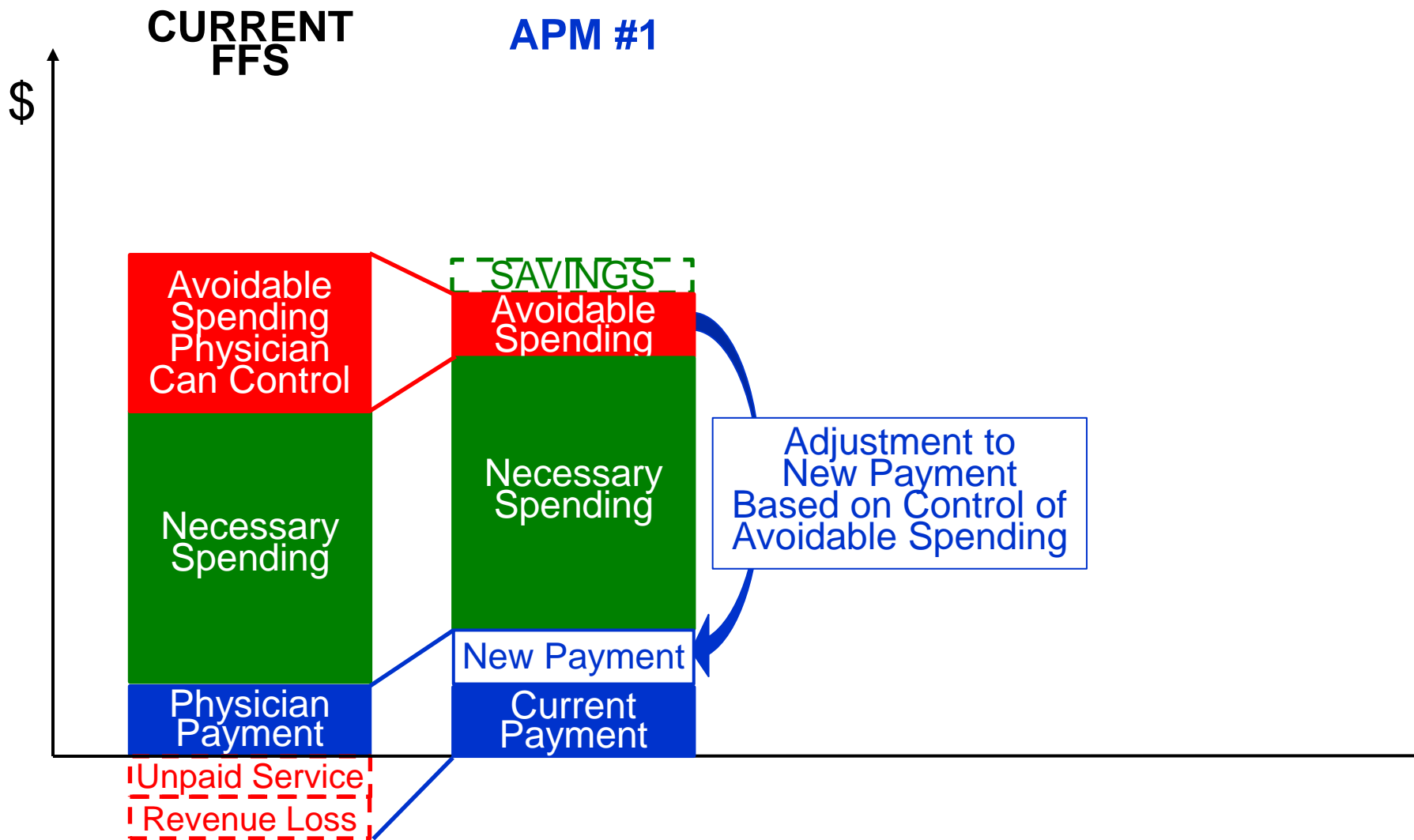
APM #6: Episode Payment for a Procedure

APM #7: Condition-Based Payment

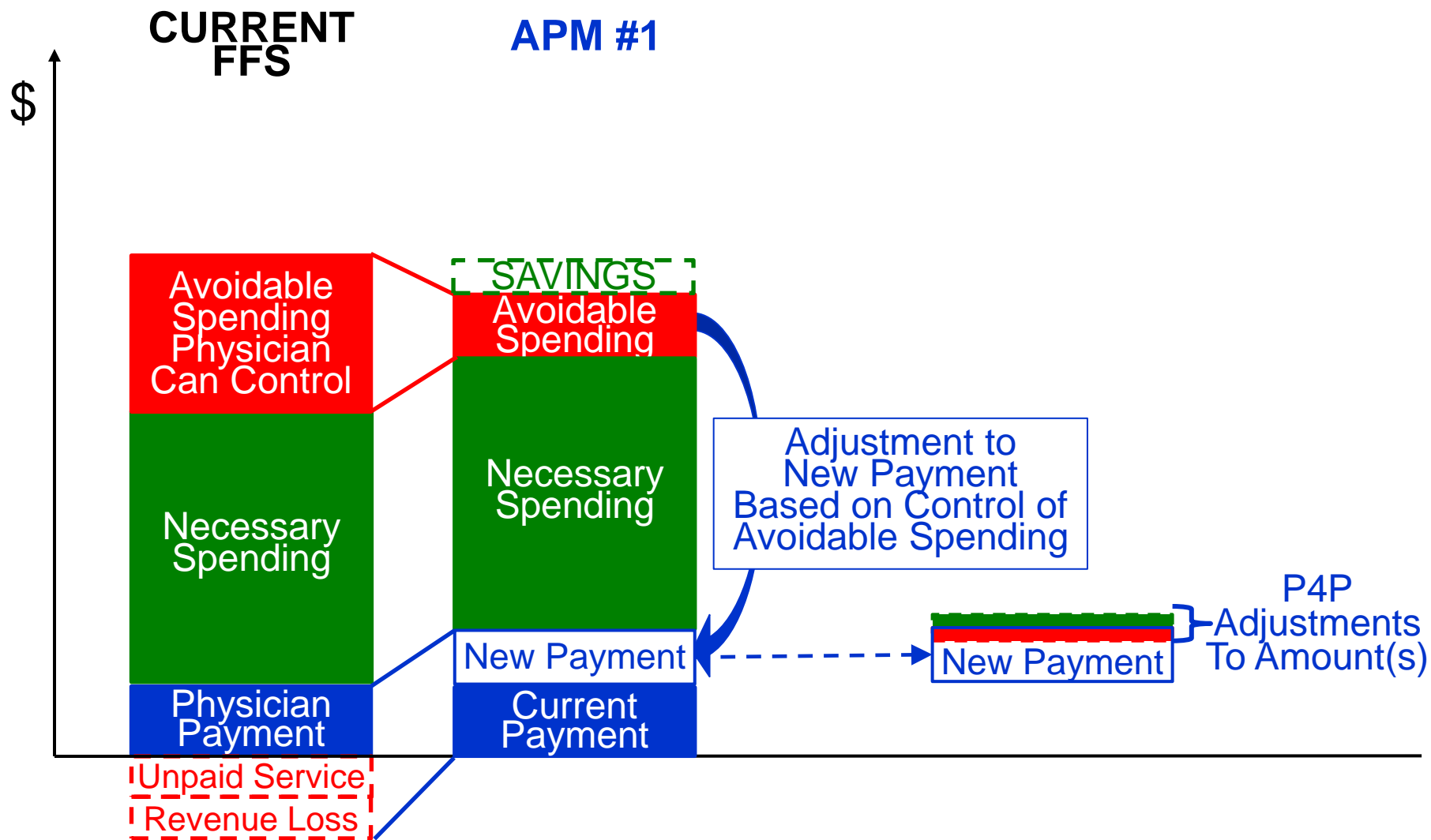
Option 1: Add New Payment(s) to Overcome Current Barriers



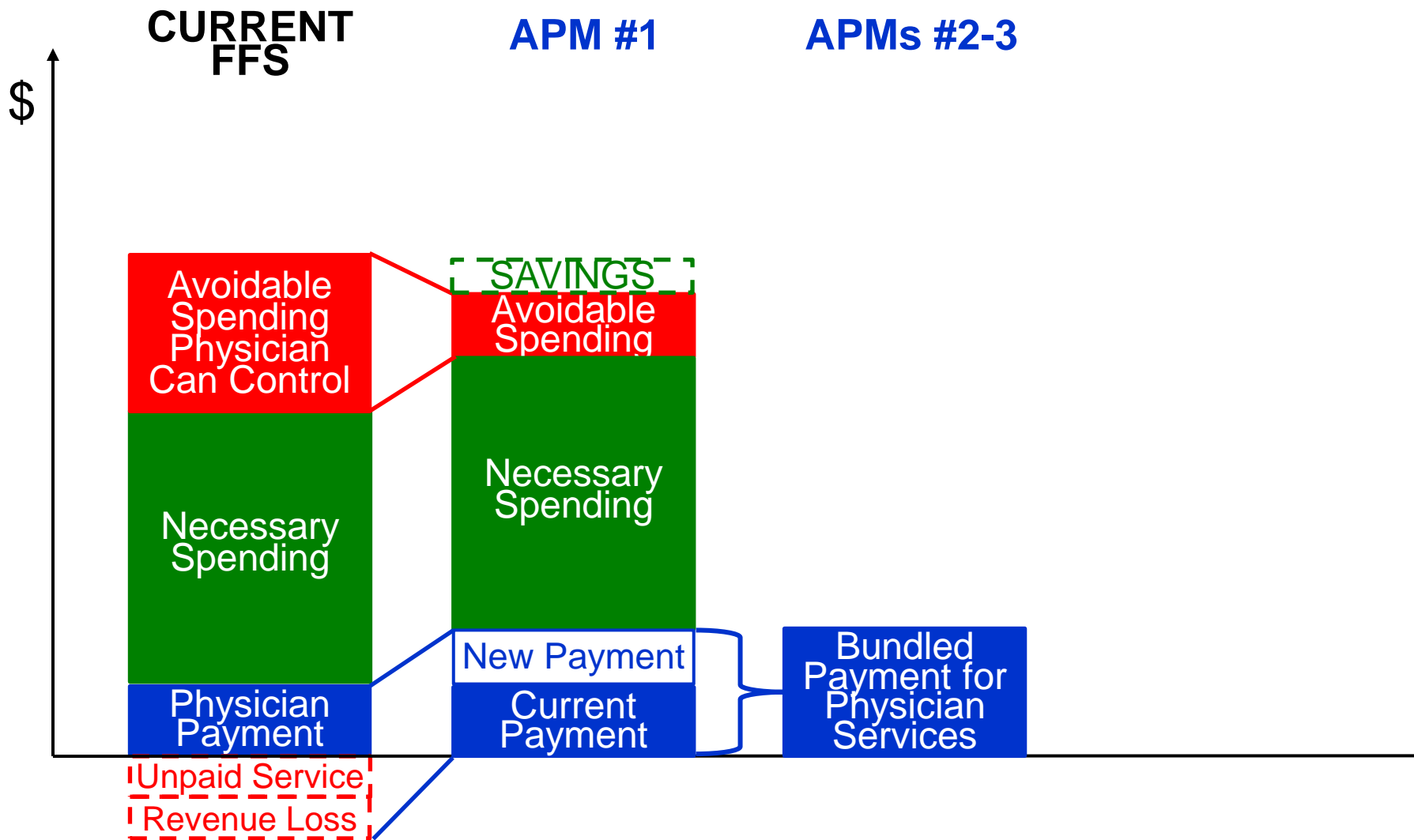
Option 1, Part 2: Add in an Accountability Component



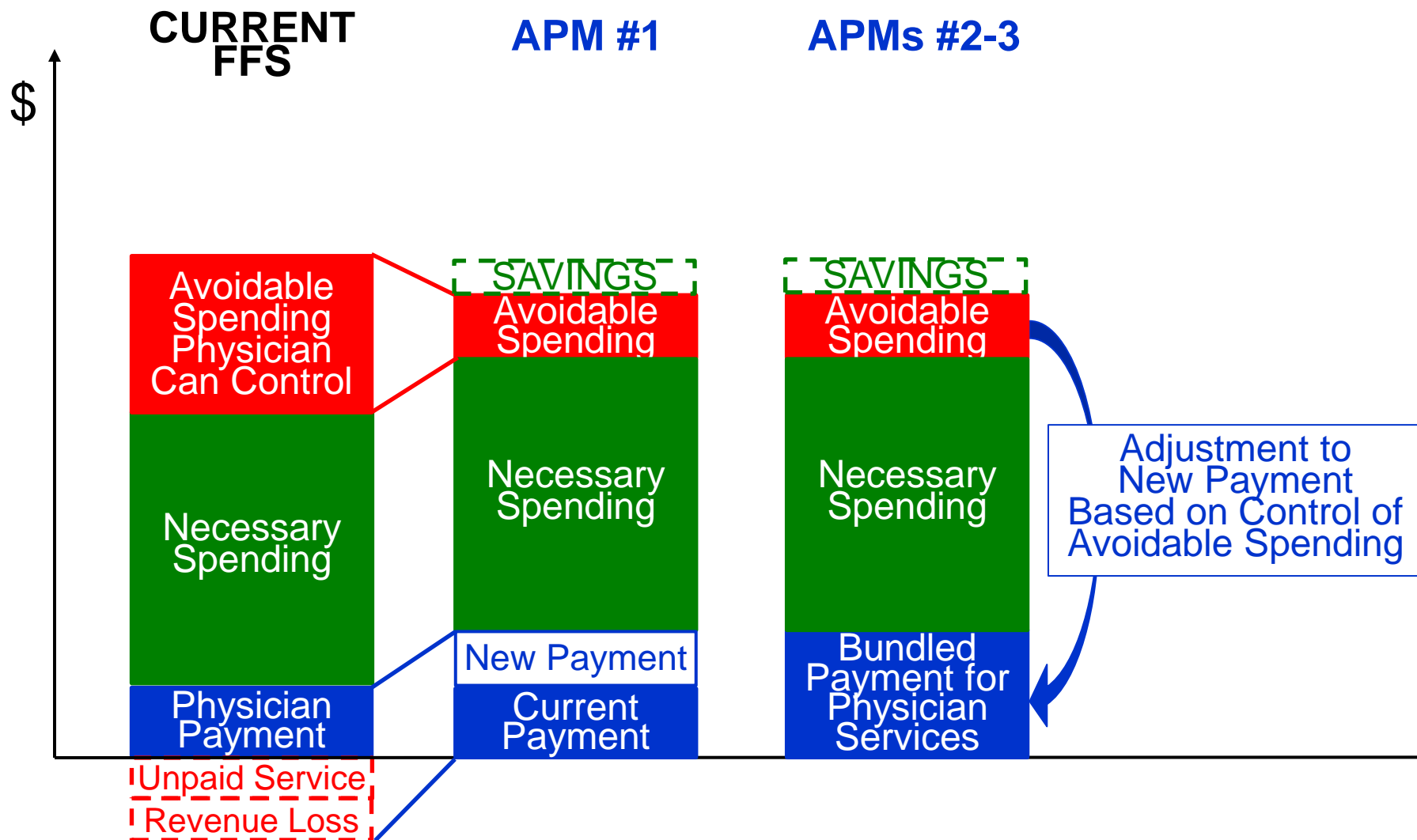
Accountability Component Could Utilize a P4P Approach



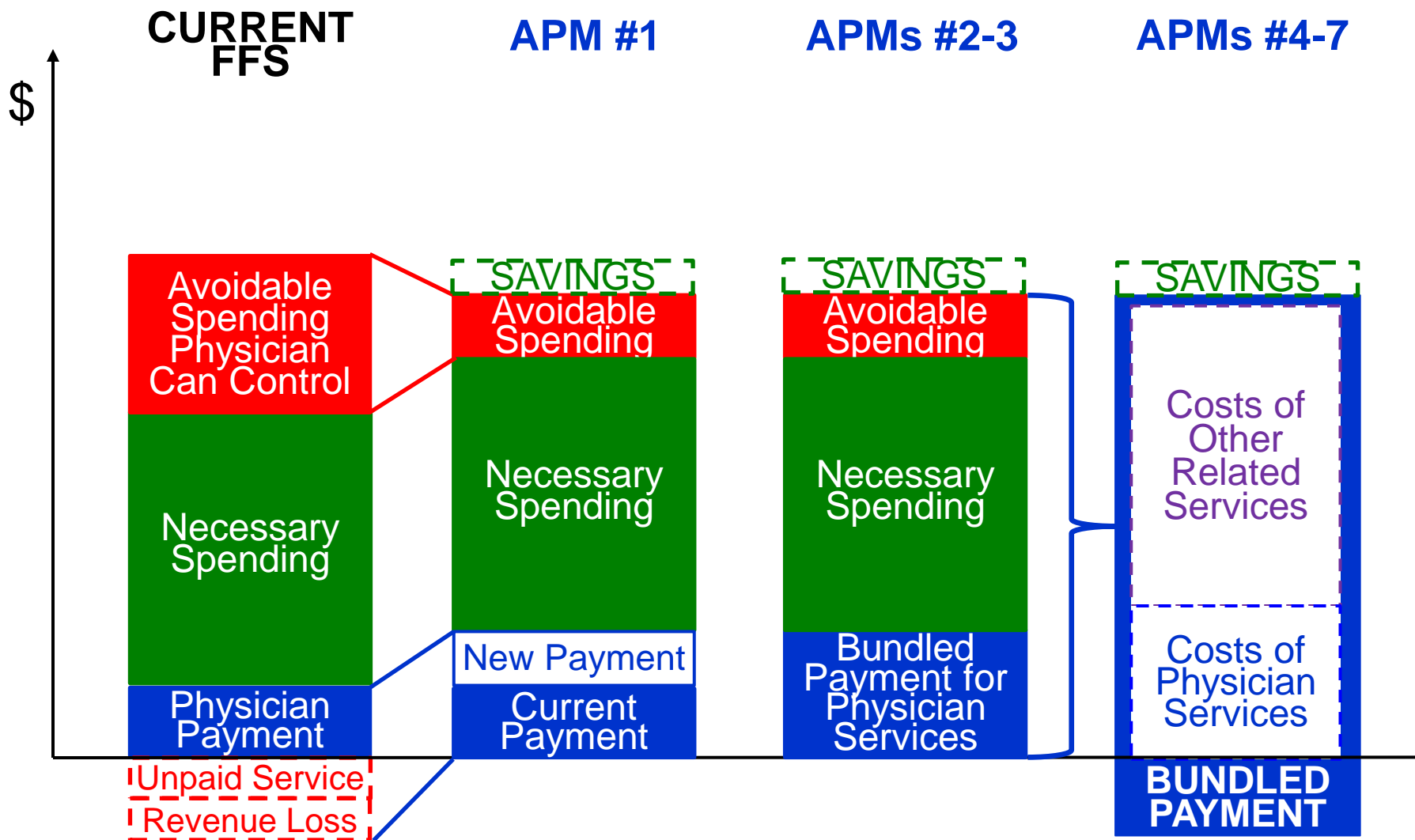
Option 2: Bundle New Payment with Existing Payments



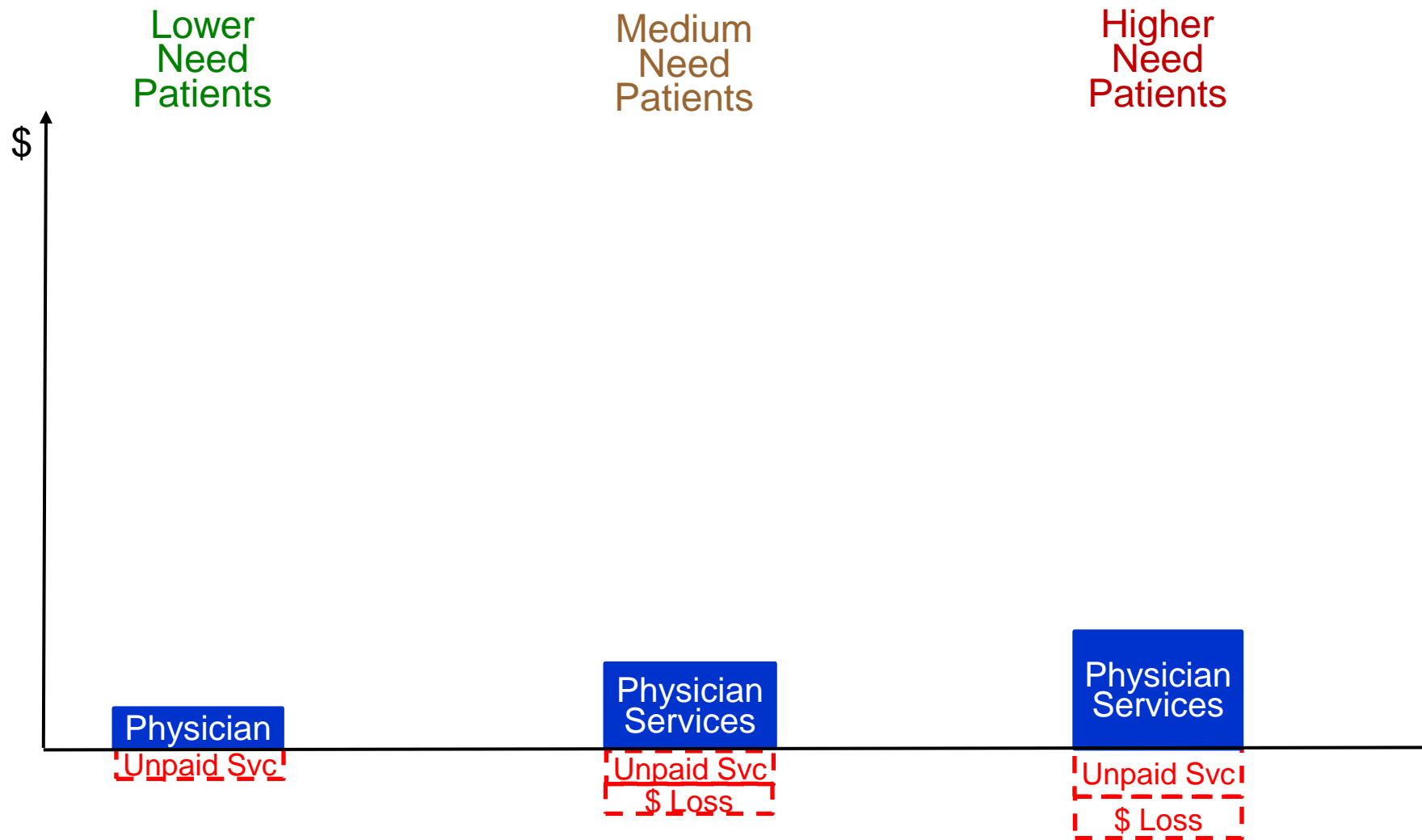
Option 2, Part 2: Add an Accountability Component



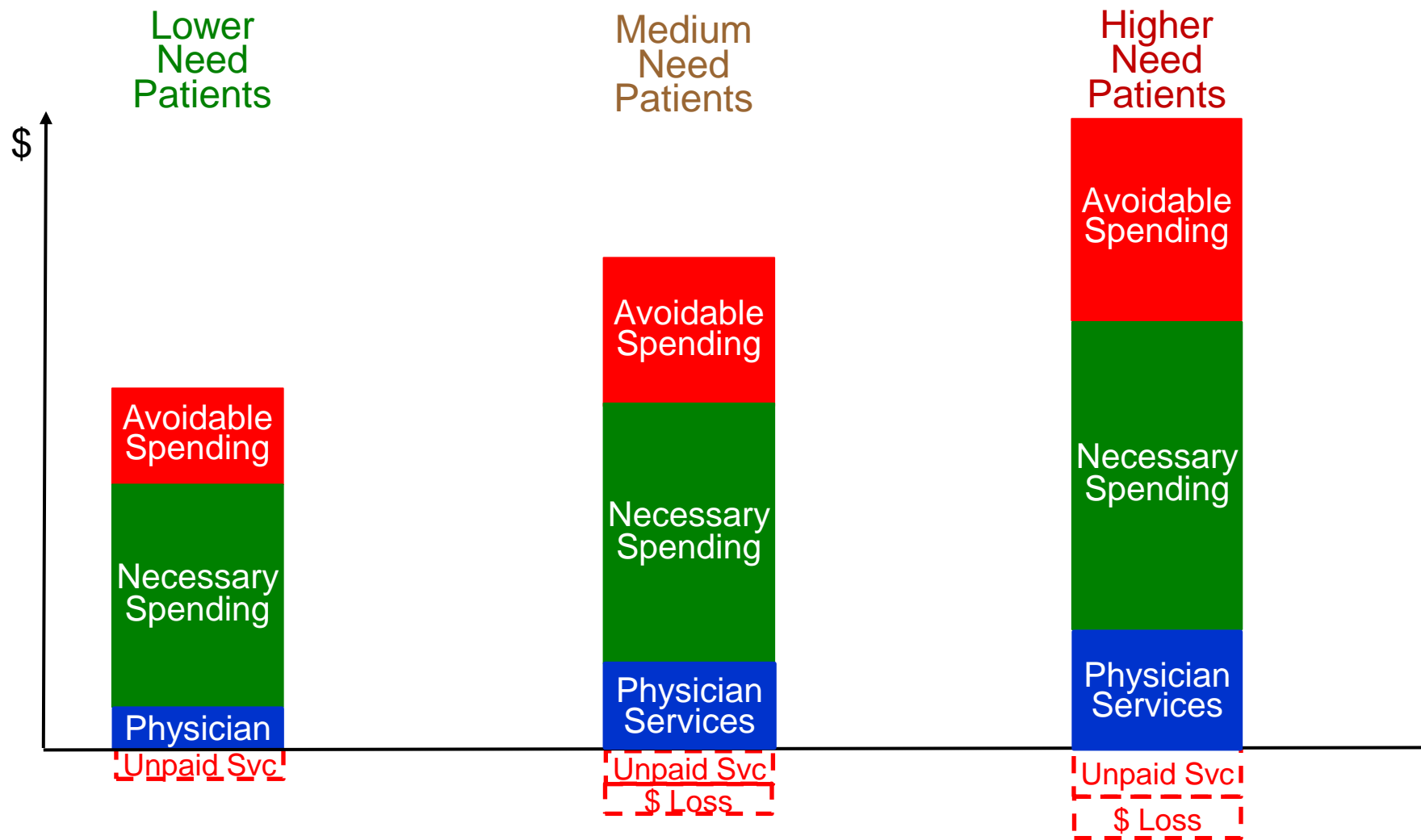
Option 3: Full Bundle Covering Necessary & Avoidable Costs



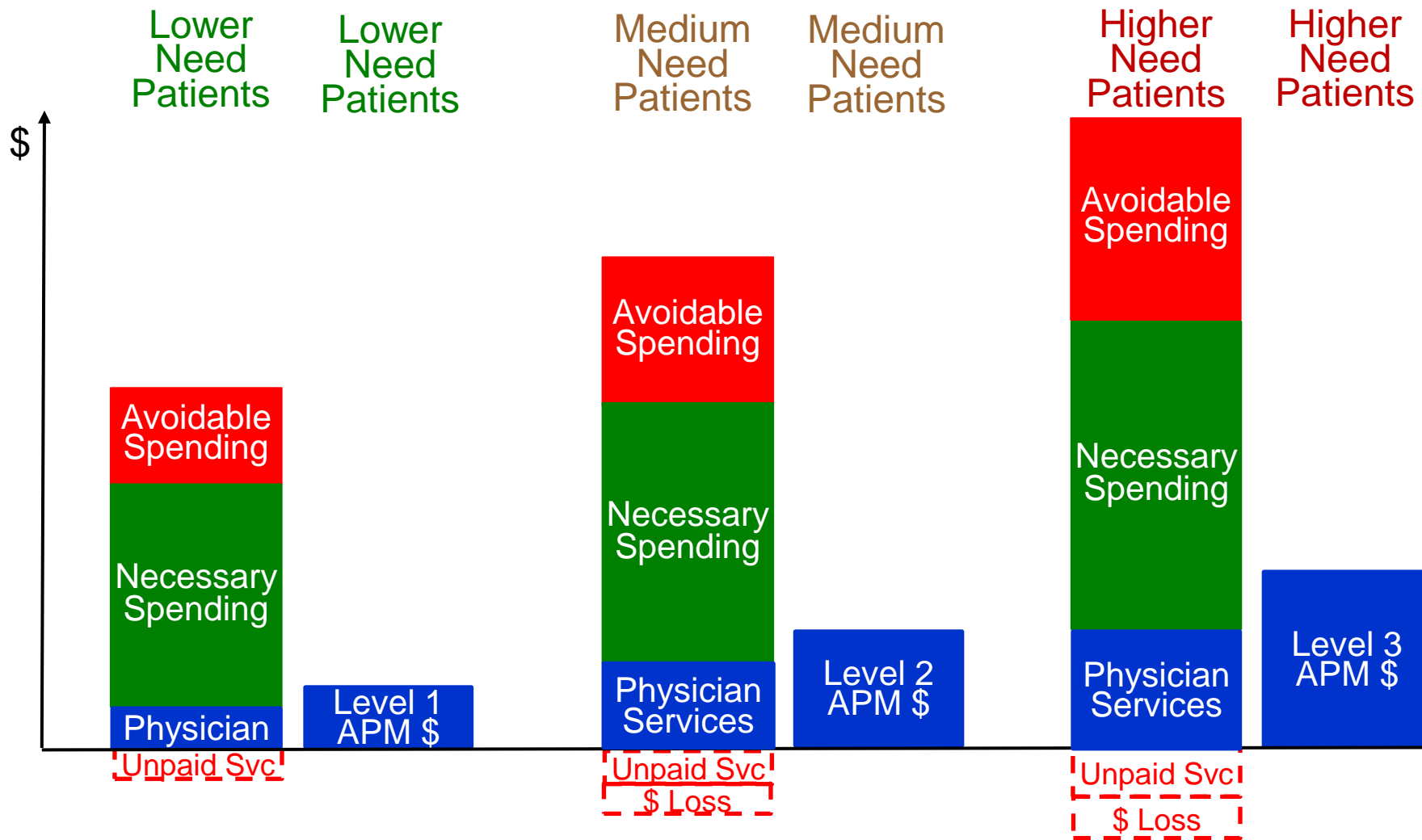
If Patients Differ in the Services They Need...



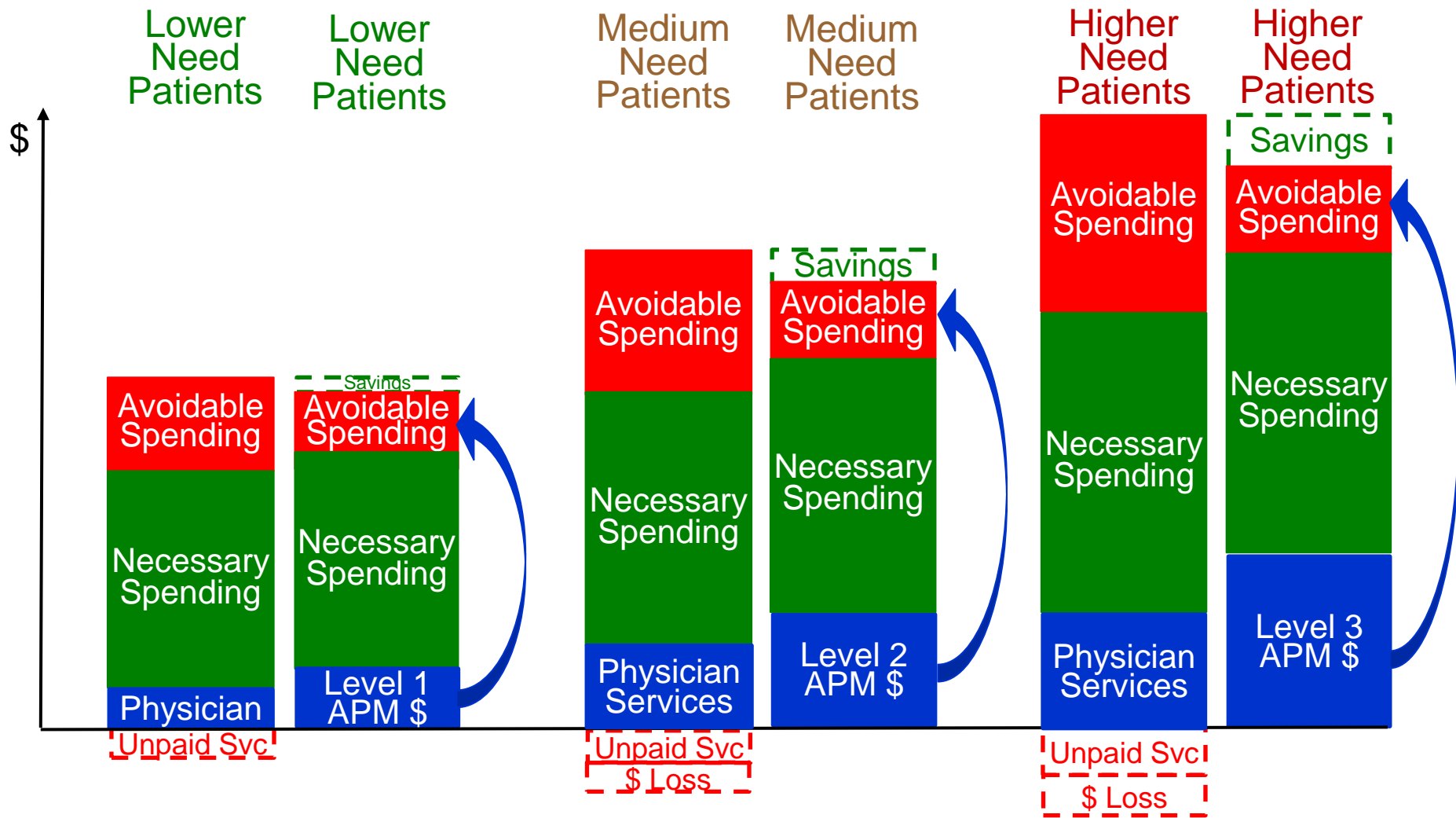
...Or if Patients Differ in Risks & Opportunities for Better Care



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



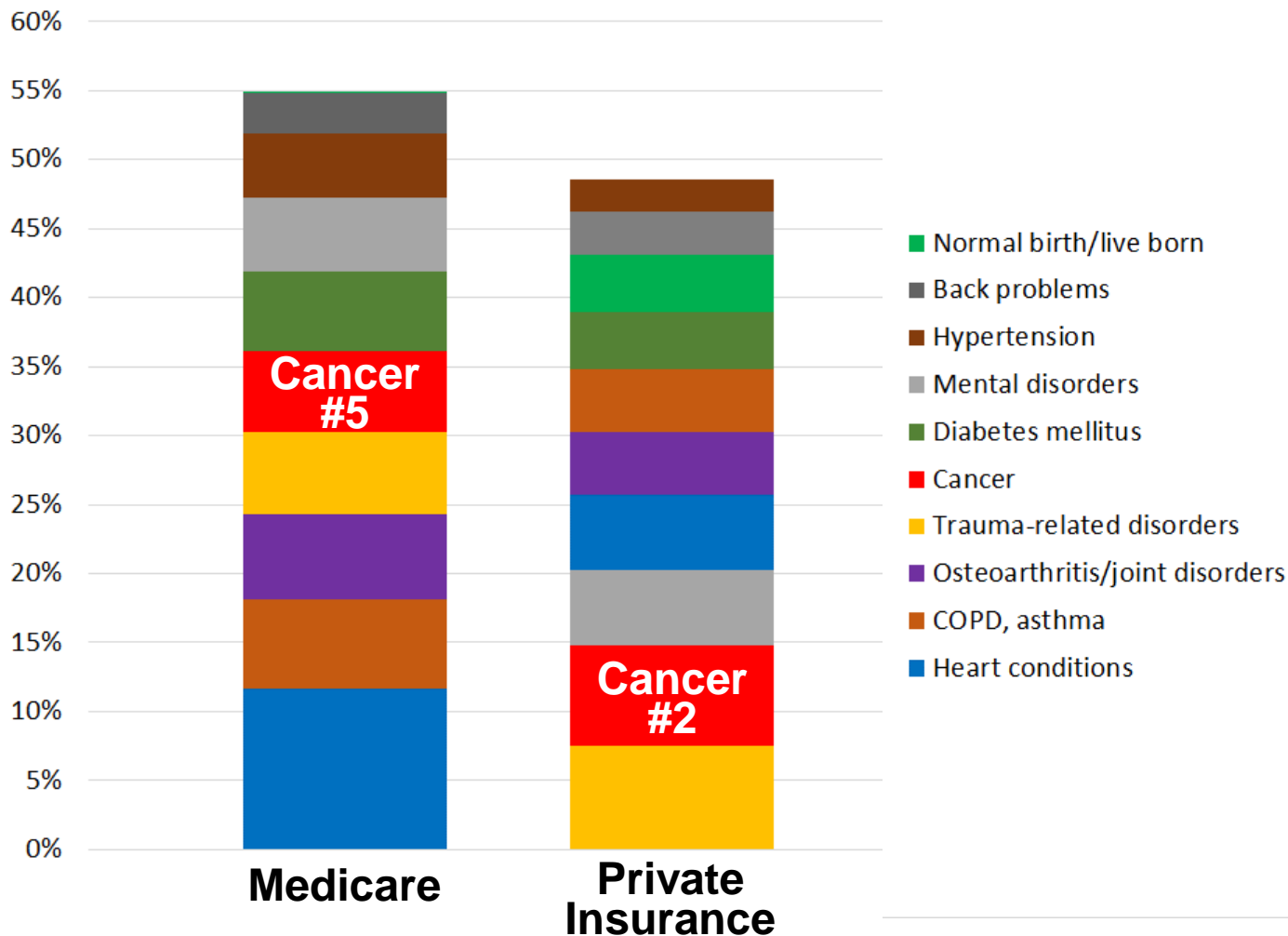
Accountability Targets Need to Be Adjusted for Patient Differences



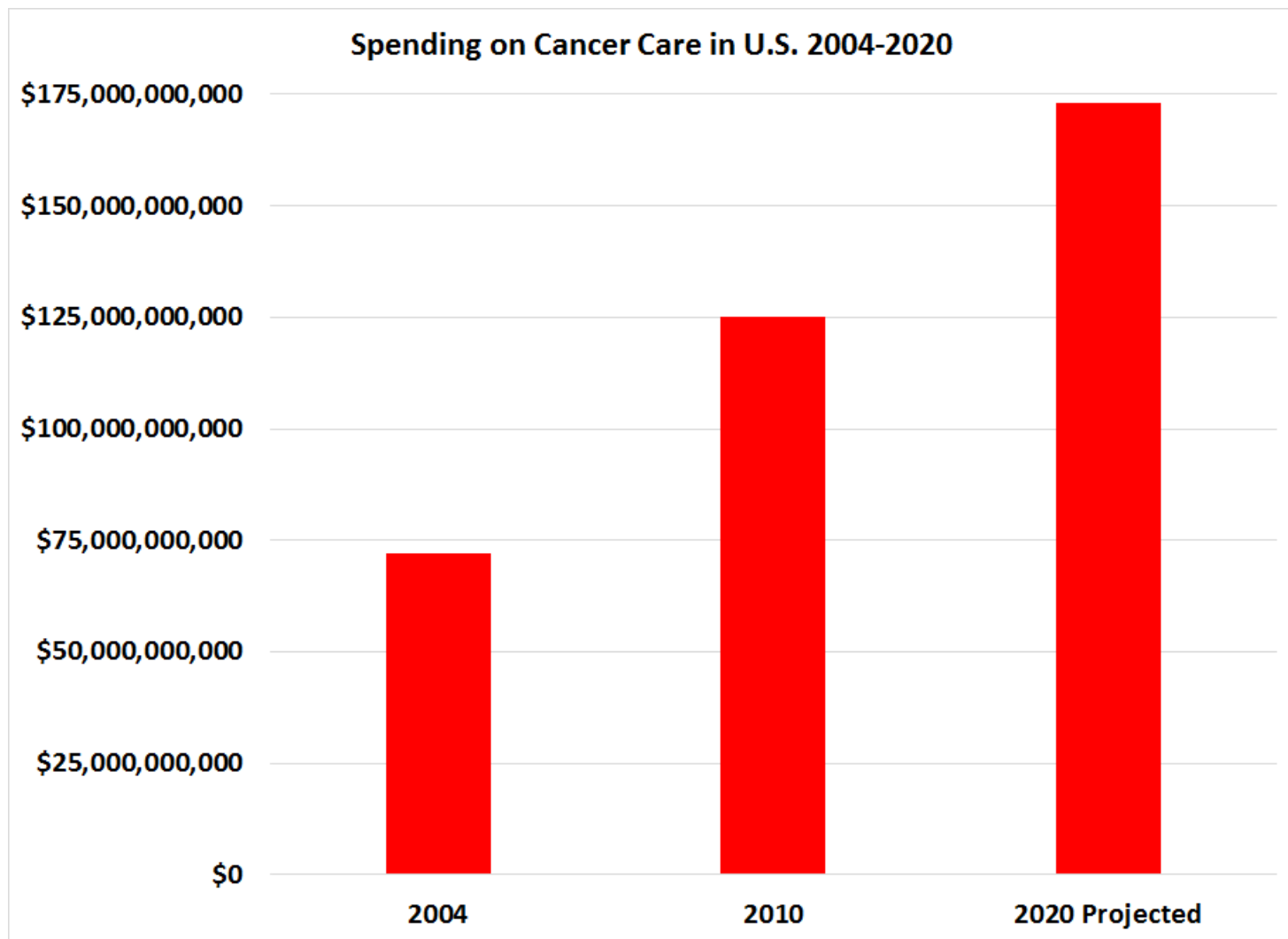
How Does All of This
Apply to Oncology?

