



**21st Century Cancer Care: Will New Models Lead
to Better Care at Lower Cost?
Wellpoint
Alliance for Health Reform
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SARAH DASH: I am not Ed Howard, for those of you who are used to him. I am Sarah Dash; I am the Vice President for Policy at the Alliance for Health Reform and on behalf of our honorary Co-Chairman, Senator Rockefeller and Senator Blunt and the Board of Directors of the Alliance, welcome to today's program.

Nobody wants to hear the words, "You have cancer." But the number of people diagnosed with cancer each year is expected to continue increasing and by 2022, there will be an estimated 18 million cancer survivors in the United States. The good news for these individuals is that improvements in cancer care are leading to increased life expectancy and survival rates. The bad news is that the quality of cancer treatment they receive may be fraught with uncertainty, if they can afford it at all. By one estimate, cancer care will cost our country an estimate 157 billion dollars by 2020. The question for today's briefing is not only why the cost of cancer care is so high, but why patients are not consistently getting the best care that they possibly could and most importantly, we will learn about how the healthcare delivery system should respond. We are pleased to have as a partner in today's briefing, WellPoint, which has recently rolled out a new program for oncology care, which we will hear about today. So we will be exploring this and other proposals from the public and private sectors that are aimed to improve the value of cancer care delivery and result in more patient centered care. If you are a health policy Wonk, which I expect most of you to be, you are going to find a lot more information in your briefing packets, some good background materials about the proposals that are in development or underway.

So now let's go ahead and get to the program. You can follow us on Twitter today by using the hashtag, #cancercare14 and if you need WiFi, the instructions are on the table or up on the screen. We have fantastic panelists today and I want to thank them ahead of time for taking time out of their busy, busy schedules to come and brief us all on this very important topic. Their full bios are in your packets and I'm going to introduce each of them briefly, welcome. Thanks for being here.

So first when we talk about patient centered cancer care delivery, we need to know what that means and in the interest of hearing that, we are going to first hear from Shelley Fuld Nasso, who is the CEO of the National Coalition for Cancer Survivorship. She is going to describe some of the key attributes of what a high valued patient centered cancer care system should look like from the patient's perspective.

Next, we are delighted to have Dr. Deborah Schrag with us. Dr. Schrag is a professor in the Department of Medicine at Harvard Medical School. She is Chief of the Division of Population Sciences in Medical Oncology at the Dana Farber Cancer Institutes. That is a mouthful, which I think means she is really, busy. She is going to help us delve into how cost and evidence factor into cancer care and give us an overview of some of the current ideas for reform.

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Third, we have Dr. Jennifer Malin. She is the Medical Director for Oncology and Care Management at WellPoint and she will discuss WellPoint's new cancer care quality program that has recently been rolled out.

Finally, we will hear from Dr. Nancy Davidson, the Director of the University of Pittsburgh Cancer Institute and UPMC Cancer Center and past president of the American Society of Clinical Oncology. Dr. Davidson will tell us about [unintelligible] value in Cancer Care program.

So with that, we will go ahead and get started with Shelley Fuld Nasso. Thank you.

SHELLEY FULD NASSO: Thank you very much for hosting this briefing and for inviting me and I'm really impressed to see this many people here who want to hear about cancer care and cancer care delivery. So I'm appreciative of all of you for coming and listening today. And I'm also grateful that we started with the patient perspective because I do think that this is all about improving how we deliver cancer care to patients who are struggling with this disease and struggling with how to pay for it and struggling with decision making about what kind of treatments that they want and how to ensure that they have the quality of life that they want while they are going through treatment.

So I will just start with a little bit about the National Coalition for Cancer Survivorship. We advocate for quality cancer care for everyone touched by cancer and we focus on policy efforts to improve both cancer treatments, but also enhance access to quality cancer care. We want to try to improve the cancer care system and make sure that its evidence based, quality drive, patient focused and affordable and accessible to all and we do that by convening advocates and industry payers, professional societies, academia providers. We had an excellent meeting this week where we talked about a lot of these same issues that we will be talking about today and really tried to bring together leaders in the community to think about how we can address some of these problems. In one of our focus areas, for a long time, has been cancer care planning, but at diagnosis and then at major transition points during treatment and the transition to survivorship. So I know that you all had access to the briefing materials and there was a reference to the IOM's report last year on delivering high quality cancer care and the striking thing about it from the patient's perspective was that -- and it wasn't really news to those of us who work in this area, but it was a great vehicle for us to talk about, that the fact that the cancer care system is really in crisis and the way we deliver cancer care is not coordinated, it doesn't necessarily -- the way we pay for cancer care doesn't value what patients want in the cancer care system. And from all the providers that I speak with and you are going to be hearing from some today, I don't think it values what providers want to do. They want to treat their patients and help their patients through this difficult time in their lives, but the way we pay for it does not incentivize that kind of care. And so they are stuck in a system where they have many pressures on how they spend their time and how they take care of their patients that aren't really what they want in how they take care of patients. So one of the recommendations of the IOM report was that the Cancer Care Team should

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collaborate with their patients to deliver a care plan that reflects their patient's needs, values, and preferences. And considers palliative care needs across the cancer care spectrum from diagnosis through end of life and in survivorship. So as I mentioned, we focus a lot on cancer care planning because we believe that if there is an adequate planning process at the beginning when a patient is diagnosed, if there is adequate time to have that shared decision making and engagement between physician and patient about what are the best options for the patient, that really takes into account the patient's needs and values and preferences. And it's not just, here is what I recommend to you as your physician, but letting the patient talk about, here is what is important to me. While I'm going through treatment, I still want to be able to do this. Or these are the kind of treatments that I'm willing -- these are the kind of side effects I'm willing to accept and these are the kind of side effects I'm not willing to accept, and be able to factor those into the treatment decision making process so that it's truly a shared decision. Many patients don't want to make that decision; they want to be able to say to their physician, what would you do if you were me? Or what would you do if this were your mother? If it's a family member who is engaged? And I think the only way for a physician to really answer that question is to know something about that person and so if they know what your values are and what you are concerned about and what you want to be able to do when you are going through treatment -- if you have a certain milestone you are trying to achieve in your life or if you really just want to be able to continue gardening and spending time with your grandchildren while you are going through treatment. You can't -- the physician can't make that recommendation if they don't know that. And if they don't have the time to talk with you and really go through an adequate planning process, they can't make the recommendations that are best for you as a patient. And the more I talk to physicians about the stresses they are under in terms of having to see 18 patients a day, that doesn't give you enough time to talk about the things that patients really want to talk about and to be able to make an informed decision about their care. And when we have a system that doctors are paid based on a margin for chemotherapy that is supposed to help support all of the other services that patients need as they are going through treatment and to be able to have a triage so that they can call a nurse and talk about their symptoms and try to address their symptoms before they end up in an emergency room. We are expecting physicians to provide this through a margin for chemotherapy that really doesn't adequate to -- it doesn't value really, the services that patients want and that patients need. So that is why we have advocated for cancer care planning as -- at the beginning of diagnosis and throughout, if there is changes in a patient's treatment status and also at the transition to survivorship.

So we are pleased to see -- we have worked on this for a long time in terms of legislation, we have talked with private payers, we talk with CMS about this and there are a number of different potential payment models that are being developed and being tested or being proposed and you will hear about some of those later today and most of these models do include this kind of planning and really better incentives for the kind of decision making we would like to see and that we believe patients want and need and that I think that physicians want to deliver.

