Challenges and Opportunities in Community Oncology

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Tennessee Oncology
• I am a practicing medical oncologist with Tennessee Oncology and OneOncology
• I have no disclosures
Background on Tennessee Oncology

- Almost 100 physicians, 1000 employees, 26 clinic locations, 9 radiation oncology centers, a phase 1 clinic through Sarah Cannon, 3 imaging facilities, and an oral specialty pharmacy

- Participating in Oncology Care Model

- Robust clinical trial research program through partnership with Sarah Cannon
Overview

• Background – current landscape in community oncology

• Challenges and opportunities in community oncology

• Impact of 3rd party authorizations and role of specialty pharmacy

• Getting ahead of volume to value shift
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Consolidation of Cancer Care

Source: COA Community Oncology Practice Impact Report, October 2014

Caring for Cancer Patients is a PRIVILEGE
As of 2018, 423 individual practices closed, 658 practices were acquired by hospitals, 359 practices reported financial instability
Related effect: Healthcare Spending in United States is Growing

Project Healthcare Spending
Average Annual Growth Rate
(2012–2024)

- 7.9% Medicare
- 6.2% NHE
- 4.8% GDP

GDP=gross domestic product; NHE=national healthcare expenditures.
Site-of-Care Shift Exacerbating Cancer Spending

Patients Increasingly Treated at Hospital

Chemotherapy Site of Care, 2006-2015

Actual and Projected

<table>
<thead>
<tr>
<th>Year</th>
<th>Private Community Clinic</th>
<th>Hospital Outpatient</th>
<th>Hospital Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>71%</td>
<td>15%</td>
<td>14%</td>
</tr>
<tr>
<td>2009</td>
<td>58%</td>
<td>24%</td>
<td>18%</td>
</tr>
<tr>
<td>2012</td>
<td>50%</td>
<td>32%</td>
<td>18%</td>
</tr>
<tr>
<td>2015</td>
<td>40%</td>
<td>42%</td>
<td>18%</td>
</tr>
</tbody>
</table>


TENNESSEE ONCOLOGY
Caring for Cancer Patients is a PRIVILEGE
Payers Highly Motivated to Reverse Trend
Willing to Spend More to Preserve Private Practices

Cost Comparison by Site of Chemotherapy

Average Annual Cost per Patient
- Physician Office: $4,361
- Hospital Outpatient: $4,981

Average Drug Costs per Chemotherapy Session
- Physician Office: $1,604
- Hospital Outpatient: $2,504

“...the strategy that we at CareFirst are trying to employ initially with our Pathways Program is to reimburse at a higher rate to community practices. We may not necessarily be directing patients away from hospitals, but we are doing something to help maintain community oncology practices.”

AVP of Pharmacy Management,
CareFirst BlueCross BlueShield Maryland

This is one explanation to the shift towards value based care...
Overview

• Background – current landscape in community oncology

• **Challenges and opportunities in community oncology**

• Impact of 3rd party authorizations

• Getting ahead of volume to value shift
Challenges Facing Community Oncology

<table>
<thead>
<tr>
<th>Margin Pressure</th>
<th>Ever increasing regulatory burden</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sequestration (28.4 % drop in part B reimbursement)</td>
<td>• MACRA/MIPS – reporting requirements</td>
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<tr>
<td>• Misinterpretation of modifier 25</td>
<td>• OCM – infrastructure investment</td>
</tr>
<tr>
<td>• Commercial payers</td>
<td>• Third party precertification</td>
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Caring for Cancer Patients is a PRIVILEGE
Oncology Paradigm Shift

- Migration from intravenous to oral oncolytics
- 20-30% community oncology practice pharmaceutical revenue is oral today
- 35-40% current oncology pipeline is oral

Closed door retail pharmacies within community oncology practices are critical for patients, practices and manufacturers.
Part D trends based on OCM baseline data

**Exhibit 3-E2: Trends in Share of Episodes with Part D Enrollment in the Expanded Baseline Period**


**Exhibit 3-E3: Percent of Episodes with Part D Enrollment by Cancer Bundle in the Pooled Baseline Period**
Part D trends based on OCM baseline data (and we are responsible for these costs in OCM)


Source: Episode characteristics file, 2012 – 2015. Note: Y-axis does not start at zero. Parallel trends tests showed that these trends were statistically different.
... just a few more whacks and all the candy will fall out!
So any opportunities to succeed?

