

Payment & Innovation in Oncology: Provider-Payer Pilot of an Oncology Medical Home Model

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WILSHIRE ONCOLOGY
▲ United in Healing with The US Oncology Network

Wilshire Oncology Medical Group

- 55 years: 1957-2012
 - 1957 in Los Angeles, continued eastward 1965-2012
 - 1988 to San Bernardino County
 - 2003 to Riverside County
- 7 Sites of Service:
 - 5 Private Cancer Centers
 - West Covina (2), Glendora, Pomona, Rancho Cucamonga, Corona
 - Medical Oncology, Radiation Oncology, Clinical Trials, IT & Administration
 - 2 County Programs: San Bernardino and Riverside
 - Serve Indigent and Medical Patients, some Medi-Medi Patients
 - In & Out Patient Professional Services in Hematology & Oncology
- 4500 New Patients and 40,000 visits (doubled since 2003)
- Experience with Many Payers and Models:
 - PPO, HMO, FFS, Capitated, Medicare, MediCal
 - Growing Managed Care business over last 22 years in Inland Empire's 3 counties

111 EMPLOYEES

- Physicians: **11**
- Nurse Practitioners: **8**
- Physician Assistants: **3**
- Administrative: **3**
- IT: **1**
- Billing/Collections: **14**
- Patient Financial Counselor: **1**
- Authorizations: **3**
- Office Support: **12**
- Clinic Liaisons: **2**
- Clinical Trials: **6**
- Managers: **8**
- Medical Assistants: **14**
- Nurses: **15**
- LVNs: **3**
- Radiation Therapists: **3**
- PET Tech: **1**
- Pharm Tech: **2**
- Controller: **1**
- (Legal, Accounting, Book keeping, Marketing, PR, Web site, outside consultants)

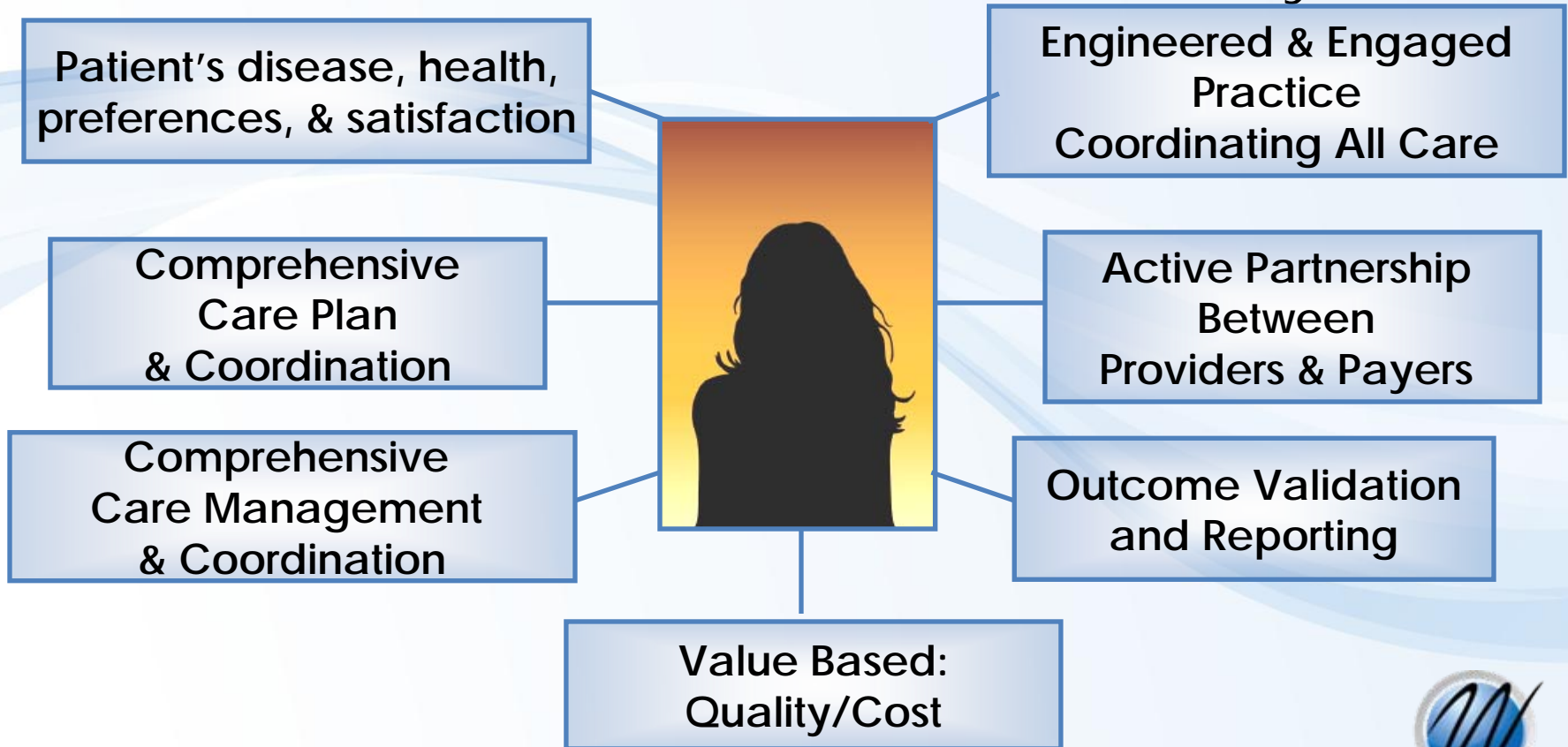
Medical Oncology Home Model

“Pay differently for Different Outcomes”

