AVBCC 2013 Steering Committee

Co-Chairs

Burt Zweigenhaft, BS
President and Chief Executive Officer
OncoMed Onco360
Great Neck, NY

Craig K. Deligdish, MD
Hematologist/Oncologist Oncology Resource Networks
Orlando, FL

Gary M. Owens, MD
President, Gary Owens Associates
Glenn Mills, PA

Linda Bosserman, MD, FACP
Medical Oncologist and President, Wilshire Oncology Medical Group Rancho Cucamonga, CA

Douglas S. Burgoyne, PharmD
President, VRx Pharmacy Services Salt Lake City, UT

John E. Hennessy, CMPE
Vice President of Operations Sarah Cannon Cancer Services Nashville, TN

James T. Kenney, Jr, RPh, MBA
Pharmacy Operations Manager Harvard Pilgrim Health Care Wellesley, MA

Kevin B. Knopf, MD, MPH
Hematologist/Oncologist California Pacific Medical Center Sutter Health San Francisco, CA

James R. Lang, PharmD, MBA
Vice President, Pharmacy Services BlueCross BlueShield of Michigan Detroit, MI

Grant D. Lawless, MD, RPh, FACP
Program Director Associate Professor University of Southern California Los Angeles, CA

Douglas M. Long
Vice President Industry Relations IMS Health Totowa, NJ

Jennifer Malin, MD, PhD
Medical Director of Oncology WellPoint, Inc Los Angeles, CA

Thomas A. Marsland, MD
President, Integrated Community Oncology Network (ICON) Orange Park, FL

Patrick McKercher, RPh, PhD
President, Patient Access Network Foundation Washington, DC

Leonard Natelson
Chief Executive Officer Hematology/Oncology Associates of Rockland Rockland, NY
Defining Value in Cancer Care: AVBCC 2013 Steering Committee Report

The AVBCC Annual Meeting experiences exponential growth in attendance and participation as oncologists, payers, employers, managed care executives, patient advocates, and drug manufacturers convened in Hollywood, FL, on May 2-5, 2013, for the Third Annual Conference of the Association for Value-Based Cancer Care (AVBCC). The conference presented an all-inclusive open forum for stakeholder dialogue and integration across the cancer care continuum, facilitating an open dialogue among the various healthcare stakeholders to align their perspectives around the urgent need to address value in cancer care, costs, patient education, safety, outcomes, and quality.

The AVBCC 2013 Steering Committee was held on the first day of the conference to define value in cancer care. The committee was divided into 7 groups, each representing a key stakeholder in oncology. The goal of the Steering Committee was to define value from the particular point of view of each of the stakeholder groups and to suggest how that particular perspective can contribute to the value proposition in oncology, by balancing cost, quality, and access to care to improve overall patient outcomes. The following summary highlights the major points addressed by each group.

Group I: Pathways

Gary M. Owens; Grant D. Lawless; Jennifer Malin: The question of value from the perspective of pathways in oncology is focused on how to decrease care variability to improve clinical outcomes at an acceptable and sustainable cost. Using pathways to eliminate care variability and to improve outcomes should ultimately result in cost efficiencies as well. Pathways must balance (1) population needs, which reflects how healthcare payers perceive the issue of pathways; (2) individual needs, which are dependent on the physician-patient relationship; and (3) societal needs, which involve patient outcomes and cost of care. The key value considerations related to oncology pathways involve:

• Comparative efficacy, which allows us to compare various products and decide which product delivers the best efficacy
• Toxicity, which is directly related to efficacy and is directly related to the value of a product
• Cost, which also must be incorporated into the definition of the value of pathways
• Finally, pathways cannot be universal but must apply to specific populations (ie, population needs); pathways need to apply to 80% or 85% of the population, but there will always be the need to deviate from pathways to meet selected individuals’ parameters.

When discussing value, it is also necessary to ask who sets the pathway; is the pathway a national or a local standard? That is, is the pathway being set up by pathways companies that are in the business of promoting pathways and selling a product, or by a public organization? We raised some of the pros and cons related to national versus regional pathways, whether private or public.

Pro: Pathways developed by national organizations
The goal of implementing pathways is to drive better outcomes and more cost-effective care. For that, we need unbiased comparative effectiveness data on cost and outcomes. Pathways also need to be able to create payment models that align financial incentives across all stakeholders.

**Pro:** Regional pathways, similarly, could be unbiased, and a regional group would be easier to structure and put together to get the right stakeholders across the table.

**Con:** A regional pathway is going to result in variations of care by those regions. Because it will not be at the local level but rather at a regional level, regions may not have the power to drive effective activities that are so essential.