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So we believe that changing the conversation is really a central part of delivery reform and in order to do that, we have to change the way we pay for care because the way we pay for care right now doesn't allow for that kind of care delivery. And now, I think that when you talk to physicians that are in academic medical centers, their payment structures are a little bit different and they might be able to have a little bit more time with patients, but much of the cancer care in this country is delivered in community setting where there is not that kind of extra layer. And so I think that we have to really look at how we pay for care to really improve this communication and treatment decision making, symptom management and coordination of care.

So we have some principles for what we believe needs to be part of any patient centered payment reform and I believe they are included in your packet and I don't want to take up too much time by going through all of them. But we aren't saying that this the model or this is the model, there is a number of models out there that you will hear about and others that we are not specifically talking about today and we think that there could be value in all of these models, but when we kind of evaluate and make comments and weigh in on some of these, there are the principles that we are looking at and that we really want to make sure that physicians are rewarded for the quality of services, not just the quantity and our current fee for service system rewards based on quantity and not just in cancer care, but across the spectrum. We want to require the shared decision making, promote evidence based care by encouraging adherence to guidelines and quality measures and standards of care. We want to help make sure that whatever payment reform models we have, considered clinical trials as an option, and that patients have an understanding of the cost sharing that they will face. There is a lot of discussion about how do we talk to patients about their share of cost but it's very important to many patients to understand that and understand what their options should be. So we want to make sure that the way we pay for care allows for that kind of discussion. There is a lot of over utilization in the system, but we want to make sure that in any payment reform, we don't go the other direction and have incentives for underutilization. And then I think also it's important that we incorporate the appropriate quality measures. There are proposals to provide physicians beneficiary per month payment. Both CMMI has one and ASCO has one. We just want to make sure that if we are going to pay this extra fee to physicians for taking care of patients, that there are quality measures to ensure that patients are getting the services that they need for that care.

And this is our website if you want to follow, we write a lot about this on our blog and I want to make sure I don't take too much time and turn it over to Dr. Schrag.

DEBORAH SCHRAG: Good afternoon, it is a pleasure to be here and it is a pleasure to follow Shelley. Really, patients need to be at the center of all of this. So I'm gonna talk a little bit about sort of an overview of some approaches to how we think about payment reform in the oncology sphere and then Doctors Malin and Davidson are going to go into a lot more detail about specific programs. So the great news is that we have lots of cancer

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drugs that are getting approved by the FDA, but the reality is, lots of them are approved and they make very small incremental benefits in patient survival. We also know that the cost of cancer care drugs can be enormous and this poses a challenge for all of us tax payers, employers, healthcare payers and those of us who are once and future cancer patients.

Why do oncology drugs cost so much? Well, there are multiple reasons and forces at play here. The development costs are high, the products are also highly valued, so they can command a high price. The products can face limited competition; they can have small market size because they can be really going after a niche group of patients. There can be a limited number of products for any single indication. The FDA approval standard is safety and efficacy and cost and effectiveness are not considered. They are patent protection laws, which we could spend a whole session discussing. There is also cross subsidization for development and global markets where the costs can be set lower. We also know that CMS, that is often the majority payer for many of our cancers, cannot negotiate over price. And of course we have a health insurance system that although it's wonderful because it inoculates us against high costs, also introduces the problem known as "moral hazard" where the cost of the drug may be \$10,000 to the system, but many people won't have any costs. So it's a double edged issue. Ultimately the high cost of medical care and cancer care in particular are passed on to all of us. We know that healthcare premiums haven't kept pace with wage increases and with the average healthcare premium for a family of four just about doubled over the past decade.

So how do we define value? This is really tricky. In essence, value is the ratio between the quality of healthcare that is delivered and the cost of delivering that healthcare. But we have challenges to finding both the numerator and the denominator and we have a long way to go. I have put up here the so-called cost curve, you hear a lot about bending the cost curve. We want to be down, we want to be over on the X axis and down on the Y axis. How are we going to get there? Well, one of the challenges is that we don't think a lot about cost effectiveness in our decision making and regulatory processes. It is double edged. On the one hand, we approve drugs simply based on whether they work, but we really don't factor cost efficiency and value into our regulatory decision making process.

So there are a number of strategies that I'm just gonna touch on briefly to promote value in prescribing cancer medicines. One is to decrease that moral hazard and have people put more skin in the game, so that before someone gets a very expensive treatment that has very marginal value, that they actually experience what that feels like. On the other hand, that also feels unfair because if one of us is so unfortunate as to be struck with a catastrophic cancer -- just like if we are struck by a tornado or some other tragedy, we want to take that risk away. We want to protect patients and families who are dealing with a health crisis. So this is not such an attractive option. We have very specific granular strategies, like prior authorization so that there is systematic review of high cost treatments, things like tiered formularies, dispensing limits, lots of specific strategies, but these aren't gonna be enough to move the needle. One thing that I think is worth listening

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to is the choosing wisely campaign that is active in oncology and this is really a group of physicians getting together, engaging and saying, let's think first and order second and try to promote high value cancer care and ASCO has been right out front on this. I can't say it enough, the number one point I would like to get across is that what we really need to get to high value are better treatments, better drugs. We need more alternatives within therapeutic class, more personalized drug regimens and we can't do it without research. Research, research, better treatments. That is what we need to maximize value.

So I'm going to get into the weeds just briefly about the current cancer care reimbursement system and where it is going. This is really tricky stuff. Essentially, historically, the model has been a buy and bill model for cancer chemotherapy. And this diagram shows you the flow of money and the flow of chemotherapy and essentially it goes from -- chemotherapy drugs go from the pharmaceutical manufacturer to a wholesaler to a drug distributor, to a medical oncology practice, which buys the product and then administers it to the patients. Before 2005, the system involved 95% of the average wholesale price. But the average wholesale price was often a lot greater than the wholesale acquisition cost and this meant large profits for oncology and you also couldn't verify what the average wholesale price actually was. The Medicare Modernization Act improved this situation and shifted to an average sales price, plus 6%. The sales price was verifiable, so that was an advantage and the 6% really was a cost to the oncology practices for acquiring the drugs, administering them, supervising, making sure things were sterile, appropriately disposed of and really be administration. Recently this was decreased to 4%.

But let's talk about the core functions of what actually happens in oncology practice. What needs to happen in oncology practice is all the caring and communication and developing plans that you heard about from Shelley, that is core. Here is what is adequately reimbursed: giving chemotherapy and the chemotherapy administration, maybe that 6%, which may or may not cover it, depending on the price of the drug. But here is what is not adequately reimbursed. What really matters to people? Counseling about decision making, symptom management, care coordination, phone calls, social work and nursing, genetic counseling, financial counseling, survivorship care planning and research. Sometimes, Saturday night, I'm on the phone with a patient and trying to prevent somebody from needing to go to the emergency room and counseling them about how to manage a bad bout of nausea and my family members, which includes some lawyers, as I have gotten up from the dinner table, they look at me and say, are you billing for that? They bill in half hour increments. And I say, no, I'm just trying to keep Mr. Jones out of the ER Saturday night. And they say, you guys don't bill for that? I'm like, nope, that is not how our system works. So it sometimes strikes the lawyers as kind of funny. But the thing to realize is that oncology care is financed by a cross subsidization model. The chemotherapy spread -- the excess on the chemotherapy is what subsidizes all the other stuff that really matters that you heard about from Shelley and doctors and patients agree, we agree on what matters. We just are stuck in this legacy system that is hard to get out from under. So I'm not going to go through it. There is a

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number of strategies to put middle folks like specialty pharmacies so that the doctor is not doing the buying and billing and you don't have supplier induced demand. They all have their problems, one is so-called "white bagging", the problem is, it doesn't completely solve the issues. Brown bagging is another strategy that involves actually the patient buying the drugs directly from pharmacy -- again, these are not perfect solutions and I can talk about them at length.