- Partnership with Payers, Providers and Patients:
- Centers on Patients with **Component Hypothesis:**
“Cost effective care,
on evidence based guidelines,
With warranted variations,
with fully engaged patients,
given when patients need it,
by experienced clinician teams led by doctors,
coordinating care with others,
in and outside the clinic,
can lower costs and
improve health outcomes
for cancer care from prevention to end of life”

Patient Centric Modeling

Team of Caregivers to focus on Patient Needs and Preferences Cost Effectively



Re Engineering Our Cancer Care

- Staff, Patients, & Administrative Engagement:
 - MD Team leaders: NP/PA, RN, LVN, MA, clerical, administrative
 - Patients: Structured Paper or Electronic reporting before visits
 - Care Planning: regimens, supportive care, sequencing, & end of life, care coordination with other specialists and primary, development of end of life tools and programs
 - Care Management:
 - Extended accessibility & oversight: proactive and reactive
 - Same Day Visits, Extended Hours of Clinic (7:30-7:30)
 - Tertiary, hospitalists, ER & urgent care MD coordination
 - Survivorship visits and transition back to primary care
 - IT and EMR for decision support before care & at point of decision making with reporting for feedback & innovation

Re Engineering Payer Relationships

- Payer Engagement
 - Capitated Managed Care: Prime Care Inland Valley
 - All cancer patients discussed or seen at earliest time, care plan from start including tertiary care management, specialty coordination with surgery, radiation, other specialists and primary care
 - Monthly joint operating committee, 2009 forward
 - Monthly Executive committee participation 2010 on
 - Medical Home Model:
 - ABC team approached 3-2008 about developing a new payment model to support comprehensive, value based care at practice based on managed care successes

Development Process with ABC

- Engagement and Partnership: 2008-Ongoing
 - “Pay differently for different outcomes”
- Meetings and Relationship Building:
 - Discussions of issues, data, goals
 - Validation of practice and plan capabilities
- Development of model and payments
 - FFS E&M Visits, Infusion Codes, Drugs @ASP+
 - Payment for Care Planning & Care Management
- Payment work around: Launch 8/1/11
- Pilot evaluation and evolution 8/11-8/12
- Pilot extension 2012-2014



Key Impactable Cost Drivers Identified

- Therapies:
 - Cost effective by stage, tumor features, evidence based guidelines, generics c/w age, co-morbidities, warranted variations, including clinical trials
 - Therapy compliance and adherence
- Supportive care: cost effective for
 - N/V, WBC & RBC Growth Factors, and Bone metastasis
- Symptom management: Initial and Interval
 - Relieve suffering, lower complication costs
 - 7 Common Toxicities of Therapy: Pain, N/V, Diarrhea, Constipation, Dehydration, Infections & Blood Clots
- Optimize Site of Care
 - Office, extended office, urgent care vs. ER and hospital and tertiary care
- End of Life Care: ACD, Therapy vs Care, Site of death



Aligned Payment Modeling

- Standard FFS: ABC PPO Patients
 - E&M visits
 - Infusion Codes
 - Drug Reimbursement: ASP+
 - IV and oral,
 - Drugs in practice, Generic Differential when able
- Plus New Codes to pay for additional Work:
 - **Care Planning** and **Care Management** Codes for additional work for better care and lower costs to improve health via comprehensive planning and care coordination
 - Tracked in pilot 1st year for S code development
 - Payment via fee schedule adjustment for launch



WILSHIRE ONCOLOGY

 United in Healing with US Oncology

Pilot Development Challenges

- ABC Leadership:
 - Dr. Kamil & Dr. Malin: active, experienced participants
 - Medical Directors: 6 over 4 years, Dr. Carlisle understand oncology issues, actively participates
- Actuary Issues:
 - Many competing assignments, oncology education process, many DATA challenges but key to validation and benchmarking
- Contracting, IT and Legal Pioneering Issues:
 - Programming limits, S Codes and Generic differential
 - Federal participation waiver

