Challenges and Changes in the Business and Management of Oncology for 2013

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Changing Oncology Landscape

- Site of Care Delivery
- Quality
- Innovation: Data and Models
- Drugs
Site of Care Delivery

- Drivers
  - CMS
  - Patient Benefit Design (Co-pays, Co-insurance)
  - Care Expectations: Technology, support, reporting
  - Certification/Accreditation

- Impact
  - Changes in Cost?
  - Continuum of Care?
  - Patient Access to Care?
  - Quality of Care?

Quality

- The Eye of the Beholder
  - Access
  - Outcomes vs Process?
  - Cost
  - “Value”
  - Evidence

- Consider
  - Source, Audience, Stakeholders, Perspective
  - NCCN, ASCO, home grown, commercial, scalability
Innovation: Data

- Big Data
  - Watson, Memorial Sloan Kettering, private
  - ASCO OncoLinx
  - NCCN

- Decision-Making
  - NCCN/McKesson/US Oncology Value Pathways
  - VIA Oncology
  - ASCO OncoLinx
  - Prior Auth portals
  - commercial

Innovation: Models

- Large Single Specialty Networks
  - US Oncology
  - Florida Cancer Specialists

- Academic Center/Cancer Center Networks and Satellites

- Mergers/ New Hospital Service Lines

- Focused Specialty Initiatives
  - Oncology Medical Home (PA, CA, NM – ComeHome, COA)
  - Pathways/Guidelines (varied, MI, PA, MD led, commercial led)
  - Oncology ACO (FI)
  - Bundled Payments/Pay for Performance (MI, PA, United)
Drugs

- Threshold of Proof of Value
  - MSK decision
- Role of Orals
  - Compliance/Adherence (37%)
  - Monitoring – Who?
- New Launches
  - Increased conversation re evidence, comparators, coverage vs use
dance
- Oncology Management
  - Still predominantly drug focused
  - Collaboration will yield results

Oncology Overview

- Many voices, no consensus yet
- Delivery Models in flux, require flexibility
- Management beyond drugs will yield greatest impact
- Open Payer/Physician/Hospital models show promise
  - How to scale
- Need for information and resources
- Need both answers and questions – sometimes in that order
- NAMCP good resource
Oncology – It’s not just about the drugs – but how to get there?

Total Cancer Spend – Not Just Drugs – Pivotal Point
Phases of Oncology Management  What and How

Continuum of Care/Evidence Focused

Treatment Focused
- Engaged Oncologists, Full Care Guidelines, Data Registries, Individualized Care.
- Data may come from both provider and Admin. could be ACO directed, could move to ongoing medical home, could be engaged providers without specific label.
- Preferred Regimens, Anticipated Claims Analysis, Medical Review
- Single Cost Focused
- Treatment Focused
- Single Cost Focused
- Perspective is Everything
- 5 Views of Main Street/Oncology
Perspectives at the Table

• Payer
  – Show me the evidence!
  – Reduce variation
  – Reduce costs
  – Good business partner
  – Good value delivered for money spent

• Provider
  – Provide patients help and hope
  – Evidence-based care and medical decision-making
  – Stay in business


National Landscape for Payers

• Frustration, Concern, Fear
  • Costs of care
  • Large pipeline
  • Looking for promises to manage black box

• Complex Issues, limited easy solutions
  • Focus on drugs – shape utilization and reimbursement
  • When does use of portals shaping approval become medical decisionmaking?
Payer/MD relations

- Payers and MDs find collaboration/talking difficult – differing perspectives
- One site in a region interesting, but not a solution
- One site with an answer that others won’t accept/endorse is not necessarily an answer
- End of day, it is about management of costs and care for efficiency and effectiveness – seen differently from each perspective
- Changing Sites of Care can change MD involvement

Who will be driving?

