Realigning Reimbursement Policies for Quality and Value in Cancer Care

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Pay for Performance Summit
Mini-Summit V: Innovative Payment in Cancer Care
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Quality of cancer care is inconsistent

• Up to 1 in 3 people treated with chemotherapy do not receive a treatment regimen that is consistent with current medical evidence and best practices\(^1\)

• People are often hospitalized during treatment because of side-effects which could be avoided by using less toxic treatment regimens and appropriate supportive care\(^2\)

• People frequently receive tests and treatment that they do not need, putting them at risk of side-effects, as well as imposing an additional care burden and cost\(^2\)

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Rising healthcare costs are unsustainable

Median household income
$52,250

Cost of family’s healthcare
$22,030

Employer premium contribution
$12,866
Employee premium contribution
$5,544
Employee expenses
(e.g. deductible, copays)
$3,600

http://www.deptofnumbers.com/income/us/#household; 2013 Milliman Medical Index
New cancer drugs are more expensive . . . and producing less value

13 new cancer treatments approved by FDA in 2012

- Survival extended by 6 months
- Survival extended by only 4-6 weeks
- Average cost of treatment per month: $5,900
Charting New Course for a System in Crisis

Care often is not patient-centered, many patients do not receive palliative care to manage their symptoms and side effects from treatment, and decisions about care often are not based on the latest scientific evidence.

IOM Recommendations to improve the quality of cancer care

• A national quality reporting program with meaningful quality measures
• Improve the affordability of cancer care by leveraging existing efforts to reform payment and eliminate waste
• Reimbursement aligned to reward affordable, patient-centered high quality care
Cancer drugs are one third of cost of cancer care

Oncology Practice Revenue Sources
Towle et al. JOP 2014;10:385-406

Systemic Therapy is One Third of Cost
Anthem affiliated health plans internal data 2013

Reimbursement model must change so that focus shifts to cancer care that is value-based and patient-centered
Our model: a Quality Initiative

The Cancer Care Quality Program provides a framework for rewarding high quality cancer care.

Oncologists participating in the Cancer Care Quality Program will receive additional payment for treatment planning and care coordination when they select a treatment regimen that is on Pathway.

Web-based platform with decision-support for Quality Initiative also improves efficiency of review against Health Plan Medical Policy and decreases administrative burden for practices.

Quarterly quality reports for practices include pathway adherence, ER and hospitalizations, NQF end of life care measures.

www.cancercarequalityprogram.com
Guidelines – very broad and inclusive

NCCN includes 64 platinum-based combinations as guideline-concordant treatment options for first line therapy of non-small cell lung cancer

NCCN Guidelines Version 1.2015
Non-Small Cell Lung Cancer

ADVANCED DISEASE:
- The drug regimen with the highest likelihood of benefit with toxicity deemed acceptable to both the physician and the patient should be given as initial therapy for advanced lung cancer.
- Stage, weight loss, performance status, and gender predict survival.
- Platinum-based chemotherapy prolongs survival, improves symptom control, and yields superior quality of life compared to best supportive care.
- Histology of NSCLC is important in the selection of systemic therapy.
- New agent/platinum combinations have generated a plateau in overall response rate (≤25%–35%), time to progression (4–6 mo), median survival (8–10 mo), 1-year survival rate (30%–40%), and 2-year survival rate (10%–15%) in fit patients.
- Unfit patients of any age (performance status 3–4) do not benefit from cytotoxic treatment, except erlotinib for EGFR mutation-positive patients.

First-line Therapy
- Bevacizumab + chemotherapy or chemotherapy alone is indicated in PS 0–1 patients with advanced or recurrent NSCLC. Bevacizumab should be given until disease progression.
- Erlotinib is recommended as a first-line therapy in patients with sensitizing EGFR mutations and should not be given as first-line therapy to patients negative for these EGFR mutations or with unknown EGFR status.
- Afatinib is indicated for patients with sensitizing EGFR mutations.
- Crizotinib is indicated for patients with ALK rearrangements.
- There is superior efficacy and reduced toxicity for cisplatin/etoposide in patients with nonsquamous histology, in comparison to cisplatin/gemcitabine.
- There is superior efficacy for cisplatin/gemcitabine in patients with squamous histology, in comparison to cisplatin/etoposide.
- Two drug regimens are preferred; a third cytotoxic drug increases response rate but not survival. Single-agent therapy may be appropriate in select patients.
- Cisplatin or carboplatin have been proven effective in combination with any of the following agents: paclitaxel, docetaxel, gemcitabine, etoposide, vinblastine, vinorelbine, pemetrexed, or albumin-bound paclitaxel.
- New agent/non-platinum combinations are reasonable alternatives if available data show activity and tolerable toxicity (eg, gemcitabine/docetaxel, gemcitabine/vinorelbine).
## Variation in outcomes across 1st line regimens for non-small cell lung cancer*

