The overriding concern for oncologists is without a doubt providing quality care to their patients. And, while payers have the same interests in mind, they have a responsibility to reign in the cost of quality care where appropriate. We explore several examples of how “tearing down the wall” between provider and payer has benefited both parties, and ultimately the health care system.

The wall between payers and oncologists is crumbling before us. In a promising trend, oncology groups and commercial health plans are moving to the same bench, sharing data, relating pathway compliance with payment, collaborating on how to reduce unnecessary hospitalizations, and most notably are finding common ground on how to realign reimbursement around quality care.

Driving the two forces are: (1) oncologists who are pressured by Medicare and commercial payers to adopt more standardization while maintaining quality care, and who continue to find some of their critical services not being reimbursed; and (2) payers who are experiencing rising oncology spend and emerging diagnostic and therapeutic options, but lack any real comparative data on the economic and clinical value of pathways by tumor type and stage.

Unprecedented payer-provider marriages have sprouted in four states: Washington, Pennsylvania, New York, and California. What’s driving the collaborations, who’s making decisions, and how the early returns are driving a new kind of business and reimbursement model are described.

Puget Sound Cancer Center-Regence Collaboration

The Courtship
At the head of the public debate in 2007 over ESA safety concerns, Regence, a health insurer in the upper northwest, wanted to look at opportunities to lower costs and manage ESA safety issues in a more comprehensive way with larger clinics. Regence had some prior authorization (PA) in place to control dosing of ESAs, but it sought to focus more on off-label use and take a more aggressive stance based on the evidence reviews that had been done by groups like AHRQ.

“We were interested in finding a more efficient way to address safe ESA use and figuring out at what point do we start initiating therapy based on a patient’s blood cell count,” notes

<table>
<thead>
<tr>
<th>Oncology Provider</th>
<th>Payer</th>
<th>Collaboration</th>
<th>Reimbursement Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puget Sound Cancer Center (Seattle/Edmonds, WA)</td>
<td>Regence</td>
<td>ESA order set policy</td>
<td>Reduced prior authorization burden</td>
</tr>
<tr>
<td>University of Pittsburgh Medical Center (Pittsburgh, PA)</td>
<td>Highmark</td>
<td>Clinical pathway lung cancer and breast cancer cost study</td>
<td>Locked-in AWP reimbursement rate</td>
</tr>
<tr>
<td>Cancer Care Northwest (Spokane, WA)</td>
<td>Premera</td>
<td>Clinical pathway non-metastatic breast cancer study</td>
<td>Realignment of reimbursement (to be determined)</td>
</tr>
<tr>
<td>New York Oncology Hematology (Albany, NY)</td>
<td>Multi</td>
<td>Clinical pathways, disease management, and advanced care planning</td>
<td>Tiered revenue source separate from fee-for-service</td>
</tr>
</tbody>
</table>
Lyn Nishida, RPh, director of Regence’s clinical services.

Coincidentally, The Puget Sound Cancer Centers (PSCC) had developed standing orders for ESA use as part of an ASCO quality measures pilot project. After setting up guidelines for non-Medicare/Medicaid patients, PSCC physicians complied 76% of the time with the ESA treatment orders. According to Richard McGee, MD, president of PSCC, this was achieved by using a standard order sheet that drove all decisions, such as first checking iron levels; starting patients on ESAs who had a hematocrit level below 33; and stopping ESA use when the hematocrit level reached 36. Eventually, PSCC was able to reach 100% compliance.

“The orders intrigued us,” says Nishida. “I would have expected some patients to fall out of the thresholds but that wasn’t the case, and [PSCC] got to 100% without any prior authorization.” PSCC’s ESA standing orders did not necessarily align with Regence’s medication policy, but they were a jumping off point. “We were willing to align their orders with our already developed policies,” said Nishida.

The Outcome

After meeting with Regence, PSCC adjusted its guideline to start ESA therapy at initiation screening if a patient’s hematocrit level was less than 30. In April 2008, after tracking and reporting one month of data, physician compliance remained at 100%. This perfection has continued through August.

Typically, oncologists would have to preauthorize under Regence’s revised ESA medication policy, but PSCC’s continued 100% compliance convinced the health plan that it could ease the PA process. Since May, PSCC’s orders are approved in advance and its documentation is evaluated later on.

“We’re not bypassing the PA—there’s still a standard review through a quarterly retrospective audit,” clarifies Nishida, “but what we’re doing is selecting prescribers who are actually performing well and have a commitment to safety and the right use of medications based on science.”

The Savings

For PSCC, the smoother PA process means a small, but important victory in reducing operational costs and improving access to care. For Regence, the relationship saves the plan in administrative costs as each PA for an ESA product can go as high as $70.

Regence is now exploring a bigger initiative to realign drug reimbursement for oncologists. Deductibles, coinsurance, and payment amounts for medications may differ depending on where an oral or IV drug lives—on the medical or pharmacy benefit. “We want to look across both IV and oral therapies to find what makes sense clinically,” says Nishida. “An IV drug may be more expensive for example, but if it has the best science we want to work with providers to align their reimbursement around that, not financial incentives.”

