Keeping Pace With Oral Chemotherapy

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Purpose: Although the rising number of oral chemotherapy agents offers many patients with cancer a more convenient and less invasive treatment option compared with infusion therapy, multiple risks and challenges have been identified with the oral regimen, including dosing errors, drug interactions, and nonadherence or overadherence. Until recently, cancer care providers had maintained a considerable amount of control, including the certainty that the right drug was being administered in the right dose, via the right route, at the right time, and to the right patient—all of which were meticulously documented in patient records. In contrast, oral chemotherapy takes much of the control out of the clinician's hands and places tremendous responsibility on the patient, raising a number of adherence and control issues. Studies regarding oral hormonal therapy for breast cancer have described adherence rates ramping down from 83% to 77% within the first 2 years of therapy. These figures continue to decrease over time to a range of 50% to 64% within 4 to 5 years. On the basis of these data and a literature review, we developed a program to promote adherence to oral anticancer protocols.

Methods: Our team took a proactive, team-focused approach and established protocols at a time when oral chemotherapies were still at a low volume. In addition to infrastructures, policies, and procedures promoting collaborative communications among physicians, nurses, and pharmacists, we developed an in-depth educational component that provides the linchpin for ensuring an effective oral chemotherapy program. Our program focuses on three key pillars: education, communication, and follow-up. Our project team first conducted an inclusive review of available literature, with the objective of designing processes that would help our program directly address existing risks and challenges. Then we introduced concepts for the formalized program to our cancer center physicians, whose support was paramount to successful implementation. The next step was to start the program with a mandatory in-service for all clinical staff, which included a presentation of the research evidence that prompted the creation of this model for oral chemotherapy. To enhance patient understanding, our team provides printed materials, individualized calendars, and in some cases preloaded pillboxes to assist patients. Concurrently, our nurses provide weekly telephone intervention for the second and third months and monthly phone interventions thereafter. Communication is key to the success of the program. This includes the use of a translation service to ensure effective communication with all non–English-speaking patients. We intervene early for those patients with financial barriers and offer a variety of referrals and resources for emotional, nutritional, and patient support services, including transportation issues.

Results: Since the inception of the program, the in-service has been incorporated into our new employee orientation. At the same time, a growing number of cancer center physicians are embracing the program. The program has received the attention of the Oncology Roundtable, which developed a Webinar around the topic, and been described in a feature article in an oncology journal. Finally, our team has been tapped to educate other pharmacists regarding oral agents, toxicity profiles, and safe handling.

Conclusion: By combining safeguards, patient education strategies, intensive follow-up, and a system of effective checks and balances, our center is taking significant steps to maximize patient safety and oral chemotherapy treatment effectiveness, while keeping pace with the rapidly occurring changes in oncology practice.

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Where Does Oncology Fit in the Scheme of Accountable Care?

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Abstract

With cancer services representing 10% of health care costs, oncology would seem an attractive candidate for achieving cost savings, which could then be shared under the umbrella of an accountable care organization (ACO), the vehicle through which the Centers for Medicare & Medicaid Services has implemented the Medicare Shared Savings Program. The Cancer Center Business Summit focused its 2011 annual survey on the topic of oncology's fit within the context of accountable care planning and discovered that oncology, for a variety of reasons, is not considered an attractive candidate for readily achievable cost savings in an ACO initiative. However, despite the somewhat marginal status of oncology within accountable care initiatives, the commercial health insurance sector has been quite active in pursuing nontraditional and innovative methodologies in payment redesign for oncology services. This article explores the key findings and implications of the 2011 Summit survey, *Positioning and Payment for Oncology Within Accountable Care Initiatives*.

