

MODERATOR



**RYAN HAUMSCHILD, PHARM.D,
MS, MBA**

Director of Pharmacy Services
Emory Healthcare and Winship
Cancer Institute
Atlanta, GA

ROUNDTABLE PARTICIPANTS



**LANI M. ALISON, MS-HCQ, BSN,
PCMH CCE**

Vice President, Quality & Value
Transformation
Integra Connect, LLC
West Palm Beach, FL



STUART GENSCHAW, MBA

Chief Executive Officer
Cancer & Hematology Centers
of Western Michigan
Grand Rapids, MI



TERRILL JORDAN, JD, LLM

President and Chief Executive Officer
Regional Cancer Care Associates
Hackensack, NJ



KATHY W. OUBRE, MS

Chief Executive Officer
Pontchartrain Cancer Center
Covington, LA

Evaluating the Management of Cancer Immunotherapy (CIT): Roundtable Discussion

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On September 27, 2021, a group of health care decision makers in oncology convened for a virtual roundtable to discuss the drivers behind product selection for cancer immunotherapies (CITs) at diverse community oncology practice settings. Ryan Haumschild, PharmD, MS, MBA, led the participants in a discussion about product attributes and other factors that influence their CIT decision-making, including the use of CIT within alternative payment models (APMs) and best practices for implementing and operationalizing policies and procedures among clinical oncology teams. This article is a summary of the stakeholder insights from the roundtable.

EVALUATING CIT ATTRIBUTES

Various therapeutic areas have multiple CIT products with clinically meaningful outcomes. However, the CIT class is crowded, and new products and indications are entering the market at a rapid pace. Additionally, nonclinical product features at the practice or organizational level may influence CIT product preferences.

Data Sources Used by Providers

Participants indicated that providers use various sources to stay up-to-date with the continuing accumulation of data on CIT products and approvals. Common sources of new data used by providers include biopharmaceutical-provided education, publications, podcasts, and other sources of clinical data, such as meetings and conversations with colleagues. However, providers find sorting through the accessible data to be overwhelming. As highlighted by Terrill Jordan, JD, LLM, "The amount of data that is available is massive."

Influences on CIT Decisions

Overall, the participants expressed that payers are the main drivers in terms of which CIT options are utilized in clinical practice. Differing payer approaches and strategies for drug management can affect inventory management by the practice and be disruptive to streamlined formulary planning,

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sometimes resulting in the need for formulary reviews sooner than anticipated. Commenting on the influence that payers have on treatment selection, Stuart Genschaw, MBA, added, “The payers will, unfortunately, tell us what we can and cannot do in regard to reimbursement. We always want to do what’s best for the patient, but the different formularies and what they’ll approve is something we need to work with quite a bit. The physicians would make the best decision clinically for the patient, and that’s what is the most important [factor] and paramount.”

Participants consider National Comprehensive Cancer Network (NCCN) guidelines the most influential data source for CIT organizational decisions. Genschaw emphasized the importance of the role that NCCN guidelines play at the organizational level, saying, “NCCN guidelines are paramount; we follow those very closely. The doctors have an idea how much these drugs cost, and that’s basically [that] they cost a lot. But I’m not sharing with them [the] margins or how much they’re going to make on any particular drug. They’re more interested in [knowing the answer to the question] ‘Is it going to get paid for, for the patient? How can we get patient assistance programs if needed?’” Other factors influencing these decisions include clinical trial and cost-effectiveness data, which involve volume, contracting data, and patient experiences. Lani M. Alison, MS-HCQ, RN, PCMH CCE, explained that the patient experience should be considered, because adverse effect management may involve visits to the emergency department and hospitalization. These factors affect the total costs of care and are important considerations with value-based contracts.

Additionally, regarding contracting, the participants indicated that they prefer volume-based contracts over market-share contracts because they are easier to manage.

Nonclinical Product Attributes

Open communication with payers is important when evaluating the nonclinical attributes of CIT products. As highlighted by Jordan, this dialogue is needed “to make sure that [the] optionality is available, and it’s an option that we can keep intact without incurring any punitive incentives or disincentives.” On the role of the payer, Kathy W. Oubre, MS, pointed out that “there are instances where a drug will

be on a payer formulary, but it’s below the cost of the drug. Sometimes they don’t review a particular drug for reimbursement for maybe a year or more after the drug [is] out.”

The Formulary Review Process

The participants indicated that a typical process of formulary review includes a clinical review by the Pharmacy and Therapeutics (P&T) committee, a financial analysis based on current contracts and reimbursement, and then a final sign-off from the clinical team. Formulary reviews are generally conducted at least once per quarter because pricing and contracts frequently change. Once updates to the formulary are made and implemented in the electronic medical record (EMR) order sets, these changes are communicated to providers through the P&T meeting minutes and messaging through the EMR.