MD Decisionmaking
- Evidence
- Quality
- Universal – Not one off options
- Out of office services – imaging, diagnostics, hospitalization, hospice, radiation oncology...etc.
- Professional Services
- Drugs

Others decisionmaking
- One stop shop – “evidence”
- Cost Shifts
- Site of service,
- Specialty pharmacy,
- Prior authorization management,
Desired Promises, from whom?

- We will manage for consistency across market
- We will price appropriately
- We will ensure right care selected for right patients
- We will report utilization and concordance with ___X___ Guidelines
- We will rein in wide variation of care and catch/fill gaps in communication/process between care providers

Five challenges for the future of Oncology Care

A. Medical Decision-making
B. Drugs
C. Evidence Based Treatment
D. Site of Care?
E. Money (Who Pays, Limitations, Expectations)
A. Medical Decision making

• Missing – tracking of decisionmaking process for individual state and stage of patient – plus being able to roll that into regional/national information for standards of care. Who will track and control?

• Whose Guidelines? NCCN and ASCO mutually accepted. Others have to justify their refinements and maintenance to someone – MD or payer or patient.
  A. Who decides
  B. Whose criteria
  C. Whose guidelines

B. Drugs

• Who Decides (formulary, evidence of success – under varying standards, allowed to give but not to be reimbursed)

• Who acquires (potentially much higher costs to payer if shipped to provider – plus higher rates of discarded drug – not good re drug shortages)

• Who approves – and who resolves opinion differences between MD, patient and approver?

• MD always liable
C. Evidence Based Treatment

- Guidelines and/or pathways – Whose?
  - Medical Community Guidelines – NCCN, ASCO
  - Medical Community Pathways – Innovent, Via, Value Pathways
  - Commercial Preferred Processes - eviti, P4 Healthcare
  - Homegrown by MDs or Payers
- Accountability – Where? Follow the Money
  - Primary Care Focused ACO
  - Oncology Medical Home (CA, MA, MI, NM, PA pilots)
- Challenges: Universal, Scalable, ROI
- Inaction is not an option

Example: Transparency Expectations

- CMS Standards for Transparency
  - Track changes for not less than 5 years
  - List all evidence considered
  - List all participating individuals in review (credentials, disclosures)
  - Minutes and voting records kept
  - Clean decision-making, with no agenda other than care

- Evidence vs Agenda
D. Site of Care

- Private MD Office
- Hospital Based Outpatient
- Private Retail Infusion Clinic

Questions
- Coordination of Care (pathology through survivorship)
- Accreditation/certification
- Cost (Overhead, billing structure)
- Patient Convenience/Comfort/Satisfaction
- Personalized care/Corporate Care
- Watch USP 797 pharmacy expectations

Watch Patient Benefit Design – may not be your friend

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Payer Spend Per Claim per 1 Million Lives by Site of Service

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E. Money

- Who sets parameters for expenditures?
  - Benefit Structure
  - Coverage Limitations
  - “Medically Necessary”

- Who Pays?
  - Payer
  - Purchaser
  - Physician
  - Patient

- Prices
  - Who Sets?
  - Bundling
  - Episodes of Treatment

Specialty Pharmacy and Oncology – An Elephant in the Room
Changing Landscape

- Majority of oncology drugs still delivered in oncology offices and acquired through buy and bill
- Growing Pressures:
  A. Frequency of oral drugs in oncology pipeline
  B. Financial pressures changing delivery models – will hospitals dispense?
  C. The Feds – will sequestration or push to ACO’s change drug acquisition trends overnight?
  D. Specialty Pharmacy and other vendors building in oncology management and delivery space

A. Oral Drugs in Oncology Pipeline

- Driving Forces
  - REMS dictated in FDA approvals
  - Limited distribution networks raise challenges to providers – forced vendor expansion outside of historical
  - Adherence – more difficult to control out of office – patient’s responsibility
  - Costs and vendors fueling payer/employer concerns
  - Medicare Advantage issues for patients and providers
  - Oral perceived as more manageable and less costly (away from providers)
B. Changing Delivery Models

• How will providers react to pressures?
  • Follow mandates for “Ship for Script” vs “Buy and Bill”?
  • Choose to replace acquisition with delivery for financial reasons?
  • Shift patients to hospitals (acquisition or shifts)
  • What choices will hospitals make? Will payers mandate for hospitals as well?
  • Will hospitals then:
    • Follow mandates
    • Replace acquisition with delivery
    • Where would they shift patients? (????Medicare????)

