Cancer Care Pathways Catching on with Payers

BY LOLA BUTCHER

Three pathways companies—Innovent Oncology, P4 Healthcare, and Via Oncology—are actively marketing their services to insurers, and others are expected to come on the scene soon. And while it is clear that the use of clinical pathways will change how oncologists are paid, exactly how that will play out is not.

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A s the insurance industry scrambles to adapt to health reform legisla-
tion, the use of cancer care path-
ways is emerging as a strategy that may help control its oncology costs.

Three pathways companies—Innovent Oncology, P4 Healthcare, and Via
Oncology—are actively marketing their services to insurers, and others are expected
to come on the scene. Clinical pathways, the vendors say, offer the opportunity to
improve the quality of cancer care while redu-
ducing costs.

That is a message that resonates with
payers, who are under intense pressure to
improve quality and bring health care costs
to a sustainable level. Richard Popiel, MD,
MBA, Vice President and Chief Medical
Officer at Horizon Blue Cross Blue Shield
of New Jersey, says urgency is essential.

“Most leading health plans, if they are
not at a sustainable trend rate within five
years, are going to be at great risk either of
not being competitive or not being sustain-
able. So plans like ours are embarking on a
broad-based process to completely trans-
form how we engage with our membership,
our doctors, our hospitals and our vendors,
and this will be reflected in, and perhaps
driven, by payment reform.”

For Horizon, that means trying out clin-
cical pathways as a route to lower its cancer
care costs. Horizon is sponsoring a pilot
program with two New Jersey oncology
practices to explore the use of Via
Oncology pathways.

While it is clear that the use of clinical pathways
will change how oncologists are paid,
exactly how that will play out is not.

P4 Healthcare, through an arrangement
with Blue Cross Blue Shield of Michigan
and OPR, a physician organization that
represents 64 Michigan oncology practices,
is working to develop a clinical pathways
program. Clinical pathways for lung,
breast, and colon cancer, as well as support-
ive care, will be made available to oncolo-
gists throughout Michigan. P4 also has
arrangements with CareFirst BlueCross
BlueShield, which insures people in
Maryland, District of Columbia and
Virginia, and Capital BlueCross, which
serves central Pennsylvania.

Innovent Oncology, a service of US
Oncology, just signed a contract with Aetna
to bring its pathways program, along with
proactive patient management and advance
care planning, to cancer patients through-
out Texas. The agreement is expected to ex-
pand to 20 other states throughout the
country.

Meanwhile, several individual oncology
practices around the country are develop-
ning pathways on their own, with the goal
of negotiating better contracts with their
payers.

The Promise & the Problem
The first promise of oncology care
pathways is that they reduce the wide
variation in current oncology practice
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with guidelines that provide the best patient outcomes. Although clinical pathways are developed in various ways, the basic idea is that scientific evidence is used to create treatment pathways that offer the combination of the greatest survival benefit and the lowest toxicity.

The second premise is that, by reducing variation, curtailing the complications associated with poor care, and eliminating the use of ineffective treatments, the cost of cancer treatment via pathways may be substantially lower than current practice.

Physicians in the US Oncology network earlier this year published a study with Aetna that found that annual outpatient costs for non-small-cell lung cancer patients treated with Level I Pathways were 35% lower than those patients treated "off pathway," with no difference in 12-month overall survival (Journal of Oncology Practice 2010;6:12-18). This study provides evidence that high-quality care is not necessarily associated with high cost.

Meanwhile, IntrinsiQ, an oncology data and analysis firm, reviewed the actual treatment decisions made by the 700 oncologists who use its Intellidose chemotherapy ordering software and compared them with the Via Oncology pathway protocols. That analysis found that payers would have spent 40% less on oncology drugs if the pathways had been followed in all cases, said the company's President, Kathy Lokay.

Adherence to a clinical pathway is not appropriate in all cases; if the Via pathways had been followed in 80 to 85% of the patient scenarios, payers would have seen their drug costs cut by 32 to 34 percent.

The problem with cancer care pathways is getting oncologists to follow them. The vast variation in treatment patterns that exists today is evidence that oncologists disagree on which therapies offer patients the best outcomes.

While some oncology leaders are able to get their colleagues on board with a pathways program, that is not easy in a single practice, let alone an insurer's entire reimbursement model, he said.

These pathways approaches all have their roots in evidence-based medicine. While some of the details of a different reimbursement model have not yet been discussed, he assumes that the practice would be paid more for its non-drug-related services.

James J. Badaracco Jr., Executive Director of The Center for Cancer and Hematologic Disease in southern New Jersey, said Horizon is paying Via Oncology for some of the costs associated with the pathways program, and Via will pass along some of that amount to his practice. Physicians will see no change in their reimbursement during the pilot. At the end of the trial, both parties will assess its success.

"Depending on whether we like [the pathways program] and Horizon likes it, we would go forward with a slightly different reimbursement model," he said. "While those details of a different reimbursement have not yet been discussed, he assumes that the practice would be paid more for its non-drug-related services.

**Pathways Marketplace**

The first three organizations to market a pathways approach all have their roots in the oncology community.

