Building the Business Case for Quality and Value in Cancer Care

Oncology Patient-Centered Medical Home®
Consultants in Medical Oncology & Hematology, P.C.
Oncology Management Services, LLC.
John D. Sprandio, M.D., FACP
What’s Wrong with the US Health Care Delivery System?

Continuum of US health care science

- Basic science – unravels mysteries
- Translational research – develop new treatments
- Policy analysts – measure outcomes, set standards

Fundamental question not adequately addressed:

How is care best delivered?

Dartmouth Center for Health Care Delivery Science, 2010

“The real rocket science now in health care is cost and quality.”

Dr. Jim Yong Kim
Former President of Dartmouth
Focus on Cost:

2012 health care costs $2.8 trillion

*Taken alone = the world's 5th largest economy*

We outspend the rest of industrialized world

90% on rescue, 10% on chronic care versus 50/50

Targeting waste due to failures in:

- Delivery
- Pricing
- Coordination
- Administrative burden
- Overutilization
- Fraud

Focus on Quality:

Legislation, Regulation, Enforcement, Policy Development, Market Demands
Era of Health Care Reform

Transitioning from Volume to Value

Value = quality/cost

Enhance quality by increasing reliability of delivery

• Focus on execution (processes) of care delivery
• Incorporation of High Reliability Principles

Control cost by reducing unnecessary utilization

• Unnecessary utilization = waste

Demonstration of results

Data transparency, accountability, rapid learning
Focus on Cancer Care

• Microcosm of the US health care system
  – High technology
  – Expensive new drugs
  – Fragmented care
• 1.6 million Americans diagnosed with cancer annually
• Direct costs exceeded $126B in 2010
• 0.69% of Commercially insured population
  – 11-12% of Commercial health care spend
• Medicare responsible for > 50% of patients
• Fastest growing cost area in medicine
Era of Cancer Care Reform

Provider Accountability

“Only those giving the care can improve it” *

Failure to control cancer cost (site of care, waste)
  • Will result in further funding cuts
  • Unintended clinical consequences for the most vulnerable
    • Reduced access, increased co-pays, reduced compliance

Failure to control shift in site of care (Community to Institutional)
  • Results in progressive diminution of the value of cancer care in the US
    • Cost of care often dramatically increased for commercial payers
    • Quality is often minimally changed

Waste reduction = Standardization of delivery

Physicians need help improving delivery, coordination & utilization
  • Chemotherapy guidelines & pathways - partially helpful
  • Improved care delivery beyond chemotherapy selection - Oncology PCMH
    • Requires practice transformation

*D. Berwick. M.D
Principles of re-designing cancer care delivery:

- Standardize/Streamline (variation in process of care)
- Simplify payment and administrative systems
- Minimize clinically irrelevant physician activity
  (Make complex decisions & maintain personal relationships)
- NCQA PPC-PCMH™ tenets (engage, educate, access, coordination)
- Accountability at physician-patient locus (care team)
- Ongoing data driven process improvement
NCQA PPC-PCMH™ Standards

Model - driving Quality, Service & Utilization

• Enhanced Access & Continuity
• Identify and Manage Populations
• Plan and Manage Care
• Self-care Support & Community Resources
• Track and Coordinate Care
• Measure and Improve
Oncology Patient-Centered Medical Home® Model

Series of practice & business methodologies enabling:

• Ownership of all aspects of cancer care delivery
• Focus on patient needs and evidence-based care
• Reduction in unnecessary variation & resource utilization
• Enhanced communication with primary care & specialists
• Real-time physician/practice performance measurement
  • Continuous process improvement
• Encourages Clinical Integration between practices
Impact on Total Cost of Cancer Care

Projected Reduction in Cancer Care Cost

1-3 %  Chemotherapy pathways program
4-6.3 %  Inpatient hospitalizations (5-25% reduction)
0.6-1.1%  ER evaluations (20-40%)
0.1-.4 %  Diagnostics
0.9-1.9%  End-of-life care coordination