Cancer Care is a Big Part of Healthcare Spending

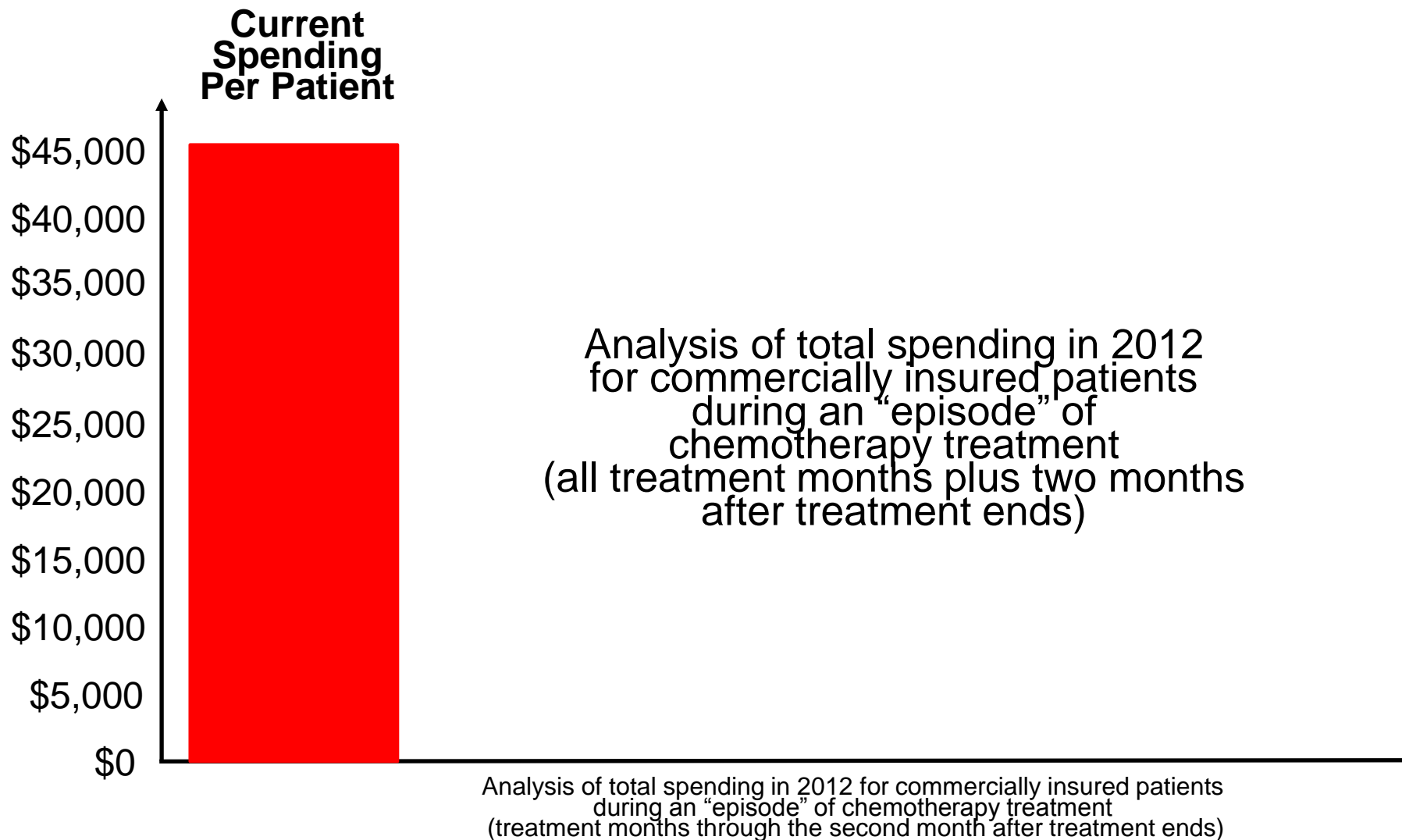
% of Total Healthcare Spending, 2014



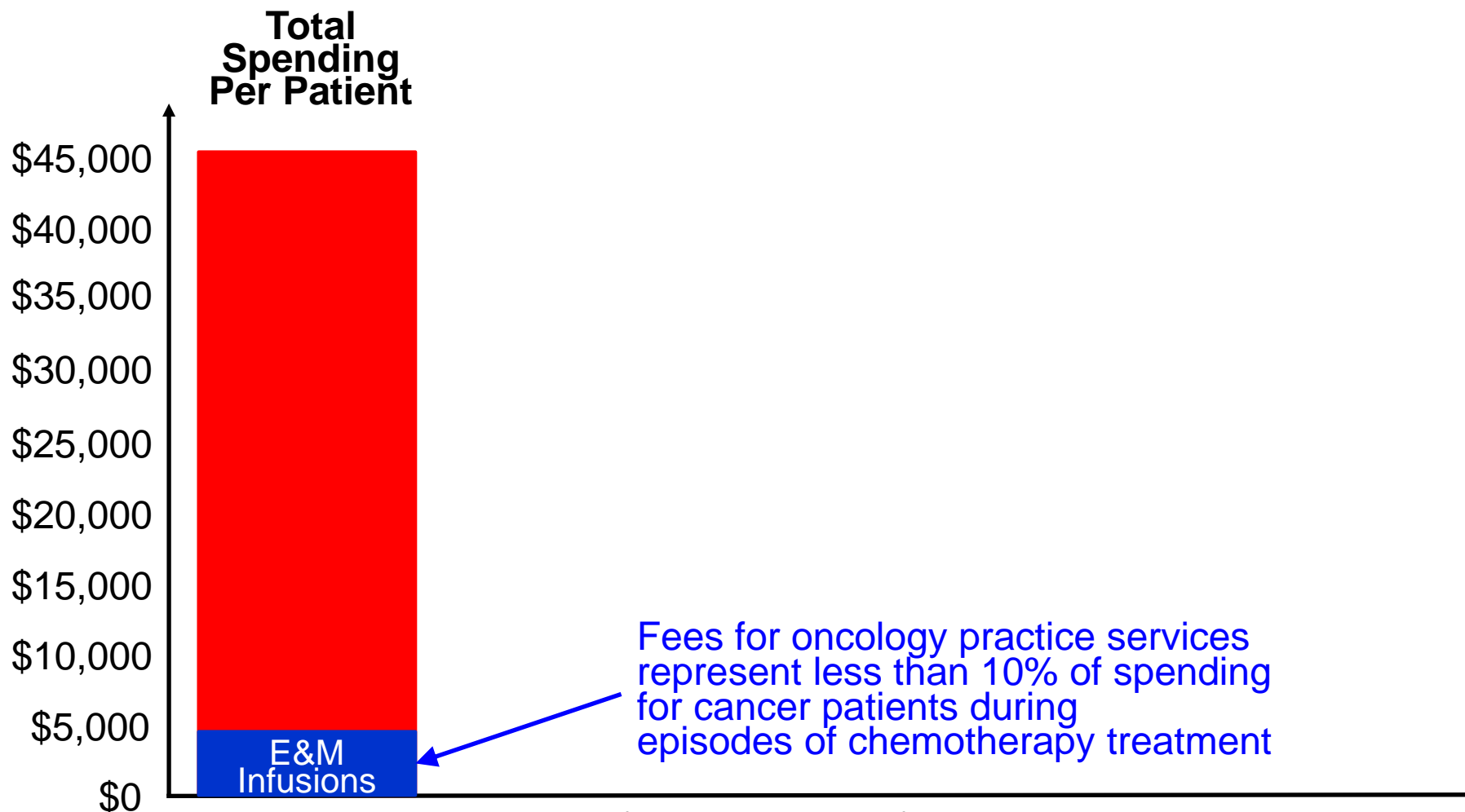
Spending on Cancer Care Has Grown Rapidly



Where Does Spending on Medical Oncology Go?

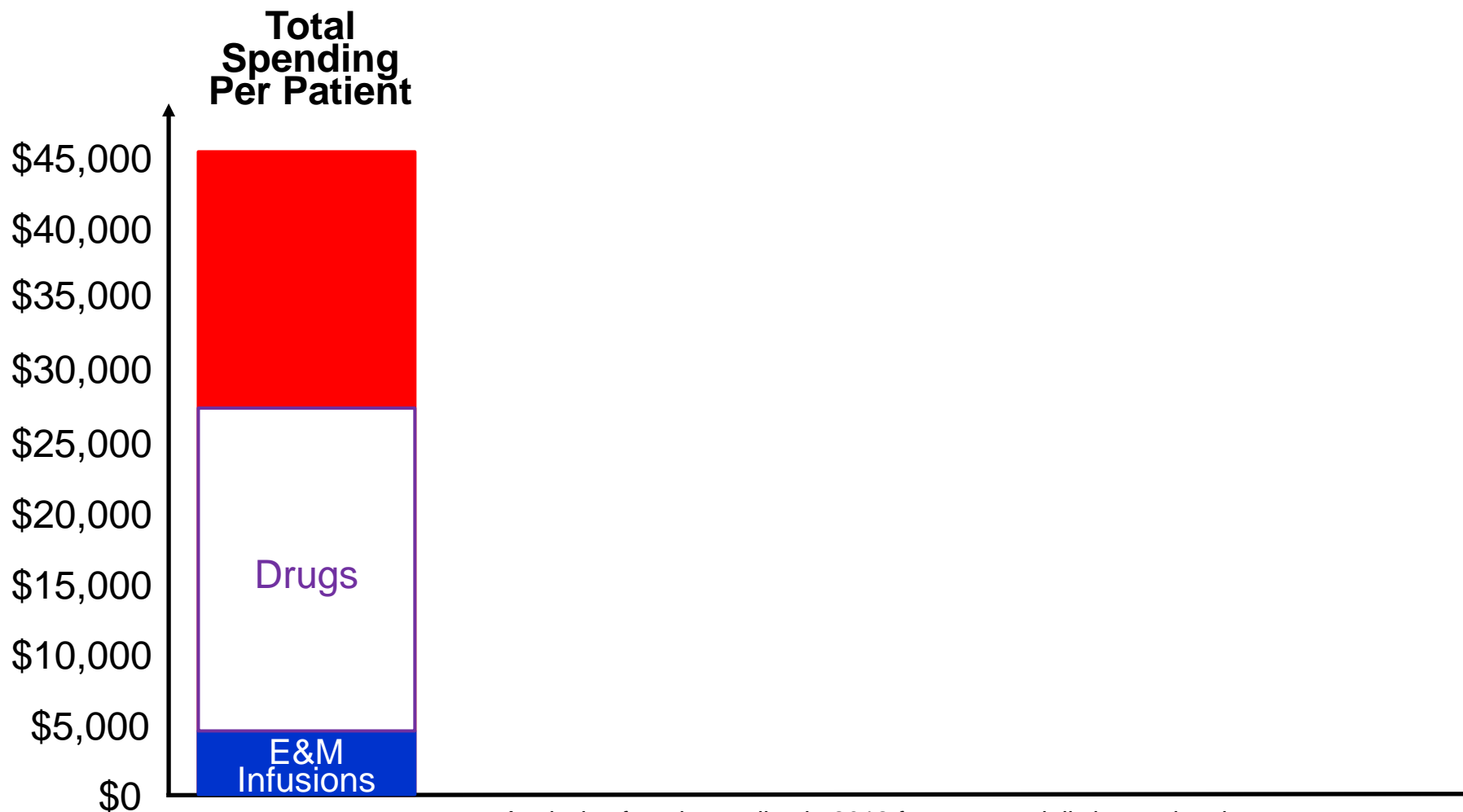


<10% of Spending Pays Oncology Practices for Services



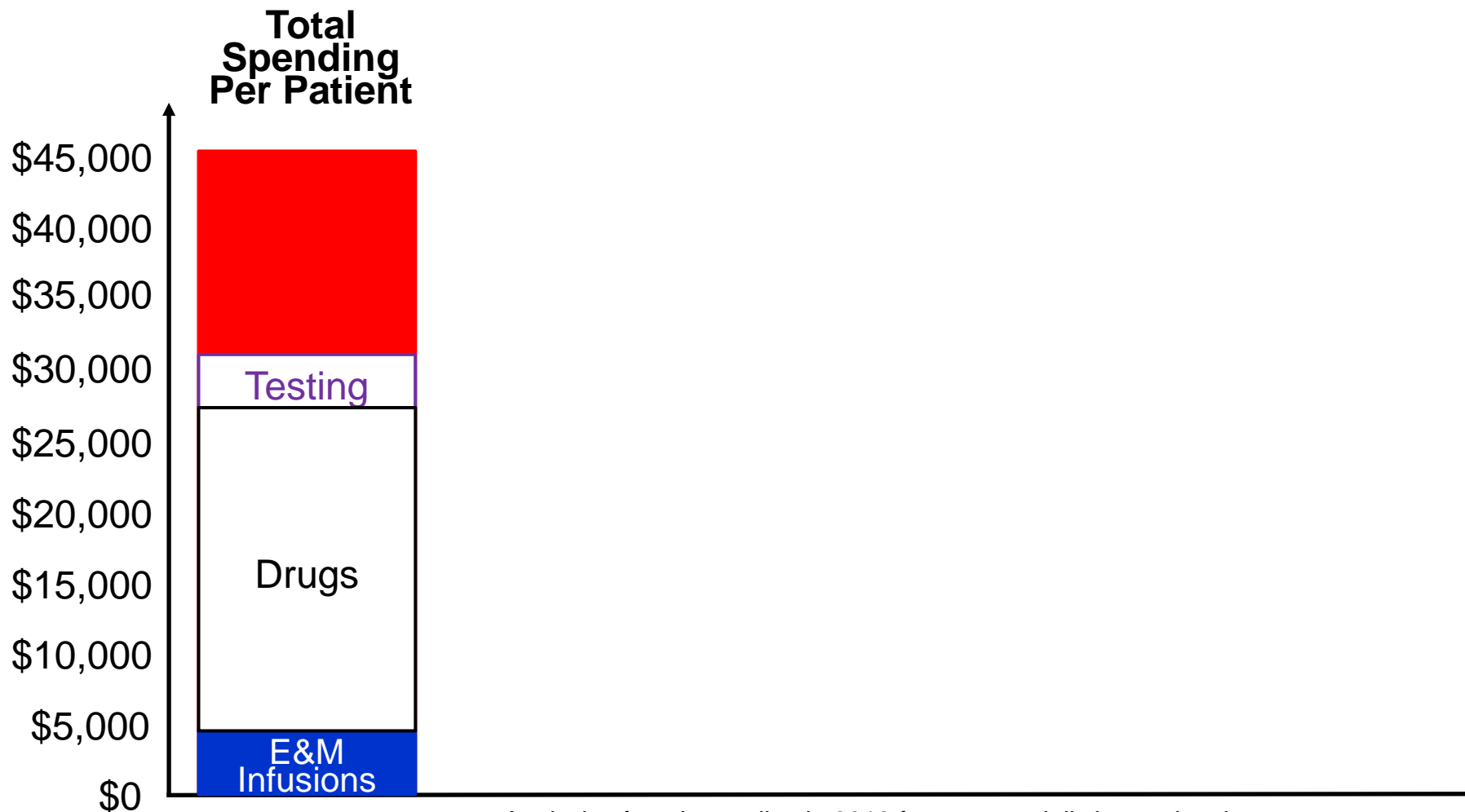
Analysis of total spending in 2012 for commercially insured patients during an "episode" of chemotherapy treatment (treatment months through the second month after treatment ends)

Half of the Spending Goes to Drugs



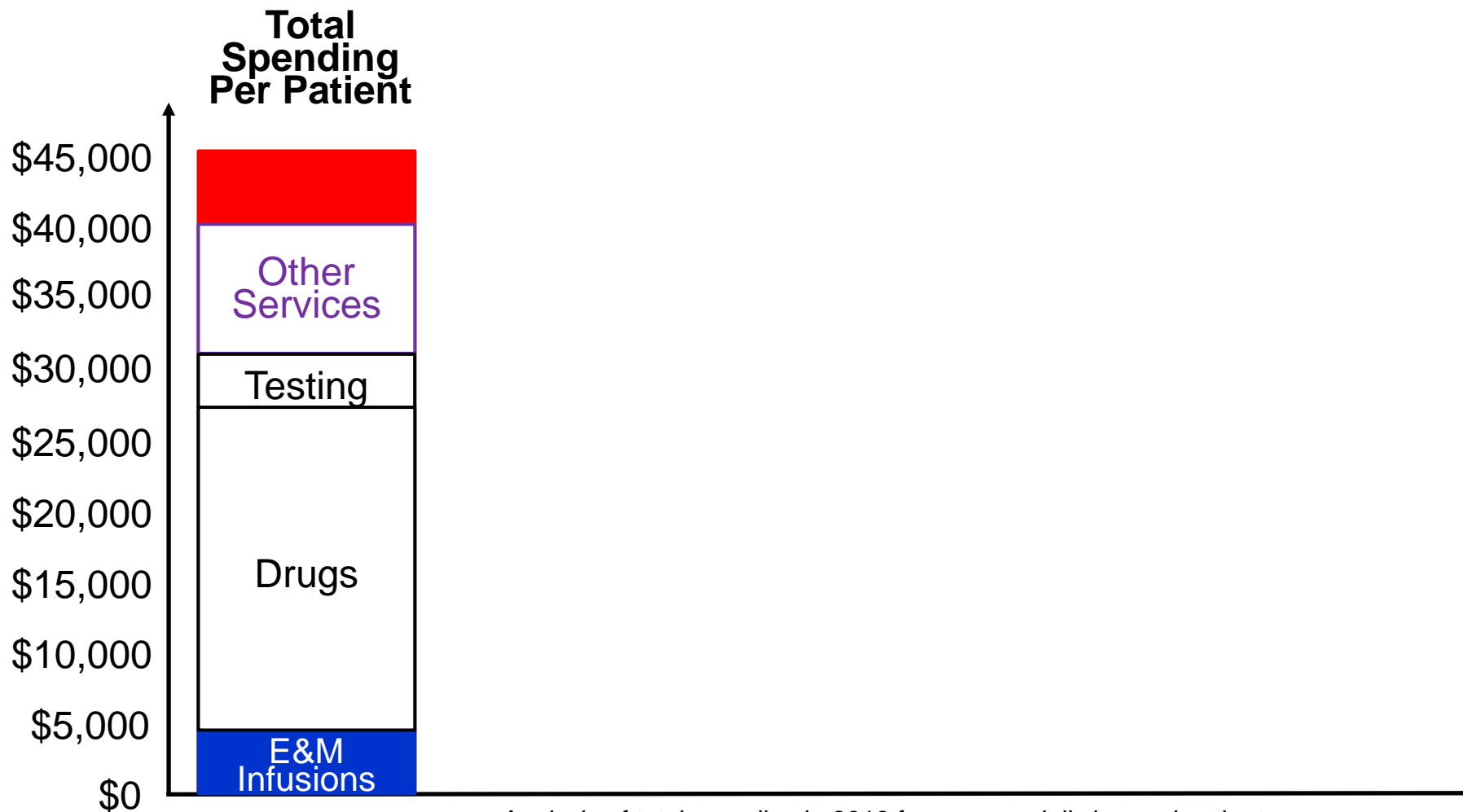
Analysis of total spending in 2012 for commercially insured patients during an "episode" of chemotherapy treatment (treatment months through the second month after treatment ends)

8% of Spending Goes to Laboratory Tests and Imaging



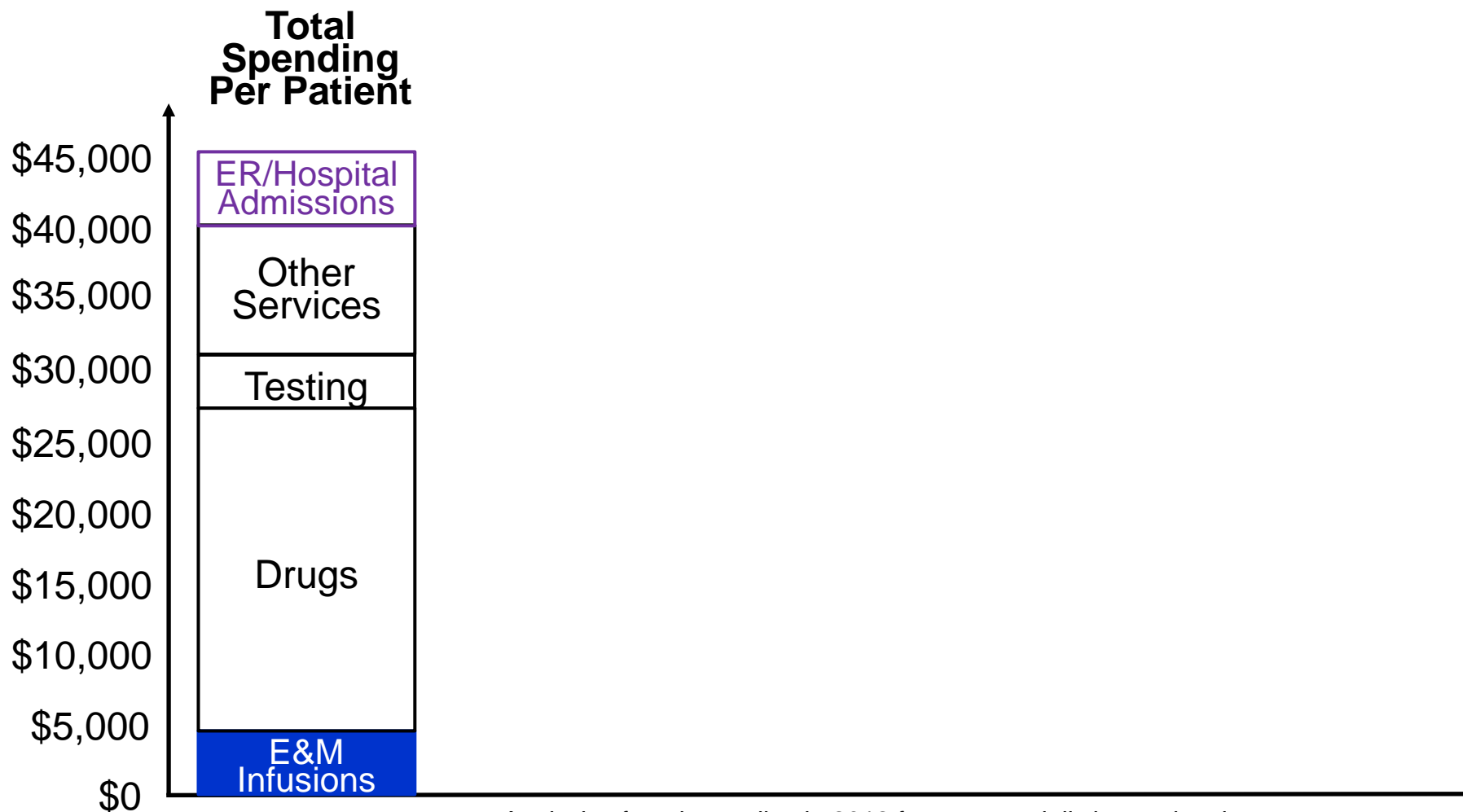
Analysis of total spending in 2012 for commercially insured patients during an “episode” of chemotherapy treatment (treatment months through the second month after treatment ends)

20% Goes to Radiation Therapy, Procedures, and Other Services



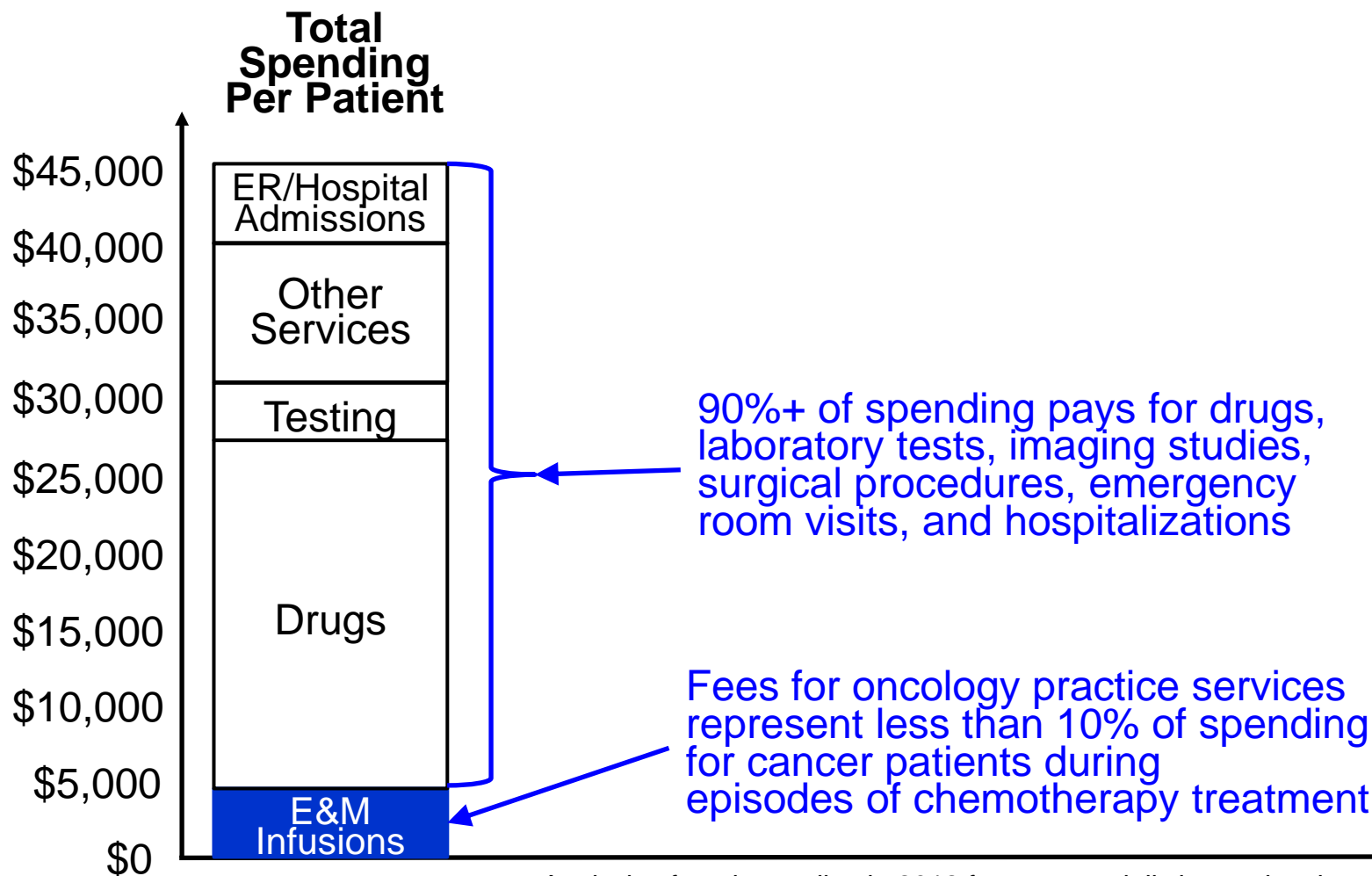
Analysis of total spending in 2012 for commercially insured patients during an “episode” of chemotherapy treatment (treatment months through the second month after treatment ends)

11% of Spending is for ED Visits & Hospital Admissions



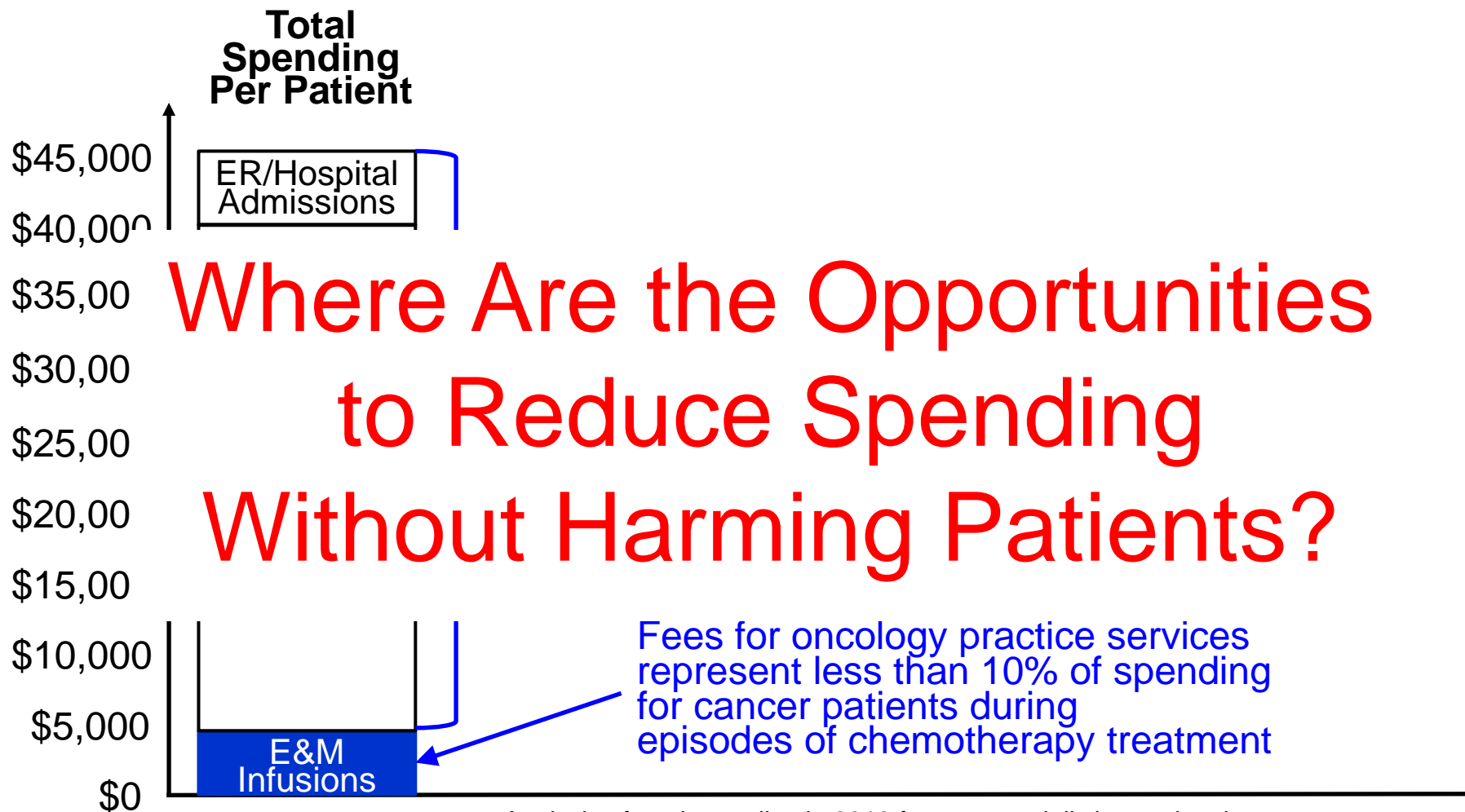
Analysis of total spending in 2012 for commercially insured patients during an “episode” of chemotherapy treatment (treatment months through the second month after treatment ends)

Most \$\$ Go to Drugs, Tests, and Admissions, *Not* Oncology Practices



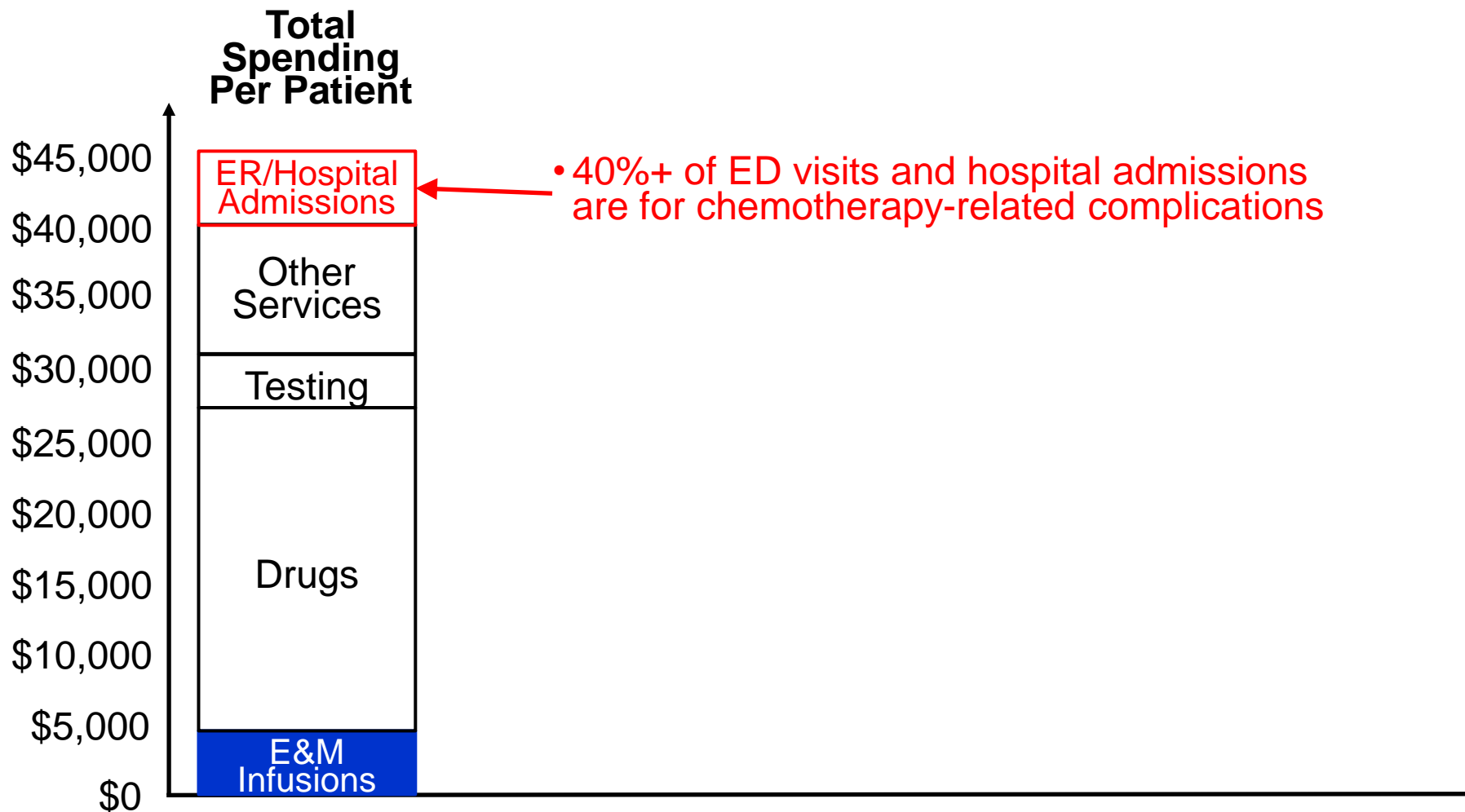
Analysis of total spending in 2012 for commercially insured patients during an "episode" of chemotherapy treatment (treatment months through the second month after treatment ends)

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)

Opportunity 1: Reducing Avoidable ED Visits and Hospitalizations



Large Reductions in Avoidable ED Visits & Hospitalizations

How We Do It

Oncology patient-centered medical home and accountable cancer care

John D. Sprandio, 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 re-engineering 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 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—*notably 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 oncologists are playing an ever-expanding role in 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 fragmented delivery of primary healthcare. In many instances, the delivery of cancer care is also fragmented—fraught with deficiencies in communication, coordination, and accountability. The oncology PCMH (OPCMH) model of cancer care may potentially serve as a practice framework for oncologists. The OPCMH model attempts to promote a value-based agenda that facilitates physician accountability, encourage clinical integration between like-minded medical oncology groups, enhance communication and coordination of care with primary care PCMH models, and collaborate with payers while maintaining a focus on patient needs and evidence-based care.

