Oncology Medical Home

GEORGIA SOCIETY OF CLINICAL ONCOLOGY

Trends & Innovations in Oncology Reimbursement

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Atlanta, GA
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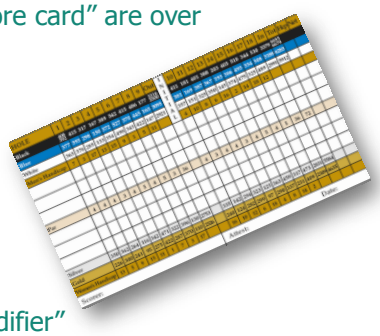
Innovation or Change

- Medicare and public payers are moving medicine towards *measured* accountability
  - Quality (*including the patient experience*)
  - Value (*weighed by cost*)
- Private payers are becoming more knowledgeable of true expenses in healthcare.
- The government's model for ACOs continues to evolve and adjust.
- Medicare is one of the top 3 political issues.
  - Needing change
  - Recipients not wanting change
- All payers are interested in the patient/family experience.

Scoring Health Care Delivery

- Days of playing "golf" without a "score card" are over
- Accountable Care Organizations
  - Cost savings
  - Quality measures
- *Hospital Compare*
  - Hospitals measured, and paid, on patient satisfaction and outcomes
- *Physician Compare*
- Physician payment "value-based modifier"
- *Quality & Resource Use Report*
  - Pilot in Iowa, Kansas, Missouri, Mississippi & Nebraska



Hospital Compare

General Information | Patient Survey Results | Timely & Effective Care | Readmissions, Complications & Deaths | Use of Medical Imaging | Medicare Payment | Number of Medicare Patients

GRADY MEMORIAL HOSPITAL
80 JESSE HILL JR DRIVE SE
ATLANTA, GA 30303
(404) 616-4252

Hospital Type: Acute Care Hospitals
Provides Emergency Services: Yes

Add to my Favorites
Map and Directions

Patient Survey Results

HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) is a national survey that asks patients about their experiences during a recent hospital stay. Use the results shown here to compare hospitals based on ten important hospital quality topics.

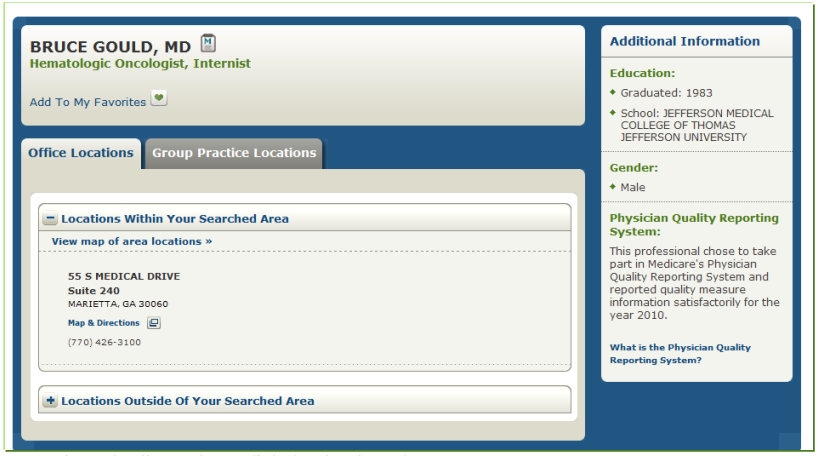
- More information about patient survey results.
- Current data collection period.