• Community practices should be more flexible at reacting to change
  • However, balance of flexibility vs. resources

• Even better, should focus on getting ahead of change (prepare to win in value based care)
  • Incentives align – keeping patients out of hospital better for patients, can improve revenue potential in OCM, and doesn’t have negative impact on unfilled capacity

• Importance of diversifying revenue streams (imaging, path, oral oncolytics)

• Stay engaged with advocacy networks such as COA, ACCC, ASCO
# Best Business Practices to Survive Now

## Market share

## Economies of scale

## Innovate

- Clinical trials
- **Value based reimbursement “experiments”** – finding the balance of preparing for VBC while still in FFS model

## Diversified Revenue Streams

- Infusion
- Retail pharmacy (taking advantage of shift towards oral oncolytics)
- Imaging
- Lab
- Pathology (we have heme path team)
- Radiation Services

## Adopt Technology – We are in the information business

- Flatiron
- Predictive analytics – one of our main focuses now: how to figure out who is at risk for hospitalizations, noncompliance, etc?
- Cognitive analytics – machine learning
Some of our business metrics

- Visit volumes for new patients and returns
- Gross revenue by line of business
- Income statement by line of business
- Days in accounts receivables
- Inventory
- Staff compensation per MD FTE
- Research accruals
- Payer mix trends

Caring for Cancer Patients is a PRIVILEGE
Advocacy Opportunity

• ACCC (Association of Community Cancer Centers)
  • Legislative Activity
    • Cancer research funding
    • Quality Payment Program (MACRA)
    • 340B Principles for Reform
    • Health equity and disparities

• Oncology Care Model
  • Support through peer-to-peer learning network, ACCC OCM Collaborative
  • Bi-annual workshops
  • Advocacy with CMMI

• Coverage and Payment Issues
  • CMMI and oncology payment reform
  • PAMA and clinical lab rates
Advocacy Opportunity

• COA (Community Oncology Alliance)
  • Legislative Action
    • Sequestration for Part B drugs
    • Site of service differential
    • 340 B reform
  • Patient Advocacy Network
  • Pharmacy Association
  • Administrators Network
  • Advanced Practice Provider Network
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• Getting ahead of volume to value shift
Evicore: disrupting prior authorization system

• Goals of Evicore:
  • “to make sure patient is getting affordable healthcare”
  • “helping [providers] navigate this complex and fragmented healthcare system”
  • “acting on behalf of patient, provider, and payer”
  • “assure that patient gets best care”

• Uses evidence to determine appropriate testing and treatments

• IT>person on telephone
Evicore: challenges for implementation in oncology

• Is overuse of radiology testing the same as in general population? For example, lower threshold to get brain MRI, CT for lung/abd symptoms, spine MRI, etc

• Difficulties of combined oral and IV/IM treatments in same regimen (faslodex/ibrance for breast, revlimid based myeloma treatments, etc)

• Are they able to keep up with newest guidelines?
Pathways as a solution for:

In addition to pathways, retail pharmacy embedded in practice can help with these issues and provide additional revenue streams.
Understanding How Community Oncology Pharmacies Can Impact Patient Care

- Faster access\(^1\)
  - Full inventory
  - Access to EMR makes patient access to medication faster
- Improved patient experience\(^2\)
  - Multiple studies confirm patients want outreach from their providers, not third parties
- Potential for improved patient adherence\(^1\)
  - Studies show better patient engagement when information comes from their providers
- Pharmacists and technicians have full EMR access\(^3\)
  - Closed door system for refills

Financial Considerations of Having Oncology Pharmacies in Practice

**Financial Assistance**

- Dedicated patient advocates familiar with manufacturer support programs¹
- Fully versed in foundation support²

