

Partnering With a Payer to Develop a Value-Based Medical Home Pilot: A West Coast Practice's Experience

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The Wilshire Oncology Medical Group has worked in many payment systems during its 54-year history. Our experiences have led us to develop a medical oncology home pilot to offer a transparent, high-quality, high-value cancer program in partnership with our largest California health plan, Anthem Blue Cross WellPoint. Changes in how we were paid by independent physician associations were the catalyst of a 20-year process of re-engineering our care delivery while maintaining participation in clinical trials. We became pioneers in staffing models and the use of an oncology electronic medical record (EMR) system. The EMR prompted us to be diligent in the evaluation and monitoring of both practice and clinical data and allowed us to use data at the practice level to create ongoing programs for continuous quality improvement.^{1,2} By 2006, we had transitioned to a customizable oncology-specific EMR standardized to incorporate treatment protocols on the basis of evidence-based medicine. We began analyzing our data to benchmark the care we provided against national guidelines.³⁻⁵ Today as a member of the nation's largest network of community-based oncologists, we continue to document our adherence to Level 1 Pathways and the costs and quality of care we provide⁶⁻¹⁰ and to study complex quality issues in cancer.¹¹

We next planned how we could better serve the preferred provider organization health plans in our market. Our goal was to demonstrate that we could deliver a comprehensive plan of care and manage their patients with cancer while creating significant savings for the patients who were facing growing copay burdens^{12,13} and the health plans that could save in lowered direct and management costs for therapy and supportive care, lessening avoidable urgent, emergency hospital care and futile, toxic therapies at the end of life. The practice would benefit from these cost savings through value-based reimbursement and lessened management by the health plan.

Four years ago, we contacted the senior leadership of the largest preferred provider organization in our market. We wanted to explore how we might share our work with the health plan and develop what we initially called a 'pay differently for better outcomes' plan. Despite the fact that our comprehensive approach did not fit into their previous oncology management models, the medi-

cals of this payer believed our proposal had merit and initiated what became a series of ongoing meetings between our groups. This led to an agreement to validate our clinical and claims data, which brought the health plan analysts and actuaries into the discussions. These talented professional actuaries were able to build models to analyze regimens by patient and regional groups, supportive care drugs, and days of emergency department (ED) care differentiated by weekday versus weekend and evaluate global hospital claims data. They validated the patient data we could rapidly pull on a real-time basis from our EMR and billing reports; whereas this proved to be a complex, time-consuming undertaking for the health plan.

We worked with medical directors whose expertise and interests were not initially in oncology but who listened and learned. A major breakthrough came with the understanding of why we cannot get oncology and value reporting down to 4 or 5 simple data points. They came to understand that cancer is not simple; you need about 10 to 20 data points to fully assess whether the right patient got the right treatment for his disease subtype in the right setting at the right cost with a measurable outcome. This information then enabled refinements and understanding of what the health plan and the health system was providing to patients. This led to site visits of our practice by the medical directors, their actuaries, and administrators to see firsthand what it was we were talking about. They saw and talked to our patients, reviewed the issues of their diagnosis, staging, tumor subtypes, comorbidities, and psychosocial needs. They saw our specialized oncology nurses in action and talked to them about their work. They talked to members of our administrative, front desk, intake, billing, disability, medical assistant, licensed vocational nurse, and midlevel provider staff. This engagement made a huge difference during our subsequent meetings. Because most health plan medical directors are not oncologists, most of what we do is not granular to them. Our team process built strong working relationships with the health plan medical directors, actuaries, and payer teams. We have recently welcomed 2 additional medical directors to the team. They bring experienced medical leadership and expertise in oncology, as well as health outcomes, to the team.

During our 4 years of collaboration, we have developed a medical on-

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colony pilot that has required great trust on all sides and the sharing of detailed presentations on the basis of verifiable data. At the practice, we came to understand and respect the many challenges health plans have, especially those related to state requirements like those in California and their need to address their responsibilities to another level of oversight—their parent organization.