View Graphs
View More Details

	GRADY MEMORIAL HOSPITAL	GEORGIA AVERAGE	NATIONAL AVERAGE
Patients who reported that their nurses "Always" communicated well.	69%	77%	77%
Patients who reported that their doctors "Always" communicated well.	82%	82%	81%
Patients who reported that they "Always" received help as soon as they wanted.	46%	64%	65%
Patients who reported that their pain was "Always" well controlled.	64%	71%	70%

 Source: http://www.hospitalcompare.hhs.gov/

Physician Compare



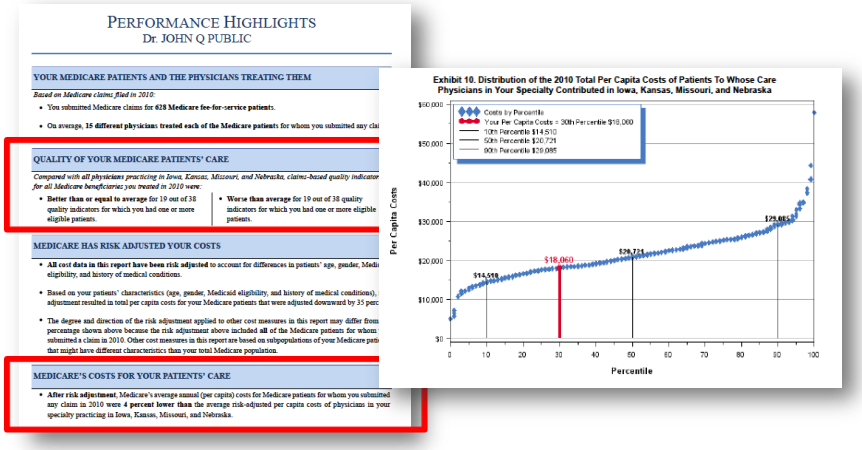
Source: http://www.medicare.gov/find-a-doctor/provider-search.aspx

Hospital Value-Based Purchasing

- All hospitals' DRG payments reduced
- Participating VBP hospitals eligible for incentive payments out of DRG reduction pool
  - Payments begin 10/12
  - Comparison to baseline period
- Payment based on measures falling into 2 areas
  - Clinical process of care (70%)
  - Patient experience of care (30%)
- Hospitals benchmarked against each other

Figure 1. Hospital VBP Linear Exchange Function

MD Quality & Use Resource Report



PERFORMANCE HIGHLIGHTS
Dr. JOHN Q PUBLIC

YOUR MEDICARE PATIENTS AND THE PHYSICIANS TREATING THEM

Based on Medicare claims filed in 2010:

- You submitted Medicare claims for **628 Medicare fee-for-service patients**.
- On average, **15 different physicians treated each of the Medicare patients** for whom you submitted any cla

QUALITY OF YOUR MEDICARE PATIENTS' CARE

Compared with all physicians practicing in Iowa, Kansas, Missouri, and Nebraska, claims-based quality indicator for all Medicare beneficiaries you treated in 2010 were:

- **Better than or equal to average** for 10 out of 38 quality indicators for which you had one or more eligible patients.
- **Worse than average** for 10 out of 38 quality indicators for which you had one or more eligible patients.

MEDICARE HAS RISK ADJUSTED YOUR COSTS

- **All cost data in this report have been risk adjusted** to account for differences in patients' age, gender, Medi eligibility, and history of medical conditions.
- Based on your patients' characteristics (age, gender, Medicaid eligibility, and history of medical conditions), adjustment resulted in total per capita costs for your Medicare patients that were adjusted downward by 35 perc
- The degree and direction of the risk adjustment applied to other cost measures in this report may differ from percentage shown above because the risk adjustment above included **all** of the Medicare patients for whom submitted a claim in 2010. Other cost measures in this report are based on subpopulations of your Medicare pati that might have different characteristics than your total Medicare population.

