

Implementation of Pathways: Payers to Share Savings With Compliant Groups by Bryan Cote

Two national health plans—Wellpoint and Aetna—are changing how they contract with oncologists while a third national plan, Humana, continues to evaluate its pathway strategy. Medical and contracting directors for all three companies say they took cues towards transforming their reimbursement strategies from the myriad of BlueCross BlueShield (BCBS) health plans that began to roll out successful pathway pilots with local oncology groups three years ago. Each of the health plans discussed in this article is at a different stage in its pathway implementation—admittedly, because there is rigorous internal discussion between contracting and medical directors over how to contract with oncologists and identify savings, in addition to what to measure, and whether to incentivize doctors in the first place.

A Look Into Wellpoint's Pathway Pilot

Wellpoint and Aetna will begin to experiment with inherently similar shared savings models with large oncology groups that follow pre-approved clinical drug pathways. To identify oncology savings, Dave Tofanelli, Regional Vice President, Enterprise Provider Contracting, Wellpoint, says the insurer had initially talked about moving to a more global payment approach for everything in medical oncology, but held

back. According to Tofanelli, “If the patient has breast cancer she gets a set number of visits, CTs, etc, but how do you adjust at the end of the day if she needs twice as many CTs, or if her cancer moves to the liver?”

By shifting gears, the insurer is first letting more oncologists administer treatment without prior authorization and then retro-authorizing the claims. “There’s been a pattern of late to let the oncologist treat since we approve most everything they do anyway,” says Tofanelli.

Second, Wellpoint plans on rolling out an incentive-based clinical pathways pilot to large oncology groups in major markets. The insurer is considering hiring an oncology management company to develop a core set of clinical pathways and collect data to determine whether pathway-compliant oncology groups generate savings to health plans, such as lower pharmacy, medical or facility costs.

Unlike Highmark BCBS in Pennsylvania, which two years ago began studying whether its breast and lung cancer pathways reduced hospitalizations, Wellpoint won’t use this as a measure of success. “We’re not incentivizing doctors for not putting patients in the hospital,” says Tofanelli. “If that’s where a patient needs to be, so be it. We need to be careful

that physicians won’t follow a pathway just to get a bonus.”

Plus, in California, health plans are not allowed according to state law to “incent physicians” financially to provide fewer services; for example, keeping people out of the hospital. According to Tofanelli, rewarding physicians for reducing hospitalizations seems to be a reasonable incentive that could benefit the payer and patient, but doctors must remain comfortable sending patients to the hospital if medically necessary. “So we have to tie any savings model in our contracts to well-defined clinical guidelines,” he says, not to bonuses that pay doctors more for keeping patients out of the hospital.

Instead of using a hospitalization focus, Wellpoint will evaluate whether clinical pathways help lower the unnecessary incidence of other diseases, evaluate chemotherapy symptoms and avoidable downstream costs. For example, dosing can drive unnecessary costs up for patients with liver cancer who receive large doses of FOLFOX infusions. Tofanelli indicates that these patients can end up in an emergency department with bowel constriction which may lead to exploratory surgery to reopen the valve, followed by a huge course of treatment to address the bowel constriction. These downstream costs



can be avoided if physicians follow clinical pathways approved by Wellpoint and administer a lower dose. Before infusing the patient with chemotherapy, the Wellpoint pathway may instruct the provider to administer magnesium intravenously. “This helps wipe out the side effects of chemotherapy and, in effect, reduce other costs,” says Tofanelli.

After its 6-month pilot is put into effect, Wellpoint will look at how it reimbursed each practice in the last year compared to the pilot period, determine whether there were savings based on the pathway, and then compensate practices for their part. “If the pathway is working but we get pushback from the state of California, we will stop the incentive,” says Tofanelli, “and, as a compromise, pay the practice a higher administrative rate.”

Aetna’s Graded Payout Approach

Alternatively, Aetna is taking a somewhat different approach. According to Ira Klein, MD, Medical Director of Oncology Condition Analysis, Aetna,

the health plan will use a shared savings model whereby it will reimburse oncology groups based on a graded payout. “Let’s say an oncologist does a great job to keep patients out of the hospital emergency department and follows a clinically-accepted, best practices chemotherapy drug treatment pathway—that’s an important measure of success,” says Klein.

Before pathway measurement, an oncology practice might average 100 hospitalizations over a 6-month period; but during the 6 months after the pathway is available, a practice sees a 20% reduction in hospitalizations or 80 hospitalizations total. To determine pathway savings, Aetna’s contracts will factor in a member’s average inpatient length of stay (LOS) in a hospital; let’s say it is 5 days for this scenario. Next, the insurer would multiply this 5-day average by the total number of hospitalizations during the 6-month period—so 5 times 100 hospitalizations before the pathway period would equal 500 total hospital inpatient days compared to 400 days (or 5 x 80) after pathway imple-

mentation. Then, Aetna would take the average cost per-day for an oncology patient admitted to the hospital—let’s say \$2,000—and multiply this by the total number of hospitalizations for the period. In our example, one would take the \$2,000 daily cost and multiply it by the 500 total inpatient days. This equals \$1,000,000—the total cost to hospitalize the oncology group’s patients before pathway implementation. Aetna would then compare this to the \$800,000 total cost in the 6-months after implementation (\$2,000 x 400 days), which would indicate that the practice saved Aetna \$200,000 by following the pathway.

