The Role of Medically Integrated Dispensing in Community Oncology
The ION Solutions Precision Medicine Center is your gateway to a single, centralized library of precision medicine testing recommendations and resources. Access all of the testing recommendations created by our physician- and pharmacist-based advisory panel as well as resources curated by ION Solutions and our precision medicine partners to help you make informed decisions for your patients.

View testing recommendations by tumor categories:
- Breast Cancer
- NSCLC
- Colorectal
- Genitourinary
- Head & Neck
- Lymphoma
- Rare Disease
- Multiple Myeloma
- Leukemia

As precision medicine continues to evolve, ION will continue to provide the tools your practice needs.
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one on one with Brian Ansay

ION Solutions has long believed that on-site pharmaceutical dispensing improves the quality and cost effectiveness of healthcare. Both the practice and the patient benefit from in-office pharmaceutical dispensing solutions. Medically integrated dispensing creates an ancillary revenue stream for the physician and saves the patient a trip to the pharmacy. In our cover story on page six, Dr. Kashyap Patel, Carolina Blood and Cancer Care; Maharshi Patel, MAH Consulting Group; and Kathy Oubre, Pontchartrain Cancer Center; present a case study on the role of medically integrated dispensing in community oncology clinics.

Precision medicine is an essential component of practicing oncology today. As demonstrated in the work of ION Solutions’ Precision Medicine Advisory Panel, molecular testing at the right time, for the right patient, using the right specimens is necessary to guide therapeutic decisions today. The need for precision medicine clinical trials is increasing in the community setting as more patient-directed therapy approaches are developed. Learn more about the growing need for clinical research in the community setting and the role AdvanceIQ Network plays on page 14.

In this issue we’re happy to share an article about physician perspectives of the Oncology Care Model. In the article, which was originally published in the Nashville Medical News, Dr. Stephen Schleicher, Tennessee Oncology, and Dr. Kashyap Patel discuss the progress and challenges of delivering patient-focused, value-based care to cancer patients. You can find it on page 22.

The oncology landscape is constantly changing, but ION Solutions’ support is steadfast. We’re committed to evolving and expanding our offerings to you so that we can continue to serve as your partner in enhancing patient care.

Thank you for your partnership.

Brian Ansay
President, ION Solutions

ION Solutions article and advertising submissions:

Article submissions and suggestions, as well as advertising inquiries, may be sent to:

Tricia Musslewhite
Managing Editor, Oncologistics
c/o ION Solutions
3101 Gaylord Parkway
Frisco, TX 75034

Editorial & Design staff:

- Chris Vorce
  Senior Director, Marketing & Communications, ION Solutions

- Sylvia Melton
  Manager, Graphic Design, ION Solutions

- Tricia Musslewhite
  Manager, Marketing & Communications, ION Solutions

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The Role of Medically Integrated Dispensing in Community Oncology Clinics

Dr. Kashyap Patel, CEO, Carolina Blood and Cancer Care
Maharshi Patel, BS, MBA, Founder, MAH Consulting Group
Kathy Oubre, COO, Pontchartrain Cancer Center

The treatment landscape for cancer patients is changing rapidly. As the management of cancer patients becomes more complex with newer diagnostic techniques, the evolution of a personalized medicine adaptation in community clinics providing care to patients is a must. Traditional chemotherapeutic agents are rapidly being replaced with immunotherapy as well as other targeted therapies. Oral oncolytics are rapidly emerging as a definite alternative to traditional long infusions of cytotoxic chemotherapeutic agents.

Between 1999-2005, 29 oral chemo drugs were approved and used. Between 2005-2017, an additional 34 oral oncolytics were approved. More than 50 percent of cancer treatment agents approved in the last two years are oral oncolytics. The majority of oral cancer drugs approved prior to 2005 were either chemotherapeutics (Cyclophosphamide, melphalan, chlorambucil, capecitabine), hormone blockers (aromatase inhibitors, Gonadotrophin release hormone inhibitors etc.) or Immunomodulators. The majority of oral oncolytics approved after 2005 are either class specifics (TKIs, CDK inhibitors, HDACS), targeted agents (Erlotinib, Gefitinib etc.) or approved with companion diagnostics (BRAF inhibitors, PARP inhibitors).