I think what we are seeing and really Dr. Malin and ASCO have been in the forefront in the Vanguard of this area, is a shift in oncology reimbursement systems and we are at the experimentation stage. We are trying to move from fee for service to evidence based medicine reimbursement framework that provides incentives to adhere to high quality guidelines and treatment Pathways. This is really taking off and these treatment Pathways are being integrated into electronic medical records and the way the healthcare payers reward providers. We are also trying to move to value based medicine reimbursement and there are many demonstration projects that are underway, but we don't yet have great evidence about how they are working. I have just listed here a few of the alternative payment models to traditional fee for service. The first one that bares mention is capitation. Well, we tried that in the 1980s and while it's highly effective at controlling healthcare costs, it really curtails freedom of choice and can restrict access to care and certainly doesn't promote innovation and research, which is essential in oncology. But the other strategies that you will hear about in more depth through my colleagues involved adherence to Pathways that promote quality, accountable care organizations and episode grouping or bundling.

So I just want to go through quickly this schematic of how these alternative payment models are intended to align healthcare spending and value. So these are approximate sort of distributions of how cancer care spending may go and you see that big, pink slice of the pie? It's chemotherapy spending. And the lavender slice is spending on hospital and emergency department care. The physicians for their office based care that is a pretty small slice, which is an orange slice. So accountable care models and a number of reimbursement reform experiments are doing, are adding the green slice and that is a per patient care coordination based payment. To pay for the kind of cognitive services and individual treatment planning that really matter to people. So really, it's a gradual transition, it is a gradual transition, it doesn't eliminate fee for service immediately, but it tries to reframe the way we reward cancer care. Ultimately, the issue is not just to shift it, but to ultimately shrink the overall size of the pie so that we are spending less overall in cancer care. The other thing you will notice is, here we are still spending money on chemotherapy. We are not trying to skip giving people drugs. We are trying to let people spend less time in the hospital and the emergency room and reward high value, high touch care that really matters to people. Again, I just want to end by emphasizing that the number one priority is research to identify better cancer treatments and that is how we are really going to improve value. And the only way we can do that is by collaborating with everyone represented on this panel. So patients, physicians, healthcare payers, employers, the public, everyone. We need more value based insurance designed experiments to

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experiment with ways to reward high value. We need to invest in data sharing platforms and learning healthcare systems so that we can do this really quickly and accelerate progress. We need to invest in research to discover better cancer treatments and we need our reimbursement systems incentivized to promote research. So I will stop and turn it over to Jen.

JENNIFER MALIN: Thank you all for coming here today, it's a pleasure to be here and to be able to share some information about a program that we just launched in July that we are very excited about.

So just a word about WellPoint. WellPoint is the licensee of 14 of the state Blue Cross/Blue Shield plans across the country. In most of our states we go under the brand name Anthem, although we do have for example, in New York, Empire. So we have a very large footprint with approximately 36 million members.

As has been mentioned already by both Shelley and Deb, one of the challenges in cancer care is that quality is inconsistent. There have been numerous studies that have shown that up to one in three people treated with chemotherapy do not receive a treatment regime that is consistent with current medical evidence and best practices. This isn't to say that they are not getting treated, but they are not necessarily getting the optimum treatment. As was also mentioned, people are often hospitalized during treatments because of side effects, which could potentially be avoided by using a less toxic regimen or by appropriate supportive care. And then there are a number of studies that show patients -- people frequently receive tests and treatments that they don't need, that puts them not only at risk of side effects, but really increases the care burden for them and their family members taking care of them. And this has been an area that ASCO has really highlighted with the Choosing Wisely initiative. As Deb mentioned, there have been a lot of new cancer drugs and some have had tremendous impact on patient's lives. The one that always comes to mind for me is [name] which change chronic myelogenous leukemia, from this horrible disease where you had to made a decision about when to transplant someone and they had a 40% chance of dying during the transplant, to a chronic illness with probably a normal life expectancy. But we have lots of new therapies available, which is great and lots of research, they are becoming more expensive and for the most part, not producing the same kind of value that we have seen with a couple of these therapies. So the question is, how can we change the system so that we not only enable the patient centered care that Shelley is talking about, but also support innovation.

I'm going to skip over the IOM because we talked about that. This is just another view similar to the pie charts that Deb shared. The pie chart on the left shows the percent of revenue for practice that comes from drugs. So you can see, as Deb mentioned, most of the revenue from practice comes from drugs and that is what subsidizes or pays for all of the treatment plan and care coordination that is required. The typical oncology practice has seven FTE's per physician. It's complex care, it requires high touch and honestly, I think if you ask us on this panel, we probably all would agree that it needs to be higher

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touch than it is now. So we need to ensure that we have the revenue to be able to support that kind of care. On the right hand side, you see the picture from the health plan perspective and this is where the dollars go for treating cancer for anyone in active treatment. So they can be getting surgery, chemotherapy, radiation therapy or any combination thereof. And so not all of these people are even getting chemotherapy and yet we see that 25% of the cost of caring for these patients is related to chemotherapy and the supportive care drugs. And those costs are rising very rapidly. So we in designing this program, wanted to come up with a way to shift the reimbursement model so that we could support patient centered care, enable the practice to stay whole and have enough revenue to be able to provide treatment plan and care coordination but not be so reliant on the margin on drugs.

So our model is a quality initiative. Our cancer care quality program provides a framework for promoting high quality cancer care. Oncologists participate in the program, receive additional payment for treatment plan and care coordination when they select a treatment regime that is on a cancer treatment Pathway. We have operationalized this system through a web based platform that has decision support so that it -- and it includes the review against the prior authorization and review against medical policy so that it decreases the administrative burden for practices.

We have also tried to be very transparent so that all of the information about our program is available on the web at the address on the screen, including all of the cancer treatment Pathways and can be downloaded by anyone.

So cancer treatment Pathways -- I want to spend just a minute on that since that is a core component of our program. If you look at some of the national guidelines, for example, NCC and guidelines, which are widely looked at as setting standards for care for cancer and you take for example their lung cancer guidelines. For a first line treatment of someone with metastasis lung cancer, there are 64 different treatment regimens that would be considered consistent with the guideline and appropriate for treatment. So they are very broad and inclusive, but they don't necessarily provide a lot of direction on what is going to be the best therapy with the best side effect profile for that patient and they don't take into account variation of cost. So what Pathways do and there are a number of groups out there that have been using this strategy, including UPMC as one of the leaders in developing this, and Pathways do is you take that broad set of regimens that might be reasonable options but you try to narrow it to those best options so that you have half a dozen options instead of 64, that have the best outcomes for patients, the best effectiveness, the best toxicity profiles and then that there are differences in cost -- choose the more value conscious choices.

So this here is U.S. oncology, which is one of the leaders in Pathway development and this is the results from their Pathways for lung cancer. They saw overall survival was exactly the same. The curves are superimposed. And they had a 30% decrease in the 12 month cost.

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So in our program, the treatment plan care coordination fee that we have established for following Pathways is \$350 per patient per month. The practice bills for that as an additional fee. In our assessment, we selected that amount because we looked at what the revenue was to the practice for using higher cost regimens and on average, according to our actuarial models, this would keep the practices whole, potentially have them come out a little bit ahead, but overall lead to more value conscious care.