MOH Pilot Outcome Deliverables

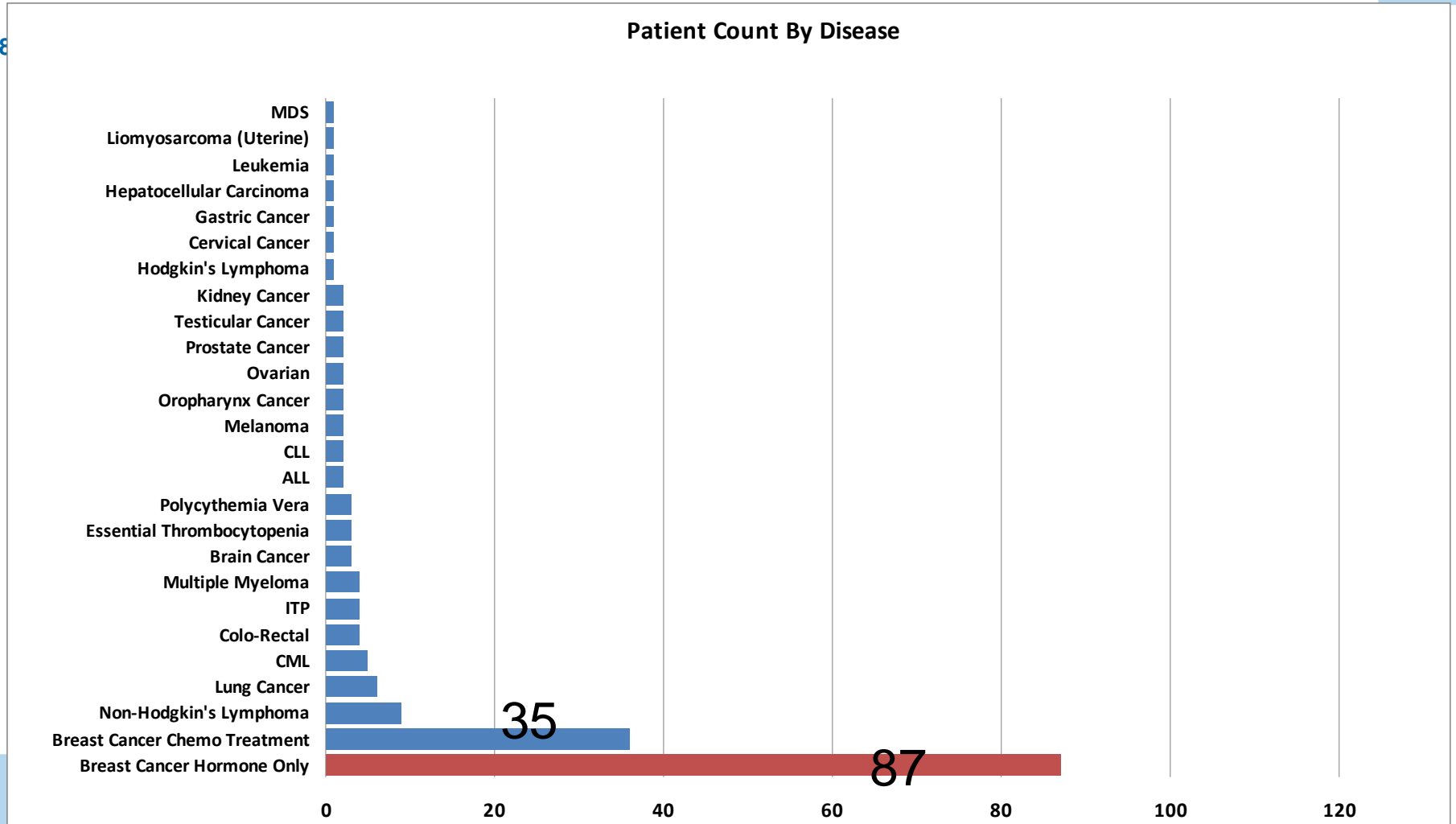
- Total Population Under Care
 - New/Follow Up; On Therapy, Off Therapy, & End of Life
- Care Planning: Therapies given to Patients
 - Therapy and supportive care by guidelines and value
 - Therapy by tumor, stage, features, line of care, PS, age
 - Therapies for Cure, Palliation and End of Life
- Care Management:
 - Proactive Interval management to improve health and avoid unnecessary urgent care, ER and hospital care
 - Interval care visits by site and type
- End of Life Care: ACD, Days from Chemo, Site of care
- Benchmarking: Quality and Financial Measures

