

Oncology Management Programs for Payers and Physicians

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Oncology disease is costly—in terms of drugs, hospitalizations, end-of-life care, imaging, and diagnostics. Most of these costs occur outside the physician’s office. As much as three-quarters of payer costs for cancer care come outside of the physician’s office and the drugs administered for treatment. Several oncology management programs promise to help rein in the rising costs of oncology but focus only on the costs incurred in the physician services and the administration and costs of drugs in the outpatient setting.

Payers are looking for help in understanding oncology. Discussion of what oncology treatment is appropriate, what delivery models will work best, and how drugs are to be managed is decidedly on the table for an increasing number of payers. There is a growing demand for consistency in care decisions and a reduction in variation (where appropriate) in treatment options.

Although some payers initially sought reduction in drug cost as the primary solution, many early oncology management programs are now showing cracks and problems. One of the first initiatives between a large managed care organization in Maryland and one external vendor started with physician incentives on the basis of higher drug reimbursement rather than on professional fee negotiations.¹ It only took 2 years for that methodology to be completely changed, taking many physicians by surprise and leading to issues with contracts and negotiations. An oncology management contract suddenly announced between another external vendor and a large managed-care entity in the southeast was not well received by physicians and is still in active dispute 2 years later.² Federal and private drug management programs that focused on setting drug prices or copay/coinsurance rates, which physicians and patients found to be unaffordable, have resulted in thousands of patients being referred to more costly hospital settings under different insurance benefits.

In 2011, more payers are looking for truly workable solutions that engage physicians, reduce variation, decrease costs

where appropriate (but not at the expense of quality care), and create a collaborative business partnership between payers and providers in a region. Physicians across the country are also seeking ways to engage payers in dialogue about the management of oncology in their regions. Individual practices, regional groups, and state associations are actively coming to the table on their own. However, the lack of common data platforms, consistent technology solutions, and wide variation among physicians in a smaller practice—let alone those in a larger group encompassing multiple practices—about how, why, and when to approach payers also create challenges and hurdles that stagnate the process. Without data and formal processes for treatment decisions and patient monitoring, physicians are unable to prove the consistency and appropriateness of their care.

Adding to this confusion, many external vendors see a business opportunity in offering solutions to either payers or providers (but primarily payers). Most are for-profit entities coming from outside the traditional triangle of payer-patient-provider. After 4 to 5 years of experience with some of these external oncology management models, both payers and providers are learning about the impact they have on the flow of care and the sustainability of some model types.

NINE MODELS FOR ONCOLOGY MANAGEMENT

There are 9 models in play for managing oncology at this point, and each has experienced varying degrees of success and potential sustainability. Our review discusses concerns, issues, and considerations for payers or providers exploring the role of each model.

Drug Management

The focus of the drug management model is on drugs used for oncology. Tools used are preferred product pricing, formularies, and prior authorizations. This model is offered by companies like

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ICORE Healthcare (owned by Magellan Health Services, Avon, CT), CareCore Oncology (Bluffton, SC), many specialty pharmacies, and P4 Healthcare (Ellicott City, MD). Although savings can be generated with this model (predominantly by dropping drug reimbursements and encouraging the use of generic or lower-cost drugs), this model does not address any aspect of oncology care other than drugs and thus shows diminishing returns over time. If decisions focus solely on the price of drugs without direct medical insight into the individual patient's medical situation and disease, there is potential for adverse/unintended consequences that affect the patient care or efficacy of the drug combinations. Physicians are not involved in this model, but they are required to accept the pricing or approval processes, even if they incur a loss on the drugs or the resources to seek approval. To the extent that drug management model pricing or policies restrict access to a drug deemed appropriate by the physician, the model moves into the realm of medical decision making by other than a physician. One national managed care organization is using an external drug pricing model that selectively prices a commonly used antiemetic drug below physician cost, despite this drug being the only one indicated for highly emetogenic chemotherapy treatments. This has reduced access to standard of care treatment for the patients covered by this insurer.

Disease Management

The focus of the disease management model is on managing symptoms and adverse effects of oncology disease and treatment from outside the physician's office. This model is offered by Quality Oncology (owned by Alere, Waltham, MA), ICORE Healthcare, and to a limited extent, Innovent (owned by US Oncology, The Woodlands, TX). The challenge for this model is that return on investment and thus sustainability have been difficult to prove. The model requires physicians' offices to provide clinical treatment plans so that banks of nurses can communicate with patients. Patient confusion ensues with multiple contacts, and physicians managing the patient care become concerned about the liability and risks of patients receiving information from other than their direct care provider with no face-to-face knowledge of the patient and the individuality of the disease and care. Although disease management is a core component of cancer care, it would be more efficient for physician cancer centers to build formal disease management models that execute tracking and monitoring of results similar to what external vendors promise payers.

