SPECIAL ISSUE: **PAYING FOR CANCER CARE** | FEATURING CONFERENCE COVERAGE: **FLASCO | ISPOR**

1995 • 2019 24 YEARS RESEARCH & LEADERSHIP

AJMC®
THE AMERICAN JOURNAL OF MANAGED CARE®

Evidence-Based ONCOLOGY™

JUNE 2019
VOL. 25 • NO. 6

ALSO IN THIS ISSUE

INSIGHTS THROUGH THE RISKY "MIDDLE ZONE" TO DRUG DEVELOPMENT. Christopher P. Austin, MD, oversees a unique mission as director of the National Center for Advancing Translational Sciences (NCATS). On Austin's watch, the center works across scientific disciplines to find ways to speed the process of turning discoveries into therapies that improve public health. For more about NCATS' mission, and its role in advancing the development of cures, see SP192.

BIOSIMILARS EDUCATION. Authors report results of an education program to increase physicians' confidence in using biosimilars and improve recognition of data for a trastuzumab biosimilar, SP188.

PATIENT PREFERENCE. An author from the National Community Oncology Dispensing Association discusses the gap between payer preferences for mail-order pharmacies and survey results that show patients prefer a medically integrated pharmacy, SP193.

REPORTS FROM SESSIONS. The Institute for Value-Based Medicine® brought sessions to White Plains, New York, and Chicago, Illinois, to discuss the Oncology Care Model and the shift to value-based cancer care, SP202-SP205.

CONFERENCE COVERAGE. Reports from meetings of the Florida Society of Clinical Oncology Spring Session and ISPOR 2019, SP195-SP197.

PRECISION FINANCING TOOLS

MIT Group Brings Together Stakeholders to Brainstorm How to Pay for Curative Therapies Over Time

Mary Caffrey

PATIENTS TREATED WITH CHIMERIC antigen receptor (CAR) T-cell therapy describe a process that is a miracle. After all else has failed, these engineered cells made with a patient's own T cells are let loose in the bloodstream to attack the cancer. For many patients who have lost hope, the treatment brings complete remission.

But the miracle comes at a cost. There's the price of the treatment itself—either $373,000 or $495,000, depending on the indication—and the total cost rises above $1 million,[1] including administration and treating adverse effects once called "the worst flu you've ever had."[2]

Right now, major academic medical centers say they are losing money every time a Medicare patient receives CAR T-cell therapy, as a reimbursement solution remains on hold.[2] But with more lifesaving and life-changing durable, curative therapies in the pipeline, the question of how to pay for CAR T-cell treatment will hardly be the last logjam of its kind.

A Novartis company, AveXis, recently said it would offer payment-over-time options for a $2.1 million single-treatment gene therapy for pediatric spinal muscular atrophy. A multistakeholder group at Massachusetts Institute of Technology has spent years exploring new payment options of this type for life-saving durable and curative therapies.

Credit: Novartis photo

CONTINUED ON SP214

ONCOLOGY CARE MODEL

Two-Sided Risk in the Oncology Care Model

Kashyap Patel, MD, ABOIM, BCMAS; Maharshi Patel, MBA; Taylor Lavender, BS, PA; Dhwani Mehta, MS, RD; Asutosh Gor, MD; Sashi Naidu, MD; and Chuck Newton, BS

THE US HEALTHCARE SYSTEM remains one of the most inefficient healthcare systems in the world. The Bloomberg Health-Care Efficiency Index ranked the United States 54th among 56 countries in 2018, tied with Azerbaijan and only ahead of Bulgaria.[1] This occurs even though the United States spends $10,244 per capita annually on healthcare, a figure representing 17% of the gross domestic product.[2]

Our expensive yet inefficient healthcare system has been blamed on a fragmented, disorganized, and uncoordinated delivery system, with silos and redundancies that create inefficiency.[3] Despite rapid advancements in treatment, the discovery of new drugs, and new technology aimed at improving patient outcomes, the overall performance of the US healthcare system in aligning incentives has not met expectations

CONTINUED ON SP216

GAINING THE PAYER PERSPECTIVE

NCCN's Putnam Serving as Point of Contact for Payers, Employers to Keep Cancer Care "Accessible"

Mary Caffrey

PUTNAM

A YEAR AGO, the National Comprehensive Cancer Network (NCCN) added the word "accessible" to its mission statement, stating that the group is "dedicated to improving and facilitating quality, effective, efficient, and accessible cancer care so that patients can live better lives."[1]

But innovative therapies won't reach patients unless payers and, increasingly, employers are willing to include them in benefit plans. So, in March, NCCN named Duane Putnam, BBA, as its director of Payer

CONTINUED ON SP221

AJMC® Managed Markets Network®

AJMC® THE INSTITUTE FOR VALUE-BASED MEDICINE® | COMMUNITY ONCOLOGY ALLIANCE COA

NCCN's Putnam Serving as Point of Contact for Payers, Employers to Keep Cancer Care "Accessible"

Mary Caffrey

CONTINUED FROM COVER

and Employer Outreach, giving these stakeholders their own point of contact.

Putnam has spent more than 30 years working at the intersection of pharmaceuticals and reimbursement, having spent much of his career at Pfizer as a director of employer relations. During that time, he has seen NCCN's clinical practice guidelines become the focal point for payers in making coverage decisions.[2,3] As employers take a more active role in benefit design, it will be Putnam's job to educate employers about NCCN's guideline development process.