A backward glance at the PCMH model

A combination of factors has led to the rapid acceptance of the PCMH model in the delivery of primary care: (1) physician 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 actionable information that can be mined from clinical databases; (3) the alignment of incentives among stakeholders, including the largest employers in the United States, medical professional societies, consumers, insurance companies, academic institutions, patient advocacy groups, state Medicaid 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 clinical team.^{1,2}

Unacceptable fragmentation of care

In order to address the fragmentation of care, there are a number of actions that physicians should take:

care for patients across the continuum, improve the coordination of care, establish a standardized comprehensive process of care, adhere to established practice guidelines, utilize a care-team approach, engage and educate patients to enhance involvement in their care, and create innovative ways of communicating with all parties involved.

EMR systems

When fully implemented and enhanced, EMR systems have the potential to promote a culture of continuous improvement that creates practice efficiencies. Furthermore, EMRs can potentially allow physicians to concentrate on their primary responsibilities of making complex medical decisions based on real time, evidence-based data while establishing and maintaining personal relationships with their

Manuscript received November 16, 2010; accepted December 3, 2010.

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Commun Oncol 2010;7:565-572

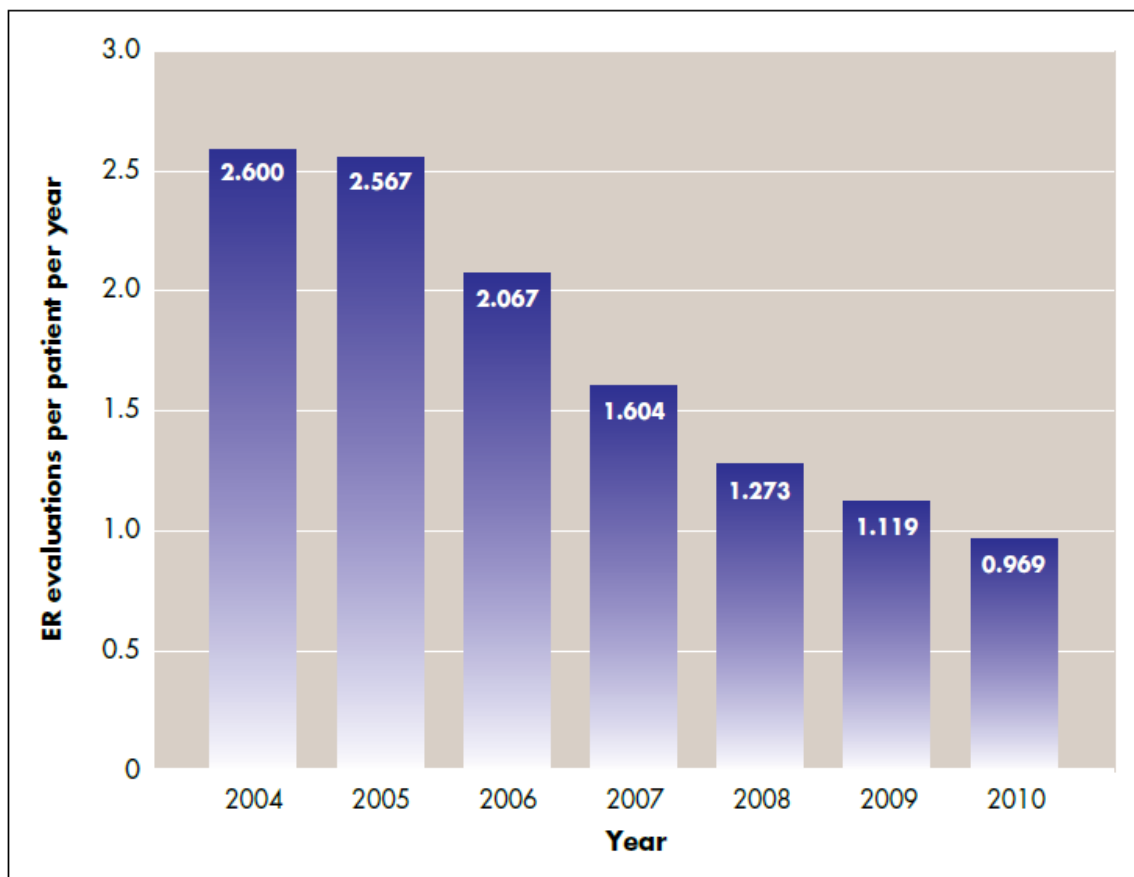


FIGURE 3 Average emergency room (ER) evaluations at Delaware County Memorial Hospital of the Drexel Hill office population per chemotherapy patient per year, 2004–2010 (YTD).

Better Care and Lower Spending Possible For End-of-Life Patients

MEDICARE INNOVATION

By Erin Murphy Colligan, Erin Ewald, Sarah Ruiz, Michelle Spafford, Caitlin Cross-Barnet, and Shriram Parashuram

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 \$5,824 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 \$56,784 for those with melanoma to \$140,891 for those with brain cancer. These far exceed the average \$38,975 per beneficiary Medicare spending in the last year of life.^{1,2} There were approximately 901,000 Medicare beneficiaries with cancer in the last year of life in 2010, and that number is expected to increase to 1.2 million in 2020.¹ Total costs of cancer care in the last year of life amounted to \$37 million in 2010 and will approach \$50 million in 2020.³ 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.^{4,5} 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.⁶⁻⁹

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.^{10,11} 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 fourteen 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.¹²

Though hospice is designed to facilitate patients' end-of-life preferences, keeping patients at home or in a nonclinical environment while reducing pain and psychological stress and pro-

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NO. 3 (2017): 433-440
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The People's Health
Foundation, Inc.

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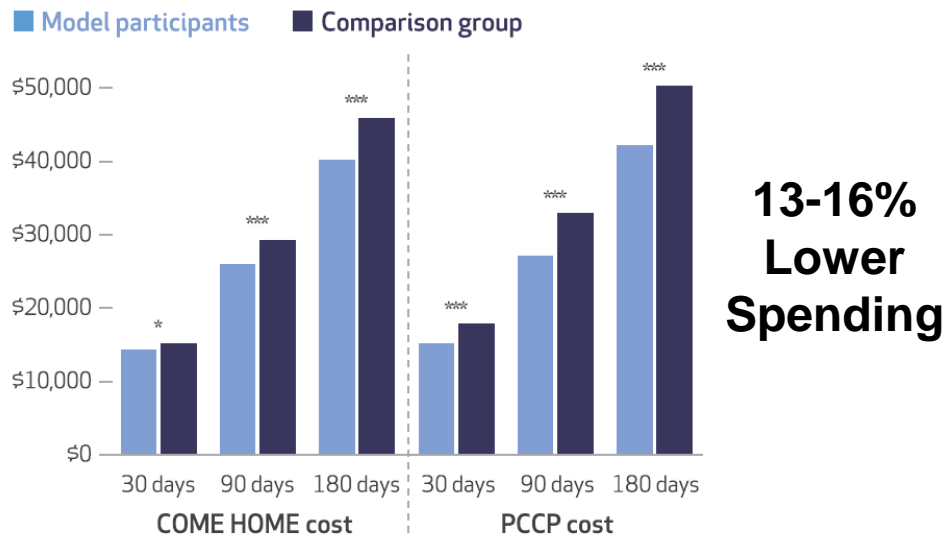
Erin Ewald is a research scientist at NQRC at the University of Chicago in Bethesda, Maryland.

Sarah Ruiz is a senior scientist at the National Institute on Disability, Independent Living, and Rehabilitation Research, in Washington, D.C. This work was completed while she was a senior research scientist at NQRC at the University of Chicago.

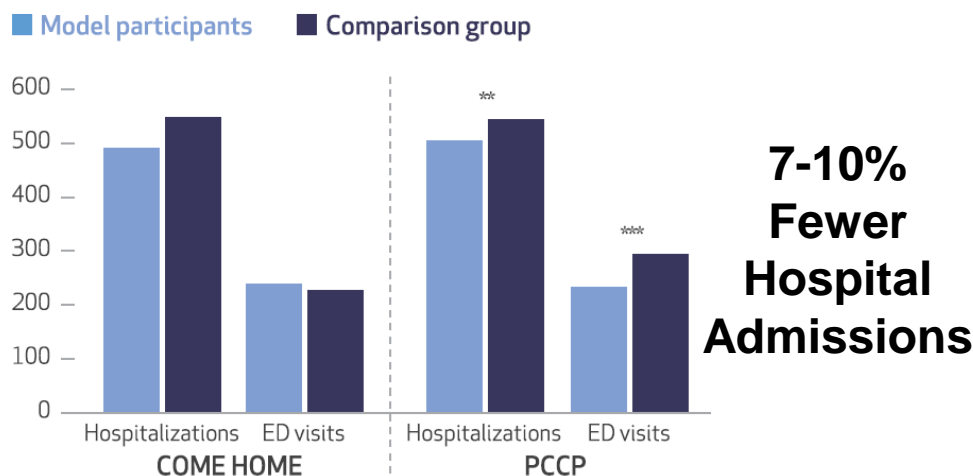
Michelle Spafford (spafford-michelle@norc.org) is a research scientist at NQRC at the University of Chicago.

Caitlin Cross-Barnet is a social science research analyst at the Center for Medicare and Medicaid Innovation.

Shriram Parashuram is a principal health economist at NQRC at the University of Chicago.

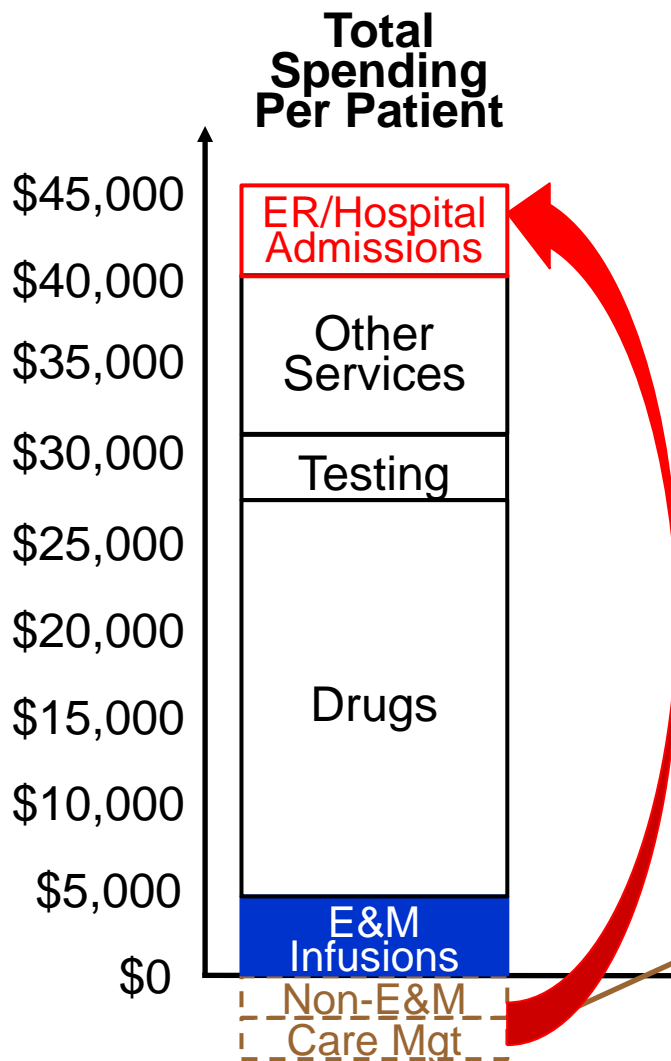


13-16% Lower Spending



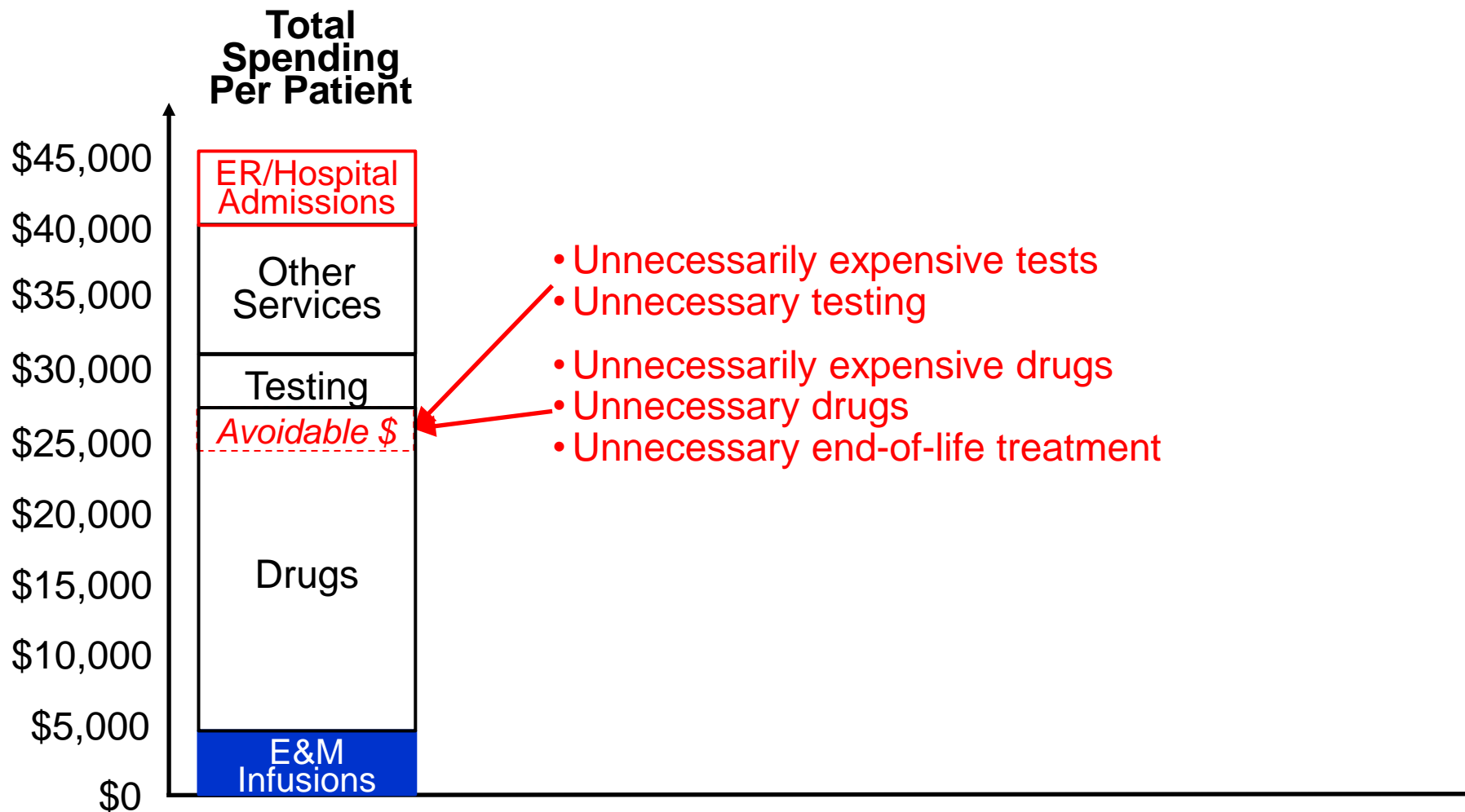
7-10% Fewer Hospital Admissions

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

Opportunity 2: Reducing Avoidable Use of Drugs, Tests, & Imaging




ASCO Choosing Wisely List Targets Areas of High Spending



An initiative of the ABIM Foundation

American Society of Clinical Oncology



American Society of Clinical Oncology

Five Things Physicians and Patients Should Question

The American Society of Clinical Oncology (ASCO) is a medical professional oncology society committed to conquering cancer through research, education, prevention, and delivery of high-quality patient care. ASCO recognizes the importance of evidence-based cancer care and making wise choices in the diagnosis and management of patients with cancer. After careful consideration by experienced oncologists, ASCO highlights five categories of tests, procedures and/or treatments whose common use and clinical value are not supported by available evidence. These test and treatment options should not be administered unless the physician and patient have carefully considered if their use is appropriate in the individual case. As an example, when a patient is enrolled in a clinical trial, these tests, treatments, and procedures may be part of the trial protocol and therefore deemed necessary for the patient's participation in the trial.

- 1

Don't use cancer-directed therapy for solid tumor patients with the following characteristics: low performance status (3 or 4), no benefit from prior evidence-based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anti-cancer treatment.

 - Studies show that cancer directed treatments are likely to be ineffective for solid tumor patients who meet the above stated criteria.
 - Exceptions include patients with functional limitations due to other conditions resulting in a low performance status or those with disease characteristics (e.g., mutations) that suggest a high likelihood of response to therapy.
 - Implementation of this approach should be accompanied with appropriate palliative and supportive care.
- 2

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

 - Imaging with PET, CT, or radionuclide bone scans can be useful in the staging of specific cancer types. However, these tests are often used in the staging evaluation of low-risk cancers, despite a lack of evidence suggesting they improve detection of metastatic disease or survival.
 - Evidence does not support the use of these scans for staging of newly diagnosed low grade carcinoma of the prostate (Stage T1c/T2a, prostate-specific antigen (PSA) <10 ng/ml, Gleason score less than or equal to 6) with low risk of distant metastasis.
 - Unnecessary imaging can lead to harm through unnecessary invasive procedures, over-treatment, 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 low-risk 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 identified ductal carcinoma in situ (DCIS), or clinical stage I or II disease.
 - Unnecessary imaging can lead to harm through unnecessary invasive procedures, over-treatment, 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, over-treatment, unnecessary radiation exposure, and misdiagnosis.
- 5

Don't use white cell stimulating factors for primary prevention of febrile neutropenia for patients with less than 20 percent risk for this complication.

 - ASCO guidelines recommend using white cell stimulating factors when the risk of febrile neutropenia, secondary to a recommended chemotherapy regimen, is approximately 20 percent and equally effective treatment programs that do not require white cell stimulating factors are unavailable.
 - Exceptions should be made when using regimens that have a lower chance of causing febrile neutropenia if it is determined that the patient is at high risk for this complication (due to age, medical history, or disease characteristics).

22%-47% Non-Adherence to Choosing Wisely Criteria

Focus on Quality

Original Contribution

Baseline Estimates of Adherence to American Society of Clinical Oncology/American Board of Internal Medicine Choosing Wisely Initiative Among Patients With Cancer Enrolled With a Large Regional Commercial Health Insurer

By Scott D. Ramsey, MD, PhD, Catherine Fedorenko, MMSci, Rakesh Chauhan, MD, Richard McGee, MD, Gary H. Lyman, MD, MPH, Karma Kreizenbeck, BA, and Aastha Bansal, PhD

Fred Hutchinson Cancer Research Center, University of Washington; and Premera Blue Cross, Seattle, WA

See accompanying article on page 344

Abstract

Purpose: The American Society of Clinical Oncology (ASCO)/American Board of Internal Medicine (ABIM) Choosing Wisely (CW) measures aim to reduce the use of interventions that lack evidence of benefit in cancer care. The study presented here characterized adherence to the 2012 ASCO/ABIM CW recommendations by linking health plan claims data with a regional cancer registry and sought to identify areas for research interventions to improve adherence.

Methods: SEER records for patients diagnosed with cancer in Western Washington State between 2007 and 2014 were linked with enrollment and claims from a large regional commercial insurance plan. Using claims and SEER records, algorithms were developed to characterize adherence to each CW measure. In addition, we calculated differences in total reimbursements and procedure-specific reimburse-

ments for patients receiving adherent and nonadherent care.

Results: A total of 22,350 unique individuals with cancer were linked with insurance enrollment records and met basic eligibility criteria. Overall adherence varied from 53% (breast surveillance) to 76% (breast staging). Within each measure, adherence varied substantially by stage at diagnosis and by cancer site in situations in which the CW measure affected multiple types of cancer. The difference in reimbursements between adherent and nonadherent populations across all five measures was approximately \$50 million.

Conclusion: Adherence to the ASCO/ABIM CW measures varies widely, as does the cost implication of nonadherence. A structured approach to evaluating adherence and cost impact is needed before developing programs aimed at improving adherence to the ASCO/ABIM CW measures.

Introduction

In April of 2012, the American Society of Clinical Oncology (ASCO) and the American Board of Internal Medicine (ABIM) Foundation, as part of the ABIM Choosing Wisely (CW) campaign, released the initial Top Five list of tests and procedures in oncology for which use should be questioned because of their failure to add clinical value (Data Supplement).¹

The CW list was designed to identify practices that are costly, widely used, and for which no evidence exists to support value, and to promote conversations between physicians and patients about using the most appropriate tests and treatments as well as about avoiding care that is unnecessary or for which harm may outweigh the benefits.

Although the CW list was selected after input from more than 200 oncologists, there was no empiric validation of either the prevalence of the care processes that were included, their costs to the health care system, or the accuracy of measurement of these processes in oncology practice. Because these are important issues for health care delivery systems, we used cancer registry and health insurance claims data to test the importance of the practices that were included on the CW list, to retrospectively review oncologists' adherence to these practices, and to

test the feasibility of using administrative data to measure adherence. These are issues of relevance to health care delivery systems and health insurers, given that implementation of the CW recommendations will require substantial investments on many levels.

Accordingly, the primary purpose of this study was to estimate adherence to the ASCO/ABIM recommendations in persons with cancer who are enrolled in a large regional commercial insurance plan. To further evaluate the relative level of cost savings that might be achieved through improving adherence to the measures, we also estimated total health care costs for persons whose care was adherent to CW recommendations versus costs for those with similar characteristics who had nonadherent care. Our findings may be helpful to health care organizations that are considering investment in measures and processes that are designed to improve adherence to the CW recommendations for oncology.

Methods

Setting and Study Population

The study was conducted by Fred Hutchinson Cancer Research Center investigators in conjunction with leaders at Premera

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...



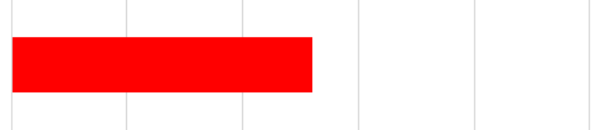
Avoid anticancer therapy in patients with advanced solid tumors who are unlikely to benefit



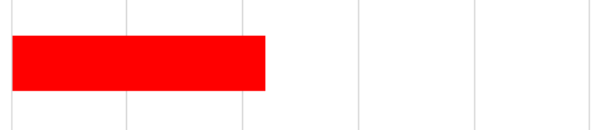
Do not use white-cell stimulating factors for patients undergoing chemotherapy with less than 20% risk of febrile...



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

Original Contribution | CARE DELIVERY

Choosing Wisely: Opportunities for Improving Value in Cancer Care Delivery?

Gabrielle B. Rocque, MD, Courtney P. Williams, MPH, Bradford E. Jackson, PhD, Audrey S. Wallace, MD, MSN, Karina I. Halliava, MD, Kelly M. Kenzik, PhD, Edward E. Partridge, MD, and Maria Pisu, PhD

University of Alabama at Birmingham, Birmingham, AL

Abstract

Introduction

Patients, providers, and payers are striving to identify where value in cancer care can be increased. As part of the Choosing Wisely (CW) campaign, ASCO and the American Society for Therapeutic Radiology and Oncology have recommended against specific, yet commonly performed, treatments and procedures.

Methods

We conducted a retrospective analysis of Medicare claims data to examine concordance with CW recommendations across 12 cancer centers in the southeastern United States. Variability for each measure was evaluated on the basis of patient characteristics and site of care. Hierarchical linear modeling was used to examine differences in average costs per patient by concordance status. Potential cost savings were estimated on the basis of a potential 95% adherence rate and average cost difference.

Results

The analysis included 37,686 patients with cancer with Fee-for-Service Medicare insurance. Concordance varied by CW recommendation from 39% to 94%. Patient characteristics were similar for patients receiving concordant and nonconcordant care. Significant variability was noted across centers for all recommendations, with as much as an 89% difference. Nonconcordance was associated with higher costs for every measure. If concordance were to increase to 95% for all measures, we would estimate a \$19 million difference in total cost of care per quarter.

Conclusion

These results demonstrate ample room for reduction of low-value care and corresponding costs associated with the CW recommendations. Because variability in concordance was driven primarily by site of care, rather than by patient factors, continued education about these low-value services is needed to improve the value of cancer care.

INTRODUCTION

Because health care costs are rising at an unsustainable rate,¹ patients, providers, and payers are collectively striving to identify where value in cancer care can be increased and how the triple aim of better health,

better health care, and lower cost can be achieved.² The American Board of Internal Medicine's Choosing Wisely (CW) campaign aims to improve value by targeting low-value services in medicine and thus increase quality of care while lowering cost.³

ASSOCIATED CONTENT

Appendix DQR 10.1200/JOP.2016.015396

DOI: 10.1200/JOP.2016.015396 published online ahead of print at ascopubs.org/journal/jop on November 15, 2016.

Rate of Non-Adherence to Choosing Wisely Guidelines

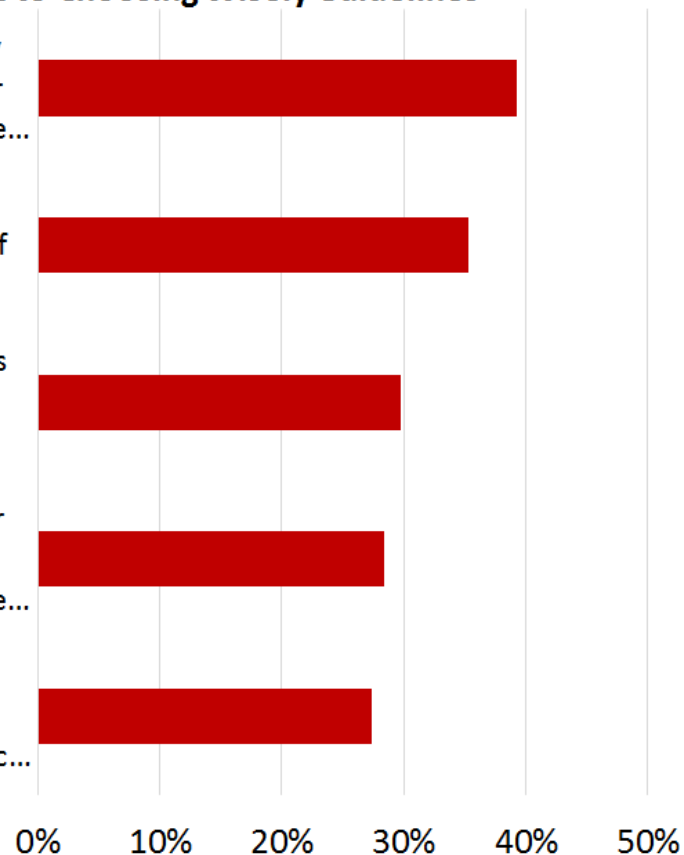
Do not use combination chemotherapy when treating metastatic breast cancer unless the patient needs rapid response...

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

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...

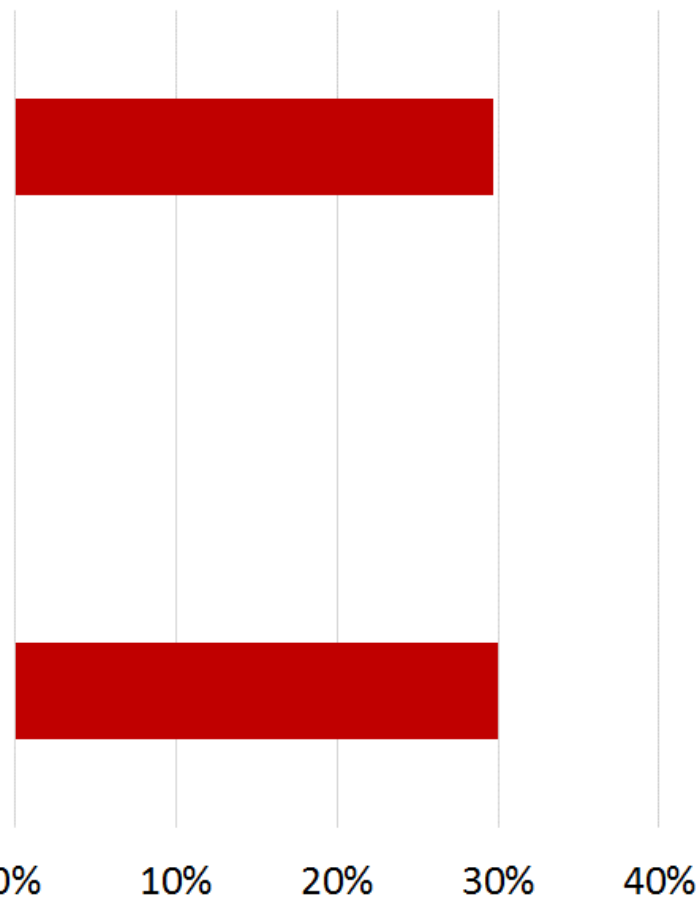
Do not give patients starting a chemotherapy regimen with low or moderate risk of nausea an antiemetic...



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

Focus on Quality
Original Contribution

Baseline Estimates of Adherence to American Society of Clinical Oncology/American Board of Internal Medicine Choosing Wisely Initiative Among Patients With Cancer Enrolled With a Large Regional Commercial Health Insurer

By Scott D. Ramsey, MD, PhD, Catherine Fedorenko, MMS, Rahul Chaudhri, MD, Richard McGee, MD, Gary H. Lyman, MD, MPH, Karina Krotzschok, BA, and Anusha Basal, PhD
Fred Hutchinson Cancer Research Center, University of Washington, and Princess Max Grace, Seattle, WA
See accompanying article on page 545

Abstract
Purpose: The American Society of Clinical Oncology (ASCO) and American Board of Internal Medicine (ABIM) Choosing Wisely[®] initiative aim to reduce the use of interventions for low evidence of benefit in cancer care. The study presented here established adherence to the ASCO/ABIM CW initiative among patients with cancer enrolled with a regional commercial health insurer and sought to identify areas for research and quality improvement initiatives.
Methods: ICD9 records for patients diagnosed with cancer in western Washington state between 2010 and 2014 were linked with enrollment and claims from a large regional commercial insurance plan. Using claims and ICD9 records, algorithms were developed to characterize adherence to each CW measure. In addition, we calculated adherence to total reimbursements and procedure-specific reimbursements for patients receiving adherent and nonadherent care.
Results: A total of 22,226 unique individuals with cancer were identified with insurance enrollment records and met basic eligibility criteria. Overall adherence across the 126 CW items averaged 66.5%. Broadly, adherence was most consistent with a regional commercial health insurer. Adherence was most consistent by step in diagnosis and by cancer site in initiation of care. The CW initiative showed modest impact on adherence in reimbursements between adherent and nonadherent populations, except for measures regarding chemotherapy.
Conclusion: Adherence to the ASCO/ABIM CW initiative varies widely, so does the cost reduction of nonadherence. A structured approach to evaluating adherence and cost impact is needed before developing programs aimed at improving adherence to the ASCO/ABIM CW initiative.

Introduction
In April of 2012, the American Society of Clinical Oncology (ASCO) and the American Board of Internal Medicine (ABIM) Foundation, as part of the ABIM Choosing Wisely (CW) campaign, released the initial Top 10 list of items and procedures to evaluate the health care system to quantify burden of their failure to add clinical value (The Supplement).
The CW list was designed to identify practices that are costly, widely used, and for which no evidence exists to support value, and to promote conversations between patients and providers about using the most appropriate tests and treatments as well as about avoiding care that is unnecessary or for which harms may outweigh the benefits.
Although the CW list was selected after input from more than 200 oncologists, there was no explicit validation of either the prevalence of the care practices that were included, their costs to the health care system, or the accuracy of measurement of these practices in oncology practice. Because there are no patient claims for health care delivery systems, we used cancer registry and health insurance claims data to test the importance of the practices that were included on the CW list, to independently assess oncologists' adherence to these practices, and to

Methods
The study was conducted by Fred Hutchinson Cancer Research Center investigators in conjunction with leaders at Princess

Journal of Oncology Practice • Vol. 11, Issue 4
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Original Contribution | **Value-Based**

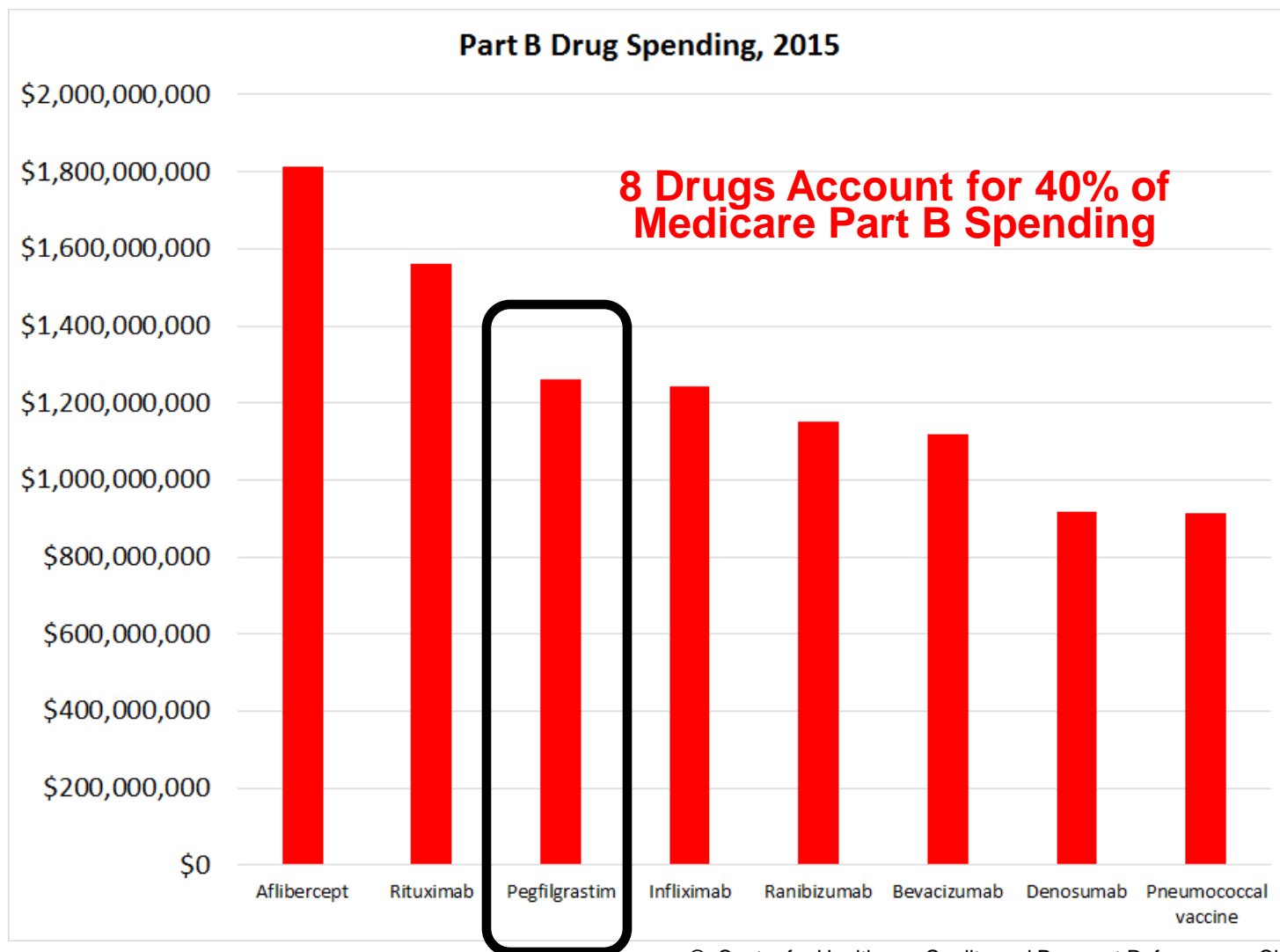
Choosing Wisely: Opportunities for Improving Value in Cancer Care Delivery?

