ONCOLOGY

Nationwide and West Region Cancer Care Report

2011–2012 Edition

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Introduction

Sanofi-aventis is pleased to present the sanofi-aventis Nationwide and West Region Cancer Care Report, 2011-2012 Edition. This is one of five sanofi-aventis regional reports that explore current clinical and business practices in oncology and their likely evolution over the next few years. This year's edition includes a close look at the management of breast cancer, colorectal cancer, and prostate cancer.

Cancer is the second leading cause of death in the United States, and treatment is characterized by regional variations in patient demographics, the provision of care, costs of care, and outcomes. The five unique Cancer Care Reports draw data from areas designated as the West, Northeast, Central, Southeast, and Southwest Regions of the United States. Each report compares regional data with information gathered nationwide, offering readers the opportunity to compare their experiences with those of colleagues across the United States.

Preserving patient access to quality patient care is a key shared objective of oncologists and health plan executives. This three-part report examines current therapies in the treatment of breast cancer, colorectal cancer, and prostate cancer, and also examines clinical, business, and managed care practices that affect care delivery, costs, and patient access to care for each of the five regions.

Part 1 of each regional report consists of three sections analyzing SDI claims data on breast cancer, colorectal cancer, and prostate cancer treatments. Findings are presented both for the region and nationwide on the selection of chemotherapy and biologic treatments, payment for treatments, the practice setting where care is delivered (hospital or physician's office), and associated charges.

In Part 2, findings from a survey of oncology practices are presented on care delivery, business management, reimbursement issues, relations with health plans, and treatments for breast cancer, colorectal cancer, and prostate cancer. Regional and nationwide responses are compared.

In Part 3, managed care executives are surveyed and results presented on preferred care settings, reimbursement issues, relations with oncologists, and coverage policies for breast cancer, prostate cancer, and colorectal cancer treatments. Three types of responses are compared: regional responses, nationwide averages, and responses of health plans serving a national market.

Your sanofi-aventis account manager will be happy to provide you with any of the other four regional reports, or with additional information on oncology care in the West Region.

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Executive Summary

Highlights from the data analyses and survey findings:

West Region and Nationwide Averages Compared

- The West Region slightly lagged the nation as a whole in the proportion of patients with early stage diagnoses of breast cancer in both the hospital outpatient setting and in physicians' offices. By payer, the West Region had a much larger proportion than nationwide of patients covered by payers other than Medicare, Medicaid, and commercial insurers, including government employee, military and railroad retirement plans and cash payers, particularly for care delivered in the hospital outpatient setting.
- The West Region also slightly lagged the nation as a whole in the percentage of colorectal cancer patients with early-stage diagnoses, by both payer and treatment setting. Again, the West Region had a much larger proportion of patients covered by "other" payers.
- The West Region had the lowest percentages of early diagnoses of prostate cancer for patients seen in physicians' offices or hospital outpatient settings of all the five regions.
- Nearly half of West Region and nationwide oncology practices are organized as private, single specialty practices (46% for both). The West Region has a smaller proportion (15% vs 20%) of hospital-owned practices.
- West Region practices are slightly smaller than average practices nationwide. Sixty-four percent of West Region practices are staffed by 5 or fewer oncologists compared with two-thirds nationwide. While 21% of practices are operated by solo practitioners in the West Region, compared with 18% nationwide, the West Region also has a greater proportion of practices with ten or more oncologists (18% vs 12%).
- Over the next five years, 64% of West Region practices anticipate no changes in their business structure, compared with 54% of practices nationwide.

Electronic Medical Records (EMRs)

- West Region practices lead practices nationwide (54% vs 44%) and all other regions in the implementation of EMRs.
- EMRs are primarily used for routine business functions both in the West Region and nationwide. EMRs are used by an average of one-quarter of practices for tracking patient outcomes, and by one-third for practice management reporting. More than half of applications are for billing, medical notes, electronic imaging, and laboratory results.