**Financial**

- Severe margin pressures³
- Evolution to orals decreases IV retail and infusion code revenue⁴
- Pharmacies add an additional diversified revenue stream⁵

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IV=intravenous.
Institutional Example:
COA, RainTree Oncology Services

• Assists member practices with administration of quality and cost-effective cancer care, while increasing practice revenue streams with an emphasis on oral prescriptions, through:
  – Negotiation and administration of GPO contracts
    ▪ >77% of the most commonly prescribed oral oncolytics under contract
  – Development of resources to evaluate care pathways that can facilitate improved patient outcomes and reduce the cost of care
  – Develop and implement technology platforms to assist in improving patient outcomes and dispensing services

The Tennessee Oncology Experience: GPOs and the Oral Channel

• 2011: 0% oral oncolytics with GPO contracts
• 2014: 80% oral oncolytics revenue under GPO contract

COA= Community oncology alliance; GPO=group purchasing organizations.
What can I expect after Park receives my new prescription? Park pharmacy staff member will contact you within 24 hours after receiving your prescription.

- Your insurance company may require a prior authorization to determine the medication prescribed is appropriate for you and your diagnosis. Prior authorizations will require 1-3 business days to process.
- Financial assistance may be available if your prescription co-pay is more than you can afford. Pharmacy staff will identify available resources, assist in completing and submitting your application, and provide an expected timeline of response.
- Medication delivery is a complimentary free service.
- Medications will be shipped to your home or designated address. Overnight priority is required for some medications.
- Prescriptions are shipped Monday through Friday. Patient service representative will discuss delivery options and schedule delivery convenient for you.
- Medication deliveries will be made up to 7 p.m.
- A signature may be required for delivery. A Park staff member will contact you to schedule delivery and ensure your availability to receive and sign.
- A Park Pharmacy staff member will contact you if notified of delays in delivery.
- Your prescription will be shipped along with a Park Pharmacy Welcome Kit and either a manufacturer starter kit (if available) and/or Park patient education material.

How do I refill my prescription?

- If you are taking an oncology or hematology-specific medication, a Park staff member will call a week before you run out of medication to schedule a refill.
- You may contact Park toll free (877) 888-2046 at any time to refill your medication. Please have your prescription number(s) available to place your order.
- An automated refill option is available toll free 24 hours a day/7 days a week at (877) 888-2046. If ordering an automated refill, please also leave a message with any specific delivery instructions or request Park Pharmacy staff contact you before medication is shipped.
- Remember to let Park know of any insurance changes, address changes, phone number changes, or special processing needs.
Overview

• Background – current landscape in community oncology

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• Impact of 3rd party authorizations and role of specialty pharmacy

• Getting ahead of volume to value shift
Prepare for the future – volume to value

CMS is all in

Commercial payers not so much
Competing in a Value-Based Market is Required

Meeting the New Demands of the Affordability Economy

Core Aims of a Value-Based Growth Strategy

**Financial**
- Move away from faltering fee-for-service economics to new payment models, revenue opportunities
- Capture greater share of premium dollar

**Clinical**
- Engage patients, center care delivery around patients
- Define, measure, and promote quality as key differentiator

**Market**
- Secure attractive risk-based contracts with purchasers
- Attract, partner with preferred providers

Source: Advisory Board interviews and analysis.
Transitioning to Value-Based Reimbursement$^1$-$^3$

<table>
<thead>
<tr>
<th>Fee-for-Service</th>
<th>Value-Based Reimbursement</th>
</tr>
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<tbody>
<tr>
<td>Competing on:</td>
<td>Competing on:</td>
</tr>
<tr>
<td>✓ Relationships with referring physicians</td>
<td>✓ Outcomes</td>
</tr>
<tr>
<td>✓ Sub-specialty expertise</td>
<td>✓ Quality</td>
</tr>
<tr>
<td>✓ High-end technologies</td>
<td>✓ Cost</td>
</tr>
<tr>
<td>✓ Facilities and amenities</td>
<td></td>
</tr>
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Source: Oncology Roundtable interviews and analysis.