The goal of implementing pathways is to drive better outcomes and more cost-effective care. For that, we need unbiased comparative effectiveness data on cost and outcomes. Pathways also need to be able to create payment models that align financial incentives across all stakeholders, so that they are not inadvertently driving care based on financial drivers. We believe that advocates could provide a supporting role for this by helping to reinforce pathways, because cancer care has evolved to the point where not every treatment choice needs to be available, regardless of cost.

In addition, end-of-life care concepts must be incorporated into pathways. The resources spent on unnecessary care at the end of life can be carefully monitored; they are often used unnecessarily and can better serve other patients who would benefit more from care. End-of-life care must be part of the pathways to prevent futile and potentially unnecessary care, considering the limited resources.

Finally, pathways probably need to include branches to allow for proven precision (or personalized) medicine decisions. But we must insist on “proven” medicine, because many precision medicine tests are directional, or they do not necessarily create decision points. We need to make sure genetic tests can actually do what they promise to do before they are incorporated into pathways. Once they are established with evidence, they can be incorporated into the pathways. Therefore, pathways have to be a “dynamic process” that incorporates new products that come to market with appropriate evidence.

**Group II: Reimbursement**

Burt Zweigenhaft; John E. Hennessy; Douglas S. Burgoyne: Our discussion involved current payment methods and what they should be in the future, focusing on 2 key points. We need to move away from the old-school fee for services that are inclusive and bundled to new approaches that will incorporate individual value-added services that are not currently covered and recognized, such as advance care directives, care planning, medication treatment management, drug adherence, side-effect management, and educational services that carry value for patients with cancer. We probably all agree that our current system of payments and reimbursements is not appropriate for the breadth of services that need to be incorporated into appropriate care today, as we need to improve how we pay for services. Recognizing and then scoring or monetizing individual components of care that have clinical utility is the greater part of the value proposition in oncology care tomorrow.

We probably all agree that our current system of payments and reimbursements is not appropriate for the breadth of services that need to be incorporated into appropriate care today.

We are beginning to recognize the great value that multidisciplinary care team members and oncologists can provide in terms of clinical management, diagnostics, and treatment, and not just dispensing drug therapy. So it will be important to measure and score clinical value-added activities to receive reimbursement for additional cogitative services. We need to move to unbundling or decoupling bundling from dispensing drugs, and start to demonstrate the value that oncologists and oncology treatments deliver for patients globally, by breaking the costs apart to recognize the value of each service; for example, administrative services improve outcomes in terms of patient compliance with oral therapies, but that service is currently not being reimbursed.

The provider will have to define what is fair market
value for the additional clinical management services delivered. It is always nontransparent and extremely difficult to recognize the value of the entire treatment continuum when we are bundling so many services into the drug-dispensing margins. One novel idea would be paying a premium reimbursement modifier for the first time that an oncologist treats a new patient versus the eighth or tenth round of treatments. How do we assess the value of these differences in the care continuum, and how should the reimbursement reflect that difference?

We did not come up with the solutions to these questions, but these are the types of questions that should be raised in relation to value and quality of care in oncology. We are, however, in agreement that we must recognize the differences in these services, and it is time to begin to pay for these different services. We need to separate the first encounter with a patient from other components of the treatment, and from reimbursement for drugs.

**Group III: Regulatory/Government**

Jayson Slotnik; Douglas M. Long: How does the federal government define value? The short answer is, it does not consider value in its decisions in oncology. So, our discussion quickly evolved into what the role of the federal government is in terms of value in cancer care. However, although we said that the government does not define value, value is directly related to cost, and the government overall defines value as the lowest cost. But the government and everybody need to take a broader perspective of value so that cost is not the only component of value.

In terms of value, we should be looking at patient care as a total engagement of the provider care and the global episode of care. We think that the Association for Value-Based Cancer Care should drive the conversation around value by making sure that the definition incorporates all related costs of cancer care, not only drug costs, as well as outcomes and measurements; we also need to provide tools to measure the outcomes in oncology. So, the definition of value from a regulatory perspective should include all of these components—total costs, outcomes, and measurements.

Mr Zweigenhaft: The Centers for Medicare & Medicaid Services (CMS), which is responsible for 45% of the patients with cancer in this country, is really the 800-lb gorilla we often talk about in healthcare. CMS truly influences the market, and your group believes that this regulatory body does not know where it is going, and it is not setting the tone in the industry; does this mean that the tone will be set outside of government services? How do you see this evolving?