Early versus Late Diagnosis

- Most patients with a diagnosis of early stage breast cancer, colorectal cancer, and prostate cancer are seen in hospital outpatient settings. Among breast cancer patients in the West Region, 88% in the outpatient setting (90% nationwide) and 72% in physicians' offices (74% nationwide) were diagnosed with early stage disease. Among colorectal cancer patients, 85% in the outpatient setting (87% nationwide) and 56% in physicians' offices (59% nationwide) were diagnosed with early stage disease. Among prostate cancer patients, 94% in the outpatient setting (96% nationwide) and 57% in physicians' offices (63% nationwide) were diagnosed with early stage disease.
- Of patients seen in physicians' offices, both in the West Region and nationwide, the proportion diagnosed with early stage cancer was higher for breast cancer (72% West Region, 74% nationwide) than for either colorectal cancer (56%, 59%, respectively) or prostate cancer (57%, 63%).
- The hospital outpatient proportion of patients with an early diagnosis in the West Region or nationwide was higher for prostate cancer (94% West Region, 96% nationwide), than for breast cancer (88%, 90%, respectively), or colorectal cancer (85%, 87%).
- Patients covered under Medicaid had the highest proportion of late stage diagnosis or metastatic disease compared with patients covered by Medicare or commercial insurance. Only 61% of Medicaid breast cancer patients in the West Region (62% nationwide) had a diagnosis of early stage cancer versus 70% of commercially insured patients (75% nationwide) and 75% covered under Medicare (73% nationwide). Only 45% of Medicaid patients with colorectal cancer in the West Region (45% nationwide) had a diagnosis of early stage disease, compared with 52% of commercially insured patients (58% nationwide) and 59% covered under Medicare (62% nationwide). Only 35% of Medicaid patients in the West Region (37% nationwide) had a diagnosis of early stage prostate cancer versus 54% of patients covered under Medicare (60% nationwide) and 64% of commercially insured patients (70% nationwide).

Care Delivery

- The favored cancer care delivery locations for West Region plans are a community physician's office (3.4 on a scale of 1 to 5, with 5 equaling most preferred), followed by a preferred provider contracted for specific cancer care services (3.2).
- About two-thirds of all plans nationwide and plans with national coverage, but 76% of West Region plans, report that they are actively managing cancer care in their medical and pharmacy benefit plans.
- While oncology practices do accept specialty pharmacy drugs in their practice, such utilization occurs only under specific situations, eg, for selected drugs, or for specific payers under limited circumstances.
- The most frequently cited reason by West Region practices (50%) and oncologists nationwide (45%) for using specialty pharmacies is that the commercial payer requires their use. A significant majority (West Region, 79%; nationwide, 75%) state that they would not accept drugs from a specialty pharmacy for use in their practice without a signed liability waiver.
- Over half of practices nationwide report that they encourage the use of clinical guidelines, most frequently those of the National Comprehensive Cancer Network. The use of guidelines is required in 18% of practices (for prostate, head and neck cancers) to 25% (for breast cancer).