Until recently, nationwide VBPMs have excluded cancer

BPCl is a National bundled pilot program:
• Model 2 (601 participants): Inpatient stay and post-acute care up to 90 days after discharge
• Model 3 (838 participants): Post-acute care services up to 90 days
However, innovation has been happening in the community (published non-govt cancer bundles)

<table>
<thead>
<tr>
<th>Bundle sponsor</th>
<th>Cancer type</th>
<th>Episode setting</th>
<th>Results published?</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBS of Florida</td>
<td>Prostate</td>
<td>Community</td>
<td>No</td>
</tr>
<tr>
<td>Cancer Treatment Centers of America</td>
<td>Prostate, breast, lung, colorectal</td>
<td>Community</td>
<td>No</td>
</tr>
<tr>
<td>BCBS of California</td>
<td>Breast</td>
<td>Community</td>
<td>No</td>
</tr>
<tr>
<td>MD Anderson</td>
<td>Head and Neck</td>
<td>NCI designated CC</td>
<td>No</td>
</tr>
<tr>
<td>Private radiation oncology practice</td>
<td>Prostate, breast, lung, bone mets</td>
<td>Community</td>
<td>Only impact was on treatment underuse</td>
</tr>
<tr>
<td>United HealthCare</td>
<td>Breast, lung, colon</td>
<td>Community</td>
<td>Decreased hospitalizations and therapeutic radiology; increase in chemotherapy</td>
</tr>
</tbody>
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The 4 largest CMS Value Based Payment Models (VBPMs)

<table>
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<tr>
<th>Type of care delivery model</th>
<th>What’s unique about it?</th>
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<td>Bundled payment</td>
<td>• Most extreme&lt;br&gt;• Only model that actually replaces fee for service</td>
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<td>• Only cancer-specific model&lt;br&gt;• Only model which Includes Medicare part D in cost estimates</td>
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<td>• Only mandatory model&lt;br&gt;• Forced 2 side risk</td>
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<tr>
<td>Accountable Care Organization</td>
<td>• Most widespread model to date&lt;br&gt;• CMS provides files to help researchers study ACO effects through claims</td>
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Oncology Care Model hits in 2016: not a bundle (although often inappropriately called a bundle)

**Centers for Medicare and Medicaid Services: Using an Episode-Based Payment Model to Improve Oncology Care**

CMS Payments to participating practices (does NOT replace FFS like a bundle does):

- **Get paid this anyway**
  - Fee for service base

- **Two financial incentives to get more money**
  1. $160/pt/mont hcoordination fee
  2. Potential for shared savings

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Kline et al., J Oncol Pract, 2015
CMS.gov
Baseline OCM characteristics show large community involvement

• Program began July 1, 2016
  • 184 practices signed up (all voluntary)
  • 6 academic medical centers – so 171 community oncology groups ➔ this is where innovation is happening!
    • Montefiore, Weill Cornell, Vanderbilt, UChicago, Cleveland Clinic, Yale
  • PPS exempt centers were not allowed
  • Baseline based on 2012-2015

• 60% are breast, prostate, lung cancer
  • Breast most common: 30-35%, included cytotoxic and endocrine tx

• Baseline (includes parts A, B, and D)
  • OCM: average episode $27,400 (median $22,300)
  • non-OCM: average episode $26,200 (median $20,900)

• Patient cancer mix will have important implications for smaller practices
  • Highest episode cost: melanoma, leukemia
  • Lowest episode cost: breast, prostate, bladder
Tennessee Oncology Value Pillars

- Pathways
- Nurse Triage
- Palliative care
- Care coordination
  - Includes docs – the phones actually still work for speaking!
- Predictive and cognitive analytics
  - In value-based reimbursement, he who manages the data best wins
  - Incorporating PRO’s into EMR
Key phases to overcoming these problems