Total  6.6 – 12.7 % reduction
Annual cancer “spend” $125B = $8-16B savings

Adapted from international consultants evaluation of OPCMH™ application to cancer care
Oncology PCMH Transformation Results

• Consultants in Medical Oncology and Hematology (CMOH), first oncology practice recognized by NCQA as Level III PPC-PCMH™ 2010
• Oncology PCMH focuses on the full spectrum of care – beyond chemotherapy guidelines - reducing the total cost of care
• Oncology PCMH model makes a business case for quality and value in cancer care by enabling full engagement of physicians
• One analysis demonstrated CMOH’s nine physicians incurred an estimated $9,468,787 less in hospital claims paid compared to national benchmark*
• Another estimate of a regional payer’s savings was consistent*
• Payment reform with some type of phased-in payment model would encourage oncology practices to adopt and continue to refine the model

*See Appendix for more information.
Incentives Driving Oncology PCMH®
Phases of Construction

Stepwise approach promoting practice transformation:

**PHASE I: Laying the foundation**
Workflow analysis, IT assessment, policy & procedure, job descriptions, prep for data collection requirements for NCQA PC-Specialty Practice Recognition program (PC-SPR), CMS, payer specific requirements, etc
- *FFS enhancement + prior authorization relief*

**PHASE II: Introduction of Patient Centered services**
Access, telephone triage, care coordination, communication, manage transitions, patient & physician portals
Patient & payer centric data collection for NCQA PC-SPR, CMS, etc
- *Phase I enhancements + case management fee*

**PHASE III: Optimization of performance**
NCQA PC-SP, CMS, or other external body recognition
- *Phase II enhancements + “dynamic” shared savings model*

Oncology Patient-Centered Medical Home®
Value Proposition

• OPCMH – clinical & business methodologies
  *Data driven* practice/patient care efficiencies
  Community and hospital-based practices

• OPCMH - organizational construct
  Oncology “plug-in” to PCMH as a PCMH-N
  Establishes care management accountability
  Communication that bridges specialists and PCMH

• OPCMH – as PCMH bridge
  Aligns oncologists for ACO, Clinical Integration, etc
  Platform for pricing bundles, episodes, etc
Appendix

- Oncology PCMH-USON/Milliman Detail-ER
- Oncology PCMH-USON/Milliman Detail-Hospitalizations
- Projected saving Oncology PCMH-USON/Milliman data
- Projected Regional Payer Savings
- CMOH Patient Goals of Therapy
- Oncology PCMH Performance Summary
Average emergency room (ER) Evaluations per chemotherapy patient per year (APCPPY) for the CMOH patient population, 2004-2011.

**USON/Milliman:** Approximately 2 emergency room visits per chemotherapy patient per year
(n=14 million commercially insured; 104,473 cancer patients)

*Source: Milliman analysis of Medstat 2007, Milliman Health Cost Guidelines 2009*
Approximately 1 hospital admission per chemotherapy patient per year

(n=14 million commercially insured; 104,473 cancer patients)

Estimated Savings Related to Reduction of Unnecessary Resource Utilization (Waste)
Assumptions – Cost Comparison of USON/Milliman vs Oncology PCMH

USON/Milliman Data Set
• Commercially insured (14 M lives)
• Age <65yrs
• 104,473 cancer patients
• Ave Remittance/Admission = $22,000 (DRGs only associated with chemotherapy side effects)
• Ave Remittance / ER visit = $800


Oncology PCMH Data Set
• All payers
• Ave age 68 yrs
• 792 chemotherapy patients
• Ave Remittance/Admission = $17,875 (aggregated remittance from all payers, most DRGs except AMI, CVA, Orthopedic events)
• Ave Remittance / ER visit* = $912 (same methodology as admission data)

