National Alliance
of Healthcare Purchaser Coalitions
Driving Innovation, Health and Value

ACHIEVING VALUE IN CANCER CARE

Striving for Patient-centered Care

A Deep Dive Powered by eValue8

DECEMBER 2018

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EXECUTIVE SUMMARY

For years, employers (and health plans) have been reticent to manage cancer care. However, the need and opportunity for effectively addressing waste and low-value care to achieve a higher quality of patient care and support has never been greater. With the dramatic advances in the ability to treat cancer through the introduction of innovative diagnostics and medications, the cancer mortality rate has dropped by 25% since the early 1990s.[1] At the same time, the costs of treatment have skyrocketed with the average costs of some common cancers now ranging from $100,000 to $300,000.[2]

These advances in cancer care and attendant cost increases magnify an old dilemma for employers: how to provide benefits and coverage that enable access to high quality cancer care and outcomes at a reasonable cost. Key concerns include:

- Ensuring that newly-diagnosed members have **timely** access to quality and appropriate care and support
- Enabling employees to make **informed** decisions regarding treatment, including the financial burden
- Achieving the best **possible health outcomes** including a caring experience for employees, prevention, early identification/diagnosis, and high-quality interventions and treatment from health plans and network
- Mitigating the high costs of inappropriate or poor quality/low-value treatment, inadequate patient-centered support and waste

To support coalitions and the employer community in these efforts, the National Alliance of Healthcare Purchaser Coalitions (National Alliance) has conducted a very thorough assessment of how health plans are managing cancer care. Questions pertained to prevention and early identification, treatment evaluation, patient support, quality and performance management, as well as recovery and end-of-life support. The complexity of cancers and diversity of patients require an agile, empathetic and highly disciplined approach to support employees and their families.

Overall results revealed that health plan performance with respect to cancer care and support varies across plans, much as it does in other areas such as behavioral health and pharmacy benefit management. More importantly, we found that even though health plans, as an industry, identified cancer care as a critical issue, the development of cancer care science has drastically outpaced the industry’s ability to effectively balance the fast growing costs with excellent quality and patient access. **It is incumbent upon employers to be a force for positive change by working with their health plans and PBMs to drive implementation of best practices, increased value and improved outcomes in cancer care.**

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[1] See: https://www.cancer.gov/about-cancer/understanding/statistics

[2] Milliman Research Report, A Multi-Year Look at the Cost Burden of Cancer Care, April 11, 2017, p. 9.

HIGHLIGHTS

Rapid advances in cancer care and support challenges the plans' ability to effectively balance the fast-growing costs with excellent quality and timely patient access. All respondents have adapted to some degree by increasing access to:

- off-label use of FDA-approved medications with prior authorizations
- emerging interventions and programs such as cancer patient-centered medical home (PCMH), specialized cancer case management programs, and site of care optimization
- palliative care with curative intent

Gaps to be addressed include the need for:

- improved identification through higher screening rates and communication among plans and members and their providers
- better provider measurement and monitoring
- stronger criteria required for inclusion in cancer network
- broader use of incentives and payment innovation models
- more comprehensive and effective member decision support/treatment option resources
- greater coordination of support and care for the patient

Key Considerations

- **Cancer screening** – compliance with screening guidelines can help to detect cancers earlier, when they're most treatable. Later stage disease can be expensive to treat – and may not be curative. Avoidance of just one late stage cancer case may be sufficient to cover the incremental cost of improving cancer screening for an employer's benefits enrollees.
- **Correct diagnosis** – ensuring patient access to second opinion services can reduce the risk of a cancer misdiagnosis, and improve the likelihood of favorable treatment outcomes.
- **Site of care** – significant differences in cost for the same service – most typically cancer drug infusions – should be delivered in the most cost-effective setting.
- **Genetic testing** – becoming increasingly important as the array of immunotherapy medications available for cancer treatment continues to grow. Genetic testing is invaluable in determining whether a particular immunotherapy will be useful in treatment of a patient's particular cancer. Employers need to be aware that there are differences in the types of genetic testing, each having a different value.
- **Financial Impact ("Toxicity")** – Irrespective of advances in the effectiveness of cancer treatment, the cost of cancer care continues to grow faster than the medical inflation rate. Employers need to ensure employees/beneficiaries have benefits, resources and support for difficult treatment decisions where cost is a major consideration.

Key Takeaways

- Increasingly, many cancers can be treated with an eye toward successful recovery, ongoing management and more effective and accommodating return to the workforce
- Stakeholders need to effectively provide an environment where standards of personalized, evidence-based cancer treatment can evolve rapidly with reasonable costs for care
    - streamlining processes to allow **timely** access to the right treatment at the right place
    - mobilization of team-based patient-centered support that considers not just clinical but also the psycho-social and financial needs of the patient and family and supports shared decision making
    - using performance data to select network providers, particularly centers of excellence (COE) and measuring and reporting performance data at all points along the patient journey
    - creating a company culture of superior benefits communication, trust and support to encourage early identification and intervention
- Opportunity to root out waste associated with high cost and poor outcomes resulting from low-value care, poor adherence and wide variations in costs based on site-of-care
- Payment transformation can play an important role in accelerating adoption of best practices

Our opportunity to enhance the value of cancer care has never been greater as employers, health plans and providers collaborate toward high value, high performing, highly responsive system of support on behalf of cancer patients and their families.

BACKGROUND AND INTRODUCTION

Statistics from the National Institute of Health show that between 1990 and 2014, the cancer death rate in the United States fell by 25%. However, the costs of this progress have pulled the value equation in the opposite direction. In 2017, national expenditures for cancer care were $147.3 billion and an estimated 1,735,350 new cases of cancer[3] will be diagnosed in the United States in 2018.

In 2016, about 15.5 million people were cancer survivors in the United States and by 2026, that number is expected to increase to 20.3 million. A 2017 report by Milliman found that the cost of treating cancer over four years ranged from $101,000 for breast cancer, to $165,000 for colorectal cancer to $282,000 for lung cancer.[2] As the population ages, continued cost increases are likely especially as new, and often more expensive, treatments are adopted as standards of care.

Nowhere in healthcare are employers facing the challenge of providing value in health benefits, defined as quality outcomes at a reasonable cost, than in cancer care and support. The fast pace of revolutionary cancer care has had a dramatic effect on employees and employers—giving rise to availability of, and demand for health benefit-related support services that were virtually unheard of just a few years ago (Table 1).

Table 1.
Emerging Support Services for Cancer Care

- Access to clinical trials
- National Cancer Institute designated cancer centers/centers of excellence
- Oncology PCMH
- Approved off-label Rx
- Genetic testing
- Personalized medicine
- Specialized case management
- Attendance at tumor boards
- Psychosocial services
- Advance care planning
- Palliative care with curative intent
- Survivorship care planning
- Quality metrics that require cancer stage, date of death
- Availability of evidence-based clinical practice guidelines

With the addition of innovative platforms such as specialized cancer PCMH, specialized cancer case management, oncology centered patient support programs or third party support such as the Cancer Care Huddle, there has been an increased demand for services (Table 2) that historically have been a part of most support service programs. While this progress is encouraging, none of these support systems are available everywhere.

Table 2.
Historical Support Services

Return to work support

Pain management

Site of care optimization

Nutrition counseling

Patient navigation

Hospice

Access to other employment-based benefits, e.g., disability insurance

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[3] https://www.cancer.gov/about-cancer/understanding/statistics

While all health plans offer some flavor of specialized cancer case management, they vary in breadth and depth. In fact, some cancer PCMHs and centers of excellence with advanced support mechanisms are available only through some health plans.

Unless coordinated and effectively integrated, these emerging offerings/platforms may lead to confusion and delayed/fragmented care. Employers and payers will need to address the challenge of providing healthcare benefits for a condition that inherently causes fear, is costly, and allows coverage for new and evolving treatments. Key concerns include:

- Ensuring that newly-diagnosed members have **timely** access to quality and appropriate care and support with limited obstacles and barriers
- Enabling employees to make **informed** decisions regarding treatment, including the financial burden
- Achieving the best possible health outcomes that include a caring experience for employees and addresses prevention, early identification/diagnosis, and high quality interventions and treatment from health plans and network
- Mitigating the high costs of inappropriate or poor quality/low value treatment, inadequate patient-centered support and waste

Over the past year, the National Alliance listened to their stakeholders—employers and coalitions—and conducted a "deep dive" in early 2018 to identify current health plans' strategies, support and activities related to cancer care delivery though a new eValue8™ module—the "2018 Oncology Deep Dive." These efforts brought together a multi-stakeholder advisory team made up of coalition leaders, employers, medical directors, health plans, and oncology experts, to develop an assessment that would address key areas outlined in this report.

Overall results revealed that health plan performance with respect to cancer care and support varies across plans, much as it does in other areas such as behavioral health and pharmacy benefit management. More importantly, we found that even though health plans, as an industry, identified cancer care as a critical issue, the development of cancer care science has drastically outpaced the industry's ability to effectively balance the fast-growing costs with excellent quality and patient access.

The goal of this report is to provide a framework for employers and health plans to collaborate across all key areas identified in this report to provide high value patient-centered cancer care that:

- clarifies the evolving cancer care benefit challenge and the diversity and breadth of steps health plans need to take to enhance the cancer patient's journey
- identifies gaps and highlights best practices
- provides meaningful recommendations that will allow for stakeholder action, both short- and long-term

The eValue8 Assessment

eValue8 is a performance evaluation tool that, for more than 15 years, has set consistent, evidence-based, employer expectations for health plan performance. It was created to support measurement the same way across vendors and across geographic boundaries and includes metrics from other credible sources such as the National Committee for Quality Assurance (NCQA), The Leapfrog Group, Centers for Disease Control and Prevention, Core Quality Measure Collaborative. Pharmacy Quality Alliance and Catalyst for Payment Reform.