<table>
<thead>
<tr>
<th>Phases</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Pathways content development</td>
<td>OnePolicy/Via/TnOnc</td>
</tr>
<tr>
<td>2) Pathways decision support technology</td>
<td>Flatiron</td>
</tr>
<tr>
<td>3) Novel payer arrangements based on pathways reporting</td>
<td>OneOncology and/or TnOnc payer/VBC strategy team</td>
</tr>
<tr>
<td>4) Automated reporting technology for payer arrangements</td>
<td>Flatiron</td>
</tr>
</tbody>
</table>

Difficult? – yes
Impossible? – no (currently being done in early stages)
Worth striving for over long-term?
**Alternative solution** to reversing trends in payer pressures?
OCM-related priorities – solidifying the foundation

1. Accurately track initiation and termination of OCM episodes
2. Technology and data management capabilities
   • Needed to report OCM clinical data and quality measures
3. Patient safety
   A. Morning safety huddles
   B. Acuity based-scheduling
   C. Adverse event reporting and incident learning culture
4. Optimize clinic staffing across 30+ clinic sites
5. Leverage core capabilities of in-house pharmacy
6. Enhanced patient education
7. Financial counseling/ patient advocate access
Fundamentals of OCM

1) Monthly Enhance Oncology Services (MEOS) payments
   • $156.80 per qualifying Medicare beneficiary

2) Performance-based payments (PBPs)
   • Variable based on performance

1) Practice Redesign Activities (required)
   A. IOM Care Planning
   B. Care Navigation
   C. Others

2) Total cost of care reduction

3) Quality measures
Examples of care coordination improvement efforts

- Enhanced patient education/chemo teaching
- Expand patient advocate/fin. counseling access
- Improving use of triage protocols
- Distress screening & mitigation
- Off-hours call technology & follow-up process
- New patient intake process
- Survivorship planning
- Access to palliative care specialists in-clinic
- “Regionalized” triage line
- Care navigator pilot
- Telemedicine pilot
- Urgent care visit scheduling
- Extended triage line hours

Highly systematized in all sites

Pilots still evolving
One key challenge with cancer care in VBC – incorporation of drug spending
Lack of control: Rising costs of drugs presents an additional challenge

- Early 2012 - Late 2014 (BP)
- Late 2016 (PP1)
- Early 2017 (PP2)

+39% from BP
+44% from BP
+3.7% from PP1

Utilization Types:
- DME
- Drugs And Blood Products
- Emergency Care
- Hospice
- Imaging
- Inpatient Care
- Labs and Pathology
- Major Procedure
- Office Visit
- Post-Acute Care
- Radiation Therapy
- Unclassified

Caring for Cancer Patients is a PRIVILEGE
### Lung Adenocarcinoma

<table>
<thead>
<tr>
<th>2015 Regimen (Benchmark)</th>
<th>Current Regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regimen</td>
<td>Price ($USD)</td>
</tr>
<tr>
<td>Carbo/taxol</td>
<td>$425</td>
</tr>
<tr>
<td>Carbo/taxol/bev</td>
<td>$34,520</td>
</tr>
<tr>
<td>Carbo/peme</td>
<td>$24,690</td>
</tr>
<tr>
<td>Carbo/peme/pembro</td>
<td>$63,884</td>
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### Lung Squamous Cell Carcinoma

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<tr>
<td>Carbo/taxol</td>
<td>$425</td>
</tr>
<tr>
<td>Carbo/gemcitabine</td>
<td>$708</td>
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<tr>
<td>Carbo/Nab-paclitaxel/pembro</td>
<td>$64,985</td>
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### Triple Negative Breast Cancer

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<tr>
<td>Regimen</td>
<td>Price ($USD)</td>
</tr>
<tr>
<td>Paclitaxel</td>
<td>$200</td>
</tr>
<tr>
<td>Nab-paclitaxel/Atezolizumab</td>
<td>$58,404</td>
</tr>
</tbody>
</table>
All episodes: Performance relative to target, by “Novel Therapy” Use

- Used Novel Therapies: -$1.11M
- Didn’t Use Novel Therapies: $4.02M

Total Cost Above Target
We are trying to understand this impact and communicate with CMMI to improve methodology