Specialty Pharmacy/Pharmacy Benefit

The specialty pharmacy or pharmacy benefit model is designed to shift oncology drugs to specialty pharmacy vendors and send the payment for oncology drugs through the

pharmaceutical benefit. Payers find greater flexibility to set member benefit structures related to drugs under the pharmaceutical benefit, but they are also finding unanticipated adverse consequences. The health status of patients with cancer changes frequently, therefore often requiring same-day changes in planned chemotherapy treatments. This is not a problem when the physician buys drugs and has an inventory from which to take the new drugs or vial sizes for the changed dose. This does become a costly problem for payers if the drug was ordered and shipped from a specialty pharmacy for a specific patient and then cannot be used. Once the specialty pharmacy ships the drug, it bills the payer, and if the drug cannot be used, it must be discarded, according to state regulations. Physicians bear the liability for drugs administered to these patients and are often unwilling to accept the risk of using drugs provided from a source they do not choose. There are some situations in which specialty pharmacy and physicians have been able to create a working relationship, but that is usually on a one-on-one basis and with tight working parameters. Specialty pharmacy vendors are most often used by physicians whose drug reimbursement is significantly below cost, particularly under Medicaid programs. Payers considering this model will want to consider the financial and liability issues and proceed with caution and in close connection to the physician cancer centers in the area. Most often, general mandates to conversion to specialty pharmacy have not gone smoothly, and many are abandoned within a short time. The largest private insurer in a major northeastern state recently mandated that all injectable and oral drugs be obtained from a specialty pharmacy, even for use in a physician's office.³ For several reasons—including additional cost of drug waste and concerns over the impact on patient care—the oncologists in that state successfully convinced the insurer to abandon that universal mandate.

Retail Infusion Centers

The retail infusion center model is being piloted in a few areas of the country. It shifts oncology treatment to freestanding infusion centers, away from physician- or hospital-based centers. Although the model has not been in play long, questions are being raised about its sustainability, about the types of patients being accepted at these centers, and about whether the model adequately allows for the viability of continued care for more complex cancer treatments. Physician concerns arise about their liability for treatments not carried out under their direct supervision and implications for efficient and effective continuity of care. Additional concerns are raised about limitations on the type of patients and treatment mix being accepted at these centers. Too many limitations (ie, cherry-picking) can undermine more comprehensive programs that

require a balance of simple and complex cases to efficiently provide care and cover resource costs.

Radiation Oncology Benefit Management

This model is offered by commercial radiation oncology benefit managers (like CareCore National, American Imaging Management [Deerfield, IL], National Imaging Associates [owned by Magellan Health Services], MedSolutions [Franklin, TN], and HealthHelp [Houston, TX]) who focus on use management and prior authorization for care provided in medical offices. This model has been challenged by the New York Attorney General, which resulted in a partial exemption for oncology from the use management program.⁴ The American Society for Therapeutic Radiology and Oncology has written formal “Quality of Care Concerns.”⁵ Payers seek assurances about evidence-based care and appropriateness of care, but oncology services may find it more productive to build programs directly with local care providers.

Oncology Benefit Management

The oncology benefit model is one that includes use management, prior authorization, approval algorithms, and a new concept called rational physician reimbursement. Vendors of this model include ICORE, P4 Healthcare, and Medco Health Solutions (Franklin Lakes, NJ). Use of external vendors to effect medical decision making without firsthand knowledge of the patient has been considered by a few payers, but none of those contracts have gone smoothly, and significant physician concern has been raised. Payer interest in this model has slowed measurably in the last 2 years, and more collaborative alternatives are being reviewed. The first contract of this type was announced in a large southeastern state in mid 2009, and the negative reaction from the oncology community was so strong that it is still being contested 2 years later and will ultimately not prove to be sustainable.²

Collaborative Payer/Physician Programs

Collaborative payer/physician programs are emerging rapidly (primarily as a solution to the stops and starts of other failed models) and eliciting great interest from payers and physicians alike. This model does require a joint approach to data and development of programs. It is a progressive relationship (step collaboration like step therapy) and, when done most effectively, starts with a joint data review and expands into a few pilot programs. Eventually, tools like guidelines or pathways or end-of-life management programs will be implemented, but those are usually not the first point of discussion—for good reason. Both payers and physicians have vastly different perspectives on goals, methodology, and issues. It takes time to build trust and understand each other’s perspec-

tives as well as to identify and prioritize cancer management for the market. Existing successful models have grown over time in selected markets and have been the product of ongoing joint effort between one or two practices and a willing key payer. The collaboration between Premara Blue Cross and Cancer Care Northwest in Oregon has been in process for about 5 years and is yielding notable care and cost results.

Seizing on one vendor tool and jumping into a relationship on the basis of that tool could lead to a less than ideal launch and to frustration on both sides; it is almost like fitting a square peg into a round hole. Flexibility and preparation are key to successful collaboration. Even as healthcare delivery evolves and models like accountable care organizations are developed, the crux of effective, efficient care will be grounded in the precepts of good medical decision making and strong data platforms. External management models will not yield the results that collaborative models can. Collaborative models and relationships are ultimately sustainable and the primary models for successful payer/physician relationships.