Reimbursement Policies

- Nationwide, the largest portion of breast cancer patients treated in physicians' offices or in the hospital outpatient setting was covered by commercial insurance (physicians' offices, 53%; hospital outpatient settings, 50%). In the West Region, commercial insurance was the dominant payer for breast cancer patients seen in physicians' offices, but for patients seen in hospital outpatient settings, 41% were covered by "other" payers. Nationwide, the largest portion of colorectal cancer patients was covered by Medicare (50% in physicians' offices, 35%,in the hospital outpatient setting). In the West Region, commercial insurance accounted for 42% of colorectal cancer patients seen in physicians' offices, but in hospital outpatient settings 45% were covered by "other" payers. The largest portion of prostate cancer patients was covered by Medicare, both nationwide (66%, 50%, respectively) and in the West Region (62%, 43%).
- Plans with national coverage (56%) report greater interest of employers seeking to participate in determining oncology reimbursement policy than do other plan types.
- Of the 17% of practices nationwide that calculate the reimbursement rate for professional services sufficient to cover costs of care delivery by using Medicare rates as a basis, 22% (33% of West Region practices), suggest that professional fees from private plans equivalent to 50% over Medicare rates would be considered fair, while 56% of practices nationwide suggest higher amounts. In the West Region 67% of practices say reimbursement for professional services of 200% over Medicare rates would be adequate. In contrast, 44% of all plans nationwide see Medicare rates as sufficient.
- Practices nationwide and in the West Region report that drug reimbursement formulas under the medical benefit of average sales price (ASP) plus 6% are most common. The most frequently used drug reimbursement rate for all plans nationwide and plans with national coverage is ASP plus 6%. For West Region plans, ASP plus 6% is tied with ASP plus 7%-12% (18% each). Twenty-one percent of plans with national coverage report rates of ASP plus 13%-18%, whereas fewer practices report those payment rates (7% nationwide and 0% in the West Region). Another 21% of plans with national coverage report still using AWP≤15%, with 13% of practices in the West Region and 6% of practices nationwide reporting that rate. About 11% of practices report that they don't know their reimbursement rates, which could account for some of the differences.

The Business of Care Delivery

- About half of all oncology practices report seeing more patients than a year ago. More than half report a decrease in net profit for their practices in the same time period.
- Reimbursement formulas by private payers are presented to oncology practices with no possibility for negotiation, report one-third of practices nationwide and 30% of West Region practices. Another 30% of West Region practices agree with the statement: "We try to negotiate the fee schedule with payers but are generally unsuccessful."
- More than half (54%) of West Region practices and 42% nationwide don't know if the majority of their managed care contracts are profitable. Only 18% of West Region practices consider most contracts to be profitable, compared with 32% of practices nationwide.

Collaboration Among Oncologists and Health Plans

- West Region practices report the least interest of practices in all regions in participating in payer oncology-related programs involving hospitals, networks, other practices, or on their own.
- All plans nationwide show high interest (3.0, using a scale of 1 to 5) in collaborating with practices in tracking of off-label drug use, and survivorship management programs.
- Potential collaborative efforts with plans that have elicited high interest (3.1 to 3.4) among practices nationwide include: improvements in quality measures; end-of-life process; participation in the American Society of Clinical Oncology's Quality Oncology Practice Initiative (QOPI); advisory panel; and guidelines.

Oncologist vs Plan Perspectives on Breast Cancer

- Oncologists favor treatment with multiple agents.
- All plans nationwide most often indicate that they have no specific policy for treatment of breast cancer patients, while most plans with national coverage approve treatment only after prior authorization requirements are met. West Region plan responses are similar to those of all plans nationwide.
- Most oncologists (74%) and plans (79%) nationwide agree to provide life-long treatment for patients with positive hormone receptor findings and metastatic disease.
- Most physicians and plans would consider introducing discussion of palliative care with breast cancer patients by stage IV.

Oncologist vs Plan Perspectives on Prostate Cancer

- Treatment choices of West Region oncologists are similar to those nationwide for patients with localized prostate cancer. Most common treatments are: radical nerve sparing prostatectomy and IMRT.
- LHRH is prescribed by more than half of all oncologists for stage I and II prostate cancer, treated either surgically or with radiation.
- Plans, especially plans with national coverage, are more likely to require prior authorization for treating patients with stage III and IV disease than for treating early-stage prostate cancer.

Oncologist vs Plan Perspectives on Colorectal Cancer

- About one-third of all plans nationwide have no specific policy concerning a range of treatments. However, more than half of plans with national coverage require prior authorization regardless of treatment. West Region plans tend to favor prior authorization but to a lesser extent than plans with national coverage.
- While most plans agree that stage III is an appropriate time to discuss the need for palliative care, most oncologists would not have that discussion until stage IV.