Mr Slotnik: CMS is a complicated entity, because of the rules that have been written for it by Congress on how CMS can provide access to care. Medicare coverage policies have evolved over time as a result of what Congress has allowed CMS to do in terms of drug coverage (eg, in the case of fail-first drug coverage in Part B, or by trying to shift drugs over to Medicare Part D or vice versa). CMS is trying to limit what it has to pay for. Nevertheless, over the past 7 or 8 years, we have seen a shift toward paying for value by Medicare, paying for what works, and paying for evidence. This began when the Medicare Modernization Act (MMA) of 2003 was passed. It has taken time to implement the MMA, because regulatory bodies, such as CMS, move slowly as a result of the politics around any change in policy, particularly as it relates to cancer care.

Value is directly related to cost, and the government overall defines value as the lowest cost. But the government and everybody need to take a broader perspective of value so that cost is not the only component of value.

But, over time, we will likely start to see more boundaries to expanded access to care. Certain things will be less accessible over time, and we have already seen this in policies evolving to limit what Medicare is paying for, using the approach of only paying for what works; however, CMS must first figure out what works, which complicates things. Sometimes when we know we pay for something that does not work, if we cannot get it there, we do not go back; we just end up with more questions than answers. This is hard to balance.

**Group IV: Advocacy Groups**

Lillie D. Shockney; Patrick McKercher; F. Randy Vogenberg: From an advocacy group's perspective, which represents the patient's perspective, we determined that value has to be very patient-specific: what each individual thinks is important and has value. One patient sees one thing as important, and yet another patient may see that as not being important. Certainly both patients should receive patient-centered care, which is easy to say but not always easy to deliver. And that care should be provided at the right time, in the right setting, and obviously with the right treatment, based on evidence-based medicine. There is a need to develop what we call “a new platform” that can guide patients and physicians in addressing a patient’s life goals.

One of the very first things we should do before we touch patients is to talk to them about their goals, their work, their plans, and find out who the patient is. For
example, if the patient is planning to start a family next year, you need to consider fertility preservation to help her or him to be able to have a family after the chemotherapy. Incorporating the patient’s life goals into the treatment considerations is important.

Value for the patient includes getting decision-making tools. In the case of patients who may become long-term survivors, we need to empower them to be able to participate in the decision-making about their treatment. We must not have treatment done to the patient, but have treatment done with the patient. The same applies to patients with metastatic disease, in terms of decision tools, to give them the power to participate in, and have their voice heard about, their treatment. More treatment does not make it better treatment, especially in the metastatic setting.

A recent study showed that between 40% and 60% of patients with metastatic cancer believe that the chemotherapy they are getting will cure them, which indicates that there is no discussion with the patient.

Value for the patient includes getting decision-making tools. In the case of patients who may become long-term survivors, we need to empower them to be able to participate in the decision-making about their treatment. We must not have treatment done to the patient, but have treatment done with the patient.

We also have to promote survivorship care to begin at the time of diagnosis. We need to be proactive about side effects and try to prevent them, instead of telling patients to expect them. Fatigue is the number one struggle for patients with cancer. The evidence shows that if a patient with cancer is power walking 3 times weekly for 30 minutes, fatigue will be reduced significantly. So why are we not making sure patients do that?

There is also value in patients having a patient advocate, which in most cases would be an oncology nurse advocate who understands the disease and the treatment and can provide education and support, and identify barriers, including cultural or financial barriers.

It is crucial to change the goals of health insurance coverage. Rather than focusing on covering treatment, the value to patients is in coverage for preventive care, which promotes health. There is more value in paying for keeping people healthy than paying for sickness.

Another big value issue for patients (as well as for providers) is continuity of care. Value-based care must ensure that we are delivering care in an efficient way, that it is effective, that we are not overtreating or undertreating, and that patients have access to care, in terms of geography and time. For example, many patients cannot afford to take time off from work to get a screening test. So that patient will not have the test. Geographic access and extended-hours access to a facility can improve overall care.

Finally, quality of life (QOL) must also be included in the patient’s definition of value. When QOL is poor, survival may not be what the patient perceives as value. Patients without QOL often prefer not to survive. Survival without QOL is not the ultimate value for patients.

**Group V: Oncology Practices**

Linda Bosserman; Thomas A. Marsland; Leonard Natelson: Oncology care is provided in academic practices and community practices but 80% of cancer care has been given in community practices. However, many of these practices are being bought up by hospitals that offer the opportunity to reduce fragmented care but will be challenged to maintain the innovation and engagement of entrepreneurial physicians. We believe that we are going to have a culture change in oncology. Until now, practices have been very physician-centric. Most physicians within a private oncology practice have 4 driving principles: (1) they love to practice medicine; (2) they value “cowboy independence” in patient decision-making and in care innovations, which was drilled into all of us in medical school; (3) they have business interests in running the practice; and (4) they are interested in research.

