

# Relooking at Value Driven Oncology Management A Purchaser Perspective

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**NCODA**

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Michael Thompson

[Mthompson@nationalalliancehealth.org](mailto:Mthompson@nationalalliancehealth.org)



# National Alliance Coalition Members



**50 Coalitions Supporting 12,000+ Purchasers, 45+ Million Americans, 300+ Billion Dollars of Medical Spend**

# The National Alliance

## National Alliance Coalition Members

### Our Unique Value Together

- National/Regional Structure
- Distributed Change Agents
- Deep & Diverse Healthcare Expertise
- Broad Relationships
- Voice of the Purchasers



**50 Coalitions Supporting 12,000+ Purchasers, 45+ Million Americans, 300+ Billion Dollars of Medical Spend**

# Oncology – A Growing Focus of Purchasers



***Oncology Purchaser Advisory Group to provide  
“Voice of the Customer”***

# Oncology – A Growing Focus of Purchasers

- Advances in cancer care have significantly improved patient outcomes -- the cancer death rate in the United States fell by 25% between 1990 and 2014<sup>1</sup>.
- The cost of these advances pulls the value equation in the opposite direction
- The cost of treating cancer over four years can range from \$101,000 for breast cancer, to \$165,000 for colorectal cancer to \$282,000 for lung cancer<sup>2</sup>.

<sup>1</sup>See: <https://www.cancer.gov/about-cancer/understanding/statistics>

<sup>2</sup>Milliman Research Report, A Multi-Year Look at the Cost Burden of Cancer Care, April 11, 2017, p. 9.

## Oncology – A Growing Focus of Purchasers

### Key concerns for purchasers

- Ensuring that newly-diagnosed members with cancer have timely access to appropriate care with limited obstacles and barriers
- Advances in cancer treatment can add an unwelcome level of financial burden to a course of treatment
  - ...yet timely access to objective, current information about the disease and attendant costs is not readily available*
- Balancing quality/improved cancer care outcomes while keeping a prudent eye on costs
  - ...yet early identification/screening rates could be improved*
  - ...yet transparent utilization, cost and quality information is not routinely collected and reported to plan sponsors and members*

## Oncology – A Growing Focus of Purchasers

### Evolving Cancer Patient Support Capabilities

- Access to clinical trials
- Cancer Teams/PCMH/COEs
- Genetic testing & Personalized Medicine  
- immunotherapy including immune cell gene therapy (CAR T-cell therapy)
- Genetic risk testing and counseling
- Clinical guidelines and pathways for use of drugs off-label
- Advance care and survivorship planning
- Palliative care (with curative intent)
- Financial counseling
- Standardized Core Quality Metrics
- Pain Management/Complementary Alternative Medicine (CAM)

### Renewed Emphasis in Mature Programs

- Hospice
- Return to work
- Site of care optimization
- Patient navigation
- Integrated psychosocial services
- Access to EAP, disability benefits

# eValue8 – Accelerating Supply Chain Improvement

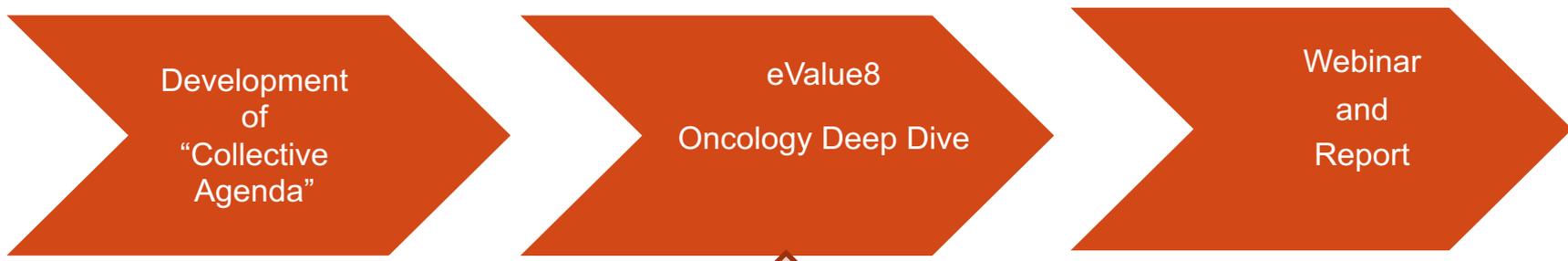
- For more than 15 years, eValue8 has set consistent, evidence-based, employer-verified priorities for health plan performance
- Measured the same way across vendors and across geographic boundaries
  - Integrated with NCQA, CDC, CPR, etc
- Assesses how health plans:
  - Improve and maintain the health of members
  - Support health care providers to improve care
  - Drive out waste and improve value
- Identifies strengths and opportunities for improvement