Methodology

This report on oncology practice and trends compares national averages with data gathered from the West Region. Part 1 reports and interprets claims data for chemotherapy and biologic regimens used in the treatment of breast, colorectal, and prostate cancer. Part 2 presents findings from a survey of oncology practices, and Part 3 presents findings from a survey of health plan executives. Each of the other four reports in this series compares national averages with data gathered from the Northeast, Southeast, Central, or Southwest Region.

SDI Cancer Data Analyses

The SDI analyses of claims data in Part 1 focus specifically on breast, colorectal, and prostate cancers. Reporting is based on information obtained through the use of the standard Healthcare Common Procedure Coding System (HCPCS) utilizing J-codes for the billing of chemotherapy and biologics. These cancer data are obtained from two proprietary databases that are maintained by SDI Health, LLC. One database uses claims data from physicians' offices and clinics (CMS1500); the other is based on billed hospital charges (Charge Data Master). SDI uses algorithms to project its data to national and regional levels. These two datasets are viewed in parallel but not commingled. Data presented in this section of the report are drawn from both datasets.

In comparisons of charges for hospital outpatient care with charges for care based in physicians' offices, hospital overhead charges (pharmacy, imaging, etc.) in part account for the higher charges often reported in hospital outpatient settings. Moreover, charges reported from any site of service, in part, provide only a rough approximation of costs and payments. Hospitals and physicians' offices use the same billing codes, but reimbursement rates differ. Medication charges incurred in physicians' offices are usually paid at contracted rates, which can be lower than billed charges. Hospitals generally pay less for chemotherapy agents and are reimbursed at lower rates but include overhead costs in their charges.

The data-reporting period includes the full calendar years of 2008 and 2009, with a review of the patients' medical histories to assign breast, colorectal or prostate cancer diagnoses. Patients diagnosed with cancer but not receiving chemotherapy were included if they visited an oncologist or hematologist in the year reported. All patients receiving chemotherapy were included regardless of the specialty of the physician providing the therapy.

Oncology Practice Survey

To gain insights from the perspective of practicing oncologists, 165 oncology practices nationwide were surveyed on a range of clinical and business issues related to the care of cancer patients. Respondents were mainly oncologists/hematologists (74%), followed by practice administrators (7%), and others (19%), primarily surgical oncologists. Of the 165 survey respondents, 28 (17%) indicated that their practice was located in the West Region. Where appropriate, comparisons were made between averages nationwide and those of the West Region. The survey was conducted in July-August 2010.

The largest proportion, and similar percentages, of both West Region practices and practices nationwide were private, single specialty practices (46% for both). More than half of practices were staffed by 5 or fewer oncologists (64% in the West Region, 66% nationwide), with West Region practices more likely to be operated by solo practitioners (21% compared with 18% nationwide) and also more likely to be practices of 10 or more oncologists (18% vs 12% nationwide).

Patient insurance coverage patterns varied little between all regions nationwide and the West Region. Nationwide, oncology practices reported that almost half of patients were covered under Medicare (48% nationwide, 43% in the West Region), followed by commercial insurance (34% for both), 9% covered under Medicaid (12% in the West Region), 3% self-pay (4%, West Region), 3% indigent (2%, West Region), and 2% listed as "other" (5% in the West Region).

