

# The National Oncology Working Group (NOW) Initiative: Payer and Provider Collaborations in Oncology Benefits Management

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Payers recognize the need to expand benefits management for oncology but struggle to find effective solutions amid the complexity of available therapies and skepticism from oncologists, who are facing their own set of economic pressures. An effort called the National Oncology Working Group (NOW) Initiative is trying to change the sometimes adversarial relationship between payers and oncologists through a collaborative model. The group, which is supported by pharmaceutical manufacturer sanofi-aventis, is developing patient-centered strategies for successful and sustainable oncology benefits management. The focus includes finding consensus between payers and providers and devising solutions for oncology management such as decreasing variability of cancer care and improving end-of-life care for patients with terminal illness. NOW is designing tools that will be tested in small-scale regional demonstration projects, which NOW participants anticipate will set an example for successful oncology benefits management that can be replicated and expanded.

*(Am J Manag Care. 2010;16(4):e94-e97)*

**For author information and disclosures,  
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## BACKGROUND ON THE NOW INITIATIVE

Pharmaceutical manufacturer sanofi-aventis began planning the National Oncology Working Group (NOW) Initiative in 2007, when commercial payers began to more actively manage oncology therapies but lacked a forum to encourage oncologist participation. During an interview with the director of oncology account management teams at sanofi-aventis, Joe Baffone said, "There had not been a platform for those discussions to happen. We needed to figure out how we could facilitate this" (oral communication, June 2009).

According to Chris Leidli, senior director of oncology marketing at sanofi-aventis, support by sanofi-aventis for the NOW Initiative complements its commitment to payer education (oral communication, June 2009). "We would like to see coverage and policy decisions in effect that ensure patients receive full access to all the available treatment options that are appropriate," Leidli said.

The effort began with plans for advisory boards, market research, and opportunities for increased interaction between payers and oncologists. sanofi-aventis partnered with AmerisourceBergen Specialty Group to recruit the NOW advisors and to facilitate meetings. Xcenda's Managed Care Network,<sup>1</sup> a panel of pharmacy and medical directors representing more than 150 million covered lives, and the International Oncology Network, an oncology drug group purchasing organization, are part of the AmerisourceBergen Specialty Group family of companies. NOW's payer advisors were recruited from the Managed Care Network, and the physician advisors were recruited through the International Oncology Network.

In addition to being active in the Managed Care Network, the NOW payer advisors are executive-level decision makers at national or regional managed care organizations. NOW's provider representatives are active in the International Oncology Network's large provider practice group and include practicing oncologists and oncology practice administrators. Advisors were chosen for their oncology expertise, willingness to collaborate with other stakeholders, and understanding of evidence-based clinical pathways. They were also selected based on their willingness to engage in multiple live meetings, Web-based surveys, and teleconferences.

In mid-2008, NOW advisors completed Web-based surveys

**In this article**  
Take-Away Points / e95  
**Published as a Web Exclusive**  
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tailored specifically to providers and payers that revealed shared concerns and opportunities for collaboration. For example, 95% of providers (n = 50) and 64% of payers (n = 50) agreed that guidelines and pathways had a “somewhat significant” or “very significant” role in their organizations. In addition, more than 80% of payers and providers surveyed agreed or strongly agreed that their groups could work together on evidence-based and cost-effective quality-of-care improvement efforts.

In June 2008, payers and providers attended separate meetings to further explore issues identified during the surveys. Those sessions were followed by a payer-provider summit in November 2008.

Once the tools that NOW is designing are ready, the group will explore the feasibility of regional demonstration projects that would call for payers and providers to identify metrics to evaluate and reward quality improvements in cancer care. Exact details surrounding the demonstration projects, including how process measures will be developed and how sites will be chosen, are in the conceptual stage. However, NOW's vision includes selecting metrics from widely accepted evidence-based clinical guidelines for oncology care such as those developed by the National Comprehensive Cancer Network or the American Society of Clinical Oncology. Oncology practices participating in the demonstration projects would report, primarily through electronic tools or processes, on quality measurement data. These data would be used to generate reports for oncology practices and for managed care plans to help evaluate the providers' progress. Practices that meet established benchmarks might receive incentive payments. The provider data will be combined with the payer's administrative claims data to give a full picture of the oncology management strategies and outcomes.

“We are trying to be part of the solution,” said Ken Trader, AmerisourceBergen Specialty Group's vice president of strategic accounts for managed care, “by changing the paradigm of how oncology is managed and reimbursed” (oral communication, June 2009).

