Current Oncology Care Issues…
A Look at the USA and Capitol Hill

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San Juan, Puerto Rico
2/4/2017
Oncology Policy in the Crystal Ball

- Policy environment for community oncology should be more favorable “for now”
- Oncology payment reform a reality, regardless of who is in power in DC
  - Embrace it and make it work in your practice
  - MACRA, OCM (Medicare); Aetna, United, Priority, etc. (Private payers)
- The drug price issue is not going away
  - Big meeting at the White House this past week
- 340B in hospitals will be an issue in 2017
  - Big fight brewing!
- PBMs fighting hard to control and dispense oral cancer drugs
  - And “tax” providers in the process
- Obamacare will be repealed and replaced; just a very cloudy picture of what “Trumpcare” will look like
- MA in Puerto Rico may be the “canary in the coal mine” on reimbursement as MA grows
Why An Improved US Political Environment?

- Obama Administration has cut Medicare drug reimbursement once (sequester) and then tried again (Part B model or “experiment”)
  - Very unlikely the Trump Administration will follow
  - GOP was very supportive in stopping Part B experiment

- HHS and CMS have not been very supportive of community oncology
  - Obama Administration consolidated cancer care

- Republicans in Congress have been more supportive of our issues
  - Trying to stop the application of the sequester cut to Part B drug payment
  - Stopping the Medicare Part B experiment
  - Acknowledging general consolidation of cancer care across the country

- HHS Secretary nominee Dr. Tom Price very supportive of physicians and our issues
Oncology Payment Reform

- Private insurers have already started years ago
  - United, Aetna, Anthem, Priority, etc.

- Medicare COME HOME project already done

- Oncology Care Model (OCM) is now rolling
  - 196 practices implementing it (or trying!)
  - Payers at all different levels of readiness

- MACRA final rule out and the implementation clock is ticking
  - Need to make choices now

- Both sides of the political aisle want “value” in payment for medical services and drugs

- Community oncology needs to be even more aggressive in moving on payment reform, especially with the change in DC!!!
Help practices make the OCM really work
  • Have close to 80% of the practices networked

Provide materials to help facilitate implementation

Created peer-to-peer information exchange
  • Dedicated listserv
  • Affinity groups
  • Meetings and calls

Brought on very experienced experts (Kavita Patel, MD, Basit Chaudhry, MD, Laura Long, MD)

Proactive outreach to CMMI on implementation issues and now big concerns

Evolve the model as needed so it actually works and can be used elsewhere
OCM Evolution to OCM 2.0

▪ OCM is a good start but has a ton of issues/problems
  • Trying to make it as “good” as possible in working through the deficiencies

▪ What would the perfect OCM-type model look like?

▪ OCM 2.0 is attempt to make the OCM better and to serve as a universal oncology payment reform model
  • Smooths the “rough edges” of the OCM 1.0
  • Takes a more global look at cancer treatment, not just the chemotherapy episode
  • Two variations:
    ▶ Single sided (no practice risk)
    ▶ Double sided (practice at risk but with a floor)
Drug Price Issue Front and Center

How the U.S. could cure drug-price insanity
by Peter B. Bach, MD
SEPTEMBER 17, 2015, 8:20 AM ET

Mylan CEO to Defend Price Hike Before Senate
By ALANA ABRAMSON
Sep 20, 2016, 6:01 PM ET

Trump Attacks Drugmakers on Pricing
He vows to ‘save billions of dollars’ by changing how the U.S. buys its drugs

President-elect Donald Trump criticized the pharmaceutical industry during his press conference on Wednesday.

Innovating and Advocating for Community Cancer Care

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Escalating drug prices are a problem and not sustainable
  • Pharma/bio companies part of the problem and need to get innovative with solutions

Escalating drug prices only part of the problem of increasing cancer care costs
  • Only 18-20% of the cost of cancer care relates to drugs
    ▶ Pharma/bio an easy target for the media, politicians, and academics
  • Technology advances and demographics are a large part of the problem
    ▶ Better diagnosis and treatment keeping people alive
    ▶ Shifting demographics and health behaviors increasing cancer cases and costs

Everyone part of the problem — and everyone needs to be part of the solution!!!
  • FDA
  • Pharmaceutical/biotechnology companies
  • Insurers — private and Medicare
  • PBMs
  • Community oncology
  • Hospitals, including 340B and cancer hospitals with special Medicare exemptions
Where is Drug Price Debate Likely Heading?

- Direct or overt price controls unlikely – regardless of Trump’s tweets
- Tough to imagine ”negotiations” between Medicare and pharmaceutical companies on drug prices
  - Pits the Trump Administration against the GOP Congress
  - Sounds good on paper; unworkable in cancer treatment
- Possible greater regulation like the insurance industry
  - Price increases regulated and have to be approved; or are at least transparent
- Push to increase competition by getting both brand and generic drugs to market faster
  - Helping generics more
- Moving to some type of “value-based” pricing for drugs
- “The Art of the Deal” opening salvo just like to Carrier, Boeing, Ford, etc.
Component Cost Drivers Present a More Complex Picture Than Just Drugs

Source: Cost Drivers of Cancer Care: A Retrospective Analysis of Medicare and Commercially Insured Population Claim Data 2004-2014, Milliman, April 2016
## Cost Drivers Vary Over Study Period