## *2018 Deep Dive Modules*

- *PBM Assessment*
- *Mental Health*
- *Oncology*

# National Alliance Oncology Initiative

“Cancer” identified as a topic of interest to follow deep dives on Mental Health and Specialty Drugs



<u>Oncology Advisory Team Sponsors</u>	<u>Oncology Advisory Team Coalitions</u>	<u>Subject Experts</u>	<u>Purchaser Advisory</u>
Cancer Treatment Centers of America	DFWBGH	NCCN	Orange Co. Public Schools
Genentech	FHCC	Consultants	Pitney Bowes
Merck	GPBCH		.Segal Consulting
	HC21		The Board of Pensions of the Presbyterian Church (U.S.A.)
	NEBGH		Wyoming School Boards Association Insurance Trust
	PBGH		

## eValue8 – Oncology Deep Dive

- Purchaser, Coalition, Sponsor and Expert input led to “Collective Agenda”
- RFI released in April with responses submitted in June
- Results shared with Steering Committee and Purchaser Advisory Committee to identify:
  - Opportunities to educate the marketplace
  - Areas where health plans need to “up their game”

# eValue8 – Oncology Deep Dive

## Respondents

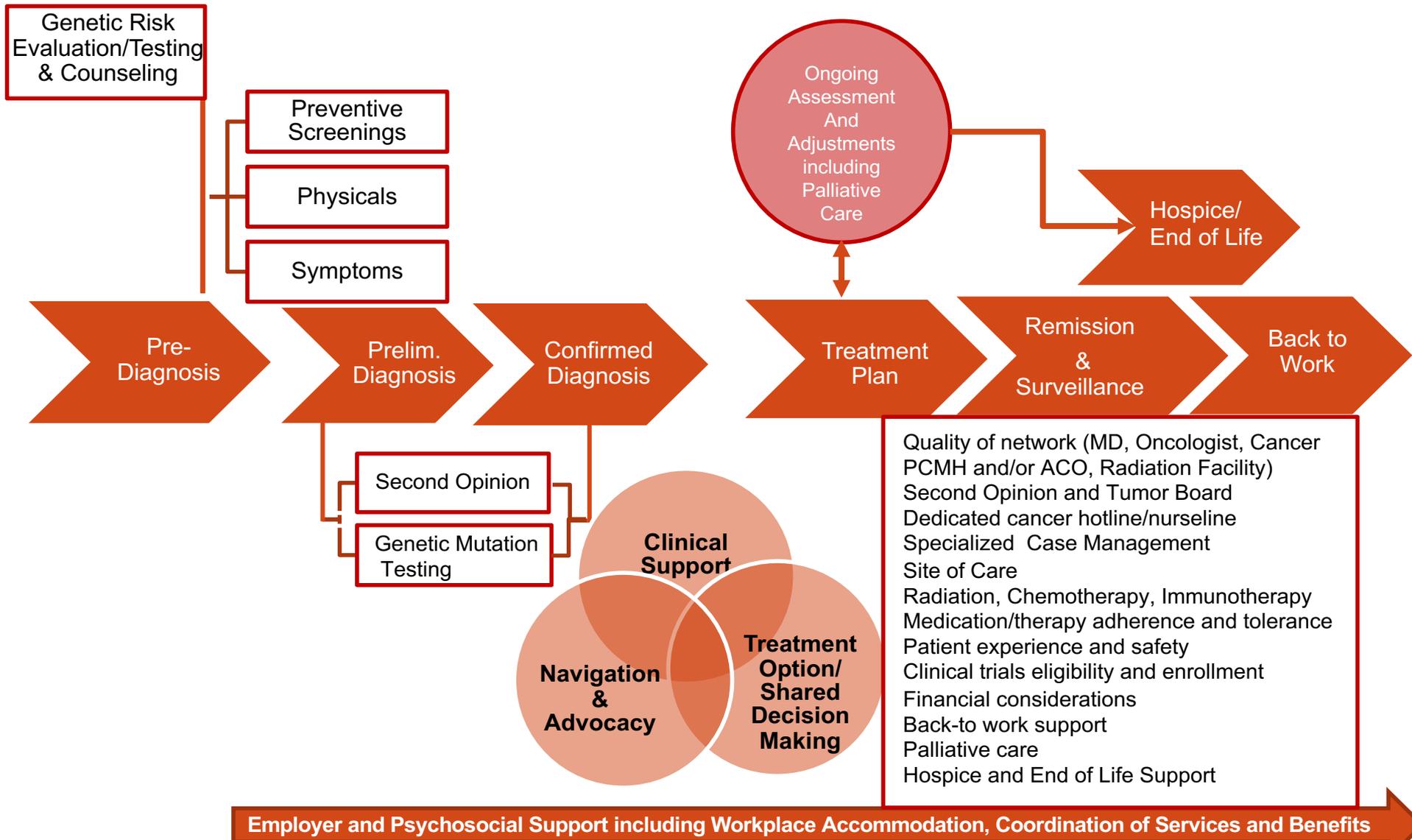
- Aetna
- Anthem
- Cigna
- Kaiser (WA)
- UnitedHealthcare