C. WWCD? What will CMS do?

• Sequestration – depth, duration and application of cuts
• ACOs – not yet oncology, but around corner
• Bundled outpatient services – like DRGs in hospitals
  • Cross many specialties, providers and services for one diagnosis
  • Role of MDs into bundles (private or employed)?
D. External Vendors in Oncology

- Oncology Management (medical and pharmacy)
  - CVS Caremark
  - ExpressScripts
  - Walgreens
  - ICORE
  - And more

Oncology and Specialty Pharmacy – Next Steps

1. Providers defining roles with SP
   1. Orals, injectables, all or selected
   2. Identify parameters for interaction with specialty pharmacy
      1. Vetting
      2. Flow of information BOTH ways
      3. Key contacts and relationships
      4. Local, regional or national

2. Payers reviewing net costs and roles for SP and providers
Points to consider

- Specialty Pharmacy not currently allowed under law to provide injectables to non-Medicare advantage patients – MDs can through Part B
- Specialty Pharmacy delivery results in unused drug when treatment plan changes on day of service
- Specialty Pharmacy communicates with patient – outside of provider care or as part of team
- Specialty Pharmacy buys drugs at rates higher than MDs
- Cancer trained pharmacists growing – role in infrastructure

Oncology Management – moving along information continuum
MD based and driven

- ASCO – Guidelines and Cancer-LINQ
- IBM Watson, Wellpoint, Memorial Sloan Kettering, others
- Innovent/US Oncology – MD Based, regular and specialty pharmacy distribution, Care pathways, McKesson technology tracks to Innovent pathways
- NCCN/McKesson- Value Pathways - web portal decision algorithm for NCCN Guidelines per indiv patient. Tracks utilization and concordance to NCCN Guidelines and Compendia
- Via Oncology – started MD Based, new payer focused partnership – CareCore National, Care Pathways. Tracks to Via pathways

Non-MD Based

- Eviti – ITA Training Partners – start evidence based, do adjust care pathways to meet client preferences, web portal, payer focused
- Cardinal (old P4) – specialty pharmacy, data reseller, older technology, preferred treatment regimens
- CVS, Express Scripts, Medco, Walgreens and other specialty phram and PBMs – designing web portals for treatment authorization, care approvals shaped to meet client preferences
- New Century Health – licensed by NCCN to integrate NCCN Compendia into web portal decision algorithms. Contracting with payers and other entities.
Other Non MD

- ICORE – older model, seems to focus now more on specialty pharmacy than oncology management
- Alere – old Quality Oncology – case and disease management model focused on oncology – also waning model
- Coram – 80 retail infusion centers across country, already or planning to handle cancer

Not all Options are created Equal

- Trust in vendors (potential baggage, agendas)
- Individuality of cancer
- Need for valid data and useable technology
- Extent of intrusion in care process and operations
- Press Releases not an indicator of success for most programs/vendors
- Limited ROI possibilities
- Bandages versus working information and knowledge
- Filling Toolbox vs one tool as solutions
- Difference between evidence and selective choice (to payer, patient, MD)
Contracting Considerations for Payer across Options

- Addresses Full Care Continuum?
- Pathways (When is a pathway not a pathway?)
- Claims data limitations
- Preferential pricing (Product Preferencing)
- Rational Reimbursement
- Gainsharing (Law of diminishing returns)
- Brownbagging/Whitebagging
- Oncology Management and role of MDs

Accountable Care Organizations and Medical Homes in Oncology - 2013
ACOs and Medical Homes – Jury Still Out

- ACO
  - Primary care
  - Most CMS “models” declining
  - Technology and culture challenges
- Medical Homes
  - Oncology pilots
  - NCCN Guidelines support
  - Cancer carveout vs other co-morbidities?

