CCBD GROUP
CANCER CENTER BUSINESS DEVELOPMENT

MGMA 2012 Oncology Hematology Program

Essential Steps to Transitioning Your Practice into an Oncology Medical Home

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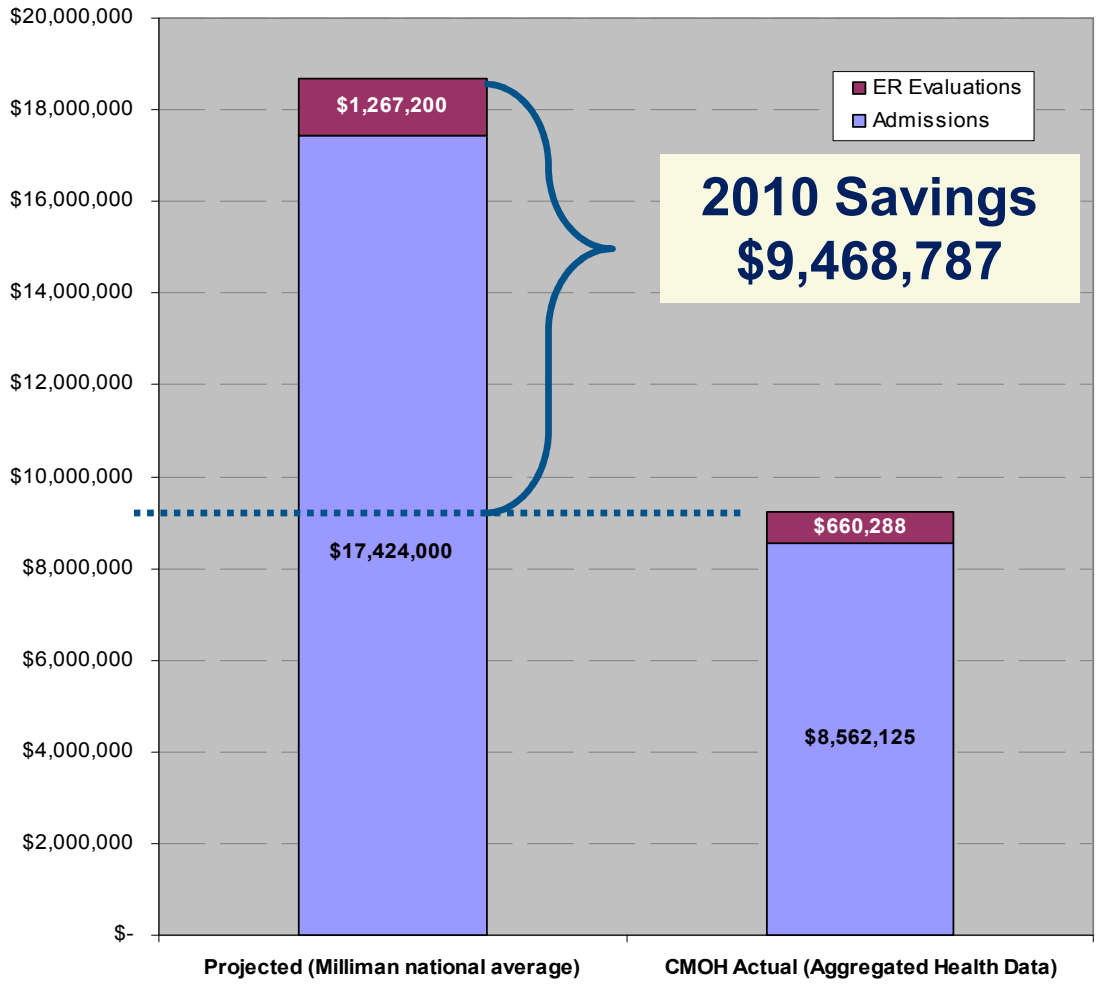
Learning Objectives

- Identify the basic features oncology/hematology practices need to have in order to transition to the oncology medical home model of care
- Describe the current status of and process for National Committee for Quality Assurance certification as an oncology medical home neighbor
- Explain the current status of payer methodologies for reimbursing oncology medical home activities and how they vary from fee for service