Members Under Care: 1st Year MOH Population Summary

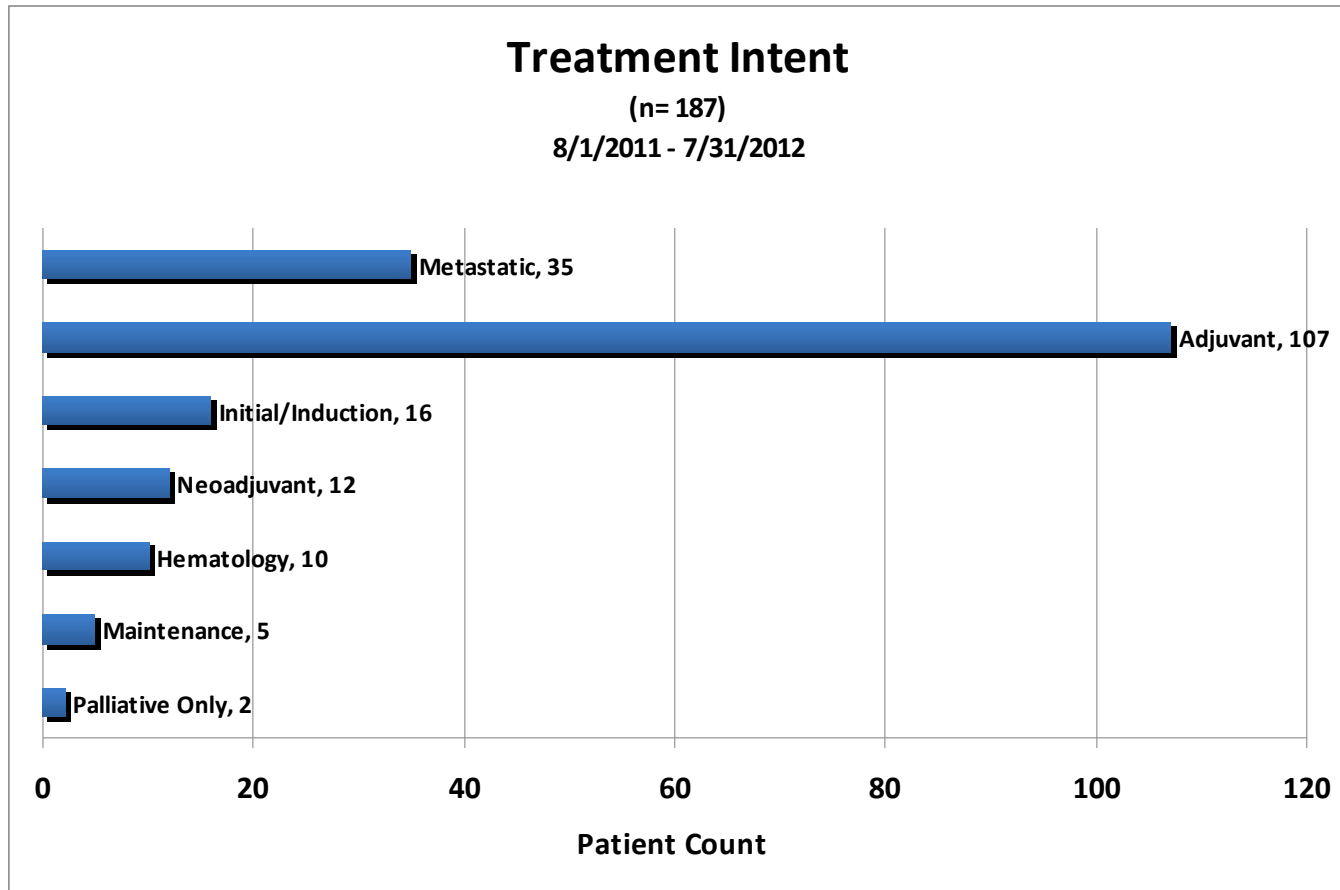
- Anthem Blue Cross PPO Only Patients at Wilshire Oncology Represents 7% of Overall WOMGI patients by income
 - **768** Unique Patients seen from August thru July 2012:
 - **80 Newly Diagnosed** Patients within the 12 month time frame (not transfer of care patients)
 - **581 Patients on Follow up Only** for Cancer or Blood Diseases
 - **107 Patients:** continuing on therapy 8/1/11 or relapsed/progressed after 8/1/11
 - **187** Unique Cancer or Hematology Patients Total **On Therapy**
 - **100 on Chemo-Bio** Therapies and
 - **87on Hormone Only** Therapies
 - **Only 24%** of patients were **on active therapy** vs. **76%** on follow up
 - **(13% on chemo-bio regimens and 11% on hormone only)**



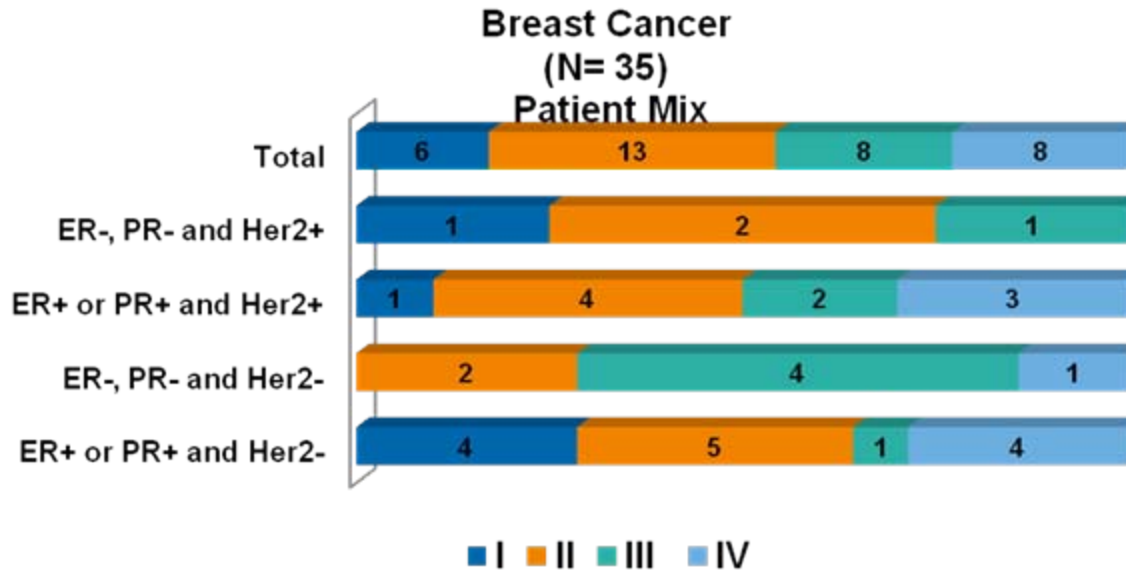
On Therapy: 187 Patients: Diagnosis & Numbers of People



