As New Jersey's oldest and largest health insurer, Horizon Blue Cross Blue Shield of New Jersey (BCBSNJ) serves more than 3.6 million members. In 2010, the company processed more than 57.6 million claims totaling more than $13 billion for its members. The company has more than 4,800 employees and is headquartered in Newark, with offices in Harrison, Wall Township, Mt. Laurel and West Trenton. ManagedCare Oncology recently sat down with Patrick Gill, Pharm.D., and William Noorigian, Pharm.D., of Horizon Blue Cross Blue Shield of New Jersey, for a unique perspective on their plan’s outlook and current initiatives for managing quality and cost of care in oncology.

MCO: When you think about managing oncology costs, what are your key goals from both a quality-of-care and cost perspective?

Dr. Gill: I think the primary focus is in prevention. We invest a lot of time and resources to encourage members to get their appropriate screenings, which in oncology means detecting the disease earlier and improving the chance of better outcomes. We all know it doesn’t always work that way though. Once the patient has a diagnosis and is prescribed treatment, our main focus is making sure the patient is getting the right kind of therapy. It’s really no different in oncology than anything else.
Dr. Noorigian: From a clinical perspective, it all centers on prescribing the right drug for the right patient. All the recent advancements in treatment, including a number of targeted drugs with accompanying genomic tests, definitely help the cause.

MCO: How does your team decide what treatments are targeted for management initiatives?

Dr. Gill: There are many layers to that decision. If there’s a genetic testing component, we will always include it for management. Any drug that has a wide range of uses that aren’t always recognized by compendia is also a potential candidate. With most drugs, our primary concern is that we don’t know exactly how a particular agent will affect a patient in the real world. In clinical trials, you’re dealing with a carefully selected population in a closely monitored environment, but there are a great deal more uncontrolled variables and patient circumstances in actual practice. In addition to these clinical and quality considerations, we’re also looking at the costs. If comparable therapies yield similar outcomes, but one is available at a lower cost, that’s always a factor.

As pharmacists, we’re the last line of defense against unforeseen outcomes. Our goal is to give providers the latitude to operate within an evidence-based framework while maintaining a watchful eye over how treatments unfold in a patient’s everyday life.

Dr. Noorigian: Specifically in oncology and the oncology market, we want to look at any kind of clinical trial data that are available and consider potential adverse events to make sure we have symptom management techniques and supportive care in place before we start using a particular therapy. That’s one specific area where you want to have tighter management interventions established.

MCO: What are the noteworthy quality and cost concerns for 2012?

Dr. Noorigian: I would definitely say — and this goes back to what I previously said — oral oncolytics and the availability of genetic testing for certain agents are an issue. With this more targeted approach, questions are naturally being raised because it’s a new technology. How is it going to be addressed and implemented?

Indications are also a concern. The status of individual agents — whether they be approved, revoked or included in the compendia — are in constant flux. Continual updates to labeling and consensus recommendations make it difficult to effectively manage the class.

Dr. Gill: From a quality standpoint, we’re seeing that things are getting more complicated. We have over 200 oncologists in our network, so treatment variability is definitely a health quality concern. If you pulled five oncologists into a room and asked them to recommend an appropriate course of therapy, you could conceivably have five different yet potentially “correct” answers.

There may not always be good comparative outcome data. This is important not only from a plan perspective but also from a physician and member perspective. And of course the pipeline impact cannot be understated in terms of cost concerns.

MCO: When investing in programs for preventing inappropriate off-label use of chemotherapy and chemotherapy support, what are the main clinical and implementation challenges?

Dr. Gill: The challenges start with medical policy development and the
research that goes into it, after which the new policy must be connected to the provider network through Web-based channels.

We also have a sort of “skunkworks” in-house to pilot our new initiatives. Through our subsidiary company, Horizon Healthcare Innovations, we have a team working on a pathways program, and they’re also considering an accountable care organization (ACO) model for oncology. Implementation challenges come first in that the medical claims systems have not been adapted to integrate important new initiatives. From a clinical perspective, we need more clinical oncology support to help steer collaborative discussions. To Dr. Noorigian’s point, the clinical side is evolving quickly, so it’s a challenge to stay current. Everyone is talking about pathways, and we have a pilot under way to evaluate the program and measure the results. Quality will obviously come first, but we’re also going to be looking at costs and getting feedback from participating providers. The biggest challenge in the industry is that there are multiple pathway programs out there from different organizations, so it’s going to be difficult to get everyone to agree on a single pathway, both clinically and operationally.

MCO: How have your providers responded to these and other management initiatives? What can be done to minimize any disruption that may occur from these initiatives?

Dr. Gill: Thus far, the providers have given positive feedback on the clinical pathways initiative. The feedback we get from our collaboration allows us to refine and advance our efforts.

MCO: What are some of the challenges your plan has experienced in implementing its clinical pathways program?

