Market Momentum in Oncology Management

Abstract

Health plans are continuing to take a more proactive approach in oncology management to tackle growing cost concerns while simultaneously promoting coordinated, high-quality care. While a variety of strategies are being tested in market, health plans piloting emerging approaches, such as oncology medical homes and bundled payments, are targeting up to a 15% reduction in the total cost of cancer care. For plans evaluating a more proactive oncology management strategy, this paper offers a framework for evaluating what strategy would best address each plan’s particular needs.

Over the next decade, advancements in personalized medicine, targeted genomics, and multi-therapy combinations are expected to help improve the quality of life of cancer patients (and survivors) while simultaneously contributing to the rapidly growing oncology spend that has gained widespread attention from health plans. Many executives are looking not only for near-term relief from rising costs but also long-term solutions that drive greater value-based outcomes and address five broad cost concerns:

1. Rising cost of chemotherapy treatment and underlying “buy and bill” methodology
2. Significant and unnecessary cost and quality variation across provider networks
3. Preventable emergency room and inpatient costs
4. Unnecessary or duplicative services due to uncoordinated care models
5. Billing variances by care setting given continued consolidation of oncology practices

The recent release of the Oncology Care Model Request for Application by the Center for Medicare and Medicaid Innovation (CMMI) has piqued interest by both plans and providers looking to evaluate if they will participate and how this program might fit with other oncology strategies they have already underway. CMMI’s increased focus on oncology, desire for multi-payer participation, and introduction of evolving payment models (e.g. episode-based payments) later this year are clear indicators that the pace of transformation within the oncology care model will continue to accelerate in the future.

The commercial and Medicare Advantage markets are already well underway testing several strategies to help address cost concerns while promoting high-quality and efficient care. For example, Aetna is targeting a 10% reduction in costs through its pilot oncology medical homes, a $12,500 savings per patient. (2) In comparison, UnitedHealthcare published the results from its bundled payment pilot which generated $20M in net savings (medical and pharmacy costs) across 810 patients, a $24,600 savings per patient. (4) Anthem also is broadly rolling out its Cancer Care Quality Program and anticipates generating a 2x-3x return on the program that offers clinical pathways for cancers contributing to 90% of chemotherapy spend. (5) In addition to publically traded companies, other health plans are investing in clinical platforms to support patient-centered care and episodes of care programs for oncology, such as Horizon Blue Cross and Blue Shield of New Jersey’s recent investment in COTA, a technology company focused on oncology management.

Results from these pilots suggest the savings opportunity could be substantial if a health plan can implement such strategies across a broader spectrum of cancer patients. The value of managing this population effectively also has become even more compelling as the ACA-sponsored risk adjustment program expands in the commercial market. For example, given a $300pmpm state average premium, a health plan could expect to receive an incremental $39,600...
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annually for an individual coded for lung cancer. This underscores that not only is it critical for a health plan to completely and accurately capture the risk profile of oncology patients (and survivors) to receive the appropriate risk adjusted premium, but also it is just as important to implement effective care management programs to help eliminate unnecessary variance in medical spend and improve clinical outcomes. While many traditional care management levers – drug reimbursement design, utilization management, and care management – are being used for incremental improvements, newer strategies are taking a more prominent role to significantly improve care, including clinical pathways programs, medical oncology homes and risk-sharing reimbursement models.

Most health plans may find they do not have the internal capabilities to implement these new models by themselves. The underlying level of complexity intrinsic to cancer (and its various permutations) exceeds the expertise at all but some of the largest plans, and the operational requirements to incorporate value-based payments in plan legacy systems can be challenging. Thus, we anticipate the vast majority of health plans will work in partnership with outside companies with oncology focused solutions that can bring the depth of oncology expertise required to appropriately design the appropriate workflows, financial arrangement, data connectivity and program management to initiate change. As these partnerships are formed, it will be important that they are designed with feedback loops to help health plans and providers continuously learn and improve processes, ultimately helping them successfully migrate to greater risk-sharing relationships.

Determine the Right Approach for Your Plan

Choosing the right oncology strategy can be challenging and a wide variety of factors can influence a health plan’s decision. We have distilled the evaluation process down to a few critical internal and external dimensions, built on a fact base of claims experience and an understanding of local geographic trends, that will help identify where the opportunity lies to more proactively manage cancer spend. Once the opportunity has been scoped, HealthScape can work with a health plan to use this fact-based framework to evaluate a series of questions to make sure the strategy chosen fits the strategic direction of the plan, expected receptivity in the market, and the availability of internal capabilities to execute.
Sources:
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