Innovation in Physician Payment and Organization for Cancer Care

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Current Oncology Care Model Unsustainable

High Cost & Trend
- U.S. spending on cancer increased from $27B to $90B since 1990
- $25-30 avg. Commercial PMPM & $80-90 avg. Medicare PMPM
- Total cost trend estimated at 15%
- Drug costs PMPY expected to rise 24% year over year

Variation & Waste
- Variation in mortality after complex cancer surgeries ranges from 5-20% across hospitals
- 20-fold variation in cost for equally effective treatments
- 90% of CSF use not consistent with national guidelines

Inadequate Patient Support
- <40% members with cancer enrolled in hospice prior to death
- 1 in 3 members with cancer admitted to ICU in the last month of life
- One-third of patients receiving chemotherapy are admitted to the hospital during therapy

Many gaps in quality of symptom management and supportive care

ASCO Quality Oncology Practice Initiative (QOPI)

1. Pain assessed on first office visit
2. Effectiveness of pain medication assessed on visit after narcotic prescription
3. Pain assessed on either of the last 2 visits prior to death
4. Pain rated numerically on either of the last 2 visits prior to death
5. Patient enrolled in hospice or referred to palliative care specialist before death
6. Patient enrolled in hospice more than 1 week before death*
7. No chemotherapy administered within last 2 weeks of life*
8. Serotonin antagonists administered with first administration of highly emetic chemotherapy
9. Corticosteroids added concurrently
10. Aprepitant administered with highly emetic chemotherapy
11. Granulocytic growth factor administered with CHOP or RCHOP**

McNiff K K et al. JCO 2008;26:3832-3837
Unmanaged symptoms during treatment and end of life lead to admissions and higher cost of care

<table>
<thead>
<tr>
<th>Active treatment</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Admissions within 30 days of cancer surgery</td>
<td>34%</td>
</tr>
<tr>
<td>Admissions with chemotherapy + radiation</td>
<td>51%</td>
</tr>
<tr>
<td>Admissions with chemotherapy</td>
<td>28%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>End of Life</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Received chemotherapy in 4 weeks prior to death</td>
<td>8%</td>
</tr>
<tr>
<td>Admitted to hospital in 4 weeks prior to death</td>
<td>53%</td>
</tr>
<tr>
<td>Admitted to ICU in 4 weeks prior to death</td>
<td>30%</td>
</tr>
<tr>
<td>No Rx for an opiate in 84 days prior to death</td>
<td>64%</td>
</tr>
<tr>
<td>Not enrolled in hospice prior to death</td>
<td>64%</td>
</tr>
</tbody>
</table>
**Challenge**

- Cancer care is complex and expensive
- Requires coordination of care among multiple specialists and attention to psychosocial distress of patients with life-threatening illness
- Payment models for office-infused drugs do change utilization – impact on cost and quality not known
- Cost to payer varies tremendously by site of care
- No simple fixes – and any change in reimbursement policy can have unintended consequences

**Anthem’s Approach**

- Oncology Medical Home Pilot
- Support community oncology practices
- Treatment planning for episode of care
Oncology Medical Home: 3 Key Components

Adherence to Treatment Pathways
• Among NCCN regimens, practice pre-specifies cost-effective choice for chemo and supportive care
• Committed to using USON Level 1 Pathways where appropriate

Coordination of Care and Disease Management
• Document comprehensive treatment plan and coordinate care with other specialists
• Proactive telephone support by Oncology RNs
• Evaluate acute events in office instead of sending to ER
• Reporting of metrics to track process and outcomes
  ✓ QOPI Quality measures
  ✓ Admissions and ER visits

End of Life Care
• Advanced directives
• Referral to hospice
Payment for Oncology Medical Home

Original intent was to reimburse for treatment planning and care coordination using a new S-Code

- Fee for each new treatment plan
- Monthly fee for case management

Delay associated with obtaining and implementing the new S-Code in claims system necessitated a modification to this approach

- Actuaries estimated revenue to practice anticipated from S-Code fees
- New contract executed with 25% increase in reimbursement, including E&M and drugs
Preliminary Data
Colony Stimulation Factor Utilization – mixed results

CSF Usage per chemotherapy episode

% patients with metastatic solid tumors who received CSF

Marked decreased in use in patients with metastatic disease where ASCO recommends against CSF
Preliminary Data