Progress in oral oncolytics also brings challenges, particularly when patients are monitored by third-party remote medication therapy managers (MTM) that do not see patients on a regular basis. Food and drug interactions are less predictable due to an accelerated drug approval process, along with variation in doses (Abiraterone with/without food, cabozatenib, interactions due to multiple class administered together).

Medically integrated dispensing creates an ancillary revenue stream for the physician and saves the patient a trip to the pharmacy.

A reduction in the number of chemotherapeutic infusions as well as novel therapy delivery systems (Rituxan Hycela, s/q Herceptin Hylecta and Velcade) led to a decline in non-drug infusion related revenues. This shifting paradigm will eventually lead to reduction in chair time requirement. The net results of the changing landscape of treatment for cancer patients will be less infusion staffing requirements and redeployment of staff in other areas. One of the solutions is to become early adopters in the oral dispensing space and create better patient care. By bringing medically integrated dispensing, oncologists can provide better care and initiate a new stream of revenue while redeploying existing experienced staff.

On-site pharmaceutical dispensing improves the quality and cost effectiveness of healthcare in today’s market. Both the medical dispensing professional and the patient benefit from in-office pharmaceutical dispensing solutions. Medically integrated dispensing creates an ancillary revenue stream for the physician and saves the patient a trip to the pharmacy.

As the newer cancer therapies for complex, acute and chronic malignant as well as non-malignant autoimmune diseases continues to evolve, the number of self-administered injectable and oral therapy options is increasing.
rapidly. These therapies account for more than half of the drugs in Phase III clinical trials for complex conditions. There are few other medical practices adding services that make a positive difference in the lives of patients. In fact, many physicians are reducing services instead of taking advantage of the benefits medically integrated dispensing can provide.

BenefitsofMedicallyIntegratedDispensinginCommunityCancerClinics

1. The practice becomes a one-stop shop for all treatment related to the patient’s cancer

By adding a medically integrated dispensary or pharmacy, oncology clinics can provide the full range of treatment options at one site. Whether patients receive intravenous therapy or need to fill a prescription for self-injectable or oral medications, they would be able to access the therapies as and when they need from a team of health professionals they have known and trusted throughout their cancer treatment journey. Whether single or multi-agent therapy, oral or injectable, they will have convenience and flexibility, along with the ability to undergo preauthorization.

2. Improved patient satisfaction and better patient experience

When drugs are dispensed from oncology clinics, the practice’s clinical staff can address any and all issues or concerns, including compliance issues and side-effect issues, adding a holistic view of the patient’s care. Patients can begin taking oral medications or learn how to self-inject medications under the supervision of health care providers. These providers have full knowledge of other co-morbidities as well as drug-drug or drug-food interactions. Because these clinicians have knowledge of the full treatment program, many subsequent anxieties and concerns can be addressed on site. If a clinician needs to adjust a medication or dosage, it can easily be done in the office rather than going back-and-forth with a mail order or external pharmacy which has no knowledge of the complexities of oncology care. When patients are dealing with serious cancers, having all their medical needs met under one roof can reduce stress when it is needed most.

3. Improved patient care and compliance

In the era of value-based care, patient experience is very important. Offering oral and self-injectable medications at a practice helps increase patient satisfaction and enhances the level of care and adherence that can be attained. One of the fundamental tenets of value-based care is shared decision making and care coordination. With medically integrated dispensing, the goals of care coordination can be achieved better, incorporating all factors including co-morbidities and medication reconciliation, leading to fulfillment of compliance and better patient care.

4. New revenue stream

Now more than ever, oncologists can add a medically integrated dispensing model as an avenue to tap into a new revenue stream while offering better care for their patients. There may not be a better time for oncology practices to consider adding a medically integrated dispensary or pharmacy to their operations. Medically integrated dispensing can provide patients with access to key oral and self-injectable therapies and can open a new potential revenue stream for practices. As with any new business venture, starting a medically integrated dispensing program requires investing in the resources needed to succeed. However, the additional revenue
stream is an added benefit to any practice as they can now realize savings opportunities.

5. **Patient assistance and support programs**

An in-office dispensary or pharmacy allows the practice’s staff to help patients with concerns about cost, coverage and patient assistance, bringing the pharmacy closer to the patient and the physician closer to the pharmacy. With robust patient assistance programs and foundations supporting underinsured and uninsured patients, as well as special programs sponsored by pharma for commercially insured patients, oncology practices can help alleviate financial toxicity concerns and improve quality of care and compliance.