## Represented Lives (millions)

Segment	Fully-Insured	Self-Funded	Total
Commercial <sup>1</sup>	18.5	56.9	75.3
Medicare <sup>2</sup>	17.7	-	17.7
Medicaid	14.2	0.9	15.0
<b>Total</b>	<b>50.4</b>	<b>57.7</b>	<b>108.1</b>

<sup>1</sup>Includes 264,000 lives for which oncology benefit is carved out  
<sup>2</sup>Includes AARP and Part D lives

# Overview of Patient Journey



# eValue8 – Oncology Deep Dive - Identification

## HEDIS Cancer Screening Results



HMO	A	B	C	D	E
Cervical Cancer Screening	Yellow	Yellow	Light Blue	Light Green	
Breast Cancer Screening	Light Green	Red	Light Green	Light Blue	
Colorectal Cancer Screening	Dark Green	Red	Light Blue	Light Blue	
PPO	A	B	C	D	E
Cervical Cancer Screening	Yellow	Yellow	Yellow	Yellow	Yellow
Breast Cancer Screening	Yellow	Yellow	Yellow	Yellow	Yellow
Colorectal Cancer Screening	Yellow	Red	Yellow	Yellow	Yellow

	25th	50th	75th	90th
Cervical	70%	75%	78%	81%
Breast	68%	71%	76%	80%
Colorectal	54%	60%	66%	72%