Introduction

Much fervor in the health care industry has been generated as a result of the March 2010 passage of the watershed Patient Protection and Affordable Care Act[1] and the Health Care and Education Reconciliation Act of 2010,[2] known together as the Accountable Care Act (ACA). Industry response was further heightened by the subsequent promulgation by the Centers for Medicare & Medicaid Services (CMS) of regulations that established the accountable care organization (ACO) as the vehicle through which CMS has implemented the Medicare Shared Savings Program established by Section 3022 of the ACA.[3]

ACA envisions a sea change in the way that health care services, including oncology services, will be delivered and paid for in the future. ACA contemplates transforming Medicare and Medicaid payments from a fee-for-service system to a value-based purchasing system. The concept is to move from payment methods that financially reward the provision of a volume of services to new payment methodologies that reward the delivery of high-quality health care services and the lowering of costs.

Against this backdrop, the Cancer Center Business Summit (Summit) focused its annual industry survey on the positioning and payment redesign for oncology services within the context

of accountable care initiatives being undertaken by providers, whether such initiatives were in direct response to federal health reform (eg, ACOs) or otherwise. The Summit is an educational forum focused on matters of oncology/cancer care delivery; oncologist-hospital alignment; and integration and the business, legal, and financial models associated with such initiatives.[4] Recognizing that the quality improvement and cost reduction tenets of accountable care were not unique to the federal government's vision, the Summit survey also took into consideration accountable care initiatives already underway or under development in the private health insurance sector, which according to one study, involve some 58% of all private payers.[5]

Survey Findings

The 2011 Summit survey, entitled *Positioning and Payment for Oncology Within Accountable Care Initiatives,* was conducted during the 4-month period of June through September 2011. Individuals at 36 organizations were surveyed through direct phone interview using a standardized survey instrument.

Candidate organizations for interview were identified from a number of sources, including: (1) roster of CMS Physician Group Practice Demonstration sites, (2) rosters of member organizations of the Dartmouth-Brookings ACO Learning Network and Dartmouth-Brookings ACO pilot sites, (3) media news releases in which organizations self-identified as launching ACOs, and (4) professional network referral and media releases identifying provider and payer organizations participating in oncology-specific payment redesign demonstration projects. A breakdown of the categories of organization interviewed is shown in Table 1.

Survey interviewees were asked to respond to the following:

(1) Market and Competitor Profile

Is the character of the local market fragmented, somewhat fragmented/partially consolidated, or highly consolidated? And is the character of the local market minimally competitive/collaborative, somewhat competitive, or highly competitive?

Because of the wide range of organizational types interviewed, there was understandably a full range of responses to this question. However, a common characteristic recognized among proactive ACO responder organizations was that they were in somewhat to highly consolidated and competitive markets and were themselves somewhat to highly consolidated organizations.

(2) ACO Readiness

With respect to viewpoint on ACOs, is the organization characterized as proactive, exploratory, nonresponsive/wait and see, or not interested/ignoring? (Table 2).

Following are some noteworthy survey interviewee comments with regard to ACO readiness:

- "The proposed rules are so onerous that I am not aware of anyone in our market running to join" (oncology practice executive, southwest).

Table 1. Five Categories of Organization Interviewed

Category	No. of Interviews Conducted	%
Health care delivery system/IDS	16	44
Academic medical center	4	11
Medical group practice	11	31
Physician network/IPA	2	6
Health plan	3	8
Total	36	100

Abbreviations: IDS, integrated delivery system; IPA, independent practice association.

Table 2. Viewpoints Regarding ACO Readiness

Viewpoint	No. of Responses	%
Proactive	10	30
Exploratory	13	40
Wait and see	8	24
Ignore/not interested	2	6
Total (health plans excluded)	33	100

Abbreviation: ACO, accountable care organization.

- "Most of our attention right now is on all the Medicare ACO data reporting requirements. How do we gather and report the data . . . our data is much better with diabetes or heart patients . . . we don't have that maturity with cancer data" (oncology executive, academic medical center, mountain states).
- "I don't think there has been a really consistent definition of cancer care . . . without that definition it's hard to dig financially into any organization's operations to determine true costs" (health plan executive).
- "Many organizations will find out they have to spend a lot of political capital with their physicians to get ready for ACO" (oncology executive, academic medical center, mountain states).
- "We are spending a lot of time and effort determining which physicians are fully aligned with us and which are not . . . because we want to know for our future ACO planning . . . we want to know who we should form relationships with" (health system cancer center executive, midwest).