Advisory Stakeholders

In developing the Oncology Deep Dive and report, the National Alliance received support from a diverse panel of subject matter experts, coalition leaders, and purchasers. Each brought a unique perspective based on their own knowledge and efforts. The purchaser voice was captured through engagement of an Oncology Purchaser Advisory Committee consisting of five purchasers from across the country as well as six coalitions which have spent considerable efforts related to oncology care. The following coalitions provided their expertise and time: Dallas-Fort Worth Business Group on Health, Florida Health Care Coalition, Greater Philadelphia Business Coalition on Health, HealthCare 21 Business Coalition, Northeast Business Group on Health and Pacific Business Group on Health.

The National Alliance is thankful for the sponsorship and collaboration with the following sponsors: Cancer Treatment Centers of America, Genentech, and Merck & Co. Inc., subject matter experts such as National Comprehensive Cancer Network (NCCN) and healthcare experts including: William Rosenberg, Charles Cutler, MD and Bruce Sherman, MD.

We are also appreciative of health plans that provided responses for this ground-breaking assessment. All of these respondents are committed to continued partnership with the purchaser community to improve access, quality and performance and the environment for cancer care. Many of the issues evaluated in this assessment are complex and will require collaboration and coordination across the industry to keep pace with the advances in the science.

Purchaser Advisory Committee

- Orange County Public Schools (FL)
- Global technology company with over 10,000 covered lives
- The Board of Pensions of the Presbyterian Church (U.S.A.)
- Wyoming School Boards Association Insurance Trust
- Segal Consulting

Health Plan Respondents

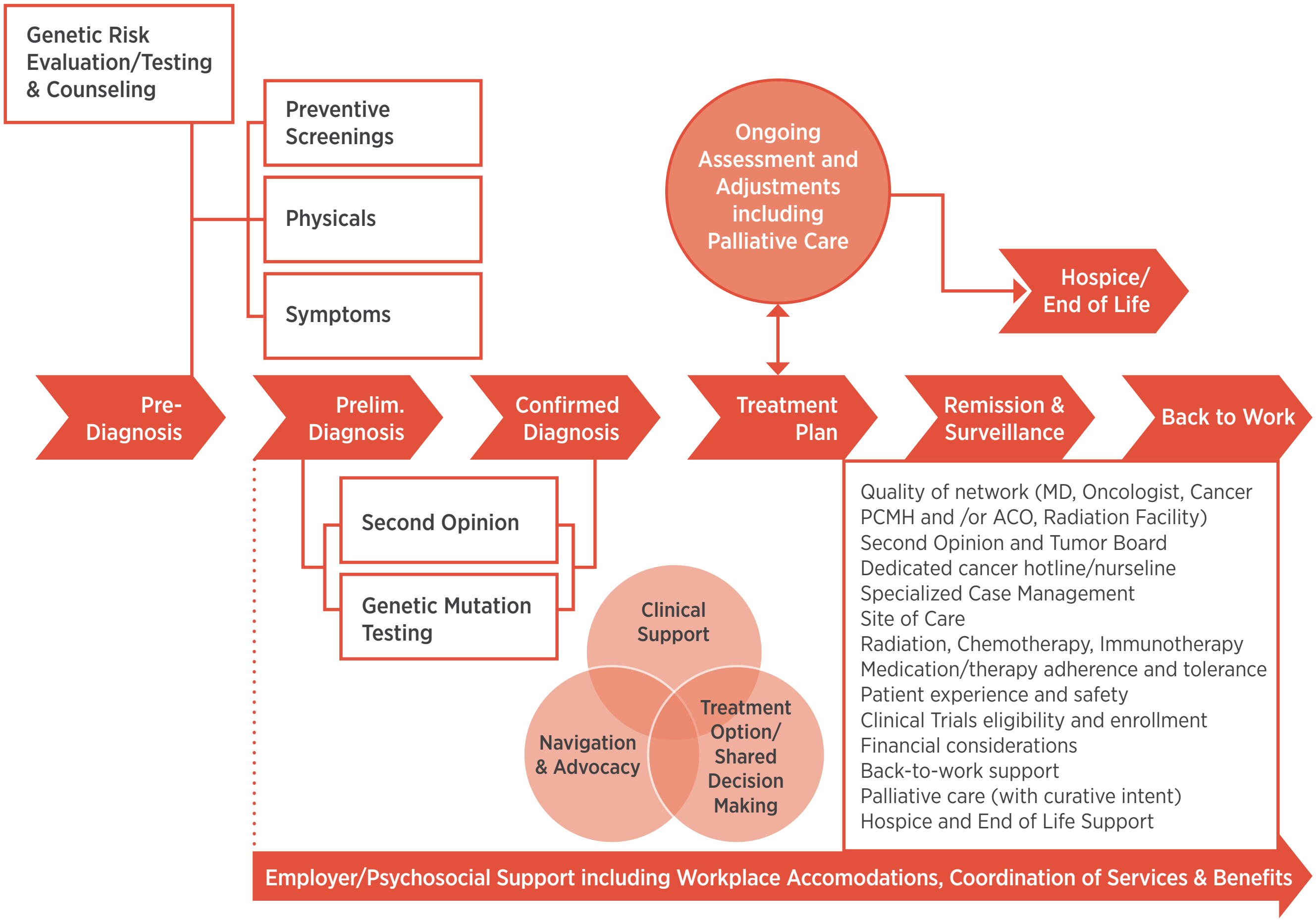
- Aetna
- Anthem
- Cigna
- Kaiser Permanente Washington
- UnitedHealthcare

In addition to the standardized assessment, respondents were invited to share strategy documents with the National Alliance. These strategy documents include activities in various areas such as supporting cancer patients, choosing the right site of care and support for cancer patients, and staying current and relevant with evolving oncology management and pharmaceutical management. These strategy documents are available from the National Alliance upon request.

Appendices

- Appendix 1: Employer Checklist
    - Navigation, Advocacy & Support
    - Clinical Support
    - Shared Decision Making/Treatment Option Support
- Appendix 2: Case Study
- Appendix 3: Glossary of Terms

Overview of Patient Journey



In the case of cancer, as indicated in the patient journey overview above, it is important for the diagnosed member to be able to engage with the care system as early as possible and to understand the breadth and depth of her benefits. In the majority of cases, this engagement needs to occur before a plan becomes aware through claims data. Creating an environment/culture where an employee will outreach to their employer and/or health plan when they receive a preliminary diagnosis can lead to a better experience.

THE DETAILED RESULTS

Early Identification and Diagnosis

A key first step in effective management of cancer is early identification and diagnosis. Tests that screen for breast, cervical and colorectal cancer have been available for a long time and market-based screening rates are available through NCQA Quality Compass and the National Alliance eValue8 process.

In the past few years, the field of genetic testing related to cancer has “exploded” bringing promise and challenges, as in some cases while there may be a genetic test, there may not exist a current treatment targeting the specific mutation.

HOW GENETIC TESTING IS USED

GENETIC TESTING IS GENERALLY USED IN TWO WAYS. It can be used as a **“screening” to identify individuals with inherited gene-specific mutations** which place them at high risk for the development of cancers such as breast, ovarian, uterine, pancreatic, stomach, and skin. A brief questionnaire can identify candidates for this type of genetic testing. Once an individual has been identified as having a gene-specific mutation, they should discuss their cancer risk with a genetic counselor and their physician. In addition, a lifelong cancer risk navigation program can assist them in understanding and receiving the appropriate types and timing of care needed to either avoid the development of cancer or make sure it is diagnosed very early to achieve the best possible treatment outcomes. Navigation programs for those with gene-specific mutations are growing in popularity as genetic testing for cancer risks becomes easier and less costly to obtain. It is important for an individual with an inherited gene-specific mutation to understand that family members should discuss with their physicians whether genetic testing is appropriate for them. Not all genetic tests require genetic counseling, counseling is less applicable in the case of testing that will guide targeted therapy versus testing that will inform individuals and their family members about risk of future cancer development.

The second use of genetic testing is when **a cancer has been diagnosed and the identification of mutations or other abnormalities within the tumor** may drive the specific treatment course through use of targeted immunotherapy or chemotherapy. A good example of this is non-small cell lung cancer, where the presence or absence of gene-specific mutations may determine use of an immunotherapy medication vs. chemotherapy. Targeted immunotherapy drugs typically have companion genetic tests, so, it is essential that these tests be performed prior to beginning treatment to ensure individuals receiving targeted treatment do, in fact, have the genetic marker indicating a likely positive treatment response. Another example where genetic mutation testing can drive treatment decisions is when breast cancer has been diagnosed. Prior to treatment, genetic testing is performed to determine whether the BRCA mutation is present. If so, then a specific approach to treatment is utilized, recognizing that BRCA-positive individuals are high risk for other related cancers.