<table>
<thead>
<tr>
<th>Service Category</th>
<th>2004-2014 PPPY Cost Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicare</td>
</tr>
<tr>
<td>Hospital Inpatient Admissions</td>
<td>22%</td>
</tr>
<tr>
<td>Cancer Surgeries (inpatient and outpatient)</td>
<td>0%*</td>
</tr>
<tr>
<td>Sub-Acute Services</td>
<td>51%</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>132%</td>
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<tr>
<td>Radiology – Other</td>
<td>24%</td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>204%</td>
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<tr>
<td>Other Outpatient Services</td>
<td>48%</td>
</tr>
<tr>
<td>Professional Services</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Biologic Chemotherapy</strong></td>
<td>335%</td>
</tr>
<tr>
<td>Cytotoxic Chemotherapy</td>
<td>14%</td>
</tr>
<tr>
<td>Other Chemo and Cancer Drugs</td>
<td>-9%</td>
</tr>
<tr>
<td><strong>Total PPPY Cost Trend</strong></td>
<td><strong>36%</strong></td>
</tr>
</tbody>
</table>

Source: *Cost Drivers of Cancer Care: A Retrospective Analysis of Medicare and Commercially Insured Population Claim Data 2004-2014*, Milliman, April 2016
Consolidation of Community Cancer Care

Source: Community Oncology Alliance 2016 Practice Impact Report
Trends in Community Oncology

- Percent of chemotherapy administered in community oncology practices decreased from 84.2% to 54.1%
- Percent of chemotherapy administered in 340B hospitals increased from 3.0% to 23.1% (670% increase)
  - 340B hospitals account for 50.3% of all hospital outpatient chemotherapy administrations

Source: *Cost Drivers of Cancer Care: A Retrospective Analysis of Medicare and Commercially Insured Population Claim Data 2004-2014*, Milliman, April 2016
PBM/Specialty Pharmacy Issues

- PBMs attempting to control oncologist decision making, control distribution of oral cancer drugs, and profit from drugs as more oral drugs come out of research
- CVS Caremark moved to shift all dispensing community oncology practices to “out of network” for Medicare Advantage plans effective January 2017
- PBMs creating tighter formularies to control what drugs get used based on the rebates they get from manufacturers
- PBMs tightening ”formulary” access to treatments and steering business to internal pharmacy facilities
- PBM rebates skyrocketing as well as their DIR Fees back to pharmacy providers
  - Patients paying more based on drug list prices; being pushed into the donut hole faster
  - Medicare paying more as patients pushed out of the donut hole faster
  - Patients and Medicare paying more as DIR/DIR Fees fueling drug prices
  - Pharmacy providers pressured with excessive DIR Fees
PBM Rebates Exploding!!!

Figure 1 – DIR by Payment Year

Source: Analysis of DIR and enrollment data from the 2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds (CY 2016 Medicare Trustee’s Report) and cost data from PDE records.
What COA is Doing

- Hired law firm that specializes in pharmacy and PBM issues
- Legal, media, and advocacy campaign that stopped CVS from excluding practices from network
  - Still engaged on this
- Fighting Express Scripts on formularies, exclusions, and steerage
- Fighting PBMs on DIR Fees

PBM DIR Fees Costing Medicare and Beneficiaries: Investigative White Paper on Background, Cost Impact, and Legal Issues

Prepared by
Peter Levine, LLC

Commissioned by the Community Oncology Alliance

January 2017
Dismantling of Obamacare

- GOP majority Congress has passed “budget reconciliation” bills (Senate and House) setting up repeal and replace
  - Reconciliation only requires majority vote in the Senate (and House)
  - Ironically, Congress used reconciliation to pass Obamacare
- Unclear as to the timing of repeal
  - Growing calls among the GOP to not repeal until a replacement is ready
  - All variations of “replace” plans but no clear path forward at this time
  - Hearings this past week on elements of repeal/replace
- CBO scored repeal bill as causing 18 million to lose insurance in first year and premiums rising 20-25% in the non-group market
  - Catch is score included no replacement
Trick Repealing/Replacing Obamacare

- Obamacare simply ingrained in the healthcare system
- Aspects of Obamacare are liked
  - Overcoming preexisting conditions, annual/lifetime caps
  - Having children up to 26 on parents’ policies
- Big dilemma is how to overcome the mandate
  - Mandating people have insurance OR pay a penalty drives the positive score (economics) on Obamacare
  - One solution is for automatic insurance enrollment
    ▶ Op out if you don’t want it
    ▶ What’s the difference?
    ▶ Not the Republican way
- Do Republicans take the opportunity to touch Medicare?
MA Issues in Puerto Rico

- Puerto Rico’s fee-for-service population not representative of the Medicare Advantage population
  - Only 12% of the eligible population with much smaller (10%) Medicare-Medicaid dual eligibles than MA (50%)
  - Fee-for-service provides a distorted benchmark for MA reimbursement, lowering it artificially

- MA enrollment in Puerto Rico exceeds 75% of the Medicare-eligible population
  - National mainland US average is 32%
  - 30% of Medicare’s fee-for-service population switching to MA each year
    - US average is 3-5%

- US has to pay attention because this may provide a model as MA continues to increase
COA 2017 Priorities

▪ Legislative focus
  • Stop the sequester cut to Part B drug payment
  • Advance “rational” oncology payment reform
  • Fix the 340B drug discount program
  • Fight abusive PBM behavior
    ▶ DIR fees to providers
    ▶ Steerage to PBM pharmacies

▪ Advance oncology payment reform
  • Make changes to the OCM
  • Develop and advance the OCM 2.0

▪ Ramp up patient advocacy initiatives
2017 Community Oncology Conference

MARK YOUR CALENDAR!
2017 COMMUNITY ONCOLOGY CONFERENCE
GAYLORD NATIONAL RESORT & CONFERENCE CENTER
APRIL 27-28
Thank You!

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