Bundled Payment and Performance Measurement for Cancer Care: The Payer’s Perspective

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Oncologists paid to deliver chemotherapy

Reimbursement model must change so that focus shifts to providing cancer care that is value-based and patient-centered

Challenges to implementation of case rate for oncology that includes drug costs

- Rapidly changing standards of practice
  - Quality measures lack specificity
  - 2 year lag from introduction of new therapy to implementation of QOPI measure
- Variation in case mix across practices
- Impact of drugs on medical vs. pharmacy benefit
- 14 state plans with multiple lines of business - commercial, ASO, Medicare Advantage, Medicare/Medicaid
- Large number of practices and providers:
  - 4500+ in-network hematology or oncology providers
  - 6200+ in-network providers which have any oncology sub-specialty
  - Heterogeneity in practice size, number of providers and payer mix
- Claims systems not easily configured to handle case rates – require custom solutions
One-third of NME approvals by the FDA in 2012 were cancer related

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Active Ingredient</th>
<th>Approval Date</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inlyta</td>
<td>axitinib</td>
<td>1/27/12</td>
<td>Renal Cell Carcinoma</td>
</tr>
<tr>
<td>Erivedge</td>
<td>vismodegib</td>
<td>1/30/12</td>
<td>Basal Cell Carcinoma</td>
</tr>
<tr>
<td>Perjeta</td>
<td>pertuzumab</td>
<td>6/8/12</td>
<td>HER2+ metastatic breast cancer</td>
</tr>
<tr>
<td>Kyprolis</td>
<td>carfilzomib</td>
<td>7/20/12</td>
<td>Multiple Myeloma</td>
</tr>
<tr>
<td>Zaltrap</td>
<td>ziv-aflibercept</td>
<td>8/3/12</td>
<td>Colorectal Cancer</td>
</tr>
<tr>
<td>Neutroval</td>
<td>tbo-filgrastim</td>
<td>8/9/12</td>
<td>Cancer treatment related Neutropenia</td>
</tr>
<tr>
<td>Xtandi</td>
<td>enzalutamide</td>
<td>8/31/12</td>
<td>Castrate-Resistant Prostate Cancer</td>
</tr>
<tr>
<td>Bosulif</td>
<td>bosutinib</td>
<td>9/4/12</td>
<td>Chronic Myeloid Leukemia (CML)</td>
</tr>
<tr>
<td>Choline C 11 Injection</td>
<td>Choline C 11</td>
<td>9/12/12</td>
<td>PET imaging agent for Prostate Cancer</td>
</tr>
<tr>
<td>Stivarga</td>
<td>regorafenib</td>
<td>9/27/12</td>
<td>Colorectal Cancer</td>
</tr>
<tr>
<td>Synribo</td>
<td>omacetaxine</td>
<td>10/26/12</td>
<td>CML</td>
</tr>
<tr>
<td>Cometriq</td>
<td>cabozantinib</td>
<td>11/29/12</td>
<td>Medullary Thyroid Cancer</td>
</tr>
<tr>
<td>Iclusig</td>
<td>ponatinib</td>
<td>12/14/12</td>
<td>CML</td>
</tr>
</tbody>
</table>

QOPI Measures for Adjuvant Therapy for Breast Cancer

- Combination chemotherapy received within 4 months of diagnosis by women under 70 with AJCC stage I (T1c) to III ER/PR negative breast cancer
- Trastuzumab not received when Her2/neu is negative or undocumented
- Trastuzumab received by patients with AJCC stage I (T1c) to III Her2/neu positive breast cancer
- Tamoxifen or AI received within 1 year of diagnosis by patients with AJCC stage I (T1c) to III ER or PR positive breast cancer

ASCO Quality Oncology Practice Initiative
http://qopi.asco.org/Documents/QOPISpring13MeasuresSummary_000.pdf
Tremendous variation in Rx cost according to disease type

Cost of Adjuvant Therapy for Breast Cancer Varies according to nodal, ER, and HER status

<table>
<thead>
<tr>
<th>Drug Cost</th>
<th>Duration of Infused Rx</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ER+ HER2 (-) low risk</strong></td>
<td>$240</td>
</tr>
<tr>
<td><strong>ER+ HER2 (-) intermediate risk</strong></td>
<td>$21,555</td>
</tr>
<tr>
<td><strong>ER+ HER2 (-) high risk</strong></td>
<td>$22,015</td>
</tr>
<tr>
<td><strong>HER2+</strong></td>
<td>$88,135</td>
</tr>
<tr>
<td><strong>Triple negative</strong></td>
<td>$21,775</td>
</tr>
</tbody>
</table>
Oncology Medical Home Pilot

Three Key Components:

☑️ Treatment pathways
☑️ Coordination of care & disease Management
- Comprehensive treatment plan and coordinate care with other specialists
- Proactive telephone support by Oncology RNs
- Evaluate acute events in office (when appropriate) instead of sending to ER

☑️ Palliative Care
- Ensuring all patients understand the goals of treatment
- Systematic assessment for need for palliative care in advanced disease
- Timely referral to hospice
- Advanced directives communicated to all providers

Delivering patient-centered care in oncology requires re-engineering:

- IT infrastructure and decision support
- Protocols for nurse-led symptom management
- Tools to guide patient centered decision-making, symptoms assessment and need for palliative care
- Change in culture regarding palliative care
- Quality and outcome measurement
- Collaborative approach to quality improvement
How to Scale?

- **Support community oncology practices**
  - Increase chemotherapy administration fees
  - Increase practice margin on lower cost generic drugs

- **Treatment planning for episode of care**
  - Pre-authorization of an episode of care
  - Additional authorization for S-code when treatment plan is on pathway

- **Continue to develop Oncology Medical Home**
  - Develop tools and metrics to be able to scale Care Coordination and End of Life Care
Implementation of new evidence-based decision-support tool to streamline approval for episode of care

**Web Portal**
- Practice submits request for episode of treatment via Web Portal
  - Single request instead of multiple
  - Direct link to Anthem medical policy and evidence-based treatment options

**Decision-Support**
- Compare against evidence-based recommendations
  - Data on efficacy, toxicity, and cost
  - Evidence-based supportive care
  - Review against Anthem medical policy
  - Identify regimens that are on pathway

**Output**
- Integrated with claims systems
- Immediate approval if consistent with Anthem medical policy
- Additional support for treatment planning when chemotherapy regimen is on pathway using S-code

**Anticipated**
- 2/2014 in Central region with phased implementation
- Reimbursement for S-code varied with performance on quality measures and care coordination
Episode-based payment models promising for radiation therapy

- Advances in radiation therapy technology primarily aimed at improving side-effects and convenience
  - IMRT
  - Brachytherapy
  - SBRT
  - Proton therapy
- More convenient treatment schedules that are less costly have had marginal adoption
- Established metrics in the field for measuring radiation dose to “off target” tissues
Women overwhelmingly prefer hypofractionated whole breast irradiation when asked:
- 62% preferred HF-WBI
- 28% preferred PBI
- 10% preferred CF-WBI

Over half of surveyed radiation oncologists never use HF-WBI and 40% use <1/3 time
Conclusions

Align reimbursement for value and better patient outcomes in oncology

Shift incentives to provide care for the patient not just manage the disease

Episode-based payment models and reference pricing may have application in radiation oncology, especially for commonly treated disease like breast cancer and prostate cancer
Thank you