And so this is a slide that shows the cost for where the practice's revenue comes for different regimens and so on the bottom, the green bar is basically the chemotherapy administration fees that a practice gets, the yellow bars is the profit margin on the drugs at 6% and then the blue bars show the impact of the ASCO payment for the treatment plan care coordination fee that they are eligible for when they select a regimen that is on Pathway. So you can see, four of these regimens are on Pathway and two are not. So you can see that the impact of this code is to, on average, increase the revenue to the practices, but it decreases the variation or the standard deviation between the regimens. So we hope that one of the impacts of this is to make the choice of treatment more based on the clinical effectiveness rather than on differences in cost and potential revenue to the practice.

So in summary, this program is designed to support quality affordable cancer care. The reimbursement for providers is aligned to achieve desired outcomes and we hope provide providers with a kind of certainty about their business models so that they can really practice in the way that they feel is best for their patients and encourage it's innovation.

NANCY DAVIDSON: Good afternoon, I'm delighted to be here on behalf of the 35,000 members of the American Society of Clinical Oncology. We are the largest organization in the world for oncology professionals, particularly physicians and we have taken this area of cost and value on in a very real way because it's part of our mission to provide the best possible care, to carry out the best research and to undertake the education that is required to maximize cancer care.

So our organization has been involved in this for a very long period of time and you can see a number of the initiatives that we have taken on. You heard something about evidence based medicine and using guidelines, the Choosing Wisely program, something called QOPI -- Quality Oncology Practice Initiative. Things that had to do with working with payers, cultivating a learning system, Cancer Link, something that we won't be able to cover today. Thinking very hard about establishing clinically meaningful outcomes in cancer research and then the two things that we are going to really focus on today, payment reform and the value in cancer care task force for ASCO. Again, these are the two of all of that menu that I really want to spend our time on.

Now, first thinking about oncology care and trying to think as oncology professionals about how to optimize it from a patient perspective and from an outcome perspective, I

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think that our proposal over the last year or so has been to think about a consolidated payment plan for oncology care, the CPOC as you see here. And the notion is that this would be a flexible payment that is going to be patient centered and the goal, as you heard from all of the speakers, is to try to match the services and the patient needs. We truly love to simplify the billing structure, provide more predictable revenue, as you already heard from Dr. Malin, and of course none of this is going to be of importance if we don't incentivize high quality, high value care and support coordinated and patient centered care.

So here are the key proponents of the proposal that we put forward. First, that doctor's offices do need to be involved in looking at quality, through the quality oncology practice initiative. A voluntary system to allow us to assess the quality of our care in a longitudinal way and to learn from it and to improve it. Second, a chemotherapy management fee and you heard that as a common theme today. The use of value based pathways as described by Dr. Malin. The concept of thinking about monthly episodes of care for which it would be bundled payments and then a key -- I'm thinking very hard about care coordination and the patient centered medical oncology home. So here is a snapshot of the way we get paid now, as you heard, on the left, and the way that we propose that we might think about payment reform. You heard that there are a variety of ways that offices and doctors get reimbursed through their EMN codes, through consultations, through administration fees, all the things that you see on the left. And the thought would be that this would be -- this would transition to a plan that would involve one kind of payment for a new patient -- a very intense time, very, very time intensive. Another level of payment during the time that patients are on treatment and decision making is required for that. A payment for transition in care, again a time of high interaction between doctor and patient. And then finally a payment that would be involved in active monitoring for patients who might be done with therapy that still requires interactions with the office. Now, this of course would have to be modified to ultimately, we would hope, include some of the chemotherapy reimbursement structure that we have talked about that could be folded in as this payment system is developed. And of course it would be important to realize that it can't be all in. That there are some things that are still going to require fee for service -- things like lab tests, bone marrow biopsies, transfusion, pump therapy, things that are not easy to incorporate into this kind of model.

This is something that would obviously have to evolve over time, using the quality measures to try to phase it in. The use of Pathways, as we have talked about, would be absolutely critical and on the bottom, I want to emphasize again, as you heard from Dr. Schrag, that this kind of payment system must take into account the need for clinical research and oncology care. If we were doing such a great job, we wouldn't need this research, but we have a lot of room to move and so we, as a society, as everybody have to really invest in this research to try to advance cancer care and that is going to require thinking about the extra effort that is required in the healthcare system.

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Where we stand with this from an ASCO perspective is that we are in the midst of a period of ongoing testing and refinement of this model, which you can look at online and which I think is in your package. We are obviously looking for feedback from our ASCO members and from other members in the cancer community and ultimately of course we hope to take this forward in discussions with Congress and with CMS.

Now the second topic that I wanted to cover amongst that menu was value. You heard a definition of value from Dr. Schrag, here it is again, the notion that this is benefits divided by costs. Both financial costs and non-financial costs. This is an area that we took up as a society in 2007 when we began to focus actually on cost. You heard I am a past President of ASCO and I'm proud to say that during my ASCO presidency that we started the cost of care task force and the goal at the time was to define the challenges that are related to the cost of cancer care and to think about strategies to address this in the context of our professional society. This was not an easy task. Doctors didn't feel that it was their goal or their job to talk about cost with patients back in 2007, so it was simply educating our membership and getting us to realize that toxicity is part of what we talked about and financial toxicity is just as real as hair loss or nausea and vomiting, was a big step forward, but I think that is a pervasive feeling in our society at this point. With time we came to realize that cost is only part of the equation and you see that last year our board asked us to refine our mission to think about the value of cancer care, focusing on physician education and guidance, focusing on patient education and assistance, promoting high value medical decision making and then ultimately assuring valued care. A very, very diverse membership on this particular committee, very stable over time, you can see that it is led by my colleague Lou Shipper from Beth Israel Deaconess, a very nice mix of providers of all types, payers, the patient voice is also at this table. Economy people, oncologists; so all of the kinds of disciplines that you would need to be able to think about how to move this particular effort forward.

First, with regard to physician education, this is an ongoing goal, to develop the educational resources that help us as doctors to help our patients. And over the last several years we have had several, we think, very influential statements that have helped to guide patients and doctors about how to individualize cancer care, especially in the setting of advanced cancer. And then also to think about this recurrently in our professional society meetings and through web based educational opportunities.

On the patient side, because this is a partnership, we think it's equally important to help enable patients, as you heard from Shelley, to be real partners in this decision making. And so one of the things that we put out as a book that you see here, a patient information book that is easy to read and helps patients to start and then guide a conversation with their healthcare team about how they are going to cope with the cost of cancer care.

You heard that Choosing Wisely is actually something that goes across medicine right now, but ASCO has been at the forefront of this, trying to think about the things that we have done as oncologists where we can stop doing them right now without harming a

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single patient and saving resources along the way. We issued two top five lists, so ten different interventions that should be questioned and don't need to be practiced by and large. You can see a couple of examples here, using imaging for example to evaluate patients with very early stage prostate cancer, using certain high priced white blood cell stimulating factors in an appropriate way. So things that we can do as physicians to try to minimize cost and maximize care right now.

Then finally, for the last 18 months or so, we had been working very hard on the value framework, which is going to be designed to support shared decision making between doctors and patients. We are going to prioritize three things -- clinical benefit of therapy, toxicity and cost and our goal is to develop a tool that can customize this information for each patient where they can put in their thoughts about side effects versus benefit for example and where individual cost issues can be put into this model. We have a draft model that is currently available that is being shared with a series of stakeholders over the summer, both patient advocates and industry and we hope to have our refined model out in early 2015 for public comment.

So thank you very much for the opportunity to review with you the series of things that we as oncology professional are trying to undertake to improve cancer care value with a focus today on payment reform and the value in cancer care task force -- thanks.