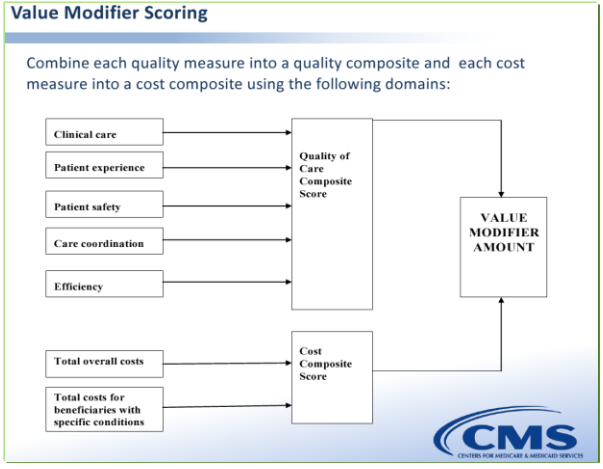
MEDICARE'S COSTS FOR YOUR PATIENTS' CARE

- **After risk adjustment**, Medicare's average annual (per capita) costs for Medicare patients for whom you submitted any claim in 2010 were **4 percent lower than** the average risk-adjusted per capita costs of physicians in your specialty practicing in Iowa, Kansas, Missouri, and Nebraska.

Exhibit 10. Distribution of the 2010 Total Per Capita Costs of Patients To Whose Care Physicians in Your Specialty Contributed in Iowa, Kansas, Missouri, and Nebraska

Source: Centers for Medicare & Medicaid Services

Physician Value Based Modifier



Source: 08/01/12 CMS Presentation on Value Based Modifier

US Compared to Others

Exhibit ES-1. Overall Ranking

Country Rankings
1.00–2.33
2.34–4.66
4.67–7.00

	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	$3,357	$3,895	$3,588	$3,837*	$2,454	$2,992	$7,290

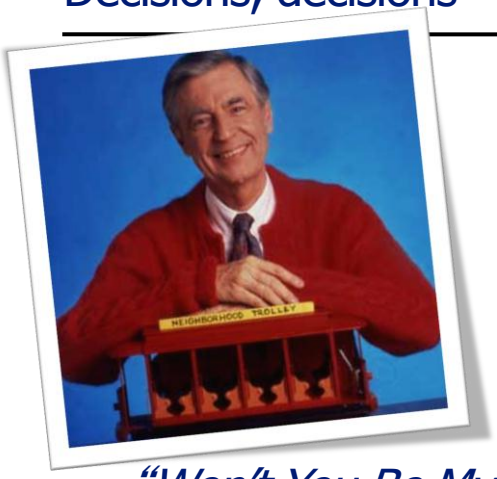
Note: * Estimate. Expenditures shown in $US PPP (purchasing power parity).
Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).

http://www.commonwealthfund.org/Publications/Fund-Reports/2010/Jun/Mirror-Mirror-Update.aspx?page=all

Implications for Oncology

- Medicare and private payers are moving towards payments based on performance
  - Outcomes
  - Value
    - *Emphasis on reducing costs!*
  - Quality
  - Patient Satisfaction
- You are going to be measured…
  - *Which tape measure do you use?*
- All want comprehensive solutions.

Decisions, decisions



ACO
versus
Medical "Home"
versus
Medical "Neighbor"

"Won't You Be My Neighbor"

Accountable Care Organizations (ACOs)

- Think of the ACO as the "medical neighborhood"
  - Different provider "neighbors" working together to spruce up the neighborhood
  - Medicare ACO model not defined by "process" but by "payment"
    - The defining payment model is "shared savings"
    - If you produce $$$ savings you get to keep a portion
      - ✓ Providing you meet quality targets
    - Providers on their own to figure out the process of making this happen
      - ✓ Savings
      - ✓ Quality
    - Some, but few ACO's folding in Oncology

CMS/Medicare Model for ACOs

- Big picture
  - Primary care driven
    - Specialists cannot take the lead in forming an ACO but can participate in it
    - Clearly is driven by primary care and large integrated systems
  - Some easing of anti-trust provisions designed to hinder coordination of care in the first place
  - Share in the savings if quality metrics (33) are met
  - Take on more risk, more potential return
- *"Cancer" mentioned only 15 times in 694 pages!*
- April 2012 – 27 Medicare Shared Savings ACOs approved
- July 2012 – Another 89 approved.