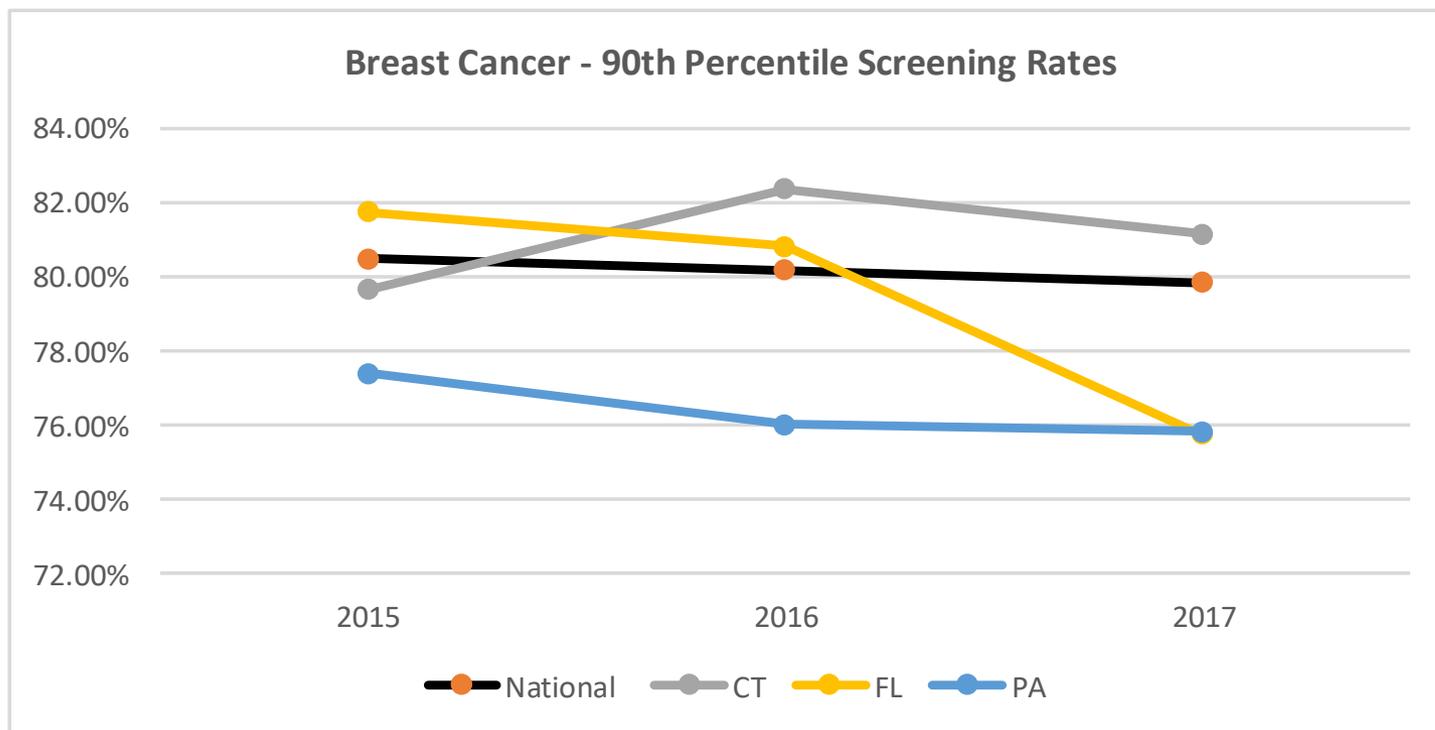
**National cancer screening rates in PPOs are all below the 50<sup>th</sup> percentile**

*The screening rate for breast cancer varies from a low of 57% (PPO in WY, HMO in NY, TX) to a high of 88% (HMO in Mid-Atlantic). The highest breast cancer screening rate for a PPO was 80%*

Source: Respondent & NCQA Quality Compass 2017

# eValue8 – Oncology Deep Dive - Identification

## Breast Cancer Screening Rates (90<sup>th</sup> percentile rate for 3 markets)



**Considerations:** Trending and geography are more relevant; however change in measure definitions make trending challenging

**Recommendations:** Ask for HEDIS rates in your markets especially in PCMH/ACO populations

# eValue8 – Oncology Deep Dive - Identification

Evidence-based Diagnosis - All plans cover genetic testing, but there is variation in how they encourage genetic counseling (GC)

## Considerations

- Not all genetic tests require counseling – less applicable in the case of testing that will inform targeted immunotherapy versus testing that will inform individuals and their family members about potential risk of future cancer development