Aetna’s contract will then stipulate how the savings are shared. As an example, Dr. Klein says, “a contract might typically have a cap on the shared savings, so the practice would be eligible for a significant percentage of that.” Typically, the health plan would also share savings with the oncology vendor that brings the clinical pathways and operational expertise to the practice. [cont. on pg 18 >>](#)

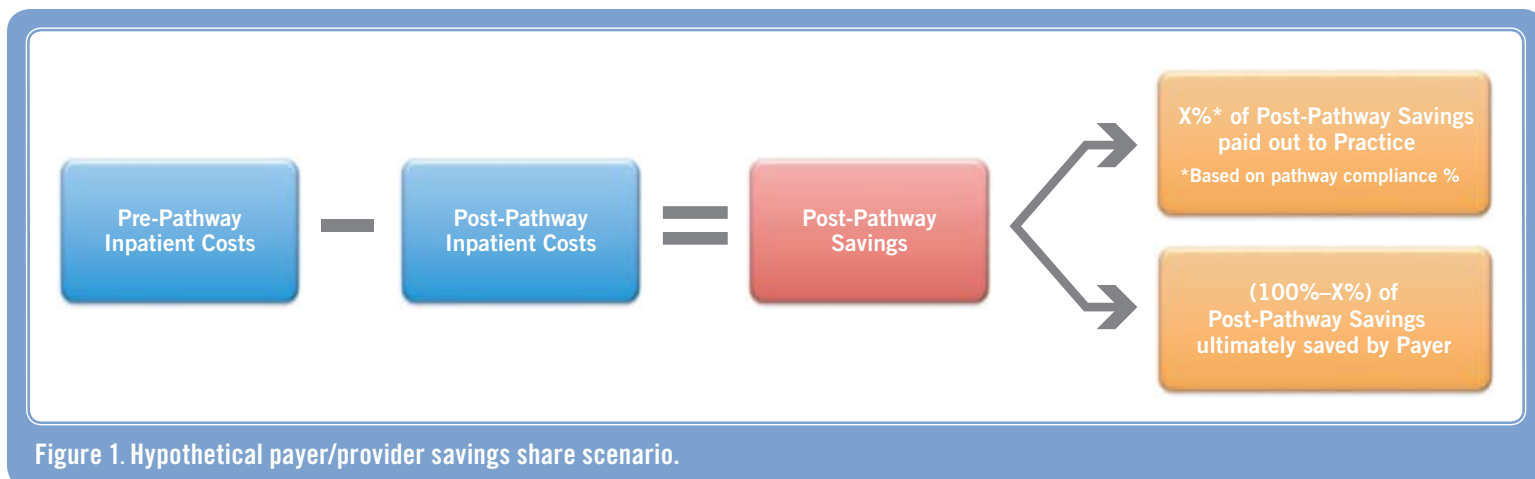


Figure 1. Hypothetical payer/provider savings share scenario.

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Graded payouts will be based on how often, in sum, an oncology group follows the approved clinical pathway. If a group is at least 80% compliant, they might, for example, be eligible to receive the “fully-capped” contracted savings amount. In their discussions with Innovent Oncology, a subsidiary of the US Oncology network, Aetna agreed early on that 100% pathway compliance was unreasonable and unsafe. “If pathway compliance was 100%, then you’d have situations where the doctor wouldn’t be paying attention to individual patient characteristics,” Klein says. “There are always treatment choices that just won’t fit the patient and we need to have the best individual therapy for each patient as a foundation of our program.”

Each contract will vary, but will likely include two targets—the pathway goal or benchmark of 80% and a minimum compliance target such as 50%, so in the event a group complies with a pathway less than this minimum they may not be eligible for any of the savings. While the latter is unlikely, Dr. Klein says it represents a “quality threshold” that Aetna is incenting.

The more a group falls below the 80% benchmark the less they may be eligible to receive in shared savings. As a hypothetical example, a contract could stipulate that 60% pathway compliance allows a group to receive 25% of the savings, or 70% pathway compliance may mean 50% of the pot.

Aetna signed its first shared savings contract with Innovent in the

spring of 2010. In the future, “we’re open to this model with any practice,” says Dr. Klein, and they are already in contract discussions with at least three small groups in one state with 35 oncologists combined. Aetna would allow oncologists to use their own clinical pathways “as long as they’re based on nationally accepted Level-1 guidelines,” says Klein.

Unlike Wellpoint, Aetna will allow oncology practices to choose their preferred oncology benefit intermediary. “Having to work with multiple oncology vendors is not our ideal situation as an insurer, but we’re trying to learn from the experiences of others who did not have success forcing a single intermediary onto practices,” says Klein.

