To Pathways and Beyond!

Oncology Medical Home: Strategies for Changing What and How We Pay for Oncology Care

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Senior Medical Director
Priority Health
Cancer Care is the Leading Edge of Medical Cost Trend for which Drugs Have Highest Rate of Rise

<table>
<thead>
<tr>
<th></th>
<th>Annual Increase</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Drugs¹</td>
<td>20%</td>
<td>$32 B</td>
</tr>
<tr>
<td>Cancer Medical²</td>
<td>12-18%</td>
<td>$88 B</td>
</tr>
<tr>
<td>Healthcare³</td>
<td>9%</td>
<td>$2 T</td>
</tr>
<tr>
<td>US GDP⁴</td>
<td>3%</td>
<td>$13 T</td>
</tr>
</tbody>
</table>

Cumulative % Increase

$55 B

$123 B

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Models for oncologist compensation and accountability for triple aim outcomes

- Fee for Service
- Pathways
- Oncology Medical Home
- Bundled Payment
- Accountable Care Network

Level of oncologist accountability for experience, health, and cost
A continuous relationship with a personal physician coordinating care for both wellness and illness

Mindful clinician-patient communication: trust, respect, shared decision making

- Patient engagement
- Provider/patient partnership
- Culturally sensitive care
- Continuous relationship
- Whole person care

The TransforMED Patient-Centered Model
A Medical Home for All
Michigan Oncology Medical Home Project

Go live in February 2012

- Natural evolution of experience with primary care medical homes
- Innovative oncology care model integrating services, streamlining care, and promoting better outcomes
- Focus on the patient not simply pathways

Collaborators

Cancer and Hematology Centers of Western Michigan
- Largest private oncology/hematology medical practice in west Michigan

Physician Resource Management
- Providing customized business solutions and services for oncology practices in Michigan
- Four medical practices in eastern Michigan

Priority Health
# Highlights of Oncology Medical Home Model

## Payment Reform
- Plan pays acquisition cost for drugs
- Difference between fee schedule and invoice paid as a care management fee for patients on chemotherapy independent of cancer type or mode of administration

## Enhanced Payment
- Annual $1500 per physician per year infrastructure development fee
- Payment for treatment planning (S0353 and S0354) and advance care planning (S0257)
- Share savings for reductions in emergency department visits and hospitalizations
- Share savings for reduced cost of imaging (FUTURE)
- Incentive payment for select quality metrics (FUTURE)

## Care Reform
- Implementation of preferred regimens, including imaging and monitoring
- Standardized care management programs
- Advance care planning program
- Survivorship programs (FUTURE)

*Holds providers accountable for the choice but not the cost of drugs*
Payment Reform Agreements

Plan pays monthly care management fee for patients receiving active IV or oral chemotherapy

- After-hours services
- Care plan oversight services
- Medication therapy management
- Patient education

Separately payable fees

- Board-certified genetic counseling
- Advance care planning
- Treatment planning
- Psychological counseling

Unchanged reimbursement

- E&M codes
- Infusion fees
- Lab and imaging payments
## Care Management Fee Eligibility

<table>
<thead>
<tr>
<th>Patient <em>is</em> eligible if they</th>
<th>Patient <em>is not</em> eligible if they</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are an active Priority Health member for any product</td>
<td>Receive selected drugs for maintenance chemotherapy</td>
</tr>
<tr>
<td>Receive infused and/or oral chemotherapy independent of when started</td>
<td>Receive chemotherapy in the inpatient or outpatient hospital setting</td>
</tr>
<tr>
<td>Receive palliative care services</td>
<td>Receive no chemotherapy during a calendar month</td>
</tr>
<tr>
<td>Independent of whether on a defined pathway</td>
<td>Receives only radiation therapy during a calendar month</td>
</tr>
<tr>
<td>No defined time period for eligibility (eg, 6 months)</td>
<td>Are enrolled in hospice</td>
</tr>
</tbody>
</table>
Care management reforms

• Preferred regimens for 4 high-volume conditions
  – Both adjuvant and metastatic first- and second-line

• Care management/navigator programs
  – To reduce side effects, reduce admissions and readmissions, and improve adherence