In terms of potential conflicts involved in formulary update decisions, Jordan indicated that at his institution, the decision-making process for adding a drug is usually without discord. He added, “The formulary committee evaluates the drug and then decides from the clinical standpoint if this drug makes sense. The business team then does the financial analysis.” Jordan noted that the formulary committee then considers the drug from a clinical perspective once more as a final review before deciding whether to put the drug on the formulary.

The Role of Physicians in Formulary Review

The participants emphasized the key role of physicians, both during the review process and in guiding treatment decisions once a drug is added to the formulary. Genschaw explained, “We’re a physician-led organization, so it’s the physicians [who] have the loudest voice. Our pharmacist does a nice job presenting the information, but in regard to internal review, physicians are at the table. We’re [organized] by disease, so [if] it’s the lung team, they are reviewing these products and providing their input; they are the key stakeholders.”

Hub Services

According to the participants, hub services are valuable because they can support an improved patient experience and adverse effect

management, potentially lowering overall treatment costs. However, patient experience is seen as relatively more important when a drug is palliative rather than curative. The participants agreed that they consider patient assistance programs and reimbursement support valuable nonclinical product attributes when comparing CIT options, as access to the medications is often a main source of concern for both patients and staff. Jordan recognized that the availability of a patient assistance program is a rate-limiting step, emphasizing, “This is really where the [financial] stress for a patient comes from.” He added that patients are usually willing to accept most other aspects of their treatment plan, “but the stress of whether or not they can afford the therapy, whether they’ll be able to receive the therapy, and so forth, is probably the most important.” Navigating this process is also a source of discomfort for the staff: “They have a patient, [and] they need to take care of that patient, and they want answers, and they want them quickly.”

THE ECONOMIC IMPACT OF APMs ON THE CIT CLASS

Although CITs have advanced patient outcomes, their costs are high, and they affect the budgets of organizations. Although individual CITs tend to have strong payer coverage, combination regimens may complicate the matter. Additionally, APMs may affect product utilization, especially for therapeutic areas with multiple CITs.

Combination CIT Regimens

Alison commented on the complexities associated with implementing combination CIT regimens, adding that she has seen some practices, particularly smaller practices, “that really feel that there are significant resources that are required for the implementation of [these] combination therapies, in addition to clinical pathways.” She indicated that this depends on how the practice is organized: “[It] especially [affects] the smaller practices that may not have the administrative padding in terms of resources [or] data to be able to actually make the changes. For them, it’s [already] very complex. They’re being asked [a lot] by NCCN and other clinical class pathways. Plus, now there [are] more things that are being added to their everyday lives, because now they need to provide a patient a combination therapy.”

APMs

In an APM like the Oncology Care Model (OCM) developed by the Center for Medicare & Medicaid Innovation, the total cost of care is a major factor in decision-making. Thus, streamlining treatment options in a therapeutic area with diversity of choice can be beneficial for contracting. However, this requires input from the physicians on their treatment preferences. When evaluating the benefit of a medication, [Jordan noted that] Regional Cancer Care Associates prioritizes the total cost to their practice rather than the total cost of care to the health care system, due to a lessened ability to control and document outside costs.

Regarding the impact of APMs on the CIT class, Alison stated, “The total cost of care is one of the major factors in OCM as well as in any other APM contracts that you evaluate or get offered. You get [data] from your contracts, from your GPO [group purchasing organization], and

then you get some comparisons of where they are; then you put in your own data. And then you get into the contractual conversations with each of these vendors or with each of these pharmaceutical companies that offer these immunotherapies.” She further noted that after these steps, the clinical standards committees come in, “[and] the physicians are involved in making the ultimate decision [on contracting].”

It’s important for us to get a sense of how easy [it will] be for our physicians to switch and our patients to switch. That takes into account a number of variables, [including] patient perceptions to switch. How receptive is [the] staff going be to a switch, and what’s the volume? Is all of the effort worth the time?

Terrill Jordan, JD, LLM
Regional Cancer Care Associates
Hackensack, NJ

Switching Therapies

Aside from cost, regarding APMs, the participants indicated that the ability to switch therapy across patients is an important consideration when evaluating CITs. Alison said, “For the [APMs], including OCM, it’s [about] a class of drugs that’s already included [in the formulary], and the physician or the provider has the ability to actually use [these agents] or not. When the physicians make a clinical decision, they’re not really looking into whether the patient is in an APM or not, however, until the staff will tell them, ‘This is how much that costs, and this [is] the [patient’s] co-pay.’ Then there’s the additional therapeutic option to make it a combination—and what is the evidence behind the combination therapy?”