Treatment Intent: All Patients



Invasive Breast Cancer Subtyping for those On Chemo-Bio Therapy

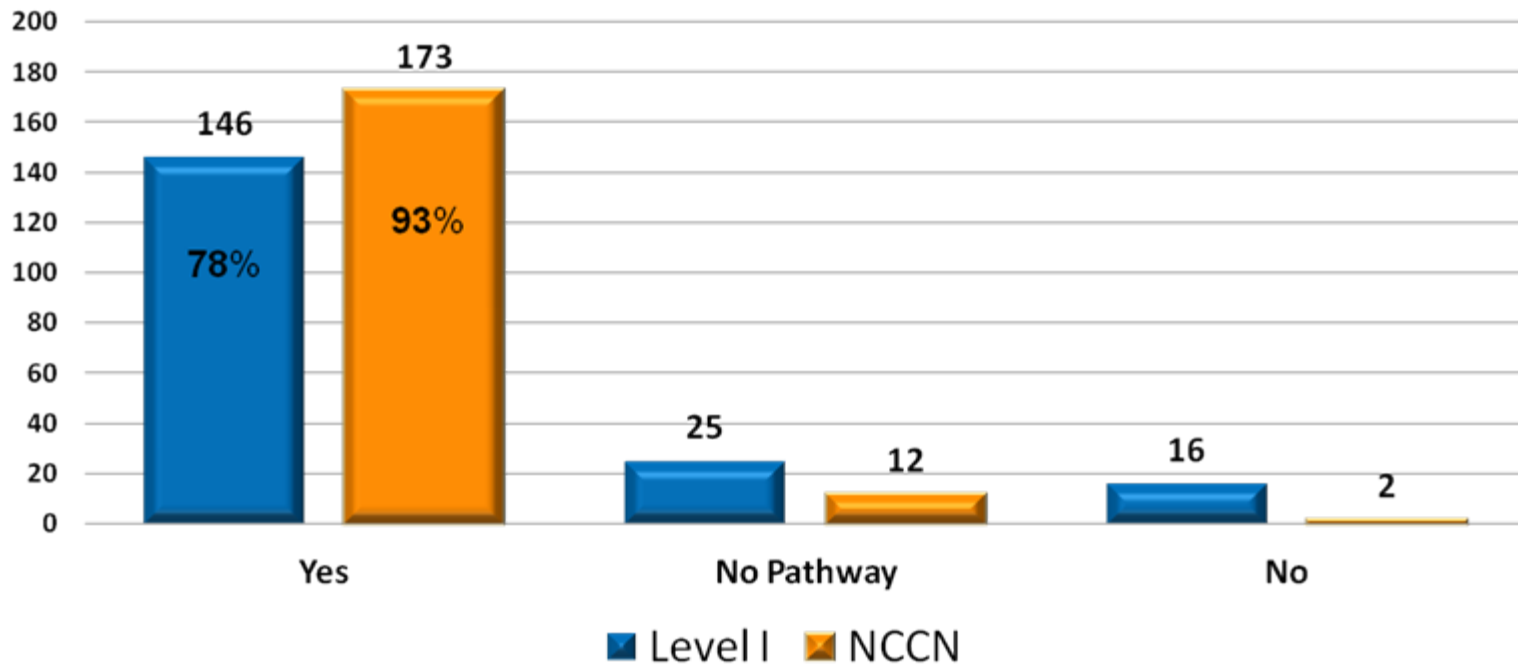


Inclusion dates: 08/1/2011 – 7/31/2012



Pathway Adherence All On Therapy: (Chemo-Bio & Hormone Only Patients)

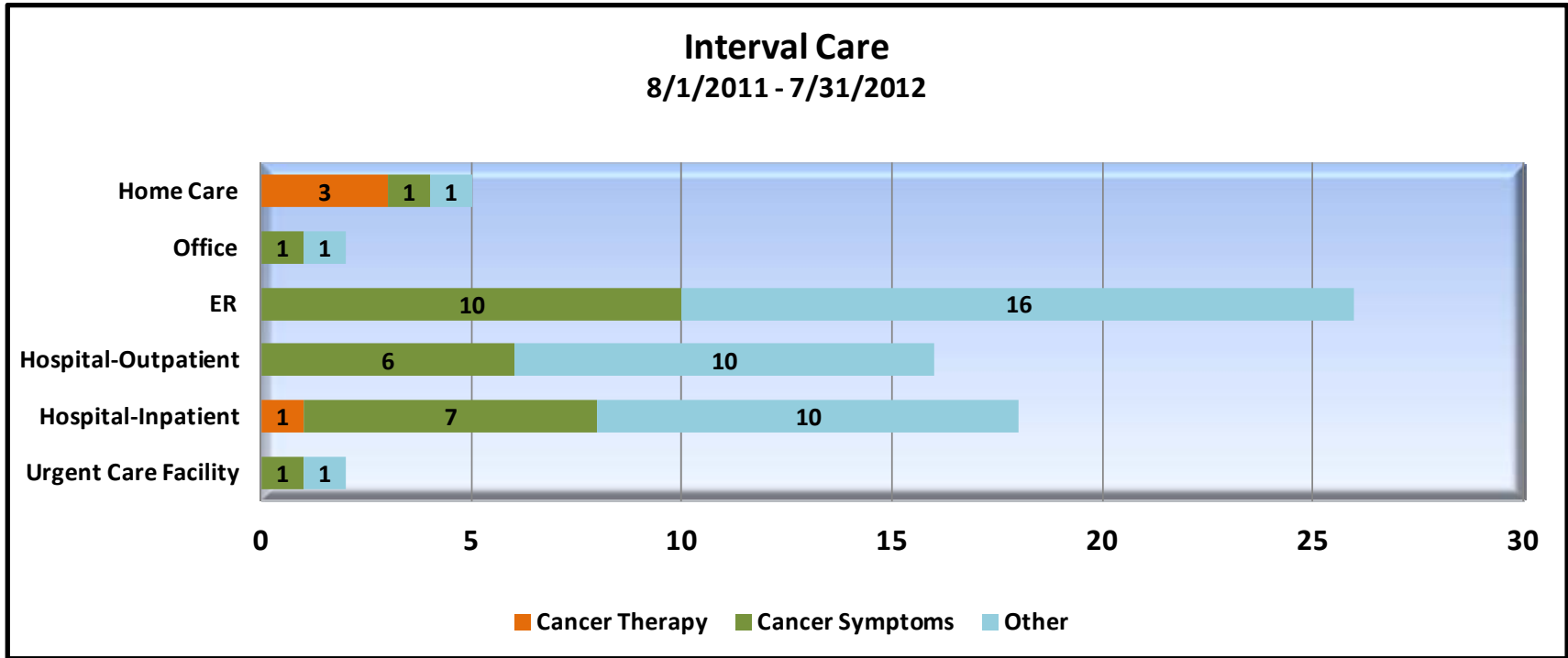
Pathway Adherence for 187 Therapy patients