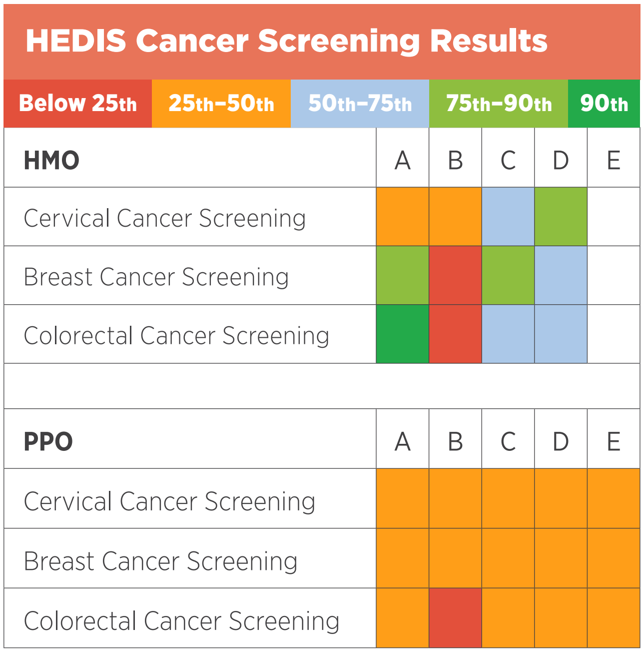
The testing results described above are produced via screening for the presence of gene-specific mutations. This represents the most commonly used testing approach. A second type of testing is referred to as next-generation genomic sequencing (NGS) and involves a more comprehensive analysis of tumor-related genetic material to identify a range of tumor mutations that can be used to guide targeted immunotherapy, providing individuals with a broader array of targeted treatment options. NGS is used to identify novel and rare cancer mutations, detect familial cancer mutation carriers, and provide molecular rationale for appropriate targeted therapy. Compared to traditional single genetic mutation screening, NGS holds advantages, such as the ability to fully sequence all types of mutations for many genes (hundreds to thousands) in a single test at a relatively low cost. However, significant challenges, particularly with respect to the requirement for simpler assays, more flexible throughput, shorter turnaround time, and importantly, easier data analysis and interpretation, will have to be overcome to ensure meaningful value in patient care.

What We Found

- National cancer screening rates in responding PPOs are all below the 50th percentile
  - Note that while trending results are more relevant, changes in measure definitions make trending challenging
  - The screening rate for breast cancer varies from a low of 57% (PPO in WY, HMO in NY, TX) to a high of 88% (HMO in Mid-Atlantic). The highest breast cancer screening rate for a PPO was 80%
- All plans cover genetic testing, but there is variation in how they encourage genetic counseling (GC)
- 3 provide full coverage for authorized genetic screening contingent upon results being interpreted by an in-network (i.e., contracted) certified genetic counselor
  - 2 plans recommend, but do not require GC as part of screening
- All plans' claims policies for genetic screening adopt and/or are internally-developed based on a combination of USPSTF, NCCN, ASCO and/or "available scientific evidence"
- The most common vehicle plans use to support appropriate care among clinicians is web-based decision support, a passive approach

Recommendations for Employers

- Ask for HEDIS cancer screening rates in your markets especially in PCMH/ACO populations
  - Note that while trending results are more relevant; however, changes in measure definitions make trending challenging
- *Ensure that genetic counseling is required and reimbursed for coverage of genetic screening/ risk evaluation*
- Ask plans to provide "active" support to clinicians for use of appropriate tests such as use of incentives, contractual/ employment requirement and feedback reporting



HEDIS Cancer Screening Results

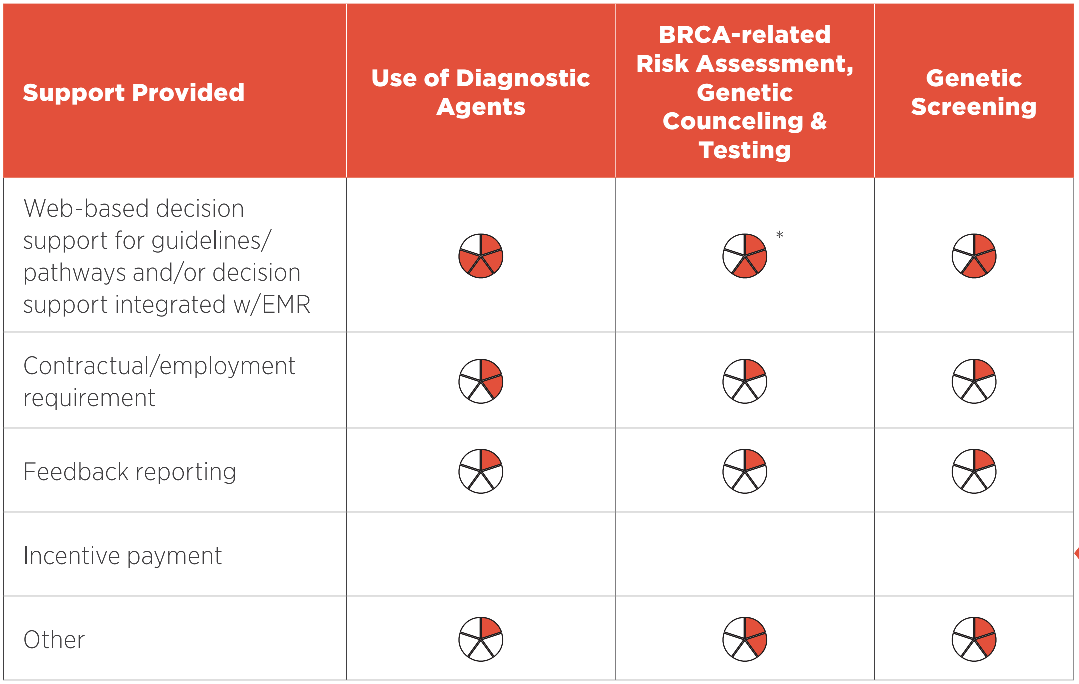
🟥 Below 25th	🟧 25th–50th	🟦 50th–75th	🟩 75th–90th	🟢 90th

HMO	A	B	C	D	E
Cervical Cancer Screening	🟧	🟧	🟦	🟩	
Breast Cancer Screening	🟩	🟥	🟩	🟦	
Colorectal Cancer Screening	🟢	🟥	🟦	🟦	

PPO	A	B	C	D	E
Cervical Cancer Screening	🟧	🟧	🟧	🟧	🟧
Breast Cancer Screening	🟧	🟧	🟧	🟧	🟧
Colorectal Cancer Screening	🟧	🟥	🟧	🟧	🟧

National HEDIS Percentiles

	25th	50th	75th	90th
Cervical	70%	75%	78%	81%
Breast	68%	71%	76%	80%
Colorectal	54%	60%	66%	72%



Support Provided	**Use of Diagnostic Agents**	**BRCA-related Risk Assessment, Genetic Counceling & Testing**	**Genetic Screening**
Web-based decision support for guidelines/ pathways and/or decision support integrated w/EMR	●●●●○	●●●○○ *	●●●○○
Contractual/employment requirement	●●○○○	●○○○○	●○○○○
Feedback reporting	●○○○○	●○○○○	●○○○○
Incentive payment			
Other	●○○○○	●●○○○	●●○○○

The number ●●●●● of colored slices (out of 5 slices) represent the # of plans. The absence of a "pie" indicates no plans offer service or have a program.

* For fully-insured only, PA for self-insured lives for 1 plan
Other support includes: outsource to eviCore with respect to use of diagnostic agents; outreach to high-risk patients for BRCA-related assessment and other genetic screening; PAs and web-based support for diagnostic imaging


40 / 0.4
160/0.17

Member Support and Access to Care

News of a cancer diagnosis can not only cause fear, but also can create complex challenges for both the employee and his/her employer. One of the key concerns is ensuring that newly-diagnosed members with cancer have the support they need to achieve timely access to quality and appropriate care. Our research revealed that health plans are at the early stages of sorting out the most effective navigation and delivery platforms for providing patients the support they need to make informed choices about their cancer care.

Aetna's Compassionate Care Program*

"Initial Data Results: A published study reported that deceased Medicare Advantage plan members served by the program from 2005 through the first quarter of 2007 experienced substantially lower hospital use compared to a retrospective control group: 79 percent fewer emergency department visits (92.7 vs. 436.8 visits per 1,000 members), 85 percent fewer acute inpatient days (2,308.9 vs. 15,216.8 days per 1,000), and 88 percent fewer days in the intensive care unit (1,188.9 vs. 9,839.5 days per 1,000). Reductions in service use were associated with approximately $12,000 in avoided medical costs per Medicare Advantage plan member served by the program.

Among commercial health plan members, the program led to a more than doubling in hospice use as well as an increase in hospice lengths of stay (13 to 15 days longer). Extending hospice benefits to 12 months did not result in increased costs compared to those without extended hospice benefits. Changes in utilization among commercial plan members followed a similar pattern but were smaller in magnitude than among Medicare Advantage plan members.

More recent data, pending publication, continues to show positive impact: significantly lower hospital visits and medical costs in the last months of life, higher rates of hospice acceptance, and earlier engagement in hospice among participants, according to Aetna."

* https://www.commonwealthfund.org/publications/case-study/2018/may/profiles-promise-advanced-illness-management

Perhaps the clearest manifestation of this state of affairs is the large gap we observed in member support at the end of life. Plans can engage members and their families during treatment by offering additional services such as psychosocial service support, care navigation, palliative care with curative intent and advanced care planning. Not everyone needs these, but the patients with advanced cancers (or those who are not responding to medication) can be identified as candidates for these services. Based on initial data from Aetna's Compassionate Care Program (highlighted left), the cost savings can easily cover the increased services and the improved end of life care. Notwithstanding this encouraging value proposition, only one of the plans in our survey reports any industry standard end-of-life Core Quality Measure (see: Provider Performance Measurement, p.26).

As detailed below, patient support services at any point along the patient survey can be offered through providers, health plans and/or employers themselves. A PCMH could provide them directly, or negotiate for the plan to offer some services, or contract with entities that offer end-of-life or other needed patient support services. Unless coordinated and effectively integrated, emerging offerings/platforms such as cancer PCMH/cancer care teams that specialize in cancer case management, support programs for the patient may lead to delayed/fragmented care. Some employers have sponsored their own "Cancer Huddles" to bring the coordination and integration needed for superior patient and family support. As cancer patients require different levels of support depending on their diagnosis and staging, access to comprehensive treatment option/decision making tools and resources should be a priority particularly at the onset of the patient's journey as well as access to post treatment support, such as return-to-work and end-of life support.

