Partnership Between a Cancer Center and Payer: Opportunities for Improved Quality of Care and Cost Reduction

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Frequently, care providers and payers are combatants rather than partners. Providers create health care costs in the care they provide, and payers desire to control or reduce costs. Ultimately, both should want the patient to receive optimal quality care, which should maximize patient outcome and would avoid unnecessary costs either from inappropriate use of diagnostics or therapeutics or from costly complications of care that might have been avoided if quality had been better. Partnerships between cancer care providers and payers, could, therefore, align incentives to provide high-quality but cost-sensitive care.

Such experiments have been undertaken between the Dana-Farber Cancer Institute (DFCI) in Boston, Massachusetts, and BlueCross BlueShield of Massachusetts (BCBSMA) to attack these issues. Their efforts have been broad based, but three examples will serve to illustrate their work. DFCI is a large academic cancer center seeing approximately 16,000 new patients per year. There are approximately 100 clinical faculty seeing adult patients; however, many are primarily research based, with a low clinical volume, although all are included in this program. Approximately 35% of patients at DFCI are insured through BCBSMA. It should be noted that the programs described in this article involve only adult cancer care; pediatric cancer care has been excluded. It should also be noted that although these initiatives were the result of DFCI and BCBSMA collaboration, they apply to all adult patients seen at DFCI regardless of insurer.

Chemotherapy Treatment Plans

The Institute of Medicine, American Society of Clinical Oncology, and other organizations have supported the concept of a chemotherapy treatment plan for many reasons.¹ The plan can articulate the stage of disease and disease characteristics such as estrogen receptor or *KRAS* status, the intention of therapy such as curative or palliative, and the specifics of treatment, including drugs, schedule, duration, and potential toxicities. This document informs other caregivers and could be given to the patient as well. A treatment plan explicitly defining these elements is often not completely contained within clinic notes or other documents, leaving other providers and covering physicians incompletely informed about the care of the patient.

In the case of DFCI, a template was created within the electronic health record (EHR) to facilitate structured entry of data. In addition, use of the template assured that critical ele-

ments of staging, treatment intent, performance status, and so on were more likely to be entered. The treatment plan requires only 2 to 4 minutes to create, and when finalized and signed, it is filed in the notes section of the EHR, where it is easily accessible to other providers. It is automatically distributed to all providers involved in a patient's care who receive standard clinic notes. The treatment plan also automatically completes a consent form specific for that patient and the therapy he or she is to receive, which may be printed and signed by the physician and patient; it is then uploaded into the notes section of the EHR. In addition, the treatment plan automatically fills the chemotherapy order templates to save time and facilitate chemotherapy ordering. The EHR used for this practice and for these initiatives is one developed by our health care system; it is not a vendor product. The ability to replicate these initiatives with other EHRs will vary depending on the EHR.

Treatment plans created for patients insured by BCBSMA are sent to the insurer at the start of treatment. This allows BCBSMA to know the proposed treatment and its intent and to alert nurse navigators who can interact with the patient, providing guidance to help him or her through the treatment. DFCI is financially rewarded for these efforts through a pay-for-performance (P4P) contract for patients insured by BCBSMA, although providers complete them for all patients regardless of the insurer. There has been acceptance of this effort by providers, physicians, nurse practitioners, and physician assistants, and compliance is high, although the providers do not receive financial compensation for the completion of these plans.

Appropriate Use of High-Cost Biologic Therapies

A team of physician experts proposed guidelines for use or nonuse of high-cost biologics such as cetuximab and bevacizumab in colorectal, breast, and lung cancers. These diseases were chosen because these drugs are frequently used for patients with these diagnoses, and they are relatively common diseases for which large phase III trials have supplied high-level evidence for use or nonuse. An example might be the nonuse of bevacizumab in patients receiving palliative chemotherapy for pancreatic cancer. The guidelines were literature based and agreed on between DFCI and BCBSMA. These represent treatment guidelines for a particular intervention for these patients, rather

than pathways of care, which are more inclusive of the entire course of care and resource use.

A tracking report was produced for the use and nonuse of these agents every other month for each physician at the DFCI main hospital and its three community satellites. The data covered all patients cared for at these sites, not just patients with BCBSMA insurance. DFCI leadership shared these data with their faculty, and the data were sent, with physician names removed, to BCBSMA (also including all patients, not just those insured by BCBSMA). Since institution of this system, compliance has been greater than 90% for each clinical scenario, and each exception is reviewed for appropriateness. In most cases, there is clinical justification for the exception. This program has wide physician acceptance. These reports were part of the P4P contract between DFCI and BCBSMA, although individual physicians did not financially benefit from this initiative.

Image Modulated Radiation Therapy

Image modulated radiation therapy (IMRT) is a widely used technology that in some clinical scenarios has benefit for patients in assuring maximal tumor effect while minimizing irradiation of normal tissues.² It is, however, more expensive than standard radiation therapy, and its usage varies widely from practice to practice. BCBSMA convened a group of radiation oncologists from Massachusetts who collectively drafted guidelines for the appropriate use of IMRT.³ These guidelines were adopted by BCBSMA. Requests for exceptions are reviewed by a practicing radiation oncologists rather than employees of BCBSMA. Initial data suggest a substantial decrease in the use of IMRT statewide in the year after implementation of this system. Ongoing evaluation of the program and its results will help to identify opportunities for future improvement.

Conclusion

Partnerships between oncology providers and payers such as BCBSMA can help align incentives directing providers toward the delivery of high-quality and cost-effective care. Open and transparent processes between providers and payers are essential to this effort if it is to be successful.⁴

As our profession transitions to this approach, there is a financial imbalance. The process of identifying potential areas of measurement and improvement, the infrastructure necessary to operationalize these efforts, and the manpower needed to

gather and analyze data add significantly to the cost of delivering care. At the same time, clinical revenues may fall (appropriately so) as use of drugs and radiation therapy is reduced. In a structured P4P program, some of that revenue can be recouped through these performance incentives, but likely not amounting to the real cost of this work. Better mechanisms need to be put into place so that providers can share in the benefits of high-quality, cost-efficient care. Currently, this is not the case, which is likely an impediment to success in this arena.

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