(3) Oncology Positioning Within ACO Responder Organizations

How are oncologists aligned with the ACO responder organization: closely aligned/employed, loosely aligned, or nonaligned/competitive? Not surprisingly, given the profile of organizations in a position to take the initiative in responding to ACO regulation, the majority (65%) indicated that oncologists were closely aligned with and/or employed directly by the organization (Table 3).

(4) Nontraditional Payment Methodologies Within ACO Responder Organizations

Nontraditional payment methodologies were defined for survey purposes as anything other than fee-for-service payment for

Table 3. Oncology Positioning Within ACO Rresponder Organizations

Alignment	No. of Responses	%
Closely aligned/employed	13	65
Loosely aligned/mixed affiliations	6	30
Not aligned/competitive	1	5
Total (health care system/IDS-AMC)	20	100

NOTE. Responses limited to health system/IDS and AMC organizations.
Abbreviations: ACO, accountable care organization; AMC, academic medical center; IDS, integrated delivery system.

oncology services, for example, capitation/subcapitation, episode of care, bundled payment, shared savings, or other methodologies that are not solely based on payment for discrete services provided (fee-for-service).

There were a limited amount of system-wide capitation methodologies reported (two health systems), but with oncologists paid at a negotiated fee schedule rate rather than a subcapitation amount. In addition, one system indicated that it was reimbursed a bundled rate from one payer for bone marrow transplantation procedures. Another system reported that it was in the process of implementing a bundled payment methodology for coronary artery bypass graft procedures, and that once in place, the system intended to pursue bundled pricing for oncology services for certain common cancers (breast, lung, colorectal, prostate, ovarian). Our assessment of this series of inquiries is that with regard to oncology/cancer care services within those organizations that are seen as most responsive and assertive with regard to an ACO undertaking, there is currently essentially no variation from traditional fee-for-service reimbursement methodologies in oncology.

(5) Prioritizing Oncology Within ACO Responder Organizations

Interviewees were asked to respond to the following observation. Did they agree or disagree with the observation, and why?

"The costs of cancer care are often singled out as escalating far more rapidly than health care costs in general (15% per year or three times the escalation in overall health care spending). Cancer patients represent only 1% of commercial patient, yet consume 10% of the commercial health insurance 'spend.' Yet oncology/cancer as a health condition/disease seems to be of lesser priority in context of ACO planning. High volume/low cost chronic diseases, such diabetes, asthma, heart disease, chronic obstructive pulmonary disease (COPD) are cited as better candidates for cost savings and for 'lower hanging' ACO shared-savings opportunities."

Below are several noteworthy interviewee responses to this inquiry:

- "ACO concepts have developed around primary care physicians, and there has been much less thought given to subspecialty care . . . a problem with our current health care system is fragmentation in subspecialty care. I think that oncology care lends itself to medical home models" (health system medical director, southeast).
- "Oncology is too big and complicated to try and tackle . . . they are cutting their teeth on the more straightforward ones . . . hip, knee, heart surgery [are] much more predictable . . . cancer is too broad to get disease focus" (health system oncology service line executive, mid-Atlantic).
- "I think that there has been a lot of focus on chronic disease because it has been more predictable from a cost perspective. The point is to address costs across the whole continuum . . . and that is where global payments may be the tool to make this happen" (multispecialty medical group practice chief executive, northeast).
- "So much of the cost occurs in the 6-months end-of-life period . . . my point is we really spend too much money on futile care because we are afraid to have the conversations about end-of-life care with all its social and political implications . . . somewhere, somebody has to be courageous enough to say this out loud" (academic medical center medical director, physician network, northeast; health system oncology service line executive, mid-Atlantic).

