Making healthcare remarkable

Cost Containment Strategies: How do we provide valuable oncology care?

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Objectives
- Understand differences in strategy based upon setting and third-party payer type
- Review national oncology guidelines/recommendations on cost-containment and value-based purchasing
- Demonstrate examples of cost-containing strategies that are relevant in both a DRG-based and fee-for-service model
- Define challenges for maintaining cost-effective and valuable care for the oncology patient

Welcome to Oncology Care

Reimbursement primer: DRG vs. fee-for-service

1. Diagnosis-related group (DRG)
   - Medical costs are reimbursed under a lump-sum format based upon primary diagnosis
   - Revenue is directly tied to the ability to manage expense below DRG reimbursement
   - Cost containment strategies historically have targeted drug expense as primary measure

2. Fee-for-service
   - Medical costs are reimbursed on an individual basis related to the primary diagnosis
   - Revenue is tied to authorization by third-party payers for each individual component
   - Cost containment strategies have historically centered around avoiding unauthorized regimens

ASCO: The State of Cancer Care in America


Cost containment - Kickin’ it old school

- Inpatient setting
  - Formulary management
  - Management approval/stewardship
  - Order set management
- Outpatient setting
  - Prior authorizations
  - Order set management
Old School – Formulary Management

- Mainstay of inpatient financial management in oncology
- Placing barriers in front of non-preferred medications leads to reduction in use
- Key questions to address with formulary decisions:
  - Drug cost
  - Clinical value of new agent/regimen vs. standard of care
  - Clinical setting

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- Drug X is:
  - An injectable agent with activity against CML with T315I mutation
  - Injected subcutaneously every 12 hours for 14 straight days
  - The only agent on the market with documented activity in T315I-mutated CML
  - Drug cost per cycle: $23,000 if treated as a true single-dose vial

- Drug X is not indicated for home use, and must be administered in the healthcare setting

- Your healthcare facility has an outpatient oncology infusion clinic, but hours of operation are 7:30 AM to 5 PM

Audience Response Question: Do you add Drug X to your hospital formulary?

A. Yes, because we feel the benefit of having an available agent for T315I-mutated CML in accelerated phase outweighs the cost of therapy in the inpatient setting
B. No, we would utilize a specialty pharmacy to white/bag/brown-bag the drug in the inpatient setting
C. Yes, but we would restrict the usage to the outpatient oncology clinic and customize operations to accommodate patients
D. No, because I’m getting a headache just thinking about the logistics
E. Yes, because it’s oncology, and we do what we want!

A real call for oncology drug approval...

- 49 yo F with newly diagnosed metastatic HER2 (+) breast cancer
- Current state:
  - Intubated in the medical ICU
  - Newly-diagnosed cardiac dysfunction with EF of 35%
  - Treatment naïve
- Provider orders emergent therapy to begin in the medical ICU with pertuzumab/trastuzumab/docetaxel
- Pharmacist questions use of pertuzumab and trastuzumab in the inpatient setting, and is told “this is what I ordered, and if we don’t give her this, she will die”
- Pharmacist escalates request to director

Old School – Prior Authorization/Approval

- A successful approach is a multidisciplinary approach with a physician champion
- Providing an outlet for non-formulary requests allows providers the ability to plead individual cases amidst the constant pressure of evidence-based medicine
Old School – Order Sets

- Standardization is the hallmark of order sets
- Predicates a path of least resistance to preferred agents
- Streamlines operations and improves efficiency within oncology workflow for all members of the care team

Old School Cost Containment – Sum it up

- Cost avoidance is king
- Old school measures still play a very important role in reduction of expenditures, particularly in the inpatient setting
- Most measures are pharmacy-driven and pharmacy-owned
- Relatively little is accomplished in terms of overall cost of care

Hello ASCO...

Choosing Wisely®
An initiative of the ABIM Foundation

ASCO: 10 Things Physicians and Patients Should Question

1. Don’t use cancer-directed therapy for solid tumor patients with the following characteristics: low performance status (3 or 4), no benefit from prior evidence-based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anti-cancer treatment.