6. **Increased clinic efficiency**

With medically integrated dispensing, patient medication coverage, pre-authorization and step therapy requirements can be explored at the time of attempted medication filling. It also enables pharmacy staff from the MD’s office to reach out to the appropriate payer department to complete required documents like physician notes, path reports and scan reports to obtain medication approval, versus a third-party prescription fill sometimes leading to waiting several weeks before medication can be obtained, also causing additional time spent by the clinic staff.

7. **Value-based care and Alternate Payment Models**

The trend of switching physician payments from volume to value requires that physicians and providers become indirect stakeholders in spending. Medically integrated dispensing allows physicians at their discretion to fill prescriptions for a limited time initially to explore patient compliance as well as tolerance. When a prescription is filled via a third-party mail order pharmacy, medication is usually sent for 90 days. If a patient cannot tolerate the medication, progresses on medications or needs dose alterations, a very expensive drug supply would then be discarded, resulting in increasing spending over medications.

Medically integrated dispensing allows the physician to control the spending on medication resulting in savings for the system.

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**Lessons Learned at Carolina Blood and Cancer Care from Optimizing Oral Dispensing: Case Study-based Learning**

**Why we decided to start oral dispensing:**

We had to start dispensing once we were selected for the oncology care model (OCM) to have better control of drug costs. Traditional pharmacy benefit managers (PBM) send a 30 to 90-day supply; frequently resulting in waste due to either disease progression or side effects. For patient attribution, the day that patient receives medicine triggers a six-month episode in OCM. With medically integrated dispensing, we were able to streamline Monthly Enhanced Oncology Services (MEOS) billing by reducing attribution errors. With split fills for less quantity, we can constrain over-spending and reduce waste.

**How CBCCA Implemented Dispensing**

- **2016**
  - We joined CMMI Pilot as an OCM Practice

- **2016 Fall**
  - BCBSSC started negotiations to join OCM for limited cancers

- **Fall 2016**
  - We reached out to ION Solutions for support to start dispensing; hired in-office pharmacy tech

- **January 2017**
  - We started oral dispensing

- **July 2017**
  - We signed an agreement with Central Processing
Growth of Oral Dispensing at the CBCCA over 2 years

Revenue Growth Quarterly and Annually
Summary of our Growth and Message for Colleagues

In summary, we strongly recommend all oncology clinics consider the addition of medically integrated dispensing as a service line for patients for the following reasons:

1) Convenience
2) Affordability
3) Preserves confidentiality
4) Increases medication compliance
5) Supplemental revenue
6) Increased patient compliance
7) Differentiates the practice
8) Provider productivity
9) Better performance in VBC and OCM

Despite a relatively small clinic size, with our foresight and collaboration with ION Solutions Central Processing we made significant progress in a very short span of time. Medically integrated dispensing is not a choice anymore. It is a case of business compulsion.
The True Purpose of your GPO

True leaders in industry.

This is more than just lip-service.
As the pioneers of performance-based contracting, we have always been focused on the future of community oncology. That long-standing commitment remains as the healthcare landscape evolves due to changing regulations and industry standards.

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As patient needs evolve, so do the tools and resources you depend upon to meet those needs. We do our part by investing in technology, research and other resources to help you elevate the quality of patient care.

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There’s a Growing Need for Clinical Research in the Community Setting

Collaboration with Industry Partners, Similar Practices Makes It Possible

By Tricia Musslewhite
Precision medicine is an essential component of practicing oncology today. As demonstrated in the work of ION Solutions’ Precision Medicine Advisory Panel, molecular testing at the right time, for the right patient, using the right specimens is necessary to guide therapeutic decisions today.

Dr. Manish Patel, Director of Drug Development for Florida Cancer Specialists & Research Institute and a member of ION’s Precision Medicine Advisory Panel, knows first-hand that precision medicine improves patient outcomes. According to Dr. Patel, there are several established therapies that have direct indications for the presence of particular mutations. For example, in patients with metastatic, non–small cell lung cancer, approximately 50 percent of patients’ tumors harbor a specific abnormality (e.g., EGFR, ALK, ROS1, BRAF, PD-L1) that could be treated with a targeted therapy. 1 Dr. Patel believes administering therapy based on known alterations in a patient’s cancer tissue is the essence of patient-directed therapy.

