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ALSO IN THIS ISSUE



SP219

ZANUBRUTINIB STUDIES. Data for zanubrutinib (Brukinsa) were reported at the European Hematology Association, including results from ALPINE showing the Bruton tyrosine kinase inhibitor compares favorably with ibrutinib in relapsed and refractory (R/R) chronic lymphocytic leukemia/ small lymphocytic lymphoma. Updated phase 2 results from MAGNOLIA show effectiveness for adults with R/R marginal zone lymphoma treated with at least 1 prior line of therapy, [SP219-SP222](#).

ONCOLOGY VALUE COALITION.

Two online meetings of the Oncology Value Coalition, featuring faculty from City of Hope, Highmark Blue Cross Blue Shield, and Cardinal Health, convened discussions of the value of genomic testing for payers and employers and the rise of real-world evidence in the FDA regulatory process, [SP206-SP209](#).



ALVARNAS FEINBERG

GUIDELINES UPDATE.

Updated guidelines from the National Comprehensive Cancer Network for Waldenström macroglobulinemia have added zanubrutinib (Brukinsa) as a preferred regimen, [SP210](#).

**BIOSIMILARS UPDATES.**

The FDA cautions Amgen about an advertisement of its Neulasta Onpro device for delivery of pegfilgrastim, and a report highlights the discounts that come with biosimilar use, [SP227-SP228](#).



Make plans for our 10th anniversary meeting, September 23-24, 2021, in Nashville, Tennessee! See [SP211](#), [SP234](#), [SP244](#).



POLICY

Health Insurance, Blood Cancer Care, and Outcomes: A Literature Review

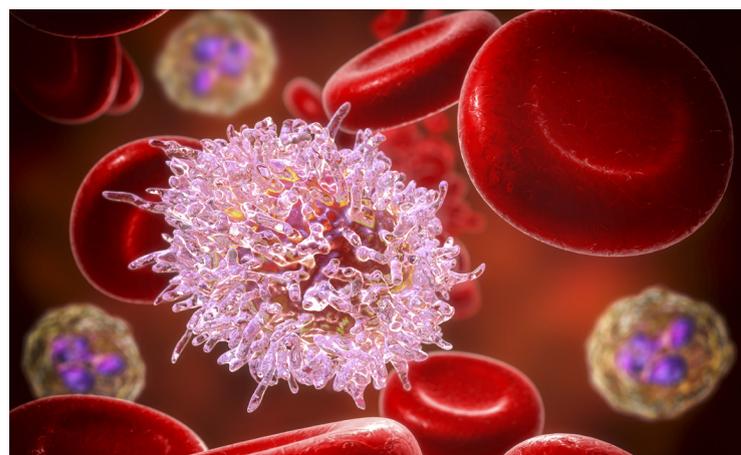
Karen Crotty, PhD, MPH; Marialanna Lee, MSc; Katherine Treiman, PhD; Maria Sae-Hau, PhD; Candi Wines, MPH; Catherine Viator, MS; and Elisa Weiss, PhD

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) established several health insurance reforms important to cancer care in the United States,¹ including prohibiting insurers from denying coverage or setting higher premiums on the basis of preexisting health conditions, expanding Medicaid eligibility to adults with incomes up to 138% of the federal poverty level, eliminating the Medicare Part D coverage gap or “donut hole,” and requiring commercial insurers to cover the cost of routine care that a patient receives while enrolled in a clinical trial. Yet despite these reforms, many patients with cancer continue to experience significant financial burden² and distress associated with their care, referred to as the “financial toxicity” of cancer.^{3,4}

Financial toxicity is particularly prevalent among patients with blood cancer, who are increasingly treated with expensive, orally administered anticancer drugs. A rapid rise in the cost of these drugs has offset the savings patients should have seen from the closing of the donut hole.⁵ Consequently, many of the more than 1.3 million people in the United States who are either living with, or are in remission from, blood cancer⁶ face higher out-of-pocket costs than patients with other cancers.⁷ Additionally, patients with blood cancer report a myriad of other access barriers, ranging from lack of insurance and inadequate provider networks to coverage denials. With recent growth in the availability of health plans that do not comply with the ACA's market reforms, these barriers are likely to grow.⁸

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An illustration of hairy cell leukemia, a form of chronic lymphocytic leukemia, showing an accumulation of abnormal B lymphocytes.

PAYMENT MODELS

Clinicians and Payers Expect to Wait and See Before Embracing CMS' MIPS Value Pathways

Erin Crum, MPH

QUALITY MEASUREMENT in federal health care programs has been around since at least 2007, when CMS introduced the Physician Quality Reporting System (PQRS) for providers caring for Medicare beneficiaries. The program continued to evolve, and it eventually became part of CMS' Merit-Based Incentive System (MIPS), CMS' first attempt to integrate several different incentive-based programs under one umbrella, including PQRS and meaningful use.¹ The goal of MIPS is to optimize patient care by utilizing financial incentives to encourage providers to deliver high-quality, cost-efficient care.