Gabriel B. Shugar, MD, Courtney P. Williams, MPH, Bradford E. Jackson, PhD, Audrey S. Walker, MD, MPH, Kristina J. Fallows, MD, Kelly M. Kretz, PhD, Edward E. Partridge, MD, and Martin P. Fox, PhD

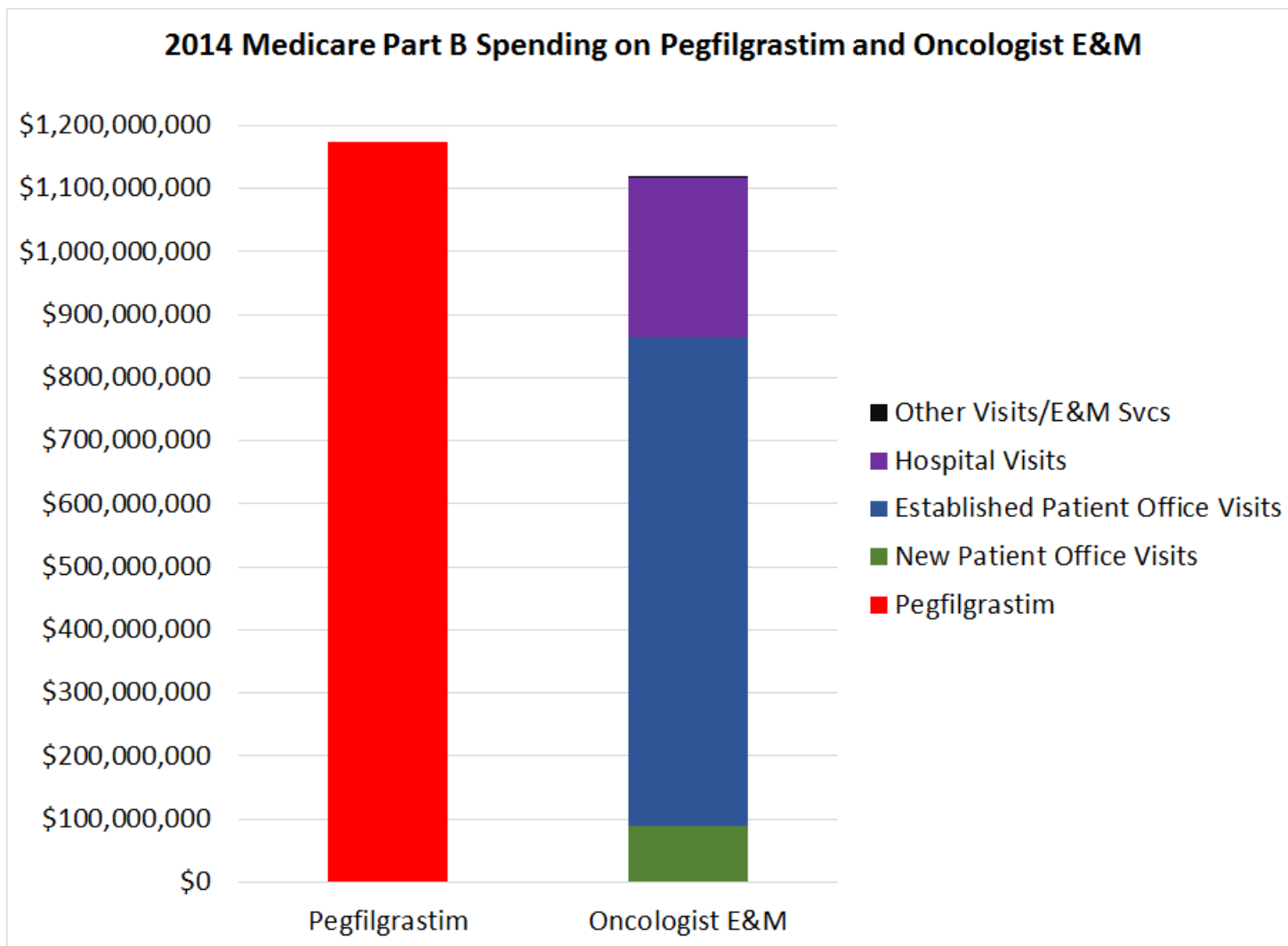
Abstract
Introduction: Patients, providers, and payers are able to identify whether value in cancer care can be increased. A part of the Choosing Wisely (CW) campaign, ASCO and the American Society for the Practice of Radiation Oncology have recommended against specific, yet commonly performed, treatments and procedures.
Methods: We conducted a retrospective analysis of Medicare claims data to compare concordance with CW recommendations across 32 cancer centers in the southeastern United States. Variability for each measure was evaluated on the basis of patient characteristics and site of care. Hierarchical linear modeling was used to examine differences in average costs per patient by concordance status. Patient and site-level scores were estimated on the basis of a potential 95% adherence rate and average cost difference.
Results: The analysis included 37,488 patients with cancer with Fee-for-Service Medicare insurance. Concordance varied by CW recommendation from 39% to 95%. Patient characteristics were similar for patients receiving concordant and discordant care. Significant variability was noted across centers for all recommendations, with a much greater site difference. Nonconcordance was associated with higher costs for every measure. If concordance were to increase to 95% for all measures, we would estimate a \$17-million difference in total cost of care per patient.
Conclusion: There is wide heterogeneity among centers for reduction of low-value care and corresponding costs associated with the CW recommendations. Because variability in concordance was most pronounced by site of care, rather than by patient factors, continued education about these low-value services is needed to improve the value of cancer care.
Introduction: Because health care costs are rising at an unsustainable rate, patients, providers, and payers are collectively striving to identify where value in cancer care can be increased and how the triple aim of better health, better health care, and lower cost can be achieved. The American Society of Clinical Oncology's Choosing Wisely (CW) campaign aims to improve value by targeting low-value services in medicine and thus increase quality of care while lowering cost.

ASSOCIATED CONTENT
Supplemental digital content is available for this article. Direct URL citations appear in the text and any supplemental material is available for the article at www.jco.org.
DOI: 10.1200/JOP.2015.000000
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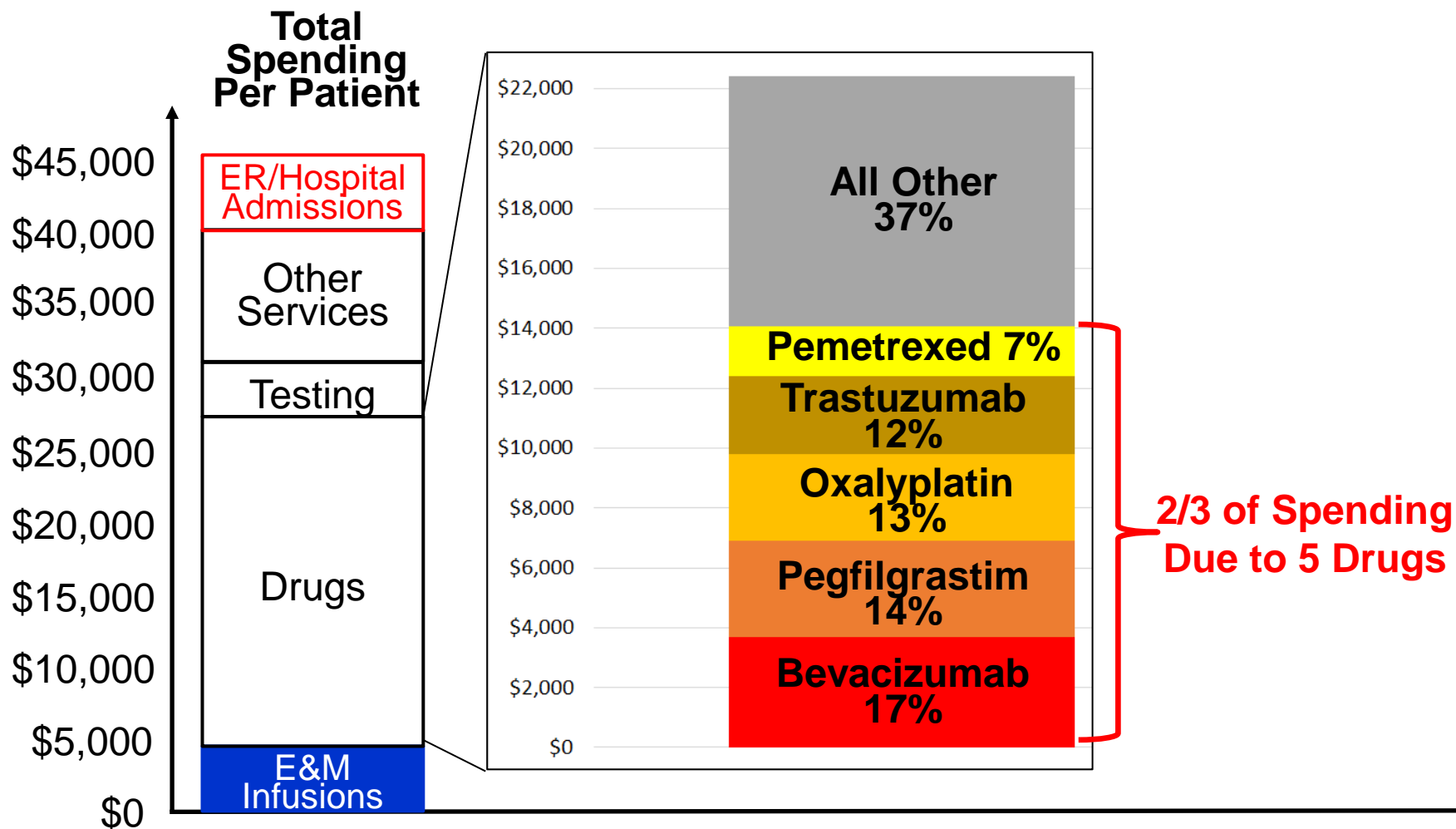
Neulasta is the #3 Part B Drug: \$1.2 Billion in Medicare Spending



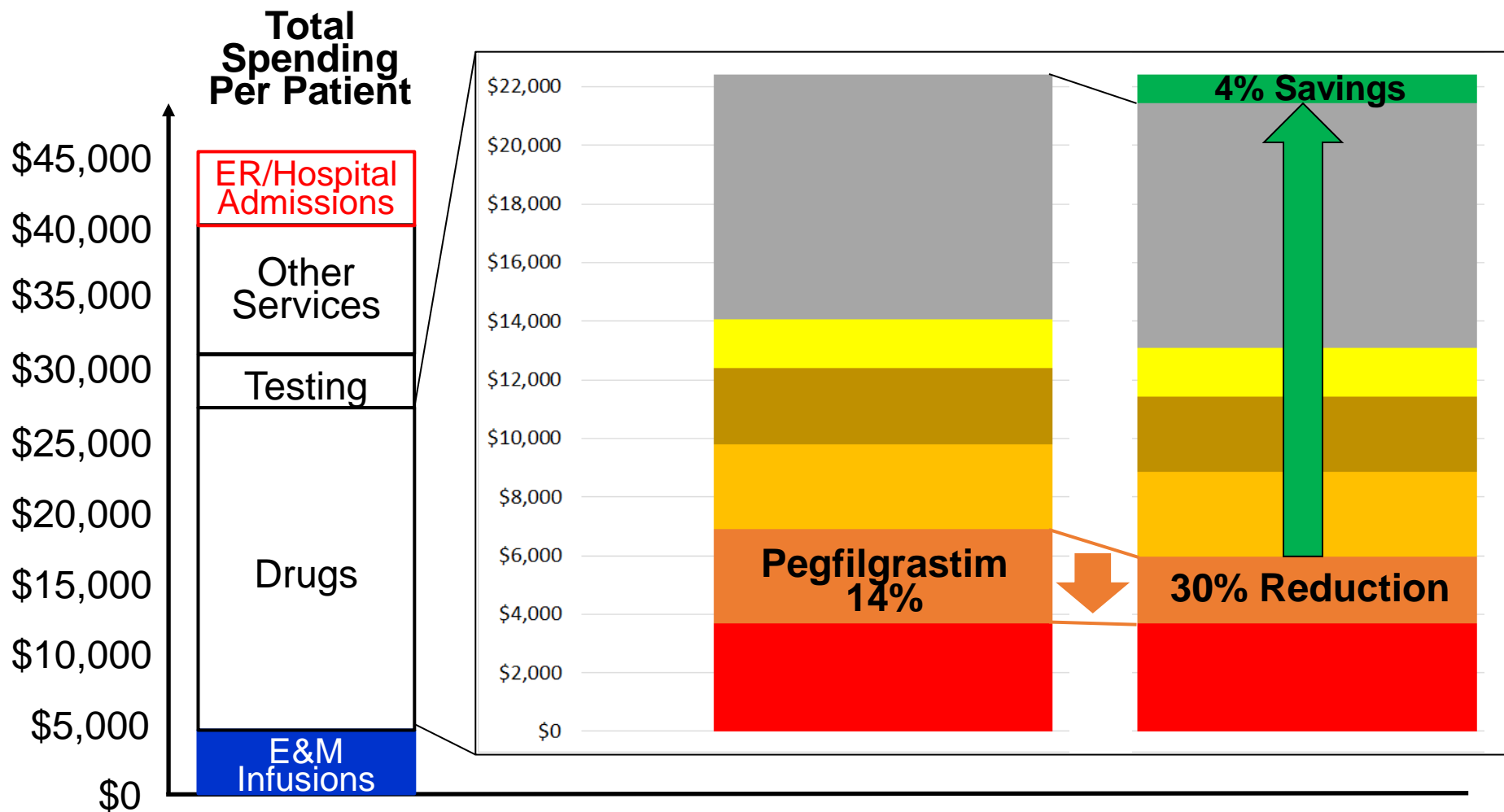
CMS Spends More on Pegfilgrastim Than on Patient Visits w/ Oncologists



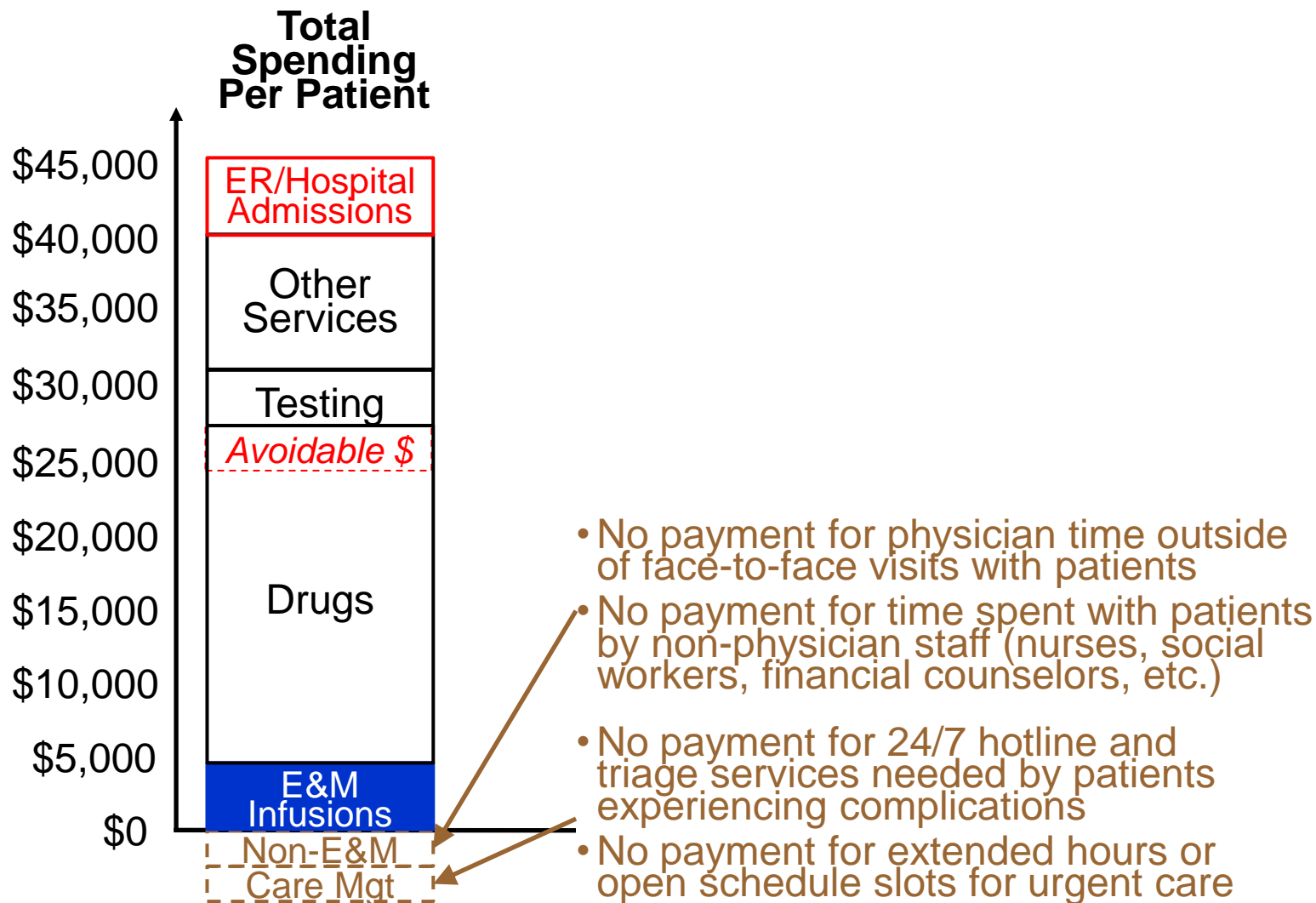
14% of Drug Spend & 7% of Total During Chemo is Pegfilgrastim



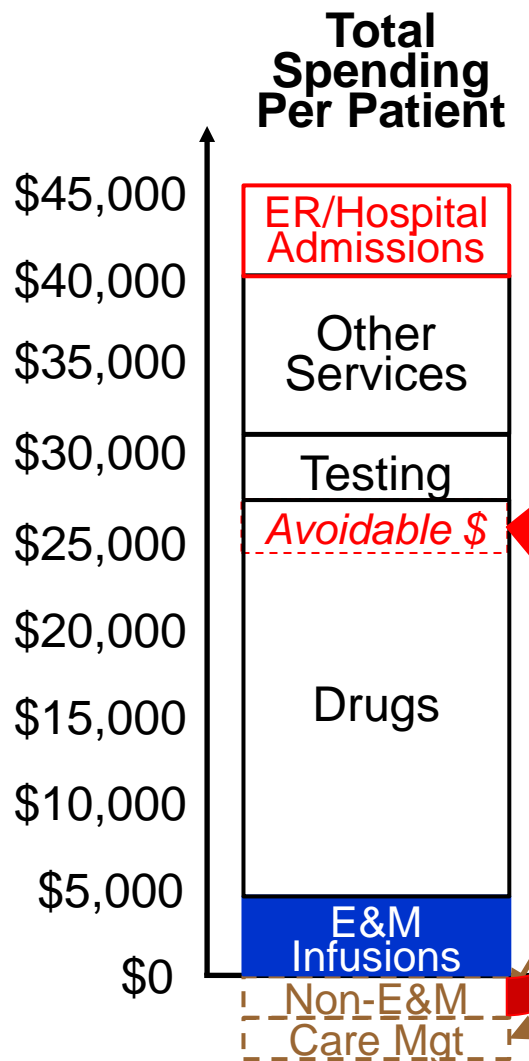
Elimination of 30% Overuse Reduces Total Drug Spend by 4%



Inadequate Resources for Effective Planning & Monitoring of Care



Inadequate Resources for Effective Planning & Monitoring of Care

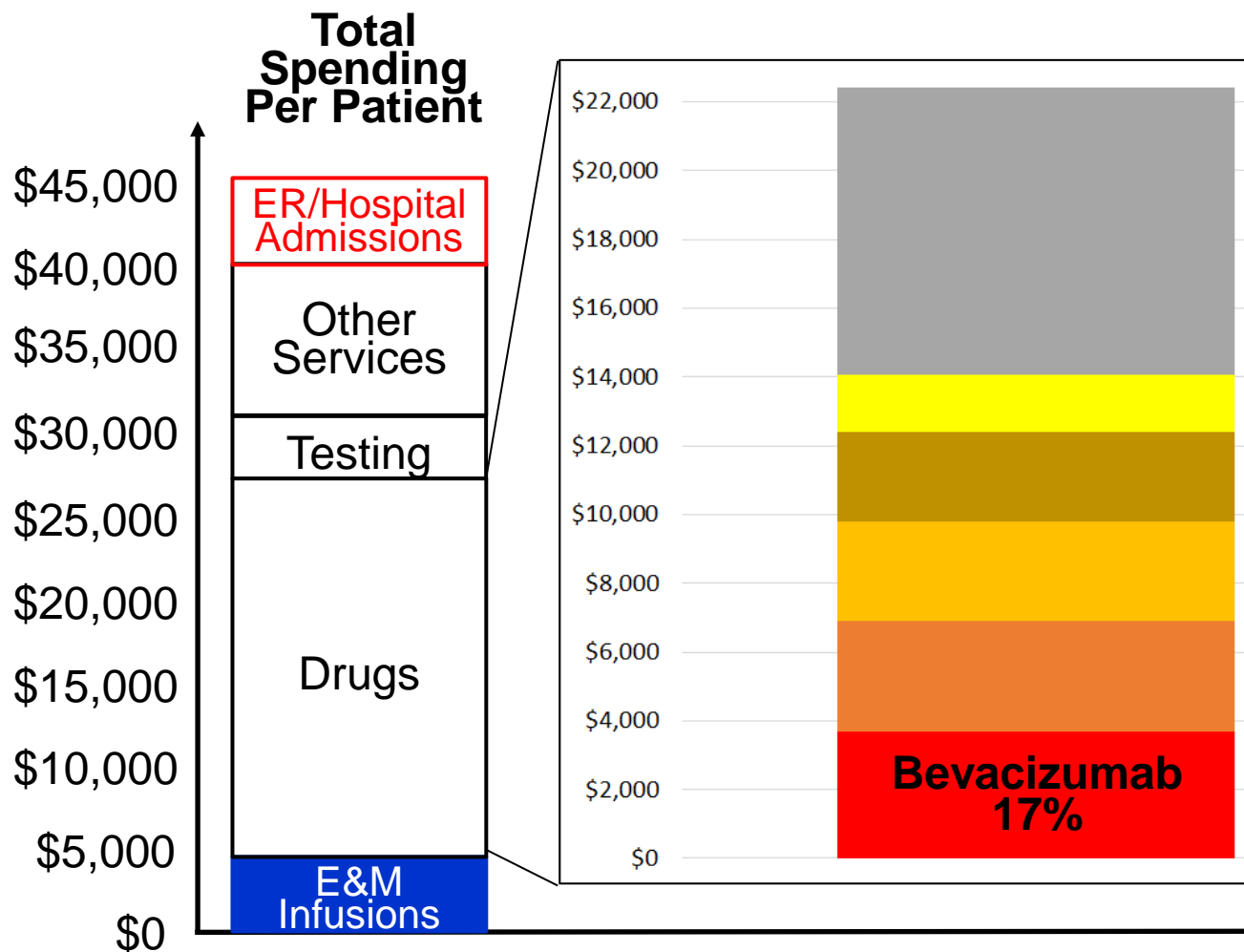


With inadequate time and care management support:

- 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

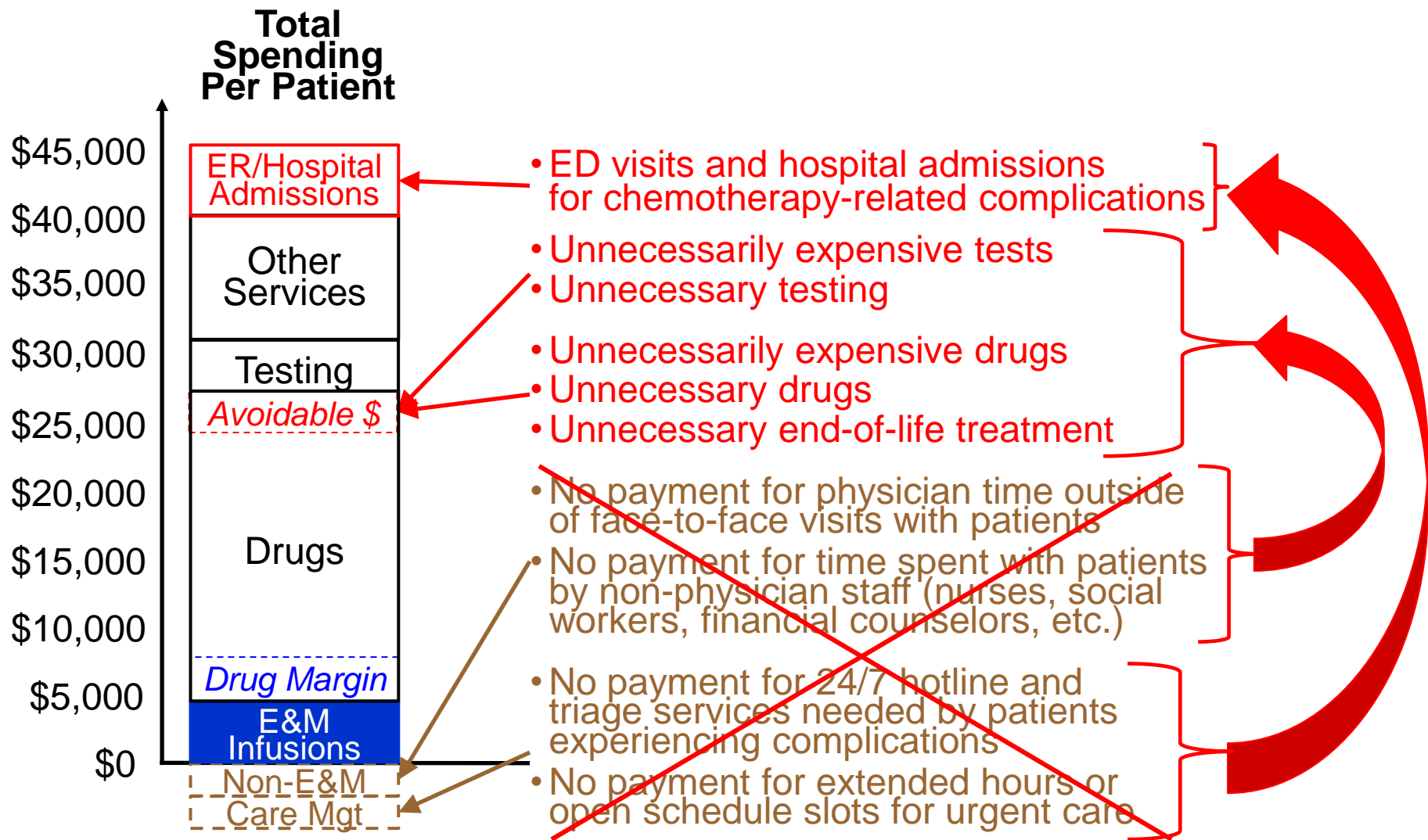


Alternative Regimens Have Similar Efficacy But Much Lower Cost

First Line Regimens for Metastatic Non-Small Cell Lung Cancer (non-squamous histology, no EGFR or ALK mutation present)

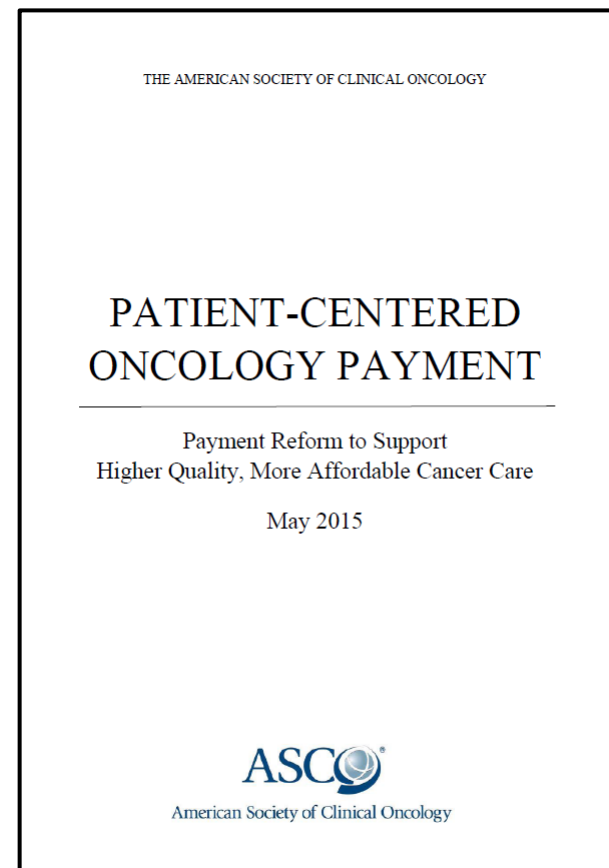
Regimen	Median Overall Survival (months)	Median Progression-Free Survival	Grade 3+ Adverse Event	Cost Difference (6 cycles)
Carboplatin + Paclitaxel	10.3	4.5	24%	
Carboplatin + Paclitaxel + Bevacizumab	12.3	6.3	61%	+~\$30,000
Sandler, A et al. New England Journal of Medicine 2006;355:2542-50				
Cisplatin + Gemcitabine	13.1	6.1	75%	
Cisplatin + Gemcitabine + Bevacizumab	13.6	6.7	76%	+~\$30,000
Reck, M et al. Journal of Clinical Oncology 2009; 27(8):1227-2415 Reck, M et al. Annals of Oncology 2010				

Failure to Pay for Good Care... Leads to Costly, Low-Value Services



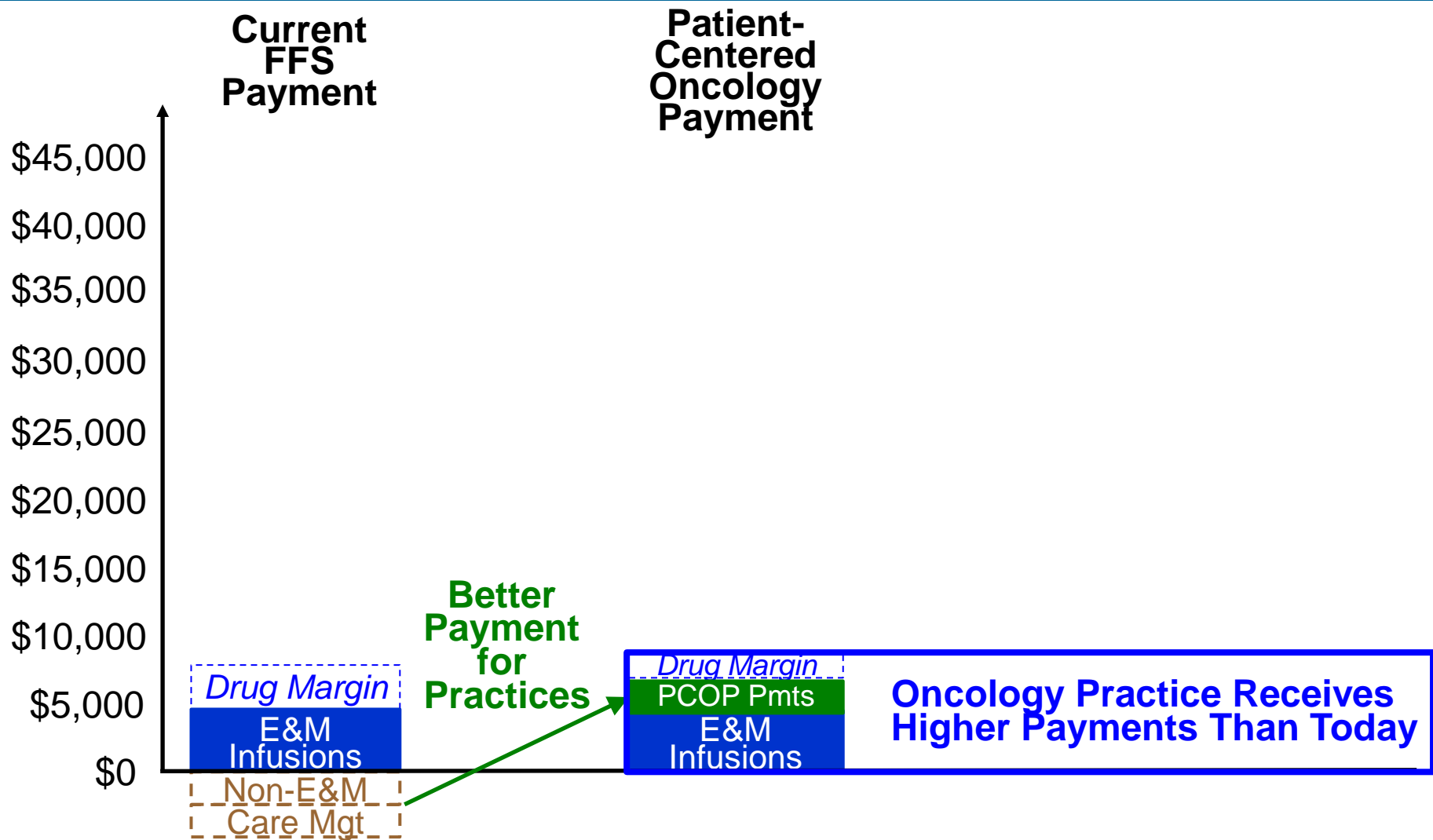
ASCO Payment Reform Developed by Oncologists & Practice Managers

- 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

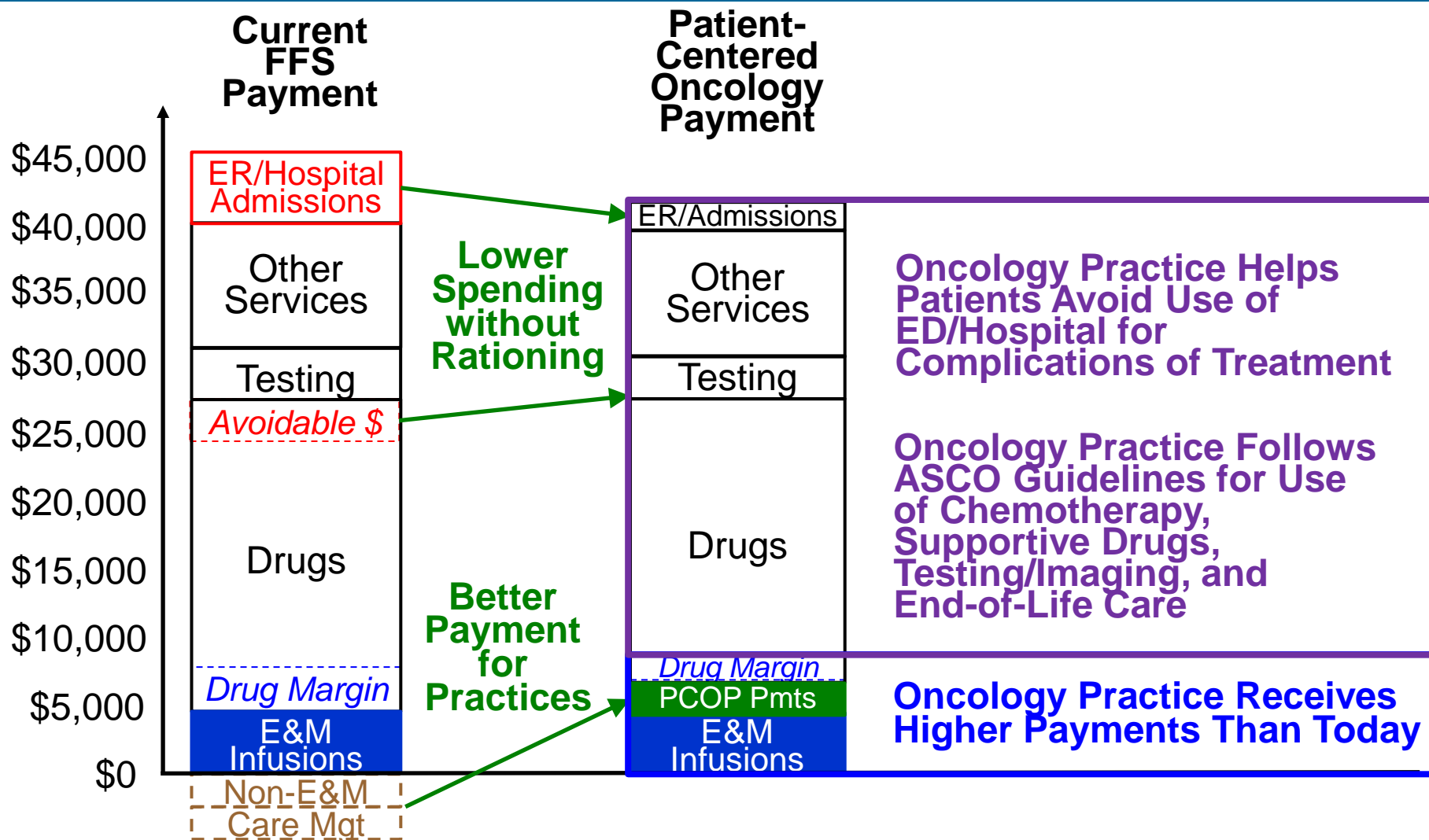


www.asco.org/paymentreform

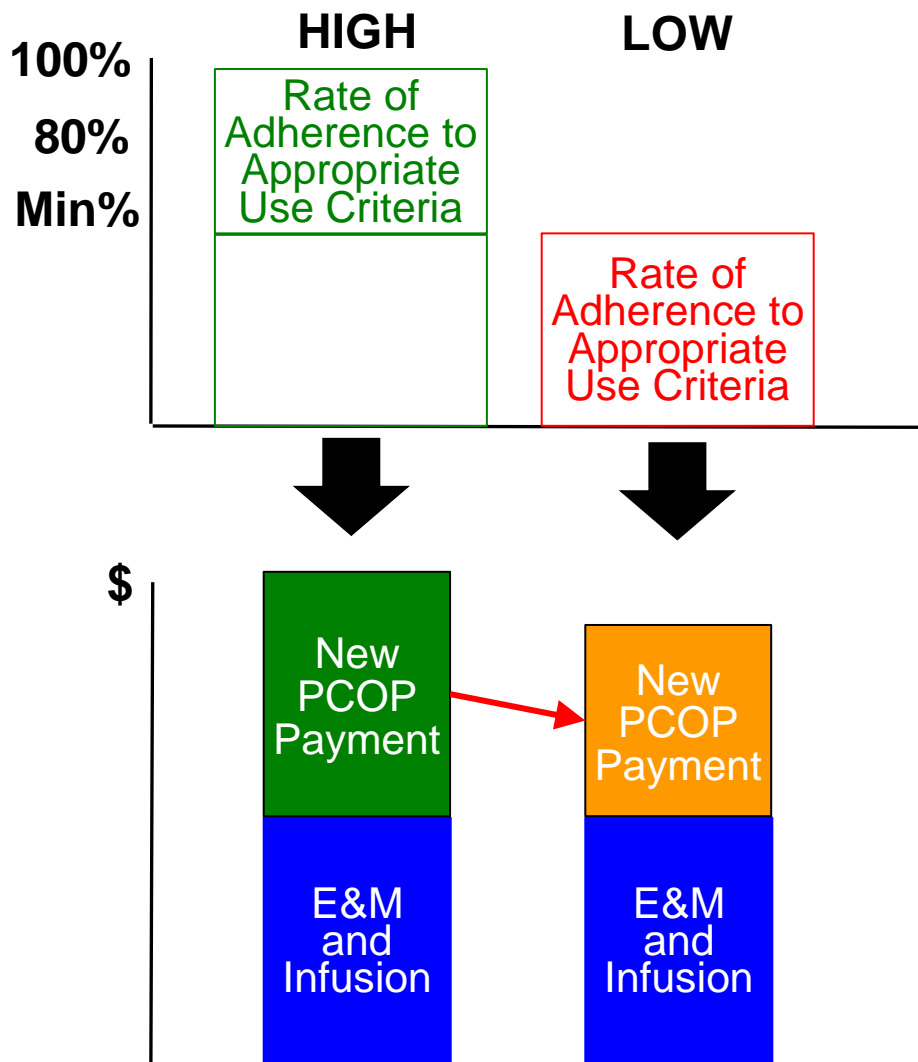
PCOP Part 1: More Payment to Practices Where It's Needed