“I direct our Phase I program and have treated many patients who had particular mutations with targeted therapies. For example, several of these patients had IDH2, PI3K, ROS1, BRAF and Her 2 neu mutations that have responded well to targeted agents that were only available on clinical trials for their disease types. The mutation panels now include tumor mutational burden (TMB) and microsatellite instability (MSI), which has led to discovering patients who may benefit from immunotherapy either off or on a clinical trial. We have many patients who are responding well to immunotherapy who could only obtain access to those drugs on a clinical trial after finding a high TMB score,” says Dr. Patel.

The need for precision medicine trials is increasing in the community setting, where 85 percent of patients with cancer are treated, as more patient-directed therapy approaches are developed. As the inclusion and exclusion criteria for these trials become more specific based on the patient population needed, molecular testing should be a consideration for every cancer patient who presents with an oncology diagnosis.

“As far as clinical trials go, the focus is really starting to get specific and narrowed down,” says Kelli Martin, RN, certified clinical research coordinator at St. Louis Cancer Care. You’re looking at this smaller population of people because these mutations are not that common. So, the opportunities are certainly there; however, it is difficult for our practice to really participate because we might only see one or two patients in a year with that particular mutation.”

Community-based practices wanting to expand an existing research program to include precision medicine trials face unique barriers beyond patient population. Such challenges include understanding who should be tested (appropriate patients), when and what should be tested (timing of testing and the specimens needed to properly perform molecular tests, such as tissue or blood samples), and identifying which molecular tests should be considered. Clinicians also face challenges related to the interpretation of test results and determining actionability, efficiently and effectively identifying clinical trial eligibility, and working with the broader team to address the operational hurdles that exist (financial support, prior authorization, timeliness
of results and sufficient samples to name a few). Providers can learn which test to select for particular mutations or alterations based on disease type on ION Solutions’ Precision Medicine Center at www.iononline.com, but some community practices will need to seek support from industry partners to meet the needs of a clinical trial program.

For help identifying available clinical trials and determining trial eligibility, practices can leverage the AdvanceIQ Network to be connected with life sciences partners offering trials or practices treating patients who meet specific trial criteria. Ganiat Mumuney, IntrinsiQ Specialty Solutions’ Senior Manager, Clinical Research, says the network aims to not only enhance clinical trial matching and capitalize on new innovative trial recruitment solutions but also connect qualified patients to the most advanced therapies available today.

The AdvanceIQ Network also is a resource for practices interested in starting a clinical research program, and more programs are needed in order to increase enrollment in clinical trials. A recent study by a research team from the Fred Hutchinson Cancer Research Center, Columbia University Irving Medical Center and the American Cancer Society Cancer Action Network (AHS CAN) found that 56 percent of patients did not have a trial available to them where they receive care. Approximately 80 percent of patients with cancer do not consider clinical trial participation because they are unaware of the option.

AdvanceIQ Network’s streamlined, regulation-compliant and technology-enabled approach to identifying, qualifying and enrolling patients in clinical trials makes it easier for practices to participate in clinical trials. In addition, practices that join the AdvanceIQ Network have access to a wide range of research opportunities that can advance the quality of patient care:

- On- and off-site sponsored trials
- Investigator-sponsored research
- Prospective patient registry studies
- Retrospective health economics and outcomes research (HEOR)
- Evidence panel studies

Participation in the AdvanceIQ Network also gives practices the ability to connect with other practices that have similar research challenges and collaborate with institutions to broaden research offerings. Martin says it’s important to have these connections to provide patients with treatment options.

“If we don’t have a clinical trial to offer a patient, we work with other institutions in the area to see if there’s something available,” says Martin.

To learn more about starting or expanding the clinical research program in your practice, email advanceIQ@intrinsiq.com.

1. Ersek J, Black L, Thompson M, Kim E, Implementing Precision Medicine Programs and Clinical Trials in the Community-Based Oncology Practice: Barriers and Best Practices. 2018 ASCO Educational Book 188
Gain access to clinical trials and research with AdvanceIQ Network

Identifying patients required for clinical trials and research is an ongoing challenge. When your practice joins AdvanceIQ Network, you will engage with other community-based, oncology practices to connect qualified patients with the most advanced therapies available today.