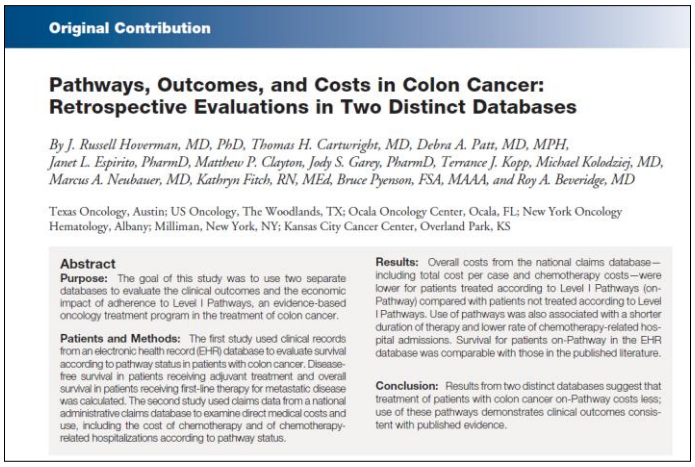
The Oncology Medical Home Model

- Think of the Medical Home as the house
  - Oncology practice becomes the "medical home" for the cancer patient
    - Oncologist does not treat all diseases but coordinates the care among other treating physicians
  - It's all about the processes that will improve quality and reduce costs
    - And measuring those processes
  - Defined by process, not payment model
    - Different payment models can be utilized to measure success

Oncology Medical Home Versus Current Reality

- Most oncology practices already function to 80-85% of the medical home model
  - Center of the patient's world
  - Care coordination
- What's typically missing?
  - Going the "next step" in care coordination
  - IT support focused on the patient
  - ***Measurement***
    - Quality
    - Value
    - Patient satisfaction
  - ***Process improvement***
    - Benchmarking

Pathways … Only Part of the Solution



Original Contribution

Pathways, Outcomes, and Costs in Colon Cancer: Retrospective Evaluations in Two Distinct Databases

By J. Russell Hoverman, MD, PhD, Thomas H. Cartwright, MD, Debra A. Patt, MD, MPH, Janet L. Espirito, PharmD, Matthew P. Clayton, Jody S. Garey, PharmD, Terrance J. Kopp, Michael Kolodziej, MD, Marcus A. Neubauer, MD, Kathryn Fitch, RN, MEd, Bruce Pyenson, FSA, MAAA, and Roy A. Beveridge, MD

Texas Oncology, Austin; US Oncology, The Woodlands, TX; Ocala Oncology Center, Ocala, FL; New York Oncology Hematology, Albany; Milliman, New York, NY; Kansas City Cancer Center, Overland Park, KS

Abstract

Purpose: The goal of this study was to use two separate databases to evaluate the clinical outcomes and the economic impact of adherence to Level I Pathways, an evidence-based oncology treatment program in the treatment of colon cancer.

Patients and Methods: The first study used clinical records from an electronic health record (EHR) database to evaluate survival according to pathway status in patients with colon cancer. Disease-free survival in patients receiving adjuvant treatment and overall survival in patients receiving first-line therapy for metastatic disease was calculated. The second study used claims data from a national administrative claims database to examine direct medical costs and use, including the cost of chemotherapy and of chemotherapy-related hospitalizations according to pathway status.