## Recommendations

- Discuss with Plan best strategy to ensure appropriate genetic counseling

# eValue8 – Oncology Deep Dive - Identification

## *Supporting Use of Appropriate Testing/Screening*

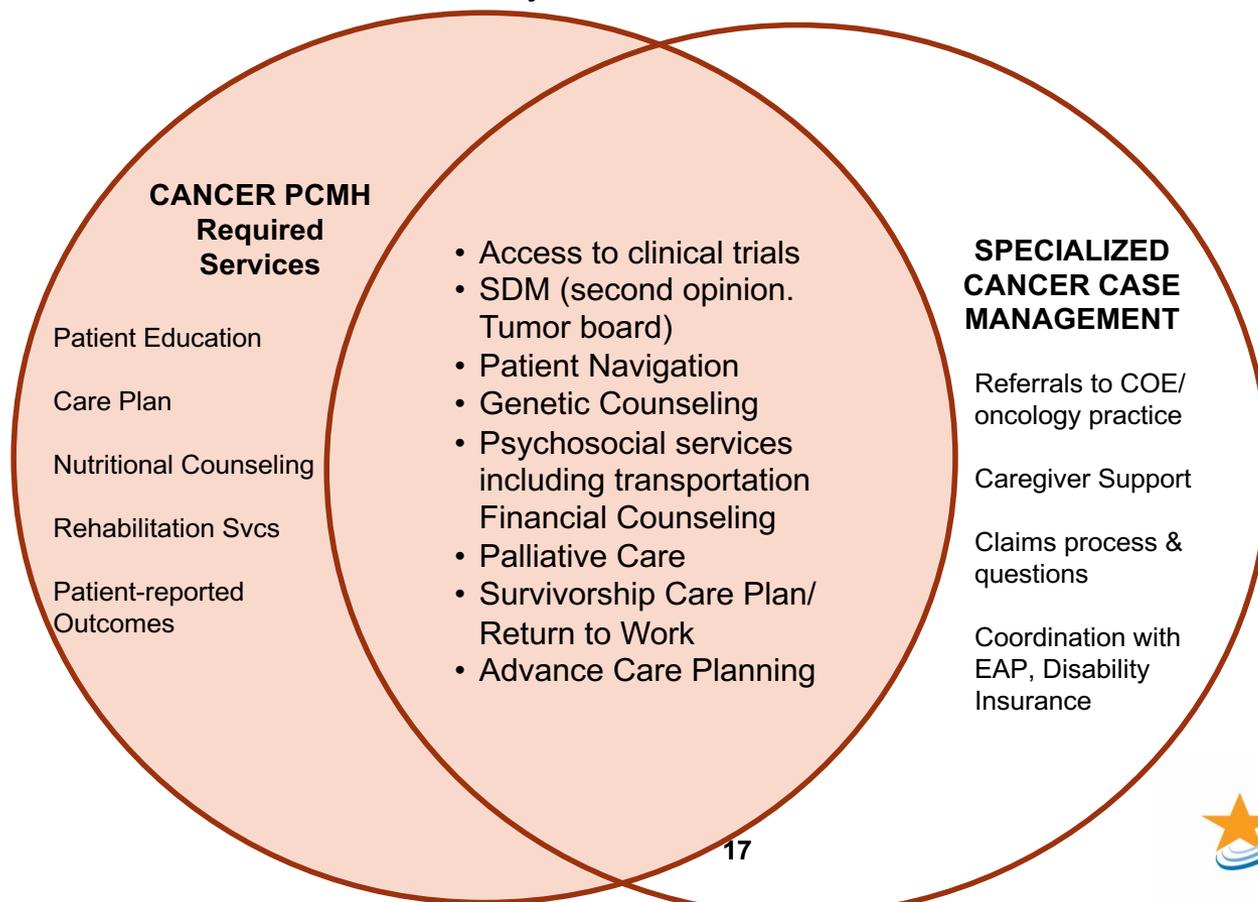
<b>Support Provided</b>	<b>Use of Diagnostic Agents</b>	<b>BRCA-related Risk Assessment, Genetic Counseling &amp; Testing</b>	<b>Genetic Screening</b>
Incentive Payment			
Contractual / Employment Requirement	C,D	C	C
Feedback Reporting	C	C	C
Web-based decision support for guidelines/pathway and/or decision support integrated w/ EMR	A,C,D,E*	A,C,E**	A,C,E
Other	B	B,D	B,D

**Recommendations:** Ask Plans to provide “active” support for use of appropriate tests such as use of incentives, contractual/employment requirement and feedback reporting

\*\*For fully-insured only, PA for self-insured lives

# eValue8 – Oncology Deep Dive – Support & Access to Care

- Most respondents provide COE, Cancer PCMH and Specialized Case Management
- Overlap of services between Cancer PCMH and Specialized Cancer Care Management
- Inconsistent scope & depth of offerings
- Attendance at Tumor Board is rarely offered