**Key Benefits**

- Connection to our community-based network of practices that have similar research challenges and needs
- Improved access to research opportunities through our network of life sciences partners
- Streamlined, regulation-compliant and technology-enabled approach to identifying, qualifying and enrolling patients in clinical trials
- Ongoing educational opportunities about evolving research methods
- Innovative approaches to address research challenges

For more information, email advanceIQ@IntrinsicIQ.com.
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- Monitor compliance to reduce audit risk
- Utilize robust analytics to support success in value-based payment models such as the Oncology Care Model (OCM)

For more information, email info@InfoDive.com
## 2020 Meeting Schedule

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Monitoring Precision Medicine Testing Adoption Progress
By Susan Weidner
Since ION Solutions launched its precision medicine testing recommendations in September 2018, the Precision Medicine Advisory Panel has continued to evolve the educational topics and testing recommendations to align with the evolution of oncology care. In one year, the number of testing recommendations found on the Precision Medicine Center has grown to nine and now includes head and neck, multiple myeloma and leukemia.

The goal of ION Solutions’ precision medicine program is to facilitate and drive the adoption of appropriate biomarker testing. With the use of testing recommendations and proactive education, we have seen significant improvement in one of our largest patient populations, those diagnosed with advanced or metastatic non-small cell lung cancer (NSCLC). These improvements have been measured through annual surveys of providers treating this patient cohort.

Initially less than 30 percent of survey participants were always requesting tissue-based molecular testing prior to starting first-line therapy. This has increased to more than 70 percent within the last 18 months. Approximately 95 percent of respondents never or infrequently considered both tumor- and peripheral blood-based testing. Though we have seen improvements where at least 25 percent are ordering both always or frequently.

Timing of test results is very important within this patient population as patients could receive either immuno-oncology (IO) or targeted therapies. If a patient has an EGFR or BRAF mutation, then initiating IO therapies can be detrimental from a patient outcome perspective. Thus, it is very important to wait to initiate therapy until all results are back, especially since PD-L1 results typically have a quicker turnaround time. In year one, more than 50 percent of survey respondents would initiate therapy before the tests were received. We have seen a significant improvement where more than 70 percent never or rarely start therapy ahead of result availability.

There are still areas for continued improvement. One area is the inability to receive testing results due to insufficient sample availability. Initially more than 40 percent of tests were not completed for this reason. Now the majority see this occurring in less than 25 percent of test submissions. This is a significant limitation from a community perspective as they do not have direct control over the sample acquisition or provision process. Continuing education with their local surgeons and pathologists is a must to continue to make strides in this area.

Another area is the coverage of biomarkers that can be tested. When we initiated the program, more than 60 percent of our survey participants were limited to only a small, actionable set of mutations via next generation sequencing (NGS). Now more than 50 percent of respondents can complete comprehensive NGS testing.

In addition to the increased adoption of genetic testing, we have witnessed encouraging things on our journey to personalized care, including the continued declining cost of genetic sequencing, which allows more patients to be tested, and more targeted therapies coming to the marketplace. Through continuing education and quality initiatives, we will maintain and demonstrate further improvements in testing adoption and appropriate utilization.

Susan Weidner currently serves as Senior Vice President, IntrinsiQ Specialty Solutions.
The Oncology Care Model
Value Proposition
Seeking the Win/Win/Win for Patients, Practices, Payers

By Cindy Sanders, Publisher & Managing Editor, Nashville Medical News
The southeastern regional VB-Onc™ meeting was held in Nashville in October, and Philadelphia hosted Patient-Centered Oncology Care 2019 on Nov. 8. Nashville co-chair Stephen Schleicher, MD, MBA, a medical oncologist with Tennessee Oncology, and Philadelphia co-chair Kashyap Patel, MD, a partner with Carolina Blood & Cancer Care Associates and associate-editor-in-chief of AJMC, recently made time to update Medical News on the progress and challenges to delivering patient-focused, value-based care to cancer patients.

“2016 launched the first cancer-specific, value-based payment model called the Oncology Care Model,” Schleicher said of the national CMS Innovation Center pilot. “There are about 185 practices involved, and the vast majority are community-based practices,” he continued, adding a handful of academic medical centers, including University of Alabama Birmingham and Vanderbilt University Medical Center in the Southeast, are also involved.

At this point in the move from fee-for-service to value-based reimbursement, everyone in healthcare is familiar with the triple aim of improving the patient care experience, improving the health of populations and reducing the per capita cost of care delivery. Yet, buying into the principles and putting them into practical application continue to be challenging for many providers.