(6) Oncology-Specific Nontraditional Payment Redesign

Despite the status of oncology/cancer care within the broader context of ACO initiatives, the commercial health insurance sector is quite actively pursuing nontraditional and innovative methodologies in payment redesign for oncology services, typically at the community oncology level. United Healthcare and Aetna have been involved in earnest with oncology-specific payment redesign pilot programs for the last couple of years: United Healthcare with its five-site episode payment pilot, and Aetna with its shared savings–oriented pilot with Texas Oncology. Much of the payer activity in bending the oncology cost curve has surfaced within the past year, with initiatives in oncology payment redesign underway with a solid representation from Blue Cross plans, including oncology-specific pilot/demonstration projects in Maryland, New Jersey, Tennessee, Michigan, South Carolina, and southern California.

Oncology-specific payment redesign methodologies tend to focus on drug cost reduction achieved through compliance with clinical pathways. The predominant model has been to compensate oncologists at a premium for compliance with agreed-on clinical pathways. Typically, 80% compliance results in enhanced drug reimbursement, and noncompliance can result in a reduction in reimbursement.

Trends to Watch for in 2012

In addition to election-year intrigue around the future of ACA as we know it today, several trends to watch for in 2012 regarding accountable care undertakings (federally envisioned or otherwise) and related experimentation in oncology payment redesign are offered. These prognostications are derived from the Summit 2011 survey experience and from anecdotal observations subsequent to the conclusion of the survey period.

- Trend 1. Expect to see an acceleration in commercial health plan/payer experimentation beyond clinical pathways, with programs that incorporate care processes to manage emergency room use, hospitalization, and advance care planning—features of the so-called oncology medical home model.
- Trend 2. Expect to see increased interest in oncology practices organizing to position themselves as specialist collab-

orators with primary care medical homes—the building block of ACOs.

- Trend 3. Expect to see renewed interest in compatible oncology practices organizing to scale as clinically integrated oncology networks, with common treatment pathways and health information exchange capabilities bringing data connectivity and advanced informatics and reporting capabilities to such networks.
- Trend 4. Expect to see increased interest and even experimentation in bundled pricing arrangements for oncology care as the final outcome of the payment redesign dialogue. As an example, the CMI Healthcare Innovation Challenge program[6] could become a proving ground for oncology bundled pricing methodologies.

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Oncology Professional Services Agreements: A Model for Hospital Affiliation That Preserves Private Practice

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Integration Trends

By way of background, there is currently a distinct trend in the health care industry toward increased integration and consolidation among providers. From the hospital perspective, the preferred model for integrating with oncologists is to directly employ them (at least in those states that permit hospitals or their affiliates to employ physicians). According to a recent study, 50% of hospitals are currently employing oncologists, and an additional 25% plan to begin employing oncologists in the near future.[1]

Hospitals have good business and legal reasons for preferring an employment model. From a business perspective, employment permits the hospital to better control its destiny in the marketplace. Under an employment arrangement, the hospital can negotiate with payers for both hospital and oncologist payment rates, can bargain for bundled or capitated payments, and can determine how those payments will be internally allocated between the hospital and oncologists (and/or other providers).

Under an employment arrangement, the hospital can also largely dictate the terms of employment, including physician duties; clinical, quality, and efficiency standards; service levels; and compensation methodology. In addition, the hospital can change compensation arrangements over time (as employment contracts expire or are terminated) to adjust to evolving third-party payment methods and economic conditions.

Moreover, as a result of current economic and regulatory pressures on oncologists, senior oncologists today are increasingly willing to consider becoming employed by a hospital. This is because payments for oncology services are not keeping up with the pace of inflation in practice costs; drug profit margins have eroded by approximately two thirds since Medicare implemented the average sale price (ASP) methodology in 2005,[2] and Medicare payments for oncology (and related ancillary services) were cut significantly in both the 2010 and 2011 Medicare physician fee schedules.[3] In addition, physicians graduating from oncology training programs are increasingly