• Patient engagement programs with a “call me first” policy

• Advance care planning (ACP)

• Survivorship program (future)
**First line**
Intensive Tx

**KRAS mutation**
- FOLFIRI + bevacizumab

**Second line**
- FOLFOX + bevacizumab
  - or
  - CapeOX + bevacizumab

**Third line**
- Clinical trial or best supportive care

**KRAS WT**
- FOLFIRI + cetuximab or panitumumab

**Second line**
- Irinotecan + cetuximab or panitumumab

**Third line**
- FOLFOX
  - or
  - CapeOX
Care reform agreements: Preferred regimens

- Physician practices must establish “preferred regimens” for at least 4 high-volume conditions in adjuvant and first- and second-line metastatic settings

- Regimens must be consistent with NCCN guidelines (www.nccn.org)

- Regimens should include Eastern Cooperative Oncology Group (ECOG) performance status or Karnofsky score
  - Should be assessed and documented at each encounter

- Regimens must include guidelines for imaging and other disease-control monitoring
ASCO and Choosing Wisely

#1 Avoid unnecessary anticancer therapy, including chemotherapy, in patients with advanced solid-tumor cancers who are unlikely to benefit, and instead focus on symptom relief and palliative care.

ASCO recommends that cancer-directed therapy not be used for solid tumor patients with the following:
1) low performance status (3 or 4),
2) no benefit from prior evidence-based interventions,
3) not eligible for a clinical trial, and
4) no strong evidence supporting the clinical value of further anticancer treatment.

Because further treatment is unlikely to be effective in these patients, emphasis should be placed on palliative and supportive care, which can increase quality of life and, in some cases, extend survival.
## Care Reforms: Advanced Care Planning

<table>
<thead>
<tr>
<th>Estimated Life Expectancy</th>
<th>NCCN Recommended Intervention</th>
<th>Reassessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Years</strong></td>
<td></td>
<td><strong>Satisfactory</strong></td>
</tr>
<tr>
<td></td>
<td>• Discuss palliative care options, including hospice</td>
<td>• Adequate advance care planning</td>
</tr>
<tr>
<td></td>
<td>• Consider introducing palliative care team</td>
<td>• Reduction of patient/family distress</td>
</tr>
<tr>
<td></td>
<td>• Assess for decision-making capacity and need for surrogate decision maker</td>
<td>• Acceptable sense of control</td>
</tr>
<tr>
<td></td>
<td>• Elicit personal values and preferences for end-of-life care and congruence with values and preferences of family and healthcare team</td>
<td>• Relief of caregiver burden</td>
</tr>
<tr>
<td></td>
<td>• Provide information about advance directive and encourage exploration of DNR option</td>
<td>• Strengthened relationships</td>
</tr>
<tr>
<td></td>
<td>• Encourage the patient to discuss wishes with family</td>
<td>• Optimized quality of life</td>
</tr>
<tr>
<td></td>
<td>• Encourage designation of healthcare proxy, medical power of attorney, durable power of attorney, or patient surrogate for healthcare</td>
<td>• Personal growth and enhanced meaning</td>
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<tr>
<td></td>
<td>• Inquire about desire for organ donation and/or autopsy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Explore fears about dying and address anxiety</td>
<td></td>
</tr>
<tr>
<td><strong>Years to months</strong></td>
<td></td>
<td><strong>Unsatisfactory</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Intensify efforts to communicate palliative care options</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consider referral to psychiatrist to evaluate and treat psychiatric disorders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• See NCCN Distress Management Guidelines</td>
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**Note:** All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

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Care Reform Agreements: Advance Care Planning

- Physician practices must establish an ACP program for patients receiving chemotherapy, at minimum to include:
  - Within 60 days of the initiation of initial chemotherapy
  - Prior to subsequent changes in therapy (e.g., disease progression)
- Place any resulting advance directives into the medical record
- Share advance directives with other treating providers, including hospital(s)
Care Reform Agreements: Care Management

Practices will establish care management programs to improve adherence, reduce side effects, reduce unplanned care, and enhance access to care.