Treatment Option Support/Shared Decision Making (SDM) Resources

Patient support, whether delivered by providers (e.g., Cancer PCMH/cancer care teams, cancer COEs), by health plans (e.g., specialized cancer case management), or employers (e.g., Cancer Care Huddle) are all evolving programs aimed at supporting a patient on their journey. While cancer PCMH/care teams and COEs focus on clinical support, some are also offering psychosocial and navigation services, some receive health plan support such as an embedded case manager. Even though specialized cancer case management is typically a plan program, many services within the program are also being performed in cancer PCMHs and COEs. Our findings in this area reflect the diversity and early—but uneven—development of patient support service offerings.

What We Found

- Only two respondents have a treatment option decision support tool specifically for cancer care with robust content, functionality, member specificity and cost
- Most respondents do not offer patient attendance at tumor board, Certified Patient Decision Aid or Certified Patient Decision Aid with SDM, i.e., face-to-face services intended to replace "informed patient consent" with "informed patient decisions"
- Only one plan has both a comprehensive end-of-life (EOL) support (financial and legal counseling program including advance directive, caregiver needs) and uses multiple strategies to identify (via claims and referrals) and engage members and family (telephonic outreach and through physicians) about EOL program/care
- Most (4) respondents can report number of claimants by type of cancer, fewer (3) can report on cancer case management program enrollment

Recommendations

- Insist that your plans improve and demonstrate broad use of their treatment option decision support and SDM tool(s)/resources including patient decision aids with shared decision making
- Insist that reports you receive contain actionable analyses for decision making
- Ask plans to assess utilization of, and improve on content, functionality, member specificity and cost estimate features of their shared decision making/treatment option support tool
- Ask plans to improve EOL support programs and activities to outreach and engage affected members and their family members
- Ask plans to report participation in end-of-life programs and collect data on date of death and events near the end of life (ER visits, late admission to hospice, chemotherapy, ICU admission) so that you can measure adoption of associated high value EOL services

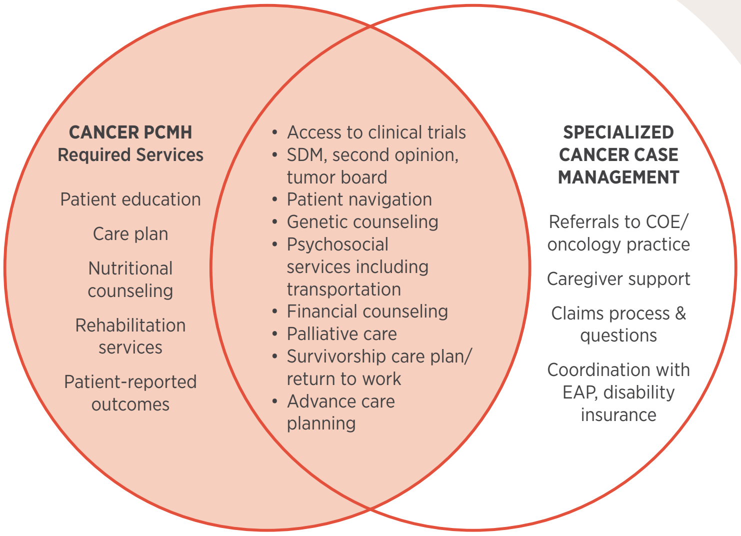
The Cancer Care Huddle is a highly coordinated approach that revolves around the employee and is organized by the employer to create a supportive, cohesive and streamlined patient experience. It is a response to the overlapping and uneven development of plan- and provider-sponsored navigation and care delivery platforms described below. Huddle team members are vendor representatives who support the cancer patient and can include health plan representatives, medical opinion experts, case managers, specialty pharmacy managers, wellness coaches, oncology care case managers, EAPs, disability managers and others. Under the leadership of the employer designated quarterback, the Huddle coordinates the work of these vendors that potentially may have multiple interactions with each cancer patient. If there is no quarterback to coordinate interactions and hand-offs, patients or their loved ones must fend for themselves. That's a tremendous burden for someone going through an already frightening experience.

Source: https://nebgh.org/wp-content/uploads/2018/07/CancerHuddle-draft_v9.pdf

Navigation and Care Delivery Platforms

Specialized Cancer Case Management and Cancer Patient Centered Medical Homes

As shown in the VENN diagram below, plan-sponsored Specialized Cancer Case Management and provider-sponsored Cancer Patient Centered Medical Homes share a longer list of potential service offerings than the either of the lists of services they may offer uniquely. The Cancer PCMH understandably offers health care delivery services that the health plans typically do not; and the health plans typically solely offer claims-, network- and employee-benefits-related services than the PCMH. These differences—and the potential coordination issues that arise when two different entities offer overlapping services—create a challenge for cancer patients and their families for whom all services may be required. Our findings and recommendations underscore this challenge.



CANCER PCMH
Required Services

Patient education

Care plan

Nutritional counseling

Rehabilitation services

Patient-reported outcomes

- Access to clinical trials
- SDM, second opinion, tumor board
- Patient navigation
- Genetic counseling
- Psychosocial services including transportation
- Financial counseling
- Palliative care
- Survivorship care plan/ return to work
- Advance care planning

SPECIALIZED CANCER CASE MANAGEMENT

Referrals to COE/ oncology practice

Caregiver support

Claims process & questions

Coordination with EAP, disability insurance

	# Plans
COE	●●●●○
Oncology PCMH/Cancer Team	●●●●○
Specialized Case Management	●●●●●

Patient identification	# Plans
Referral from physician	●●●●●
Claims with cancer diagnosis	●●●●○
Prior authorization for PET, MRI imaging, ER visit	●●●○○
Admission to the hospital with cancer Dx	●●○○○
Predictive modeling at risk for hospital admission or ER use (Effective 3Q2018)	●○○○○

Back-to-Work Support	# Plans
Facilitates coordination of treatment (e.g., infusion) with work schedule	●●●●●
Assists employee in attending to comorbidities	●●●●○
Assists employee in arranging for work at home and modifying work requirements	●●●○○

●●●●● The number of colored slices (out of 5 slices) represent the # of plans. The absence of a "pie" indicates no plans offer service or have a program.

What We Found

- Most respondents provide COE, cancer PCMH and specialized case management
- Services offered by Cancer PCMHs and Specialized Cancer Case Management programs overlap
- Inconsistent scope & depth of offerings
  - Only one plan required cancer PCMH to provide patient-reported outcomes, genetic counseling, financial counseling, rehabilitation services, nutrition counseling, and survivorship care plan
  - Attendance at tumor board is rarely offered
- The most common back-to-work support is facilitating coordination of treatment (e.g., infusion) with work schedule

Recommendations

- Demand health plan commitment to patient-centered cancer care matching patients with the best cancer care support option available to them today, whether it's plan-, provider/cancer center- or third-party-sponsored
- Set expectations for delineation of responsibility for provision of cancer support (not clinical) services
- Ask plans to assess cancer care program offerings based on the extent to which they provide new, frequently needed services specific to cancer patients and not provided by cancer PCMH/COEs
- Require health plans to report by "offering" (cancer PCMH, COE, Specialized Case management)
  - % of patients participating
  - Number of interactions with cancer patients
  - % of cancer patients identified by tactic (e.g., PA, pharmacy, referral, claims, etc.)
  - Overlap of patients

Pain Management/Complementary Alternative Medicines

For all of the efforts providers, health plans and employers have made to support patient centered cancer care, patients have clearly made their preferences known with respect to pain management and complementary medicine. Cancer pain is one of most prevalent symptoms in patients with cancer and cancer patients have taken the lead in seeking out non-traditional treatments, e.g., acupuncture, massage, and medical marijuana. Our survey found plan responses to these patient demands, ranging from adoption of NCCN guidelines for acupuncture in conjunction with pharmacologic intervention as needed to a generally hands-off approach to the federally not-approved use of medical marijuana.

What We Found

- Plans are most similar in their coverage policies with respect to massage (covered with different requirements) and marijuana (not covered by four of the five)
- Coverage of acupuncture varies widely
  - Two plans typically do not typically cover acupuncture although one will allow in lieu of anesthesia
  - Two others cover acupuncture with prior authorization (PA); another states that coverage varies with plan design

Recommendations

- Discuss strategies for offering and covering complementary alternative treatments with your plan(s)

Nutritional Support

One feature of patient-centered cancer care, regardless of the platform, is integrated teams of care and support providers. Our survey found that benefit coverage policies are not consistently keeping up with the growing recognition of the importance of nutrition in cancer care. Patients who are receiving adequate nutrition have a better prognosis, respond better to chemotherapy and can tolerate higher doses of anticancer treatments. Cancer and cancer treatments may affect taste, smell, appetite, and the ability to eat enough food/absorb the nutrients causing malnutrition; malnutrition can cause the patient to be weak, tired, and unable to fight infection or finish cancer treatment; and, malnutrition may be made worse if the cancer grows or spreads.

A number of case management options are available, including dietary counseling, nutrition supplements, as well as appetite stimulant pharmacotherapy. In general, the type of nutrition support is determined by the nature of appetite loss, the anticipated duration of radiation or chemotherapy treatment affecting appetite, current nutritional status, and patient preference.

What We Found

- Coverage of nutritional support to maintain optimal “weight” during therapy varies widely
    - Two plans maintain historical coverage criteria that are not specific to nutritional support for oncology treatment; another covers for cancer patients with Prior Authorization (PA); another states that coverage varies with plan design

Recommendations

- Ask your plan to review and update its policy on nutritional support to maintain optimal weight for oncology treatment

Ensuring Appropriate Use

With the emerging diagnostic and treatment options in the field of cancer, ensuring value in care delivery balances timely access to services with eliminating waste and overuse. In most of these instances, the health plan can impact both the outcomes and costs of cancer care delivery either through the delivery system or in their interactions with members. Almost all use evidence-based third-party guidelines and other clinical literature in policies and some use a more prescriptive approach—clinical pathways.