The Oncology Medical Home
Fundamental Economic Proposition



- **$1.0 M annual savings in cancer spend per Med Oncologist (9 MDs in example)**
- **$900 K from reduced hospital admits**
- **$100 K from reduced ER encounters**
- **Source: Consultants in Medical Oncology & Hem, Drexel Hill, PA (Sprandio et. al) internal claims data**

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Fundamental Care Management Proposition

- Evidence-based care that engenders standardization and minimizes variation
- Enhanced communication and care coordination among cancer specialties and with primary care (PCMH neighbor)
- A patient-focused care experience with “real time” availability, consistent & timely response/intervention
- Promotes collaboration with payers toward modified reimbursement methodologies
- Facilitates physician accountability, encourages clinical integration and promotes a pay-for-value agenda

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Fundamental Issue: Getting from Here to There

From Here

- Multiple providers with fragmented communication and care coordination processes, variation in treatment, limited data analytics & decision support systems
- Payment predominantly fee-for-service with “buy & bill” for drug with wide variation in contract terms among payers

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Fundamental Issue: Getting from Here to There

To There

- Definitive care coordination process among providers, evidence-based standards to limit variation, robust data analytics & decision support systems
- Modification of fee-for-service, enhanced pay for care coordination, less reliance on buy & bill for drug, shift risk of cost to providers (capitation? episode of care? bundled pricing?) with consistency in contract terms among payers

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Getting from Here to There is Scary!

Getting from Here to There involves a practice operational transformation which challenges the status quo. It can be a scary proposition!

- **Why do it?**
- **Who Benefits?**
- **What does it take?**
- **Who takes the initiative (who blinks first)?**
- **Who are the pioneers?**
- **How do you get paid?**

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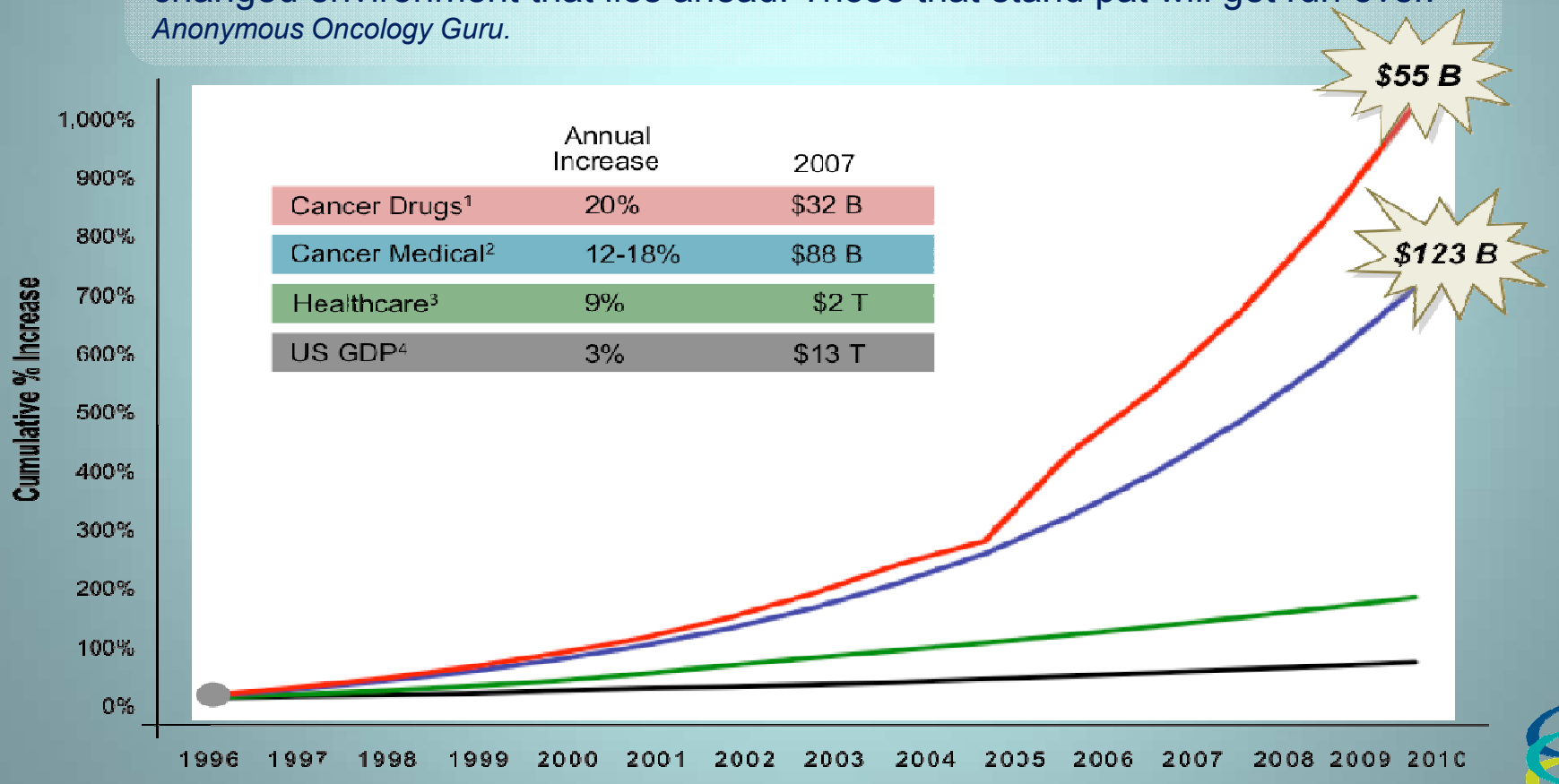
Why do it?