But we now have a shortage of oncologists, and the question is, do we need physicians to run the business and do the negotiations, or do we need them to use their 14 years of training to lead teams that take care of patients, which no one else can do?

We believe that more systems of care are being created because patients want to have integration and focus on their overall health. As we move toward a patient-centered system, we need to remember that patients do not care how their doctor gets paid. Patients want to get the care they need—the right care, at the right time, in the right setting, for the best price. Cancer care is no longer about the doctor, it is about the patient. And it is moving from a focus on treatment at any cost to education and discussions with patients and payers about the overall health impact of care.

The physicians are willing to work in systems, and it does not matter if the system is owned by physicians (as in the Healthcare Partners, IPA), by Kaiser (when the payer owns the system), or by a hospital or hospital system. As systems compete, we are going to have real-world data and outcomes-based care that will allow us to continually refine what is offered to achieve the best value, but the fact
is that patients today want to go into a health system. In California, for example, we have 3 systems in the north: Sutter Health, Catholic Healthcare West, and Kaiser, and some outliers. San Diego also has 3 big systems. And although our big region in southern California is fighting and arguing, everyone is going to come together quickly, because Kaiser has taken a 40% market share in California: this is a clear message from consumers that they want integrated and cost-effective care that is focused on their health, with easy web access to their clinicians, their data, and their individual health information.

In the Medicare Advantage plans in Kaiser, patients do not have a copayment for chemotherapy or radiation. Other Medicare Advantage plans with smaller Individual Practice Associations in California can have up to 20% copays; just recently, annual out-of-pocket maximums have been established. One of my patients with stage I breast cancer said, “If I have a recurrence, I don’t want to have copays. I’m switching to Kaiser.” We are seeing people with private PPO insurance, including professors and business professionals, switching to Kaiser for comprehensive, integrated care; these are people who would not have gone with Kaiser before. This is a culture change, and we all have to reengineer our practices to engage the patient, the payer, and our colleagues. To do that, we need to standardize care, we need to have care and payment integration, and we need to have scale.

It is possible that not every small private oncology practice will have to go out of business, but all practices are going to need some networked resources to empower them.... We are going to have to rethink our systems and put the patient at the center, which is where value is in cancer care.

Our partners in the pharmaceutical companies know what they currently need from a regulatory perspective to get a drug on the market, and they have been able to use data from clinical trial patients on progression-free survival, disease-free survival, and overall survival, with support for significant toxicities to get those drugs on the market. But they do not know where real-world data come into this picture: which real-world data, from whom, and for which comorbidities have what benefits, with what toxicities and preferences for impact on their overall health, especially in advanced terminal diseases. These are all relevant questions.

We need our drug development partners to pay for all the new and expensive drugs and to figure out the value of those drugs with data that matter to patients. The value perspective means that we know what the cost is in relation to all the relevant outcomes and whose outcome is going to be the most important. How can we begin to get honest data to patients? We have had a lot of data provided to doctors, and we have been incentivized to give drugs to patients, but we have not been incentivized to improve health. We are now moving toward improving health. If patients with lung cancer in the real world live about 1 year, what educational materials should be provided to a patient at various ages, with various comorbidities, to discuss a therapy that may delay death but with significant risks of hospitalizations, suffering from toxicities, and the possibility of dying from the therapy? We have been incentivized and trained to focus on treatment using the few patients who might achieve an unusual long-term benefit while overlooking the many who suffer needlessly during the time they have left to live. As was noted in one example, we can reduce patient fatigue during chemotherapy by instituting power walking, which is treating to improve health—not a major focus of doctors.
Most physicians have not been trained or able to focus their teams on the benefits of nutrition and exercise on long-term health, despite all the data we have. We need a different payment system that will recognize the components of care that patients need in these new systems.

Survivorship is just now starting to be addressed by physicians, yet it lowers recurrence risk and improves overall health outcomes. Most women with breast cancer are going to die of heart disease, not cancer. As oncologists, we have been incentivized only to focus on the risk of recurrent breast cancer and not to deal with other health issues, such as lipids, bone density, or cardiac risk that interact with adjuvant therapies to impact long-term health. That’s not treating for health.

Personalized medicine will require teamwork. We need to change the physician role. Young physicians are willing to lead and participate in teams, and they want to practice medicine. They are happy to go into systems, but they need a fair compensation to lead an integrated team, regardless of whether it is with a pharmacist, nurse practitioners, physician assistants, or nurses, who are also undervalued in our system. Nurses are experts at compliance, adherence, patient education, and overcoming barriers for our patients, but when the reimbursements for infusion and drugs were removed, that changed the role of nurses, who are now only administering chemotherapy. Nurses need to be better valued in the system for their knowledge and their skills.

