Oncology Patient–Centered Medical Home

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In the current dynamism of health system restructuring in the aftermath of healthcare reform, community-based oncology practices and institutionally based cancer programs have a significant opportunity to lead positive change that will position them better in the new world order. This article presents the oncology patient–centered medical home as a physician-driven, patient-focused value proposition that can really make a difference for patients, oncologists, and the cost of healthcare.

Before 2008, approximately 85% of all cancer care in the United States was delivered in a community setting by independent practitioners. The remaining patients received care from institutionally based cancer programs. An admittedly flawed chemotherapy reimbursement model provided medical oncology practices a steady revenue stream that allowed practices to assume an increasing degree of responsibility and expense for supporting, educating, and navigating patients through an increasingly complex cancer care delivery system. Private and institutionally based practices flourished, and in many cases, patient care was enhanced.

Times have changed. The Medicare Modernization Act passed in 2003 put into motion fundamental changes in the methodology of chemotherapy drug reimbursement. These changes fully impacted oncology practices in 2008, with independent community-based practices being the most economically vulnerable.[1] It is now widely recognized by providers and payers that the current net reimbursement to independent practices for evaluation and management services, plus the remnants of the buy-and-bill method of paying for chemotherapeutic agents, has not kept pace with the complexity of tasks required of medical oncologists if they are to maintain existing levels of service. More importantly, the current reimbursement model virtually eliminates the ability of community-based oncology practices to answer the urgent call of healthcare reform to deliver improved quality and value while focusing on patient needs and the delivery of consistent care. Many institutional programs, on the other hand, still have the resources to focus on care coordination, patient safety, evidence-based guidelines, and preparing for more integrated payment models, including participation in accountable care organizations (ACOs).

In March 2011, the Community Oncology Alliance (COA) reported a significant shift in the site of care delivery from the community to institutionally based cancer programs with a further trend in the closure of private practice sites and the pervasive financial instability of those still operating.[1] Best guesstimates today from COA suggest that 65% of cancer care is delivered by independent community-based physicians and 35% by their institutionally based counterparts (T. Okon, personal communication, January 2012). In retrospect, before 2008, one could argue that neither site of care was optimally delivering consistent, standardized, coordinated cancer care to the most vulnerable segment of our healthcare system's patient population. Many stakeholders would argue that cancer care has become more fragmented and less coordinated in both settings since 2008.

THE RESPONSE

Community-based physicians have not led the response to the current economic challenges confronting their practices. Third-party vendors promoting chemotherapy pathway programs and institutionally based cancer programs are seizing that opportunity.

Pathway Programs

The chemotherapy pathway programs have had some positive effects in partially addressing quality of care and cost issues.[2] However, this approach can only provide a limited advancement of the value proposition from a patient service, disease management, and long-term payer perspective as a result of the inherent need to design the pathway intervention to be minimally disruptive to a practice's operations to promote physician acceptance and implementation. The payers and the pathway vendors have largely enjoyed the positive economic effect; the impact for the practices, which have already been economically deflated by the effects of the Medicare Modernization Act, is often neutral. Pathway programs offer the opportunity to lock in to current reimbursement levels, but this, unfortunately, does not support current or future practice infrastructure needs. This strategy is still effectively centered around a modified buy-and-bill drug reimbursement model, devoid of a patient-centered value proposition. It has become

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clear that the impact of a pathways program on the total cost of cancer care delivery is finite—in the 1% to 3% range, according to a 2011 analysis by McKinsey & Company.[3] This, alone, is not the answer to the escalating total cost of cancer care.

Hospital- and Academic-Based Programs. By leveraging existing favorable contracts with payers and extending the 340B chemotherapy pricing program to extended—and unintended—patient populations, institutional programs are consolidating their markets by virtue of their ability to offer economic shelter to independent practices. According to COA, the number of community-based physicians entering into employment or management arrangements with institutionally based programs accelerated in 2011.[1] This shift in the site of care delivery has been accompanied by substantial—sometimes spectacular—increases in the cost of care, often without demonstrable enhancement of quality and with a resulting diminution of value. This is not the answer to the escalating total cost of cancer care.

Independent Community-Based Practices. Independent practices are considering several strategic options in the search for economic predictability or a sustainable business model: contractual alignment (employment, management arrangement) with community or academic institutions, integrated delivery systems, or accountable care organizations; participation in vendor-driven programs to stabilize revenue; association with a larger regional/national network of medical oncologists for negotiating purposes; regional consolidation under a single tax ID for the purpose of negotiations with payers; alignment with a multispecialty, physician-centric ACO; participation as an individual practice in a regional ACO; and engagement in physician-directed care transformation to deliver a new value proposition to payers and begin to define and demonstrate value in cancer care.

The last option offers potentially the most important opportunity for real clinical and financial change. But it provides a dual challenge. First, it requires nothing short of a substantial, disruptive, and coordinated response by the practice to re-engineer the delivery of care. Second, it requires the creation of a sustainable business model for independent community-based practices by actively engaging with payers in the development of new payment methodologies that will support these different processes of care capable of producing remarkable results.

