2012 Cancer Center Business Summit

Transitioning to Value Based Oncology: Strategies to Survive and Thrive

2012 Cancer Center Business Summit

Transitioning to Value Based Oncology: Strategies to Survive and Thrive

Oncology's Fit in an ACO World: Report of Findings of the 2012 Cancer Center Business Summit Industry Survey

Disclosure Information

Ronald Barkley, MS, JD

Employment or Leadership Position: President, Cancer Center Business Development Group; Partner, TRG Healthcare

Consultant or Advisory Role: Consultant, Business Advisor

Stock Ownership: Yes

Honoraria: No

Research Funding: Yes. **Foley & Lardner; HillCo HEALTH**

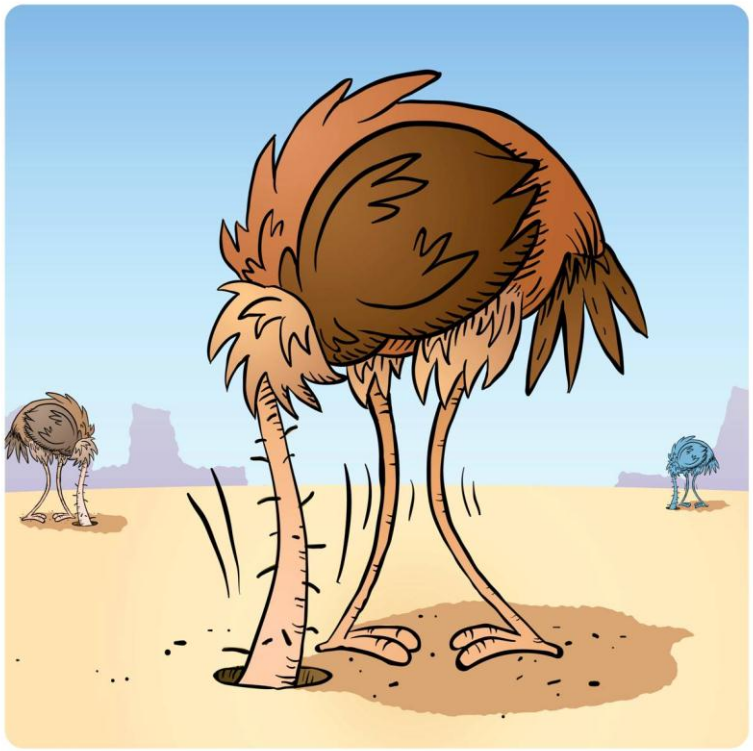
Expert Testimony: No

Other Remuneration: No

Please note, all disclosures are reported as submitted to the Cancer Center Business Summit and are available at cancerbusinesssummit.com.

Oncology's Fit in ACOs

One Line of Thinking . . . Oncology/Cancer Care is



- Low incidence
- High cost
- Too much variation
- Too complex of a condition
- **Therefore, why bother?**

Why Bother?

- $128 B U.S. annual cancer spend is second only to cardiovascular related conditions
- Cancer = 1% of patient population, but 10% of healthcare costs
- Average annual cost for cancer patient = $80,000 to $110,000 v. $6,800 average per capita all patients
- Known: cancer spend can be reduced by 7% to 13%
- Oncology contribution to shared savings can get close to = all PCP savings combined

Putting the Savings in Perspective

Cancer incidence rate per 1,000 Medicare population	**21**
Average cost per cancer patient (during MSSP year)	$80K
Average cancer cost per 1,000 Medicare lives	$1.7M
Potential cancer cost savings rate (7% to 13%)	10%
Potential cancer cost savings per 1,000 Medicare lives	$170K
“Average size” ACO in # Medicare lives (50-150 PCPs)	17,000
“Average size” ACO potential cancer cost savings	**$2.9M**

The ACO World as of October 2012

32 Medicare Pioneer ACO s

116 Medicare MSSP ACO s

6 PGP Transition Demos

200 Commercial ACOs

400 Medicare ACO Applications for class of January 2013

350 ACOs and Counting (9% market share)

2.5 M Medicare ACO Beneficiaries = 5% Medicare Population

Medicare ACO Basics

- ACO is the vehicle through which CMS looks to transition health care delivery from volume-based to value-based
- The Triple Aim:

Improve Experience of Care
Improve Health of Populations
Reduce per Capita Cost

- Primary care oriented: Medicare beneficiaries attributed to PCPs associated with the ACO (100 – 300 attributed per PCP)
- ACO providers share cost savings below FFS-based Expenditure Benchmark (50%/50% MSSP – 60%/40% Pioneer)
- Excludes 99th percentile outlier costs (about $100,000)
- " If ACO is effective, then someone is making less money"