Overall, hospitals consider value not by traditional economic terms of cost versus quality, but value by market share—how many patients they serve, how many doctors they have, the status of the doctors, the size of the hospital, and the hospital’s appeal to the patient, who is seen as a consumer.

We need a different payment system that will recognize the components of care that patients need in these new systems. Our group had many challenges in deciding what the actual outcome end points should be. Until we standardize the data and demand real health outcomes from our care, we will remain challenged in our current delivery models, which are fragmented, with costs that are not sustainable now. As we see systems delivering integrated care with real-world data on health outcomes, we see consumers choosing them. That is stimulating others to come together in systems that can compete better on cost, quality, and care to improve value to consumers. As competition expands, we can all learn from each other as the German systems have done.

**Mr Zweigenhaft:** Do you believe that community oncology will be around in the future, or are we all going to be working in the systems?

**Dr Bosserman:** I think we will have many different models. Healthcare is still regional, but a community practice cannot do it alone anymore. They have to be a part of some system, which is empowered by an electronic medical record system or a network. Telemedicine is going to have a bigger role. I think we will have big integrated systems with managed care, but primary care physicians do not want to manage cancer. That remains the role of the oncologists, and that is cost-effective.

**Mr Zweigenhaft:** Our group agreed that the reimbursement system has to change to recognize the value of nurses to patients. We also need to agree what the diagnostic value is for the patient. Is the first positron emission tomography (PET) scan worth more than the seventy-fifth scan? At a recent meeting’s survivorship session, a woman who had lost her husband to cancer asked, “How many PET scans do you think he had in his last 2 years of life? He had 75 scans. Was the value of the first scan the same as the value of the seventy-fifth scan?” This is a sign of a broken system. We need to move to a system of reimbursement that only pays for value-based care.

**Groups VI: Hospitals**

**Kevin B. Knopf; Craig K. Deligdish:** The ability of hospitals to deliver value is unclear. Hospitals are not focused on value as cost versus quality of care but on value as volume. In northern California, for example, there are 3 main systems: Kaiser has more than one third of the market share; Sutter Health system has 28 hospitals in various foundations and different maturities; and Catholic Healthcare West is still surviving. There are also several academic centers. Sutter Health is looking for larger contracts and is focused on attracting patients with good insurance or Medicare, but not Medicaid. We had difficulty defining what a hospital actually is. The model is different with each system. In Kaiser, a hospital is part of a large staff model HMO, with alignment of outpatient and inpatient healthcare financially. Catholic Healthcare West has a private practice model with some interplay between the oncologists and the hospital system. By contrast, Sutter Health, as well as Catholic Healthcare West, have a traditional hospital model, in which oncologists are separate from the hospital and so are the ancillary services. There is a growing movement toward “Foundation acquisition” of oncology practices in the Sutter Health system.

So, overall, hospitals consider value not by traditional
economic terms of cost versus quality, but value by market share—how many patients they serve, how many doctors they have, the status of the doctors, the size of the hospital, and the hospital’s appeal to the patient, who is seen as a consumer—the traditional “heads and beds” model. Therefore, buying a proton beam therapy machine, for example, to deliver radiation to patients with prostate cancer makes sense, because it gives the hospital status to have this expensive type of radiation, the healthcare system can charge a $50,000 premium per patient for this advanced technology, and it impresses people within the organization and can serve as a marketing tool. The hospital can advertise that it has this advanced type of radiation, with no regard to whether it has true value to the patient or to the payer. Cost is not seen as part of the value equation.

Whether this will change depends on the payment system and on how hospitals and providers will be paid in the future. At present, hospitals are still looking at the number of beds that are being occupied by patients and the number of patients being treated, and in oncology the number of “chairs per person per day” being used for chemotherapy. They are not looking at the cost-effectiveness of a particular chemotherapy regimen as much as how many patients are being treated daily. Hospitals are not yet in the habit of looking at overhead costs or even at patient outcomes.

A landmark development was when Leapfrog partnered with the CMS and another policy think tank to review hospitals based on their CMS violations and made this information available online to patients. The idea is that patients would be able to choose a hospital based on how many (or few) CMS violations it has and would go to the one with the best compliance. But, in many cases, patients still select a hospital based on their health plan.

We wonder when hospitals would start to look at value. We believe that hospitals would not look at value until they are forced to by reporting systems from the public about their outcomes. That may take a while until the outcomes from cancer services are reported, and the outcomes are based on what we can measure and what we, as oncologists, think are important things to measure. The value of these outcomes may not be public knowledge and may not be tracked for a while, even though we have increasingly better information systems. Ultimately, we believe that value lies in patients’ outcomes based on the treatment received.