For Diseases with NCCN Pathways, Compliance was $173/175 = 99\%$
 For Diseases with Level I Pathways, Compliance was $146/162 = 90\%$



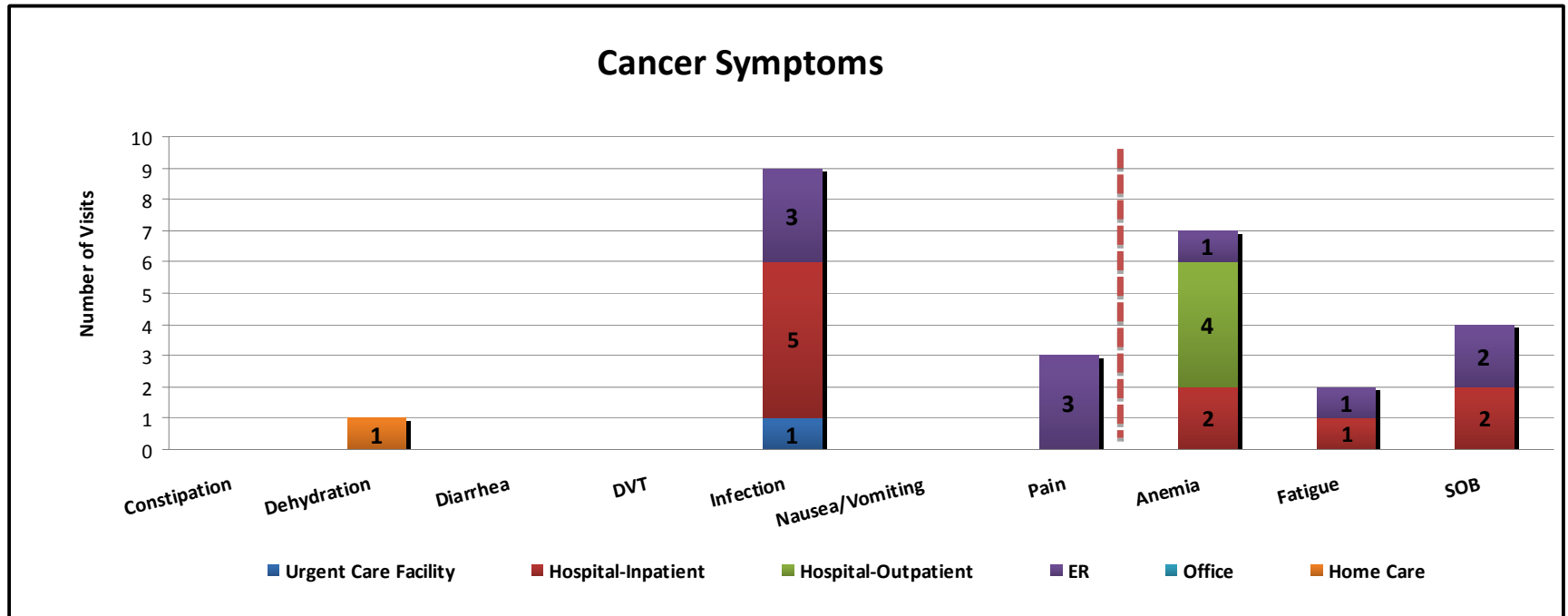
Interval Care: Sites by 3 Visit Categories



69 Interval Care Events from 615 Cycles of Chemo-Biotherapies
 60 ER or Hospital = 1 visit per 10 cycles or 10% of all cycles vs
 reported benchmarks of 30%