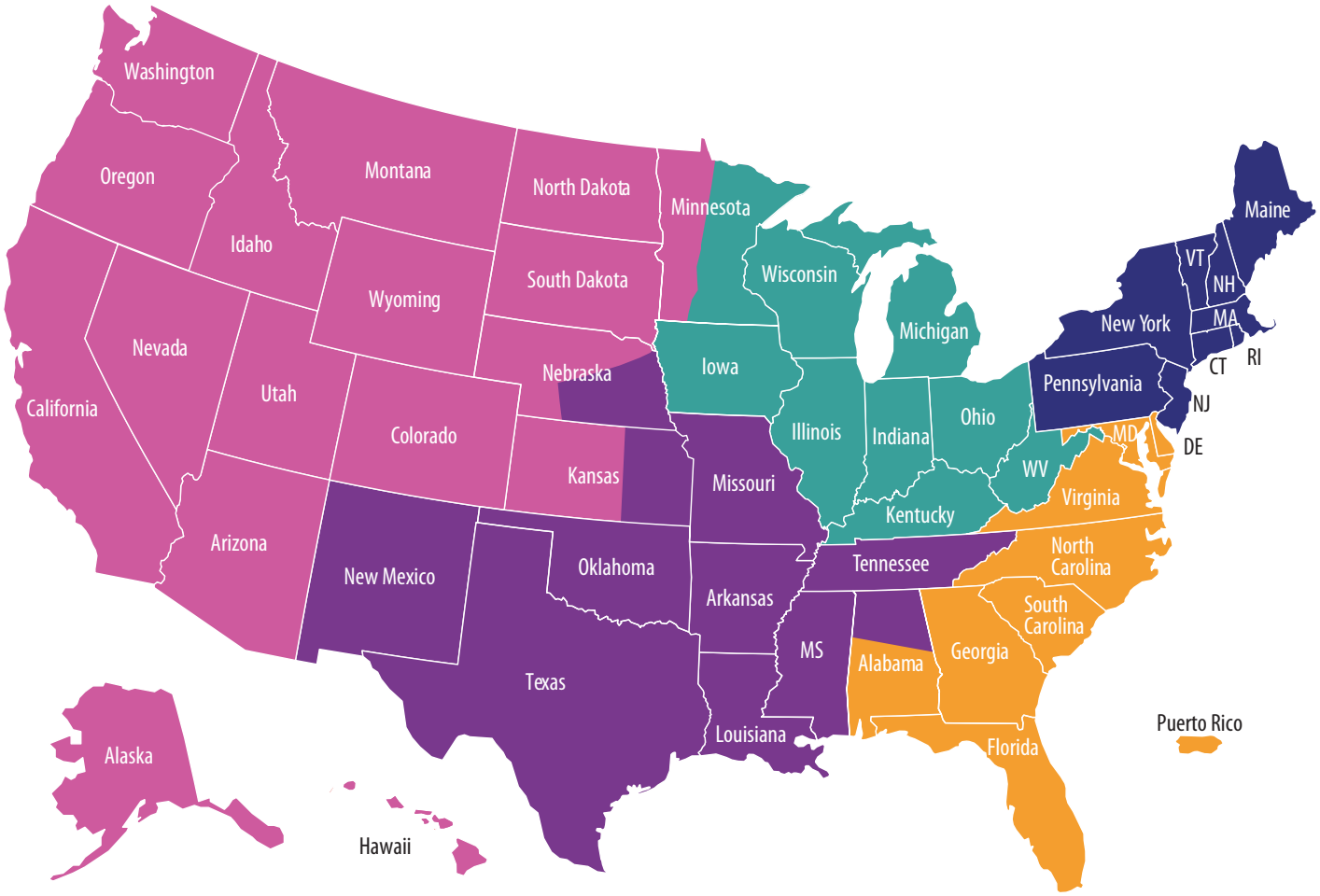
Managed Care Survey

The managed care survey was completed by 123 health plan executives nationwide: HMO/PPO pharmacy directors (39%), HMO/PPO medical directors (15%), managed care executives (9%), and others (37%), most of whom were clinical and staff pharmacists. Of the 123 survey respondents, 34 (28%) had members primarily in the West Region; 18 (15%) represented plans with national coverage. Some managed care organizations reported members in more than one region, resulting in a total of more than 100%. Three datasets are compared: all plans nationwide, plans that provide national coverage, and plans in the West Region. The managed care survey was conducted in July-September 2010.