Source: Dominant Health System, claims paid 2010

Applied CMOH’s 792 Chemotherapy Patients treated at practice sites within practice’s dominant health system to USON /Milliman’s Per Chemotherapy Patient Per Year formula for Admissions and ER visits. Variance (lower costs) by CMOH practice a function of lower utilization and $ / admissions and ER visits (Oncology PCMH model)
2010 Estimated Savings to all Payers – Comparing Oncology PCMH projected cost reduction to USON/Milliman Study
(see assumptions slide)

- $8,861,875 savings from fewer Hospital Admissions
- $606,912 savings from fewer ER Admissions
- Estimated savings equivalent to:
  - $11,955 per chemotherapy patient per year
  - $1.0 M per hematologist/oncologist per year

Example: 792 chemo patients comparing CMOH and USON/Milliman study utilization
(see prior slide)

CMOH utilization & remittance data applied to 792 patients
- 479 Hospital Admissions
- 724 ER Evaluations
- $17,875 aggregated cost of admissions
- $912 average cost of ER visit

Milliman utilization & remittance data applied to 792 patients
- 792 admissions
- 1584 ER visits
- $22,000 average cost of admission
- $800 average cost of ER visit
Not included in USON/Milliman based projected savings calculation:

- Physician fees – ER, radiology, specialists (related to ER and hospital admissions avoided)
- 22% reduction in CMOH overall OP visits (hematology & oncology)
- 12% reduction in CMOH chemotherapy patient OP visits PCPPY
- 17% reduction in IP visits for those patients who are admitted
- Reduction in chemotherapy administered, ER & admissions final 30 days
- Improved management of complicated hematology patients
- Improved management of cancer patients on hormonal therapy
- Improved management of cancer patients during survivorship
## Estimated Payer X Savings

(30% of patients)

### Annual Impact on Hospital Payments - change in utilization 2008-2010

**Per Chemotherapy Patient Per Year (*aggregated remittance data utilized)**

<table>
<thead>
<tr>
<th>Units</th>
<th>Hosp Payt</th>
<th>Chemo Pts</th>
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<tr>
<td>Hospital admissions</td>
<td>-0.475</td>
<td>$17,875.00</td>
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<tr>
<td>ER visits</td>
<td>-1.157</td>
<td>$912.00</td>
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**Not included in above:**

- Physician fees – ER, radiology, specialists (related to ER & hospital admissions avoided)
- 22% reduction in CMOH overall OP visits (hematology & oncology)
- 12% reduction in CMOH chemotherapy patient OP visits PCPPY
- 17% reduction in IP visits for those patients who were admitted
- Reduction in chemotherapy administered ER & Admissions within last 30 days of life
- Improved management of complicated hematology patients
- Improved management of cancer patients receiving hormonal therapy
- Improved management of cancer patients during survivorship

**Annual Estimated Total Savings to Payer X**  

(> $3,000,000)
End of Life Care

Data

• Hospice Average Length of Stay:
  2009: 26 days
  2010: 32 days
  2011: 35 days
  \[34\% \text{ increase}\]

• Place at time of death:
  70\% \text{ home 2010}
  74\% \text{ home 2011}

• ER visits & hospital admissions last 30 days of life:
  2010: 39.3\% \text{ total practice Admissions}
  2011: 36.4\% \text{ total practice Admissions}
  2010: 23.8\% \text{ total practice ER visits}
  2011: 20.1\% \text{ total practice ER visits}
## Oncology PCMH Model in Action

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
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<tr>
<td>Clinical Nurse Triage Management &amp; Enhanced Access</td>
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<tr>
<td>Number of symptom related calls</td>
<td>2102</td>
<td>2594</td>
<td>3261</td>
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<td>Patients Seen within 24 hours</td>
<td>197</td>
<td>261</td>
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<td>% Symptoms Managed at Home</td>
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<td>Utilization Measures</td>
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<td>NCCN Guideline Compliance</td>
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<td>Hospital Admissions (PCPPY)</td>
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<td>Hospice Length of Stay (days)</td>
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<td>ER Evaluations occurring in last 30 days of life</td>
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