Report on the ASCO 2010 Provider-Payer Initiative Meeting

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Introduction

It may be too obvious to state, but in order to take care of patients, providers need skill, structure, and support. Although ASCO is primarily viewed as disseminating and promoting development of the scientific backbone of care through educational symposia, guideline development, quality monitoring, journal publication, investigator funding, and its annual and disease-specific meetings, the organization also provides significant resources regarding day-to-day practice issues. This is reflected in the support of policy advocacy; the Practice Management Curriculum; State/Regional Oncology Societies infrastructure; and government relations, including those with Congress and the Centers for Medicare and Medicaid Services. However, it is notable that there has been little formal interaction with private payers. This was recognized by the ASCO Board of Directors, and a formal planning group was formed to develop a meeting of private payers; leaders in innovative care delivery and payment models; and providers, including representatives of ASCO volunteer physicians and staff. The planning committee was composed of representatives of these three groups.

It was apparent that this endeavor required participants' sensitivity to potential antitrust issues, which can be significant whenever groups of payers and providers gather. In order to address this issue proactively and to ensure the group's compliance with antitrust laws from the onset of planning, ASCO retained expert antitrust counsel, Andrew I. Gavil, JD, of the Howard University School of Law, who brought good humor and appropriate constraint to all discussions, from planning through the postmeeting debrief. All attendees were asked to affirm their commitment to compliance with relevant antitrust laws, and a list of "dos and don'ts" was established (Appendix Fig A1, online only). Any topics or discussions that might be construed as an effort to control or capture the price or cost of oncology services were assiduously avoided. We identified specifically protected areas of interest for discussion. Some, such as methods of administrative simplification, are identified as such within the Patient Protection and Affordable Care Act (ACA). Others, such as promotion of research (including comparative effectiveness research), pathway development and adherence, and collaboration between payers and providers for improved quality of care, represent specific efforts to promote better care (as opposed to simple reimbursement issues) and were therefore appropriate for inclusion. Finally, we agreed that a global awareness of the extent and sources of practice variation and presumed associated inefficiency could help focus our discussions.

In sum, the goal of ASCO's Provider-Payer Initiative was to establish a forum for open dialogue between medical oncologists and the payer community to promote enhanced shared understanding of the various challenges each stakeholder currently experiences; identify opportunities to improve the quality, safety, and affordability of care; and promote collaborative working relationships among these two parties, with the goal of promoting dissemination of best practices and innovation.

Participants

The participants at the September 27, 2010, meeting included individuals from the payer community; leaders in innovative care models and systems analysis; and ASCO staff, leadership and membership. Those representing the payer community included staff from America's Health Insurance Plans, Aetna, BlueCross BlueShield Association (an association of 39 independent, locally operated Blue Cross and Blue Shield Companies), Anthem Blue Cross, CareFirst BlueCross BlueShield, Blue Cross Blue Shield of Massachusetts, Blue Cross Blue Shield of Michigan, HealthPartners, Horizon Blue Cross Blue Shield of New Jersey, Highmark, Anthem Health Plans of Virginia, Premiera Blue Cross, and UnitedHealthcare. Leading innovators presenting information and participating in discussions included representatives of the Massachusetts General Physicians Organization, Dartmouth Institute for Health Policy, Geisinger Health Systems, and the American College of Surgeons' Commission on Cancer. We were privileged that ASCO leadership, including current and past presidents George Sledge, MD, and Douglas Blayney, MD, were able to participate. Other staff, leadership, and committee representatives from ASCO were present as well.

Presentations and Context

The agenda focused on areas where there seems to be a relatively easy opportunity for improvement in the quality, efficiency, or total cost of care. The achievement of specific standardization of claims submission serves as an example, and an important Health Affairs article¹ prompted a presentation by one of the authors, Mr. James Heffernan. He shared data demonstrating that administrative costs have grown from 22% to 31% of health care expenditures, mirroring similar increases in the number of health care administrative personnel over the past several decades. And despite this disproportionately large resource expenditure, the benchmarks of both errors and expense of claims and collections in health care compare poorly with those of other industries. For example, in the health care industry, remittance errors occur at a frequency of 10% and expense

is 6% of collections, compared with a manufacturing industry standard payment error rate of 3% and payment expense of 0.034%.

Though not ideal, Massachusetts General Physicians Organization's professional billing office has ranked among the lowest in cost nationally over the past 5 years. This has been accomplished with relatively rapid payment turnover and a short average time for claims in accounts receivable status. Using Medicare processes and forms as a standard of both clear billing requirements and rapid efficient payments, it becomes apparent how other systems might improve the overall revenue cycle for practices, thus saving considerable time and money. Not only would standardization of claims allow universal electronic submission and decrease staff training required for each individual payer, but the decrease in errors would decrease the time wasted on correction. Using an average practice model, it was demonstrated that each doctor could realize 4 hours of time savings weekly and save 24% of office billing costs. This translates to \$7 billion if applied to all doctors in the United States.