Quality Care and Reimbursement

By Bryan Cote

By Bryan Cote

Tearing Down Walls:

cont. on pg 32
The UPMC-Highmark Collaboration

Reduced hospitalization costs were the eye-opening outcome of a lung cancer study at the University of Pittsburgh Medical Center (UPMC) in which it worked with Pennsylvania’s largest commercial payer, Highmark, to compare costs of care before and after pathway implementation.

The Courtship

UPMC began creating clinical pathways in 2005. Since then, 13 pathways have been developed including breast, lung, prostate and colon among others, and compliance has been met at least 80% of the time. For its part in collaborating, Highmark has continued to pay UPMC at a fixed AWP percentage as part of an agreement formed in late 2005. However, as UPMC gradually increased pathway compliance (it’s at 91% overall today), both Highmark and UPMC leadership wanted to see if there was any positive effect on cost savings from the pathway.

Highmark chose lung cancer to study first. According to Bob Wanovich, Pharm D, vice president of pharmacy affairs for Highmark, every disease has diversity, but lung cancer is relatively easy to target from a claims analysis standpoint.

The Savings

Just 400 total patients per group were studied but even without a statistically relevant sample both sides saw the analysis as a launch point. The study compared UPMC physicians with non-UPMC physicians, evaluating cost of visits, costs of therapy and supportive agents, and hospitalizations before and after pathway implementation.

Stan Marks, MD, deputy director of clinical services for UPMC Cancer Centers and a member of Highmark’s corporate board had his doubts that lung cancer pathway compliance would significantly affect patient care costs, but a key hospitalization result surprised him (Fig. 1):

- UPMC showed clear reductions in hospitalization costs post pathway—a decrease of $1,766 per patient—whereas physicians not following the pathway saw a $578 increase in hospitalization costs
- Overall spending increased 1% among UPMC physicians, compared with 5.5% for the non-pathway physicians

On the other hand, some of UPMC’s numbers were not favorable. Therapeutic and supportive costs went up more than $1,700 per patient after the pathway was implemented, mostly attributed to UPMC’s approval of Avastin® for lung cancer post implementation of the study.

“Obviously this is still raw data,” says Dr. Marks. “We believe that by standardizing care and using the same regimens and supportive agents we had some success in reducing neutropenic fevers.”

Highmark, too, acknowledged the study’s limitations. Wanovich said, “We controlled as much as we could but this was largely anecdotal—you just can’t show cause and effect here.” But the hospitalization cost decreased, and more importantly, the fact that UPMC kept its total spend flat was significant enough to keep the collaboration moving.

Figure 1. Hospitalization Cost Analysis. Source: UPMC Cancer Centers/Highmark. Reprinted with permission.
A second joint study is underway to look at breast cancer. “We want to advocate for standardization,” says Wanovich, “If we get another finding that shows consistency, then we have something to build on.” For breast cancer, Wanovich indicates that the hospitalization cost comparator will not necessarily be the critical number to evaluate since some savings could show up in the office.

**The Reimbursement Case**

Early success with standardization is contagious and has begun to foster reimbursement experimentation. For example, word of UPMC’s pathways caught the attention of CareFirst BCBS of Maryland. “[CareFirst] is using the UPMC pathways as a template for their own physicians, letting them have input in adjusting the pathways to fit their population,” says Dr. Marks.

Oncologists who meet a 60% compliance threshold are eligible to be reimbursed at ASP +20%; however, if they fall below that percentage CareFirst can lower the percentage below the 20% benchmark.

Wanovich has another perspective regarding this incentive. “I don’t know if we would base the incentive on just drugs,” he contends. “Drugs are a significant component, but that incentive could be shortsighted. We might look at reimbursement for administration, inventory, and incent certain activities like counseling, and for practices that put in place good controls and safety processes. A lot more people can self-administer and give drugs orally, so you can’t make all the incentives line up with office administration.”

**Cancer Care Northwest-Premera BCBS Collaboration**

In Washington, Premera BlueCross is investigating how to realign reimbursement to respond to provider concerns. Dave Johnson, MD, regional medical director, says oncologists want to get paid for what they do rather than rely on medication reimbursement; and Premera, like Highmark, may help to compensate for ancillary services that should be paid (such as patient navigators and social workers), but which are not currently reimbursed.

**The Courtship**

Washington’s largest carrier, Premera, works closely with a large group that has a big market share—Cancer Care Northwest (CCNW)—to evaluate the economic and clinical effect of pathways. In 2005, it helped CCNW reorder some pathways in which regimens with comparable efficacy and side effect profiles were not ranked by cost. Today, CCNW’s pathway compliance mirrors UPMC’s: up to 92% this year across pathways. Dr. Johnson says, “There’s a reimbursement advantage in some cases in hitting that bar.”