<table>
<thead>
<tr>
<th></th>
<th>Estimated Survival (months)</th>
<th>Grade 3-4 Adverse Events</th>
<th>Any serious AE (Hospitalization)</th>
<th>Deaths on Rx (Deaths due to Rx)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rx A</strong></td>
<td>13.0 <em>(NR)</em> mos.</td>
<td>N/V risk: Moderate*</td>
<td>53% (**)</td>
<td>&lt;1% (&lt;1%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FN + infection: 1%</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Neuropathy: 11%</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Debilitating fatigue: 6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rx B</strong></td>
<td>10.4 <em>(9.6-11.2)</em> mos.</td>
<td>N/V risk: High</td>
<td>35% (**)</td>
<td>7% (1%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FN + infection: 4%</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Neuropathy: ND</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Debilitating fatigue: 5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rx C</strong></td>
<td>11.8 <em>(10.4-13.2)</em> mos.</td>
<td>N/V risk: High</td>
<td>37% (**)</td>
<td>7% (1%)</td>
</tr>
<tr>
<td></td>
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<td>FN + infection: 1%</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Neuropathy: ND</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Debilitating fatigue: 7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rx D</strong></td>
<td>13.1 <em>(NR)</em> mos.</td>
<td>N/V risk: Moderate</td>
<td>** (**)</td>
<td>&lt;1% (&lt;1%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FN + infection: 1%</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Neuropathy: 3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Debilitating fatigue: 4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rx E</strong></td>
<td>13.4 <em>(11.9-14.9)</em> mos.</td>
<td>N/V risk: Moderate</td>
<td>75% (19%)</td>
<td>5% (4%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FN + infection: 4%</td>
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<tr>
<td></td>
<td></td>
<td>Neuropathy: 4%</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Debilitating fatigue: 5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bleeding: 4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rx F</strong></td>
<td>12.6 <em>(11.3- 14.0)</em> mos.</td>
<td>N/V risk: Moderate</td>
<td>** (20%)</td>
<td>** (2%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FN + infection: 2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neuropathy: 0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Debilitating fatigue: 11%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Non-squamous histology; first line platinum based chemotherapy indicated when no EGFR or ALK mutation present  ** Not reported

Socinski JCO 2012; Sandler NEJM 2006:355; Scagliotti JCO 2008:26; Reck Annals of Oncology 2010; Patel 2012
Little variation in patient outcomes but marked variation in treatment cost

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Estimated Survival (months)</th>
<th>Deaths on Rx (Deaths due to Rx)</th>
<th>Cost (4 cycles)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbo/Paclitaxel</td>
<td>13.0 (NR) mos.</td>
<td>&lt;1% (&lt;1%)</td>
<td>$452</td>
</tr>
<tr>
<td>Gem/Cis</td>
<td>10.4 (9.6-11.2) mos.</td>
<td>7% (1%)</td>
<td>$886</td>
</tr>
<tr>
<td>Cis/Pemetrexed</td>
<td>11.8 (10.4-13.2) mos.</td>
<td>7% (1%)</td>
<td>$25,619</td>
</tr>
<tr>
<td>Carbo/nab-Paclitaxel</td>
<td>13.1 (NR) mos.</td>
<td>&lt;1% (&lt;1%)</td>
<td>$24,740</td>
</tr>
<tr>
<td>Carbo/Paclitaxel/Bev</td>
<td>13.4 (11.9-14.9) mos.</td>
<td>5% (4%)</td>
<td>$39,770</td>
</tr>
<tr>
<td>Carbo/Pemetrexed/Bev</td>
<td>12.6 (11.3-14.0) mos.</td>
<td>** (2%)</td>
<td>$64,988</td>
</tr>
</tbody>
</table>

Socinski JCO 2012; Sandler NEJM 2006:355; Scagliotti JCO 2008:26; Reck Annals of Oncology 2010; Patel 2012
US Oncology found pathways associated with same overall survival and 30% lower cost

Outcomes associated with pathways vs. usual care for advanced non-small cell lung cancer