Plans use Medicare-approved guidelines as a factor in pre-authorization. In general, if the proposed therapy is consistent with the NCCN, ASCO, or NCI guidelines, the plans will routinely approve coverage. This process allows for rapid and straightforward approval of most PAs. If not, they will ask for more information to determine whether the proposed therapy is reasonable.

Guidelines can be used to streamline processes with ACOs, PCMHs, or bundled payment programs. Plans can confirm to providers that they will approve care consistent with guidelines and furthermore assign "gold card" status for providers who demonstrate a consistency with guidelines.

A challenge in implementing guidelines or pathways is the availability of detailed clinical data such as stage of the cancer, nodal involvement, kidney function, other clinical functions, hormonal sensitivity, or the presence of specific genes. Because it is not routinely available, the plan would need access to the members' EMR or have it provided by the physician.

Site of Care

The site of care (SOC) chosen can drive significant differences in the cost of cancer care. For example, Milliman reported that the cost of chemotherapy can vary by 30% to 50% between a physician's office and a hospital outpatient setting.[4] Given the growing cost of cancer care, it is not surprising that all plans in our study monitor the cost of chemotherapy by site of care.

Tactics used encourage appropriate site of cancer care	# Plans
Specialized cancer case management: use best value sites	●●●●○
PA process — radiation therapy	●●●○○
PA process: appropriate source of dispensing (e.g., hospital vs. community-based vs. PBM)	●●○○○
PA: use high value sites	
Specialized cancer case management process — radiation therapy	●○○○○
Provider contracting strategies: use best value sites	
Benefit plan design (lower cost share for infused oncology drugs administered in the MD office or home)	
Change coverage of certain clinician-infused drugs requiring clinician administration form the Rx benefit to the medical benefit to prevent fragmenting care across the two benefits and keeps the relationship between the prescriber and the member intact	
Site of care optimization program (identifies members who could select a more cost effective solution for infusion; plan works with the identified members and health care professionals to find ways to reduce cost and increase convenience)	
Channel dispensing of oncology drugs into owned specialty pharmacy for oral therapies	

●●●●● The number of colored slices (out of 5 slices) represent the # of plans. The absence of a "pie" indicates no plans offer service or have a program.

What We Found

- All monitor cost and utilization of chemotherapy by SOC (hospitals vs PBM vs oncologist office)
- Plans typically use the "softer touch" of specialized cancer case management to steer members to best value sites of care
- The other commonly used tactic is PA
- Provider contracting strategies, benefit plan design and SOC optimization are used infrequently

Recommendations

- Ask your plan to provide evidence for best value sites of care and steerage results by tactic

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[4] *Comparing Episode of Cancer Care Costs in Different Settings: An Actuarial Analysis of Patients Receiving Chemotherapy*, Commissioned by Genentech, August 29, 2013.

Provider Management

Patients view physicians as trusted advisers as they navigate the healthcare system on their "journey." It is important that, in addition to working with providers to use the best value sites of care, health plans provide resources and incentives to support providers in providing the optimal care.

What We Found

- The most common vehicle plans use to support appropriate care is web-based decision support (passive)
- Incentive payments and feedback reporting is rarely used

Recommendations

- Ask plans to provide stronger encouragement for appropriate use of cancer treatment, personalized medicine and new expensive drugs such as use of incentives, contractual/employment requirements and feedback reporting

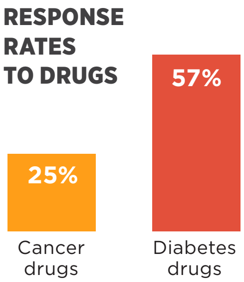
Support Provided	Cancer Treatment	Personalized Treatment	New Expensive Drugs
Web-based decision support for guidelines/pathways and/or decision support integrated w/EMR			
Contractual/employment requirement			
Incentive payment			
Feedback reporting			
Other*			
None of the above			


The number of colored slices (out of 5 slices) represent the # of plans. The absence of a "pie" indicates no plans offer service or have a program.

* Other support includes: outsource to eviCore with respect to use of diagnostic agents; additional second opinion expertise with respect to personalized treatment; national precertification list and/or review by a physician panel with clinical trial experience for new, expensive drugs

Pharmaceutical Management

Critical to achieving high value care and better outcomes in cancer care is timely access to the most appropriate medication for an individual patient, and assurance that medications are administered and/or taken appropriately. Given that response rates to cancer drugs average about 25% compared to 57% for diabetes drugs,[5] and given the advances in genetic testing, it is critical that pharmaceutical management supports and promotes the appropriate use of personalized medicine. By understanding which patients are likely to benefit from a specific treatment intervention,[6] outcomes may often be improved while lowering costs and reducing side effects.



Appropriate Use

Plans are increasingly under pressure to provide access to, and coverage for off-label uses of FDA-approved medications. Advances in the science of cancer care have increased the effectiveness of treatments and increased permitted off-label use of chemotherapy agents, all at increased costs. Many of these expensive, specialty medications may have a companion genetic test that will help predict outcome of therapy in any given patient.

Almost all plans in our survey use evidence-based third-party guidelines and other clinical literature in developing formularies, prior authorization, medical coverage policies and, for some clinical pathways, for appropriate use of therapy.

Plans using NCCN/other approved guidelines need clinical information that's hard to get and this can affect turnaround time (TAT). As a result, balancing appropriate use and faster access to needed medications needs continued consideration and dialogue among all stakeholders.

% of claims paid in 2017 for drugs used for cancer treatment that were subject to PA

Plan	Fully-Insured	Self-Funded
A	<5%	<5%
B	25%<50%	<25%
C	<5%	<5%
D	50%<75%	50%<75%
E	75%+	75%+

- Percent of claims may not reflect Rx claims from both medical and pharmacy claims
- Numerator may include entire book of business not just the customers in the oncology program

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5 Spear BB, Heath-Chizzi M, Huff J. Clinical application of pharmacogenetics. *Trend Mol Med.* 2001; 7(5):201-204

6 Personalized Medicine Coalition. The personalized medicine report: 2017 – opportunity, challenges, and the future. http://www.personalizedmedicinecoalition.org/Userfiles/PMC-Corporate/file/The-Personalized-Medicine-Report1.pdf. Accessed July 21, 2017.

What We Found

- Four of the five plans surveyed require prior authorization (PA) for off-label use based on a Medicare-recognized source; one did not specify source(s) used, but did establish policies through quarterly P&T committee meetings
- Most have not automated one-off exceptions for self-funded or fully-insured business, but two have automated exceptions
    - hard coded into claims system
    - lifetime approval processes at point of service
- Only one plan had major difference in % of claims with PA between fully and self-insured
- Plans vary greatly in how they define PA activity metrics

Recommendations

- Insist that plans and PBMs implement a process to identify drugs requiring frequent PAs and/or high percentage of approvals by prescriber and discuss necessity of those with you
- Insist that plans and PBMs work with clinicians to expedite receipt of needed clinical information for PA decisions
- Ask plans and PBMs to review the following with you on a quarterly basis:
    - drugs on PA lists that are frequently reviewed by approval status
    - turnaround time for PA [from both time of initialization and from time of receipt of all information from provider]
    - denial rates for PA
    - process for updating PA list

Quality

Medications for cancer therapy are considered to be specialty medications; non-oral medications for infusion require special handling so accreditation of pharmacies by a third party organization is recommended. Moreover, for specialized medications, instead of contracts with manufacturers for formulary position and market share, health plans and PBMs should be investigating value-based contracting which includes metrics such as a specific outcome which may be medical, e.g., "proportion admitted to hospice for less than three days," or it could be tied to increased adherence, or patient satisfaction. Moreover, for specialty medications, value-based contracting based on specific outcomes or patient adherence may offer an attractive alternative to formulary-position-based contracts.

The greatest barrier to outcomes-based contracting is the difficulty of defining and measuring outcomes in a manner that can be incorporated into a legal agreement and operationalized in practice. For example, how might a provider contract account for the following:

- If the patient's condition deteriorated, but not as much as would have been reasonably expected, was this a successful treatment? How would this be measured and, since it would drive payment, how would it be audited?
- If the population statistic, for example, "per cent of population with colorectal-cancer screening" were low, was that due to the provider's shortcomings, culturally-driven patient reticence or the % of the population not yet due for the screening?
- If a five-year survival rate is the most commonly accepted measure of cancer treatment success, how might outcomes attributable to a chemotherapy agent **this year** be measured?
- And if the survival rate were to be measured, how would the contract describe a method for determining whether or not the drug was administered correctly and with or without other drugs that might affect outcomes?

What We Found

- Four of the respondents require accreditation of pharmacies that dispense specialty pharmaceutical products. URAC (4) and Joint Commission (3) accreditations are the most commonly required accrediting organizations
- Four respondents use PA or channel management to encourage the use of the appropriate source of dispensing (e.g., hospital vs. community-based vs. PBM) for cancer drugs among providers
- Only two respondents have outcomes-based contracts; another is having discussions

Considerations

- Outcomes-based contracting for oncology medications is very much at an infancy stage
- A big barrier is plans'/PBMs' inability to implement and to measure outcomes
- Some health plans/PBMs have adopted value-based contracts based on ICER economic analyses

Recommendations

- Ask plans/PBMs what oncology products could be included in outcomes-based contracts and to update/include you in discussions for products of interest to you

Member Support and Access to Medications

Gene and mutation-based cancer diagnosis and treatment have transformed some once-deadly cancers into manageable chronic diseases but have also resulted in potentially extreme out-of-pocket costs.

Monitoring patients with financial "side effects" is not easy. Plans do not have ready access to information about prescriptions written but not filled and when prescriptions are no longer filled, it can be difficult to discern if that is due to cost or due to a change in treatment plan. Patients can be at high risk for these costs particularly when they receive off-formulary drugs at an in-network hospital.