Complex Pilots have Grey Areas

- Challenges by MDs or payers for guidelines more limiting than NCCN
- Episode of Care pilots have slowed due to oncology complexity
- Internal Payer Attention Varies
- Challenges for use of data has raised suspicions levels
- “Real” agendas being challenged of erstwhile partners

- Oncology Management Still in Transition
Oncology Medical Home and ACOs

- Accountable Care Organization – Modeled for Medicare, Primarily a reimbursement model that requires physician/hospital coordination and accountability. Focused on primary care..uncertain savings/reward at a high cost. Does not consider oncology. (FL only oncology ACO)
- Oncology Medical Home – practice operational model of care coordination and accountability...built in expectation of reimbursement support...goal: to establish role for oncology within changing delivery models such as ACOs
  - Projected Savings of 6 – 13%
    - Michigan – pilot with state association, health plan and large practice
    - CA – pilot with large health plan and large US Oncology practice
    - NM – Medicare supported pilots for 8+ private practices across country with local health plans – common software driven
    - PA – Key practice – nationally certified as patient centered medical home, working to build health plan contracts
    - Community Oncology Alliance – steering committee of stakeholders to identify OMH elements and common expectations
- National Committee for Quality Assurance-offers Patient-Centered Medical Home certification (1 oncology practice – only one?)

What does all this mean?
Keep It Simple

- Both payers and MDs start with trust of ASCO/NCCN Guidelines, Compendia
- It takes providers and payers to address total cost
- When different practice systems or EMRs track to specialized guidelines or pathways, causes confusion/lack of consistency across practices/markets
- Whether or not MDs comply with “evidence” is source of perspective and friction between payers and MDs
- Build relationships and future projects AFTER trust and communications established

Logical Steps (Needed Yesterday)

- Participation in ASCO’s QOPI
- ASCO QOPI Certification
- Hospitals – JCAHO, Commission on Cancer
- Patient Satisfaction Surveys – ONCOLOGY specific
  - www.medicalhomeoncology.org
- Real World data monitoring and tracking
  - Yet to be determined
Pressure points for Payers

**Common Practice and even services to be catalogued, measured, valued, and marketed**

- Triage - Incoming/outgoing phone calls (reason and resolution)
- Avoided ER visits and hospitalizations
- Admissions and Readmissions per cancer case
- Prescriptions and resulting outcomes (compliance and adherance)
- ER visits/hosp. Admissions Counted, identify reason, followup
- Conversations re EOL, hospice, palliative care
- Disease and Symptom management steps, coaching and counseling documented every time

What is Real Reform in Oncology?

- A change in Perspective (Total Spend vs Drugs)
  - Affects software
  - Affects reimbursement
  - Affects Quality Perception
- Focus on the Basics
  - It’s not about the drugs, but the medical decision-making
  - Nationally accepted standards of evidence
  - Documentation (Proof, Outcomes, and Information)
- Collaboration fastest route to success, but trust needed
Summary

- Oncology is about far more than drugs (75% +)
- Window of opportunity for employers/payers and MDs
- Effective, evidence based tools that work in concert with care providers are now available BUT credibility is critical
- Medicare has added challenges, not solutions
- Care and Insurance is Local
- Collaboration vs Collision
- We can't afford everything, evidence helps to draw lines
National Association of Managed Care Physicians (NAMCP)

The mission of NAMCP is to improve patient outcomes by providing educational material, evidence-based tools and resources to medical directors from purchasers, plans and provider systems. NAMCP works with medical directors to identify and strategically position our industry to respond to the various opportunities and challenges on the horizon. We support initiatives empowering medical directors with information they need to make healthcare decisions and promote healthcare quality.