**The Challenge**

As Premara and CCNW explore greater collaboration, they’ve uncovered limitations. For example, Premera will focus next on studying its number one cancer by volume—non-metastatic breast cancer—but there are implementation issues. Premera is working with area cancer centers and asking the centers to share administrative data for all non-metastatic breast cancer patients who have Premera, and then match those numbers up with CCNW’s. “Our goal is to figure out how to do this comparison,” says Johnson, adding that he wants to know the stage of the disease as well, “without that, this is very challenging.”

If successful, Premera will attempt to do a chart review of a match control group in 2009. “To do this right, it would be great to know the functional status. With CCNW, it’s easy to do this.”

cont. on pg 34
Tearing Down Walls: Payers and Providers Align Quality Care and Reimbursement

Plus, the payment mechanism is different for these services than for fee-for-service office visits. US Oncology’s approach is to align with the payer’s medical management needs and budget, not its provider relations division who contract fee for service.

The Savings

There are no formal numbers to report, but US Oncology-affiliated practices plan to use their own provider staff to conduct the disease management work, i.e., making phone calls with patients or their surrogates to identify patient goals, address clinical, social, financial and spiritual needs, report the dialogue, and track results. Dr. Kolodziej likes how the dialogue is managed by the oncology providers and ensures that expectations are addressed as a patient’s cancer progresses.

Participating payers would receive a report that shares information on several measures, such as the number of its oncology patients who are completing advanced directives, number of ER visits per patient, hospice length of stay, and therapeutic treatments in the last 14 days of life. Metrics like these will be input by each practice on a web-based platform and allow US Oncology at the corporate level to measure and compare data over time; an EMR is not necessary.

The payment piece is a version of a gainsharing model. Payers will contract directly with Innovent, which will pay individual US Oncology practices a fee for achieving certain performance measures. “This allows the practices a new revenue stream of per patient per month dollars, and supports the payer,” says Lokay. Payment will be tiered, so practices with higher performance measure compliance (ie, 85%) get a better fee. Payers could win with reductions in hospital ER costs and lower end-of-life care costs.

New York Oncology Hematology (NYOH) is among two pilot sites. Expansion is planned into Minneapolis, Chicago, Las Vegas, Indianapolis, and Portland, Ore. NYOH has 40 oncologists serving 50% Medicare patients and 50% commercial patients, most with regional carriers.

For the program to work, Dr. Kolodziej says the US Oncology groups need to respect the evidence, be open to discuss their pathways with payers, and buy into the cultural changes.

What’s in it for Industry?

The major takeaway for pharmaceutical managed markets and account teams is that commercial and Medicare plans are now more aggressively seeking help from oncologists in designing studies that align reimbursement with first-line therapies and evidence-based treatment standards. It represents a larger share opportunity for products with a cost-savings story to tell, but also the possibility for brand erosion. At the same time, this trend represents a communication challenge for sales forces who must understand that doctors are being incentivized...
based on their pathway compliance, and that payers are moving toward more standardization, putting greater restrictions on use of second-line and third-line agents.

**Conclusion**

For all its clinical benefits, collaboration is clearly being driven by the day to day, give and take of oncology economics. Some payers, and now even a physician practice management company, while less willing to give a higher drug ASP or AWP, have compromised and begun to explore new ways to link pathways and quality care with reimbursement. The model will evolve and payers will continue to work with individual providers to test the merits of standardization and better understand the effects of pathway compliance on patient care costs. These case studies represent great progress, but there’s no official blueprint yet. Highmark’s Bob Wanovich may have captured it best when he said that there’s no perfect path. Each oncology group will need to adopt what works for them and invest in an open dialogue. Something to think about for your next negotiation.

---

**Case Study: Quality Care Is Primary Concern**

Wilshire Oncology, one of the largest oncology groups in Southern California seeing 4,500 new cancer patients a year, is seeking a new reimbursement model since Blue Cross of California—the state’s largest PPO with about 8 million members—unilaterally adopted Medicare’s policy in 2007 and set reimbursement for oncology drugs at ASP +6%. Wilshire is negotiating with BC of California to be paid for all the care it provides to its patients, including patient care management, inventory costs, psychology support, and payment for doctors based on their training.

Wilshire’s executive director Steve Balalian says quality should drive all collaboration to avoid scenarios like this one:

A 60-year-old patient who had lung cancer chose to be treated at Wilshire after her original oncologist told her she had just a few months to live. Wilshire took over treatment and two years later the patient was still alive. Then the IPA (which acts like an insurer) told the patient that Wilshire could not treat her anymore. They didn’t tell her why and she was instructed to go back to the previous physician or not be eligible to continue to participate in the plan.

In this case, payer-provider collaboration failed. Wilshire may have incurred additional costs up front to address the patient’s clinical needs, but in Balalian’s opinion, Wilshire’s investment in quality and in a treatment path that kept her out of the hospital and helped her maintain a higher quality of life was ignored.

---