The greatest proportion of West Region plan members were enrolled in HMOs (44%, the largest proportion for all regions), followed by Medicare (18%), Medicaid (17%), self-insured groups (9%), PPOs (8%), and other (5%). Proportions for all plans nationwide were similar for HMOs (34%), Medicare (21%), PPOs (16%), Medicaid (16%), and other (3%), though higher for self-insured groups (11%). Significantly more members of plans with national coverage were covered under Medicare (30%) and self-insured groups (19%), with far fewer covered under Medicaid (5%).

In some charts, percentage totals may not add up to 100% because of rounding.

Map of Regions



The regions of the five Oncology Nationwide and Regional Cancer Care Reports break generally at state lines, as shown on the map.

This report compares responses from the West Region to responses nationwide.

- Northeast
- Southeast
- Central
- Southwest
- West

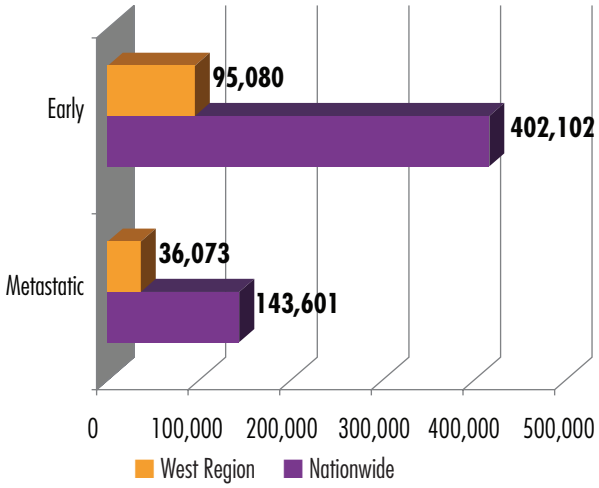
SDI Data on Patients with Breast Cancer

More than 2 million women living in the United States have been diagnosed with breast cancer at some point in their lives, and 1 in 8 women in the US will be diagnosed with breast cancer during her lifetime.[1] Breast cancer is initially suspected when a lump is discovered during an examination or mammography. A biopsy is used to confirm a cancer diagnosis. A breast cancer diagnosis is considered early stage when only a single cancer diagnosis has been made, while patients with metastatic disease have received both a primary diagnosis and a secondary cancer diagnosis.

The National Comprehensive Cancer Network (NCCN) provides consensus-based treatment guidelines at their Web site (www.nccn.org) that can be used, along with a practicing physician's clinical judgment, to establish a treatment plan. Under the NCCN guidelines, treatment for early stage localized breast cancer is surgical excision (lumpectomy or total mastectomy) possibly followed by risk reduction counseling, radiation therapy, genetic counseling, and tamoxifen treatment. Metastatic breast cancer is treated more comprehensively, following a workup that includes, among other considerations, determination of tumor estrogen/progesterone receptor status and HER2 (human epidermal growth factor gene) status to better predict disease aggressiveness and guide treatment options. The 5-year survival rate for female cancer patients during the period 1999 to 2006 relative to the general population was reported to be 89% overall, and 98% for those who received an early stage diagnosis.[1]

The data in Figures 1-6 include patients diagnosed with breast cancer in 2009, without regard to their treatment regimen. Figures 7-11 include data on chemotherapy and biologic treatment delivered in physicians' offices and hospital outpatient settings in 2009. Comparisons are made between national averages and those of the West Region. The accompanying text describes changes from 2008 to 2009.

Figure 1 Number of Patients with a Diagnosis of Breast Cancer Seen in Physicians' Offices