Increasingly, there is greater off-label use of medications that are FDA approved, making timely coverage and reimbursement decisions even more critical. Another consideration is ensuring that a member is at an optimal BMI to tolerate the therapy, and that nutritional support is covered. In patients with cancer, weight loss is often associated with nutritional deficiencies, which can negatively impact an individual's immune status.

What We Found

- All respondents assist members in obtaining manufacturer or foundation provided specialty drug copay assistance
- When member receives cancer treating agents (oral and/or injectable) that are not on preferred drug list (PDL) while undergoing treatment at an in-network COE/hospital/facility, they likely will be responsible for higher cost share
  - Two respondents noted presence of PA before onset of therapy to help ensure use of covered medications
- Only one respondent monitors the volume of prescriptions for oral cancer drugs that are not filled but information is not routinely reported to Employers and none of the respondents monitors the volume of patients who discontinue chemotherapy due to cost; only one assesses the need for financial assistance when a patient's out-of-pocket costs are a barrier to adherence to drug therapy

Recommendations

- Ensure your plan design covers genetic testing that will help guide appropriate therapy
- Ask plans/PBMs to monitor and assess reasons for non-adherence
- Ask plans to use Pharmacy Quality Alliance (PQA) specifications on monitoring primary non-fulfillment
- Initiate discussions on strategies to mitigate catastrophic costs in instances where member receives cancer treating agents (oral and/or injectable) that are not on preferred drug list while undergoing treatment at an in-network COE/hospital/facility

Ensuring Quality and Performance

The concept of preferred provider networks reflects the very idea of value in healthcare: access to a number of limited, high-quality providers in return for cost reductions. Not long after the widespread adoption of preferred provider networks during the 90s, it became clear that employers and their employees preferred broad networks more than deep price discounts. Running somewhat contrary to this trend was the development of COEs (and, more recently, "high-value tiered networks") where the number of providers was very limited and the advantage in quality much emphasized.

The concept behind COEs is that value can be maximized by directing patients with relatively rare, high-cost conditions (e.g., transplants) to centers with the most expertise and experience. Conditions amendable to COEs will be expensive no matter where they are treated, and the thought is that the high quality of COEs tips the value equation in their favor.

Oncology Network and Radiation Facility Selection Criteria

Given the high cost and complexity of treating some cancers, the assumption and expectation is that carefully selected cancer care provider networks could be an important avenue to delivering high-value cancer care

Our findings beg the question of what criteria health plans *should* consider when selecting network providers who see cancer patients. As discussed elsewhere in this report, the scarce *outcomes* data most employers would like to see (e.g., 5-yr survival rates) and the somewhat more readily available *process* quality measures (e.g., compliance with practice guidelines), are likely much more relevant to the current value equation than the above *structural* quality measures.

As the treatment of cancer becomes more complex and more survivors return to work, more and more cancer patients and their families can benefit from the efforts health plans are making in specialized cancer case management or cancer PCMH programs and similar services that are offered at cancer COEs.

What We Found

Criteria beyond board certification is rarely used in selecting networks and facilities for cancer care

HOSPITALS

- **Only two respondents** consider criteria such as NCI Comprehensive Cancer Center Designation/ Cancer Center Designation and/or CAHPS Quality Measures from the Cancer Care Survey

ONCOLOGISTS

- **Only one respondent** considered criteria beyond Board Certification in oncology specialty or subspecialty, i.e., Participation in ASCO's Quality Oncology Practice Initiative (QOPI) and QualityCertification Program (QCP) program

RADIATION THERAPY SITES/FACILITIES

- **One of five respondents** has separate requirements (accreditation) for hospital-based radiation therapy
- **Two of five** have separate requirements for hospital outpatient radiation therapy and free-standing radiation therapy facilities

COEs

- **Four of five** have COEs for cancer care, although some are not exclusively oncology COEs that provide end-to-end cancer care
- **Only one** requires all of its 36 COE hospitals to have NCI-Comprehensive Cancer Center Designation and considers two of other listed accreditations/designations. It also considers 5-year survival data by type of cancer and requires regular tumor board sessions and CAHPS Quality Measures from the Cancer Care Survey
- **Only one** considers but does not require all listed accreditations/designations. It does not consider any of the listed quality outcomes
- **While another** does not consider any of the listed accreditations/designations, it does require one of the listed quality outcomes – frequency of hospital-acquired infections

Considerations

- Clinical outcomes more important than participation in accreditation/ credentialing program
- Some accreditation/designation programs may include outcomes criteria, e.g., the NCI Comprehensive Cancer Center Designation
- Not all cancer care require COEs

Recommendations for Employers

- Ask your plan about any specific criteria beyond credentialing and Board Certification they use for selecting their oncology networks, COEs and radiation facilities/providers
- Ask for specific outcomes measures used in evaluation for COEs
- Ask if they consider patient safety data e.g., chemotherapy and/or radiation overdose
- Have plans show you what quality information is displayed in directories

Cancer Patient-Centered Medical Home (PCMH)

A *Cancer* Patient Centered Medical Home (PCMH) builds on the principles of a PCMH. It encourages practices to organize care around the patients with cancer, work in teams and coordinate and track care over time. In addition, cancer care medical teams in some organized delivery systems essentially function as Cancer PCMHs.

What We Found

- Health plans vary in their adoption of cancer PCMHs
- The four plans that offer PCMH (range of 5-21 PCMHs) vary widely in standards required and type of support provided to the clinicians
- None of the plans requires that oncology PCMHs provide a patient portal or have population health assessment capability

Recommendations

- Probe beyond **availability** of cancer PCMHs—ask for details of plan standards, required services and plan-provided resources for their cancer PCMHs

Standards for PCMH	# Requiring
Use of evidence-based guidelines	🟥🟥🟥⬜⬜
Quality improvement processes	
Quality reporting required	
Uses oncology-certified EMR	🟥🟥⬜⬜⬜
Patient and caregiver activation	🟥⬜⬜⬜⬜
Participates in national quality initiative(s)	
Documented care coordination with other physicians	
Has population health assessment capability	
Provides patient portal	

🟥🟥🟥🟥🟥 The number of colored slices (out of 5 slices) represent the # of plans. The absence of a "pie" indicates no plans offer service or have a program.

Plan-Provided Resources	# Providing
Case manager that works with RN for patients w/complex comorbidities	🟥🟥🟥⬜⬜
Quarterly reports on attributed patient resource utilization, including ER visits	
National teaming collaborative for participants to share best practices	
Patent management fee	🟥🟥⬜⬜⬜
Opportunity to share in savings	
Daily report on hospital admissions	
Oncology non-clinical navigator-single point of contact	
Next day report on patients admitted for inpatient care	🟥⬜⬜⬜⬜
Locally-based clinicians with oncology experience as the primary point of contact for providers/practices meet regularly to evaluate date on outcomes and quality metrics, areas for improvements, and opportunities for innovation	

Provider Performance Measurement

Rapid improvements in the diagnosis and treatment of cancer care—and concomitant cost—have raised the bar for health plans' efforts to drive value in healthcare purchasing. The Core Quality Measure Collaborative, led by AHIP, Centers for Medicare & Medicaid Services and the National Quality Forum, reflects a rare consensus among disparate healthcare stakeholders on what is important to measure "as soon as possible." To date, only two plans are collecting some of the agreed-to measures.

Measurement of cancer care presents two very large challenges to health plans. First, its measurement requires data elements that typically are not readily available to health plans, for example: patient charts, date of death and, in the case of carved-out pharmacy benefit plans, pharmacy data. The second challenge reflects the rapid evolution of cancer care itself: as diagnosis and treatment modalities change, so must the metrics. The sparsity of data collected in accordance with the Core Quality Measures Collaborative reflects the difficulty of these challenges and should be viewed as the beginning of a long but necessary journey.

About *CMS Core Quality Measures*

The stated purpose of the Core Quality Measures was to be meaningful to patients, consumers, and physicians such that the alignment of these core measure sets will aid in:

- promotion of measurement that is evidence-based and generates valuable information for quality improvement
- consumer decision-making
- value-based payment and purchasing
- reduction in the variability in measure selection
- decreased provider's collection burden and cost

LEARN MORE: https://www.ahip.org/ahip-cms-collaborative-announces-core-sets-of-quality-measures/

Core Quality Measures*	# Plans
Breast cancer (3 measures) 3 of the 3 measures	◔
Colorectal cancer (3 measures) 3 of the 3 measures	
Breast cancer (3 measures) 2 of the 3 measures	
Colorectal cancer (3 measures) 2 of the 3 measures	
Proportion receiving chemotherapy in the last 14 days of life	
Proportion with more than one emergency room visit in the last 30 days of life	
Proportion admitted to the ICU in the last 30 days of life	
Proportion not admitted to hospice	
Proportion admitted to hospice for less than 3 days	
Prostate cancer (2 measures)	
Oncology: medical and radiation - pain intensity quantified (0384)	

● The number of colored slices (out of 5 slices) represent the # of plans. The absence of a "pie" indicates no plans offer service or have a program.

* Developed by the Core Quality Measures Collaborative, led by the America's Health Insurance Plans (AHIP) and its member plans' Chief Medical Officers, leaders from CMS and the National Quality Forum (NQF), as well as national physician organizations, employers and consumers.

Measured in any setting	# Plans
Cancer PCMH — quality reporting related to inpatient admissions, ER visits, pain experience, and depression incidence; patient experience	◔
Cancer PCMH — patient satisfaction survey, pathway compliance adherence	
Cancer PCMH — cancer type, stage, performance status collected directly from providers are combined with date from other sources, e.g., claims	
ACO — measures that may be applicable to cancer care: avoidable emergency room utilization, ambulatory sensitive condition admissions, non-trauma admissions, 30 day readmissions, breast cancer screening, colorectal screening, cervical cancer screening, total cost of care	

● The number of colored slices (out of 5 slices) represent the # of plans. The absence of a "pie" indicates no plans offer service or have a program.