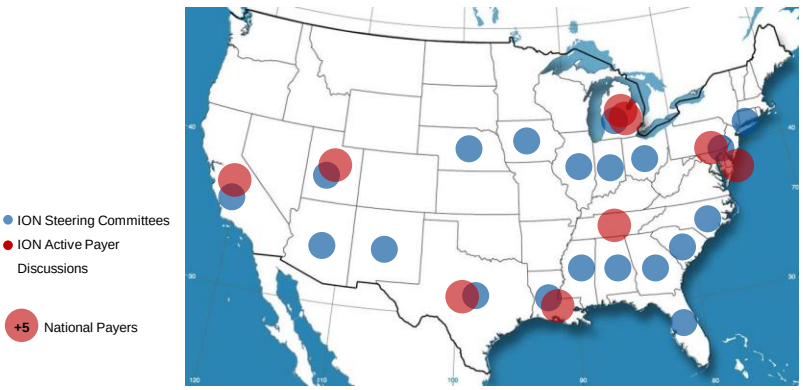
Results: Overall costs from the national claims database—including total cost per case and chemotherapy costs—were lower for patients treated according to Level I Pathways (on-Pathway) compared with patients not treated according to Level I Pathways. Use of pathways was also associated with a shorter duration of therapy and lower rate of chemotherapy-related hospital admissions. Survival for patients on-Pathway in the EHR database was comparable with those in the published literature.

Conclusion: Results from two distinct databases suggest that treatment of patients with colon cancer on-Pathway costs less; use of these pathways demonstrates clinical outcomes consistent with published evidence.

Proof of OMH Viability in Actual Practice

- Dr. John Sprandio has made his practice a patient-centered oncology medical home
  - Re-engineered the process of care
  - Imbedded IT functionality
  - Increased physician efficiency through standards
  - Promoted a culture of physician accountability and "time, touch and teaching"
  - Placed a constant focus on patient-related disease *management* and *coordination* of care
  - Measuring quality and value (costs)
  - Working with private payers on contracting/reimbursement
- PriorityHealth contracting with *Cancer & Hematology Centers of Western Michigan – Base pay, case management , incentives on positive outcomes.*
- *CMMI award for oncology - Barbara McAneny M.D.*

Other Initiatives



Measure, negotiate then payment

- Define exactly what is quality and value in cancer care and measure it
  - Use your own tape measure
- Put value and evidence-based medicine in the context of a model that works for cancer care
  - Model needs to work for clinical & business operations
  - Use your own tape measure
- Implement new, viable payment models
  - Examples — shared savings, bundled, episode of care
  - Use your own tape measure

Using Medical Home as the Framework

- Mindset change to go the next step
  - Care coordination
  - Patient focus
    - Education
    - Satisfaction
- Measuring what you do
  - Quality
  - Value
- Continuous process improvement
  - Benchmarking

What is the COA OMH Gameplan?

- Create general consensus and unity among stakeholders about what each wants from cancer care
  - Patients
  - Payers
  - Providers
- Agree on quality and value
  - Measures
    - Benchmarking measures over time
  - Patient satisfaction
- **Create a template for viable payment**
  - **Private payers**
  - **Medicare**
- Help practices implement
  - Process change
  - Payer contracting

COA OMH Implementation Efforts

- COA Board
  - Set overall strategy & direction
  - Empower the process
- Steering Committee
  - Provide guidance & consensus
  - Identify stakeholder perspectives
  - Develop quality & value measures
  - Oversee overall implementation
- Implementation Team
  - Identify practice needs
  - Establish an implementation roadmap
  - Create information sharing among practices

Steering Committee

Oncologists	Bruce Gould, MD (GA) Northwest Georgia Oncology	Payers	Lee Newcomer, MD United Insurance Group
	Patrick Cobb, MD (MT) Frontier Cancer Center		Ira Klein, MD Aetna Insurance Company
	Roy Beveridge, MD McKesson/US Oncology		Michael Fine, MD Healthnet
	John Sprandio, MD (PA) Consultants in Medical Oncology		Dexter Shurney, MD Vanderbilt Employee Health Plan
Administrators	Scott Parker (GA) Northwest Georgia Oncology		John Fox, MD Priority Health
	Robert Baird (OH) Dayton Physician Network	Patient	Kathy Smith, NP (CA) Cancer Care Associates
Cancer Care Advocates	Gwen Mayes, JD, MMSc NPAF	Nurse	Marsha Devita, NPA (NY) Hem Onc Assoc of CNY
	Robert Hauser, Pharm D ASCO	Pharmacist	Karen Kellogg, Pharm D (UT) Utah Cancer Specialists
	Trish Goldsmith NCCN	Business Partner	Mark Johnson International Oncology Network