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A physician-led response built around the National Committee for Quality Assurance's (NCQA's) standards for the primary care patient-centered medical home (PCMH) program has been created to address these challenges. The NCQA standards provide a template that calls for a physician-led care team to direct disease management, care coordination, the standardization to the evidence base, and patient engagement and education.[4] Results from primary care PCMH projects suggest elements of the model have a positive effect on quality, cost, and satisfaction of the patient and the clinical team.[5,6]

In 2010, Consultants in Medical Oncology and Hematology (CMOH)—a 9-physician, single-specialty practice outside of Philadelphia—became the first oncology practice recognized by the NCQA as a level III PCMH.[7] The growing national attention focused on this model has, in large part, stemmed from CMOH's success in effectively minimizing unnecessary resource use. CMOH has lowered emergency department visits by 68%, hospital admissions per patient treated with chemotherapy per year by 51%, and the length of stay for admitted patients by 21%. CMO has also seen a 22% reduction in outpatient visits per patient per year in the general (hematology and oncology) patient population and a 12% reduction in outpatient visits per patient per year in the chemotherapy subpopulation. CMOH has demonstrated that the processes of improving the delivery of cancer care and reducing unnecessary use (waste) are intertwined; they are one and the same.

The aggregated economic savings to CMOH's payers is estimated to be in the range of $1 million per physician per year. The magnitude of the savings is a reflection of the cost of caring for a concentrated population of clinically vulnerable, older, chronically ill patients with multiple comorbid conditions and unique psychosocial needs. Although CMOH is in the process of replicating this model in other practices, the data presented, thus far, are from the single practice. This begs the question of the validity and reproducibility of this model.

VALIDITY

CMOH's internal data have recently been directly compared with the internal cost and use data of a national payer. The results of that comparison were consistent with CMOH's own data. The necessary validation of this model can only occur with the cooperation of payers and significant expansion of the model to other practices.

REPRODUCIBILITY

The Congressional Budget Office's *Lessons from Medicare's Demonstration Projects* identified several successful components of the demonstration projects, including the ability to "gather timely data on the use of care, especially hospital admissions; the focus on transitions in care settings, especially primary care to specialist referral; using a team-based care approach; targeting interventions toward high-risk enrollees; limit the cost of [and insertion of third parties into the] intervention."[8(p8)] None of the

disease management and care coordination demonstration pilots outlined in the report reduced Medicare spending. In part, this resulted from the use of costly third-party vendors. These vendors were required because the physicians involved were not called upon to transform the delivery of care within their own practice and needed outside intervention, thus negating savings from decreased use.

Bohmer[9] suggests that, instead of only focusing on the problems of definition and measurement of value in healthcare, it is equally important to understand how "health care delivery organizations reliably deliver higher value."[9(p2045)] He proposes that the ability to disseminate and consistently deliver high-value clinical innovation and system improvement is based on similar, portal habits of care management: extensive specification and planning, micro system design, measurement and oversight, and commitment to ongoing process improvement.

Many organizations engage in some or most of these habits, which explains the common response from oncologists after the presentation of CMOH's results: "I think we do that." Bohmer points out that high-value organizations "systematically . . . integrate [all 4 habits] into a comprehensive system for clinical management that is focused more on clinical processes and outcomes."[9(p2045)] The oncology PCMH (OPCMH) model with re-engineered processes of care on the basis of the NCQA template, the merger of operational and clinical decisions, and the developed infrastructure support facilitate the baking of these 4 habits into the practices' "structures, culture, and routines, [with the understanding that these are] not simply short lived projects."[9(p2045)] CMOH has replicated this model of care in another similar-size practice; its performance is currently under evaluation.

SUMMARY

"The good news is: the possibility of change has never been greater. The bad news: if it's going to be the right change, the burden is yours," stated Berwick in this year's closing remarks of the Institute for Healthcare Improvement National Forum. "If improvement [of care delivery] is the plan, then *we* own the plan. Government can't do it. Payers can't do it. Regulators can't do it. Only the people who give the care can improve the care . . . . It is not possible to claim that we do not know what to do. We have the templates."[10(p8)] Using the NCQA template, the CMOH integrated team of caregivers developed exactly what Berwick has called for: "an electronic line-of-sight contact with each other all day long, weaving a net of help and partnership with patients and families."[10(p8)] The template exists.

Oncologists know what to do. We need to move quickly to define, measure, and maximize the value of the OPCMH model to become responsible, accountable, and able to achieve the goals of better cancer care, better health, and lower cost through improved delivery of care.

Payers need to respond quickly to develop a contractual platform around this model so that it can be expanded and verified. It potentially provides a sustainable business model for the community oncologist because it transforms the delivery of cancer care within the practice without the need for insertion of a costly third-party vendor. It can also provide a framework for the improvement of cancer care delivery by all oncology care providers. Under the current fee-for-service system, the OPCMH model is economically unsustainable. Without payer support, there will be further loss of community-based practices; costs will escalate, and the value of the delivered care will decline, thus forcing arbitrary reductions in funding without full consideration of the clinical implications. The patient-centered healthcare reform initiative in cancer care will be lost.

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