The model that hospitals are using to define value remains based on the number of daily computed tomography scans, the number of daily PET scans, and the number of patients in the hospital per bed per day rather than the value of the specific procedure or imaging study.

Hospitals will change the way they define value depending on future changes in healthcare, such as the implementation of accountable care organizations (ACOs) or competition among health systems. If systems begin to compete on costs, hospitals may begin to look at them.

Hospitals will change the way they define value depending on future changes in healthcare, such as the implementation of accountable care organizations or competition among health systems. If systems begin to compete on costs, hospitals may begin to look at them.

We had different views on whether pay for performance will become the new payment system or whether it is a failed model. Patients today choose a hospital in part based on their perception of quality of care, which may be affected by the marketing efforts of hospitals rather than on meaningful outcomes. Will that change in the future? How does the patient define quality of care?

This takes us to the providers and the way that they practice medicine today, which is changing, even in oncology. Many physicians today prefer to work in a hospital, where they work fewer hours than in private practice and are paid a set salary. They are not willing to take on administrative responsibilities or any risk. But there is a shortage of oncologists today, and we believe that nurse practitioners will play a bigger role in oncology in the future. Their role in patient care may level out with that of oncologists at some point. It is not clear how this will affect oncologists in a hospital system.

Will hospitals start to tease apart the value of the care provided by oncologists? Evidence shows that the newer generation of doctors increase the cost of care, because, rather than thinking about what is possible, they tend to order many tests, which may reduce the value of care, when the testing is not necessary or is not cost-effective; this depends on the individual physician. This leads us to ask, “Will we eventually begin to measure the value of an individual physician or the value of the cost data?” We don’t have information systems ready to measure that at this point, and it is not clear when this may happen.

**Mr Zweigenhaft:** With regard to hospitals assuming risks, if they are currently focused on the number of patients and the number of “chair time” per day in cancer care, do they have the infrastructure to measure what oncologists do and to deal with risks when the current system falls apart? Are hospitals ready to manage risk?

**Dr Deligdish:** We do not believe that hospital systems
are in a position to manage risk. In most communities, hospital systems drive the relationship between the health plan and the providers, and if they are unwilling to accept risk in the oncology arena, this indicates that they are not ready to assume risk management elsewhere. We are not aware of many situations in which hospitals have created relationships where they have agreed to accept downside risk. Some hospital systems have created relationships with health plans that are based on a profit-sharing type of arrangement, which is a different type of an ACO. These ACOs are specific to oncology (ie, they have no primary care patients), and they are based on a relationship in which the hospital has agreed to provide some services that potentially could measure quality or outcomes for providers who care for patients with cancer.

Another development in hospitals is that, in the past, an oncologist in a private clinic had access to all hospital systems. But recently, hospitals have been trying to capture physicians and restrict them to the specific hospital, where a provider is limited to one system. This is not fully enforced yet, but it could become an issue. This takes us back to the idea that to continue to be a community practice, the practice has to be large enough to be dominant in that particular community so that the hospital system cannot afford to not have the practice as part of their team.

**Group VII: Managed Care Organizations**

James R. Lang; James T. Kenney, Jr; Matthew C. Palmgren: We began the discussion by focusing on risk. We are unaware of anyone taking downside risk in oncology. Oncologists are trying to survive, and some programs involve upside risk, especially related to pathways. There is downside risk for those who do not participate in pathways, because the standard fees have not changed over time, and the only increases are the pathways fees. In addition, inflation reduces payments for providers, but there is no true downside risk. Next, we discussed payment for quality, which for us means payment for HEDIS (Healthcare Effectiveness Data and Information Set) measures, not actual outcomes. Managed care organizations (MCOs) are paying for various markers, which are not the same as true outcomes. MCOs have enough data, or enough collected information, to determine outcomes.

Drug reimbursement is a big issue. Both CMS managed care health plans have been squeezing reimbursement. There are many cases where managed care is driving down reimbursement collectively, forcing providers or patients to buy alternate types of drugs based on cost. Can we avoid this? Blue Cross Blue Shield (BCBS) of Michigan, for example, as well as other plans, increased the payments for generic chemotherapy drugs, so the payment for a small vial of generic 5-fluorouracil, for example, is small, but the overall treatment involves a much bigger reimbursement; that is, many plans are moving away from the “buy-and-bill” model for drugs to the bundling payments model.