To address the disconnect and discuss the latest trends in delivering the most effective, cost efficient, patient-centered care, the American Journal of Managed Care® (AJMC) and its Institute for Value-Based Medicine® host regional and national conferences to share insights on payment reform and patient care initiatives and at the intersection clinical, operational and financial performance.

“We feel by providing patient-centered care, it has allowed us to fulfill our purpose as a doctor. At the end of the day, we all have a purpose. I see myself as not just a dispenser of medicine but as a healer.”

-KASHYAP PATEL, MD

Value-Based Care

“2016 launched the first cancer-specific, value-based payment model called the Oncology Care Model,” Schleicher said of the national CMS Innovation Center pilot. “There are about 185 practices involved, and the vast majority are community-based practices,” he continued, adding a handful of academic medical centers, including University of Alabama Birmingham and Vanderbilt University Medical Center in the Southeast, are also involved.
While the goal of the Oncology Care Model (OCM) is to save dollars while providing high-quality, coordinated care, Schleicher said there is an absolute ‘patients first’ mentality. With many novel oncologic drugs costing thousands of dollars, Schleicher stressed OCM doesn’t look to restrict effective treatment but rather to find savings elsewhere.

“First, when there’s a drug that comes out that is FDA approved that we know has beneficial properties for a patient - right patient, right time - we’ll do everything to ensure that drug is administered,” he said. “Where two drugs with equal efficacy are available where there is a big cost difference, the goal is to use the one that’s less expensive as long as there are no additional side effects.”

Schleicher continued, “The challenge is a lot of payers think there are many more times in a patient’s treatment when there are two options that are of equal efficacy ... but that is the exception rather than the rule.”

Instead, the focus is on care coordination to try to keep patients comfortable and progressing in their treatment plan in the home and clinic rather than higher acuity settings.

“It’s better to keep the patient out of the hospital, and it’s higher value care to do that,” Schleicher pointed out. “It’s best for the patient and for society.”

He added deploying palliative care with a focus on symptom control, using analytics to parse reported patient outcomes and improving communication and care coordination to holistically manage patients are a few of the innovative tools being used to bend the cost curve.

The recent regional VB-Onc conference drew attendees from the back office to the front lines of care to bring everyone up to speed on where things stand with OCM and discuss the larger challenges to succeed in a value-based delivery model.

“The Oncology Care Model is a five-year pilot, so it ends in 2021,” Schleicher noted. However, he speculated CMS would either extend the model or move to something more substantial like a bundle payment. “I don’t see anyone in the government or commercial payers backing away from value-based care anytime soon.” He added, “Patients are already overwhelmed with their diagnosis and treatment. Anything we can do to limit unnecessary financial strains on patients I think we all agree is important.”

For practices that haven’t yet dipped their toes into the value-based waters, Schleicher said it might not be an optional course in the future. While OCM was a voluntary program, he pointed out the new radiation oncology bundle is mandatory.

The problem for many smaller practices is a lack of resources and infrastructure to effectively participate in an analytics-intense model. “We’re not good at understanding our costs, and that’s the first step in value-based care,” he noted. “It really takes analytical tools to understand how you are doing among your peers and your colleagues nationally.”

In addition to understanding costs, he said measuring how you are doing on pathway adherence, understanding the patient experience, and taking a hard look at dispensing futile care at the end-of-life are all important aspects of value-based care. Schleicher, who also serves as chair of the quality and value committee for OneOncology said the impetus behind creating a national network for community-based oncology practices was to leverage economies of scale, intellect and expert knowledge to help practices prosper in this new model while maintaining their independence as a private practice.

“Unfortunately, practices that are on their own might not have the expertise or resources to adapt to value-based care. For small practices, that’s where larger, innovative groups like OneOncology can add tremendous value,” Schleicher said. “We’re all in this together for our patients ... we’re not competitors in this space.”
Patient-Centered Care

The Philadelphia conference turned the focus to the patient in the middle of the Oncology Care Model. As an OCM site, Patel has seen how putting the model into action is a win/win for patients and providers at Carolina Blood & Cancer Care Associates. “Once we were designated by Medicare as an Oncology Care Model participant, we got additional funding which allowed extra investment in care coordination and expanded access,” he noted.

Not only did the practice purchase a new CT scan and start offering clinical trials, but they also invested in ancillary services in the clinic including in-house spiritual and hospice counseling, nutritional services and yoga sessions.