2. Don’t perform PET, CT, and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis.

3. Don’t perform PET, CT, and radionuclide bone scans in the staging of early breast cancer at low risk for metastasis.

4. Don’t perform surveillance testing (biomarkers) or imaging (PET, CT, and radionuclide bone scans) for asymptomatic individuals who have been treated for breast cancer with curative intent.

5. Don’t use white cell stimulating factors for primary prevention of febrile neutropenia for patients with less than 20 percent risk for this complication.

6. Don’t give patients starting on a chemotherapy regimen that has a low or moderate risk of causing nausea and vomiting antiemetic drugs intended for use with a regimen that has a high risk of causing nausea and vomiting.

7. Don’t use combination chemotherapy (multiple drugs) instead of chemotherapy with one drug when treating an individual for metastatic breast cancer unless the patient needs a rapid response to relieve tumor-related symptoms.

8. Avoid using PET or PET-CT scanning as part of routine follow-up care to monitor for a cancer recurrence in asymptomatic patients who have finished initial treatment to eliminate the cancer unless there is high-level evidence that such imaging will change the outcome.

9. Don’t perform PSA testing for prostate cancer screening in men with no symptoms of the disease when they are expected to live less than 10 years.

10. Don’t use a targeted therapy intended for use against a specific genetic aberration unless a patient’s tumor cells have a specific biomarker that predicts an effective response to the targeted therapy.

ASCO 10 Things – Changes to the Landscape

- For the first time, oncologists shifting view of oncology healthcare costs from “It’s not my inpatient problem” to “It’s our global problem”

- Healthcare decisions based upon eliminating waste from the system as a whole
What is the driving factor for eliminating waste from the system?

Overall efficiency in all WHO member states
1. France
2. Italy
3. San Marino
4. Andorra
5. Malta
6. Singapore
7. Spain
8. Oman
9. Austria
10. Japan
37. United States of America


ASCO: The State of Cancer Care in America

How do we provide valuable oncology care?


Healthcare Costs – Oncology Specialty Medications

- Specialty medications are expected to make up 35% of total pharmaceutical sales by 2016
- Oncolytics account for greater than 50% of all specialty medications
- In 2 years (between 2010 and 2012), a survey noted a 25% increase in the number of oncologists who would prescribe a therapeutically-equivalent oral medication over an intravenous alternative, if given the choice


ASCO – The State of Cancer Care in America

Value Statement

“Payers should align payment systems with the goal of delivering high-value, patient-centered care, and provide funding and support to help struggling practices make the transition to value-driven payment models.”


ASCO – The Literal $1 Million Question

How do you define value?

A. Clinically meaningful advances in primary endpoints of published literature
B. Ancillary measures, such as quality-adjusted life year (QALY), that account for both clinical endpoints and cost
C. Patient satisfaction in their plan of care
D. Guideline-driven, customized plan of care based upon risk factors, tumor markers, and disease characteristics

Audience Response Question: How do you define “value” in terms of oncology medications?
High-Value Care: A Case

- JC is an 87 yo AAM, originally diagnosed with stage III colon cancer and given definitive treatment with FOLFOX
- After watch and wait period of 19 months, JC presented with metastatic disease, now known to be KRAS-mutated
- Current treatment regimen is FOLFOX+ bevacizumab
- After 7 cycles, JC has progressive disease
- Social history:
  - JC lives at home alone, 2 children live within 10 mile radius
  - JC has Medicare Part D prescription insurance
  - Former Army Ranger with great exercise tolerance prior to most recent chemotherapy
- JC has an ECOG performance status of 1

Audience Response Question: Which of the following choices would you recommend for JC’s 2nd-line therapy?

A. Continue with FOLFIRI-based therapy and switch VEGF agent to ziv-aflibercept
B. Continue with bevacizumab-based therapy and switch chemotherapy for FOLFOX
C. Initiate therapy with regorafenib
D. Do nothing

Value in Care: Determining Value

- No magic formula, but several components necessary
  - Clinical data
  - Patient’s wishes
  - Cost
  - Many more
- Current state
  - ASCO has asked for 3rd party payers to reimburse based upon value
  - This requires 3rd party payers to define value!


