

## Panel Advises on Clinical Pathways: What, Why, and How by Bryan Cote

Like politics, all cancer care is local. To keep it that way some managed care organizations and community oncology groups are developing pathway programs collaboratively to realign reimbursement incentives and to prepare for the coming wave of expensive, single source biologics set to hit the market in the next five years. At the 2009 Cancer Care Business Summit, a panel of oncology pathway pioneers shared their thoughts during a session titled “Clinical Pathways: What, Why, and How”. Highlights from that discussion are described below.

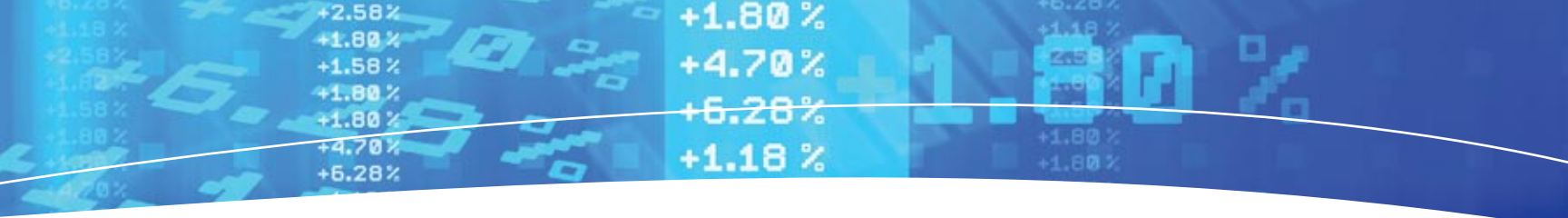
Panelists
<b>Mary Jo Briggs, RN, MPA</b> , Director, Value Based Healthcare, Premera Blue Cross Blue Shield
<b>Bruce Cutter, MD, MMM</b> , Medical Oncologist, Cancer Care Northwest
<b>Peter G. Ellis, M.D.</b> , Deputy Director, Clinical Services and Associate Chief Medical Director, UPMC Cancer Centers
<b>Jeff Forringer</b> , President, IntrinsicQ, LLC
<b>Ira Klein, MD, MBA, FACP</b> , Medical Director, Oncology Condition Analysis, Aetna
<b>Michael Kolodziej, MD</b> , Medical Director, US Oncology, New York Oncology Hematology
<b>Kathleen Lokay</b> , Senior Vice President, Commercial Oncology Services, UPMC Cancer Centers
<b>Warren Dodge</b> , Moderator, President, Oncology Metrics

### Clinical Pathways Are More Than Just Treatment Algorithms

In a collaborative model, community oncologists share insights with their largest payers on practice operations, clinical, billing and administrative data, utilization management experiences, and expenses. For example, Washington’s largest carrier by volume, Premera, has had a pay for performance program for clinical pathway adoption for seven years with Cancer Care Northwest in Spokane. They are currently considering avenues to expand pathways and recently began looking deeper into its clinical pathway for non-metastatic breast cancer data. Premera has now asked area cancer centers to share clinical stage data so that it can be combined with administrative data for all non-metastatic breast cancer patients. These patient numbers are then benchmarked against Cancer Care Northwest’s numbers to validate differences. Though there have been barriers with implementation, both parties have deemed the collaboration a success and thus demonstrates that clinical pathways can fuel broader discussion.

As more payers and providers develop trust and a commitment to achieve common goals deepens, it is the small payer that can benefit most from these interactions because small payers typically lack oncology experience. For instance, “If a company has an important drug and it costs \$50,000 per weekly dose for six months, we have no control in that pricing decision,” said Bruce Cutter, MD, Cancer Care Northwest. “We need to take drug cost into account when developing pathways; if it’s the best drug, we should use it, but if there is another drug equal in terms of patient factors (efficacy and toxicity) we should choose the less expensive one to emphasize value.”

Kathy Lokay, formerly of US Oncology and currently Senior Vice President of Commercial Oncology for UPMC Cancer Centers, said there are multiple ways to monetize the value of pathways. For providers, they need to think



of pathways in both an offensive and defensive strategic way: defensively to protect their financials, but offensively to find ways to save and appropriately standardize to help patients improve outcomes and ultimately administrative reimbursement.

### Prior Authorization for Single Source Biologics

A flurry of single source biologics with attractive side effect profiles is expected to enter the cancer care market without competition in the next few years. Precedent suggests payers would require prior authorization on most if not all of these drugs as a utilization-control move. According to the panel, this would be a mistake. Requiring prior authorization on the coming wave of expensive oncology-specific biologics is an option on the table, but not Aetna's preferred option, as it might preclude payers from engaging in relationships with community oncologists, academic centers, hospitals and cancer centers. In lieu of precertification, payers, said Ira Klein, MD, Medical Director of Oncology Condition Analysis, Aetna, could try a single specialty arrangement with an oncology provider, or build a private label insurance product in which the plan acts as a third party administrator. Prior authorizations would close the door to these arrangements and stall recent collaboration amongst oncology groups and payers.

Dr. Klein suggested that at Aetna they want to move from a do-more/get paid-more reimbursement model to a holistic coverage and reimbursement approach with clinical pathways as the foundation. The only way to achieve this is through strong collaborative efforts with provider groups.