# eValue8 – Oncology Deep Dive – Support & Access to Care

## Considerations

- Developments in cancer care have had a dramatic effect on employees and employers – complex treatments, return to work, long term chronic management of previously fatal conditions
- Unless coordinated and comprehensively offered, evolving offerings may lead to delayed/fragmented care
  - Cancer PCMH /Cancer Care Teams
  - Specialized Cancer Case Management
  - Cancer Center Patient Support programs
- Clinical and mortality data necessary for assessment of cancer care value are not routinely available
  - End-of-life programs (palliative, hospice care) can provide improved quality of life and health care value

# eValue8 – Oncology Deep Dive – Support & Access to Care

## Recommendations

- Demand health plan commitment to “Patient Centered Cancer Care” matching patients with the best cancer care support option available to them (whether plan-, provider/cancer center- or third-party-sponsored)
  - Improve Patient Decision Aids with Shared Decision Making/Treatment Option Support tools
- Assess Cancer Care Program offerings based on the extent to which they provide new, frequently needed services specific to cancer patients
  - Require health plans to report by “offering” (cancer PCMH, COE, Specialized CM) on percentage of patients participating, as well as number and type of interactions
- Improve EOL support program and activities to support affected member and their family members
  - Collect data on date of death and events near the end of life (ER visits, late admission to hospice, chemotherapy, ICU admission)

## eValue8 – Oncology Deep Dive – Appropriate Care

### Key Areas of Focus:

- Cancer Treatment
  - Personalized Treatment
  - New Expensive Drugs
  - Site of Care
  - Use of Clinical Pathways/Guidelines
  - Pharmaceutical Management
- 
- The most common vehicle plans use to support appropriate care is web-based decision support (passive)
    - Incentive payments and feedback reporting is rarely used

# eValue8 – Oncology Deep Dive – Appropriate Care

## Considerations

- The site of care chosen can drive significant differences in the cost of cancer care. Milliman\* reported that the cost of chemotherapy can vary by 30% to 50% between a physician's office and a hospital outpatient setting
- Given use of Cancer PCMHs and COEs, it is unclear if differentiating Plan use of Clinical Pathways versus Guidelines should be factor
- None of the Respondents included use of imaging, surgical intervention, site of care, palliative and EOL care and post-treatment surveillance in Pathways

## Recommendations:

- Ask Plans to provide stronger encouragement for appropriate use of cancer treatment, personalized medicine and new expensive drugs such as use of incentives, contractual/employment requirement and feedback reporting

# eValue8 – Oncology Deep Dive – Pharmaceutical Management

***Advances in the science of cancer care have increased the cost and effectiveness of treatments and increased permitted off-label use of chemotherapy agents***

- Plans are virtually uniform in that 4 of 5 plans require prior authorization for off-label use based on a Medicare-recognized source; one did not specify source(s) used, but did establish policies through quarterly P&T committee meetings
- Most have not automated “one-off” exceptions for self-funded or fully-insured business, but two have automated exception
  - hard coded into claims system
  - lifetime approval processes at point of service
- Only one plan had major difference in % claims with PA between fully and self-insured

**% of claims paid in 2017 for drugs used for cancer treatment that were subject to PA**

Plan	Fully-Insured	Self-Funded
A	<5%%	<5%%
B	25%-<50%	<25%
C	<5%	<5%
D	50%-<75%	50%-<75%
E	75%+	75%+

- Percent of claims may not reflect Rx claims from both medical and pharmacy claims
- Numerator may include entire book of business not just the customers in the oncology program

## eValue8 – Oncology Deep Dive – Pharmaceutical Management

- Most require accreditation of pharmacies that dispense specialty pharmaceutical products.
  - URAC and Joint Commission are most commonly required accreditations
- Most use PA or channel management to encourage the use of the appropriate source of dispensing (i.e., hospital vs. community-based vs. PBM) for cancer drugs among providers
- Only 2 respondents have outcomes-based contracts; another respondent is having discussions
- Only one respondent monitors the volume of prescriptions for oral cancer drugs that are not filled but information is not routinely reported to Employers
  - All respondents assist members in obtaining manufacturer or foundation provided specialty drug copay assistance
  - None of the respondents monitor the volume of patients who discontinue chemotherapy due to cost;
  - only one assesses the need for financial assistance when a patient's out-of-pocket costs are a barrier to adherence to drug therapy