Commercial ACO Basics

- Same basic objective as Medicare ACO, but a bit more practical focus on reducing costs (claims)
- Typically involves a commercial health plan + physicians +/- hospital in a customized contractual arrangement (often no new "O" in Commercial ACO)
- Health plan pays something different, a "premium," for improved outcomes and reduced costs
- Predominantly PCP oriented, but more recently an interest in incorporating specialists – specialty specific ACOs
- Payment methodologies vary widely, for example: pmpm, care management fee, but often with a shared savings basis
- Currently more Commercial ACOs than Medicare ACOs

The 2012 Summit Industry Research Survey

Survey Participants by Region

Location	Medicare ACO	Commercial ACO*	Thought Leaders	Totals
Northeast	13	1	6	20
Southeast	7	2	5	14
Midwest	7	1	5	13
Southwest	5	0	1	6
West	8	1	0	9
National	0	2	0	2
Totals	**40**	**7**	**17**	**64**

***Commercial ACOs interviewed were ones that have an oncology-specific component**

Focused interviews conducted by Candice Leonard, PhD. June – August 2012

Survey Inquiries & Responses

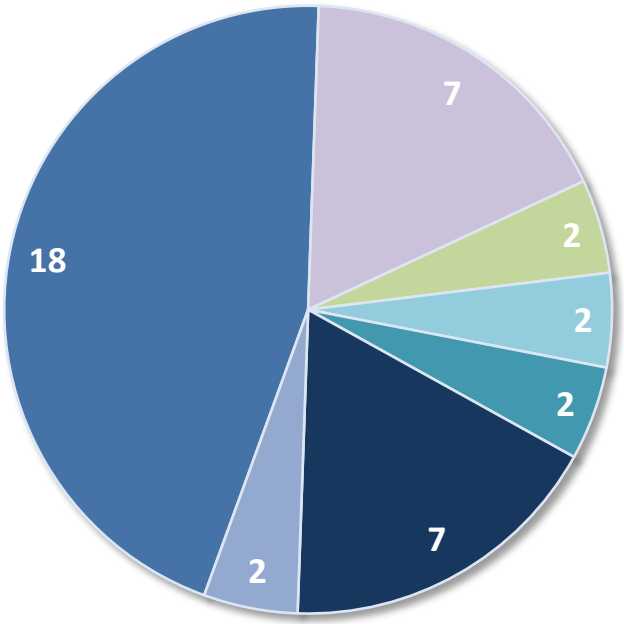
Specialists in Medicare ACO leadership role?

Specialty	Number	Percent
PCP exclusive	8/40	20%
Yes, Oncology	15/40	38%
No Oncology, but Yes, other specialties	13/40	33%

Of the 13 responses , "No Oncology, but YES, other specialists," the predominant "other" specialty was Cardiology 11/13

Survey Inquiries & Responses

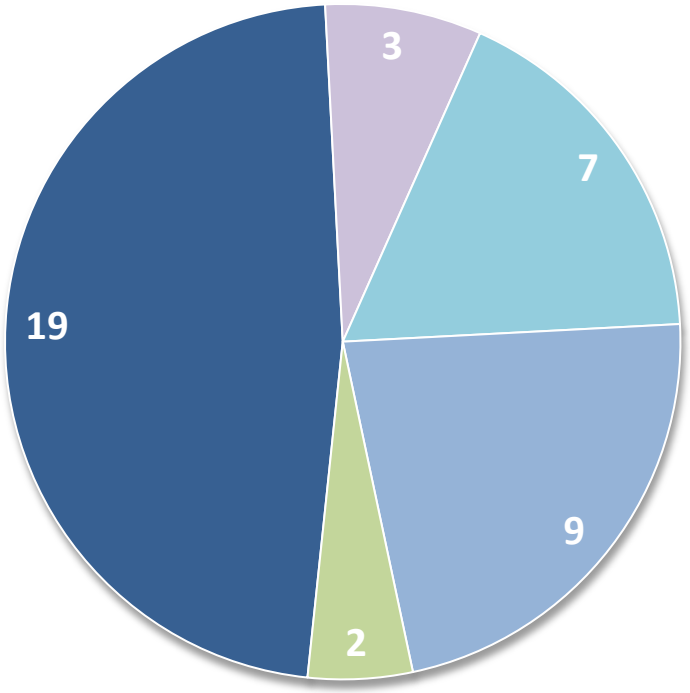
Oncologists Participating in ACO Shared Savings?