"Fee-for-service is going to fade away. Buy-and-bill is going to fade away. Smart practices need to prepare now to survive and even thrive in the changed environment that lies ahead. Those that stand pat will get run over."
Anonymous Oncology Guru.



Courtesy Ira Klein, M.D., Aetna. March 2012.

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Who Benefits?

Patients

- A patient-focused care experience with consistent & timely response, i.e. “patient-centered care”
- Become better educated healthcare consumers – how to access and relate to the “system”
- Personal relationship with physician
  - Explanation, prediction, plan of treatment/intervention
- Care coordination & communication
- Real time/on demand access to care (example: nurse triage)

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Who Benefits?

Physicians

- Standardization of the science of medicine so physicians can practice the art of medicine
- Stabilization of practice revenue and income
- Standardized data compilation/presentation leading to decision support at point of care
- Improved physician efficiency

  Enhances physician-patient relationship, make complex medical decisions based on data, timely coordination & communication capabilities (HIE)

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Who Benefits?

payers

- Reduction in their “cancer spend.”
- Derived principally from:
  - reduction in unnecessary hospital/ER incidents
  - adherence to chemotherapy guidelines/pathways
  - rational end-of-life care
- Processes of care focused on reduction of potentially avoidable complications with Improved coordination of care between all parties
- Care appropriate to patient’s clinical condition/performance status
- Increased patient engagement

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What Does it Take?

- Commitment from physician leadership to embrace and to unrelentingly support practice transformation to the oncology medical home model of care
- Commitment from significant payer(s) of the practice (25% to 40% of payer mix) to fairly compensate physicians for the effort of transforming and functioning as an oncology PCMH (and reducing their oncology spend by $1.0 M per MD)
- An organized process and enabling tools for practice operational transformation – getting from current status to oncology medical home

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What Does it Take?

Three phases of medical home construction

Phase 1: Laying the Foundation

Readiness assessment, GAP analysis, workflow re-design

Phase 2: Introduction of New Services

Phase 3: Optimization of Performance

Aligning reimbursement with each phase of construction

Barr, M. The Patient-Centered Medical Home: Aligning Payment to Accelerate Construction. *Medical Care Research and Review.* American College of Physicians. May 2010. mcr.sagepub.com.

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What Does it Take?