SARAH DASH: Well, thank you so much to all of our panelists for their wonderful presentations and now it is your turn to ask question for the next 45 minutes. If you have a question, will you please stand at one of the mics on either side of the room and identify yourselves and ask your question. If you are shy, you should have a green card in your packet and you are welcome to write your question there and please do indicate if you are Congressional staff on that card and hand it to one of the staff members on the side of the room and they will bring it up to the podium. You can also tweet a question to hashtag #cancercare14. So with that, I believe we have a question from this gentleman.

AUDIENCE MEMBER: Thanks very much, not a Congressional staffer. Sorry. It doesn't look like I jumped in front of anybody. My name is John Graham from the National Center for Policy Analysis and this is very impressive, I thank you all very much for speaking. I think my question may be for Dr. Malin. The most expensive patients, if you look at the top 1% or 5%, they have co-morbidities and you have all talked about oncology, but how do you coordinate the care when the cancer patient is also a psychiatric patient or has arthritis or Alzheimer's or whatever? Because what drives everybody crazy, especially in the prescribing space is the specialists prescribing across each other. So I understand that --

JENNIFER MALIN: I think it's an excellent question and there was an article on Health Affairs maybe about a year ago that showed I think the average number of physicians that patients with cancer sees in the six months before they die is something like 16 or something and it was a staggering number. So I think I see what we are doing is really the

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first step. I think really recognizing that treatment plan and care coordination is a key part of what oncologists do and then over time, building in ways to leverage things like our primary care provider network and to improve collaboration that way or to specifically have models like oncology medical homes where it's not -- I think just about the kind of general care coordination, which is how they have been set up so far. But really, making the oncologist front and center and the person who coordinates all the care. Again, I think it depends a lot -- you know, this is obviously the oncologists perspective, some of my primary care provider colleagues would disagree, but especially when people are diagnosed with advanced cancer, that tends to trump the other conditions and become kind of front and center. And so I think having the way to ensure that the oncologist is maybe taking over responsibility and getting recognized for that financially, because they would be more complex cases, might be something going forward.

AUDIENCE MEMBER: Ken Finegold from the Office of the Assistant Secretary for Planning and Evaluation, Office of Health Policy, Division of Healthcare Financing Policy, HHS and speaking only for myself; let me say the Department is very interested in anything that is better care at lower cost. Most of the discussion is about Medicare since most people who are diagnosed with cancer are on Medicare, but some people are on Medicaid and that is what I work on. So I was wondering if there are any examples of particularly exciting, innovative approaches at the state level in Medicaid, because that then offers possibility for experimentation that we can all learn from.

DEBORAH SCHRAG: Thank you for that comment. Not nearly enough. So as you know, CMS has some innovation projects that involve Medicaid and the vast majority of those projects are focused on Medicare. We need to do a lot more with Medicaid. There are a few initiatives -- one of the issues of Medicaid is we don't even have the data, so their projects to link Cancer Registry data with Medicaid claims data, I think that is actually very promising. To just figure out what the issues are. Medicaid is a simmering caldron of different kinds of problems. One is problems of under use and access, where people can't get into the system. They have insurance, but they have trouble navigating and getting in and finding providers who will take their insurance and the care coordination needs are immense. And then we also have overuse of people getting drugs that perhaps -- or cancer treatments that perhaps are low value or getting care in systems that are not optimally resourced to deliver high complexity care. Or obstacles to participating in cutting edge research. So I could not agree with you more. We absolutely have to do a lot better in Medicaid and obvious we have to tailor it to particular cancers. Cancers that affect young people. You know, we cure Hodgkin's disease. That is a triumph. We cure testicular cancer. And we have to make sure that people who are indigent and people who have American's With Disabilities get the opportunities to have those cures. It's been hard to measure.

JENNIFER MALIN: I will just add that while we are rolling this program out across our different health plans, primarily starting with the fully insured population, self-insured population, our commercial plans and our Medicare Advantage plans, we do plan

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probably third or fourth quarter next year, to include our Medicaid managed plans so that they would also be part of the Pathways program, the Cancer Care Quality program. And I think one of the aspects of this that I haven't really talked about but is very exciting is that when the practices participate in this program, they register their patient and their treatment plan in our web portal. So that provides us with a variety of case management opportunities, so we will be able to actually learn prospectively what some of the barriers are that people have thought are access issues. Not just access to providers, but there is a lot of access issues in the Medicaid population in terms of not necessarily having the flexibility to take time off work. You know, if they need a family member to drive them and they can't get off work -- there is a lot of different barriers. So I'm hopeful that we will be able to leverage the platform and the experience to start to understand that and then tailor support to the Medicaid population.

AUDIENCE MEMBER: That is exciting in itself, but also in terms of the data needs that Deborah mentioned, because Medicaid data system, as anyone who works in Medicaid knows, is really 51 systems with a substantial time lag, but from within the managed care side, you have access to both payment information and clinical information, so potentially there would be a lot of value coming out of that work.

AUDIENCE MEMBER: Mike Miller, I'm a Health Policy Public Affairs Communications Physician Consultant. And I read the title of this meeting, it was like Will New Models Led to Better Care at Lower Cost. I was wondering, how much of those new models will be payment models and how much will be delivery system models and I think the speakers have covered a little bit of both, but there is one issue that I think I have heard about over the last several years about the cost of care in community oncology practices versus hospital outpatient clinics and sort of the same care, the same doctors, just who owns the entity. And the hospital outpatient costs reported to be higher, I believe. I think there have been proposals for Medpack, I believe, for what they called, I think "agnostic location, diagnostic payment policies". I wondered if any of you guys could -- nobody wants to talk about it? I'm seeing you shaking your heads. If somebody wants to comment about those factors?

DEBORAH SCHRAG: Yeah, so I will tackle that quickly. So I think the reason we didn't touch on it is purely based on time. It's a critical issue. So the same cancer care costs less when it's delivered in a community based office practice setting than when it's delivered in the context of a hospital outpatient department. So the reimbursement can be different for the same care and that is one of the many usual features of our Byzantine complex system. But the other key feature is that there has been a shift over time away from community based practice. So community based practices are merging, consolidating, being bought up by larger healthcare systems and that is a huge shift that we are seeing. And one of the reasons for that is that coordinating all of this, assuming the risk, is really challenging. I mean, this is not your family practice doc with the shingle on the corner. Acquiring these drugs, managing the inventory, having all the specialists and all the resources, it is incredibly difficult to do that and that is one of the reasons why

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you have seen small practices or even multi-specialty group practices merge. Again, it would be great to get to a site of care agnostic model and to preserve the ability to deliver cancer care in the community where it has historically dominated. At the same time, we have to make sure that community practitioners are equip to deliver high quality care and to ensure that patients treated in the community have access to research and cutting edge treatments and the same chance of cure as anyone else.

AUDIENCE MEMBER: I'm Jep Landers of the Dallas Morning News, I had a question for Dr. Davidson. With CMS and the FDA effectively barred from considering cost and effectiveness and anytime the FDA accepts a drug, the insurance companies pretty much pass it through and the patients are in no position to challenge the cost of the drug because it's a life or death circumstance for them in many instances. The physician seems like the actor who could really push back and we did see that, I guess, in New York a couple of years ago, that ultimately led to the pharmaceutical manufacturing lowering the cost of this drug that was being presented. Yet, the system as its set up right now, seems to put the physician in the position as the pharmaceutical company, which is to maximize what they can realize for the drug, because chemotherapy is so important to an oncologist practice. What you are trying to do with value and with cost seems like it would reorient the physician's role in this so that the physician might be able to talk about the cost, first of all, with the patient and then maybe push back. But I don't know if you are going to go that far.