Being as oncology practices vary in size and services, Aetna will allow groups in each market to choose, most likely, from a select group of vendors who meet Aetna’s clinical criteria, and can support the pathway programs with proven infrastructure, results, and the ability to do full risk sharing. “Certain intermediary vendors fit certain practices better than others,” he adds. To evaluate whether a clinical pathway is successful and generates savings, Aetna will use its intermediaries to track several metrics, but expects to use these four criteria the most: clinical pathway compliance; total inpatient hospital days; total emergency department visits; and total drug spend. “We put the criteria together so the doctor would be incentivized to be a kind of medical home for the oncology patient,” says Klein. In addition, to

build the program for the long-term, “We’re trying to take the same set of metrics and apply them to different vendors in the contract, even if the contracts themselves are not exactly the same.”

Aetna’s pathways will ideally include anti-cancer drugs, erythropoiesis-stimulating agents, and supportive medications such as those to treat nausea. Individual oncologists and practices will see their performance status on a quarterly basis, blinded, in order to evaluate their treatment patterns against their peers and other groups nationally. For the Innovent program, each time a physician treats a patient with a nonpathway drug that choice is flagged and entered into Innovent’s electronic health record system, so that Innovent and the practice can evaluate and study these retrospectively in a continuous total-quality-management process.

Humana’s Exploration

Unlike Wellpoint and Aetna, Humana is still evaluating its clinical pathways approach in oncology. The insurer has discussed outsourcing pathway development and contract incentives, but there are internal skeptics. According to Louis Hochheiser, MD, Corporate Medical Director of Clinical Policy at Humana, “Pathways make more sense in radiation oncology,” but less so in medical oncology. Humana uses an outside company to work with providers to ensure the quality of treatment plans for its radiation oncology business. These treatment plans give the radiation oncologists “flexibili-

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man to make these work—we're more interested in partnering with them beyond simple pathway programs," he says. "Using P4 is a payer-centric policy since they bring no value to the provider." For instance, Tennessee Oncology does not want to pay for P4's remittance tool. "We can show compliance with our EMR source data, which is clearly more accurate than their claims data," says Patton

Jeffrey Scott, MD, Chief Executive Officer, P4 Healthcare Oncology fully agrees. "There's no doubt that an



Jeffrey Scott, MD

EMR is a better solution for measuring compliance," he says. "Oncology practices can go to the payer directly and get gold carded with more reimbursement or get out of a PA [prior authorization]. They should do this. The challenge is it's difficult for a single practice to put in a pathway, adopt them across geographies [and] handle the infrastructure."

Dr. Scott, formerly a founding partner of Georgia Cancer Specialists and medical director at ION, says P4 has played an advocacy role in bringing pathway programs to payers. "We don't set fee schedules but when we went into BCBS of Tennessee we were informed that they were in discussions with two other companies and were looking at lower fee schedules in their pathway programs," around ASP

+12%-15%, he explains. "It needed to be higher."

Now, as several oncologists in Tennessee confirmed, the commercial specialty pharmacy fee schedule being offered to them is ASP +20% and practices that voluntarily opt to participate in the BCBS of Tennessee-P4 pathway program will receive an ASP +27% rate. While that may sound like a great rate to some, part of the challenge in Tennessee is that practices have been paid based on AWP at a rate equivalent to about ASP +37%, several oncologists said.

"I understand that this seems like a cut, but you have to wonder is AWP sustainable and, if not, compared to other regional plans in Maryland, Alabama, Michigan, an ASP +27% is not bad," says Dr. Scott.

However pathway incentive contracts shake out, just 29% of oncologists, according to an informal OBR poll, said that sharing savings with an intermediary is fair. Most of the 71% against the intermediary model are small group or solo oncology practices, some of whom said they are unsure what oncology intermediaries do. Most oncologists agree that an 80% threshold is appropriate for therapeutic oncology as a compliance "target" or "goal." As most payers are advocating, pathway compliance needs to roll out slowly. To ultimately require greater than 80% compliance, such as United Healthcare is trying to attain, is difficult, says Dr. Patton. "Ninety percent is high for therapeutic pathways, although 95% may be okay with supportive care," he says.

Concluding Thoughts

There is a certain measure of collaboration continuing in oncology today, but as Dr. Patton's views illustrate, a healthy amount of caution still exists as payers experiment with pathways and contracting. "I like the shared savings model very much," he says. "It incentivizes cost-effective patient management." But pathway incentive contracting models coming into place do not mean, nor should they mean, the end of healthy debate among providers and payers. Several local and regional health plans are swiftly moving toward pathway pilot consideration; and needing expertise, some will outsource and some won't. In either case, doctors from all corners of the cancer care continuum—such as Dr. Klein, Dr. Patton and Dr. Scott—agree that discussion needs to continue about the appropriate level of physician treatment independence and the right way to measure success and share in it.

Dr. Patton, for example, does not endorse the third-party approach while Aetna, seeing potential pitfalls in a take-it-or-leave it model, will offer intermediary choice. Perhaps in six months we may have more clues from Wellpoint and Aetna. Clearly, the bigger plans with more cancer lives to cover seem to be breaking ground on pathways implementation; and as good, autonomous, and yet cost containing models evolve, perhaps the best models will trickle down to smaller plans too. **BC**