**Starting January 1, 2014, BCBS of Michigan will begin to reimburse nurses for managing the patient.**

Starting January 1, 2014, BCBS of Michigan will begin to reimburse nurses for managing the patient. The patients will be identified by the plan, which will add extra reimbursement to the physician’s practice.

We are also seeing a significant increase in outpatient clinic costs. It is difficult for the health plan to try and manage this process, because the plan often has contracts with the hospital networks. When the plans squeeze the system in one place, it impacts the rest of the contracts. The problem is that it is very difficult to isolate the outpatient hospital reimbursement within the totality of the reimbursement contracts.

In addition, plans would like to incentivize home infusion and ambulatory infusion, but this is often very difficult to do. In addition, there is not much effort today to educate patients about infusion, and there are no benefits designed to help patients transition to home or ambulatory infusions.

With regard to drug innovation and companion diagnostics, the main issue is the lack of appropriate clinical data for companion diagnostics, especially in oncology. There is a great need for more data and outcomes related to the use of diagnostics tests in association with specific oncolytics. The problem for health plans is that there is not enough evidence to try to understand the outcomes and make coverage decisions regarding what tests and what downstream drugs should be used and when.

A related topic is comparative effectiveness research (CER). Clearly health plans want CER-based evidence, but, to date, the information coming from this research is not comprehensive enough. A study may compare 1 drug versus another type of treatment or 2 drugs, but not the entire scope of therapies available for the same condition. For example, there are at least 7 major therapies...
for prostate cancer, but the research only compared 2 or 3 treatments. That is not sufficient. Furthermore, there is not enough money to study all of these companion tests. Doing a government-supported comparative effectiveness study for these tests would require approximately $2 billion annually, and who has this type of money?

The role of formularies historically has been seen as getting the right drug to the right patient at the right time. Plans would like formularies to be evidence-based, but that is not always the case, because plans do not have all of the necessary evidence to make decisions based on it. Today, with health plans having 80% to 90% generic drug dispensing rates, or even higher in the case of Kaiser, formularies are going to change their approach to benefits from time to time. To address costs, we sometimes offer coupons for areas that include expensive brands. Currently, formularies have 3 to 5 tiers, and it is difficult to know where formularies will be in 3 years.

The use of prior authorizations is increasing in the medical benefit. Prior authorization is not easy, because plans are not used to dealing with claims data. The data are often not in real time, and therefore may not be accurate, because the claims can come in 3 weeks after the patient received the medication or treatment. Nevertheless, plans are clearly focusing on prior authorization on the medical benefit side.

Mr Natelson: As a representative of small oncology private practices, we are being squeezed by health plans, and they refuse to negotiate an increase with us. Prior authorization is costing us money, but the payer will not increase our reimbursement, even though we have to hire staff to do the prior authorization. This pushes many oncologists to join a hospital, where they will not have to deal with all this. But payers will negotiate with the hospital, because hospitals are a lot bigger and have market share, which makes it necessary for payers to deal with them. But the payer tells the private practice, “if you don’t play by our rules, we are going to not keep you in our network.” It is surprising that private insurance plans do not see that they should help community oncology stay in business, because they are less expensive and deliver quality care at a lower cost.

A level 3 office visit in community oncology costs 60% of what a level 3 visit would cost in a hospital setting. It costs the payer more, but the payer is forcing community oncology to sell out to a hospital. The reality is that hospitals can then put pressure on payers to increase their reimbursement, because hospitals have market share; if the payer is not complying, the hospital will find another payer.

So, the dilemma is why payers are squeezing community oncology out of business, while they end up dealing with a hospital system that is bigger than they are and can therefore put pressure on the payer to increase their fees. How do you balance this gap?

Dr Lang: It is fair to ask how we can keep oncologists inside different plans. One way some plans try to do this is by the use of pathways, as was discussed earlier. Everyone is trying to tie value to pathways, whether it is pay-for-performance pathways, pathways based on the National Comprehensive Cancer Network Guidelines®, or the pathways used by P4Health (by Cardinal Health) in Michigan. What they are all trying to do is bring value by changing the profit margins.

Our current payer system is broken, and we need to fix it. Most of the reimbursement in oncology today is based on drugs. The question is how to take advantage of that in the near future while changing the dynamics of the system later...and paying for value and quality.

Eliminating the margins altogether on drugs will take 5 or 6 years, because we have to come up with a new payment system. Many plans are using generics to adjust the margins. We are adjusting the margins based on the guidelines now, because this helps to use generics in oncology. Our current payer system is broken, and we need to fix it. Most of the reimbursement in oncology today is based on drugs. The question is how to take advantage of that in the near future while changing the dynamics of the system later, after getting rid of all the margins and paying for value and quality, as every group has been discussing here.