PCOP Part 2: Implement ASCO Guidelines & Avoid ED Visits



Payment Based on Adherence to Appropriate Use Criteria



Choosing Wisely
An initiative of the ABIM Foundation

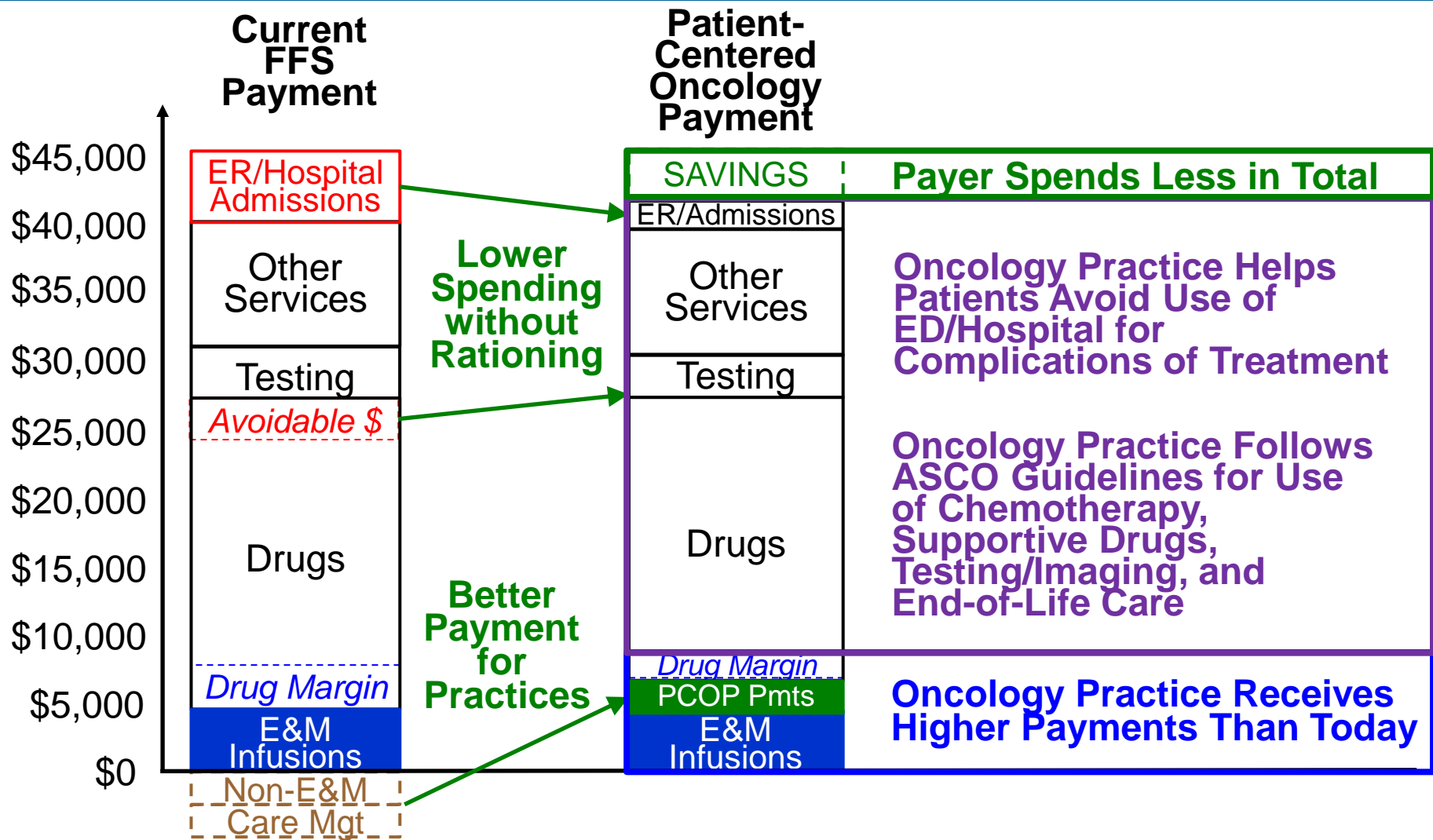
American Society of Clinical Oncology
ASCO
American Society of Clinical Oncology

Five Things Physicians and Patients Should Question

The American Society of Clinical Oncology (ASCO) is a medical professional oncology society committed to conquering cancer through research, education, prevention, and delivery of high-quality patient care. ASCO recognizes the importance of evidence-based cancer care and making wise choices in the diagnosis and management of patients with cancer. After careful consideration by experienced oncologists, ASCO highlights five categories of tests, procedures and/or treatments whose common use and clinical value are not supported by available evidence. These tests and treatment options should not be administered unless the physician and patient have carefully considered if their use is appropriate in the individual case. As an example, when a patient is enrolled in a clinical trial, these tests, treatments, and procedures may be part of the trial protocol and therefore deemed necessary for the patient's participation in the trial.

- Don't use cancer-directed therapy for solid tumor patients with the following characteristics: low performance status (3 or 4), no benefit from prior evidence-based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anti-cancer treatment.**
 - Studies show that cancer directed treatments are likely to be ineffective for solid tumor patients who meet the above stated criteria.
 - Exceptions include patients with functional limitations due to other conditions resulting in a low performance status or those with disease characteristics (e.g., mutations) that suggest a high likelihood of response to therapy.
 - Implementation of this approach should be accompanied with appropriate palliative and supportive care.
- 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 low-risk cancers, despite a lack of evidence suggesting they improve detection of metastatic disease or survival.
 - Evidence does not support the use of these scans for staging of newly diagnosed low grade carcinoma of the prostate (Stage 1c/T2a, prostate-specific antigen (PSA) <10 ng/ml, Gleason score less than or equal to 6) with low risk of distant metastasis.
 - Unnecessary imaging can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.
- 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 low-risk 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 identified ductal carcinoma in situ (DCIS), or clinical stage I or II disease.
 - Unnecessary imaging can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.
- 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, over-treatment, unnecessary radiation exposure, and misdiagnosis.
- Don't use white cell stimulating factors for primary prevention of febrile neutropenia for patients with less than 20 percent risk for this complication.**
 - ASCO guidelines recommend using white cell stimulating factors when the risk of febrile neutropenia, secondary to a recommended chemotherapy regimen, is approximately 20 percent and equally effective treatment programs that do not require white cell stimulating factors are unavailable.
 - Exceptions should be made when using regimens that have a lower chance of causing febrile neutropenia if it is determined that the patient is at high risk for this complication (due to age, medical history, or disease characteristics).

PCOP Result: Better Care, Better Payment, Payer Savings



Analysis of PCOP Shows Large Net Savings from Better Payment

THE AMERICAN SOCIETY OF CLINICAL ONCOLOGY

PATIENT-CENTERED ONCOLOGY PAYMENT

Payment Reform to Support
Higher Quality, More Affordable Cancer Care

May 2015



American Society of Clinical Oncology

Costs and Savings from Patient-Centered Oncology Payment

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

For 500 New Patients:

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

www.asco.org/paymentreform

Potentially Large Win-Win-Win for Payers, Patients & Practices

THE AMERICAN SOCIETY OF CLINICAL ONCOLOGY

PATIENT-CENTERED ONCOLOGY PAYMENT

Payment Reform to Support
Higher Quality, More Affordable Cancer Care

May 2015

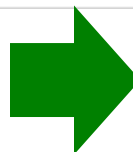


American Society of Clinical Oncology

www.asco.org/paymentreform

Costs and Savings from Patient-Centered Oncology Payment

	Current Average Spending Per Beneficiary	With Proposed New Payments and Estimated Savings	% Change
Month Prior to Treatment			
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PCOP		\$220	
Total	\$50,048	\$48,089	-3.9%



For 500 New Patients:

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

What About the CMMI Oncology Care Model?

ONCOLOGY CARE MODEL

OCM PERFORMANCE-BASED PAYMENT METHODOLOGY

Version 1.1
June 27, 16

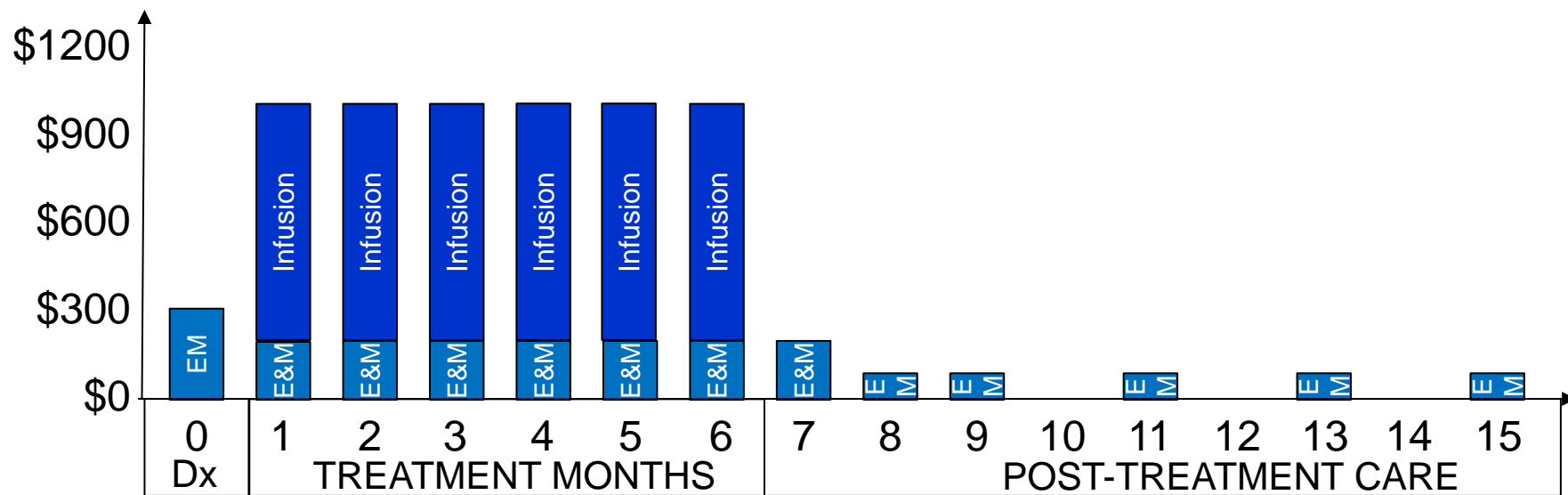
Prepared by:
RTI International
3040 E. Cornwallis Road
Research Triangle Park, NC 27709

Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003



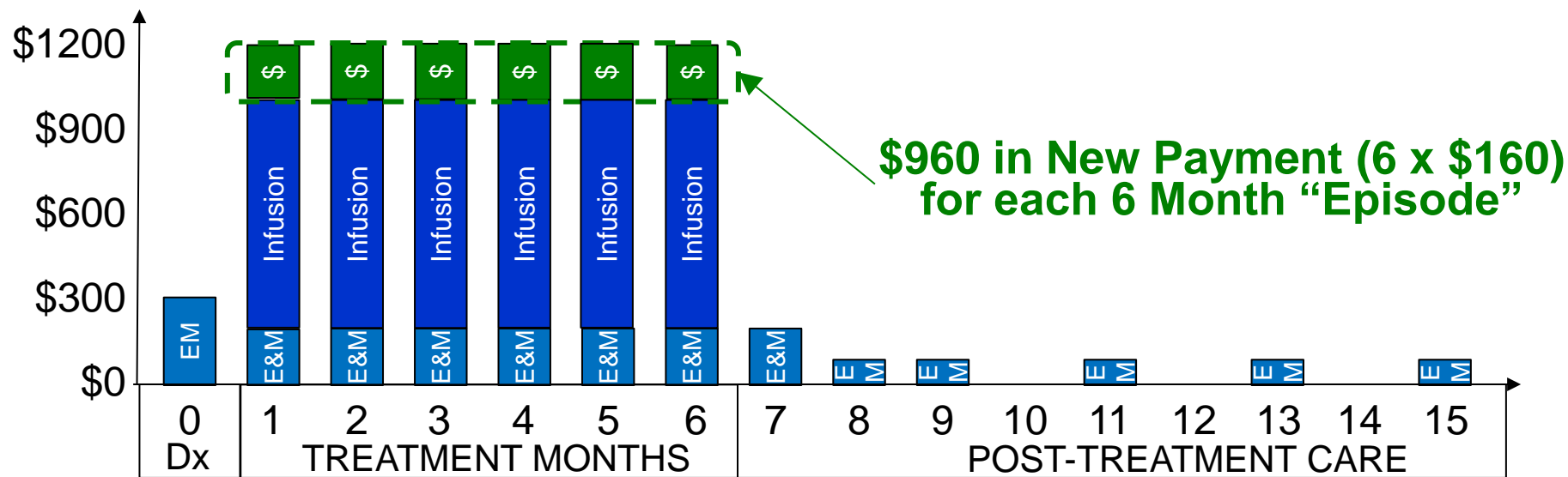
The Oncology Care Model Doesn't Eliminate Current FFS...

HOW ONCOLOGY PRACTICE IS PAID TODAY



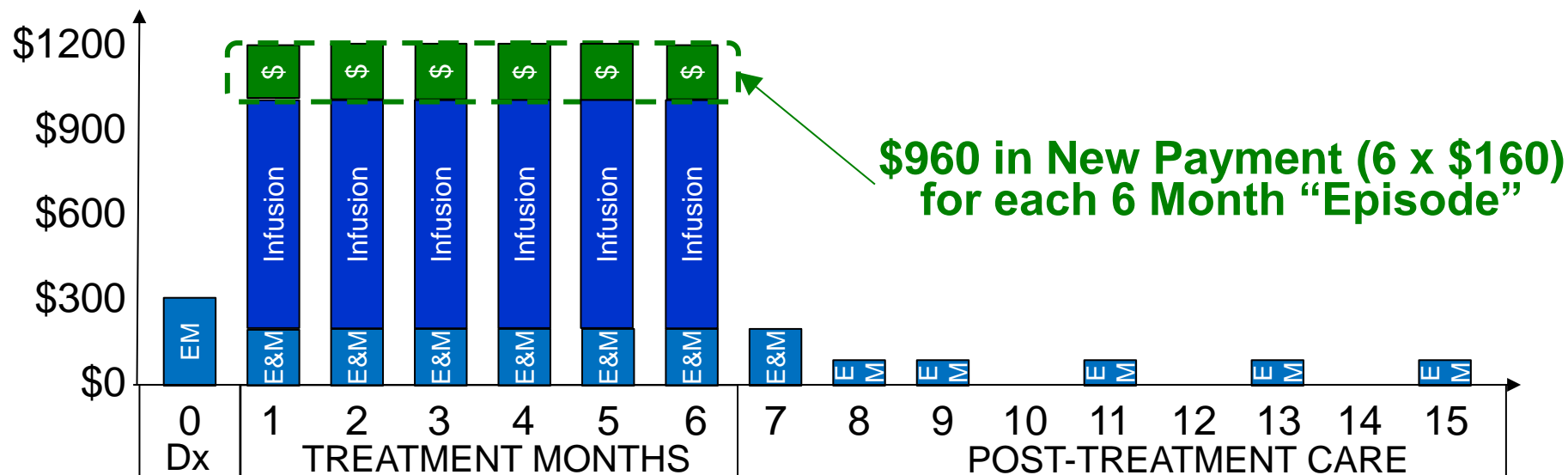
It Adds New Monthly Payments...

HOW ONCOLOGY PRACTICE IS PAID IN CMMI OCM PROGRAM



It Adds New Monthly Payments... But Only If Chemotherapy is Given

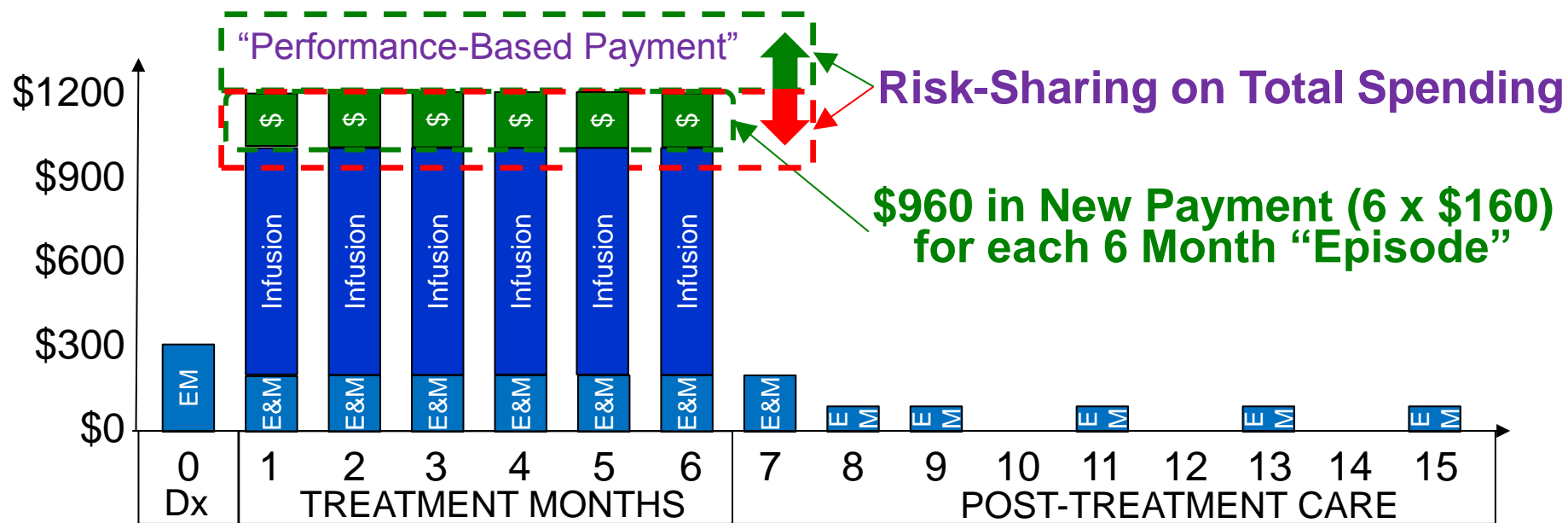
HOW ONCOLOGY PRACTICE IS PAID IN CMMI OCM PROGRAM



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

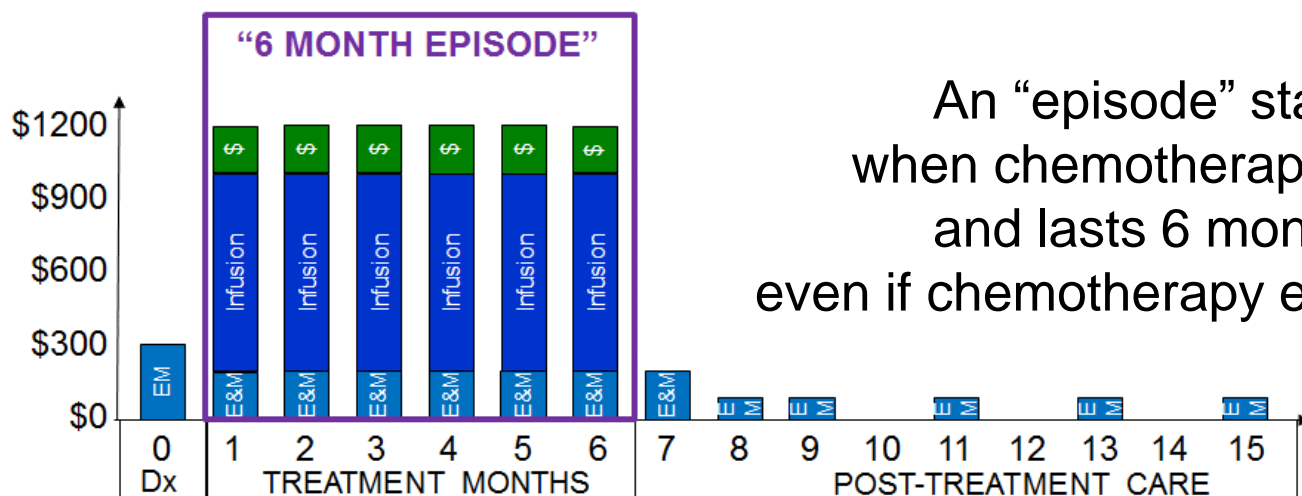
HOW ONCOLOGY PRACTICE IS PAID IN CMMI OCM PROGRAM



Problems with Risk Under OCM

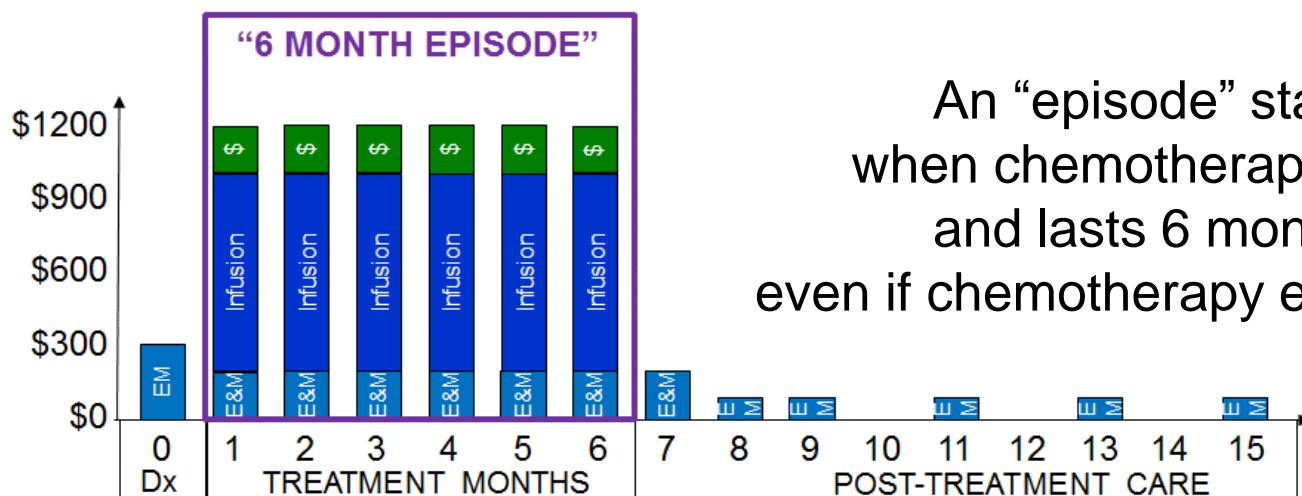
- **Performance-Based Payment (Risk-Sharing)**
 - Practices would receive bonuses for delivering cheaper, less effective treatments to patients and for avoiding important surveillance testing
 - Practices would be penalized for treating higher-cost types of cancer and for health problems the patient 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

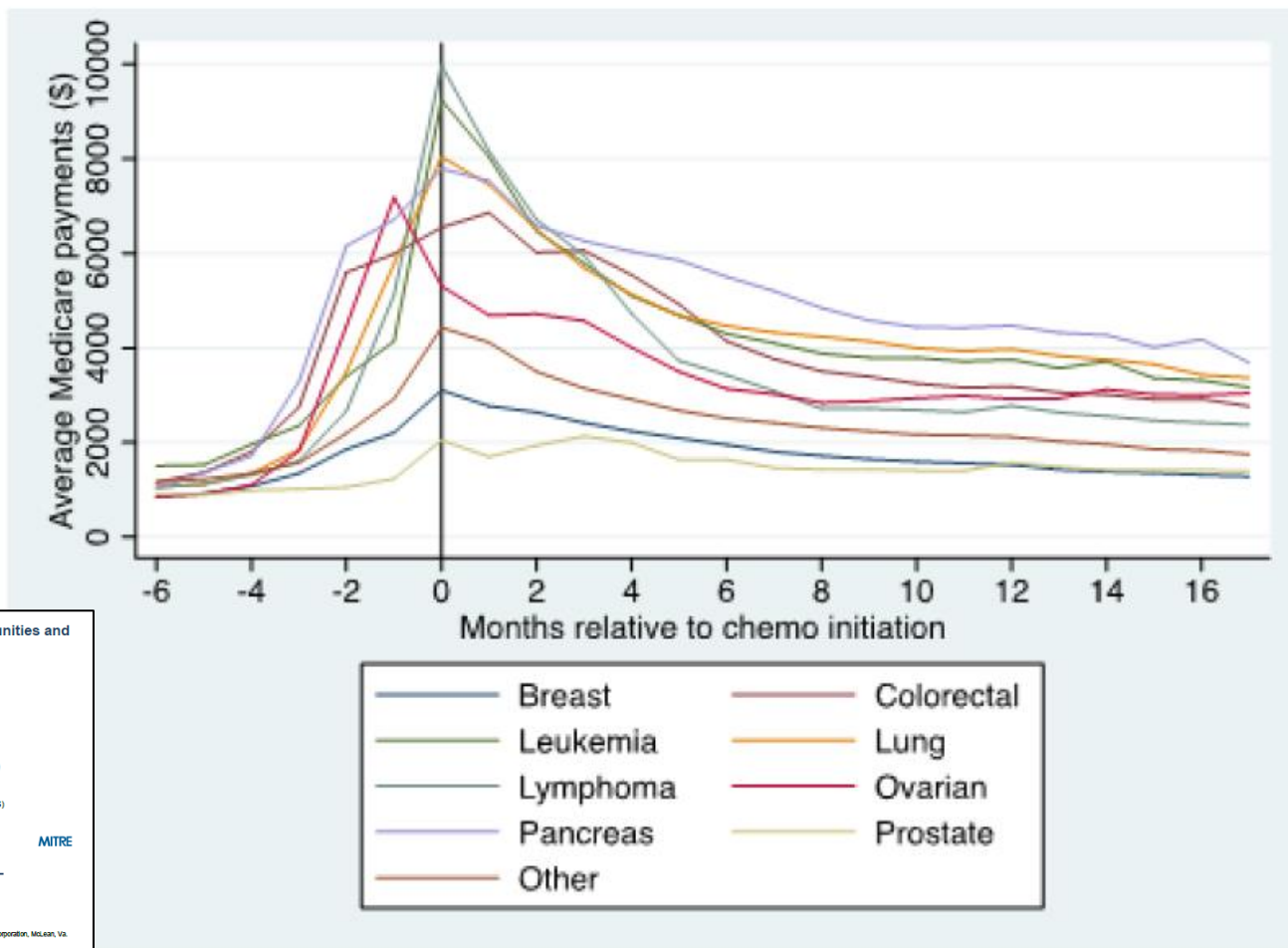


An “episode” starts when chemotherapy starts and lasts 6 months even if chemotherapy ends sooner

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



Specialty Payment Model Opportunities and Assessment

Oncology Model Design Report

Contract No. HHS-M50020-12-0-0008

Task Order No. HHS-M500-T0008

A product of the CMS Alliance to Modernize Healthcare (CAMH) Federally Funded Research and Development Center

Sponsored by the Centers for Medicare & Medicaid Services (CMS)



MITRE

Peter Huckfeldt, Chris Chan, Samuel Hershman, Aaron Kohler, Jodi L. Liu, Andrew W. Mulcahy, Isaac Ongles, Caren Stevens, Justin W. Timine, Peter S. Hussey

Published by the RAND Corporation, Santa Monica, Calif. and The MITRE Corporation, McLean, Va.

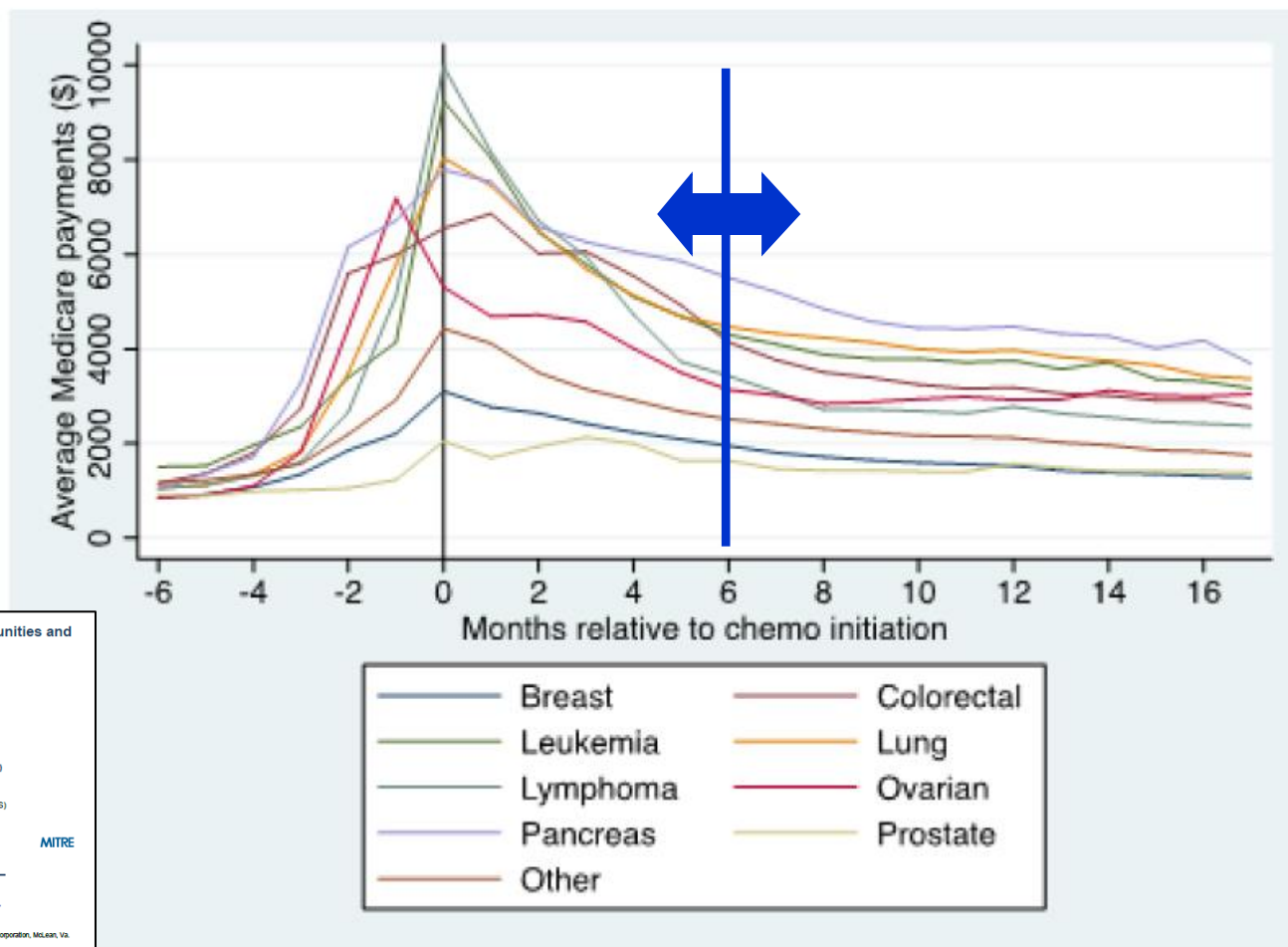
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Monthly Spending In First Six Months vs. Later

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



Specialty Payment Model Opportunities and Assessment

Oncology Model Design Report

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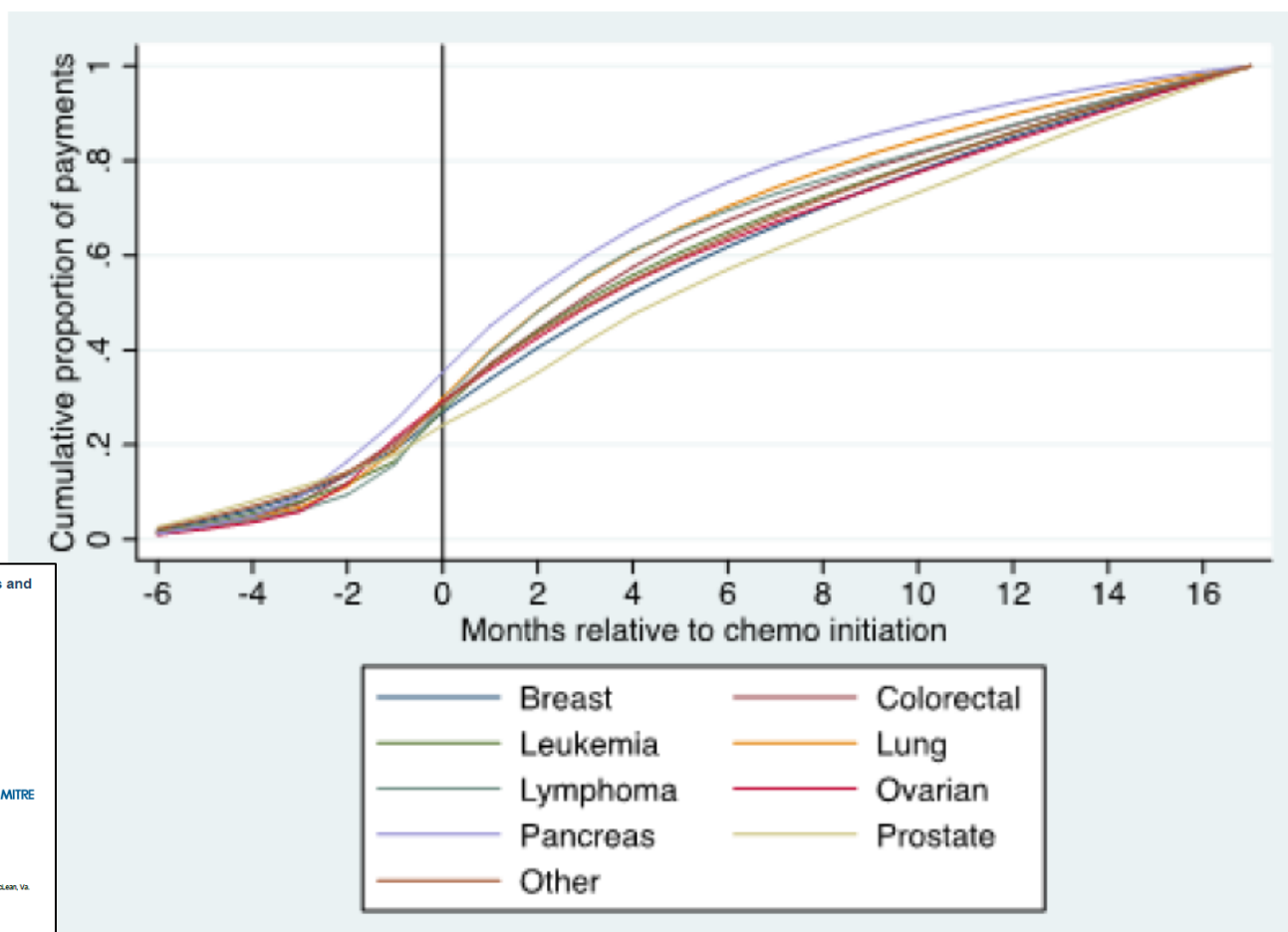
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Cumulative Spending By Month