Treatment in Physicians' Offices

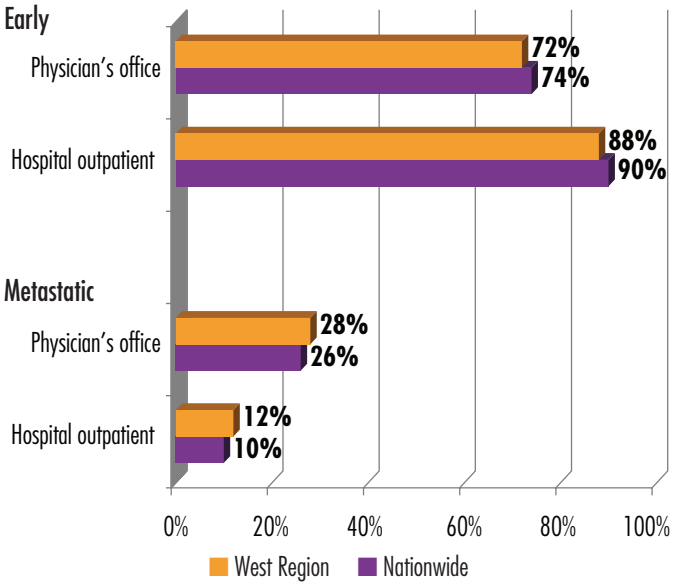
Almost 550,000 patients diagnosed with breast cancer were seen in oncologists' or hematologists' offices nationwide during 2009 (Figure 1). These patients may or may not have received chemotherapy during these visits. More than 130,000 (24%) of these patients were seen in the West Region.

Treatment by Setting and Cancer Stage

Nationwide in the hospital outpatient setting in 2009, of the 1.3 million patients with a breast cancer diagnosis receiving treatment, 90% were diagnosed at an early stage, while 10% were diagnosed with metastatic disease, up from 87% and 13%, respectively, in 2008 (Figure 2). In the West Region in 2009, 88% of patients receiving hospital outpatient treatment were diagnosed at an early stage, while 12% were diagnosed with metastatic disease, up from a ratio of 85% to 15% ratio in 2008. The West Region had the lowest percentage of early diagnoses treated in the outpatient setting in 2009 of any of the five regions examined.

Among the almost 550,000 patients nationwide with a breast cancer diagnosis receiving treatment in physicians'

Figure 2 Patients Diagnosed with Breast Cancer by Disease Stage and Treatment Setting

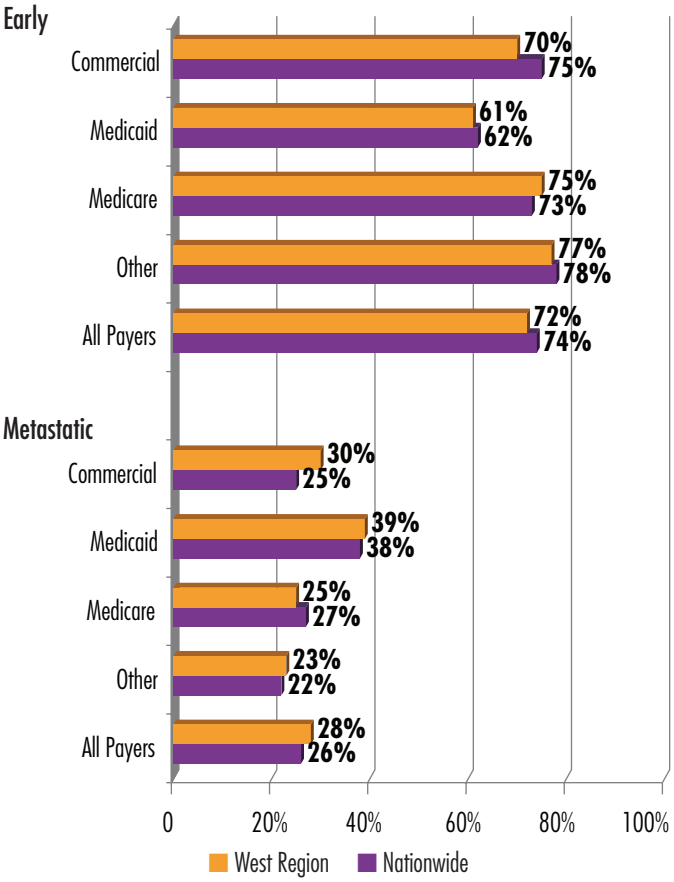


offices in 2009, 74% were diagnosed at an early stage while 26% were diagnosed with metastatic disease, the same percentages as in 2008. In the West Region, 72% of breast cancer patients treated in physicians' offices were diagnosed at an early stage while 28% were diagnosed with metastatic disease in both 2008 and 2009. The 2009 West Region proportions were the same as in the Southwest Region; the other three regions had higher percentages of patients with early diagnoses treated in physicians' offices. The proportion of cancer patients seen in physicians' offices was significantly higher for breast cancer patients than for patients with colorectal cancer or prostate cancer.