Evidence-Based Oncology™ (*EBO*) spoke with Putnam about his new role and the challenges ahead.

***EBO*: Why is it important for NCCN to have a designated point of contact for payers and employers?**

PUTNAM: In 2018, NCCN added the word "accessible" to its mission statement to read, "NCCN is dedicated to improving and facilitating quality, effective, efficient, and accessible cancer care so patients can live better lives." Most of those patients are somebody's employee or the dependent of an employee, or members of a payer. So, what we want to do is keep that mission top of mind for the payers and employers, because they have so much influence on access.

What I can do is make it more convenient for them to have one point of contact here at NCCN. It helps me to learn their priorities related to cancer care, and it helps me see where their priorities overlap with each other and where they do not.

EBO: NCCN guidelines have become the gold standard for payers who are making coverage decisions. Have payers learned about your appointment, and if so, what kind of feedback have you received?

PUTNAM: The NCCN Guidelines and derivatives are utilized by CMS and private payers for coverage policy for approximately 85% of covered lives in the United States. As for employers, and their knowledge of NCCN, there's still room for improvement, but I'm pleased at the initial uptake. That's part of my goal in the weeks to come—to take the initiative and to build a bridge to work together.

***EBO:* How do you envision these relationships informing guideline development?**

PUTNAM: These relationships will not inform guideline development, as the development of the NCCN Guidelines is protected by a very strict firewall. The firewall surrounding those processes includes financial support policies, panel participation policies, communication policies, disclosure policies, and policies regarding relationships to NCCN business development. Payers and employers, like any stakeholder, are welcome to submit data for consideration by the NCCN Guidelines Panels via NCCN.org. This process and our full firewall policy can both be found on NCCN.org.

***EBO*: We are hearing more and more about employers—not just large employers but also midmarket employers—taking a more active role in benefit design and wellness to hold down healthcare costs. Much of your career has been spent engaging employers. How have you seen the role of the employer evolve, and how do you see it evolving in this era of transformative, but expensive, cancer therapies?**

PUTNAM: Purchasers, employers, and payers may look at this as a cost center. Fortunately, over the last decade or so, employers have become more educated consumers; they are no longer willing just to hire outside help and rely on them exclusively to do what needs to be done. They are asking good questions.

What's interesting is that the employers are actually a collection of consumers. So, employers are consumers, but they have employees who are consumers, and once again, NCCN is able to help both groups through the NCCN Guidelines and NCCN Guidelines for Patients. You need a surround sound approach for the employers and the employees when they are in with their treatment team, every doctor will say, "The better educated the patient is, the easier my job is." We would like to share the materials we have and help the employer.

It's hard to ignore the cost of care, but if you put that in perspective and look at the lost productivity and the cost of replacement workers, the costs for absence, short-term disability, and long-term disability, the direct costs become a smaller piece of the pie. Hopefully, we will help employers look at evidence-based care as an investment to maximize rather than a cost to try to minimize.

***EBO*: At the most recent conference, major emphasis was placed on the need to expand genomic testing across cancer states. How are payers doing in reimbursement for testing?**

PUTNAM: There's an opportunity there…if [the tests] are proven and evidence-based, they can actually reduce cost and reduce waste because they can help the clinician select effective and efficient treatments. The NCCN Biomarkers Compendium, based directly on the NCCN Guidelines, supports clinical decision-making related to the use of drugs and biologics, biomarker testing, imaging, and radiation therapy for people with cancer. The goal of the NCCN Biomarkers Compendium is to provide essential details for those tests, which have been approved by NCCN Guidelines Panels and are recommended by the NCCN Guidelines. The tests that measure the changes in the genes, the gene products, which can be used for diagnosis, for screening and monitoring, surveillance, providing predictive and prognostic information—they are all included in there. We are hoping that the NCCN Biomarkers Compendium is used by payers, much the same way the drugs and biologics compendium is now utilized as a reference for coverage decisions. The challenge is how to wade through the different tests that are coming out to make good decisions and to make sure they are evidence-based and can stand up to scrutiny.

***EBO:* What other major challenges do you foresee over the next 1 to 2 years with payers and employers?**

PUTNAM: Payers are aware of the NCCN Guidelines. The employers, maybe not so much, which is understandable. We need to let them know what NCCN is about and what we do, as well as the fact that NCCN is dedicated to improving and facilitating quality, effective, efficient, and accessible cancer care so patients can live better lives. I want them to understand how diligent we are in that mission.

As stated earlier, NCCN has strict policies to shield the guideline development process from external influences. And I think that's maybe where the employers are less informed. If anybody is concerned that someone is influencing the people who are advising [the guidelines panels], so that it becomes self-serving for those third parties, that's great for me, because I can look anybody in the eye and say, "It's not the case with NCCN."

A second challenge would be understanding how to best help employers and payers utilize the NCCN Guideline to support a robust continuum of care design that is evidence-based. The goal should be not how much to spend, but how well. ◆

REFERENCES

1. About NCCN [National Comprehensive Cancer Network]. NCCN website. nccn.org/about/. Accessed May 10, 2019.
2. McGivney WT. The National Comprehensive Cancer Network: present and future directions. *Cancer.* 1998;82(10 suppl):2057-2060.
3. McGivney WT. NCCN guidelines and their impact on coverage policy. *J Natl Compr Canc Netw.* 2010;8(6):625.