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

Contract No. HHS-M50020-12-00008

Task Order No. HHS-M500-T0008

A product of the CMS Alliance to Modernize Healthcare (CAMH)
Federally Funded Research and Development Center

Sponsored by the Centers for Medicare & Medicaid Services (CMS)



MITRE

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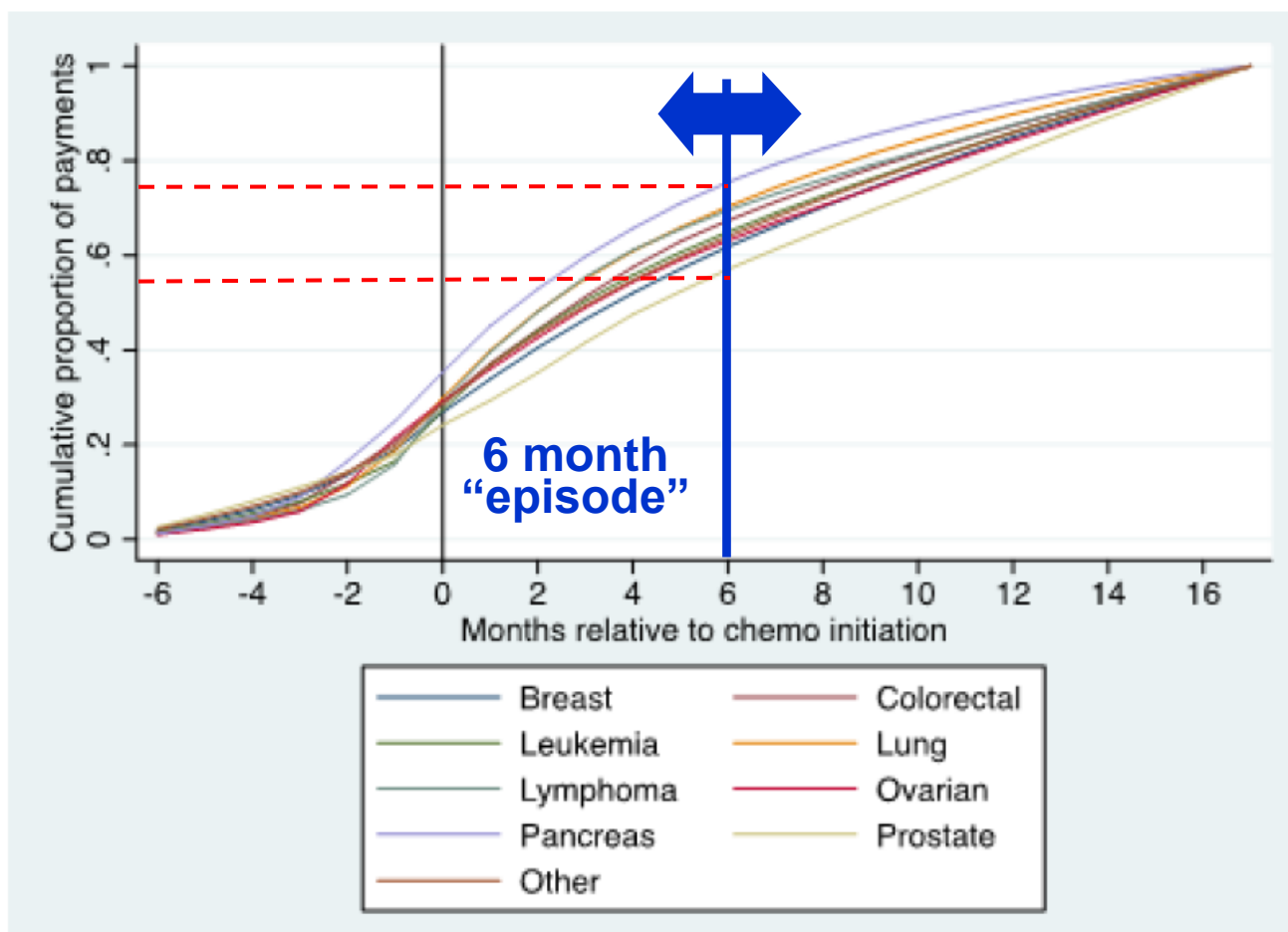
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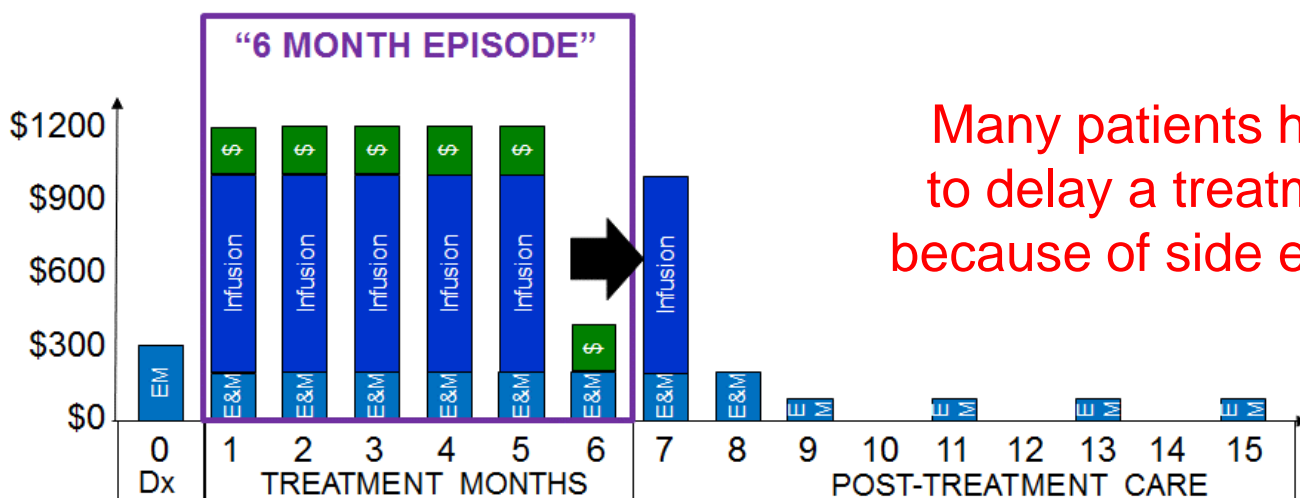
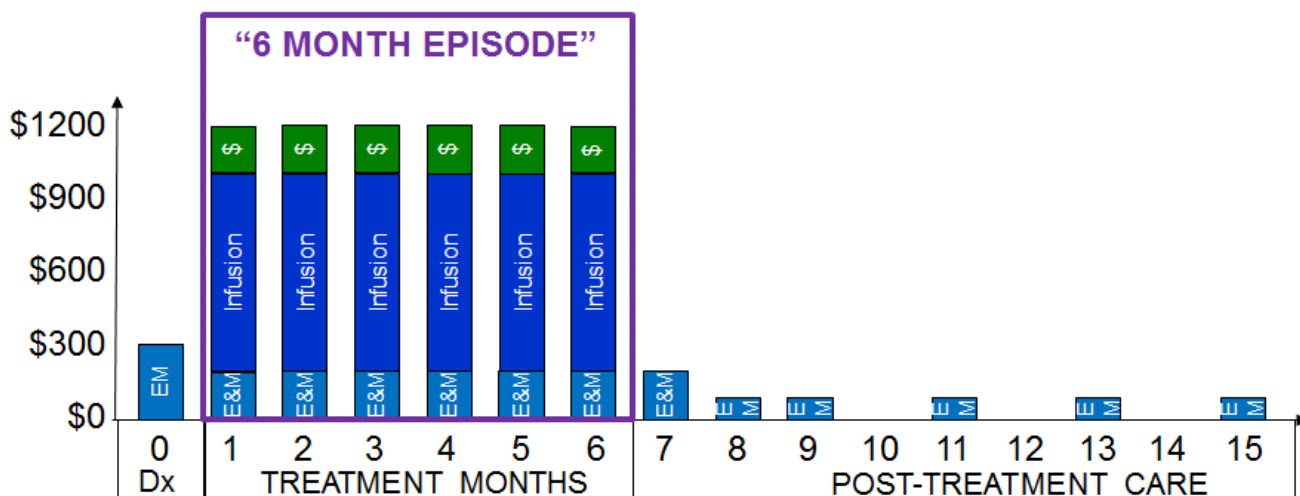
For more information on this publication, visit www.rand.org/ivhs

6 Month Episodes?

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

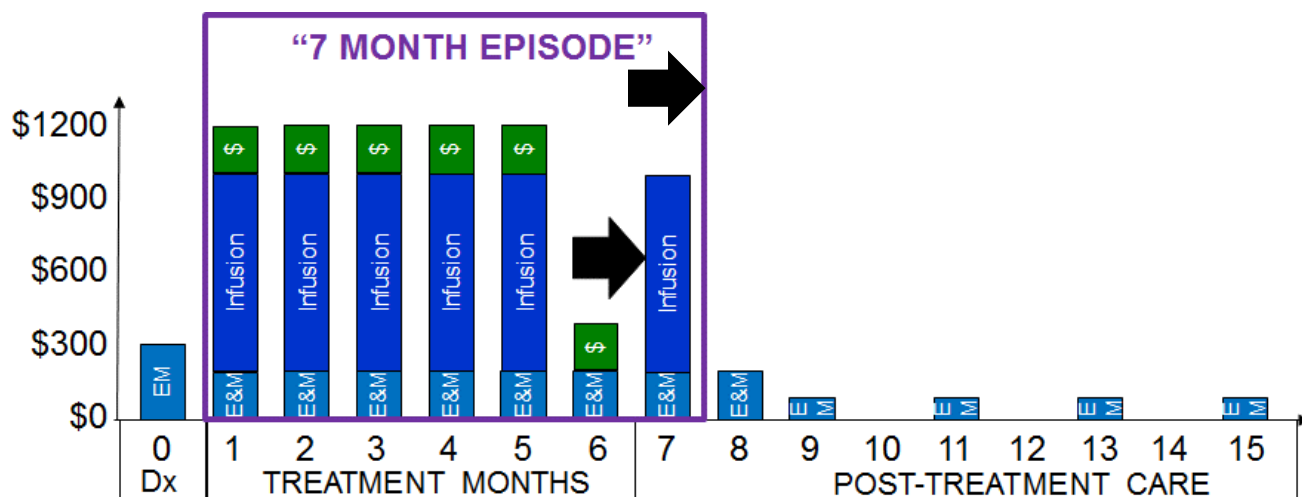
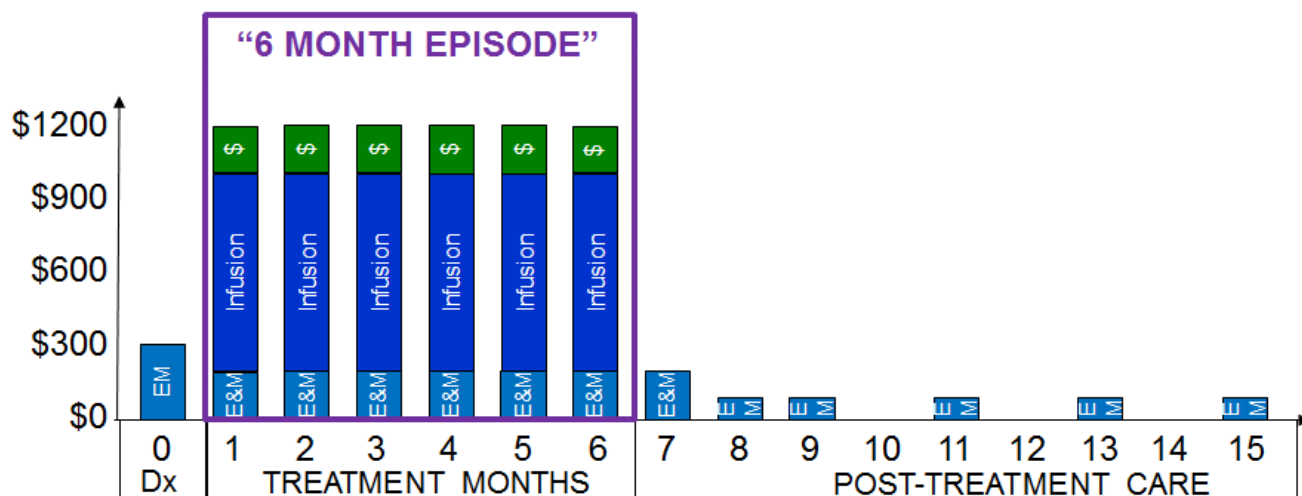


What Happens If One of the Patient's Treatments is Delayed?

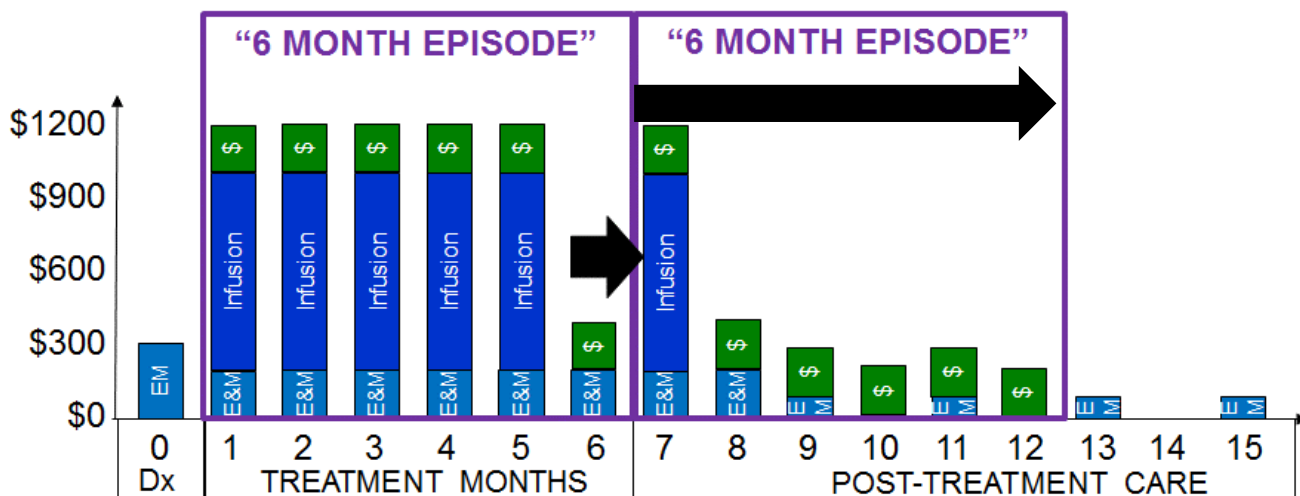
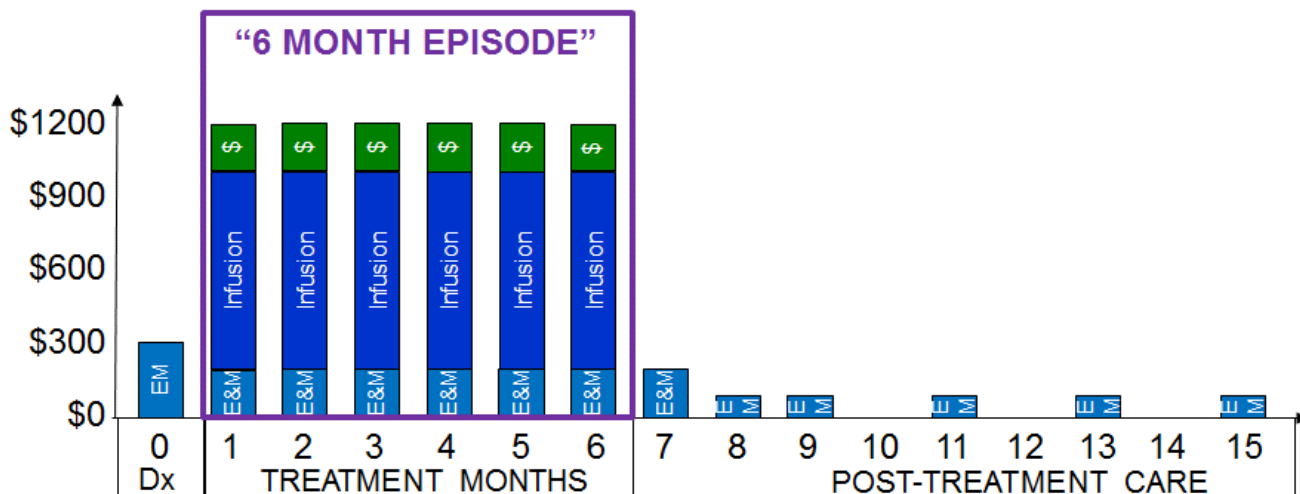


Many patients have to delay a treatment because of side effects

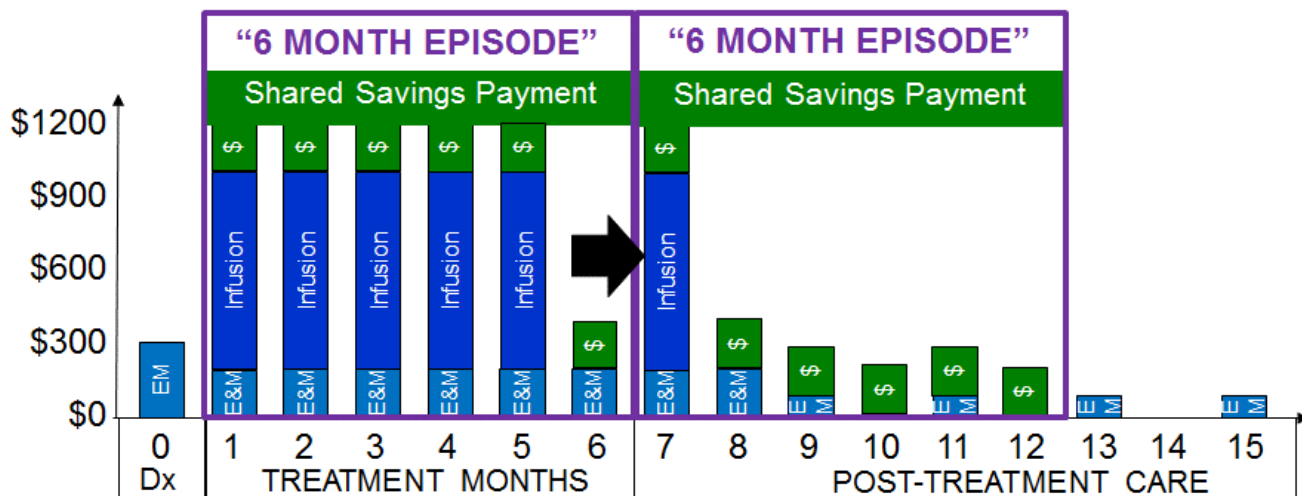
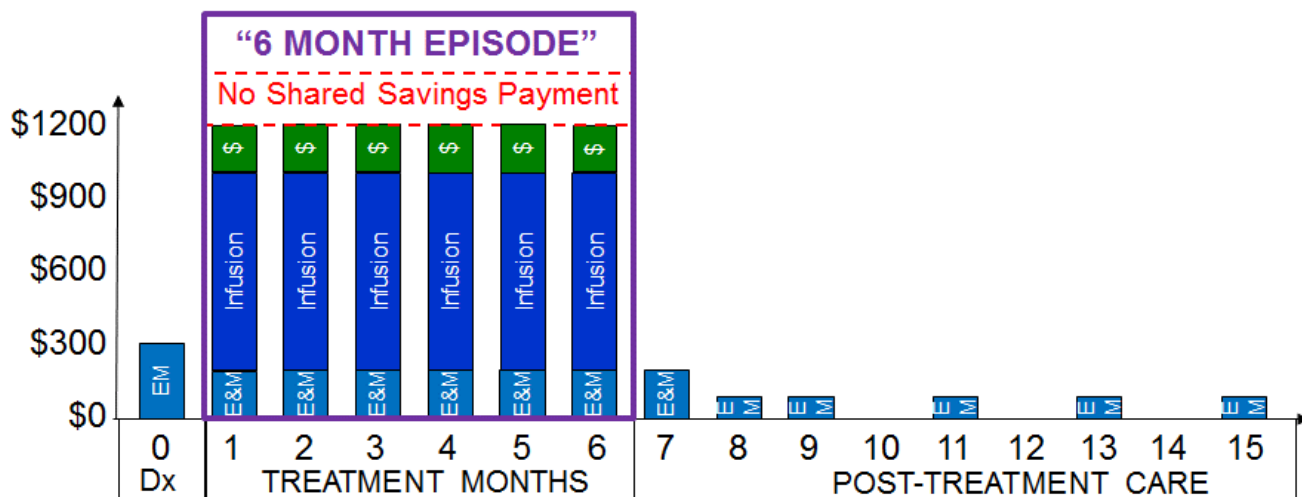
Logic Would Say That It's Now a Longer (7 Month) Episode



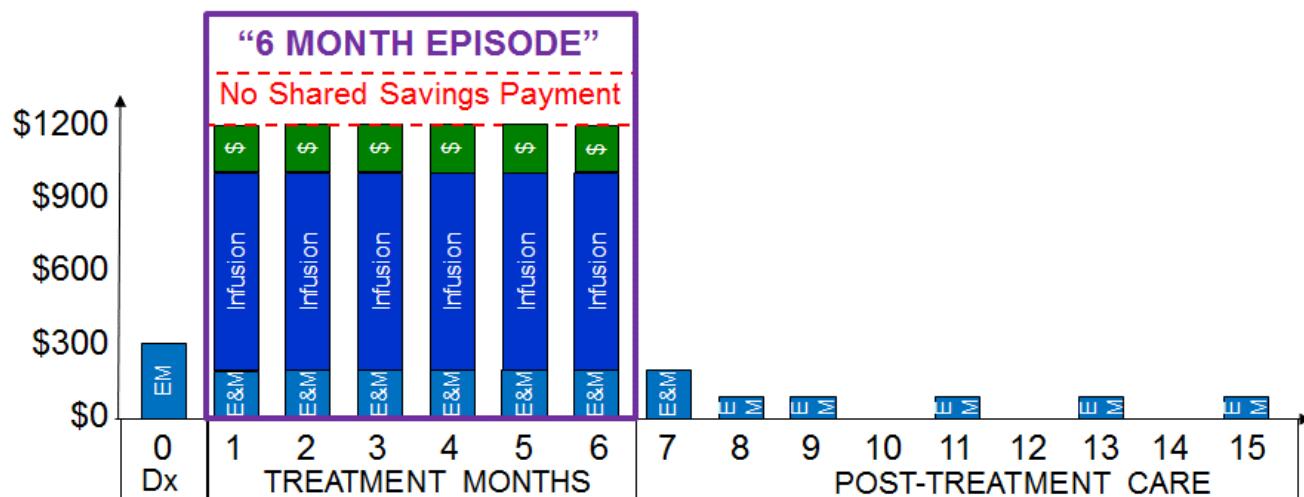
But CMMI Says It's a *New Episode* With \$960 More in Payments



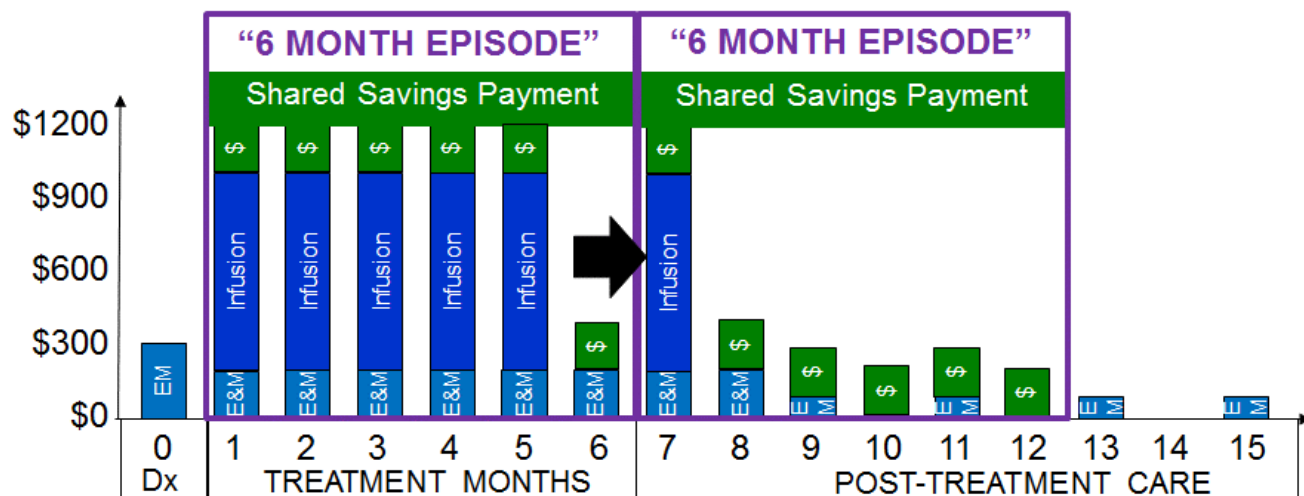
And Shared Savings Is More Likely With Same Spending in 2 Episodes



Undesirable New Incentives for Oncology Practices



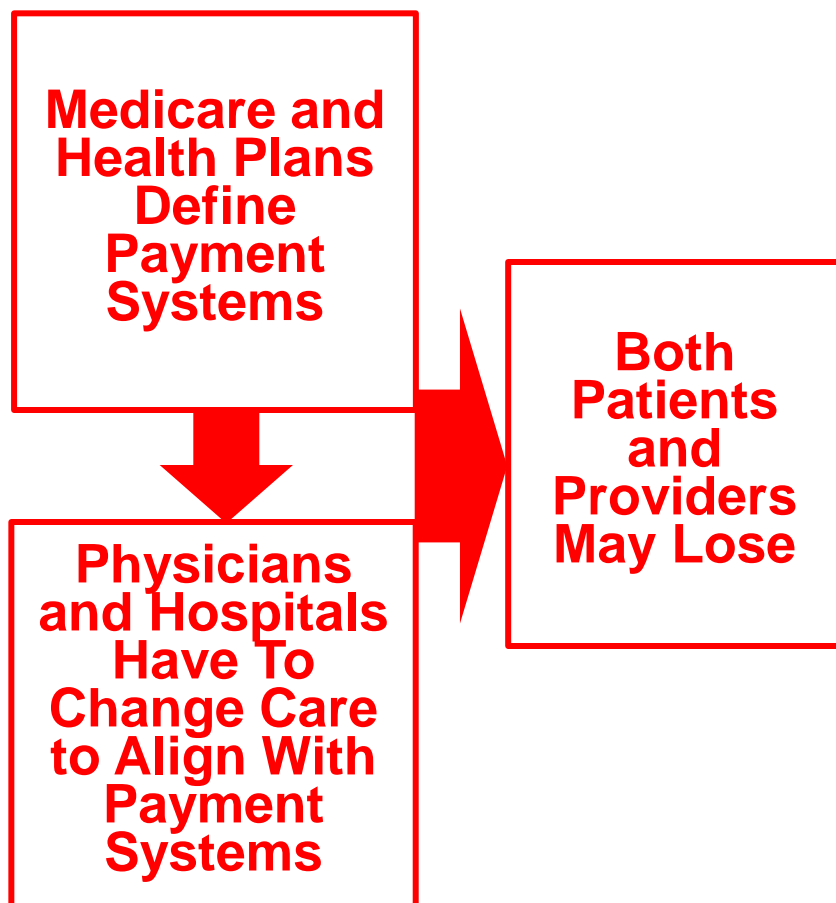
Penalty for Helping Patients Avoid Side Effects?



Incentive to Stretch Out Treatment?

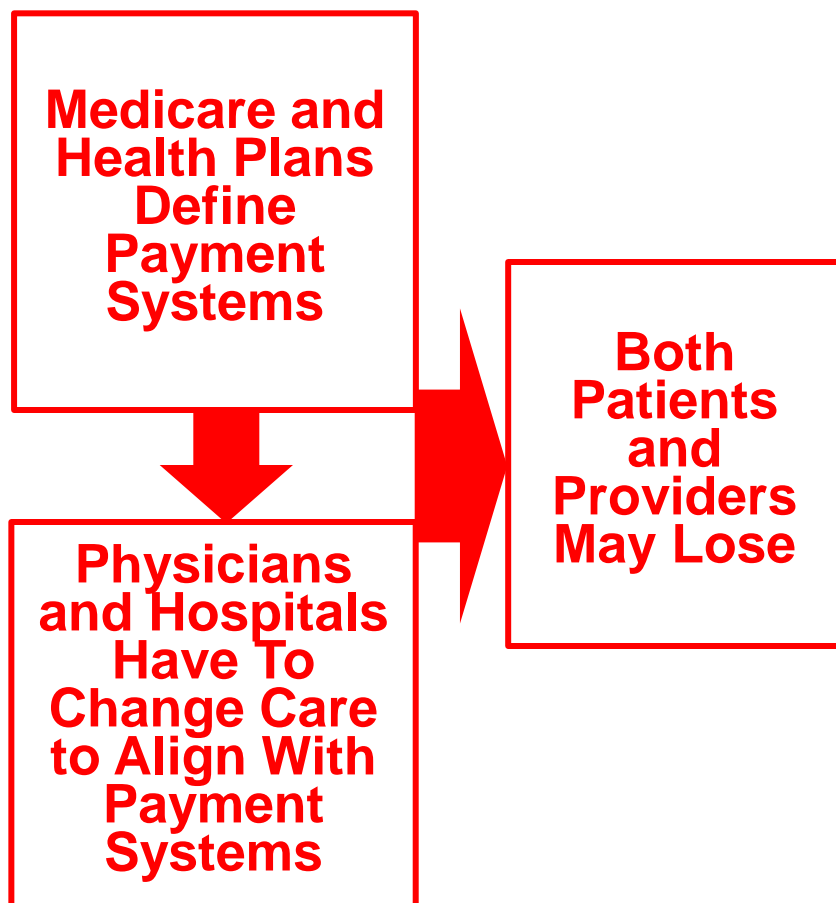
Top-Down vs. Bottom-Up Design of Care & Payment

CMS ONCOLOGY CARE MODEL

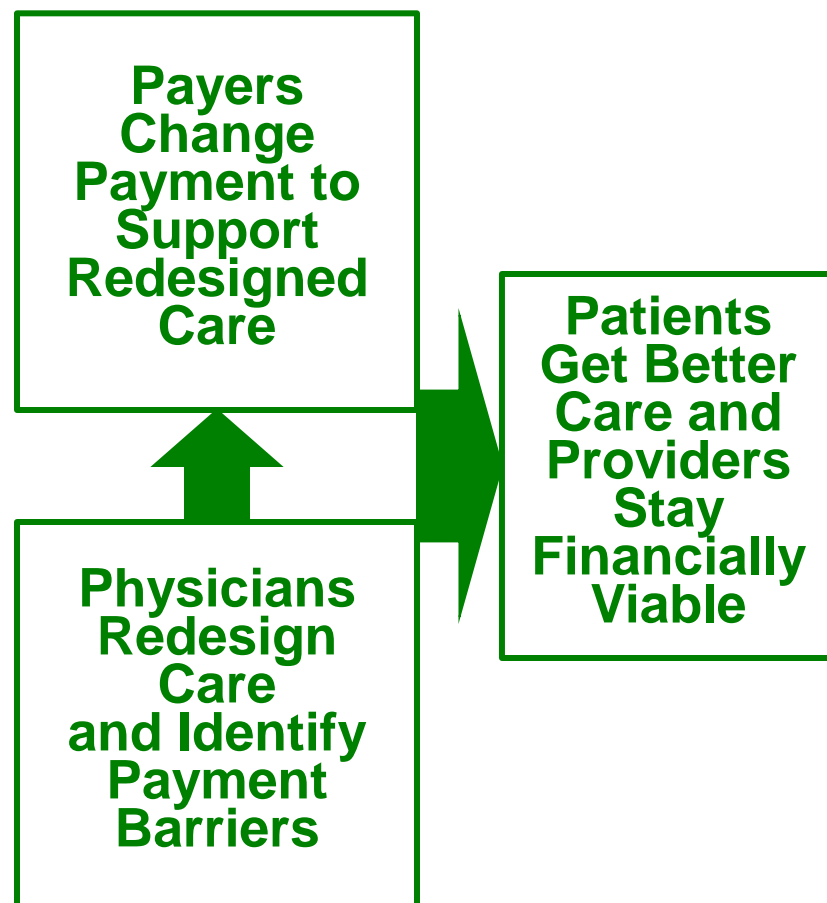


Top-Down vs. Bottom-Up Design of Care & Payment

CMS ONCOLOGY CARE MODEL



ASCO PATIENT-CENTERED ONCOLOGY PAYMENT



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?

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

Surgical Oncology?

Radiation Oncology?

Many Types of Avoidable Spending Already Identified

Choosing Wisely
An initiative of the ABIM Foundation

American Society of Clinical Oncology
ASCO
American Society of Clinical Oncology
Five Things Physicians and Patients Should Question

The American Society of Clinical Oncology (ASCO) is a medical professional society committed to advancing cancer through research, education, prevention and delivery of high-quality patient care. ASCO recognizes with cancer. After careful consideration the expectation value are not supported by available evidence. These items are not appropriate in the individual case. An exception therefore deemed necessary for the patient's participation in medical professional decisions. Patients with any specific concerns should emerge following the development of these items. ASCO

- 1 Don't use cancer-directed therapies based on low evidence-based information.**
 - Studies show that cancer directed therapies based on low evidence-based information (e.g., low-level evidence) are not supported by available evidence. These items are not appropriate in the individual case. An exception therefore deemed necessary for the patient's participation in medical professional decisions. Patients with any specific concerns should emerge following the development of these items. ASCO
- 2 Don't perform PET, CT, or radionuclide bone scan for early prostate cancer.**
 - Imaging with PET, CT, or radionuclide bone scan for early prostate cancer, despite the availability of low-risk cancer, despite the availability of low-risk cancer, despite the availability of low-risk cancer, despite the availability of low-risk cancer.
- 3 Don't perform PET, CT, or radionuclide bone scan for early breast cancer.**
 - Imaging with PET, CT, or radionuclide bone scan for early breast cancer, despite the availability of low-risk cancer, despite the availability of low-risk cancer, despite the availability of low-risk cancer, despite the availability of low-risk cancer.
- 4 Don't perform surveillance imaging for breast cancer.**
 - Surveillance imaging with serum tumor markers for breast cancer that has been treated with curative intent in asymptomatic patients.
 - False-positive tests can lead to harm the patient.
- 5 Don't use white cell count to monitor for neutropenia for patients with breast cancer.**
 - ASCO guidelines recommend using white blood cell count to monitor for neutropenia in approximately 20 percent and equally important. Exceptions should be made when using this complication (due to acute, medical illness).

Choosing Wisely
An initiative of the ABIM Foundation

American Society for Radiation Oncology
ASTRO
American Society for Radiation Oncology
Five Things Physicians and Patients Should Question

- 1 Don't initiate whole breast radiotherapy in women age ≥50 with early-stage breast cancer without considering shorter treatment options.**
 - Whole breast radiotherapy decreases local recurrence and improves overall survival. Most studies have utilized "conventionally fractionated" radiotherapy (approximately 4 weeks). Patients and their physicians should consider shorter treatment options.
- 2 Don't initiate management of low-risk prostate cancer without discussing active surveillance.**
 - Patients with prostate cancer have a number of reasonable management options, including active surveillance.
 - Shared decision-making between the patient and the physician can lead to the best outcome.
 - ASTRO has published patient-directed written decision aids on prostate cancer management that can give patients confidence about their choices, improve their understanding of the options, and help them make a decision that is right for them.
- 3 Don't routinely use extended fractionation for palliation of bone metastases.**
 - Studies suggest equivalent pain relief following 30 Gy in 10 fractions compared to 20 Gy in 5 fractions.
 - A single treatment is more convenient but may be associated with more toxicity.
 - Strong consideration should be given to a single 8 Gy fraction for palliation of bone metastases.
- 4 Don't routinely recommend proton beam therapy outside of a prospective clinical trial.**
 - There is no clear evidence that proton beam therapy for prostate cancer is superior to conventional photon therapy.
 - Clinical trials are necessary to establish a possible advantage of proton beam therapy.
- 5 Don't routinely use intensity-modulated whole breast radiotherapy as primary treatment for breast cancer.**
 - Clinical trials have suggested lower rates of skin toxicity after use of IMRT in breast cancer.
 - In these trials, the term "IMRT" has generally been applied to describe intensity-modulated whole breast radiotherapy.
 - While IMRT may be of benefit in select cases where the anatomy of the breast is complex, it is not routinely recommended.

Choosing Wisely
An initiative of the ABIM Foundation

Society of Gynecologic Oncology
SGO
Society of Gynecologic Oncology
Five Things Physicians and Patients Should Question

- 1 Don't screen low risk women with CA-125 or ultrasound for ovarian cancer.**
 - CA-125 and ultrasound in low risk, asymptomatic women have not led to diagnosis of ovarian cancer in earlier stages of disease or reduced ovarian cancer mortality. False positive results of either test can lead to unnecessary procedures, which have risks of complication.
- 2 Don't perform Pap tests for surveillance of women with a history of endometrial cancer.**
 - Pap testing of the top of the vagina in women treated for endometrial cancer does not improve detection of local recurrence. False positive Pap smears in this group can lead to unnecessary procedures such as colposcopy and biopsy.
- 3 Don't perform colposcopy in patients treated for cervical cancer with Pap tests of low-grade squamous intraepithelial lesion (LSIL) or less.**
 - Colposcopy for low-grade abnormalities in this group does not detect recurrence unless there is a visible lesion and is not cost effective.
- 4 Avoid routine imaging for cancer surveillance in women with gynecologic cancer, specifically ovarian, endometrial, cervical, vulvar and vaginal cancer.**
 - Imaging in the absence of symptoms or rising tumor markers has shown low yield in detecting recurrence or impacting overall survival.
- 5 Don't delay basic level palliative care for women with advanced or relapsed gynecologic cancer, and when appropriate, refer to specialty level palliative medicine.**
 - There is now an evidence-based consensus among physicians who care for cancer patients that palliative care improves symptom burden and quality of life. Palliative care empowers patients and physicians to work together to set appropriate goals for care and outcomes. Palliative care can and should be delivered in parallel with cancer-directed therapies in appropriate patients.