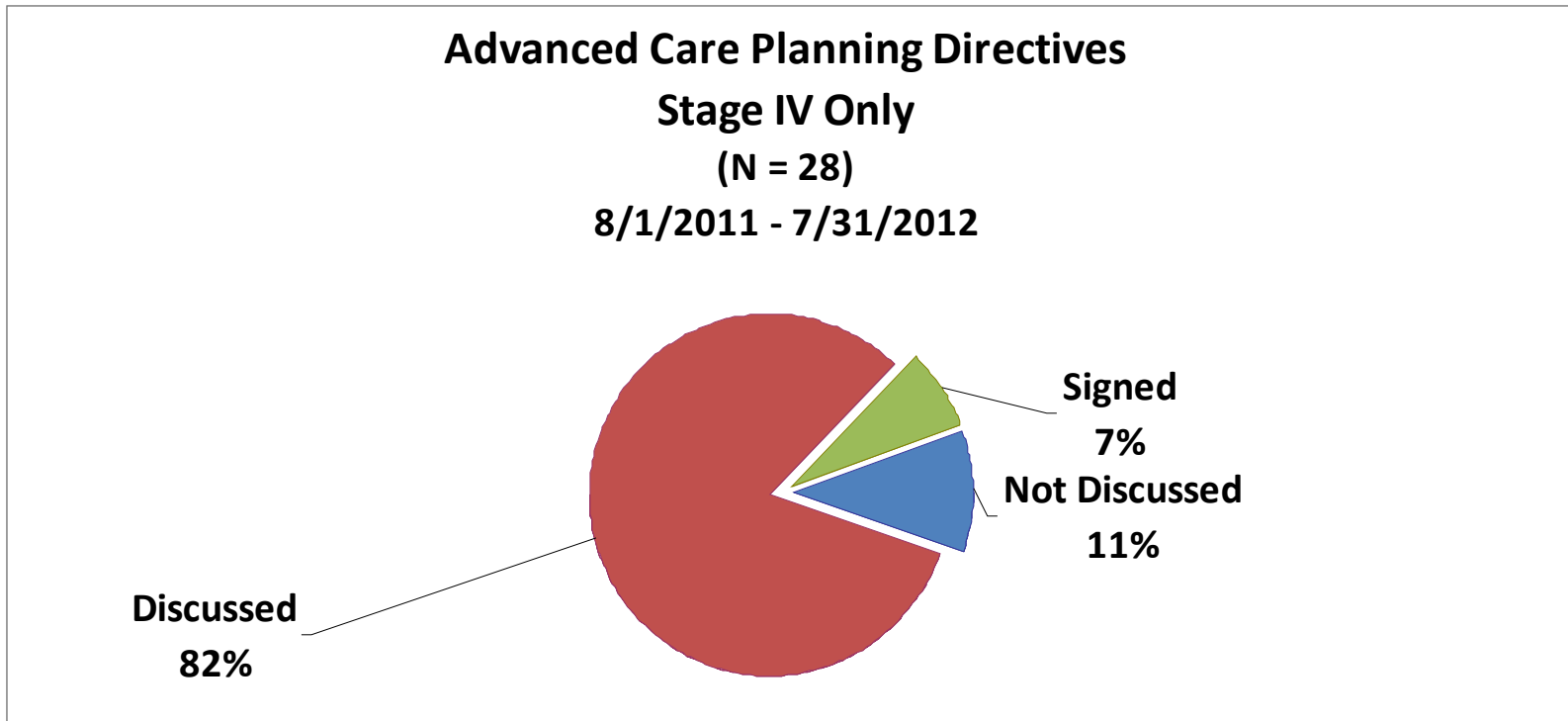
Interval Care: Cancer Symptoms ALL including details for the 7+3 common toxicities for care management



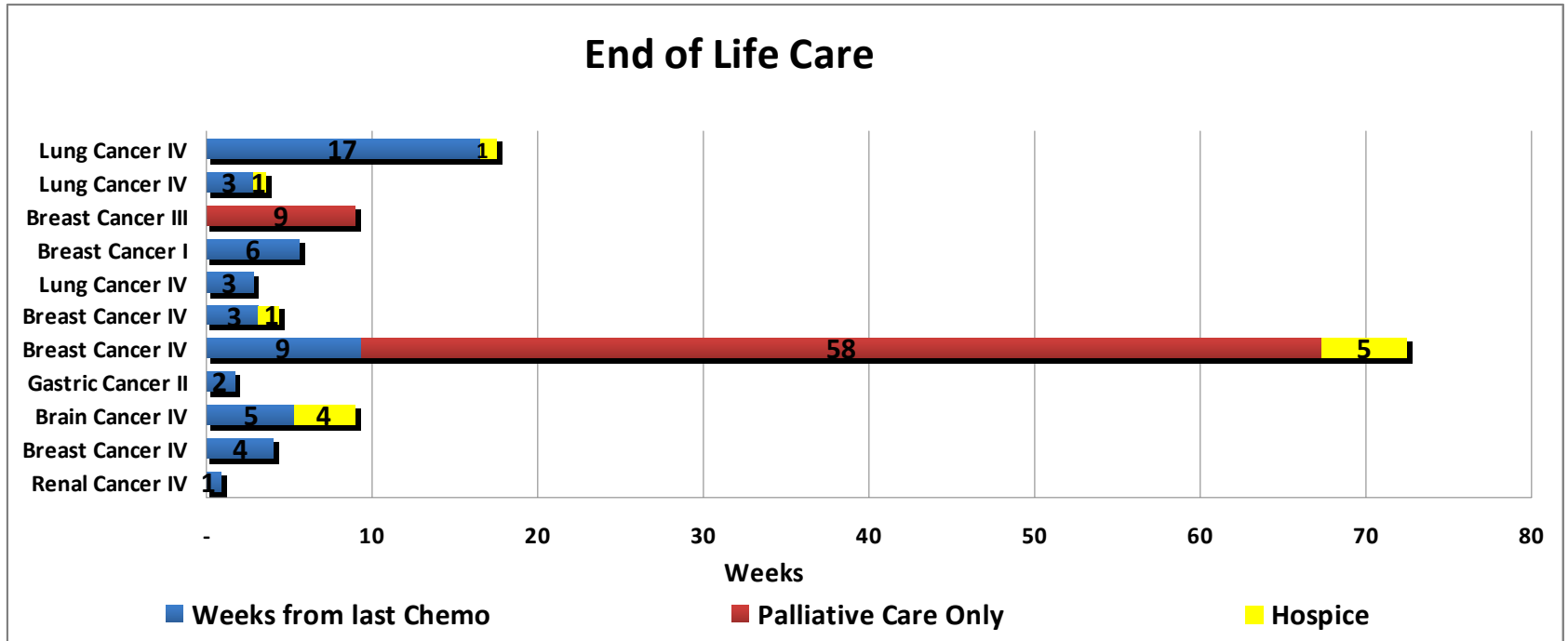
13 Visits, 11 in Hospital or ER for 7 Targeted Care Management Symptoms From 615 cycles of Chemo-biotherapy = 1 ER/Hospital/56 cycles, 2% 13 visits for other 3 common cancer symptoms. 24 ER/Hospital visits for all cancer symptoms/615 cycles.