Recognition – Certification

- Who defines the oncology PCMH standard? The "GAP" between current/traditional practice operational status and medical home operational status? How do you know when you've arrived there?
- National Committee for Quality Assurance (NCQA) established standards and offers Recognition as a Patient-Centered Medical Home (PCMH) (ncqa.org/tabid/631/default.aspx)
- Can NCQA PCMH recognition be applied to a specialty practice (a PCMH neighbor), such as oncology?

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What Does it Take?

- In April 2010, NCQA PCMH recognition status awarded to Consultants in Medical Oncology & Hematology – CMOH Drexel Hill, PA (John Sprandio et. al) as the first (and only) oncology practice with NCQA PCMH recognition
- Current Status of Recognition – Certification
  - NCQA
  - Oncology Professional Organizations (ASCO, COA)
  - Recognition by Payers
  - ACP Council of Subspecialty Societies Policy Paper establishing definition of PCMH Neighbor. Neil Kirschner, Ph.D. October 2010

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NCQA Standard	Element
PCMH 1: Enhance Access/Continuity	Access during office hours (M)
	After-hours access
	Electronic access
	Continuity
	Medical home responsibilities
	Culturally, linguistically appropriate services
	The practice team
PCMH 2: Identify/Manage Patient Populations	Patient information available electronically
	Clinical data available electronically
	Comprehensive health assessment documented
	Use data for population management(M)

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NCQA Standard	Element
PCMH 3: Plan/Manage Care	Implement evidence-based guidelines
	Identify high-risk patients
	Case management (M)
	Medication management
	Use electronic prescribing
PCMH 4: Provide Self-Care Support/Community Resources	Support self-care process (M)
	Provide referrals to community resources

The Oncology Medical Home Standards

NCQA Standard	Element
PCMH 5: Track/Coordinate Care	Test tracking and follow up
	Referral tracking and follow up (M)
	Coordinate with facilities and manage care transitions
PCMH 6: Measure/Improve Performance	Measure performance
	Measure patient/family experience
	Implement CQI (M)
	Demonstrate CQI
	Report performance (internally)
	Report data externally

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Who Takes the Initiative (who blinks first)?

- **Provider-Driven Initiatives**
  - Oncology practices (see Pioneers)
  - Hospitals as a component of an ACO initiative
- **Payer-Driven Initiatives**
  - Often with intermediaries (P4, CareCore)
  - Historically, payer initiatives have been pathways focused
- **CMS-CMI ($1.0 B to think out of the box)**
  - The Health Care Innovation Challenge January 2012
  - At least 3 oncology-specific applications submitted

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Who are the Pioneers?

The "A List"

[A Note re: pioneering efforts. Sometimes pioneers discover uncharted and wonderful new territory. Other times pioneers just end up an with an arrow in their backs. Objective is to be in the former group as opposed to the latter]

- Consultants in Medical Onc & Heme (CMOH), Philadelphia
- United Healthcare (5 pilot sites)
- Texas Oncology (via Innovent/US Oncology)
- Oncology Physician Resource (OPR), Michigan
- Wilshire Oncology, So. California
- P4 - CareFirst Blue Cross, Maryland
- Priority Health, Michigan
- Community Oncology Alliance (COA) Medical Home Initiative

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How do you get paid? Pricing Strategies

Where do all these savings come from?

- **Projected % Reduction in Cancer Care Cost**
  - 1.0%-3.0% Chemotherapy pathways adherence
  - 4.0%-6.3% Inpatient hospitalizations
  - 0.6%-1.1% ER encounters
  - 0.1%-0.4% Diagnostics
  - 0.9%-1.9% End-of-life care coordination
  - 6.6%-12.7%
- **With U.S. "cancer spend" at $125 B annual, the oncology medical home for all comers would translate to $8 B - $16 B annual savings to the healthcare system**

Courtesy John D. Sprandio, M.D.
Adapted from evaluation of OPCMH financial impact by major National Consulting Firm. 2010.