Overall survival by Pathway status

<table>
<thead>
<tr>
<th>Pathway status</th>
<th>3 month</th>
<th>6 month</th>
<th>9 month</th>
<th>12 month</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients (n = 1,409)</td>
<td>0.82</td>
<td>0.64</td>
<td>0.53</td>
<td>0.46</td>
</tr>
<tr>
<td>On pathway (n = 1,095)</td>
<td>0.82</td>
<td>0.65</td>
<td>0.53</td>
<td>0.45</td>
</tr>
<tr>
<td>Off pathway (n = 314)</td>
<td>0.80</td>
<td>0.64</td>
<td>0.54</td>
<td>0.46</td>
</tr>
</tbody>
</table>

Log-rank $P = .867$

12-month cumulative cost by Pathway status

Neubauer M A et al. JOP 2010;6:12-18
Anthem’s Approach to Pathway Development

Data from trials, publications, and compendia for many different patient populations are extracted, reviewed, and analyzed.

Medical evidence is synthesized by national experts into clinical guidelines. Evidence is also used by health plan committees to develop medical policies and utilization management guidelines used in making benefit coverage determinations.

Pathways are a subset of regimens supported by evidence and clinical guidelines and aligned with health plan medical policies. Pathways are intended to be applicable for 80%-90% of patients and are selected based on:

1. Clinical benefit (efficacy)
2. Side effects/toxicities (especially those leading to hospitalizations & impact quality of life)
3. Strength of national guideline recommendations
4. Cost of regimens

WellPoint’s external advisors include ~10 oncologists from geographically diverse academic and community oncology practices who have specific interest in quality of care; 4 are affiliated with NCI-designated cancer centers, 6 with Blue Centers of Distinction, and 6 have served on national committees for organizations such as NQF, ASCO, and IOM to improve the quality of cancer care.

WellPoint Pathways are developed through a rigorous evidence based medicine process and reviewed by external advisors.
Include Pathways for cancers contributing to 90% of chemotherapy spend

<table>
<thead>
<tr>
<th>Tumor Types</th>
<th>Cumulative Chemotherapy Cost %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer</td>
<td>27%</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>45%</td>
</tr>
<tr>
<td>Lung Cancer</td>
<td>56%</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>67%</td>
</tr>
<tr>
<td>Myeloma</td>
<td>71%</td>
</tr>
<tr>
<td>Ovarian Cancer</td>
<td>75%</td>
</tr>
<tr>
<td>Pancreatic Cancer</td>
<td>78%</td>
</tr>
<tr>
<td>CNS</td>
<td>81%</td>
</tr>
<tr>
<td>Melanoma</td>
<td>82%</td>
</tr>
<tr>
<td>Leukemia</td>
<td>88%</td>
</tr>
<tr>
<td>Prostate</td>
<td>~90%</td>
</tr>
</tbody>
</table>

Confidential & Proprietary
Cancer Care Quality Program administered by AIM Specialty

**CLINICAL REQUEST**
Request is made by a Provider via the AIM ProviderPortalSM

**TREATMENT REVIEW**
Treatment request reviewed against an evidence-based regimen library for alignment with health plan medical policy for members in that health plan. Wellpoint's Pathways are based on efficacy - toxicity and cost are also highlighted.

**DECISION RENDERED**
Immediate approval is granted if consistent with plan medical policy. Clinical experts available as necessary for peer-to-peer discussion. Notified if Pathway option available.

**PATHWAY ADHERENCE**
Practice authorized to bill S0353 and S0354 for Treatment Planning and Care Coordination when regimen is on pathway. Quarterly Analytics and Reporting are available.

The WellPoint Cancer Care Quality Program will be administered by WellPoint subsidiary AIM Specialty Health, a separate company.
Treatment planning payments support cost-effective care

Enhanced reimbursement for treatment planning and care coordination will be provided when patient is registered with the Cancer Care Quality Program and treatment regimen in on pathway

S0353 reimbursed $350 once at the onset of treatment
S0354 reimbursed $350 no more than monthly while managing care for an established patient*

S-code billing authorization is triggered through AIM ProviderPortal when practice selects a regimen that aligns with Anthem Cancer Treatment Pathways
Impact of enhanced reimbursement and support for Pathways

Mean Practice Revenue across regimens

without S code $ 3,010 (SD $1,488)

with S code $ 3,943 (SD $1,230)

S code reimbursement decreases variation in revenue across regimens
Initial Participation in Cancer Care Quality Program in Central Region

Participation July-Dec:
- 616 practices
- 5538 patients
- Mean 8.7 pts/practice
- Range 1 to 275

New Chemo Claims Sept-Oct: members registered with CCQP
Anthem’s Model: Value for All Stakeholders

- Quality affordable cancer care
- Reimbursement for providers aligned to achieve desired outcomes
- Encourages innovation