• Lung cancer
  o 118 episodes above target
  o 62 (53%) above target despite no ED visits, hospitalizations, or post acute care
    o Of these, 43 (69%) included immunotherapy, of which 77% of cases were guideline concordant based on new standards of care

• Bladder cancer
  o 13 episodes above target
  o 5 (38%) above target despite no ED visits, hospitalizations, or post acute care
    o All 5 (100%) included immunotherapy, of which 4 (80%) of cases were guideline concordant based on new standards of care

To be presented at ASCO, 2019
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<td>• First model that applies to MSK</td>
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MACRA/MIPS

• **Mandatory** (different than ACOs or OCM!)

• Affects all physicians (and physician groups) who are not in a two sided alternative payment model
  • 1 sided OCM does NOT count as exclusion (and no 2 sided risk OCM practices yet)
  • Recently allows track 1 MSSP (will discuss later) to count as exclusion
  • Excludes physician groups who
    1. are in their first year of Medicare Eligibility
    2. meet low volume threshold (sees <100 Medicare beneficiaries per year and/or have <$10K in Medicare billing charges)
MIPS/MACRA

Adjusted Medicare Part B payment to clinician

The potential maximum adjustment % will increase each year from 2019 to 2022

Merit-Based Incentive Payment System (MIPS)

2019 2020 2021 2022 onward

Maximum Adjustments

+/-

+4% +5% +7% +9%

-4% -5% -7% -9%
How the payment adjustment score is calculated

Year 1 Performance Category Weights for MIPS

- **Quality**: 50%
- **Cost**: 10%
- **Clinical Practice Improvement Activities**: 15%
- **Advancing Care Information**: 25%

Replaces meaningful use. Ex: sharing tests, plans, etc with patients (ex. MSK portal)

Practices pick 6 measures that best fit their group

CMS.gov
Quality: cancer specific measures are focused on palliative care

<table>
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<th>Cancer</th>
<th>Measure</th>
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<tbody>
<tr>
<td>Breast</td>
<td>If HER2+ get Herceptin (and if HER2 neg do not)</td>
</tr>
<tr>
<td>Colon</td>
<td>If KRAS+, do not receive EGFR inhibitor</td>
</tr>
<tr>
<td>General</td>
<td>Proportion of patients receiving chemotherapy in last 14 days of life</td>
</tr>
<tr>
<td>General</td>
<td>Proportion of patients with more than 1 ED visit in last 30 days of life</td>
</tr>
<tr>
<td>General</td>
<td>Proportion of patients admitted to ICU in last 30 days of life</td>
</tr>
<tr>
<td>General</td>
<td>Percentage of patients who died from cancer not admitted to hospice</td>
</tr>
<tr>
<td></td>
<td>(or admitted to hospice less than 3 days before death)</td>
</tr>
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Importance of palliative care integration
Link Between Palliative Care & Cost Reduction (applies to all VBPMs)

• Emanuel et al. Arch Intern Med 2002: One third of expenditures in the last year of life occurred in the last 30 days. Expenditures of patients using hospice were 30% lower.

• Zhang et al. Arch Intern Med 2009: In patients reporting an EOL conversation with physician, costs were 35.7% lower. Higher costs were associated with worse QOP.

• Nicholas et al. JAMA 2011. Advance Directives in regions with high levels of aggressive care significantly lowered spending.

• Cheung et al Cancer 2015. Aggressive care in Cancer Care Ontario was associated with 43% higher costs. Chemo in the last 2 weeks predicted for costs. Aggressive palliative care reduced costs in the highest quintile.
Concluding thoughts...

Key Future Success Factors

• **Scale/position in local market**-market share matters!
• Participate in multiple networks
• Sufficient –in-network referral sources-narrow networks
• New value proposition-position for value based reimbursement
• Quality/Patient-centric care
• **Ready to compete in 2 sided risk** value based care
• Harmonize timing of payment/delivery changes
“It is not the strongest species that survive, nor the most intelligent, it is the one most adaptable to change”
-Charles Darwin
Thank you!