Choosing Wisely
An initiative of the ABIM Foundation

American Academy of Hospice and Palliative Medicine
AAHPM
American Academy of Hospice and Palliative Medicine
Five Things Physicians and Patients Should Question

- 1 Don't use aggressive medical interventions for patients with advanced cancer.**
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Opportunities to Improve Value in Surgical Oncology

PATIENT

**Alternative Payment Model
for Medical Oncology**

**Bundled/Warranted 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

PATIENT

Condition-Based Payment for Patient's Cancer

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

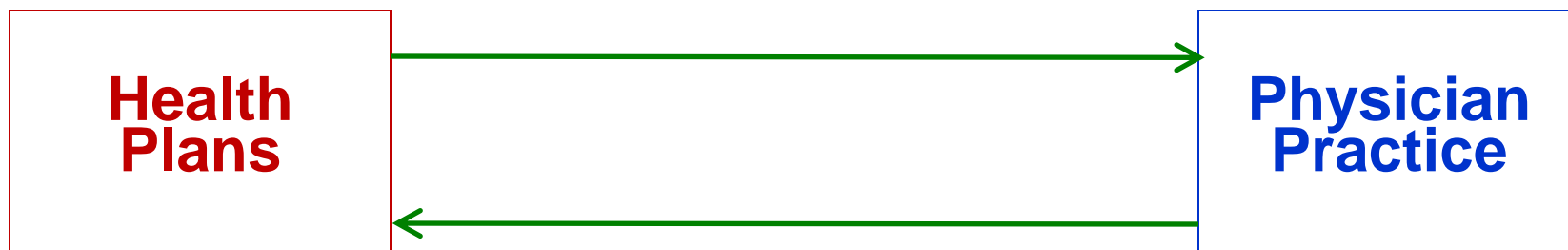
- Will fee levels from payers be adequate to cover the costs of delivering services?
- What utilization controls will payers impose on your services?
- What “value-based” reductions will be made in your payments based on “efficiency” measures?
- What “value-based” reductions will be made in your fees 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



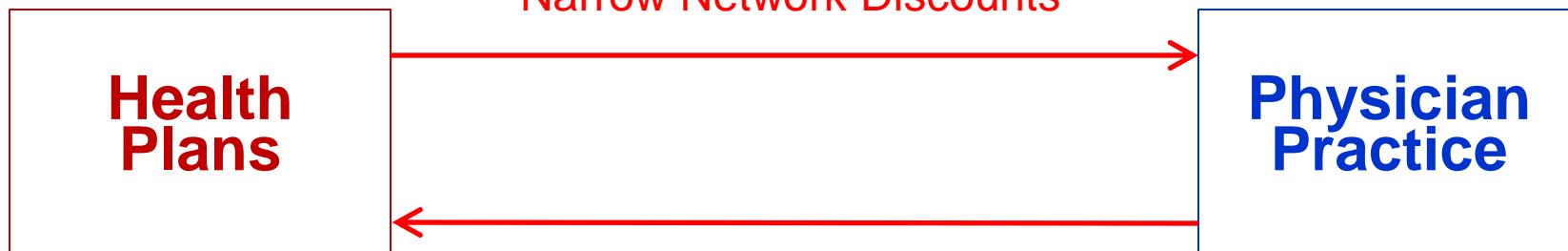
Higher Value Care:

- Better Quality
- Lower Spending

Most Health Plans Resist True Payment Reforms

“Value-Based Purchasing”

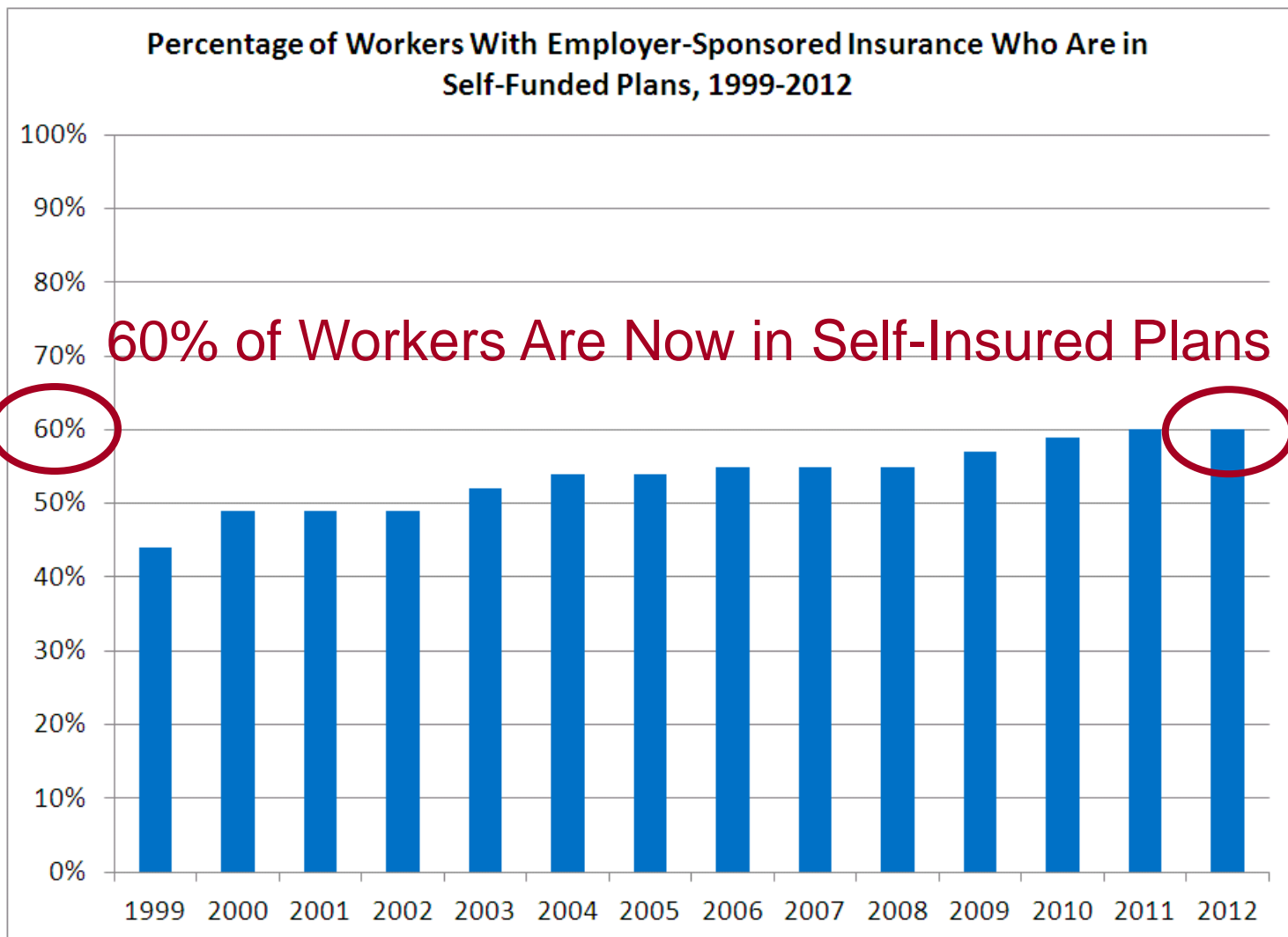
- FFS + P4P
- Shared Savings
- Narrow Network Discounts



Low Value Care:

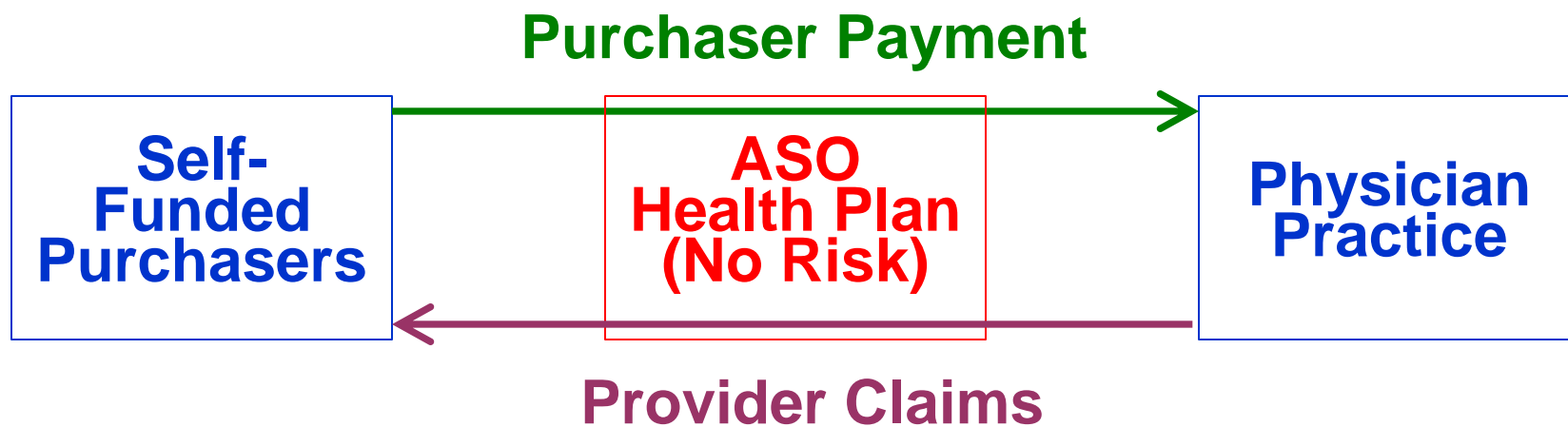
- Poor Quality
- High Avoidable Spending

For Most Workers, *Employers* are the Insurer, Not a Health Plan

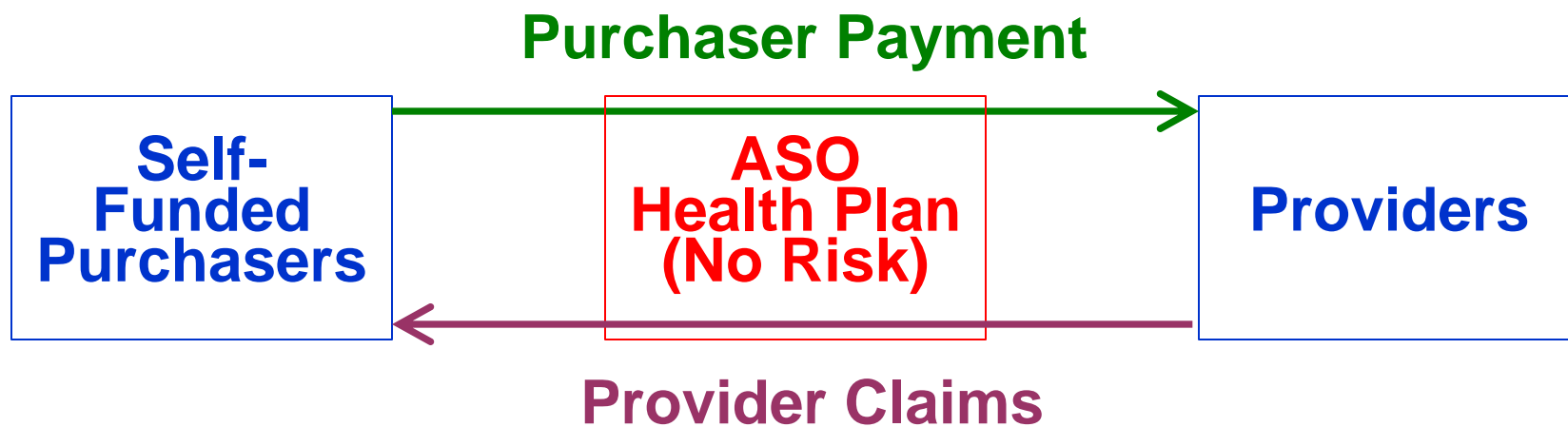


Source: Employer Health Benefits 2012 Annual Survey. The Kaiser Family Foundation and Health Research and Educational Trust

For Self-Funded Employers, The Health Plan is Just a Pass Through



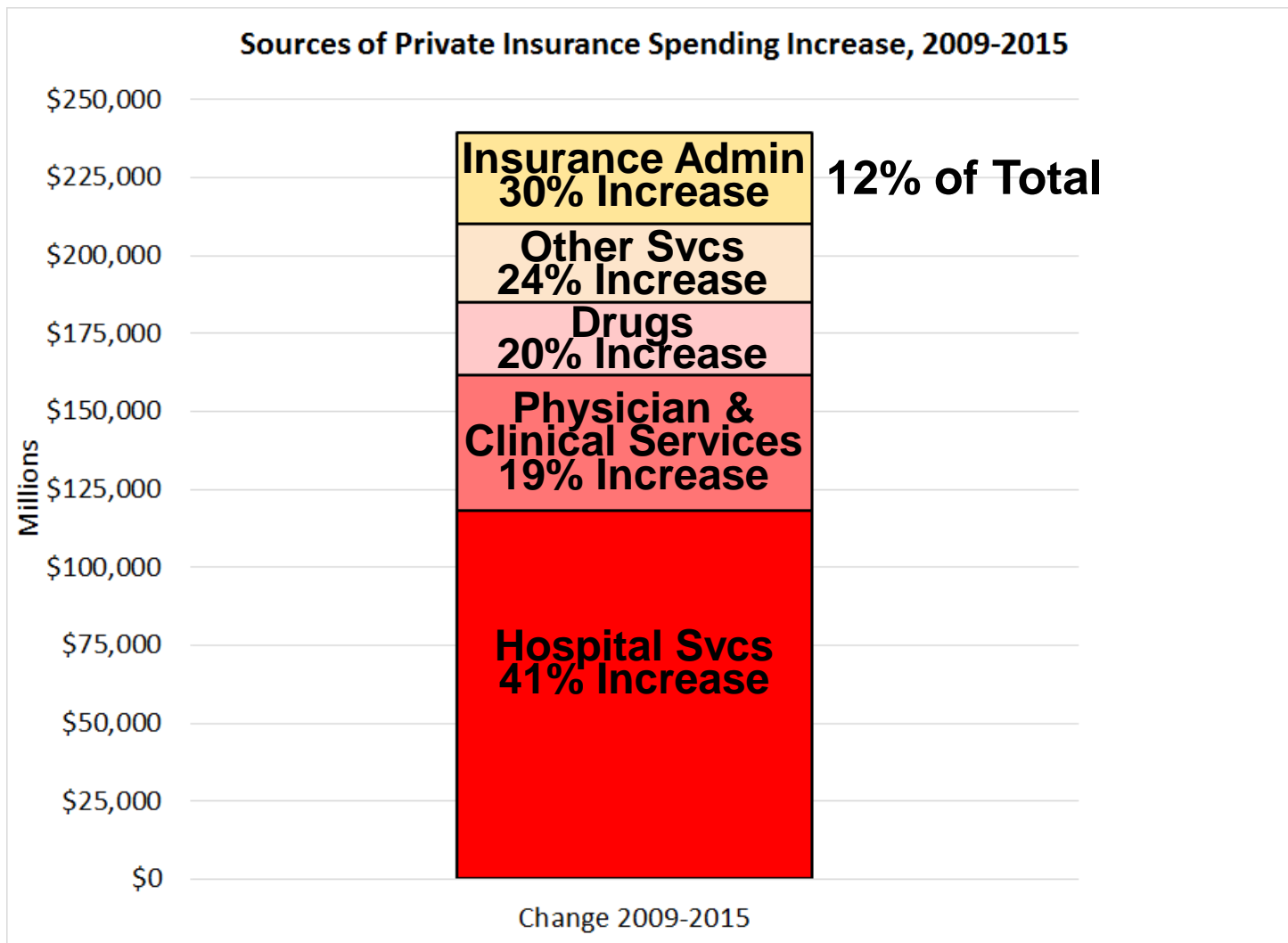
Little Incentive for Health Plans to Support Payment Reforms



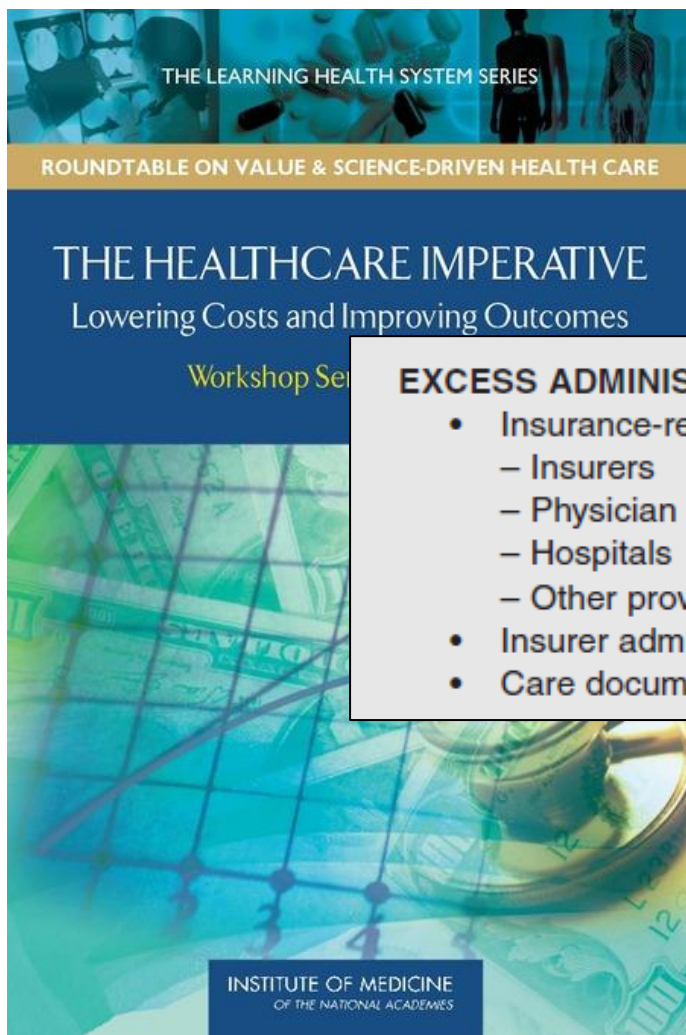
True Payment Reform Means:

- 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



25% of Avoidable Spending is Excess Administrative Costs



Excess Cost Domain Estimates:
*Lower bound totals from workshop discussions**

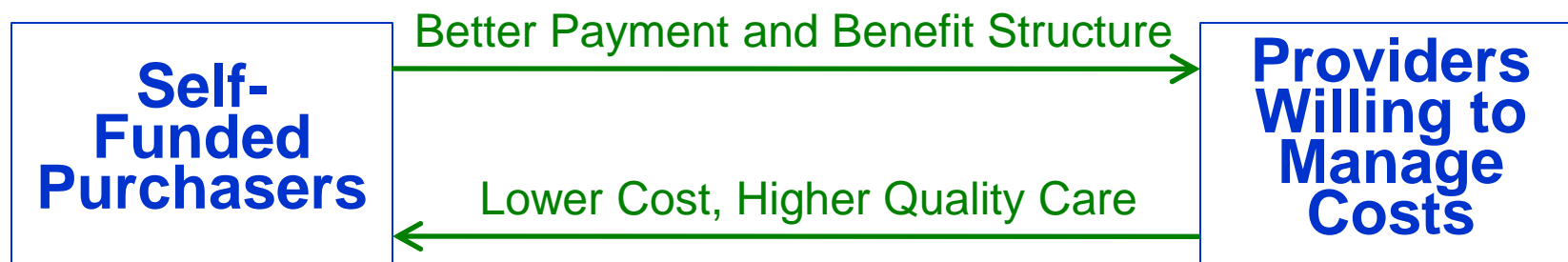
UNNECESSARY SERVICES	Total excess = \$210 B*
<ul style="list-style-type: none"> • Overuse: services beyond evidence-established levels • Discretionary use beyond benchmarks <ul style="list-style-type: none"> – Defensive medicine • Unnecessary choice of higher cost services 	
INEFFICIENTLY DELIVERED SERVICES	Total excess = \$130 B*
<ul style="list-style-type: none"> • Mistakes—medical errors, preventable complications • Care fragmentation • Unnecessary use of higher cost providers • Operational inefficiencies at care delivery sites 	

EXCESS ADMINISTRATIVE COSTS	Total excess = \$190 B*
<ul style="list-style-type: none"> • Insurance-related administrative costs beyond benchmarks <ul style="list-style-type: none"> – Insurers – Physician offices – Hospitals – Other providers • Insurer administrative inefficiencies • Care documentation requirement inefficiencies 	

<ul style="list-style-type: none"> • Product prices beyond competitive benchmarks <ul style="list-style-type: none"> – Pharmaceuticals – Medical devices – Durable medical equipment 	
MISSED PREVENTION OPPORTUNITIES	Total excess = \$55 B*
<ul style="list-style-type: none"> • Primary prevention • Secondary prevention • Tertiary prevention 	
FRAUD	Total excess = \$75 B*
<ul style="list-style-type: none"> • All sources—payer, clinician, patient 	

*Lower bound totals of various estimates, adjusted to 2009 total expenditure level.

A Better Approach: Purchaser/Provider Partnerships



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)

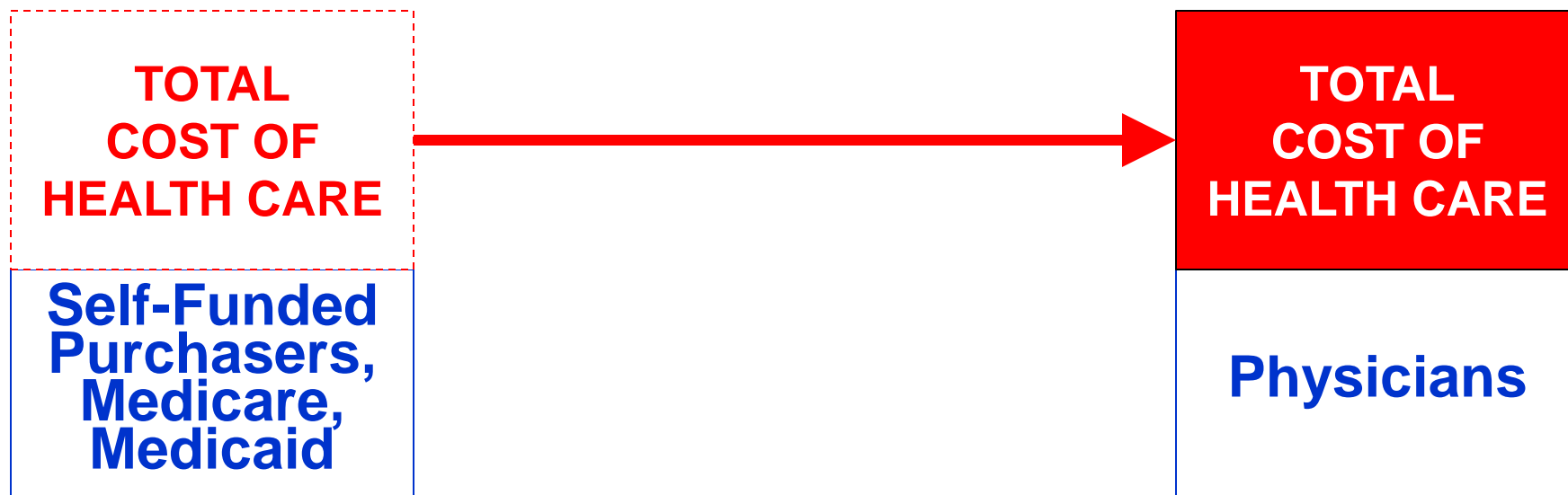
Purchasers Have Total Risk Today

**TOTAL
COST OF
HEALTH CARE**

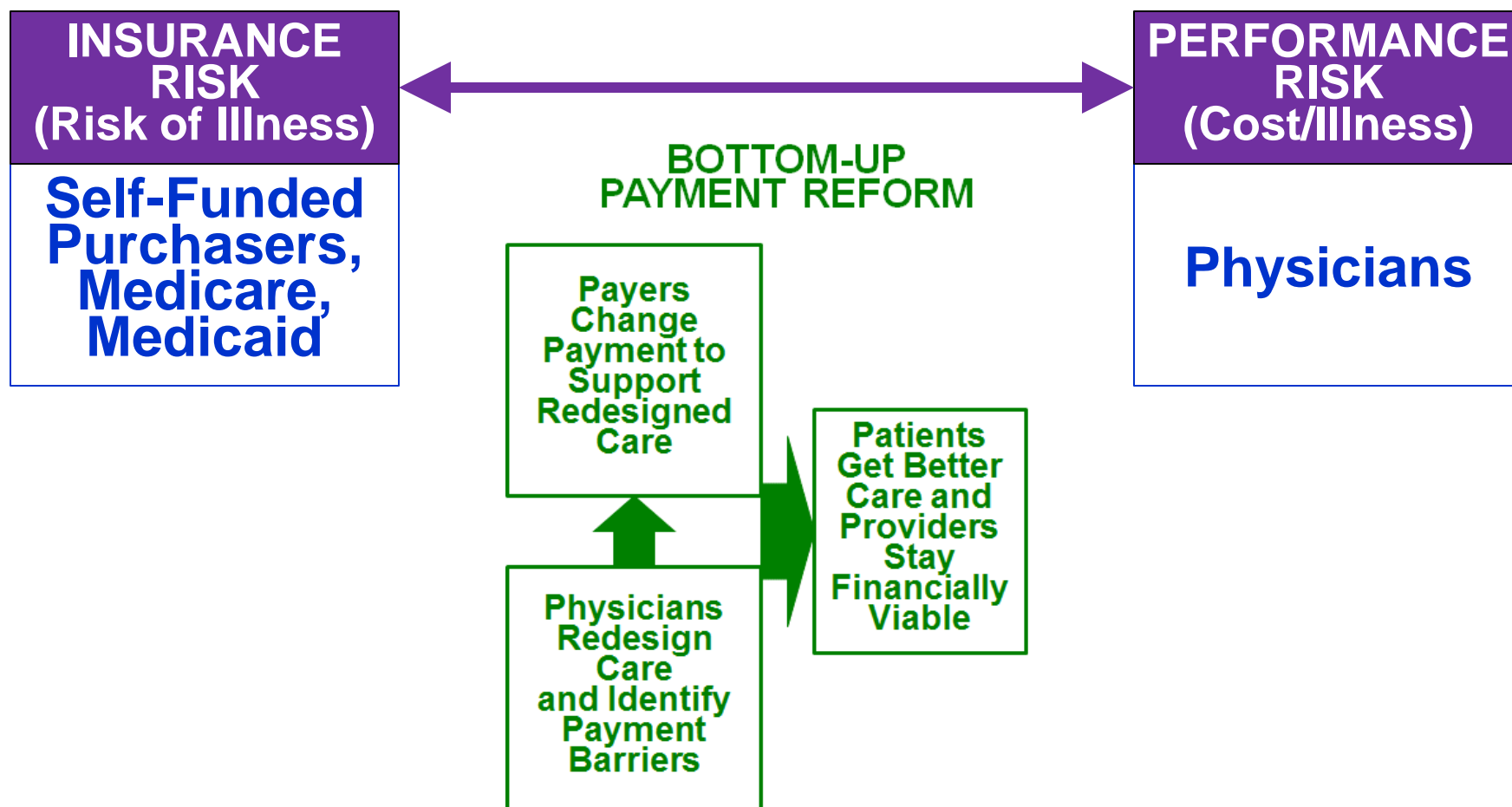
**Self-Funded
Purchasers,
Medicare,
Medicaid**

Providers

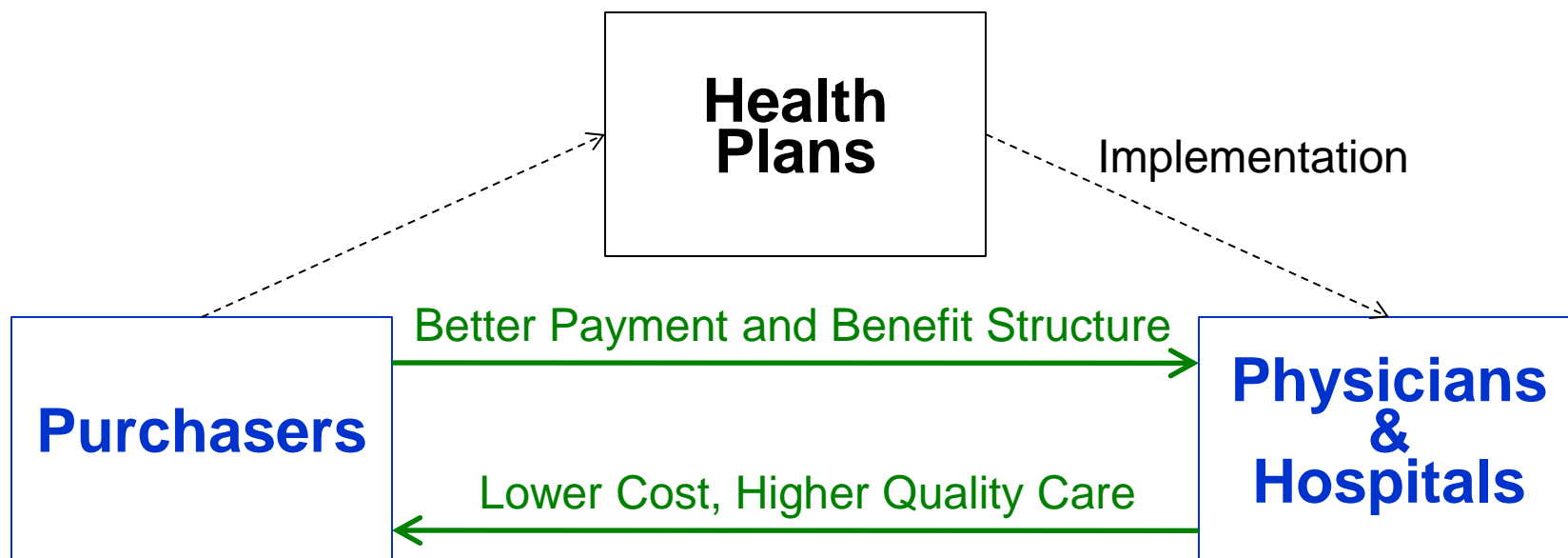
The Goal Should *Not* Be to Shift Total Risk to Physicians



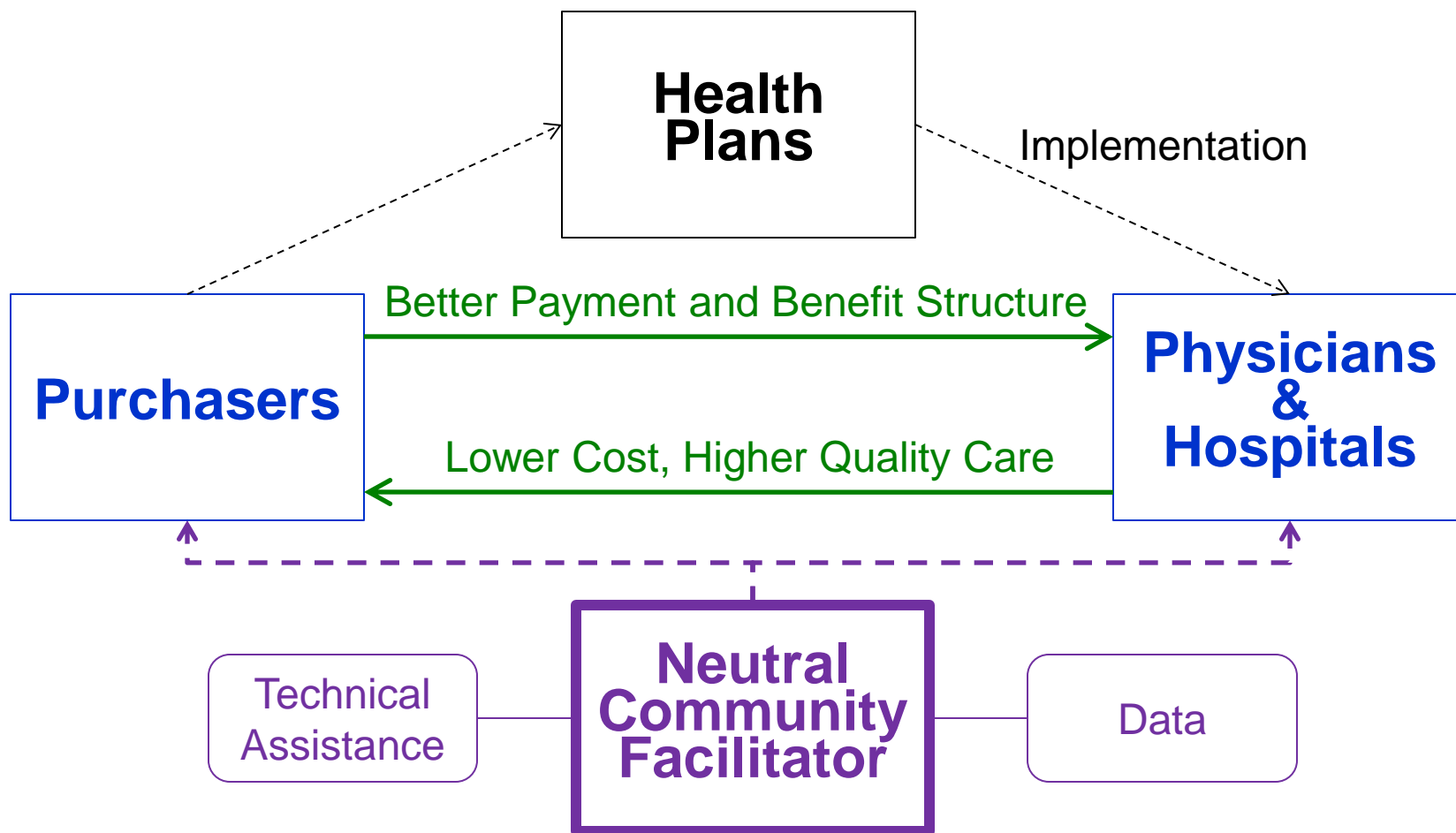
Physicians Should be Accountable for *Costs They Can Control*



Health Plan Implements Changes Purchasers/Providers Agree On

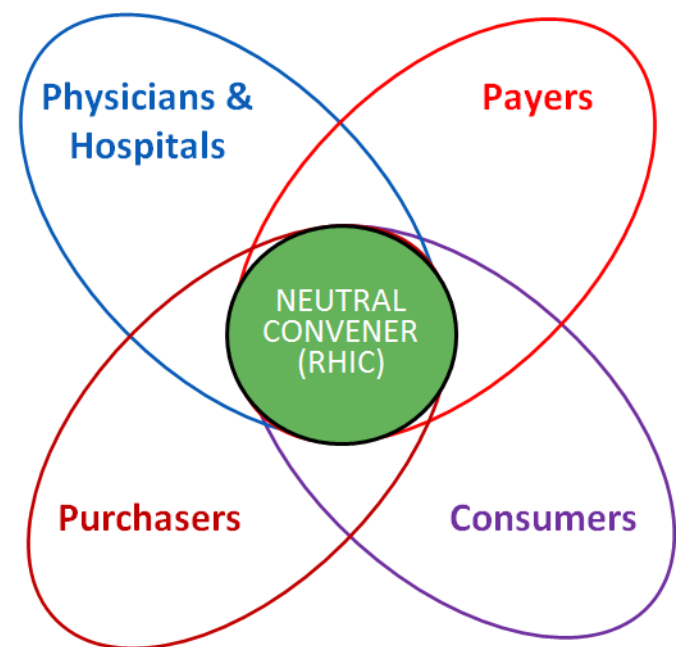


Facilitator Needed to Provide Data and Technical Assistance



Regional Multi-Stakeholder Groups Facilitate Win-Win-Win Solutions

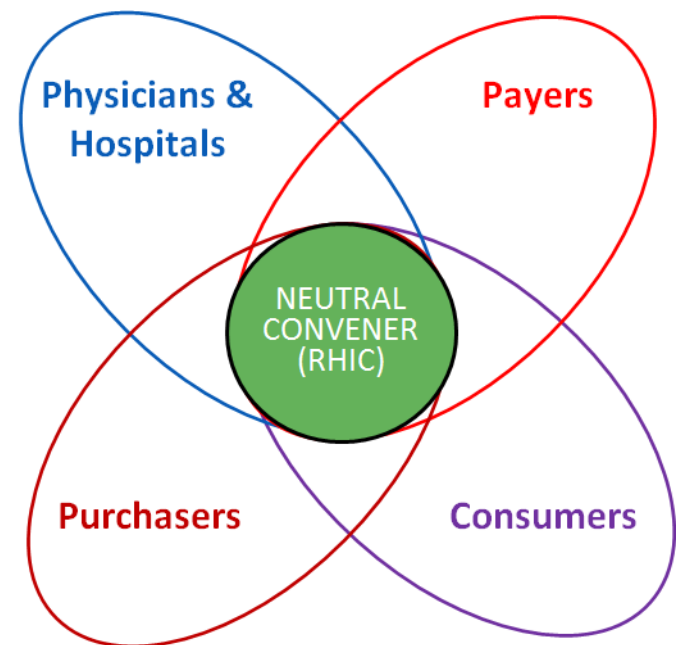
Regional Health Improvement Collaboratives (RHICS)