Value-based oncology care:
The future is now

Audience Response Question: Which of the following choices would you recommend for JC’s 2nd-line therapy?

<table>
<thead>
<tr>
<th>Choice</th>
<th>Survival improvement (months) vs placebo arm</th>
<th>Cost of 1 month of therapy (AWP)*</th>
<th>Adverse Effects (grade 3/4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOLFOX/bevacizumab</td>
<td>1.4</td>
<td>$9,372</td>
<td>FN: 4% Vomiting: 4% Bleeding: 8%</td>
</tr>
<tr>
<td>FOLFIRI/ziv-aflibercept</td>
<td>1.4</td>
<td>$8,436</td>
<td>FN: 4% Vomiting: 13% Bleeding: 3% Dehydration: 4%</td>
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<tr>
<td>Regorafenib</td>
<td>1.4</td>
<td>$12,370</td>
<td>Neutropenia: 1% Hemorrhage: 2%</td>
</tr>
<tr>
<td>Do nothing</td>
<td>0</td>
<td>$0</td>
<td>None</td>
</tr>
</tbody>
</table>

* Based on 2 m2 and 100 kg

Clinical benefit

Cost of therapy* = VALUE

* Costs include financial, physical, emotional, and spiritual costs

Deciphering the value puzzle

- Understand current state and value therein
- Utilize tools, such as clinical pathways, to gather data around quality and cost of current treatments
- Use data set to benchmark care versus industry and national standards of care
Deciphering the value puzzle – WellPoint Anthem

- First group to publicly release clinical pathways in a non-proprietary fashion

- Pathways are based on:
  - Clinical benefit (efficacy)
  - Safety/side effects (especially those leading to hospitalizations & impact of quality of life)
  - Strength of national guideline recommendations
  - Cost of regimens


Why are clinical pathways the new “it” factor?
(P.S. these aren’t new)

- Dual role in providing quality care in today’s market
  - Fee-for-service: utilizing pathways at a high rate can lead to expedited authorizations for treatment from third-party payers
  - Value-based model: low cost, high value care selected for patients

- Provide performance metrics for care
  - Individualized metrics per disease state for real-time analysis of care
  - Provider metrics to track performance with pathways, both for compliance and treatment outcomes (on and off pathway)

- Agreement to pathway model helps manage care across all settings of care for the oncology patient
  - Inpatient
  - Outpatient infusion
  - Home

Is there data to support pathways? – US Oncology Colon Data

<table>
<thead>
<tr>
<th>Setting</th>
<th>On-Pathway (N)</th>
<th>Off-Pathway (N)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjuvant Setting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall costs</td>
<td>$103,379</td>
<td>$156,020</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Duration of therapy</td>
<td>5.7 months</td>
<td>8.7 months</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hospitalization rate/patient</td>
<td>0.23</td>
<td>0.30</td>
<td>0.236</td>
</tr>
<tr>
<td>Disease-free survival</td>
<td>NR</td>
<td>26.9 months</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Metastatic Setting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall costs</td>
<td>$131,059</td>
<td>$191,222</td>
<td>0.067</td>
</tr>
<tr>
<td>Duration of therapy</td>
<td>10.8 months</td>
<td></td>
<td>0.053</td>
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<tr>
<td>Hospitalization rate/patient</td>
<td>0.2</td>
<td>0.43</td>
<td>0.181</td>
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<tr>
<td>OS (metastatic disease)</td>
<td>20.9 months</td>
<td></td>
<td>0.03</td>
</tr>
</tbody>
</table>

Where do we go from here?

- Oncology costs are continuing to climb

- Traditional cost-containment measures are inherent to the system and will continue to be in the future

- Newer value-based systems will further drive the balancing act of clinical value versus total cost of care

Questions
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