Implementation Team

- Carol Murtaugh RN OCN, NE (Chair)
- Kent Butcher, OK
- Kristy McGowan, UT
- Maryann Roefaro, NY
- Donna Krueger, IL
- John Hennessey, KS
- Alice Canterbury, SC
- Marissa Rivera, CA

Progress to Date

- Identified, recruited, and implemented the Steering and Implementation Committees
- Defined stakeholder needs in cancer care
  - Patients
  - Payers
  - Providers
- Steering Committee endorsed 16 quality, value outcomes measures
- Developed patient satisfaction tool
- Developing practice tool kit and implementation guide
- Developed a payment reform task force of physicians and administrators.
- Discussing "Recognition" with certification entities.

The Strategy

Consolidated View of Needs

Patients	Payers	Providers
Best Possible Outcome	Best Possible Clinical Outcomes	Best Outcome for Patient
Docs with the 3 A's (Able, affable, accessible)	Member Satisfaction / Experience	Satisfied patients and family
Least Out Of Pocket Expense	Control Total Costs / Variability	Fairest Reimbursement to Provide Quality Patient Care
Education and Engagement of the Patient in the Care Plan	Productivity / Survivorship	Compensated for Cognitive Services Including Treatment Planning, End of Life Care and Survivorship.
Best Quality of Life	Meaningful Proof of Quality / Value	Less Administrative Burdens

The Strategy

Consolidated View of Needs

Patients	Payers	Providers
Coordination of Care	Care in the Lowest Cost Setting	Less interference by Third Parties
Honesty about Diagnosis and Prognosis	Value to members, providers and stockholders	Help with patient assistance
Least Amount of Pain, Toxicity, Hospitalizations	Total quality management	Fewest hospitalizations
Timely Communication of Test Results	Ensure that Treatments Given are Evidenced Based and Most Cost Effective	Safety
Availability of Clinical Trials	Advance care planning and end of life discussions	Ability to spend some time at home

A closer look:

Quality, Value, Outcomes Measures

COA Medical Home Measure
% of chemotherapy treatments that have adhered to NCCN guidelines or pathways.
% of cancer patients with documented clinical or pathologic staging prior to initiation of first course of treatment.
of emergency room visits per chemotherapy patient per year.
of hospital admissions per chemotherapy patient per year.
% of patient deaths where the patient died in an acute care setting.
Average # of days under hospice care (home or inpatient) at time of death.
% of patients that have Stage IV disease that have end-of-life care discussions documented.
Survival rates of stage I through IV breast cancer patients.
Survival rates of stage I through IV colorectal cancer patients.
Survival rates of stage I through IV NSC lung cancer patients.
% of cancer patients undergoing treatment with a chemotherapy regimen with a 20% or more risk of developing neutropenia and also received GCSF/white cell growth factor.
% of chemotherapy patients that received psycho/social screening and received measurable interventions as a result of the psycho/social screening. This screening to be completed through an endorsed and recognizable program or procedure.

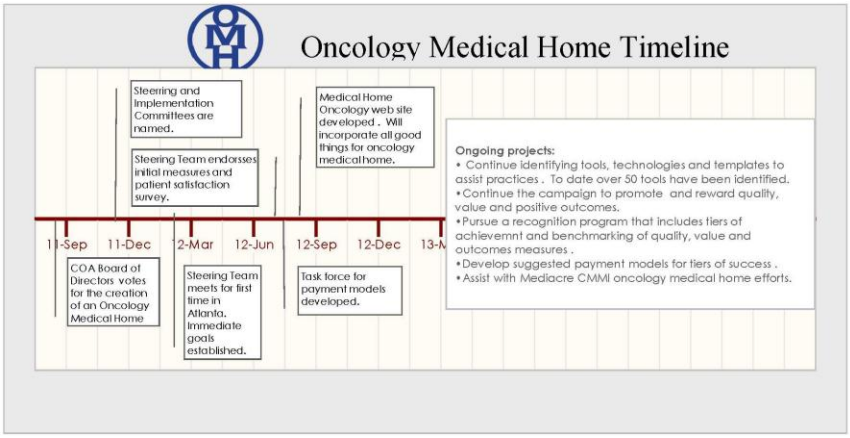
A closer look:

Measures — Patient Satisfaction

- Based on cahps Surveys and Tools to Advance Patient-Centered Care
- Organized and standardized for cancer care
- Timeliness of care and responses
- General satisfaction
- Automated if/when possible
- Benchmarked
- Being tested by 5 sites

A closer look:

Project Summary



A closer look:

Payment Reform Task Force

- Go beyond
  - Pay for Reporting
  - Pay for Guideline Adherence
  - Pay for Episode of Care
- Provide appropriate, realistic reimbursement
- Recognize and reward quality, value, and positive outcomes.
- Do not prioritize cost savings over best patient treatment
- Incent patient engagement and feedback
- Do not further destabilize the unstable Medicare pricing system leading to drug shortages

A closer look:

Payment Reform – Current Models

- Episode of Care – United Healthcare
- Cost neutral dugs with case management and quality/value incentives – Priority Health
- Case Management ?? – Aetna
- CMMI – To be defined – Quality, value and outcomes based.
- Pathway Compliance – Lots and lots of places
- CMS –
  - PQRS
  - E-Prescribe
  - Meaningful Use
- Others?

How to get there from here

Step 1 – Read Up on the Subject

- *Medical Home: Disruptive Innovation to a New Primary Care Model* – Deloitte Center for Health Solutions
- *Benchmarks for Value in Cancer care: An Analysis of a Large Commercial Population* – JOP 9/2011 US Oncology Research
- Oncology Patient-Centered Medical Home and Accountable Care Organization – Community Oncology, 12/10
- *Early Evaluations of the Medical Home: Building on a Promising Start* – American Journal of Managed Care, 2/11
- *Pathways, Outcomes, and Costs in Colon Cancer: Retrospective evaluations in Two Distinct Databases* – JOP, 5/11 Supplement

Step 2 — Start Thinking Differently

- New Twist on Policies/Procedures
  - New Patients
  - Tracking Results
  - Active /Inactive Patients
  - End of Life Care
  - Other
- Market your uniqueness
  - They don't know what they don't know…
    - Local payers
    - Large employers
    - Hospice organizations
    - etc.
- Official Chant – "Quality… value… quality…value"

Step 3 — Get Busy (Or busier)

- Patient Management
  - GPO Tools
  - Patient Portal
  - Pathway Compliance
  - ASCO QOPI
  - Medicity, Inexx — Information Exchange Tool
  - ASCO Survivorship Templates
- Patient Assistance
  - ACCC Patient Advocacy Assistance Guide
  - NCCN Patient Guides
  - NCI Patient Guides/Tools
  - ASCO Managing the Cost of Care
  - 5 Wishes

Step 3 — Get Busy (and even busier)

- Practice Management
  - Readiness Assessment
  - GPO Tools
  - National Business Group on Health (NBGH) – Cancer Toolkits
  - E&M Audit Tools
  - Clinical Trials Tools
  - ONS Telephone Triage Guidelines
  - Draft Letters to:
    - Employers
    - Payers
    - Other
  - Patient Satisfaction Survey
  - Consulting Services/Tools

Always keep patients first…

Thank You!

Bo Gamble
Bgamble@COAcancer.org

Coming soon…. www.medicalhomeoncology.org

CMS Proposed Fee Schedule Model Available

Hill Day on 09/19/12

www.communityoncology.org (COA & CAN)
www.COAadvocacy.org (CPAN)
www.facebook.com/CommunityOncologyAlliance
www.facebook.com/StopCancerCareCuts