The pathway to adoption of these types of standards may be more easily accomplished locally, as opposed to nationally, because of the impact of state law. However, national payment clearinghouses already are affecting the system, as they provide customized payer claims output after receipt of generic practice claims data. However, although the clearinghouses may improve the overall cost of claims submission, the necessity for individualized payer claims formatting does not add global efficiency. A pathway to effecting these changes was proposed, starting with Medicare and Medicaid, moving to Medicare Advantage plans, ERISA (self-insured) plans, and then finally to other insurers.

Administrative simplification in precertification could also be beneficial to both practices and payers. Lee Newcomer, MD, Senior Vice President for Oncology, United Healthcare, presented a payer's perspective on this issue and underscored the meeting theme that variance in care often translates to unnecessary care. Noting both the widely popularized research of the Dartmouth Institute of Health Policy and proprietary information from UnitedHealthcare, he demonstrated the huge variation in resource consumption by patients with cancer. Correlations of interest included the observation of a geographic correlation in high levels of resource use between patients with cancer and those with congestive heart failure. In addition, expenses over either the last 2 years or the last 6 months of life correlated with the availability of care as reflected in the number of hospital beds or specialist physicians in a particular geographic area.

Newcomer also noted that there was widespread noncompliance with National Comprehensive Cancer Center (NCCN) guidelines for some recommendations. For treatment with bevacizumab in patients with breast, colon, and lung cancer, UnitedHealthcare's assessment showed that 63%, 25%, and 53% (respectively) of treatments were discordant with guidelines. He asserted that these findings establish a case for precertification of services. However, precertification processes are expensive and time consuming for both payers and providers.

UnitedHealthcare has promoted compliance with NCCN compendia as a means of circumventing the need for precertification, and has published tools to verify and clarify its interpretation of NCCN standards. Nevertheless, providers continue to routinely waste both their own and UnitedHealthcare staff time by calling to verify not only patient insurance coverage, but also that a particular treatment is included in the standards. In conclusion, Newcomer restated an over-riding theme of the meeting, "How can the professional society assist with this problem?"

Innovation in care leading to system cost savings may also relate to better care. Matthew Mumber, MD, past president of the Georgia Society of Clinical Oncology and now at the Harbin Clinic (Rome, GA), presented information concerning the value of providing information to patients throughout the course of their illness via patient navigators. He noted the value of navigators in promoting colorectal cancer screening through colonoscopy, achieving recommended care for economically disadvantaged patients with breast and gynecologic cancers, and in care for breast cancer in general. He also highlighted a study demonstrating that end-of-life navigation in the form of early palliative care intervention improved survival and decreased cost in stage IV non-small-cell lung cancer.² Mumber offered the opinion that successful use of patient navigation will require more than insurance case managers or provider-sponsored navigator programs, but a transformational change in the way providers, payers, and patients see their responsibilities.

Victor Vogel, MD, MHS, FACP, Director of the Geisinger Cancer Institute, discussed their innovative care and payment model, ProvenCare. He discussed how this process was first demonstrated to lower costs and improve outcomes in cardiac bypass surgery and then discussed a ProvenCare lung cancer initiative. This collaborative effort between Geisinger and seven additional institutions (with a control group of 14 surgeons) provides a stepwise, checklist-based system of care for lung cancer, designed to address appropriate preoperative evaluation, surgical technique, postoperative care, and post-hospital discharge care management. It is hypothesized that this systematized, checklist-based care will lead to better outcomes in terms of decreased cost and complications as well as improved survival.

Lawrence Shulman, MD, Chief Medical Officer at Dana-Farber Cancer Institute, outlined an approach that Dana-Farber was undertaking with Blue Cross Blue Shield Massachusetts that aims to improve and ensure quality while reducing cost. He presented a series of initiatives including the creation of treatment plans specifying tumor characteristics, treatment intent, and components of treatment; tight guidelines for use of expensive biologic therapies in gastrointestinal cancers; use of navigator interventions in streamlining breast cancer survivorship care; and early interventions by palliative care specialists in end-of-life care. A major initiative of the program establishes guidelines to control use of intensity-modulated radiation therapy. Shulman noted that the majority of the cost for these projects, which is significant, is borne by the provider, Dana-Farber Cancer Institute, and that the efforts will likely reduce Institute revenues. Pay-for-performance dollars are attached to meeting preset goals, although

methods need to be established so that cost savings realized by the payers can be shared by the providers.