Dr. Gill: We’ve only enacted the clinical pathways initiative with a handful of practices and only in a pilot capacity. At this point, it’s been very transparent as a means of better understanding the merit of using this type of program. That aspect has helped significantly, but down the road, when both sides aren’t freely exchanging information, we may see some contention. Now we’re challenged with next steps: Do we test multiple pathways? Do we develop pathways with physicians in our network? How do we support physicians in using the pathways? Early signs look encouraging, and it looks like we’re saving a modest amount of money, but these savings may become more pronounced over time. Still, even if the pathways initiatives end up being cost-neutral, they may be worthwhile if they allow us to deliver a higher level of quality care. Specifically, if pathways can help to improve the quality of treatment up front, that could lead to significantly better outcomes as well as help to curb some end-stage costs in the long run. If and when pathways become the norm, the challenge then becomes how practices differentiate themselves. If everyone is using the same treatment protocols, will offices turn to reporting outcomes to set themselves apart from the rest? This all remains to be seen.

MCO: What is the concern with site-of-service changes? How should payors measure site-of-service changes?

Dr. Gill: We prefer to see drugs administered in the physician’s office.
because it’s a more convenient and cost-effective means of delivering care. Clearly, there will always be situations where patients need to be in the hospital to receive treatment. That said, when clinically appropriate, we believe patients are well served when receiving care in the company of their own physicians in the physician’s office setting.

**MCO:** Some cancer care is provided through home health care. In your experience with this distribution channel, what are the opportunities?

**Dr. Gill:** Home care is not fully realizing its potential. The main reason for this is that home health care agencies haven’t yet demonstrated a strong competency for the intensive management necessary in oncology. For the most part, chemotherapy is too complicated and/or risky for home infusion, and few companies in the industry have demonstrated the clinical prowess necessary to manage these types of agents. For this same reason, providers generally are not fully comfortable with sending their patients to home health agencies to receive treatment.

**MCO:** Many new treatments for cancer are oral products. Does this present a different management strategy than traditional injectables?

**Dr. Noorigian:** The genetic testing component available with some of these newer targeted oral therapies creates a unique opportunity for management. Beyond this, there’s a more robust level of management that you can apply with regard to utilization management on the pharmacy side, where these agents are covered. I think the biggest challenge with the oral oncolytics is that patients are being left on their own now. With injectables, you have guaranteed compliance; you can monitor the patient and keep a close eye on tolerability and potential toxicities. With the oral, this intensive level of provider oversight isn’t there, which means that compliance and side effects become the issues. In some cases, you have oral treatments without an IV counterpart and in some cases you have both. That’s where cost will come into play. While we may want an oral therapy, the physician may want an IV therapy for various reasons. Taking this into consideration, I think it’s important that providers aren’t penalized for choosing an oral agent.

Another challenge that comes into play with oral agents is how the drug should be supplied. With an injectable, you have a single infusion or a cycle, versus an oral given every day. This opens up a whole host of questions surrounding quantity limits.

**MCO:** Can you comment on how benefits are changing as a tool to manage injectable costs?
Dr. Gill: In our market, thus far we have not seen changes in benefit designs specific to oncology.

MCO: How do you view the movement to consumer-directed health plans and the role this trend will play in the injectable management? Have you seen any examples with your membership today?

Dr. Gill: It’s interesting, but what we normally see is that patients who select this option tend to be healthy with low utilization and low costs.

Granted, patients who are healthy now can ultimately become sick. It’s a value and risk decision for the members during open enrollment. We have found that when members choose this option and have no indication that they’re going to hit their deductible, they’re very wise shoppers. A concern for us is that other patients, because of out-of-pocket costs, would avoid or not access benefits to the degree necessary for remaining on an adherence schedule.

MCO: If you could fix one thing to improve your ability to manage oncology costs, what would you want to change?

Dr. Gill: The most difficult part of managing oncology costs stems from the very nature of cancer as a disease: You have a patient who’s very sick with an often dire outlook and a physician who wants to do anything he or she can to help that patient. At one point, there’s nothing left to do and the prospect of ceasing treatment must be discussed. It’s extremely difficult for a health plan to insert itself into this conversation without seeming insensitive, so some means of approaching end-of-life care would be valuable. Clinical pathways may provide a potential solution, but only if end-of-life care is a consideration built into the design of the program.

MCO: Speaking to that point, studies have shown that approximately one-third of patients with cancer receive chemotherapy in the last several weeks of their life. So what is the best strategic approach to optimizing the use of hospice?

Dr. Gill: Clinical pathways programs may offer some sort of assistance, but only if the pathways actually contemplate end-of-life care. Most often, these programs are focused on the right course of treatment but not necessarily the point at which to initiate hospice discussions. If you’re incenting physicians to move patients into hospice, it suggests that you’re incenting them to end their care of patients. It would be nice if there was some kind of guideline from the American Society of Clinical Oncology or the National Comprehensive Cancer Network advising when to have these discussions. A neutral third party directing hospice care would certainly be advantageous from a payor perspective.

MCO: There has been a lot of discussion in the past regarding reimbursement strategies for oncologists and other providers who administer injectable drugs. What is the next horizon for payors who wish to optimize the use of high-quality, cost-efficient chemotherapy?

Dr. Gill: I think it all comes down to making sure that reimbursement is reasonable for both parties. It has to be adequate enough for the provider to acquire the drug and pay their bills. Something on the cusp between a pathway program and an ACO model would be ideal. The consolidation of practices in alignment with hospitals is evidence of the reimbursement pressures that physicians are experiencing right now. More than ever, we need to work collaboratively with these practices and really see where each other is coming from.