Patel said, “We keep two open slots at the clinic every day so if a patient needs to be seen, they don’t have to wait two to three weeks for an appointment. We see patients as they need to be seen.” As a result, he continued, “We’re able to reduce the likelihood of a patient going to the ER after hours, which works best for the patient ... and for us.

“The patient doesn’t have to waste seven to eight hours of their life (in the ER), and I don’t have to round early the next morning,” Patel added with a chuckle. “Our patient satisfaction rate has gone up to the top tier in the 80-90 percentile.”

While the physicians love not going to the hospital as much, the change runs much deeper than that. “It’s a win/ win for everyone,” Patel explained. “We feel by providing patient-centered care, it has allowed us to fulfill our purpose as a doctor. At the end of the day, we all have a purpose. I see myself as not just a dispenser of medicine but as a healer.”

By taking the holistic view, he said clinicians now really see patients as human beings with aspirations and expectations. “We broke all the silos. Instead of seeing the compartments, we now see the whole patient. We’ve become part of the patient’s microecosystem.”

In addition to the increased satisfaction levels, Patel said the feedback the practice receives every six months from CMS shows a third win ... lowered cost. “We reduced our hospitalizations by about 30 percent and reduced the total cost of care by about 17 percent,” he said. “About 50 cents on every dollar in oncology is spent in hospital-related services, but if you reduce the number of patients going to the hospital, it will significantly bend the cost curve,” he concluded.

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HICN use Discontinued, Practices Must use MBI for Medicare Reimbursement

For almost two years, The Centers for Medicare & Medicaid Services (CMS) issued MBIs (Medicare Beneficiary Identifiers) to Medicare recipients, replacing the Health Insurance Claim Number (HICN).

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required CMS to remove Social Security numbers (SSN) from all Medicare cards by April 2019. CMS replaced the HICN with a new, randomly generated MBI.

The MBI has 11 characters, like the HICN, which can have up to 11. Each MBI is randomly generated which makes MBIs different than HICNs, which are based on the SSNs of Medicare recipients. MBI characters are “non-intelligent” so they don’t have any hidden or special meaning.

As a reminder, each person with Medicare will get his/her own randomly generated MBI. Spouses or dependents who may have had similar HICNs will each get their own different MBIs.

The Railroad Retirement Board (RRB) also mailed new Medicare cards with MBIs. The RRB logo will be in the upper left corner and “Railroad Retirement Board” at the bottom, but you can’t tell from looking at the MBI if your patient is eligible for Medicare because they’re a railroad retiree. You’ll be able to identify them by the RRB logo on their card, and CMS will return a “Railroad Retirement Medicare Beneficiary” message on the Fee-For-Service (FFS) MBI eligibility transaction response.

CMS ended the MBI transition period on Dec. 31, 2019. Starting on Jan. 1, 2020, regardless of the date of service, Medicare transactions will be rejected if the MBI is not used. There are a few Medicare plan exceptions, including appeals; some adjustments (Drug Data Processing, Risk Adjustment Processing and Encounter Data); and Retrospective Reporting.

To learn more, visit CMS at: https://www.cms.gov/medicare/new-medicare-card/index

Texas Voters Approve $3B for Cancer Research

On Nov. 5, Texas voters approved a ballot initiative to provide $3 billion in additional funding to the Cancer Prevention and Research Institute of Texas (CPRIT). This achievement is the result of a passionate campaign spearheaded by the American Cancer Society Cancer Action Network (ACS-CAN) in Texas, and will enable CPRIT to continue funding scientific research for cancer care and prevention for at least 10 more years. Nearly 5 million clinical services have been provided to Texans via CPRIT, creating more than 98,000 jobs.

Following Steve Collis’ leadership, AmerisourceBergen has a strong history of advocating for policies to support cancer patients and their providers. Steve is a founding Vice Chairman of ACS’ CEOs Against Cancer Pennsylvania chapter, and he also serves on ACS’ Global Council for CEOs Against Cancer. The ABC Government Affairs team worked with Barry Fortner, Senior Vice President and President Specialty Physician Services, who serves on the ACS CEOs Against Cancer Texas chapter and with ACS-CAN Texas leadership to support this critical initiative, garnering support from several legislators with strong ABC ties including State Sens. Jane Nelson (R-12), Kirk Watson (D-14) and Rep. John Zerwas (R-28).
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