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PRACTICE TRANSFORMATION

ASCO, COA Release Updated Standards for Oncology Medical Home

Mary Caffrey

ON JULY 13, the American Society of Clinical Oncology (ASCO) and the Community Oncology Alliance (COA) released updated standards for the Oncology Medical Home (OMH), putting renewed emphasis on the importance of palliative care and ASCO's Quality Oncology Practice Initiative (QOPI), which seeks to promote safety and best practices in the administration of chemotherapy.¹ Details on the new standards were published in *JCO Oncology Practice*.²

A joint statement from the 2 groups stated that the new standards offers a roadmap for delivering “equitable, high-quality cancer care.”³

“In releasing the new standards, ASCO and COA seek to achieve a broad consensus among all stakeholders—including patients, clinicians, payers, purchasers, and employers—on what patients with cancer should expect and receive from their cancer care teams,” the groups said.

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ASCO, COA Release Updated Standards for Oncology Medical Home

MARY CAFFREY

CONTINUED FROM COVER

Also in their statement, ASCO and COA stated that the standards “provide an opportunity for the entire oncology community to work toward a value-based model of care that will benefit all patients with cancer.”

“Every single patient has the right to high-quality, evidence-based, and cost-effective cancer care. However, our challenge as clinicians and as a broader oncology community has been to define what that high-quality cancer care looks like,” ASCO President Everett E. Vokes, MD, emphasized in the joint statement. “These new, comprehensive standards will remove ambiguity and serve as a strong foundation for all stakeholders to work together to ensure that every single person receives the care they deserve, throughout the entire patient journey.”

COA members have been working with OMH standards since 2012; the effort grew out of an earlier initiative on the patient-centered medical home. The idea of creating standards for care coordination, informed decision-making that involves both doctor and patient, and communication standards to ensure that patients and families are active participants in cancer care—that care is something done *with* them, not *to* them—guided the development of CMS’ Oncology Care Model (OCM), which is set to expire next year.⁴

“These new OMH standards provide oncology practices with a single set of cancer care delivery expectations that benefit patients, payers, employers, and other stakeholders,” said COA President Kashyap Patel, MD. “As practices transition into value-based care delivery, those that adopt this framework will be able to focus on a standardized process that measurably demonstrates high-quality, patient-centered, and efficient care.”

In the article in *JCO Oncology Practice*, the authors said the new standards were based on a set of core principles, which include the idea that each patient should have a personal relationship with a physician responsible for meeting needs “across all stages of care” and the oncology practice should be physician-led. The standards also include that care is coordinated and integrated, that access to care is enhanced, that quality is measured and continually improved, and that pay structures recognize the added value of the Patient-Centered Medical Home.²

The new joint standards are the basis of an upcoming 2-year, ASCO-led OMH certification pilot, details of which will be released over the next few months. The standards will cover 7 areas of cancer care, including 2 new areas, or domains, that have been designed since the original set. They are:

- (1) patient engagement, which includes shared decision-making;
- (2) access to care in the right place at the right time;
- (3) value-based treatment, including documentation of the use of evidence and clinical pathways, and referral to clinical trials;
- (4) access to equitable, comprehensive, and coordinated team-based care;
- (5) continuous practice quality improvement, including the use of data and patient-reported outcomes;
- (6) advance care planning and palliative and end-of-life care, including discussions of goals; and
- (7) adherence to chemotherapy standards based on QOPI certification program standards.

Bo Gamble, COA’s director of strategic practice initiatives, told *The American Journal of Managed Care*[®] that the new standards were developed with a multistakeholder team of physicians, a nurse, patient advocates, and leaders from employer coalitions who fund health care. The updated standards reflect the addition of the domains to elevate the importance of end-of-life care and adherence to QOPI certification, he said.

The hope is that payers can coalesce around a common set of pay-for-performance standards, as least with regard to care delivery. All oncology payment models have 3 basic elements, Gamble said: care delivery, payment methodology, and performance measures. He pointed to research that was presented by COA indicating that its members deal with up to 35 different oncology payment models across public and commercial plans.⁵

“It’s gotten crazy,” Gamble said. Such diversity becomes impossible for practices to manage. It would be preferable, he said, to reach agreement with payers to at least standardize the platform for care delivery, with payers differing on the payment methodology.

Some experts have said that a multimodel system can be unethical, if physicians feel the evidence points to one method being superior.

Will payers buy in? Gamble is encouraged by early discussions as COA works with ASCO on the upcoming OMH certification pilot. “So far, so good,” he said. Compared with the last iteration of the OMH, “this program is much more structured and goal-oriented.”

This pilot, he said, will address a major weakness of the current OCM: A dashboard will gather clinical data to offer real-time information that includes comparisons with peers. The information delay in the current Center for Medicare and Medicaid Innovation (CMMI) program means providers find out about weaknesses well after the fact.

With oncology practices still waiting to hear what will come after the OCM ends in 2022,⁶ “We hope that CMMI will take notice,” he said. ♦

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