### KEY FINDINGS, POTENTIAL CHALLENGES, AND SHARED GOALS

In interviews, NOW advisors say that oncology benefits management has a poor track record, mostly because payers and providers have conflicting incentives. In addition, NOW participants agree that payer reactions to the growing costs of healthcare, such as increasing patient cost sharing

#### Take-Away Points

An effort called the National Oncology Working Group (NOW) Initiative is trying to change the sometimes adversarial relationship between payers and oncologists through a collaborative model that includes the following:

- Developing patient-centered strategies for successful and sustainable oncology benefits management.
- Finding consensus between payers and providers and devising solutions for oncology management.
- Designing tools that will be tested in small-scale regional demonstration projects.

or cutting physician reimbursements, are not sustainable solutions.

Rising premiums have prompted many employers to reduce employee benefits and to shift more of the costs of care to patients. However, increasing patient cost sharing can negatively affect patients' access to therapy.<sup>2</sup> At the same time, payers looking for ways to manage resources have alienated some oncologists by imposing performance metrics without much input from the physician community.

Oncologists are affected by cuts in public program reimbursement for infused and injectable therapies, wider availability of oral oncolytics, and increased competition from hospitals and other practices. “The concepts around the NOW initiative could become a template for [payers to have] a conversation with oncologists,” said Kenneth Schaecher, MD, a NOW payer advisor and medical director of SelectHealth, a managed care organization covering 500,000 beneficiaries in Utah and Idaho. In an interview, Dr Schaecher commented that the current system incentivizes physicians to prescribe high-cost therapies and pays them more for the volume of services rendered rather than for improvements in quality and efficiency in patient care (oral communication, June 2009).

The economic pressures facing oncology are likely to continue. Anticancer therapies dominate the pipeline for new drugs. In 2008, there were 630 drugs in development for cancer, including those in phase 2 and phase 3 clinical trials and those awaiting approval by the US Food and Drug Administration.<sup>3</sup> The next-largest therapeutic area, treatments for conditions affecting the central nervous system, had 321 drugs in development.

Oncology agents accounted for 3% of health plan spending in 2008, a figure that was expected to jump to 5% between 2009 and 2011.<sup>3</sup> The increases are projected because of increased costs for therapy and greater utilization.

Efforts to develop measures to benchmark the quality of cancer care must be implemented fairly and appropriately so as not to compromise patient care or lose credibility with providers. Guideline development must balance controlling healthcare spending with maximizing patient safety, increas-

ing efficacy, and improving quality of life. Payer clinical guidelines in oncology need to allow providers sufficient flexibility in medical decision making. Cancer care, perhaps more than any other medical specialty, is complicated by vast differences in diagnoses, staging, physician training, and available therapies, as well as by patient variation in medical history, genetics, and desires for treatment. Clinical guidelines cannot be applied uniformly in every case, and their applications to actual treatment decisions require a degree of flexibility.

The NOW advisors agree that providers should not have to adhere to a given guideline in every instance and should be offered an opportunity to justify to payers what may likely be a more appropriate course of treatment for a specific patient. Measures could look at a percentage of a physician's patients who meet a certain metric rather than an absolute number. For example, physicians might receive a bonus payment if they achieve a 50% reduction in the number of patients with stage IV non-small cell lung cancer receiving fourth-line therapy. At the same time, physicians could receive bonus payments for providing weekend and extended patient visits, offering patient education for adverse effect management, and documenting initial and ongoing disease treatment planning with patients.

NOW participants say the lack of trust between providers and payers is one of the biggest challenges to their initiative's success and to oncology benefits management efforts in general. However, NOW advocates say that their approach could work because they are focusing on shared objectives, including increasing appropriate access and use, managing limited resources, improving quality of care, and identifying metrics to measure quality, safety, and value.

"I think the most important message is that we need to do it together," said Jeff Patton, MD, a NOW advisor and practicing medical oncologist who is the chief medical officer of Tennessee Oncology. "We all need to be at the table" (oral communication, June 2009).

## FOCUS AREAS FOR CHANGE

### Decreasing the Variability of Care

NOW advisors agreed that there is a need to reduce variability in oncology care by promoting the adoption of widely accepted clinical guidelines for assessing new patients, treatment, and posttreatment follow-up. NOW is evaluating and creating data collection tools to assist in this process and is defining specific metrics to assess baseline and follow-up rates.

NOW participants created a model designed to decrease variability of care in cancer treatments. The schema is shown in the **Figure**.

Although payers and providers would decide the exact specifications for such a program, NOW participants en-

visioned a model that would pair 1 large oncology practice with approximately 5 payers. They would focus initially on supportive care and on specific disease states such as breast, lung, and colorectal cancers. Next, the groups would assess and quantify existing care processes. They would choose easily identifiable claims-based data for metrics. Potential incentives could include giving bonus payments based on a percentage of savings, offering a differential fee schedule, or removing requirements for prior authorizations. Metrics could include reduced emergency department and hospital utilization and costs and patient satisfaction.