NANCY DAVIDSON: I agree with you that the physicians are in the middle of this, in part because our job is to provide the best possible care and advocate for our patients. I think that the stance we have taken as a community is that there are some things that we can do right now to maximize or optimize our practice and we talked about a couple of those. Dr. Malin mentioned -- I'm going to put on my University of Pittsburgh UPMC hat for a moment, to let you know that in that day job of mine, we oversee a cancer care network that has 40 community sites across Western Pennsylvania and so one of the things that we did some years ago was to put in a place a Pathway program that allows us to do something of what you are talking about, right there on the ground for us. We have evidence based Pathways that allow us to look as oncology professionals and we think that we are well suited to do that, at the most efficacious regimen for a particular clinical situation and if things are equally efficacious, then we look at the toxicity and obviously we pick the least toxic regimen and if all of those things are equal, then we look for the least costly regimen. In using that, we have been able to put together a series of pathways that cover about 95% of decisions that oncologists are going to have to make to allow us to frame that discussion with our patients, to help us to choose between those 64 regimens that she talked about, for lung cancer, to make it possible to maximize, optimize care and to minimize cost. Another thing this does, actually, is to promote the use of clinical trials where possible on a pathway like this. A clinical trial is the first choice for the patient in question. If she or he is willing and if they are medically eligible, because we do think that advancing cancer care is extremely important. So I think that doctors in the middle of this now, as they need to be, we are the best advocates for our patients and I

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think our professional society takes that very seriously and is trying to help us to be well positioned to have those discussions. We also, as you heard, are at the forefront of trying to think about how to change the payment system so that we can get out from this very difficult position in which we find ourselves.

The second question you asked is, what are we as doctors doing to push back against the pharmaceutical industry? Well, of course that is a really charged discussion. It is suggested that it's us versus them and I don't think that is the case at all. I think we actually all share the same goals. Oncologists and patients aren't going to be anywhere without pharma and so I think this is something where we are all going to have to work together to try to identify the best solutions to serve those patients that Shelley represented so eloquently.

AUDIENCE MEMBER: Ed Leonard, Office of Personnel Management. My question overlaps a bit with the last one, but I think it's different enough to pose it. Some new cancer treatments only provide a small incremental value, but they all seem to cost \$100,000 per year or more. In Great Britain there is a system by which such therapies are evaluated on the basis of quality adjusted life years and its appealing in it's simplicity because it suggests you can apply this formulaic analysis and determine whether you will accept a drug in the National Health Service compendium in Britain and that conceivably we might do something like that here. I believe the gentleman was referring to Sloan Kettering a couple years ago, declined to add a new oncolytic to its formulary, just because the incremental value was small and the incremental cost was great. But I'm asking if this is just so far out of the picture in this country that it's not worth mentioning or was it the time constraints of today's discussion that resulted in this not being brought up? Thank you.

JENNIFER MALIN: I think that a number of the approaches that you heard about today have maybe similar objectives to the approach of nice in the UK and if you take it a high level that the objective is to maximize the value of the healthcare provider to their population. I don't think any of the approaches that you have seen that advocate it here, have sort of thresholds in terms of a cost benefit threshold. I think largely that is probably because I think the consensus is there is a lot of waste in our system, so for example, Zaltrap was not included in Memorial Sloan Kettering's formulary, not because it had a small incremental benefit for the cost, but because it had no benefit compared to the other treatments that were available for the same thing, at a higher cost. And I think you know, the approach -- the Pathways approach that Dr. Davidson described, at UPMC and the approach that we have taken is really about -- it's not so much about an absolute value threshold, as for this patient population, what is the relative benefit of the different treatments available? Can we find the best treatments and look at the best benefit -- you know, the treatments with the most benefit, the best side effect profiles and then all else being equal, we look at cost and I think the -- I would say there is a lot of room in the system to optimize that before we have to a point of really drawing a line in the sand about incremental value.

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DEBORAH SCHRAG: One more addition to your comment about NICE. NICE has run into a lot of trouble because the evidence base isn't there. Right? We are trying to juggle -- we have people who are dealing with life threatening illnesses and they want to get drugs that may help them. They want to get access to those new treatments. Potentially life saving treatments as quickly as possible. And that means that sometimes when evidence first comes out, evidence that the FDA considers to lead to regulatory approval, we have information on a small group of patients. Sometimes its only 500 people. And then to generalize to the experience for everyone, our clinical trials often don't involve people who are older or people who have other competing medical problems and we approve treatments before we fully understand them. So NICE has really been confronted with trying to make difficult decisions in an information background. In the U.S., because our CMS and FDA are not allowed to consider cost based on the statute and how they are -- we haven't taken that approach. But we still can do a lot with value based insurance design. And I just want to give you one example. We have a treatment that Nancy gives all the time that helps cure more women with breast cancer, Tamoxifen. And Nancy, you probably give that several times a week. And women need to take it, it's a daily pill and you have to take it for a long time to get the benefit. And it is an inexpensive treatment, but guess what, people don't take it. Well, we know that some people don't take it because they have to pick it up every month at the pharmacy and they have a small co-pay, maybe even just \$30. But that is high value care. We shouldn't charge for that at all. That should be completely covered. That is like, wellness care for cancer survivors. So we have an all or nothing -- it's covered or not -- system. Value based insurance design would say, if this is high value, we are going to cover it, please do it. If something is lower value, you may have tiering in a higher price. So I think we can achieve the same thing that NICE is trying to do through strategic initiatives that will be more consistent with, I would say, American culture and values.

SARAH DASH: If I could just add a question and tie together a few of the things that all of you have touched on. You know, you have talked about quality measures and the need for more research and also the increasing personalization of medicine -- cancer is of course not just one disease. So how does the system incorporate new evidence, whether it be figuring out which pathways really work the best if new treatments come online. How does that get incorporated into the new pathways and what kind of data are needed to make that happen? And to the patient perspective, are there adequate quality metrics that encapsulate what patients really want?

NANCY DAVIDSON: I will start on the Pathways part. Again, I can speak to the microcosm within which I work, but I think this is probably characteristic of many Pathway programs. We have committees for each of those disease groups, these are people who are self defined, interested and experts. It's a mix of people who practice every day in community settings and people who practice in academic settings. We have professionals who help to make sure that brought to their attention every quarter is the new evidence that has emerged at our medical meetings and our medical literature,

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wherever it comes to us. And that group will sit and look at the quality of the evidence and you know, there is a pretty good literature about phase three trials and so forth, down the line, about how to interpret them. They will look at the quality of evidence, they will try to compare this new therapy with the old therapies and then they will figure out whether or not they think that this new treatment trumps what is already in there. Whether in fact its -- like you talked about at Memorial, where it added nothing, so it's not something that should be considered, or that this is a new standard of care or a new alternative care and if it is, how can it be stacked up against the other ones? So this is a dynamic process. You know, in some ways, even my wish is fixed in stone, it would be easier to do and remember, but cancer care is changing all the time. We hope because of progressing cancer research. So this is something that needs to be repetitively done as we learn about what is new in our field and what should be the new therapy and what old therapies might perhaps be supplanted, or what so called new therapies may be new, but they are not any better. So I think this is something where the oncology community is taking this to heart in a very real way. In one practice setting, where I work, certainly I think in the setting of our colleagues, our payers have similar efforts to try to help us to focus our pathways down. I do agree with you, Sarah, that -- I think for many of these things, the patient perspective probably hasn't been measured as much as we might like and that I think should be a huge part of what we do as we do our research going forward.