Mr Natelson: We need to get away from prior authorization and use pathways to replace prior authorization. Payers should tell community oncology that they are not going to increase their overhead and that they are going to work with the community oncology.

Dr Lang: That is where quality of management comes in. Payers are willing to replace prior authorization with pathways, mostly with pathways that follow the NCCN guidelines. Payers are telling providers that if they follow these pathways they will eliminate the prior authorizations and get rid of some of the administrative overhead that is caused by the payer. The truth is, we need a tool to ensure that doctors and pharmacists follow the best evidence; not all doctors and pharmacists follow the latest information. That is what prior authorization does and what pathways based on clinical guidelines can do.

You are right that oncology is moving so fast, and the prior authorizations are changing almost every 6 months.
because of new evidence, new published research, and new evidence-based guidelines. Health plans have no intention of putting oncologists out of practice, but the system is moving too fast and we need time to adapt to new information. Payers have created some of the problems for oncology practices, but that is not their intention. There is a major shift in the dynamics of oncology. As noted, BCBS of Michigan is rewarding for quality of care in its new program. Providers that are 80% compliant get a 10% increase in payment. For oncologists, this could be up to 20%, and we are paying the increased margin on 13 generics. As mentioned before, on January 1, 2014, BCBS of Michigan is instituting provider-delivered care management fees, which will also pay for oncology nurses, who are not being paid today for their patient management.

The program started with 50 practices 3 years ago, paying for these fees for primary care physicians. A year ago, it expanded the coverage to 400 practices, and they have 400 nurses in the state of Michigan who are employed by these organizations. The third phase will be launched in January by paying these fees to oncology practices. It involves many changes to the practice, such as making nursing appointments and having space for nurses to see patients. This is not bulletproof, and it has taken much work to get started, but it is working and it is a major shift. The payment is on a patient-by-patient basis, and the plan sends monthly reports that indicate which patients are eligible. Again, this is not perfect, but the plan did not pay for these services at all before. It is a start in the right direction.

Value in Oncology

Dr. Owens: Taking this discussion as a whole, 4 words have emerged from every group, identifying 4 major issues that are directly related to the definition of value in cancer care. The first word is change. Everybody here recognizes that the status quo cannot continue, and change looks very different for the various stakeholders. The next word is data. Each group mentioned data, and not just data, but data that can be turned into information that ultimately could be used to make reasonable clinical, economic, and management decisions. The third word is outcomes—understanding what outcomes the specific stakeholder is looking for, how they can be measured, and how to provide for them. Finally, the fourth word is cost. Clearly, cost is the elephant in the room. We know that the current cost trends are unsustainable. We know that we need more value out of what we spend. Cost is a concern for every single stakeholder in this room. Other important words that were mentioned today include quality and access, and they are inherently related to the 4 key concepts we have just discussed.

There are many other common important words or concepts that are relevant to the definition of value in oncology, but those 4 were the ones that registered for me across the entire discussion. This was a very impressive attempt to define value, and the conversation should continue in the future to reflect on new developments in oncology.

Call to Action

• Clinical pathways: Oncology pathways must incorporate the needs of the population, the individual patient, and society at large in determining the best allocation of resources. Pathways must also allow for some degree of variation, and should be informative not only for active treatment but for discontinuing unwarranted treatment. Pathways must always be a dynamic process to adapt to new evidence and to new clinical guidelines.

• Reimbursement: New models for reimbursement in oncology are needed, moving away from fee for service. These models should consider the value of different services, not only of the oncologist but also services related to patient education and management provided by nurses, as well as cognitive services, administrative duties, and other services that are not traditionally covered by insurance, and these should also seek to eliminate waste.

• Regulatory: The government should define value in oncology in a broad way to incorporate quality of care, access, and other significant measures of value, and not only cost, as is currently the case.

• Patient advocacy: The patient’s unique perception of value should be honored, recognizing that value for patients with cancer is not always to extend survival, but rather to maintain quality of life. Patients must also become wiser partners in shared decision-making.

• Oncology practice: Community oncology practices continue to be threatened, largely because of payment and reimbursement concerns; they must therefore reengineer their practice models to meet the changing needs and realities in healthcare overall and specifically in oncology.

• Hospitals: Hospitals that provide cancer care must redefine themselves and their approach to the patient. They must become more transparent and be able to deliver value for patients and for society as their core principle. They must also begin to look at cost and waste.

• Managed care organizations: Health plans must work in collaboration with providers and provide more support and better direction to oncologists. To improve outcomes, payers must be willing to partner with providers to meet current and increasing challenges in oncology.