Payers Working Collaboratively With Providers to Adopt Clinical Pathways and New Care Delivery Models

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Over the past year, both the volume and intensity of concern about the unsustainable growth of cancer care costs have mounted steadily. Oncology clinical pathways, once widely disdained as “cookbook medicine,” are being adopted through successful payer-provider collaboration and provider compliance with pathways that generally exceed early expectations.^{1,2} Emerging in parallel with clinical pathways are new cancer care delivery models, notably accountable care organizations (ACOs), that are striving for sustainable cost and quality balance through better coordination of care and more effective integration of palliative care.

Reimbursement Intelligence (RI), a market access consulting firm, recently completed a survey with medical and pharmacy directors from 49 leading payer organizations, representing more than 100 million covered lives (Table 1). The goal of the survey was to gain a better understanding of how payers are initiating or collaborating with providers to implement cost-management and delivery models.

Anticipated Expansion of Oncology Clinical Pathways

The payer survey, fielded in July 2012, showed that oncology clinical pathways have been adopted (40%) or will be adopted within 2 years (36%) by more than three-fourths of responding payers. Adoption was broadly defined to include pathways that are both mandatory and recommended. Among plans that have already adopted pathways, the top five goals were to improve quality, reduce clinical variation across providers, reduce oncology drug costs, reduce cost overall, and reduce costs associated with end-of-life care.

Payers have targeted specific tumor types for pathway implementation, identifying breast, lung, and colorectal cancers as their initial priorities, followed by multiple myeloma (Figure 1). If payer predictions are accurate, by 2014 pathway penetration will be close to 100% in colorectal cancer, more than 90% in breast and lung cancers, and approaching 80% in prostate cancer.

Payers rating specific criteria for selection of tumor types for the development of clinical pathways identified the cost-burden associated with tumor treatment, and the need to improve quality of care as the 2 most important criteria (72% and 72% of respondents, respectively). Other influential considerations were the degree of clinical variation for a particular tumor type (67%) and prevalence of the tumor type (62%).

Payers report their organizations have been flexible around adjustments to pathways, with most adjustments (84%) made to allow provider flexibility around therapeutic options, such as allowing off-pathway drugs to be used to avoid drug-drug interactions. For example many of the multiple myeloma and bladder cancer pathways we examined include recommendations for treatment and diagnostics but do not include mandatory compliance to a protocol. Pathways generally have integrated traditional cost-management measures, including prior authorization (86%), step edits (71%) and formulary placement or tiering (52%).

In light of ongoing discussions about the cost-saving potential of earlier implementation of palliative care and end-of-life discussions,³ our survey specifically probed payers about how palliative care is being addressed in oncology clinical pathways. A minority of respondents indicated that palliative care will not be referenced in pathways (14%), and nearly three times as many respondents (43%) stated that palliative care will be recommended as a course of action when appropriate (eg, “Palliative care should strongly be considered”).

Payer Formation of Accountable Care Organizations (ACOs)

The RI survey of leading payers confirmed that interest in ACOs as a cost-management mechanism for oncology is high. A minority of payers (21%) indicated they currently have an ACO, but more than half of respondents (56%) plan to have an ACO within 2 years. Payers anticipate modest first-year cost savings after forming an ACO, but expect savings to increase substantially 3 years after formation (Figure 2).

Respondents identified three cost areas as the primary potential contributors to ACO-related cost reductions. These were better coordination of care (86% of respondents), reducing inappropriate uses of therapies (81%) and earlier initiation of palliative care where appropriate (71%). When probed on ways in which an ACO potentially could influence oncologic drug costs, 2 prominent areas were identified by a majority of respondents: more conservative use of supportive care therapies (71%), and earlier initiation of palliative care (69%).

Overall, payers were realistic and pragmatic in identifying challenges to implementing new oncology care delivery models, identifying provider alignment and infrastructure/data acquisition as the two most significant challenges (87% and 71%,

Table 1. Payer Survey Demographics

Characteristic	Segment	Number of Respondents (% of total)	Covered Lives (% of total) Total = 108,494,500
Title	Medical director	19 (39%)	42,780,000 (39%)
	Pharmacy director	30 (61%)	65,714,500 (61%)
Plan size	Small (< 750,000)	19 (39%)	5874,498 (5%)
	Medium (750,000-2.5 million)	14 (28%)	17,680,000 (17%)
	Large (> 2.5 million)	16 (33%)	84,940,000 (78%)
Channel	Commercial	31 (63%)	72,882,500 (67%)
	Medicare	8 (7%)	21,992,000 (20%)
	Medicaid	10 (20%)	13,620,000 (13%)
Regional versus national	National	16 (33%)	49,664,500 (46%)
	Regional	22 (67%)	58,730,000 (54%)

Figure 1. Payer prioritization of tumor types for pathway implementation. Q1: For which tumor types has your plan already developed pathways? Q2: What are your plan's next priorities for development of clinical pathways in oncology?.

respectively), followed by care coordination, provider incentives, and organizational structure (each 65% of respondents).

Rapid Payer Adaptation to Change

The rate at which payers appear to be adapting to substantial changes in oncology care delivery models is encouraging. Although precise quantification of cost-savings associated with clinical pathway adoption and ACOs are difficult to quantify,¹ our survey confirmed that providers and payers are collaborating at the community level to implement sweeping changes to the oncology care model.

References

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Author's Disclosures of Potential Conflicts of Interest

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Figure 2. Payer estimates of oncology cost savings 1 year and 3 years after formation of an ACO. Q1: What percentage reduction in oncology costs would you anticipate achieving within 1 year after forming an ACO? Q2: What percentage reduction in oncology costs would you anticipate achieving 3 years after forming an ACO?

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