- 18 -Yes, but specialist pay formula not yet determined
- 7 - Yes, but no changes in current oncologist comp formula
- 2 - Yes, if specialists take on risk
- 2 - Oncologists NO, but other specialists yes
- 2 - PCP Exclusive
- 7 - Yet TBD if/how specialists participate
- 2 - Declined to answer

Survey Inquiries & Responses

Medicare ACO - Commercial ACO Relationships



- 19 - Yes (some with multiple Commercial ACOs)
- 3 - Yes and talking to more
- 7 - Not now, but currently in talks
- 9 - Not now, but plan to soon
- 2 - None planned

Moving toward multi-Payor, addressing the "free rider" effect?

Toward Accountable Cancer Care
Environmental Characteristics

It's a Sea Change

- Different than integrated healthcare of the '90's: IT connectivity data analytics, decision support tools
- Care coordination emphasis
- Patient-centered orientation

It's About the Data

- Quality and outcome measures – must prove it
- Forces us to examine how we do things
- You won't get the referrals if you can't prove you're cost effective

Toward Accountable Cancer Care
Environmental Characteristics

New Payment Models

- Fee-for-service expected to be phased out in 5 -10 years
- No consensus on best pay methodology
- But oriented toward shared savings approach - you prove it and we'll share it

Pathways

- General acceptance that pathways reduce variation and costs and improve outcomes
- The high cost of drug is the elephant in the room
- Health Plan: "Yes, from time-to-time we have conversations with pharma about drug prices. The conversation is quite simple. We ask and they say here's our price"

Toward Accountable Cancer Care
Moving Toward Value

The Patient Experience

- Communication breakdowns – must fill the gaps
- Educate and engage patients re goals of treatment, prognosis, side effects
- Timely advanced care planning

Fragmentation – Lack of Coordination

- Formal care management agreements among providers - clearly define the patient hand offs - the transitions
- Navigators – define scope and identify who will pay for them

Toward Accountable Cancer Care
Moving Toward Value

Unnecessary use of ER

- Keep treatment patients out of the ER
- Pro-active treatment of side effects
- Patient access to provider 24/7 – nurse triage protocol

Oncology Medical Home

- A recognized care model that enhances communications, coordination, physician accountability
- Increased interest from Payors in specialty medical home – cancer and CKD in particular
- Costs of transition to the oncology medical home model is a barrier to more widespread adoption

Toward Accountable Cancer Care
Moving Toward Value

End-of-Life Care

- Keep patients out of the hospital, ICU
- Timely utilization of palliative care and hospice services
- Recalibrate patient & family expectations

Moving Toward Value

- Current state
- Prognosis
- Treatment Options
- Side Effects
- Advanced Directive
- Palliative & Hospice Care

Timely and forthcoming physician → patient communication & education, at diagnosis and ongoing

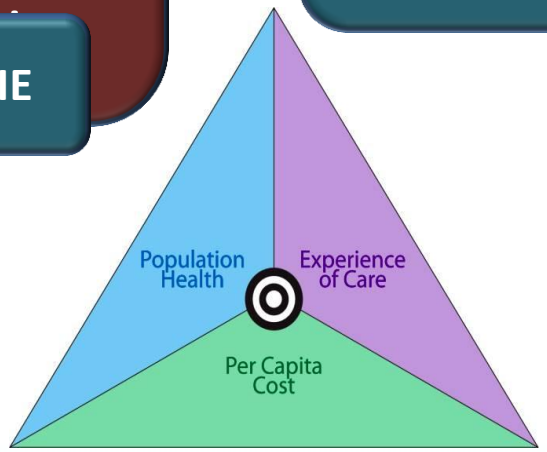
Patient can make informed choices & anticipate possible side effects

Clearly defined care management plan & improved provider → provider

EMR and HIE

Improved care coordination; strategic use of navigators

Patient experience is less fragmented



Better managed EOL care; more focus on QOL

Reduced ER use & hospital admits/re-admits

Therefore, What?

Actionable Insights

1. **Accept that we are in transition** - the accountable care paradigm isn't going away
2. **Honest organizational self-assessment** - identify your strengths and where you have gaps – move to close the gaps
3. **Explore opportunities** – approach local ACOs and health plans – tell them you want to contribute to bending their cancer cost curve
4. **Propose to take leadership role** with them in oncology-specific model - Oncology Medical Home or Oncology ACO
5. **Get your major health plan(s) engaged** up front
6. **Address informatics infrastructure** – what clinical and business data elements are you measuring and how savings being measured?
7. **Don't do too much volunteer work** - determine how you will be paid for all this excitement!

Oncology's Fit in an ACO World

Thank You for Your Interest

Ronald Barkley, MS, JD, Principal Investigator
rbarkley@ccbdgroup.com
Candice Leonard, PhD, Senior Researcher
CandiceJLeonard@gmail.com

Research funding provided by
Foley & Lardner and HillCo HEALTH