SHELLEY FULD NASSO: I would love to just add something. I think that one of the things that we really have to grapple with is, how do we talk to the patients about risk and benefit of treatments in a way that they really understand it? Sometimes these treatments that are approved that have -- what is generally on average an incremental benefit, there is sometimes a tail or a group of super responders that respond really well to it and patients always want to be that person. And the chance of them being that person are pretty small, in some cases. So how do we really explain that to patients and then let them decide? Maybe they really understand that the chance is small and they still want to do it because they have young kids and want to do whatever they can to be there for their kid. Maybe if they really understand that and the side effects, they might choose not to try that treatment because it might not be worth it. But we have to really do a better job of explaining that to patients so that they understand not just the side effects and what the chances are that they are going to get that but also really want the chance is that they are going to have the benefit that some people may see and so they can weigh that into their decision making. I don't think we always do the best job of that and I think sometimes that goes back to, we don't have the time. But I think it's also, patients always want to be that super responder and may not be. But we have to respect that if we can educate them about what these risks and benefits are, and let them make an informed decision, that they can make the right decision for them.

JENNIFER MALIN: I'm not sure if this was part of the question, but I think sometimes there are people that raise questions about whether Pathways are at odds with personalized medicine. And I think in fact, actually, Pathways or some version 2.0 of them are actually going to be critical to implementing personalized medicine. Its already

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quite challenging now when you just have a couple of different mutations to try to figure out how you tailor the treatment to that mutation and when you are in a situation where there is two or three overlapping mutations and who has which combination, it's going to become even more challenging. And I think all of the pathways that I'm aware of, both in PMC, our Pathways, any time there is a new mutation identified where that treatment can now be personalized or targeted to that mutation, there is a new pathway branch point that breaks off to address that.

DEBORAH SCHRAG: So an issue that is critical to realize the promise of personalized medicine is accessed information and information comes to us in the form of data. So we have to educate patients, communities, everyone about how valuable access to that information is. What if patients with diabetes don't get any benefit from a particular drug? Well, that wasn't detected in the Seminole clinical trial that led to approval and you need thousands and thousands of cases to realize that this is not so safe for patients with diabetes. Or that there is a sliver of people who get exceptional benefit and will be so called exceptional responders. We really -- all of us want our healthcare information to be kept private and we have worked really hard to implement HIPPA policies, to keep that information secure and safe so no one ever has to experience any kind of discrimination or confidentiality privacy breach. But at the same time, we have to educate people that by pooling our information together, you know, rising tides float all boats. It helps everyone because we can learn faster about what works and what doesn't. So we need to really work with our engineers and our crackerjack software programmers to cooperate. The medical community, the payer community and information management wizards, so that we can leverage this information to personalize care faster while also preserving confidentiality and that is how Pathways will harmonize with personalized medicine. And so I guess to the gentleman from ASPY, we want access to that Medicaid data. We want the Medicaid data to link with electronic medical records data and we want to be able to tell people with Medicaid -- we don't care who you are -- Joe Smith, Susan Jones, we just want to learn from your experience and information -- we want to learn from your surveys and what your cancer care experience was like, so that the system can innovate and do better. But we can't get access to that information, so maybe you can help us.

AUDIENCE MEMBER: I'm Rich Brennan, I'm with the National Association for Home Care and Hospice and I first of all wanted to commend the panel on first of all succinctly describing a very complex and challenging environment to practice in. Secondly, a lot of the similarities that are shared by home care and Hospice providers seem to be shared by oncology and hematology, meaning that we are trying to come up with ways of managing complexity and longitudinal care coordination and even working on HL7 standards that would have a home health plan of care. Be able to function electronically between the physicians and those in home care and Hospice. But I thought it was extraordinary as far as what I would like to learn today, if I may ask, is you touched on it a little bit, just in the last answer, was the use of technology in these new models of care and how those can help to function and also combat the necessary challenges that you face with the complexity. Just in the care coordination space and also the need for the care planning

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and care coordination, just seemed extraordinary to me, to be able to take that time to necessarily cognitively think what the patient's needs are and to match those to the clinical trials and the other things that you are trying to establish in the clinical pathways. It was extraordinary.

The second thing I would like to learn is, it looked like on your graph there was a little bit of growth of home care and the delivery of home care in this space and I just wanted to find out if I could find anything more. Thank you.

JENNIFER MALIN: I guess that was directed at me. I don't remember having home care in any of my graphs -- oh, Dr. Schrag? Maybe Dr. Schrag can address that point.

DEBORAH SCHRAG: I did have home care in there and when we talk to patients and families and we really do do that, not enough, but we do. People with advanced cancer in particular or those who have a short amount of time, do not want to be in the hospital and they do not want to be in the emergency department on Saturday night. So yes, one strategy is to shift some sorts of care to home setting and there are multiple strategies to do that. That doesn't mean putting everyone in hospice care and not letting them get cutting edge treatments. But we have to figure out how to be more strategic to deliver more high value care at home where it can be less expensive. So I think that that is a feature of most healthcare reform benefit design programs.

JENNIFER MALIN: I guess I will maybe speak at a higher level. I think we focus very much on the oncology Pathways and care management or treatment plan care coordination perspective, but I think one of the other big -- one of the other important things is to decrease barriers to palliative care and I would think kind of home care kind of broadly often falls within that kind of concept of care that is really attentive to what the patient and their family need, which is broadly what palliative care is about. And I think there are a number of steps that can be taken. One that WellPoint took on our commercial plans this year is that we changed the standards Hospice benefit from requiring a life expectancy certification of six months to 12 months. That is not that we expect people to be on Hospice for 12 months. I think on average we see people on Hospice around one month, today. So it's an underused service and we hope that by changing some of those requirements that it helps to decrease the barrier that patients and their physicians feel about suggesting that it is appropriate care.

SHELLEY FULD NASSO: And one of the quality measures for a lot of these programs is really how long patients who die of cancer are in Hospice before they die. Because it is predictable when someone has a terminal cancer and patients are not really spending enough time with that extra support of Hospice care at the end of their lives, unfortunately.

AUDIENCE MEMBER: Good afternoon, Jose Fernandez with the Men's Health Network. My question is for Dr. Malin. You mentioned in your presentation that people

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are often hospitalized due to over treatment and from things that could have been prevented. And one of the biggest issues that men face is simply going in for like a PSA test for example. I was just wondering, how do you go about finding a happy medium between making sure that patients get the treatment that they need without going over to the point that most men are afraid to even go in to get test.

JENNIFER MALIN: Well, I think there is sort of -- that is a question with a lot of questions in it. So I think the issue of hospitalizations that I raised and I think Shelley raised, is not so much that people are being hospitalized when they shouldn't be hospitalized. That there is quote, overuse of hospitalizations, but it reflects a lack of emphasis on the system on doing the things that could be done to keep that person from needing to be hospitalized in the first place. So if you select cancer treatment that has lower toxicity, then they are less likely to have to go into the hospital. If you make sure they are getting -- if they have a therapy that has a high chance of causing nausea and vomiting, that they are actually getting the appropriate anti-medic therapy, then they are less likely to go in the hospital. If they have a lot of pain from their cancer, if that is getting treated appropriately, then they are less likely to go in the hospital. So it wasn't so much to say we are treating people that we shouldn't be treating. It's just that we can do a better job if we ensure that there is enough support for treatment plan and care coordination and we put the right incentives in place so that practices can really focus on taking care of that patient and figuring out what they want and where they want to spend their time.