The next step was to agree on a conceptual framework for payments. First, we agreed the health plan *wants* doctors to coordinate and deliver quality cancer care to their members. This required us to break out the work, people, documentation, reporting, and analytics for our pilot. Second, we agreed the health plan *wants* to pay for their members to get high-value care—high-quality care at the best overall price with high patient satisfaction. Third, we agreed that the evaluation and management (E&M) code payment system does not cover the additional complex work involved in creating comprehensive care plans or for comprehensive care management. Comprehensive care plans involve medical, surgical, radiation oncology, often other specialists, sometimes inpatient, sometimes outpatient care, clinical trials when appropriate, supportive care, psychosocial care, rehabilitation, recovery, survival, and at times, end-of-life care. Paying for a clearly coordinated comprehensive plan ensures the most efficient care for patients who then have a clear plan to navigate and a team to look to as they move through their care. Then, once on the often highly toxic and costly cancer care plan, personalized education and expectant management can minimize suffering and speed interval care in the outpatient setting to minimize avoidable ED and hospital care. End-of-life care was another area in which better data were needed to determine why people get third-line therapy or beyond for some cancers although many studies show patients would choose hospice and palliative care if they were better informed about the futility of many end-stage therapies. We were able to show the time and motion work for the care management that goes on for each cycle of care beyond the standard E&M visit and beyond the underfunded infusion codes and drug margins no longer covered by average sales price (ASP) plus 6% to 10%.

Our teams met almost monthly during 2009 and 2010 until our work was validated and the health plan agreed to proceed with what we now call the Medical Oncology Home Pilot. Legal and technical considerations delayed the launch until August 2011. An initial federal waiver was needed for some patients to participate in a pilot, and a payment system had to be worked out within the current information technologies capabilities and coding systems for the health plan. Health plans in California are required to provide the same quality of care to all members. Therefore, pilots that are likely to provide a much higher level of care for some patients versus

others can have specific funding challenges (especially those funded through federal dollars).

Since our agreement to move forward in 2010, our group affiliated with the US Oncology Network (The Woodlands, Texas), which is supported by McKesson Specialty Health (The Woodlands, Texas). This has been key to expanding the progress of our pilot. Just as our pilot was launched, the health plan, like many nationwide, was seeing community doctors migrate to large hospital systems, which have higher costs to health plans and patients but provide financial stability to providers. The greater understanding of the care and costs community oncologists have traditionally coordinated and managed has made health plans realize that their ratcheting down of payments for E&M codes, inadequate infusion payments, and ASP plus 6% or even ASP plus 10% reimbursements have not adequately covered the cancer services that patients need. It has also incentivized more high-cost ED and hospital care and duplication among the many caregivers when care is not coordinated. Our national network affiliation has given the practice access to experts in health plan relations, a larger medical home team, and a sophisticated actuarial team to expand our analytic capabilities for benchmarking our pilot regionally and nationally. We are also collecting data on practice administrative and delivery costs and the potential cost savings to patients and the health plan to enable future refinements of medical oncology home payments. Our aggregate team now has weekly calls and quarterly or more meetings with the health plan team to review and benchmark the results. Our first 3 months of data exceeded our goals. Our 6-month reports in February will meet or exceed our expectations, with full benchmarking data expected shortly thereafter.

Although the path has been long, we are hopeful that our pioneering efforts can launch others into making value-based cancer care a reality. It has been essential to have a clear vision that, as oncology specialists, we know the field—what and how we can best coordinate, provide, document, and report as high-quality care for our patients with cancer at the lowest costs that also supports high patient satisfaction. It has taken a leap of faith on the part of both our practice and the health plan to be totally transparent on the processes, working to understand and fund the full costs of delivering care. We expect to have a validated, transparent, and accountable medical oncology home model that is scalable and available to others in our state and across our country. We hope the sharing of these pioneering efforts will encourage others to reach out to their payers to further expand these efforts.

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