Network for Regional Healthcare Improvement
www.NRHI.org

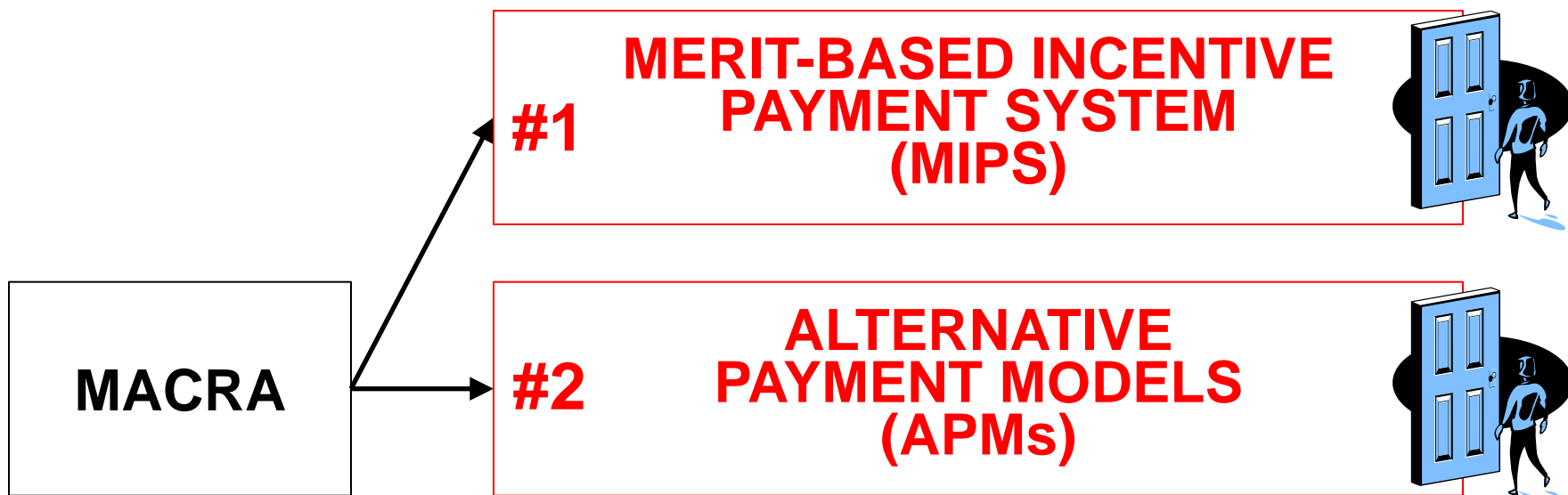
Florida Needs a Mechanism for Multi-Stakeholder Collaboration

Regional Health Improvement Collaboratives (RHICS)

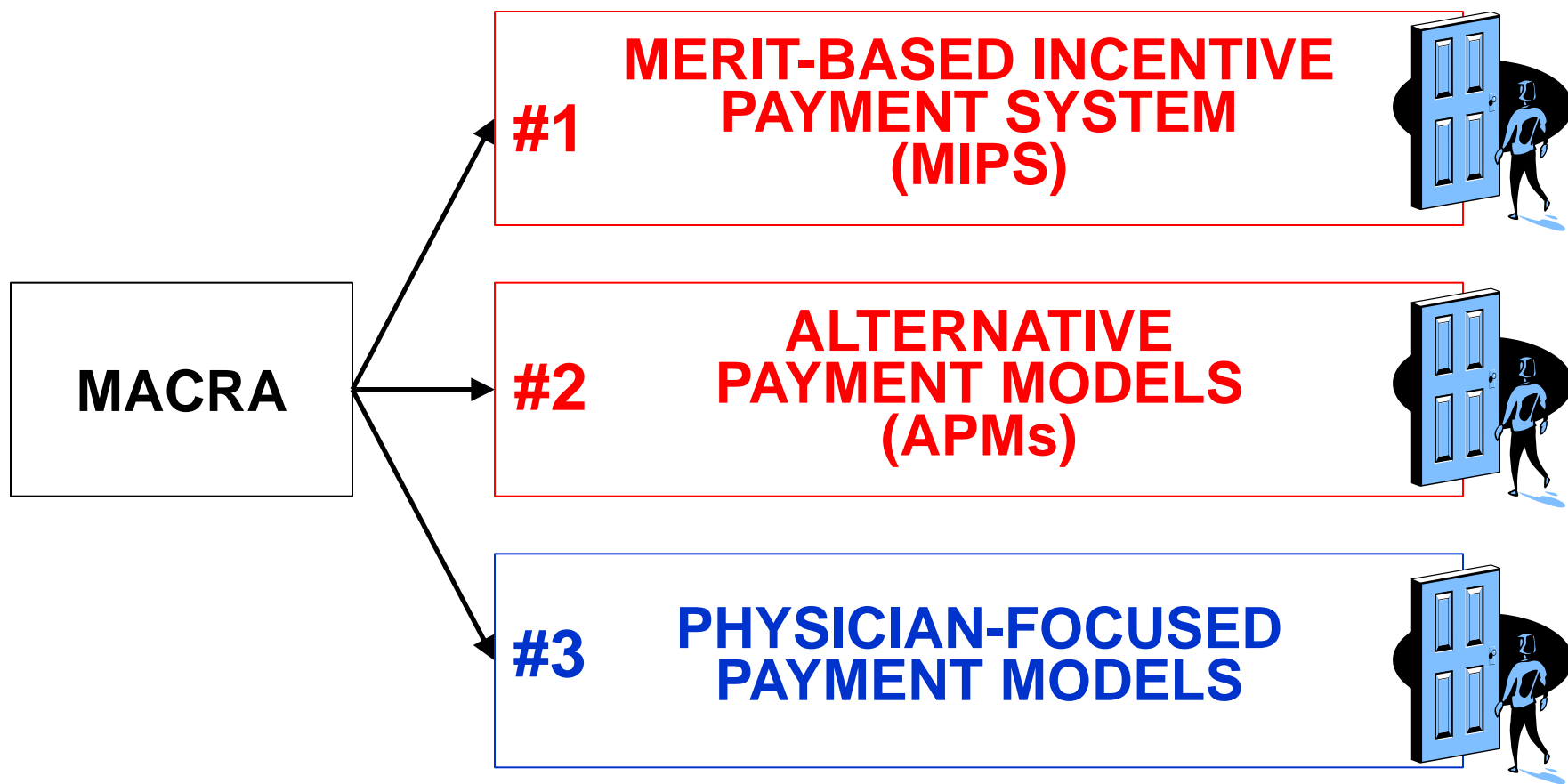


Network for Regional Healthcare Improvement
www.NRHI.org

There Are NOT (Just) Two Choices Under MACRA



There are 3 Paths to the Future: Which Will Oncologists Choose?



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

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2. Plan to retire before 2019

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3. Design/implement physician-led APMs for oncology

If You Don't Like Doors 1 & 2, What Should You Do?

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- ~~2. Plan to retire before 2019~~
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

HOW TO CREATE ACCOUNTABLE CARE ORGANIZATIONS
Harold D. Miller
www.CHQPR.org

Transitioning to Accountable Care
INCREMENTAL PAYMENT REFORMS TO SUPPORT HIGHER QUALITY, MORE AFFORDABLE HEALTH CARE
Harold D. Miller

Ten Barriers to Healthcare Payment Reform
And How to Overcome Them
Harold D. Miller

Making the Business Case for Payment and Delivery Reform
Robert Wood Johnson Foundation
Harold D. Miller
Center for Healthcare Quality and Payment Reform

Measuring and Assigning Accountability for Healthcare Spending
Fair and Effective Ways to Analyze the Drivers of Healthcare Costs and Transition to Value-Based Payment
Harold D. Miller

Payment Reform Series No. 3
The Building Blocks of Successful Payment Reform:
Designing Payment Systems that Support Higher-Value Health Care
Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform
April 2013

The Payment Reform GLOSSARY
Definitions and Explanations of the Terminology Used to Describe Methods of Paying for Healthcare Services
First Edition

BUNDLING BETTER
How Medicare Should Pay for Comprehensive Care (for Hip and Knee Surgery and Other Healthcare Needs)
Harold D. Miller

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A GUIDE TO PHYSICIAN-FOCUSED ALTERNATIVE PAYMENT MODELS
Better Care for Patients
Financially Viable Physician Practices
Lower Spending for Payers

IMPLEMENTING ALTERNATIVE PAYMENT MODELS UNDER MACRA
How the Federal Government Can Accelerate Successful Health Care Payment Reform
Harold D. Miller
First Edition



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APPENDIX

Example of Win-Win-Win Approach
for Physicians, Hospitals, and Payers
Using Condition-Based Payment

Example: Reducing Preventable Admits During Cancer Treatment

	CURRENT		
	\$/Pt	# Pts	Total \$
Oncology Pract.			
E&M/Infusions	\$4,500	1000	\$4,500,000

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

	CURRENT		
	\$/Pt	# Pts	Total \$
Oncology Pract.			
E&M/Infusions	\$4,500	1000	\$4,500,000
Hospitalizations			
Admissions	\$15,000	350	\$5,250,000

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

	CURRENT		
	\$/Pt	# Pts	Total \$
Oncology Pract.			
E&M/Infusions	\$4,500	1000	\$4,500,000
Hospitalizations			
Admissions	\$15,000	350	\$5,250,000
Total Spending		1000	\$9,750,000

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)

How Would You Improve Payment and Lower Total Spending?

	CURRENT			FUTURE			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000	?			
Hospitalizations							
Admissions	\$15,000	350	\$5,250,000	?			
Total Spending		1000	\$9,750,000	?			

Improve Care for Patients By Paying for Triage/Response

	CURRENT			FUTURE			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000	\$4500	1000	\$4,500,000	
Triage/Respond				\$200	1000	\$200,000	
Total Practice		1000	\$4,500,000		1000	\$4,700,000	+4%
Hospitalizations							
Admissions	\$15,000	350	\$5,250,000				
Total Spending		1000	\$9,750,000				

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

	CURRENT			FUTURE			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000	\$4500	1000	\$4,500,000	
Triage/Respond				\$200	1000	\$200,000	
Total Practice		1000	\$4,500,000		1000	\$4,700,000	+4%
Hospitalizations							
Admissions	\$15,000	350		245		\$3,675,000	-30%
Total Spending		1000	\$9,750,000		1000	\$9,375,000	-14%

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

	CURRENT			FUTURE			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000	\$4500	1000	\$4,500,000	
Triage/Respond				\$200	1000	\$200,000	
Total Practice		1000	\$4,500,000		1000	\$4,700,000	+4%
Hospitalizations							
Admissions	\$15,000	350	\$5,250,000	\$15,000	245	\$3,675,000	-30%
Total Spending		1000	\$9,750,000		1000	\$9,375,000	-14%

Oncology Practice Wins

Patient Wins

Payer Wins

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 But What About Hospitals?

	CURRENT			FUTURE			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000	\$4500	1000	\$4,500,000	
Triage/Respond				\$200	1000	\$200,000	
Total Practice		1000	\$4,500,000		1000	\$4,700,000	+4%
Hospitalizations							
Admissions	\$15,000	350	\$5,250,000	\$15,000	245	\$3,675,000	-30%
Total Spending		1000	\$9,750,000		1000	\$9,375,000	-14%

Oncology Practice Wins

Hospital Loses

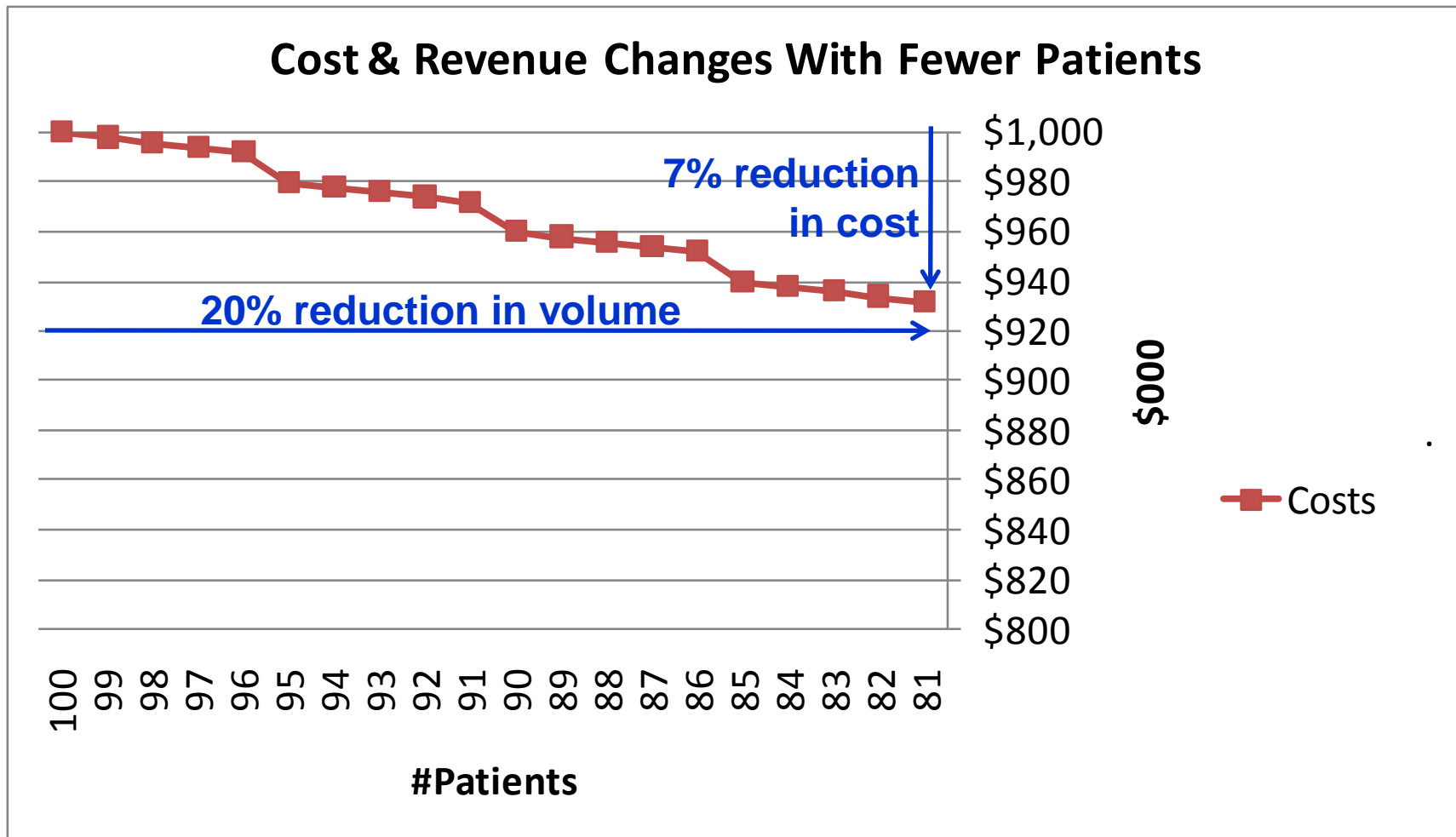
Payer Wins

Better Payment for Cancer Treatment Management

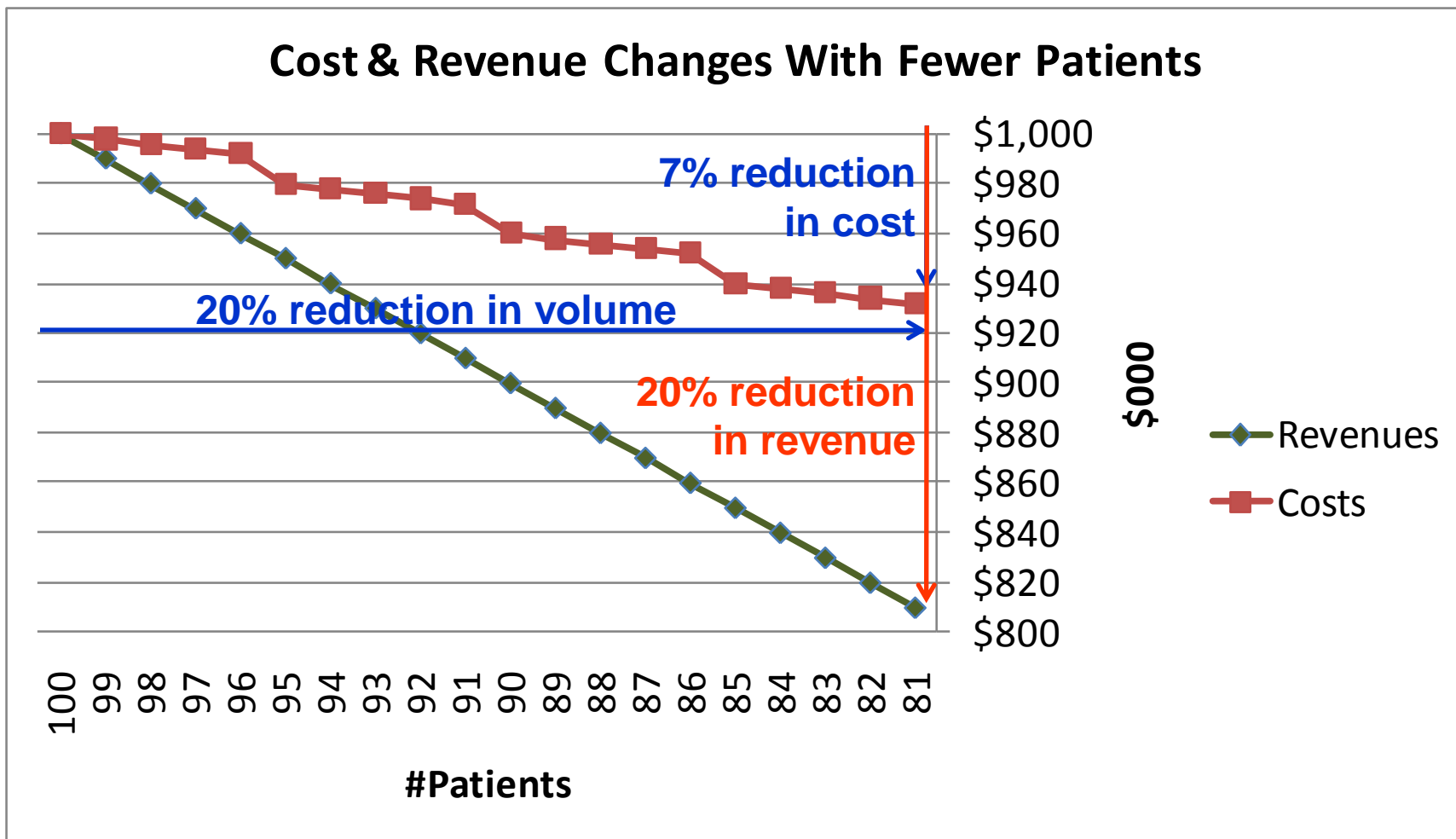
- Oncology practice paid additional \$200,000 (\$200/patient) to set up a triage system and provide rapid treatment in the office for complications of treatment (nausea, fever, etc.)
- Result is a 30% reduction in preventable hospital admissions

What Should Matter to Hospitals is *Margin*, Not Revenues (Volume)

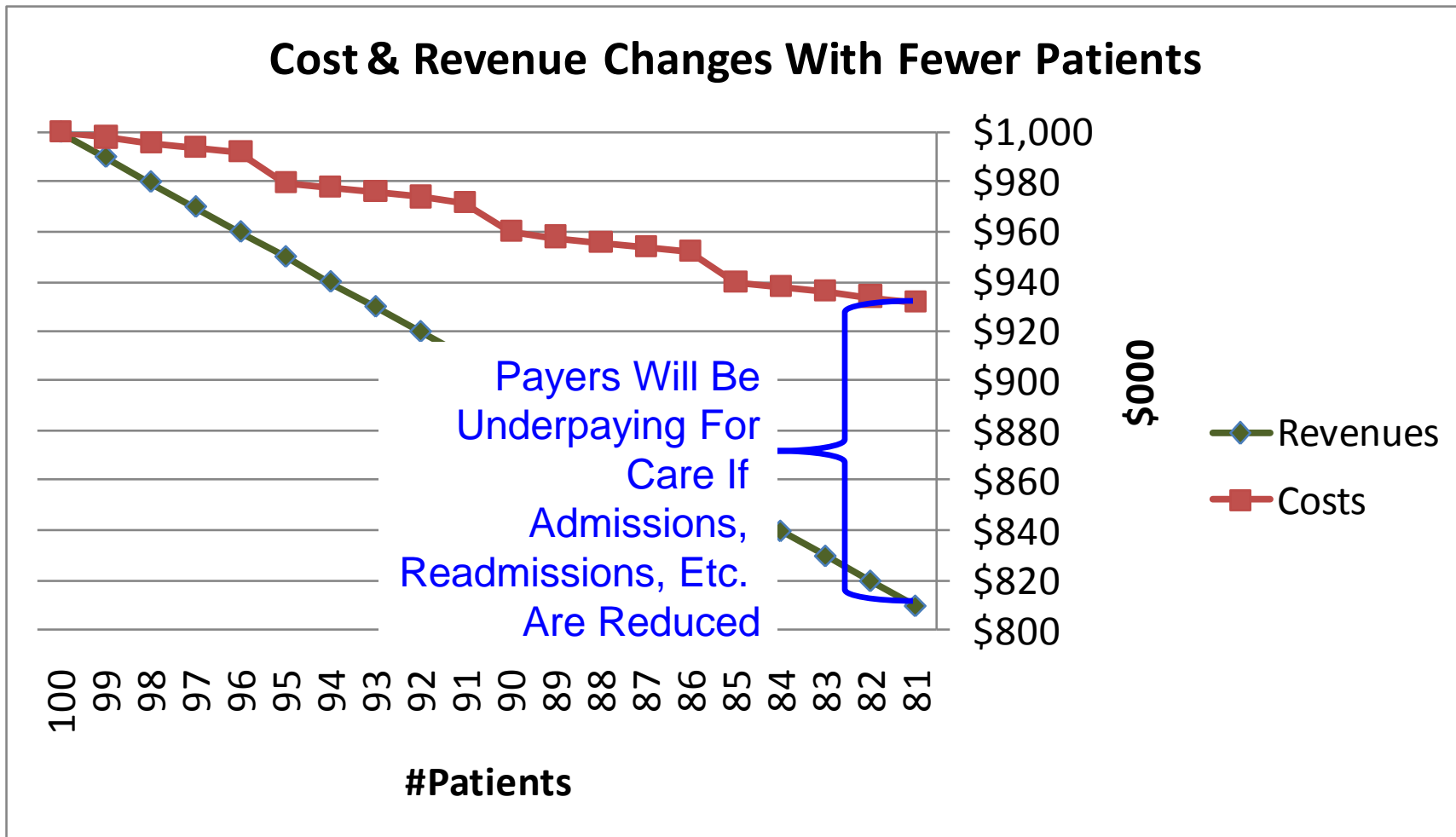
Hospital Costs Are Not Proportional to Utilization



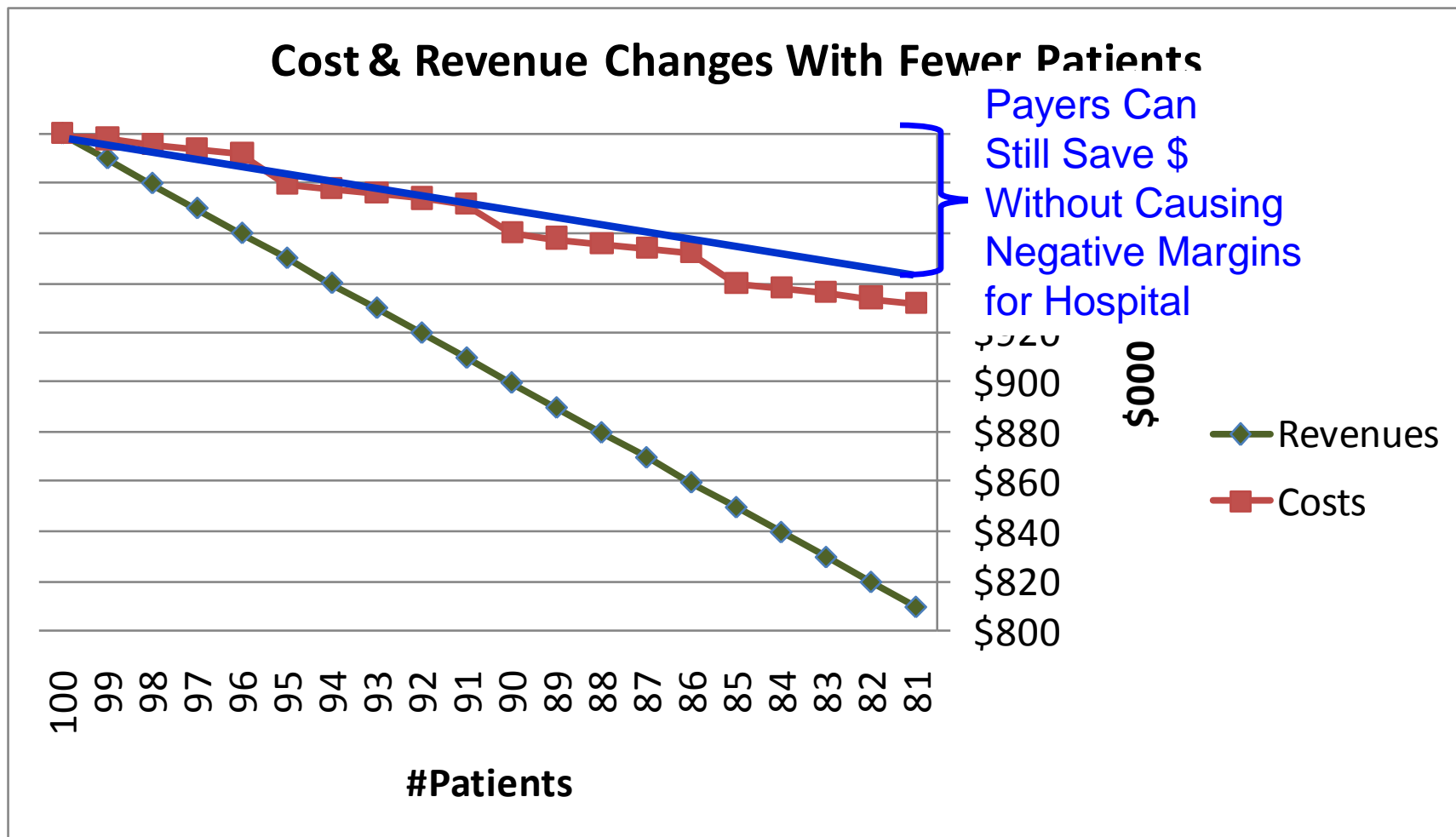
Reductions in Utilization Reduce Revenues More Than Costs



Causing Negative Margins for Hospitals



But Spending Can Be Reduced Without Bankrupting Hospitals



We Need to Understand the Hospital's Cost Structure

	CURRENT			FUTURE			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000	\$4500	1000	\$4,500,000	
Triage/Respond				\$200	1000	\$200,000	
Total Practice		1000	\$4,500,000		1000	\$4,700,000	+4%
Hospitalizations							
Admissions	\$15,000	350	\$5,250,000	\$15,000	245	\$3,675,000	-30%
Total Spending		1000	\$9,750,000		1000	\$9,375,000	-14%

We Need to Understand the Hospital's Cost Structure

	CURRENT			FUTURE			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000	\$4,500	1000	\$4,500,000	
Triage/Respond				\$200	1000	\$200,000	
Total Practice		1000	\$4,500,000		1000	\$4,700,000	+4%
Hospitalizations							
Fixed (65%)	\$9,750		\$3,412,500				
Variable (30%)	\$4,500		\$1,575,000				
Margin (5%)	\$750		\$262,500				
Total Hospital	\$15,000	350	\$5,250,000				
Total Spending		1000	\$9,750,000				

Now, If the Number of Admissions is Reduced...

	CURRENT			FUTURE			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000	\$4,500	1000	\$4,500,000	
Triage/Respond				\$200	1000	\$200,000	
Total Practice		1000	\$4,500,000		1000	\$4,700,000	+4%
Hospitalizations							
Fixed (65%)	\$9,750		\$3,412,500				
Variable (30%)	\$4,500		\$1,575,000				
Margin (5%)	\$750		\$262,500				
Total Hospital	\$15,000	350			245		
Total Spending		1000	\$9,750,000				

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

	CURRENT			FUTURE			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000	\$4,500	1000	\$4,500,000	
Triage/Respond				\$200	1000	\$200,000	
Total Practice		1000	\$4,500,000		1000	\$4,700,000	+4%
Hospitalizations							
Fixed (65%)	\$9,750		\$3,412,500	\$9,750		\$3,412,500	0%
Variable (30%)	\$4,500		\$1,575,000	\$4,500		\$1,575,000	
Margin (5%)	\$750		\$262,500	\$750		\$262,500	
Total Hospital	\$15,000	350	\$5,250,000	\$15,000	245	\$3,637,500	-31%
Total Spending		1000	\$9,750,000		1000	\$8,332,500	-14%

... Variable Costs Will Decrease in Proportion to Admissions...

	CURRENT			FUTURE			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000	\$4,500	1000	\$4,500,000	
Triage/Respond				\$200	1000	\$200,000	
Total Practice		1000	\$4,500,000		1000	\$4,700,000	+4%
Hospitalizations							
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				
Total Hospital	\$15,000	350	\$5,250,000		245		
Total Spending		1000	\$9,750,000				

...And Even With a Higher Margin...

	CURRENT			FUTURE			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000	\$4,500	1000	\$4,500,000	
Triage/Respond				\$200	1000	\$200,000	
Total Practice		1000	\$4,500,000		1000	\$4,700,000	+4%
Hospitalizations							
Fixed (65%)	\$9,750		\$3,412,500			\$3,412,500	0%
Variable (30%)	\$4,500		\$1,575,000	\$4,500		\$1,102,500	-30%
Margin (5%)	\$750		\$262,500			\$273,000	+4%
Total Hospital	\$15,000	350	\$5,250,000		245		
Total Spending		1000	\$9,750,000				

...The Hospital Comes Out Ahead With Significantly Lower Revenue

	CURRENT			FUTURE			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000	\$4,500	1000	\$4,500,000	
Triage/Respond				\$200	1000	\$200,000	
Total Practice		1000	\$4,500,000		1000	\$4,700,000	+4%
Hospitalizations							
Fixed (65%)	\$9,750		\$3,412,500			\$3,412,500	0%
Variable (30%)	\$4,500		\$1,575,000	\$4,500		\$1,102,500	-30%
Margin (5%)	\$750		\$262,500			\$273,000	+4%
Total Hospital	\$15,000	350	\$5,250,000			\$4,788,000	-9%
Total Spending		1000	\$9,750,000				

And the Payer Still Saves Money

	CURRENT			FUTURE			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000	\$4,500	1000	\$4,500,000	
Triage/Respond				\$200	1000	\$200,000	
Total Practice		1000	\$4,500,000		1000	\$4,700,000	+4%
Hospitalizations							
Fixed (65%)	\$9,750		\$3,412,500			\$3,412,500	0%
Variable (30%)	\$4,500		\$1,575,000	\$4,500		\$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		1000	\$9,750,000			\$9,488,000	-3%

I.e., a Win-Win-Win-Win for Patient, Practice, Hospital, & Payer

	CURRENT			FUTURE			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000	\$4,500	1000	\$4,500,000	
Triage/Respond				\$200	1000	\$200,000	
Total Practice		1000	\$4,500,000		1000	\$4,700,000	+4%
Hospitalizations							
Fixed (65%)	\$9,750		\$3,412,500			\$3,412,500	0%
Variable (30%)	\$4,500		\$1,575,000	\$4,500		\$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		1000	\$9,750,000		1000	\$9,488,000	-3%

Oncology Practice Wins

Hospital Wins

Payer Wins

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

	CURRENT			FUTURE			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000	\$4,500	1000	\$4,500,000	
Triage/Respond				\$200	1000	\$200,000	
Total Practice		1000	\$4,500,000		1000	\$4,700,000	+4%
Hospitalizations							
Fixed (65%)	\$9,750		\$3,412,500			\$3,412,500	0%
Variable (30%)	\$4,500		\$1,575,000	\$4,500		\$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		1000	\$9,750,000		1000	\$9,488,000	-3%

Trying to Renegotiate Individual Fees Is Impractical

	CURRENT			FUTURE			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000	\$4,500	1000	\$4,500,000	
Triage/Respond				\$200	1000	\$200,000	
Total Practice		1000	\$4,500,000		1000	\$4,700,000	+4%
Hospitalizations							
Fixed (65%)	\$9,750		\$3,412,500			\$3,412,500	0%
Variable (30%)	\$4,500		\$1,575,000	\$4,500		\$1,102,500	-30%
Margin (5%)	\$750		\$262,500			\$273,000	+4%
Total Hospital	\$15,000			\$19,543	245	\$4,788,000	-9%
Total Spending		1000	\$9,750,000		1000	\$9,488,000	-3%

Look at What is Being Spent on the Patients' *Condition*

	CURRENT			FUTURE			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000				
Triage/Respond							
Total Practice		1000	\$4,500,000				
Hospitalizations							
Fixed (65%)	\$9,750		\$3,412,500				
Variable (30%)	\$4,500		\$1,575,000				
Margin (5%)	\$750		\$262,500				
Total Hospital	\$15,000	350	\$5,250,000				
Total Spending	\$9,750	1000	\$9,750,000				

...Offer to Manage Care for a Lower, But More Flexible Payment

	CURRENT			FUTURE			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000				
Triage/Respond							
Total Practice		1000	\$4,500,000				
Hospitalizations							
Fixed (65%)	\$9,750		\$3,412,500				
Variable (30%)	\$4,500		\$1,575,000				
Margin (5%)	\$750		\$262,500				
Total Hospital	\$15,000	350	\$5,250,000				
Total Spending	\$9,750	1000		\$9,488			-3%

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

	CURRENT			FUTURE			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000				
Triage/Respond							
Total Practice		1000	\$4,500,000	\$4,700	1000	\$4,700,000	+4%
Hospitalizations							
Fixed (65%)	\$9,750		\$3,412,500				0%
Variable (30%)	\$4,500		\$1,575,000				-30%
Margin (5%)	\$750		\$262,500				+4%
Total Hospital	\$15,000	350	\$5,250,000	\$4,788	1000	\$4,788,000	9%
Total Spending	\$9,750	1000		\$9,488		\$9,488,000	-3%

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

	CURRENT			FUTURE			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000			\$4,500,000	
Triage/Respond						\$200,000	
Total Practice		1000	\$4,500,000	\$4,700	1000	\$4,700,000	+4%
Hospitalizations							
Fixed (65%)	\$9,750		\$3,412,500			\$3,412,500	0%
Variable (30%)	\$4,500		\$1,575,000		245	\$1,102,500	-30%
Margin (5%)	\$750		\$262,500			\$273,000	+4%
Total Hospital	\$15,000	350	\$5,250,000	\$4,788	1000	\$4,788,000	-9%
Total Spending	\$9,750	1000	\$9,750,000	\$9,488		\$9,488,000	-3%

Condition-Based Payment Provides Flexibility to Redesign Care & Pmt

	CURRENT			CONDITION-BASED PMT			Chg
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusions	\$4,500	1000	\$4,500,000			\$4,500,000	
Triage/Respond						\$200,000	
Total Practice		1000	\$4,500,000	\$4,700	1000	\$4,700,000	+4%
Hospitalizations							
Fixed (65%)	\$9,750		\$3,412,500			\$3,412,500	0%
Variable (30%)	\$4,500		\$1,575,000		245	\$1,102,500	-30%
Margin (5%)	\$750		\$262,500			\$273,000	+4%
Total Hospital	\$15,000	350	\$5,250,000	\$4,788	1000	\$4,788,000	-9%
Total Spending	\$9,750	1000	\$9,750,000	\$9,488		\$9,488,000	-3%

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

	LOWER RISK PATIENTS		HIGHER RISK PATIENTS		
		# Pts		# Pts	
Oncology Pract.					
Total Practice		500		500	1000
Hospitalizations					
Total Hospital		62		183	245
		500		500	1000

Lower-Risk (12%)
of Hospital Admission

Higher-Risk (37%)
of Hospital Admission

Example of Risk-Stratified Condition-Based Payment

	LOWER RISK PATIENTS			HIGHER RISK PATIENTS			TOTAL
	\$/Pt	# Pts	Total \$	\$/Pt	# Pts	Total \$	
Oncology Pract.							
E&M/Infusion	\$4,500	500	\$2,250,000	\$4,500	500	\$2,250,000	\$4,500,000
Triage/Intervene	\$100	500	\$50,000	\$300	500	\$150,000	\$200,000
Total Practice	\$4,600	500	\$2,300,000	\$4,800	500	\$2,400,000	\$4,700,000
Hospitalizations							
Fixed			\$853,125			\$2,559,375	\$3,412,500
Variable	\$4,500		\$279,000	\$4,500		\$823,500	\$1,102,500
Margin			\$68,250			\$204,750	\$273,000
Total Hospital	\$2,401	62	\$1,200,375	\$7,175	183	\$3,587,625	\$4,788,000
Total Spending	\$7,001	500	\$3,500,375	\$11,975	500	\$5,987,625	\$9,488,000

Lower Payment
For Lower-Risk
Patients

Higher Payment
For Higher-Risk
Patients

Still
Lower
Total
Spending