### Realigning Reimbursement Incentives While Maintaining Quality

Some payers and providers are using their collaborative pathway success to explore how to realign drug reimbursement around quality. The panel described efforts to consider different cost vs quality models such as changes to deductibles, coinsurance, and payment amounts for medications—depending on their benefit (medical or pharmacy). Some payers are looking across both I.V. and oral therapies to find what makes sense clinically, and

matching reimbursement incentives appropriately. An I.V. drug may be more expensive for example, but if it has the best science, the payer can work with the oncology group to align their reimbursement around it without worrying about financial incentives.

At Premera, the insurer lacked critical clinical data to explore these models—data that Cancer Care Northwest had, said Mary Jo Briggs, RN, Director, Premera's Value Based Healthcare. "We cannot rely only on our claims data, so we augment it with CCN's clinical data to help assess the effect of clinical pathways on the overall cost per episode," Briggs said. "Cancer Care Northwest assessed clinical quality outcomes and patient satisfaction so that we had a more complete picture of the effect." Premera and Cancer Care Northwest are now using this foundation to explore how to realign reimbursement around quality. "Perhaps we can demonstrate something for the industry about what to do and what not to do." Premera has added an oncology advisory group to help educate internal medical policy and pharmacy and therapeutics committee members, and plan to expand their role to educate employers and benefit designers about how to adapt their approach to oncology.

All stakeholders are affected. Pharmaceutical companies, for their part, are incentivized to price drugs higher or providers will be less likely to prescribe the drugs, since higher priced agents are still an economic engine for oncologists, said Aetna's Dr. Klein. "We will continue to have this discussion without a good answer until we change the way we pay, operate, incent, and measure drugs."

The panel suggested increasing margins on cheaper drugs as one solution to ease economic burdens confronting physicians who forgo generics in some cases because the incentives aren't aligned properly.

### Paying for Active Management

The clinical pathway discussion morphed at times into how to better compensate oncologists for actively managing patients. With surgery, radiation oncology and chemotherapy, for example, providers [cont. on pg 30 >>](#)

are actively managing their patients in a value-added way. “We would be interested in possibly adding something (not necessarily reimbursement, but some incentive) that shows we know the patient is in active management compared to, for example, a breast cancer patient on maintenance therapy,” said Dr. Klein. “We would [need to] tweak the definition of episode of care to definable active management episodes and look at patient outcomes per condition.”

## Thinking about Pipelines

When developing or tweaking clinical pathways, it’s easy to focus on the current market conditions and reimbursement challenges. That’s a mistake, the panel advised. The oncology marketplace is in a trough of drug approval right now with products going off patent and a number of new expensive agents not yet on the market. The panel urged oncology leaders to design clinical pathways and resultant reimbursement models with pipelines in mind.

## Clinical Pathways Adherence and Outcomes

Clinical pathways measurement can be relatively straightforward—is the patient being treated on or off pathway? If 50 percent are off, there is a problem, the panel concluded. Cancer Care Northwest and UPMC have both reached 90 percent plus pathway adherence, but panelists representing both organizations agreed that there is no clear path in some cases, and that evidence and sound medical judgment must drive treatment decisions at the point of care.

When trying to determine if a physician is treating on pathway the panel warned against using claims data alone. Instead, they recommend setting up systems to identify and collect the patient’s cancer stage, performance status, and dosing. Without these ingredients, payers and providers will find it difficult to manage a pathway and measure its value. For example, even when identifying dosing, be sure to pay attention to suboptimal doses. You may see, for example, that a large percent of prescribers (as high as 50 percent in one case) are giving doses lower than recommended, although the data looks as though the patient is being treated based on the pathway.

The collaboration between UPMC and Highmark led to development of 15 pathways, and in two years the duo has measured hospitalization savings for lung cancer patients—comparing savings from pathway physicians vs non-pathway physicians. They are planning to release breast cancer analysis soon.

## Conclusions

Like diabetes’ A1C measurement, clinical cancer care pathways have given physicians and payers at a local level a starting point—a foundation from which to facilitate other discussions, evaluate treatment outcomes, and determine future therapeutic decisions. Framed as a tool to standardize, clinical pathways have in many ways become less about standardization and more about customization.

On the horizon is greater attention and investment from the largest payer, CMS. Billions are potentially earmarked for Medicare demonstrations and other projects to use clinical pathways to drive efficiency and uniformity of care. This is promising, but the panel expressed caution, noting that federal programs or reimbursement decisions could challenge community-based interaction. Ideally, policymakers can learn from the positive collaboration that has taken place thus far between local payers and providers. **BC**

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The American Cancer Society said it was not currently rethinking or restating its guidelines to emphasize the inadequacies of breast and prostate cancer screening, contrary to an October 20 New York Times article reporting that the ACS was changing its position to say that the benefits of screening for those cancers had been overstated.

*(U.S. News & World Report, 10/21/09)*

Some upcoming Phase 3 clinical trial results expected through early '10 include: Poniard’s picoplatin data for small cell lung cancer in 4Q '09 (likely in November); Genta’s Genasense® data for metastatic melanoma in 4Q '09; and Bristol-Myers Squibb’s top-line data on ipilimumab for previously untreated metastatic melanoma.

*(TheStreet.com, 10/23/09)*