# eValue8 – Oncology Deep Dive – Pharmaceutical Management

## Considerations

- Plans using NCCN/other approved guidelines need clinical information that's hard to get and this can affect turnaround time (TAT)
- Balancing appropriate use and faster access to needed medications needs continued consideration and dialogue among all stakeholders
- Members need to be aware of which medications are covered on formulary and/or under medical benefit –
  - Where member receives cancer treating agents (oral and/or injectable) that are not on Preferred Drug List (PDL) while undergoing treatment at an in-network CoE/hospital/facility, they likely will be responsible for higher cost share
- Outcomes-based contracting for oncology medications is very much at an infancy stage
  - A big barrier is Plans' /PBMs' inability to implement and to measure outcomes

# eValue8 – Oncology Deep Dive – Pharmaceutical Management

## Recommendations

- Insist that Plans/PBMs implement a process to identify drugs requiring frequent PAs with high percentage of approvals by prescriber and discuss necessity of those with you
- Insist that Plans and PBMs work with clinicians to expedite receipt of needed clinical information for PA decisions
- Ask Plans and PBMs to review pre-authorization protocols with you including process for updating
  - On a quarterly basis, review drugs on PA lists that are frequently reviewed by approval status, turnaround time for PA, denial rates for PA
- Ask Plans/PBMs to monitor for, and assess reasons for non-adherence
  - Use PQA specifications on monitoring primary non-fulfillment
- Discuss strategies to mitigate catastrophic costs where member receives cancer treating agents that are not on Preferred Drug List while undergoing treatment at an in-network CoE/hospital/facility
- Discuss what oncology products could be included in outcomes-based contracts and to update/include you in discussions for products of interest to you

# eValue8 – Oncology Deep Dive – Quality & Performance Management

## **Oncology Network and Radiation Facility Selection Criteria**

- Criteria beyond Board Certification rarely used in selecting networks & facilities for cancer care

## **Centers of Excellence**

- Only one requires COE hospitals to have NCI-Comprehensive Cancer Center Designation.
  - It also considers 5-year survival data by type of cancer and requires regular tumor board sessions and CAHPS Quality Measures from the Cancer Care Survey
- Only one considers but does not require all listed accreditations/ designations.
  - It does require one of the listed quality outcomes – frequency of hospital-acquired infections

## **Cancer Patient Centered Medical Home (PCMH)/Cancer Medical Team**

- Health plans vary in their adoption of Cancer PCMHs
- The four Plans that offer PCMH vary widely in standards required and type of support
- None of the Plans require that oncology PCMH provide a patient portal or have population health assessment

# eValue8 – Oncology Deep Dive – Quality & Performance Management

## Considerations

Measurement of cancer care presents two very large challenges to health plans:

- Measurement requires data elements that typically are not available to health plans, e.g., patient charts, date of death and, in the case of carved-out pharmacy benefit plans, pharmacy data.
- Keeping pace with rapid evolution of cancer care itself: as diagnosis and treatment modalities change, so must the metrics. Clinical Outcomes are more important than participation in accreditation/credentialing program
- Some accreditation/designation programs may include outcomes criteria, e.g., the NCI Comprehensive Cancer Center Designation
- Not all cancer care require COEs
- Opportunity to raise the bar by using new measures as standards for PCMH/COE/radiation facilities

Payment innovation in oncology lags behind what is being done on other areas:

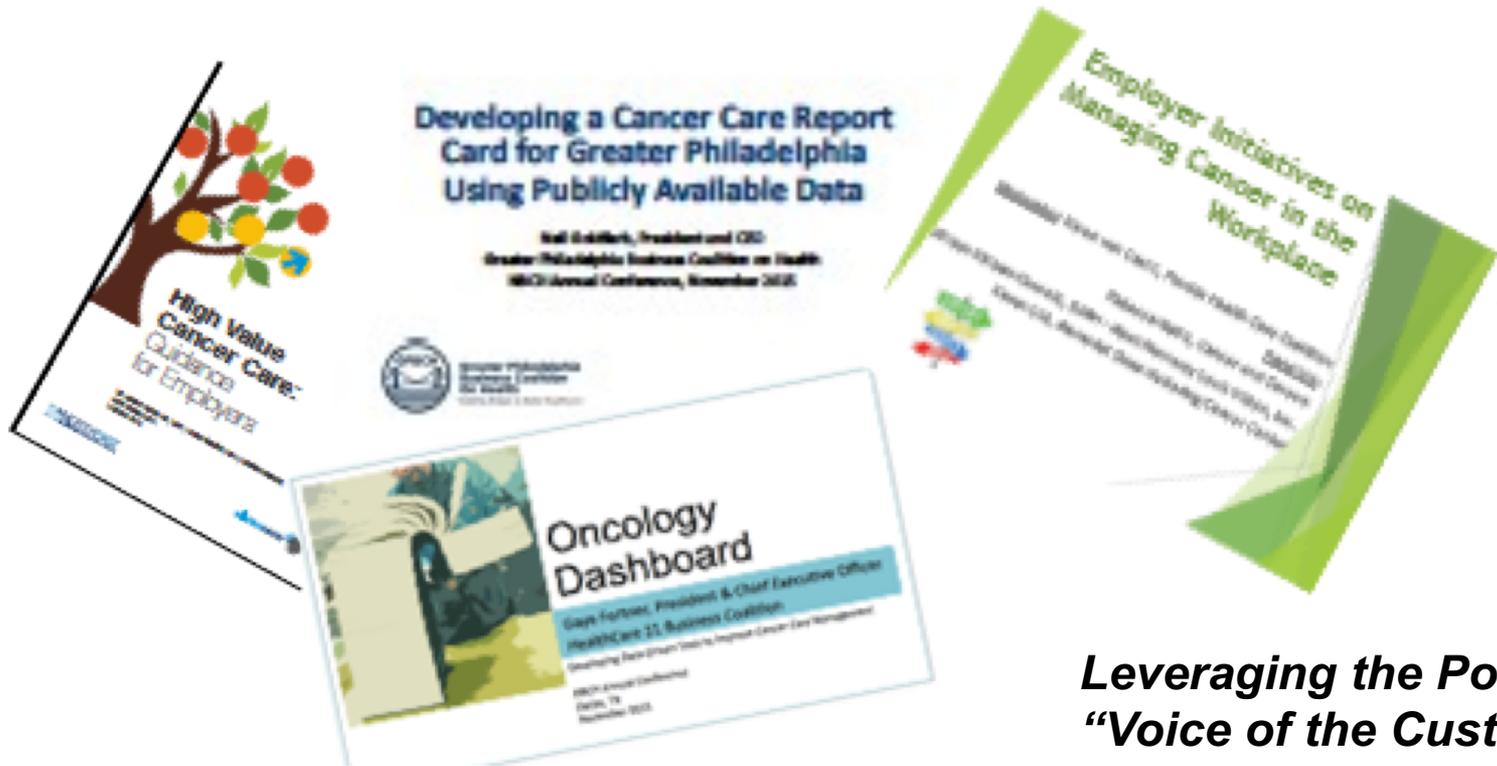
- Current payment transformation efforts focus more on screening than on treatment
- Models focus on rewarding desired behavior as opposed to penalizing outliers
- Diversity of cancer patients presents a challenge for episode/bundled payments

# eValue8 – Oncology Deep Dive – Quality & Performance Management

## Recommendations

- Ask for specific criteria beyond credentialing and Board certification they use for selecting their oncology networks, COEs and radiation facilities/providers
  - consider patient safety data e.g., chemotherapy and/or radiation overdose
  - Look for quality information to be displayed in directories
- Probe beyond availability of Cancer PCMHs - ask for details of Plan standards, required services and Plan-provided resources for their Cancer PCMHs
- Insist that Plans implement measurement-based care, e.g., Proportion admitted to hospice for <3 days among its oncology providers, especially those in PCMH and COEs
  - Develop timeline/plan of action for implementation of measurement, feedback reporting and inclusion in payment models
- Investigate collection of mortality data from eligibility disenrollment and/or other sources in order to collect Core Performance Measures that require date of death.
- Monitor payment innovation developments

# Oncology – A New Frontier on Real Value!



***Leveraging the Power of  
“Voice of the Customer”  
To Move the Market***