- **Innovent Oncology** is a service of US Oncology. Its Level I Pathways are developed and maintained by physicians, and about 1,000 oncologists are using them. Physicians use decision-support software that uses US Oncology's proprietary electronic health record or a web portal to help select the most appropriate treatment and to track and benchmark pathways performance.
- **Via Oncology** is a wholly owned for-profit subsidiary of the University of Pittsburgh Medical Center, and UPMC oncologists developed its pathways. (The UPMC oncology group was formerly affiliated with US Oncology, and Ms. Lokay, Via Oncology's President, was a top executive at US Oncology, including head of Innovent.) A web portal enables oncologists to apply Via Oncology pathways for decision support and to monitor adherence.
- **P4 Healthcare** was started by a group that includes Jeffrey Scott, MD, an oncologist who cofounded Georgia Cancer Specialists and later International Oncology Network. The P4 Pathways program provides software, consulting, and training that allow a group of oncologists to develop pathways in a specific insurance network or geographic region to develop pathways and monitor their use.

Dr. Scott said he expects to see pathways programs coming from many other sources—pharmacy benefit managers, group purchasing organizations, and even state medical societies—as awareness grows about the twin benefits of improved care and lower costs.

But even those who see clinical pathways as inevitable for oncology wonder how the evolution will occur.

"Pathways are being talked about almost like a given now," Ms. Lokay said. "Because they are finding that all pathways are not created equal, oncology groups and payers are turning their attention to assessing which pathways program is the best."

"And the other big question under discussion is crafting a business model that will work. The challenge is to change reimbursement so that savings from adoption of pathways are shared."

She said she finds forward-looking physicians more open to clinical pathways than are payers, who worry that physicians cannot be trusted to hold themselves accountable. Payers typically want to monitor physicians' compliance themselves.

"In our model, we are asking payers to set aside external review if oncologists adopt pathways."
Antonio Tito Fojo on Putting Trial Results in Context with Costs: “The Bar for What We Call ‘Significant’ Has Fallen So Low We Risk Tripping Over It”

BY ROBERT H. CARLSON

WASHINGTON, DC—Scientists would always hope their research projects show positive results, with findings that benefit patients, but as has been seen with chemotherapy in general and biological agents in particular, benefits are mostly incremental.

With a blockbuster—in imatinib for CML, platinum for testicular cancer—there’s no need to justify the cost-benefit ratio. But what about the novel, targeted agents that improve outcomes by single-digit percentages, cost tens of thousands of dollars per treatment cycle, and carry significant risks of debilitating side effects? In a Special Session here at the American Association for Cancer Research Annual Meeting on that much-discussed topic, one speaker showed how data from trials with barely statistically significant benefits nonetheless became acceptable regimens currently found in practice guidelines.

Chemotherapy & Marginal Benefits

Antonio Tito Fojo, MD, PhD, Senior Investigator and Head of the Experimental Therapeutics Section at the National Cancer Institute, began his talk by warning the audience that he would be a little more critical than they were used to.

Dr. Fojo’s principal message was that “increasingly, therapies that demonstrate at best marginal benefit are being approved for the treatment of cancer.”

Cetuximab was his first example. Dr. Fojo described the European FLEX study treating non-small-cell lung cancer with a cisplatin-vinorelbine combination, with or without cetuximab. The key result he cited was a 1.2-month survival advantage with the addition of cetuximab, 11.3 months vs 10.2 months.

The trialists’ conclusions he quoted had a familiar ring: “The addition of cetuximab to platinum-based chemotherapy represents a new treatment option for patients with advanced non-small-cell lung cancer.”

How could a benefit that minimal be considered grounds for adding that regimen to the medical oncologists’ armamentarium, Dr. Fojo questioned.

“Would you characterize this trial as encouraging, disappointing, and marginal, but what is it about these words that we’re afraid to use them?” he said.

Eye Openers

His next set of slides relating to cost were eye openers, showing how the average cost of drugs to treat one patient with cisplatin-vinorelbine per protocol in this trial added up to $1,920.

“For an extra 1.2-month survival advantage with cetuximab, add $71,712 per patient, Dr. Fojo said. “That’s not the cost of life, that’s the cost of that drug, and I would argue that it’s a bit too steep.”

He said another cetuximab NSCLC trial, the US BMS099 study, using a taxane-carboplatin platform, showed no statistically significant survival advantage to adding cetuximab, and the overall response rate improved only from 17.2% to 25.7%. But it did show toxicities similar to FLEX, including a 10.5% rate of acneiform rash and a 5.5% rate of infusion reaction.

“What is it about ‘ineffective’ that we do not understand?” Dr. Fojo said.

Another example of questionable benefit is the E2100 trial of bevacizumab in breast cancer, he said. Combining bevacizumab with paclitaxel increased overall survival by 1.5 months—25.2 months with paclitaxel-placebo vs 26.7 months with paclitaxel-bevacizumab—but at an additional cost of $90,816 per patient for bevacizumab over the $3,029 cost of paclitaxel.

‘Institutionalized Mediocrity’

These trial results wouldn’t mean much unless practitioners started using the costly, marginally effective regimens routinely, he continued, noting that in fact the FLEX study did influence ASCO’s practice guidelines.

“If bevacizumab and cetuximab are an important part of our armamentarium seven years from now—especially in breast and lung cancer—we will have failed miserably in our quest to bring better therapies to patients. More so than personalized medicine, what we really need are better and less expensive drugs.”

Mr. Badaracco, of The Center for Cancer and Hematologic Disease, said the physicians in his practice have mixed enthusiasm for the pathways approach, but agree that they need to get experience with a concept that is gaining traction.

“It’s our thinking that we would like to be leaders rather than followers for when things change, and we know they are going to change,” he said. “And we would prefer to be on board and be prepared for it.”

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