Specific target areas include:

- Chemo-induced nausea and vomiting
- Dehydration
- Constipation and diarrhea
- Fever and febrile neutropenia
- Depression
- Fatigue

Care management to include protocols for both **patient education** and **phone triage**

- To encourage patients to be more proactive in their own care
- To ensure consistency in response by on-call clinician

Triage Disposition

- 75% Home
- 12% Office same day
- 8% Office next day
- 4% Direct admit
- 1% ED

priorityhealth.com
Evidence-Based Interventions for Mucositis

RECOMMENDED FOR PRACTICE

- Oral care protocols

LIKELY TO BE EFFECTIVE

- Cryotherapy for patients receiving bolus mucotoxic chemotherapy with short half-life (bolus 5-fluorouracil, melphalan)
- Palifermin for patients undergoing hematopoietic stem cell transplantation for hematologic malignancies

EFFECTIVENESS NOT ESTABLISHED

- Allopurinol
- Amifostine
- Anti-inflammatory rinses
- Antimicrobial Agents
- Benzylamine HCl
- Immunoglobulin
- L-Alanyl-L-glutamine
- Low-level laser therapy
- Multiagent ("magic" or "miracle") rinses
## Performance Metrics

### DOMAIN: End of Life
- % of cancer patients admitted to the hospital in the last 4 weeks of life
- % of patients prescribed chemotherapy in last 2 weeks of life
- % enrolled in hospice within 3 days of death
- % of new patients with ACP discussions within 60 days of the first dose of chemotherapy
- % of patients with an advanced directive in the medical record within 60 days of starting chemo

### DOMAIN: Office Triage: Case management
- # of calls per symptom type with disposition (home, same day visit, next day visit, ED, direct admit, other)
- ECOG performance status or Karnofsky score documented at each chemotherapy contact
- Non-elective hospital admissions per 100 patient chemo months
- ED visits per 100 patient chemo months

### DOMAIN: Office Chemotherapy: Measure applies to all patients in the practice
- % compliance with preferred regimen for first-and second-line chemotherapy
- 90% compliance with NCCN guidelines; others adjudicated with evidence of ACP
- % of chemotherapy infusions administered in an office setting

### DOMAIN: Patient Satisfaction
- Community Oncology Alliance patient satisfaction tool, annually
Characteristics of a “successful” provider-payer partnership

- Commonality of purpose—preserving access to community oncologists
- Co-development of program and metrics
- Willingness to share each other’s data
- Trust!

Trust is like the air we breathe. When it’s present nobody really notices. But when it’s absent everybody notices.

You can't shake hands with a clenched fist.
Collaboration in the model home model

Plan and Practice Collaborations

• Developed a technical manual summarizing agreements
• Utilization & quality performance metrics
• Developed a shared savings model for reduced utilization
• Developing an incentive program for quality metrics
• Securing funding for transformation
• Publish the qualitative and quantitative results
Oncology Medical Home Benefits

**Provider**
- Compatible with existing pathways programs
- Reimbursement for patient care management
  - Both IV and oral chemo
- More predictable reimbursement
- Shared savings on performance metrics
  - Reductions in ED visits/hospitalizations
  - Reduced cost of imaging
- Reduced risk for drug carrying cost
- Waived PAs on drugs and imaging
- Enhanced readiness for ACOs

**Payer**
- Reduced variability of cancer care
  - Per NCCN guidelines
- Comprehensive care management programs:
  - Reduce side effects and readmissions, and improve adherence
- Reduction in avoidable costs
  - Reductions in ED visits/hospitalizations
  - Reduced cost of imaging
- Enhanced independence of community practices

**Manufacturer**
- Optimal treatment selection (sequencing)
- Improved time on therapy
  - Via side effect management and patient/provider education
- Data on pathway selection and compliance
- Maintenance of community-based practices

**Patient**
- Enhanced cancer care regimens coordinated with NCCN
- Enhanced access to oncology provider
  - Continuity of care in provider office
  - After-hour services
  - Medication therapy management
- Improved quality of life:
  - Reduce side effects/readmissions, and improve adherence
- ACP and survivorship programs

**PriorityHealth**

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Questions?

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Associate Vice President of Medical Affairs

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