NAMCP Member Medical Directors include:

- Health plans (HMOs, PPOs)
- Employers (Purchasers)
- Medical Groups
- Hospitals
- Government and Military
- PHO’s, IPA’s, MSO’s
- Integrated Healthcare Delivery Systems
NAMCP Medical Directors Oncology Institute

- The impact of cancer in managed care continues to be a significant factor in the medical loss ratio. Due to the advances in early detection and treatment of cancer, people are living many years after a diagnosis.
- In 2004 about 11.1 million people with previous diagnosis of cancer were living in the United States. Approximately 65% of people diagnosed with cancer are expected to live at least 5 years after diagnosis.
- Cancer, while distinctly different, is treated as a Chronic Illness for many cancer survivors.

NAMCP Medical Directors Oncology Institute

- The purpose of the Medical Directors Oncology Institute is to provide information and resources to Medical Directors from Purchasers, Health Plans and Provider systems about Cancer and open lines of communication with practicing Oncologists.
- The Institute is led by an Executive Leadership Council of Medical Directors from Purchasers, Plans and Provider systems. The Council is chaired by Alan Adler, MD of Independence Blue Cross. The Council will oversee the direction of the NAMCP Medical Directors Oncology Institute.
Oncology Institute Strategy

- 2009 - 2010 – build infrastructure
  - ELC Council
  - Web Resources
  - Oncology Institute Conference Track
- 2010 – 2012 – build relationships and core
  - Consulting support
  - Corporate Partners expansion and engagement
  - Oncology Partners engagement (COA, NCCN, ASCO, ACCC, Onpoint Oncology)
  - Visibility – internal (ediscussion/webinar) and external (Eye For Pharma)
- 2012 – 2013
  - COA Cost of Cancer Study
  - NAMCP Medical Directors Guide: Oncology
  - NAMCP Drug Delivery Impact Study
  - Expand Resources, Research, Relationships, Results

Oncology Institute Research

- Annual NAMCP Oncology Institute Survey
- Oncology Total Cost of Care
  (Avalere/COA/Participating Members)
- Oncology Drug Delivery Impact Study (Onpoint Oncology, Improve Rx and sanofi)
NAMCP Medical Director’s Guide: Oncology

Subtitle: The 2012 Oncology Landscape, and How Oncology Trends and Management Challenges Will Affect Medical Directors of Plans, Purchasers and Providers, and NAMCP Strategies to Address These Issues

• Feb 2013 Supplement to Journal of Managed Care Medicine
  • [http://www.namcp.org/Journals/JMCM/Articles/16-1/PullDowns/Info%20JMCM_16-1_Supplement.htm](http://www.namcp.org/Journals/JMCM/Articles/16-1/PullDowns/Info%20JMCM_16-1_Supplement.htm)
Overview

- Avalere analyzed data for the 2008-2010 period from four health plans that submitted claims for patients diagnosed with cancer
- Avalere estimated total costs of care for cancer patients managed in the office setting versus a hospital outpatient department (HOPD)
- The results compare average costs of a treatment episode from the initiation of chemotherapy or radiation therapy
  - Costs include plan and member payments
  - Costs potentially include treatments unrelated to cancer therapy
- We also risk-adjusted the results for the influence of:
  » Patient age and gender
  » Patient prior history of cancer
Chemotherapy Key Findings

- **Chemotherapy**: Patients on chemotherapy being managed in a HOPD have higher episode costs compared to patients managed in an office setting
  - Regardless of the length of the episode, patients receiving chemotherapy in a HOPD cost 24 percent more than patients receiving chemotherapy in an office
  - Patients with chemotherapy episodes lasting full 12 months and managed in a HOPD cost $35,600 more than office-based patients
  - Patients with chemotherapy episodes lasting only 30 days and managed in a HOPD cost $3,100 more than office-based patients