What We Found

- This is currently a gap in Plan cancer care measurement activities
- Even when measured, cancer care metrics are typically not used in feedback reporting and payment
- Provider performance measurement is lagging even in cancer PCMHs and ACOs

Considerations

- Opportunity to raise the bar by using applicable Core Quality Standards for Cancer PCMHs, COEs and radiation facilities
- AHIP was a leader of led the Core Quality Measures effort
- Could some of these measures be consideration used in outcomes-based contracting with manufacturers
- Updating data systems to capture the data needed to measure on cancer care value, e.g., mortality, is complex and costly

Recommendations

- Insist that your plans implement within a year, one or more Core Quality Measures, e.g., Proportion admitted to hospice for <3 days among its oncology providers, especially those in PCMH and COEs
- Ask your plan to provide you with a timeline/ plan of action for Core Quality Measure implementation, feedback reporting and inclusion in payment models
- Employers and their payers should investigate collection of mortality data from eligibility disenrollment and/or other sources in order to collect Core Quality Measures that require date of death.

Payment Transformation

The goal of payment transformation is to align incentives in a manner that encourages delivery of high value care as an alternative to traditional fee-for-service payment. It should be noted that the diversity of cancer patients with specific types of cancers, differing genetic markers, comorbidities and individual responses to therapy, presents a challenge to creating and implementing episode-based or bundled payments but strategies to overcome this are being pursued.

What We Found

- Payment innovation in oncology lags behind what is being done in other areas
    - Current payment transformation efforts focus more on screening than on treatment
    - Models focus on rewarding desired behavior as opposed to penalizing outliers

Considerations

- Diversity of cancer patients and duration of treatment present a challenge for episode and bundled payments

Recommendations for Employers

- Employers should monitor payment innovation developments but should temper expectations

Payment Transformation/Innovation	# Plans
Incentives to provide appropriate screening services - retrospective	●●●●○
Enhanced payments for adherence to recognized care guidelines	●●●○○
Shared savings	●●○○○
Incentives for provider to engage in shared decision making (retrospective & prospective)	●○○○○
Episode or bundled payments – prospective	
Enhanced payments for adherence to clinical pathways	
Shared risk arrangement	
Episode or bundled payments – retrospective	
Incentives to provide appropriate screenings services – prospective	
Incentives for providers to use artificial intelligence (e.g., Watson) to diagnose and treat cancer	

●●●●● The number of colored slices (out of 5 slices) represent the # of plans. The absence of a “pie” indicates no plans offer service or have a program.

APPENDIX 1

EMPLOYER CHECKLIST

(summarizes all objectives and recommendations outlined in this report)

The following provides potential key objectives to improve the value and outcomes of your organization's cancer care benefits as well as suggested areas and actions that should be addressed with your health plan(s).

Navigation, Advocacy & Support

OBJECTIVES:

a. Develop and communicate a patient-centered approach for cancer care benefits that provides comprehensive support to employees and families impacted

b. Obtain health plan commitment to patient-centered cancer care and match patients with the appropriate cancer care support option available (through plan, provider/cancer center or third-party-sponsored)

c. Set expectations for delineation of responsibility for provision of cancer support (not clinical) services

d. Review current coverage and policies that impact cancer care

e. Determine strategies that mitigate the related financial concerns associated with cancer patients

f. Review End-of-life Programs to determine appropriate benchmarks and care strategies are in place

CURRENT NAVIGATION SERVICES

☐ Insist your health plan review cancer care program offerings and assess the extent to which they provide frequently needed services specific to cancer patients both within and outside the PCMH/COEs. Also be sure to review all services provided for better care coordination and reduce duplication, as appropriate.

SELECTED COVERAGE POLICIES

☐ Review current coverage policies to assess against coverage needs including the following and update as necessary

- ▶ Appropriate genetic testing is in place that guides effective treatment for specific cancers
- ▶ Nutritional support protocols are in place to maintain optimal weight for oncology treatments
- ▶ Effectiveness of various pain management/complementary therapies and appropriate coverage options

MEMBERS' FINANCIAL CONCERNS

☐ Monitor for non-adherence to cancer therapy drugs and request a report that identifies reasons for non-adherence

☐ Confirm health plan and PBM provide timely notifications to members on the overall cost of therapy treatments when the request for high-cost medications is received

☐ For in-network COE/hospital/facility, insist that strategies are in place to mitigate catastrophic costs for instances where member receives appropriate cancer treating agents (oral and/or injectable) that are not on preferred drug list (PDL) while undergoing treatment

☐ Confirm availability of financial counseling services through health plan and/or EAP and that consistent member communications of these services are in place

END-OF-LIFE PROGRAMS

☐ Request data on participation in end-of-life programs, including applicable Core Quality Measures (see: Provider Performance Measurement)

☐ Determine how the health plan collects, or plans to collect, data on events near the end of life (percentage and length of participation, ER visits, late admission to hospice, chemotherapy, ICU admission) necessary to report Core Quality Measures, including assessment of the feasibility of collecting mortality data from eligibility disenrollment and/or other sources

Clinical Support

OBJECTIVES:

a. Encourage pre-diagnosis and diagnosis screening policies, metrics, appropriate use of cancer treatments, new expensive drugs, personalized medicine and use of incentives

b. Enable Prior Authorization (PA) program design that minimizes stress for patients, facilitates timely and appropriate treatment and allows for immediate, automated approval for standard therapy

c. Support payment transformation that rewards better value and patient-centered outcomes

d. Implement broad program support for patients and families – clinical, nutritional, psychological, financial, end of life, etc.

e. Ensure quality & performance improvement with quarterly reporting of key performance metrics and progress against specific plans to improve related program and payment strategies

PRE-DIAGNOSIS AND DIAGNOSIS

- ☐ Confirm use of HEDIS cancer screening rates in your markets especially in PCMH/ACO populations
- ☐ Determine how health plan provides "active" support to clinicians for use of appropriate tests such as use of incentives, contractual/employment requirement and feedback reporting

TREATMENT

- ☐ Review criteria for the Plan's or PBM's prior authorization process for drugs, radiation therapy and other cancer therapies, including process for updating criteria
- ☐ Determine activity metrics for prior authorization process that includes approvals, denials, and turnaround time, including detailed definitions of program metrics
- ☐ Review how health plans/PBMs work with clinicians to expedite receipt of needed clinical information for PA decisions, including processes to identify drugs requiring frequent PAs and/or high percentage of approvals by prescriber
- ☐ Determine if PCMH, COE, ACO programs exempt providers from PA. If so, assess why and if it is appropriate.
- ☐ Confirm use of (or plans to use) Pharmacy Quality Alliance (PQA) specifications on monitoring primary non-fulfillment

ENSURING QUALITY AND PERFORMANCE

- ☐ Determine the criteria and evaluation outcomes measures needed beyond credentialing and Board certification used for selecting current oncology networks, COEs and radiation facilities/providers, that will promote higher quality and performance
- ☐ Request patient safety data e.g., chemotherapy and/or radiation overdose and use to determine any changes to policies or other processes associated with patient care
- ☐ Determine availability of cancer PCMHs, including details of plan standards, required services and plan-provided resources (refer to "Navigation and Care Delivery Platforms" and "Cancer Patient-Centered Medical Home (PCMH)/Cancer Medical Team)")
- ☐ Implement quantifiable, quality measures (e.g., proportion admitted to hospice by oncology providers for more than 3 days) especially those in PCMH and COEs. Include timeline/plan of action for implementation feedback reporting and inclusion in payment models

PAYMENT INNOVATION

- ☐ Discuss payment innovation developments and efforts to push on moving away from FFS arrangements

Shared Decision Making/Treatment Option Support

OBJECTIVES:

a. Move patient decisions from “informed consent” to “informed decision” through treatment options, decision support and SDM tool(s)/resources

b. Ensure reporting with actionable analyses for decision making, including quarterly reports for high priority areas (e.g., prior authorization processes, End-of-life programs)

c. Monitor and improve optimization of site of care

d. Shift toward outcomes-based contracting over time

e. Periodically assess updates to programs and support services

INFORMED PATIENT DECISION-MAKING

☐ Review health plan’s shared decision making(SDM)/treatment option support tool for proper content, functionality, member profile and cost estimate features

☐ Determine current utilization of SDM by cancer patients, by type of cancer and with and without Certified Patient Decision Aids (PDAs) and if not optimal, determine plan of action to enhance for better usage/engagement

☐ Request samples of quality information displayed in directories and available to members

☐ Determine if optimal genetic risk evaluation/screening strategy(ies) are in place to ensure appropriate counseling and decision-making

ACTIONABLE REPORTS

☐ Request that reports be current and automated and provide custom actionable reporting options

☐ Request reports by “offering” (Cancer PCMH, COE, Specialized Case Management) that includes:

- ▶ % of patients participating and length of participation
- ▶ Number of interactions with cancer patients
- ▶ % of cancer patients identified by tactic (e.g., PA, pharmacy, referral, claims, etc.)
- ▶ Overlap of patients
- ▶ Detailed definitions of reported metrics

SITE OF CARE OPTIMIZATION

☐ Request that evidence is used to determine best value sites of care, tactics for steering patients to highest value sites of care and that steerage results by tactic are monitored or tracked

OUTCOMES BASED CONTRACTING

☐ Review oncology products and services that could be included in outcomes-based contracts (including products of specific interest to employer)

APPENDIX 2

CASE STUDY

Mary is 50 years old and has been having regular mammograms. This year she scheduled another mammogram after receiving a reminder from her health plan. Her primary care doctor also reminded her to do so after receiving a report from the health plan about her past testing and a reminder about preventive care including breast, colon and cervical cancer screening. After years of normal mammograms, she was found to have a mass in her right breast on this year's exam. Her primary care doctor has referred her to a surgeon for further evaluation and treatment.