Jordan noted that it is important to consider challenges associated with switching all patients’ therapies because they affect the practice’s ability to “deliver under the alternative payment contract and ultimately achieve the incentive.” He added, “It’s important for us to get a sense of how easy [it will] be for our physicians to switch and our patients to switch. That takes into account a number of variables, [including] patient perceptions to switch. How receptive is [the] staff going be to a switch, and what’s the volume? Is all of the effort worth the time? If it’s a small volume, it may not be worth all the angst [of] making the switch; we may just bypass it until we see [the] appropriate volume associated with that particular product.”

BEST PRACTICES FOR IMPLEMENTING AND OPERATIONALIZING POLICIES AND PROCEDURES AMONG CLINICAL ONCOLOGY TEAMS

Institutions have unique ways of operationalizing product preferences and ensuring provider alignment, which are critical to meeting organizational objectives. Measuring and reporting prescribing patterns help organizations achieve their objectives of providing high-quality care while allowing predictability of product use.

Communicating With Clinicians

The participants highlighted the importance of communicating with clinicians concerning the product preferences across their organization. Additionally, peer-to-peer feedback on clinical pathway adherence influences providers to change their prescribing behavior if it deviates from their peers'. Regarding communicating product preferences among clinicians, Genschaw said, "A lot of them already know what's coming down the pike. Emails are pretty effective, [as are] discussions at these meetings, and then implementation through the EMR. They'll learn pretty [quickly] what's been standardized within the practice."

According to Alison, "[Clinicians] will always ask about [changing product preferences]. And although they have been to high-level meetings, it's always [the case that] the devil is in the details." She added, "The practice administrators are overwhelmed themselves. Aetna wants this, Anthem wants that, and so forth; this is OCM. Once you can influence one or two of them [with practice patterns], they will talk to each other and then they share; make it simple for them, and make it relate to what they have already been doing."

Concerning the importance of communicating the rationale behind decisions that are made, Oubre noted, "For us, it's about the providers but it's also about the APPs [advanced practice providers], the nurses, the financial assistance people. They all need to understand why we're doing all these things, because a lot of these value-based care models differ by payer, and some of us have more than one, and all of them look a little bit different." She explained that payers' product preferences vary, and "it all becomes very complex. It can be psychologically very wearing after a while. But if we have had more adherence [as a result of explaining] 'the why' to everyone, then we're all kind of swimming up the stream together." Additionally, Oubre indicated that educating everyone instead of focusing only on educating clinicians "helped us from an adherence point of view, because if physician A wrote a treatment plan that wasn't in line with that particular payer, I had multiple people along that line making sure that we were staying within those guidelines and [that if] we didn't do something, that we weren't going to get [approved]."

Financial Threshold

Practices have flexibility to make utilization management decisions based on financial considerations in settings where drug choices that have comparable clinical efficacy are available. Jordan added that the threshold varies depending on the contract, and they take into consideration the impact of potential changes on their performance when making decisions.

CONCLUSIONS AND KEY TAKEAWAYS

The participants emphasized the important role of data in improving practices and helping them navigate the growing complexities associated with oncology care. Genschaw appreciated the discussion around data, noting, "Things have evolved. I've been around for a while, and we're kind of in the big data business now, and it's intriguing. [The] kind of data we have access to—we take that data and implement [it in order to] make improvements in the practice."

Oubre commented on the evolving nature of oncology care, stating, "I think the business of oncology continues to grow in its level of complexity, [and] it's constantly changing. Whether we'll move to OCF [Oncology Care First] remains to be seen, but the amount of data currently available has really helped us in managing a lot of these complexities, [even though] there [are] still a lot of holes."

We have to include the patients in this journey because they're the receivers of everything that we do, especially now that all [these data are] thrown to the community practices as well as the physicians, but it still comes down to the patient experience.

Lani M. Alison, MS-HCO, RN, PCMH CCE
Integra Connect, LLC
West Palm Beach, FL

Jordan stated that science drives the economic considerations to a certain extent. "As the science drives [the] complexity of oncology care, it's going to impact the complexity of all [APM] offerings. And so, we'll see additional complexity as more and more products hit the market and as more and more options are available in different classes." He added that he anticipates that with various service models, the associated complexities will continue to grow, and there will be a number of different strategies based on the targeted payment model that they are working with. Jordan highlighted the challenges faced and the associated management costs, adding, "I think the business is going to get much more challenging in terms of management. It's getting more expensive, and I don't know that the [APM] rewards are aligned with the expense our practice [is] going to be asking [for] the management."

In conclusion, Alison pointed out the importance of taking into consideration the perspective of the patient, who is the receiver of these services. "We have to include the patients in this journey because they're the receivers of everything that we do, especially now that all [these data are] thrown to the community practices as well as the physicians, but it still comes down to the patient experience." •