Trend suggests decrease in related hospital admissions

Hospitalizations per Chemo Episode

- All Cancers
- Breast Cancer
- Other Solid Tumors
- Heme Malignancies

Pre-Pilot - California Ave.
- All Cancers: n=61
- Breast Cancer: n=14
- Other Solid Tumors: n=20
- Heme Malignancies: n=27

Pre-Pilot - OMH
- All Cancers: n=12
- Breast Cancer: n=5
- Other Solid Tumors: n=5
- Heme Malignancies: n=2

OMH Pilot

Legend:
- Pre-Pilot - California Ave.
- California Ave.
- Pre-Pilot - OMH
- OMH Pilot
Savings Associated with Treatment Pathways Offset Increase in Treatment Planning Fees

- Total Regimen Cost ($ thousands)
  - Highest Cost Rx Alternative
  - Estimate based on California Avg.
  - OMH Pilot

- Drug Costs
- Treatment Planning Fees

OMH Pilot:
- Total Regimen Cost: $1,400
  - Drug Costs: $1,000
  - Treatment Planning Fees: $400

Highest Cost Rx Alternative: $1,400

Estimate based on California Avg.: $1,000

OMH Pilot: $1,400

Anthem BlueCross
Lessons Learned from Oncology Medical Home Pilot

Change takes time
- Collaborative approach needed to support and nurture new care delivery models

Substantial resources required from both health plan and practice
- Develop and refine metrics
- Actuarial and financial analyses
- Quarterly in person meetings to review data + additional meetings to collaborate, develop protocols and tools, quality improvement

Small numbers of patients in the practice also enrolled in health plan present challenges to assessing impact on ER visits and hospitalizations
- Standardized data across practices needed in order to have a benchmark – but only a proportion of practice’s patients are health plan members
- Need process measures to track/audit Care Management

Need to determine critical elements of the Oncology Medical Home to impact patient outcomes and in order to determine ROI and implement in other practices/scale
How to Scale?

- **Support community oncology practices**
  - Increase chemotherapy administration fees
  - Increase practice margin on lower cost generic drugs

- **Treatment planning for episode of care**
  - Pre-authorization of an episode of care
  - Additional authorization for S-code when treatment plan is on pathway

- **Continue to develop Oncology Medical Home**
  - Develop tools and metrics to be able to scale Care Coordination and End of Life Care
Increase practice reimbursement for unprofitable lower cost generic drugs

<table>
<thead>
<tr>
<th>Code</th>
<th>Drug</th>
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<tbody>
<tr>
<td>J9265</td>
<td>Taxol</td>
</tr>
<tr>
<td>J9206</td>
<td>Irinotecan</td>
</tr>
<tr>
<td>J9045</td>
<td>Carboplatin</td>
</tr>
<tr>
<td>J9000</td>
<td>Doxorubicin HCl</td>
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<td>J9190</td>
<td>5-FU</td>
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<td>J9070</td>
<td>Cyclophosphamide Inj</td>
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<tr>
<td>J9370</td>
<td>Vincristine Sulfate</td>
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<td>J9360</td>
<td>Navelbine</td>
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<tr>
<td>J1625/26</td>
<td>Granisetron</td>
</tr>
<tr>
<td>J2405</td>
<td>Ondansetron</td>
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Implementation of new evidence-based decision-support tool to streamline approval for episode of care

**Web Portal**
- Practice submits request for episode of treatment via Web Portal
  - Single request instead of multiple
  - Direct link to Anthem medical policy and evidence-based treatment options

**Decision-Support**
- Compare against evidence-based recommendations
  - Data on efficacy, toxicity, and cost
  - Evidence-based supportive care
  - Review against Anthem medical policy
  - Identify regimens that are on pathway

**Output**
- Integrated with claims systems
- Immediate approval if consistent with Anthem medical policy
- Additional support for treatment planning when chemotherapy regimen is on pathway using S-code

- Phased implementation starting with radiation therapy
- Reimbursement for S-code varied with performance on quality measures and care coordination
Conclusions

Align reimbursement for value and better patient outcomes in oncology

Shift incentives to provide care for the patient not just manage the disease

Preliminary data from the Anthem/Wilshire Oncology Medical Group Oncology Medical Home Pilot suggest this model may provide the opportunity to achieve these objectives
Thank you