Payers weigh in on comparative effectiveness

The buy-and-bill compensation model of drugs doesn’t lead to the best incentives for patients and physicians, and most oncologists agree, but many—more than a quarter of them in a survey I wrote about for Oncology Business Review (to appear in September’s OBR)—do not think comparative effectiveness (CE) studies are a way to realign incentives and lower costs without compromising outcomes.

HERE’S THE PAYER-SIDE REACTION:

“I would have thought more oncologists would have favored the comparative effectiveness model,” Sam Rajan, RPh, says of the results.

Rajan, formerly senior vice president of clinical operations at MemberHealth/Universal American and currently a principal at CoverMyMeds in Cleveland, says oncologists are clearly concerned about further cost controls.

“But what is interesting is that 25% say CE policies will never improve quality here in the United States,” Rajan says. “They need to be compensated fairly, but it is difficult to set their compensation based on buy/sell spread on the product that they use.”

“I would agree that greater focus on cognitive services and realigning incentives is needed, but comparative effectiveness may not ultimately save money if it’s not legislatively mandated,” says Mona Chitre, RPh, clinical strategy director at Excellus BCBS in Rochester, NY.

Joel Brill, MD, chief medical officer at Phoenix-based Predictive Health, thinks the survey results are interesting because they arrive on the heels of payment fluctuation ahead. In 2010, chemotherapy IV infusion reimbursement may decline about 40% under CMS’ Physician Fee Schedule proposal.

“I’d expect this to force more doctors to redirect patients to the hospital—even more than indicated in the survey,” Brill warns. How a cost effectiveness or CE policy here would affect where patients receive care is not yet known.

“It seems to me that all these proposals to change how oncologists are paid, especially for drugs, miss the mark,” Sheldon Josephs, administrator at the Center of HemOnc in Sacramento, says in response to the results. “Yes, oncologists are responsible for the variability of treatment costs, but not for the underlying cost of the drugs being administered. Greater adoption of pathways would take the problem of treatment variability off the table.”

MANAGED MARKET TAKEAWAY

Take a look at the survey results when they appear in September, and you will begin to see how you can fill gaps in physician understanding about CE, as well as foster cross-setting dialogue among payers and providers.

Closing disparities and realigning incentives can still be achieved, but it seems, based on the survey, that there is more your customers on both sides can learn and share about the true value of CE studies, episode-based payment, and other ideas, such as salaried MDs.
How PDL committee tracks prior authorization trends

The chart below illustrates the number of prior authorizations (PA) approved by month in Louisiana for its Medicaid program. The yellow line represents July–December 2005, the orange line covers all of 2006, and the purple line gives a glimpse of the first half of 2007 through June. The reason for the low number of PAs in September 2005 is because of Hurricane Katrina. Louisiana lifted PA requirements generally across the board in September 2005, and once it reinstated PA restrictions, the number of requests skyrocketed because “doctors were prescribing whatever drug they wanted without looking at the list,” says Germaine Becks-Moody, PhD, the state department of health and hospitals’ pharmacy program manager.

She notes that the P&T committee actually requested that the state track these data each month to help it understand the effect of its decisions. For example, if the committee opted to remove a drug from the PDL as of February 1, 2007, it might then look at the ensuing months to see whether physicians were switching to the PDL products or requesting PAs, Becks-Moody explains. In this case, you can see from the chart that PA requests increased in March and then again in April, “so the committee might ask us to look into the reason and could, in theory, adjust its decision if the trend continued,” she says.

Editor’s note: To read Louisiana’s April 2008 formulary, click here.
Emerging trend: MD salaries, physician shift, and what to do about it

More physicians will become employed at hospitals and change the face of medical staffs. This might have some effect on pharmacy treatment policies, perhaps leading to greater standardization, says Todd Sagin, MD, an internist from the Boston area who has spent most of his career in private practice and hospital medicine and who has most recently served as a consultant for the Greeley Company Medical Staff Institute. This physician shift takes on greater significance as support increases on a grassroots level for MD salaries—a new model of compensation that some doctors and executives say would work to realign incentives around quality.

Looking at the situation from a managed markets perspective, you may begin to think about programs that address this trend and assist hospitals and physicians about how to think about their formularies, medication management, and adherence in new ways.

Conversation

Plans looking to align reimbursement incentives based on pathway compliance

CareFirst of Maryland is likely to reimburse oncologists at an average sales price (ASP) plus 20% for hitting pathway compliance thresholds. This means that doctors must meet the standards of care for prescribing by tumor type, and if they don’t, their reimbursement could be as low as ASP plus 12%. The major takeaway for managed markets and account teams is that commercial plans are now more aggressively seeking help from your physician specialists in designing studies that align reimbursement with first-line therapies and evidence-based treatment standards, as long as the providers follow the standards. It represents a larger share opportunity for certain products and for new launches with a cost-savings story to tell. It also represents a communication challenge for the sales force, who must understand the following:

- Physicians are being incentivized based on their pathway compliance
- Payers are moving toward more standardization, putting greater restrictions on use of second- and third-line agents

CareFirst used pathways developed by the UPMC Cancer Centers of Pittsburgh and let its network physicians in Maryland provide feedback to customize it, since UPMC’s focus is on doing clinical trials. In the first year of the program, CareFirst will require a 60% compliance rate with the pathway. With UPMC, the payment for reaching an 80% compliance rate for UPMC physicians has been the average wholesale price (AWP) minus 15% from Highmark, which represents 70% of the non-Medicare market in Pennsylvania, and “favorable reimbursement” from...
the center’s other major payer, UPMC Health Plan, says Stan Marks, MD, deputy director of clinical services for UPMC Cancer Centers.

Highmark has worked collaboratively with UPMC to develop retroactive studies that assess the cost benefits of standards-of-care pathways, says Bob Wanovich, RPh, vice president of pharmacy at Highmark. Its analysis of lung disease showed a worthwhile reduction in hospitalizations among UPMC physicians since its pathway implementation, compared to a control group of non-UPMC doctors.

I’ll have results for an additional study on breast cancer by the fall.

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CMS policy change in home health

Starting in 2010, Medicare will require all home healthcare providers to track more patient outcomes and medication information dealing with depression, falls, and a host of other conditions. The information will be collected manually in most cases, but transmitted to agency offices and ultimately CMS every 60 days for evaluation. Medicare may use the findings to understand and inform policy around the most effective therapeutic approach for diseases in the home health setting. Our sister company, Beacon Health, tracks these issues with customers. If you’re interested in accessing this market, please reach out at your convenience.

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Survey snapshot

more attention from internal stakeholders for these reasons, including greater commercial sales resources and greater voice internally. In one program, nurses in the LTC setting listen to a promotional program via audio conference on recognizing and/or managing a disease; of the 4,216 attendees, a portion of customers were targeted by the state in advance. Account managers met with them to listen and, immediately post-program, discuss how the product could help meet the clinical team’s quality of care challenges. The program included a pre-program baseline survey, post-program assessment, and three-month follow-up; the insights were shared with attendees for additional program topics. To show ROI, the company/brand used results of the assessments and sales interactions to show that the program directly produced utilization increases.

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