AUDIENCE MEMBER: Hi, Karen Fisher with the Senate Finance Committee. I have a couple of questions that I hope you can deal with. One for Dr. Malin. Your program just started in July of 2014 -- first of all, the presentations were great and really on target, so thank you -- started in July 2014. Can you tell us about how many -- what the uptake has been so far? Number two for you, on your S Code, do you have requirements in terms of the care coordination, in terms of how much, how many phone calls, all of those sort of non-face to face requirements or is the payment only associated with the drug regiment treatment pathway? And number three, this issue of pathways -- how do we deal with differences across pathways? So for example, between UPMC's Pathways and WellPoint's. If they are the same, great, that would be great to know. If they are different, how do we -- when we sort of look at the program like the Medicare program, try to deal with the differences in the pathways that are developed and who are the best people to make those decisions about what the pathways are? Thanks.

JENNIFER MALIN: Okay, I will go I guess, last first since I remember that one. I may have to ask you to refresh my memory on some of the others. So I think first all, one step on the Pathways that would be helpful for all of us is if they were publicly available. So that is something that we have done and we would encourage the other Pathway developers to do that as well. Then they can be transparent, be compared and any differences between them can be understood. The second thing though is that even without that transparency, which would be -- you know, which I think is desirable being

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there, to date when I have had the opportunity to compare our pathway with other pathways, they are pretty similar. And at least what I tell practices who say well, do I have to follow five different pathways for five different payers? What I tell them is if -- I don't want you to practice differently by different insurance or different payers. I think if you sit down and you select one pathway that you are going to follow, you are going to probably be on our Pathway 80% to 90% of the time as well. There just are not going to be that many situations in which they wouldn't line up. And if there are, that is something we should learn from and understand. Can you remind me of your other questions?

AUDIENCE MEMBER: [inaudible]

JENNIFER MALIN: So the challenge with putting in accountability criteria, which is what you are asking, for treatment plan coordination is, what are the measures that show that you are doing good treatment plan care coordination? I'm not really aware of good measures that are out there. I know people are struggling with trying to develop them, but they are not really there. Then what is going to be the burden of measuring it? So at this point we don't -- we are trying to encourage a change in behavior and so we are putting the program out there, but we don't really have any specific requirements on what you have to do to show that you have had treatment plan care coordination. I think over time that will change. We are going to be providing reports back to practices starting next year and not just on their following a pathway, but on the percent of hospitalizations that they are -- and percent of ER visits on treatment and I hope that over time we will be able to capture the patient voice and patient experience. And so I think over time we might have different payment levels for treatment plan care coordination based on how well practices perform on different measures like that. Then lastly, uptake in the -- we started in our Midwest states and in Georgia and we are still trying to get a handle -- we had to kind of wait for claims run out to see how many people gave chemotherapy, submitted a claim, without going through our portal. But we have been getting about 400 or so treatment regimen requests a week through the portal and our estimate is that that's probably about 80% of the new treatments. So to us that seems like a pretty robust uptake, and on Pathway currently is sort of in the 55% to 60% range, which was higher than we expected at launch.

SARAH DASH: We have time for a couple questions and we have gotten a couple of questions on cards that are somewhat related, so I will go ahead and ask those. So the first question has to do with how we think that payment reform will reduce the cost of care to the patient ultimately and how will this reduction in cost, if any, kind of get back to the patient? And then another one that relates to communication to the patient population and to transparency and this one was specifically for Dr. Malin, but I encourage anyone to answer, which is, how does this information get communicated to the membership, to the patients? How do people know what is covered and what is not? What the new regimen may be?

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JENNIFER MALIN: So the first one was -- oh, the cost getting translated back to the member and the patient. I mean, as everyone here knows, the whole shifting of cost around and the different parts of the system is very complex, but I would say at the most basic level for patients, if they are on a treatment, that the best treatment for them that is lower cost, they are going to have lower co-pays and cost sharing. So that -- I think it's hard to say that having a more expensive treatment for a patient is better regardless of their -- if they have any co-pay at all and most people do. The other part is that we all are kind of patients before we -- we are all facing the cost here before we realize we are patients so the other impact of the rising cost of cancer care just like the rest of healthcare is that we have increasing premiums and other costs associated. So hopefully as Dr. Schrag showed, by bending the cost curve, we can slow the rate our premium increase. In terms of communicating about both reimbursement approaches and things like Pathways to our membership and specifically to patients for our providers -- so we encourage providers to tell their patients about the program. We encourage them to tell about the \$350 a month and we also encourage them to tell the patients that they are getting 6% or 10% or 4% or whatever margin on the drugs as well and what rebates they might be getting for prescribing particular drugs that month. So we think that open discussion about cost and transparency is key at all levels. We don't know when our members are about to start chemotherapy so it's not really feasible for us to kind of reach out to people and say, oh, do you know about this program? So we are doing outreach more globally though. So through events like this we have been very open and talking in the press. We hope that when members select Anthem for their health plan that they realize that this is part of the package and that they have cancer, we think that this is actually a good thing for them and we hope that it's a selling point. And we have been doing other member communication through newsletters and things like that.

SHELLEY FULD NASSO: I think it's going to be really important that we figure out with all these different payment models, how we are going to talk to patients about it. I don't think they understand how cancer care is paid for right now. I mean, I'm glad you encourage your physicians to talk to patients about it, but I haven't seen a survey, but I bet if we did a survey of cancer patients, they don't understand that there is a margin, a chemotherapy margin that their physicians are receiving and that that is how their care is being cared for. And whenever I talk to patients and if I say that, they are very shocked by that. So I don't think that that's something that they understand. But if we shift to a different model where we are talking about a bundle or we are talking about a payment for a month, we are going to really have to explain to patients how that works, especially when it comes to their cost sharing piece of it. Because I know for example, ASCO's model had a monthly payment for active surveillance. When a patient has completed treatment but you are still providing survivorship and follow up care and surveillance for potential future cancers. But if a patient has a cost sharing piece of that, they are going to need to understand well, why am I paying now? I'm not really seeing my physician. So we are going to have to figure out how we talk to them about that. I believe that CMMI's proposed oncology care model, that has that beneficiary per month payment, it does not have any cost sharing for the patient for that payment. And so you know, if these

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payments are between payer and physician and there is not a patient cost sharing, it will certainly be easier to explain to patients, but I think it is definitely something we need to consider and I haven't really seen that very well considered in any of the plans that I have seen. But I do think patients don't understand how it works right now. So I know that I have heard some concern, well, do patients understand that the doctors are getting \$350 a month for -- based on what treatment they provide? Do the patients understand that the doctors are getting 6% of an expensive chemotherapy drug? That is more than \$350 a month and they don't understand that. So I think that we can't just narrowly focus on that piece without looking at the whole system and the transparency. It's not like we are not being transparent with patients, they just don't know. They don't understand and they don't really have a need to understand that right now. But if we are going to shift the model, we have to think about how we communicate that to patients.

JENNIFER MALIN: I just wanted to underscore one of the points that Shelley made. With our treatment plan care coordination fee, we -- for most of our plans, there is no patient co-pay for that, but one of the areas that we were restricted are with HSA plans because the IRS will require you to have that cost of care unless it preventative care. So for all the kind of people in this room that have the ability to change regulations like that, I think care coordination fees are going to be an increasing model in the future and it's probably not something that we want to have people have to bear a co-pay of.

SARAH DASH: Well, thank you so much to our panelists for a really enlightening and sensitive take on this really important issue.

[applause]

We will be continuing the discussion about affordability and what patients and consumers know when they choose a health plan on November 14th at our next briefing, on the eve of the next open enrollment period for the marketplaces. We hope you will join us for that. Please, before you leave, fill out one of your blue evaluation forms, that helps us to plan our briefings. And check out our website, allhealth.org for information and for a transcript and a video of the presentation in a few days. Thank you so much again and have a great afternoon.

[applause]

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