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How do you get paid? Pricing Strategies

- Initial approaches have been pathways compliance oriented, for example 20% increase in drug reimbursement with 80% pathways compliance and prudent use of generics
- With recognition that pathways are only a part of the equation, a migration occurring from pathways only programs to medical home programs (which include pathways)
- Value proposition: If pathways compliance will get me 1% to 3% cost savings, why not go for 7% to 13% oncology PCMH cost savings ($1.0 M per med onc per year)?
- Possible answer: it's a lot easier to achieve pathways compliance than it is to transform practice cultures

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How do you get paid? Pricing Strategies

The Health Reform "Shared Savings" Precedent

- Accountable Care Organization (ACO) as vehicle for implementing shared savings program (MSSP) of ACA
- Under MSSP, providers share in 50% to 60% of cost savings from services provided to designated Medicare beneficiaries who receive plurality of care through participating PCP
- PCP-PCMH viewed as foundation of an ACO, so what if you applied PCP-PCMH principles to oncology PCMH?
- $1.0 M annual savings per med onc x 50% Medicare patients = $500 K x 50% = $250 K per med onc per year (additive to current fee-for-service revenues). Any takers?

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How do you get paid? Pricing Strategies

Aligning reimbursement with each phase of medical home construction

Phase 1: Laying the Foundation

- Premise: practice to get paid something for transition of practice operations to new model – gearing up to deliver
- One-time fee. In one example = $5K per MD. Another example = $ pmpm as advance on shared savings
- I like: E&M enhancement at 130% of current fee schedule = approx $100K per MD during the transformation period
- And include pre-cert waivers (if on pathways, why pre cert?)

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How do you get paid? Pricing Strategies

Phase 2: Introduction of New Services

- Care management fee. For example flat rate per new cancer patient or monthly rate per active treatment month. Either way, target $850 per patient for PCMH care management fee
- CMS New "S" codes available April 2012 (commercial use)

  S0353 Cancer Treatment Plan Initial

  S0354 Cancer Treatment Plan Change

Phase 3: Optimization of Performance

Commencing Year 2 (after Phase 1 start up period), 30% to 40% shared savings to oncology PCMH practices with or without "true up" against start up or care management fees

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How do you get paid? Pricing Strategies

Summarize Oncology PCMH Pricing Model

The following elements are additive to fee-for-service base and represent financial impact assuming 100% of patients are involved (Medicare and commercial)

Phase	Methodology	$ Per Oncologist
Phase 1: Transition	130% E&M	$100,000
Phase 2: “Go Live”	Care Management Fee ($850 x 150)	$127,500
Phase 3: Optimize Performance	40% Shared Savings	$400,000

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How do you get paid? Pricing Strategies

Dilemma: how to measure the savings?

- Practice PCMH performance v. practice historic?
- Practice PCMH performance v. non-PCMH practice performance?
- Practice PCMH performance v. market performance?
- All cancers or limited to select sites (breast, lung, colon)?
- Accounting for new drugs and technologies?
- Who has the data and the capability to handle the complex data analytics? What about data cooperation among payers?

End-game: position for risk sharing: episode, bundled pricing

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To Summarize

- Fundamental economic proposition is a savings of $1.0 M per year per medical oncologist
- Derived principally from reduced hospital/ER incidents, adherence to chemotherapy guidelines/pathways and rational end-of-life care *(the doctor said what?!)*
- Fundamentally a care management proposition
- Getting from here to there involves a practice operational transformation that challenges the status quo. It can be scary
- If you don't do it, somebody else will – government, commercial payers, your competition

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To Summarize

- If you do it right, everyone wins – patients, physicians, payers (hospital may lose in short run – reduced census– but think ACO, please)
- Requires physician resolve, a willing payer (or two or three) and an organized process/tools to conduct transformation
- Align reimbursement with each of 3 phases of construction
- Oncology PCMH Recognition-Certification status is unsettled
- Maybe a total of 7 or 8 “A List” Pioneers in oncology PCMH
- Approach to getting paid: enhanced E&M to support transition, care management fees upon “go live” and share in savings thereafter. How/who is going to measure the savings?
- End game: learn true costs and position to assume risk (cap, episode of care, bundled pricing)

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Thank You for Your Interest

Questions?

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