Front-End Compliance Programs (Pathways)

Front-end compliance programs or pathways are often considered a model, but they are actually tools to be used in a collaborative payer/physician program. The goal of a front-end compliance program is to support evidence-based medical decision making by physicians at the point of the decision for cancer treatment. Payers encourage these programs because of their documented ability to reduce treatment variation, follow evidence-based guidelines, and ultimately decrease costs over the full continuum of care rather than just for drugs. Physicians seek these programs because they can prove that they use evidence-based care and, hopefully, streamline the payer acceptance of those choices. Two programs that are physician-driven are Innovent Oncology and Via Oncology (owned by the University of Pittsburgh Medical Center, Pittsburgh, PA). Another emerging program is from a partnership between the National Comprehensive Cancer Network (NCCN) and Proventys (Newton, MA). This is the only program that uses technology to document and support physician decision making directly from the nationally recognized standards of care—the NCCN guidelines. Other programs use reinventions of those guidelines as a result of the proprietary rights of NCCN. Another external vendor that is starting to offer a front-end solution to payers as an authorization tool for use by physicians is eviti (owned by ITA Partners, Philadelphia, PA).

Physicians are usually actively engaged in a front-end compliance pathway program and, through the decision-making iterations, usually arrive at recommended treatments for the state and stage of disease of individual

patients. Approximately 20% of the time, that treatment is not selected, but the physician documents the reasons why for a continuous information loop. Pathways programs address more than 90% of cancers, but they may be difficult to implement at the first round of discussions with payers and providers for a variety of technical, cultural, and procedural reasons. Pathways are a hot topic for both payers and providers, but they can cause delays if introduced too quickly in the relationship. There will be a fine balance between the engagement of a clinical community and the full transparency of data and information exchange and the application of Web portals for clinical decision making. If that balance is not achieved, some front-end decision-making programs will likely fail if they are perceived as tools for limiting care choices instead of as tools to support physician medical decision making.

Back-End Compliance Programs (Preferred Treatment Menus)

A back-end compliance program is also a tool rather than a model for oncology management. It is called back-end because it relies on data collection after treatment or on treatment documentation (with some added manual data) to prove compliance retroactively against a menu of several preferred treatments. This menu is unique to each disease but not tailored to an individual patient's state and stage of disease. Practices agree to allow a cookie into their practice system to retrieve all claims data for reporting purposes. P4 Healthcare has executed some contracts for this model, predominantly with payers as a compliance tool. Contracts executed with payers and then announced to physicians have traditionally not gone smoothly. Most states in which these back-end contracts have been introduced have not seen them fully executed as a result of conflicts that have arisen. Challenges with existing back-end compliance programs center around limited data sets, management of data, and concerns about the sustainability of the preferred menu model for payers and physicians. Major drug distributors International Oncology Supply and McKesson have developed software programs to track treatment regimens and provide reporting in a back-end manner as well, but to date, they have no known contracts supporting payer/physician relationships.

SEVEN ESSENTIAL ELEMENTS FOR SUCCESSFUL ONCOLOGY MANAGEMENT

When evaluating potential models that may become the cornerstone of an oncology management model, there are at least 7 elements to consider as indicators for sustainability and success.

- Will it lead to the right care in the right setting at the right time? If not, it only addresses a limited scope of oncology and is likely to be unsustainable and self limiting.
- Does it contribute to a decrease in variation yet still allow for the complexity of oncology and physician medical decision making? If not, it will be difficult to engage the physicians and will become unsustainable and self limiting.
- Does it fully engage physicians? If physicians are not involved in the development and decision making around the program, it greatly increases the likelihood that the program will entail onerous requirements or interfere with efficient and effective patient care and thus become untenable. External vendors that provide models that will be imposed on physicians rather than engage physicians collaboratively will quickly prove the model unsustainable. Physicians are the link between the patient and the care provided as well as the primary drivers of efficient, quality care. The engagement of other care professionals (like nurses and pharmacists) and patients and their role in the care process are also significant factors, but this discussion focuses on the interactions between the care provider, who makes the medical decisions, and the payer.
- Does it affect the total oncology spectrum? If it does not and focuses on only 1 aspect of oncology care, such as drugs, it may lead to penny-wise and pound-foolish results and not be successful in the long run.
- What data are obtained, how, and by whom? Reporting is the only way to create information, and information becomes proof of what was done or not done. Information will only be effective if it is fully shared between the payer and the provider, so models or solutions that track one-sided data will ultimately fail.
- Does the program support a journey or a single step? Oncology is complex and rapidly changing. Building trust and collaborative relationships paves the way for a series of evolving projects. In the early years of these relationships, programs have been announced with great fanfare and have slowly disappeared quietly, primarily because they were built around 1 solution and did not build the groundwork for an ongoing collaborative relationship.
- Under healthcare reform, payers will be held accountable for monies spent proportionately on administrative costs rather than on medical care expenditures. Collaborative programs and models that support and directly interact with physicians rather than external vendors will also support payers on medical costs.

Ultimately, success for both physician/payer relationships will hinge on trust, data, mutually acceptable evidence-based decision making, accountability, and support for the physician-based community care model. Successful management of oncology lies in the medical decision mak-

ing and not in the drugs; it will address the costs along the full continuum of care. Careful selection of partners and models will support rather than hinder successful payer/physician oncology strategies, although the journey will entail a truly broad and strategic approach rather than reliance on 1 model or tool.

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