Radiation Therapy Key Findings

- **Radiation therapy**: Depending on the treatment duration, episode costs for patients receiving radiation therapy in a HOPD are lower or higher compared to episode costs for patients receiving radiation therapy in a freestanding location
  - Patients with radiation therapy episodes lasting up to 60 days (2 months) and managed in a HOPD cost between $800 and $1,700 more than patients managed in an office
  - Patients with radiation therapy episodes lasting full 3 months and managed in a HOPD cost $3,000 less than office-based patients
  - Across different cancer types, patients are managed in the two settings at approximately the same rate
key findings

- About 1 in 10 cancer treatments have variations in treatment between the original planned dosing and the actual day of treatment for the most common cancers: breast, lung, colon and prostate
- Over 90% of those variations in treatment result in the planned dose not being given on the day of treatment
- The rest of the variations result from dose increases or dose decreases
- If drugs are pulled on the day of treatment from a general inventory maintained by the cancer provider (Direct Acquisition Model), only those drugs which are actually used are billed to the health plan by the cancer provider, so no waste of drug in comparison to the original prescription occurs.
- If drugs are delivered to the cancer practice for administration based upon the original planned prescription by the cancer provider (External Delivered Model), they are billed out to the health plan by the external vendor upon shipment, not upon actual utilization for the patient
Key Findings – cont.

- If drugs are delivered from an external vendor to the cancer practice for a specific patient under the planned prescription and are not used for that patient – those drugs cannot be used for another patient, nor returned...they must be handled as “waste” and discarded by the cancer provider, resulting in a cost to both the health plan and the provider, in addition to the cost of the drugs actually used for treatment of the cancer patient.

- Based upon the results of this study, on a conservative basis, the cost of such potential “waste” to the health plan (in addition to the drugs actually used for treatment) under a External Delivered Model, could reach about $5,000 per treating physician, and are possibly significantly higher under less conservative assumptions.

- There is a potential high impact of “waste” dollars in drug use even resulting from low (under 10%) variations resulting from same day treatment changes – for both chemotherapy drugs and ancillary drugs that are delivered to the cancer provider for use, but that “waste” does not occur when cancer drugs are used from within the cancer provider’s own acquired inventory.

- Drug shortages are a significant issue in oncology today, and delivery policies that cause large numbers of unused drug to be destroyed would only exacerbate cancer drug shortages.

Summary

- Management of costs in cancer is critical to health plans

- significant potential financial costs for payers under a shift to a External Delivered Model before the costs of the drugs actually used in treatment for the patients.
  - Conservatively, almost $5,000 per treating oncology provider
  - conservatively, at least one in ten cancer treatments for the top four cancers

- Slight Variations can lead to High “Waste”
Summary – cont.

- Potential high dollar impact to payers even if there are fairly low (under 10%) variations in drug use resulting from same day patient health status changes.
- Many chemotherapy drugs observed in this study have notable rates of variation from planned doses – most between 10 and 20% and some even as high as 100%.
- In lung, prostate and colon cancers, there is even a higher potential dollar impact on health plans from variations in ancillary drugs used to support high density chemotherapy administration than there is in the chemotherapy drugs used for those cancers.
- Ancillary and chemotherapy impact is fairly equal for breast cancer treatments. – yet ancillary drugs are more likely to be considered as candidates for movement to Delivered Drug Models through a specialty pharmacy.

Implications for NAMCP members

- Potential for unintended high dollar costs
- Evaluation of specific strategies related to delivered drug models and acquired drug models
- Seek increased collaboration with providers to develop coordinated programs that minimize potential waste
- Ask providers about current observed “waste” under existing delivered drug models
- Consider delivery times and quantities shipped and possible impact on “waste” from current vendors
Thank You, and Good Luck
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