John Fallon, MD, of Blue Cross Blue Shield of Massachusetts, discussed how a global payment model can affect quality of care. Given the incentives of fee-for-service care to increase volume with little or no incentive for preventive or less costly care, he noted the value of integrated care and the importance of primary care. He emphasized that value might be seen differently from the perspectives of patients, treating specialists, primary care physicians, employers, payers, and third-party regulators. Fallon underlined the opportunity to align interests across these groups and share cost savings among the parties if and when they could be realized. He stressed the importance of doing this while reporting quality, safety, and survival outcomes of treatments.

Douglas Blayney, MD, formerly Medical Director at the University of Michigan and now at Stanford, represented the Michigan Oncology Quality Consortium (MOQC) in presenting a collaborative pay-for-participation program sponsored by Blue Cross Blue Shield of Michigan (BCBSMI). The payer has supported participation of Michigan medical oncology practices in ASCO's Quality Oncology Practice Initiative (QOPI) by paying for practice data extraction, facilitating QOPI participation by more than 40 Michigan practices. Using practice-specific data and comparing them with those of other Michigan practices and the national QOPI cohort, MOQC has helped practices to identify performance quality gaps, such as the use of resources (particularly chemotherapy) at the end of life, deficits in symptom management (such as pain control), and the appropriate use of *KRAS* testing in colorectal cancer care. Blayney outlined a four-act structure, of which Michigan QOPI participation (value comparison) is act I. Act II, value-based cost sharing; act III, clinical re-engineering; and act IV, paying for more quality would follow as both better care and better value are realized.

Stephen Edge, MD, FACS, Chair of the Commission on Cancer (COC) of the American College of Surgeons and Professor of Surgery and Oncology at the Roswell Park Cancer Institute and University at Buffalo, presented a provocative talk on the potential to use tumor registries, specifically the COC's National Cancer Data Base (NCDB), to assess cancer care use and quality. Twenty-five percent of all acute cancer care and 70% of all cancer treatments are done at COC-accredited programs, making the NCDB more robust and complete than other registries. Further, the registry has built-in tools for quality analysis as a part of its cancer program certification process. However, the data in the registry are not complete for some cancer treatment, particularly for therapies given in the outpatient setting (eg, chemotherapy and radiation). Edge presented findings of a collaborative study between the NCDB and UnitedHealthcare and Anthem Blue Cross Blue Shield of Ohio, which demonstrated that private payer claims data could be linked to the NCDB and provide specific information describing quality of care state-wide in Ohio. He stressed the value of such collaborative efforts in developing meaningful community-wide evaluation of cancer care for use in quality improve-

ment. A few of the providers on the committee expressed concern that these databases would be used to garner resource consumption use statistics on individual practitioners without adequate comorbidity or patient consent information, and noted that the COC recently began requiring that National Provider Identifier numbers be included with all submissions. However, Edge was clear that the COC has strict confidentiality agreements that prohibit such inappropriate use of the data or sharing of any individually identifiable data on patients, providers, or hospitals.

Marcus Neubauer, MD, of the Kansas City Cancer Center and Chair of US Oncology's Pathways Task Force, discussed the construction and value of clinical pathways applied to delivery of cancer care. In the context of rapidly increasing costs for drugs coupled with limited evidence that care is improved by increased drug utilization, he claimed a clear rationale for adopting pathways that decrease unnecessary variation by promoting evidence-based care and measuring outcomes and resource consumption. He outlined general principles used to create US Oncology's Level 1 Pathways, emphasizing five principles: (1) science (eg, efficacy, toxicity) comes first; (2) assume there is no significant difference, then consider cost; (3) design pathways that work for at least 80% of patients; (4) allow exceptions in the context of a carefully predefined peer review process; and (5) always promote clinical research as a first option. Neubauer presented a sample physician dashboard used for reporting pathway adherence/compliance. He addressed three major cancer care cost drivers: variable use of drugs and diagnostics during treatment, deterioration of patient health during and between treatments, and ineffective interventions near the end of life. He proposed that pathways based on evidence can lower costs associated with each of these drivers, and presented published evidence that adherence to US Oncology's Level 1 Pathway for metastatic non-small-cell lung cancer significantly decreased costs without negatively affecting survival.³

Sam Silver, MD, PhD, Assistant Dean for Research at the University of Michigan, reviewed the rationale for clinical research. Using the examples of studies in chemotherapy for non-Hodgkin's lymphoma, surgical treatment of breast cancer, and larynx preservation in head and neck cancer, he pointed out benefits that both patients and payers derive from clinical research. He discussed the legal landscape of state laws and research payment coverage, as well as new changes that will result from the ACA. He contrasted these changes with the 2000 recommendation from the National Academy of Sciences specifying that Medicare (and other payers) should reimburse routine care for patients on and off clinical trials in similar fashion, and reimburse for costs of treating conditions that result from unintended consequences of clinical trials. These recommendations were mirrored in an executive memorandum to Medicare signed by President Bill Clinton in June 2000 and in a Medicare national coverage decision first published in 2000 and updated in 2007. Routine costs are defined to exclude the investigational item itself, items and services required solely for the provision of an investigational item and monitoring for its effect, and care customarily provided by the research sponsors free of charge for