Mary's Journey

	SUPPORT/ACCESS TO CARE	APPROPRIATE USE	COMMENTS
Initial evaluation	▶ Clear identification of network surgeons ▶ Clear identification of centers of excellence for cancer care ▶ Member support for provider choice and scheduling ▶ Information about breast cancer evaluation and treatment options ▶ Shared decision-making tools ▶ Clear statements about second opinions	▶ Clear and timely approval process for additional imaging ▶ Clear and timely approval process for biopsy ▶ Clear direction for site of service	
Biopsy shows aggressive breast cancer	▶ Clear process to obtain treatment opinions including oncology, surgery and radiation therapy ▶ Clear process to obtain second opinions ▶ Shared decision-making tools ▶ Information about treatment options ▶ Information about centers of excellence ▶ Offer to arrange tumor board if multiple treatment options exist	▶ Clear and timely approval process for testing including tumor genetics, hormone receptors ▶ Clear and timely process for approval of next steps in treatment ▶ Plan uses national guidelines to inform utilization management decisions	If there is a COE or cancer PCMH, the providers may offer some of these services; the plan should know which services are available and inform the member

	SUPPORT/ACCESS TO CARE	APPROPRIATE USE	COMMENTS
Patient chooses mastectomy	▶ Utilization review approves hospital stay and follows inpatient course ▶ Plan works with hospital staff on discharge needs ▶ Plan helps arrange follow up appointments and home health needs, if any	▶ Clear process to approve admission considering network and site of care	
Patient follows up with oncologist; she has an unusual form of breast cancer that is resistant to standard treatment but has responded well to a new medication. Oncologist recommends genetic testing for patient and family	▶ Plan approves oncology care ▶ Plan offers referral for second opinion at center of excellence	▶ Plan reviews request for genetic testing using national guidelines ▶ Plan reviews request for new medication that is not on the formulary ▶ Plan reviews recent NCCN guideline for updates	
Patient starts on new medication	▶ Plan adds drug to the formulary at tier 4	▶ Plan implements prior authorization for the new drug with strict requirements	For new-to-therapy patients, consider a program to mitigate likelihood of discontinuation
Patient suffers significant side effects from new drug	▶ Plan offers patient and family support ▶ Support includes palliative care to manage symptoms ▶ Curative intent maintained		

APPENDIX 3

GLOSSARY OF TERMS

American Society of Clinical Oncology (ASCO)	Founded in 1964, the American Society of Clinical Oncology is the world's leading professional organization for physicians and oncology professionals caring for people with cancer. Source: https://www.asco.org/about-asco
Assay	An assay is an analysis done to determine: 1. The presence of a substance and the amount of that substance. Thus, an assay may be done for example to determine the level of thyroid hormones in the blood of a person suspected of being hypothyroid (or hyperthyroid). 2. The biological or pharmacological potency of a drug. For example, an assay may be done of a vaccine to determine its potency. Source: https://www.medicinenet.com/script/main/art.asp?articlekey=8412
Biomarker	A biological molecule found in blood, other body fluids, or tissues that is a sign of a normal or abnormal process, or of a condition or disease. A biomarker may be used to see how well the body responds to a treatment for a disease or condition. Also called molecular marker and signature molecule. Source: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/biomarker
Chemotherapy	Treatment that uses drugs to stop the growth of cancer cells, either by killing the cells or by stopping them from dividing. Chemotherapy may be given by mouth, injection, or infusion, or on the skin, depending on the type and stage of the cancer being treated. It may be given alone or with other treatments, such as surgery, radiation therapy, or biologic therapy. Source: https://www.cancer.gov/publications/dictionaries/cancer-terms/
Clinical Practice Guidelines	Guidelines developed to help health care professionals and patients make decisions about screening, prevention, or treatment of a specific health condition. Source: https://www.cancer.gov/publications/dictionaries/cancer-terms/
Comprehensive Cancer Center	A cancer research center that gets support from the National Cancer Institute (NCI) to do cancer research and provide services directly to cancer patients. Scientists and doctors at these centers do basic laboratory research and clinical trials, and they study the patterns, causes, and control of cancer in groups of people. Also, they take part in multicenter clinical trials, which enroll patients from many parts of the country. Comprehensive Cancer Centers also give cancer information to health care professionals and the public. More information about the NCI Cancer Centers Program can be found on the NCI's Web site at http://cancercenters.cancer.gov. Source: https://www.cancer.gov/publications/dictionaries/cancer-terms/
Genetic Counseling	A communication process between a specially trained health professional and a person concerned about the genetic risk of disease. The person's family and personal medical history may be discussed, and counseling may lead to genetic testing. Source: https://www.cancer.gov/publications/dictionaries/cancer-terms/

Genetic Marker	A genetic marker is a DNA sequence with a known physical location on a chromosome. Genetic markers can help link an inherited disease with the responsible gene. Source: https://www.genome.gov/glossary/index.cfm?id=86
Hospice	A program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease. Hospice offers physical, emotional, social, and spiritual support for patients and their families. The main goal of hospice care is to control pain and other symptoms of illness so patients can be as comfortable and alert as possible. It is usually given at home, but may also be given in a hospice center, hospital, or nursing home. Source: https://www.cancer.gov/publications/dictionaries/cancer-terms/
ICER	Founded in 2006, the Institute for Clinical and Economic Review (ICER) is an independent and non-partisan research organization that objectively evaluates the clinical and economic value of prescription drugs, medical tests, and other health care and health care delivery innovations. Source: https://icer-review.org/about/
Immunotherapy	A type of therapy that uses substances to stimulate or suppress the immune system to help the body fight cancer, infection, and other diseases. Some types of immunotherapy only target certain cells of the immune system. Others affect the immune system in a general way. Types of immunotherapy include cytokines, vaccines, bacillus Calmette-Guerin (BCG), and some monoclonal antibodies. Source: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/immunotherapy
Mutation	A gene mutation is a permanent alteration in the DNA sequence that makes up a gene, such that the sequence differs from what is found in most people. Source: https://ghr.nlm.nih.gov/primer/mutationsanddisorders/genemutation
National Cancer Institute	The National Cancer Institute, part of the National Institutes of Health of the United States Department of Health and Human Services, is the Federal Government's principal agency for cancer research. The National Cancer Institute conducts, coordinates, and funds cancer research, training, health information dissemination, and other programs with respect to the cause, diagnosis, prevention, and treatment of cancer. Access the National Cancer Institute Web site at http://www.cancer.gov. Also called NCI. Source: https://www.cancer.gov/publications/dictionaries/cancer-terms/
National Comprehensive Cancer Network (NCCN)	The National Comprehensive Cancer Network® (NCCN®), a not-for-profit alliance of 27 leading cancer centers devoted to patient care, research, and education. A listing of member institutions can be found at: https://www.nccn.org/members/network.aspx Source: https://www.nccn.org/about/default.aspx
Next Generation Sequencing (NGS)	Next generation sequencing (NGS), massively parallel or deep sequencing are related terms that describe a DNA sequencing technology which has revolutionised genomic research. Using NGS an entire human genome can be sequenced within a single day. In contrast, the previous Sanger sequencing technology, used to decipher the human genome, required over a decade to deliver the final draft. Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3841808/

Palliative Treatment or Palliative Care	Treatment that relieves symptoms, such as pain, but is not expected to cure disease. Curative treatment can be used at the same time as palliative treatment, but the main purpose of palliative care is to improve the patient’s quality of life. Source: https://www.cancer.org/cancer/glossary.html (American Cancer Society)
Radiation Therapy	The use of high-energy radiation from x-rays, gamma rays, neutrons, protons, and other sources to kill cancer cells and shrink tumors. Radiation may come from a machine outside the body (external-beam radiation therapy), or it may come from radioactive material placed in the body near cancer cells (internal radiation therapy or brachytherapy). Systemic radiation therapy uses a radioactive substance, such as a radiolabeled monoclonal antibody, that travels in the blood to tissues throughout the body. Also called irradiation and radiotherapy. Source: https://www.cancer.gov/publications/dictionaries/cancer-terms/
Targeted Immunotherapy	Targeted cancer therapies are drugs or other substances that block the growth and spread of cancer by interfering with specific molecules ("molecular targets") that are involved in the growth, progression, and spread of cancer. Targeted cancer therapies are sometimes called "molecularly targeted drugs," "molecularly targeted therapies," "precision medicines," or similar names. Targeted therapies differ from standard chemotherapy in several ways: ▶ Targeted therapies act on specific molecular targets that are associated with cancer, whereas most standard chemotherapies act on all rapidly dividing normal and cancerous cells. ▶ Targeted therapies are deliberately chosen or designed to interact with their target, whereas many standard chemotherapies were identified because they kill cells. ▶ Targeted therapies are often cytostatic (that is, they block tumor cell proliferation), whereas standard chemotherapy agents are cytotoxic (that is, they kill tumor cells). Source: https://www.cancer.gov/about-cancer/treatment/types/targeted-therapies/targeted-therapies-fact-sheet
Tumor Board Review	A treatment planning approach in which a number of doctors who are experts in different specialties (disciplines) review and discuss the medical condition and treatment options of a patient. In cancer treatment, a tumor board review may include that of a medical oncologist (who provides cancer treatment with drugs), a surgical oncologist (who provides cancer treatment with surgery), and a radiation oncologist (who provides cancer treatment with radiation). Also called multidisciplinary opinion. Source: https://www.cancer.gov/publications/dictionaries/cancer-terms/
United States Preventive Services Task Force (USPTF)	The U.S. Preventive Services Task Force is an independent, volunteer panel of national experts in disease prevention and evidence-based medicine. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services. Source: https://www.uspreventiveservicestaskforce.org/

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