Advanced Care Directives: Stage IV Chemo-biotherapies



End of Life Care: 11 Patients/768 Died over 12 months



6 died at home: 5 on Hospice, 1 on Palliative only, refused hospice
 5 died in hospital: 2 early unexpected deaths, 3 who refused PO/H care
 Average LOS for 5 hospitalized: 3.6 days (2,2,6,4, and 5 days)

Average time from last treatment to death for 11 patients was (11.8 Weeks) slightly less than 3 Months



Quality Measures

Quality Measures			
	<u>Measure</u>	<u>Total</u>	<u>% Compliant</u>
EOL/Advanced Care Planning			
Pain assessed on either of the last 2 visits before death	10	11	91%
Hospice enrollment	5	11	45%
Hospice enrollment or palliative care referral/service	5	11	45%
Hospice enrollment within days of death	0	5	100%
Chemo adm with the last weeks of life	2	11	82%
Customized Disease Measures			
NSCLC			
Performance status documented for pts with initial Stage IV or distant mets NSCLC	4	4	100%
Positive EGFR mutation for pts with Stage IV NSCLC who rec'd first line EGFR tyrosine k	0	1	100%
NHL			
Granulocytic growth factor adm with CHOP to pts & older with NHL	5	5	100%
Granulocytic growth factor adm on same day as CHOP NHL	0	0	
Rituximab adm with CD- antigen expression is negative or undocumented	0	5	100%
ColoRectal			
Adjuvant chemo rec'd within months of dx for Stage III colon CA	0	0	
Number of LN documented for resected Colon CA	3	3	100%
12 or more LN examined for resected colon CA	3	3	100%
Adjuvant chemo rec'd within months of dx for Stage II or III Rectal CA	0	0	
KRAS testing for pts with met colorectal CA who received anti-EGFR MoAB therapy	0	0	
Breast			
Complete fam hx doc for pts with invasive breast ca	120	120	100%
Comb Chemo rec'd within months of dx with Stage 1 (tc) to III ER/PR neg breast ca	20	20	100%
Test for Her-2 /Neu Over expression or gene amplification with ICD-9 of 174.0-9	108	108	100%
Trastuzumab rec'd when her-/neu is negative or undocumented	0	58	100%
Tamoxifen or AI rec'd with year of dx by pt with stage 1 (tc) to III ER or PR+	90	90	100%
IV Bisphosphonates or Denosumab adm for breast CA bone mets	10	10	100%



MOH Pilot Learning to Date

- Data Is Promising:
 - Care Planning choices can save money for patient & payer: all types of therapy
 - Care Management can significantly reduce ER and Hospital visits: 10% vs. 30%
 - End of Life Care: can lower end of life hospitalizations and improve time from last therapy to death (12 weeks) as well as Hospice/Palliative Only use 6/11= 55%
 - Benchmarking shows high compliance with nationally validated quality measures
- Opportunity to continually optimize care with payer partnership
 - Transfusions, IV-Ig examples
 - Generic costs: AI example
 - After hours care opportunities
 - Sequencing of care choices based on statistical science vs. marketing
- Opportunity to enhance benchmarking and relevant metrics 2012-2014
 - Improved understanding of costs per cancer types and sequencing options
 - Improved understanding of practice costs to deliver care
 - Expanding Interval care documentation for standardization and tracking
 - Expanding End of Life Support tools for patients & providers
 - Standardizing quality measures to be most relevant for patient outcomes and costs
 - Better engaging patients: implementing electronic data capture and office coordination
 - Opportunity to scale and expand to other providers

Medical Oncology Home

Quality

- Evidence Based
- National quality standards
 - Validated
- Outcome driven

Cost

- Access
- Affordability

Patient Centered Value Based Cancer Care

Payer Partnership

- Value based payments
 - Partner with delivery system
 - Partner with patient

Delivery System

- Care givers
- Research
- Facilities
- Pharmaceuticals
 - Devices