any enrollee in the trial. Unfortunately, many payers, particularly self-insured companies not subject to state regulators, have not adopted similar policies, and although the ACA addresses these issues, it falls short of the National Academy of Sciences' recommendations. The statutory language does not specifically require reimbursement for items and services required for evaluation and treatment of complications of the investigational treatment. In addition, employer-based plans can opt to preserve existing coverage in order to qualify for "grandfathered" status, exempting them from the clinical trials provision and other consumer protections. Silver noted that his own employer has deemed its health plan to be grandfathered, notifying him that it "may not include certain consumer protections of the Affordable Care Act that apply to other plans." He concluded by noting that research adds minimally (5% to 10%) to the cost of care and challenged payers to collaborate with providers to meet the clinical research reimbursement goals set forth by the National Academy of Sciences.

Naomi Aronson, PhD, of the Blue Cross Blue Shield Association Technology Evaluation Center, discussed the current emphasis on clinical effectiveness research to lead to an improved evidence base for important clinical decisions. She explained the Patient Centered Outcomes Research Institute and the current 100 priority topics of the Institute of Medicine for comparative effectiveness research.⁴ She described the work of the Association's Technology Evaluation Center, which is an Evidence-based Practice Center of the Agency of Health Care Research and Quality and is designated as the Comprehensive Comparative Effectiveness Review Center for Cancer and Infectious Disease. She described the limitations of the current evidence base, including use of progression-free survival and other "soft" surrogate or secondary end points, noninferiority trials, pervasive under-reporting of adverse effects, and publication bias. She observed that cost effectiveness and cost considerations are key to a sustainable and affordable health care system but have been the political third rail of comparative effectiveness research. Aronson urged specialty societies like ASCO to take a position of social and ethical leadership on comparative and cost effectiveness issues.

Summary and Next Steps

The ASCO Provider Payer Initiative meeting was convened to explore ways in which providers and payers could work together to improve patient care. Several key themes emerged from the presentations and discussion and represent an opportunity to move toward the meeting goals.

1. First, nothing is more important than providing our patients with high-quality care. It is absolutely clear that payers are as interested in this as providers and that both parties' interests are aligned with those of patients. This is not lip service to an idea, but real understanding that we are aligned in our goal of helping people face and surmount cancer.
2. It is clear that variation in care represents a quality gap and is associated with unnecessarily expensive and wasteful care. There is evidence that variation in practice is significant and frequently outside of accepted guidelines and risks providing

suboptimal and more expensive care. Providers can and should play a significant role in formulating an aggressive approach to the measurement of guideline adherence. Providers must also explore ways to improve quality of care while reducing cost in end-of-life care. Models for this exist, and new ones can be developed. If providers do not take the initiative, then payers will be forced to continue to impose their own guidelines on providers and patients through preauthorization and other mechanisms.

3. Both payers and providers can work together to improve efficiency and reduce administrative costs. The amount spent on administrative overhead by both providers and payers is unacceptable and represents health care cost with no real benefit to patients or providers. Reduction in administrative overhead could be accomplished by unification and simplification of payment mechanisms, as well as replacement of preauthorization programs by quality programs noted above.

Provider organizations such as ASCO should continue to work on these important issues at a national level. Some state oncology societies have negotiated arrangements with payers, for example, the Michigan Oncology Society with BCBSMI and QOPI in which a pay-for-participation program was established. In Massachusetts, a program was developed to recognize quality efforts of physicians using chemotherapy treatment plans and summaries. Some individual practices have also worked with payers to develop new policies and procedures designed to improve efficiency that have allowed more focus on patients. These types of state and individual examples should be encouraged. Much can be learned from them, and program benefits can be shared with colleagues and payers in other states, disseminating programs that are successful. There also may be valuable lessons learned that apply at the state and national levels.

The ASCO Provider-Payer Initiative meeting represents a beginning and not the completion of a project. Most important, the dialogue between payers and providers needs to be expanded, continued, and made meaningful through movement toward improved quality, efficiency, and outcomes in care. To accomplish this, the ASCO Clinical Practice Committee has established a working group to continue this dialogue and plan for an annual meeting of payers and providers, with the idea that patients will be added to the discussion.

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ASCO's EHR Social Networking Site

ASCO has developed a social networking site, where oncologists and their practice staff can connect and share information about the use of electronic health records (EHRs) in oncology practices. This Web site also serves as a platform for oncologists and EHR vendors to discuss the advancements, usability, and challenges that emerge in using EHRs in oncology offices. Become a member today!

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