### End-of-Life Care

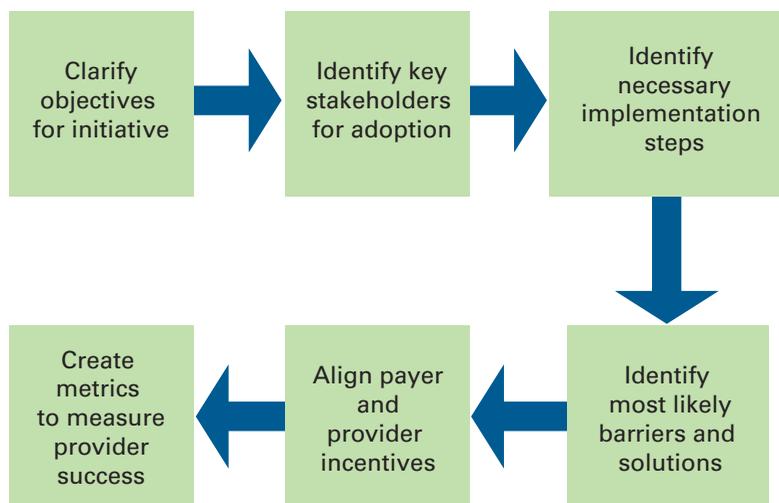
NOW has identified end-of-life care as another area of focus. According to a 2008 study<sup>4</sup> of Medicare beneficiaries 65 years and older who had been diagnosed as having cancer, the cost of treating cancer in the last year of life is the most expensive period for payers, although that varies depending on the tumor site, stage at diagnosis, and length of survival.

According to Dr Schaecher, opportunities exist to save money and to encourage high-quality care that will not equate to rationing. For instance, Dr Schaecher said that, if patients are better educated about the poor outcomes associated with some fourth-line high-cost drug therapies and are offered improved management of adverse effects such as nausea and pain, it can help to avoid costly trips to the emergency department or inpatient hospitalizations. Hospitalizations are the largest cost component for treatment-related expenses for most tumor types.<sup>4</sup>

The 2008 study by Wright et al<sup>5</sup> found that patients with terminal cancer who had conversations about end-of-life care with their physicians had less aggressive medical care before death and earlier hospice care. The study also reported that aggressive care, including intensive care unit admissions, resuscitation, ventilation, and chemotherapy, was associated with a lower quality of life for patients and with a higher risk for major depressive disorder among bereaved caregivers.

NOW's ideas for improving end-of-life care focus primarily on how healthcare for a patient with cancer is transitioned following diagnosis of metastatic disease. Suggested process improvements include the following: (1) implementing an education protocol for providers and patients, (2) revising reimbursement methods to offer higher payments for delivering superior supportive care and for counseling patients, (3) creating a survey tool to assess patient and family member attitudes and knowledge about end-of-life issues, (4) offering more communication and sensitivity training to encourage providers to have discussions with patients and to implement disease management processes for end-of-life treatment, and

■ **Figure.** National Oncology Working Group (NOW) Initiative Participants Created a Model Designed to Decrease Variability of Care in Cancer Treatments



(5) leveraging agreed-upon metrics such as length of time off chemotherapy, percentage of patients choosing hospice, cost of care during the last 6 months of life, patient and caregiver satisfaction, rate of patients switching oncologists, and number of lines of chemotherapy, emergency department visits, hospital days, or days in hospice.

## RECOMMENDATIONS AND NEXT STEPS

The idea behind NOW's demonstration projects is to create models for oncology benefits management that are simple, easily replicated, measurable, and sufficiently flexible to be customized on a local or regional scale. The projects must also be affordable, sustainable, and economically beneficial to providers and to payers. NOW is continuing its work in 2010. Although it is too early to measure the project's success, these open and longitudinal conversations between payers and oncologists are a promising start.

### Acknowledgment

We thank Robert S. Hauser, MD (Geriatric Oncology Consortium, Inc) for his logistical support.

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**Funding Source:** Partial funding for this project was provided by sanofi-aventis.

**Author Disclosures:** All the authors (AMS, CER, LMB, AS, BJL) are employees of AmeriSourceBergen Specialty Group, whose companies include the International Oncology Network, the Managed Care Network, and Xcenda.

**Authorship Information:** Concept and design (AMS, CER, LMB, AS, BJL); acquisition of data (AMS, LMB, AS, BJL); analysis and interpretation of data (AMS, LMB, AS, BJL); drafting of the manuscript (AMS, CER, AS); critical revision of the manuscript for important intellectual content (AMS, CER, BJL); obtaining funding (LMB); administrative, technical, or logistic support (AMS); and supervision (BJL).

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