Patients Seen in Physicians' Offices by Disease Stage and Payer Type

Among patients seen in physicians' offices in 2008 and 2009 nationwide, commercially insured patients had consistently higher rates of early breast cancer diagnoses than those covered by Medicare or, most notably, Medicaid (Figure 3).

Figure 3 Patients with Breast Cancer Seen in Physicians' Offices, by Disease Stage and Payer



Nationwide in 2008 and 2009, 75% of commercially insured patients received an early-stage diagnosis. This compares with 73% of Medicare patients (72% in 2008) and 62% of Medicaid patients (61% in 2008). Lower rates of early diagnosis for persons covered under Medicaid are not surprising, says Dawn Holcombe, MBA, president of DGH Consulting. "Medicaid patients are more likely to have difficulty accessing care because of low provider reimbursement rates and/or patients may seek care on more of a reactive basis," she notes.

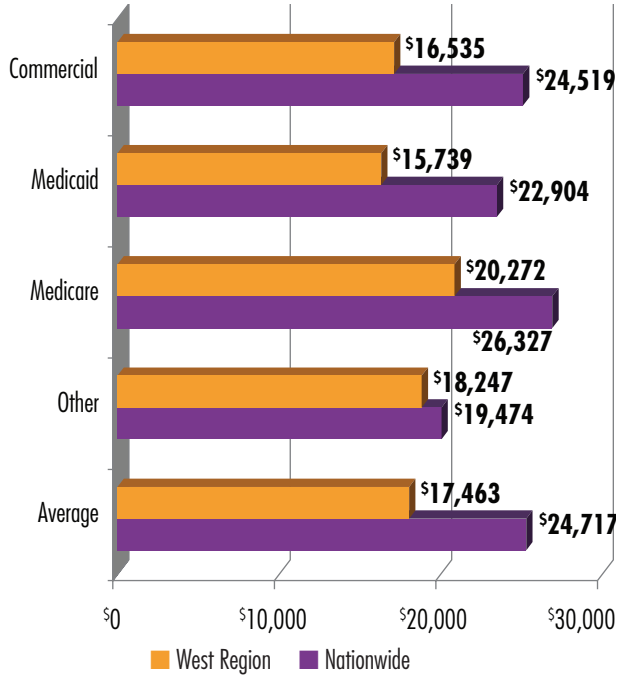
In the West Region, three-quarters of patients treated in physicians' offices in 2009 with Medicare as their payer received an early-stage diagnosis (73% in 2008), compared to 70% of commercially insured patients (unchanged from 2008) and 61% of Medicaid patients (62% in 2008).

Average Charges in Physicians' Offices, by Payer

Nationwide, the average charge per patient for treatment of breast cancer in a physician's office was $24,717 in 2009, similar to the 2008 average of $25,000 (Figure 4). In the West Region, the average charge in 2009 was $17,463, down 14% from the 2008 charge of $20,386.

The decrease in charges in the West Region was led by Medicaid, for which the average charge for treatment in a

Figure 4 Physician's Office Average Charges for Patients with Breast Cancer, by Payer



physician's office dropped 24% in 2009, followed by "other" payers (down 17%), commercial payers (down 16%) and Medicare (down 3%). Nationwide in 2009, the average charge for "other" payers was down 9%, and for commercial payers the average charge dropped 5%; Medicare and Medicaid saw increases of 7% and 3%, respectively.

Hospital Outpatient Charges

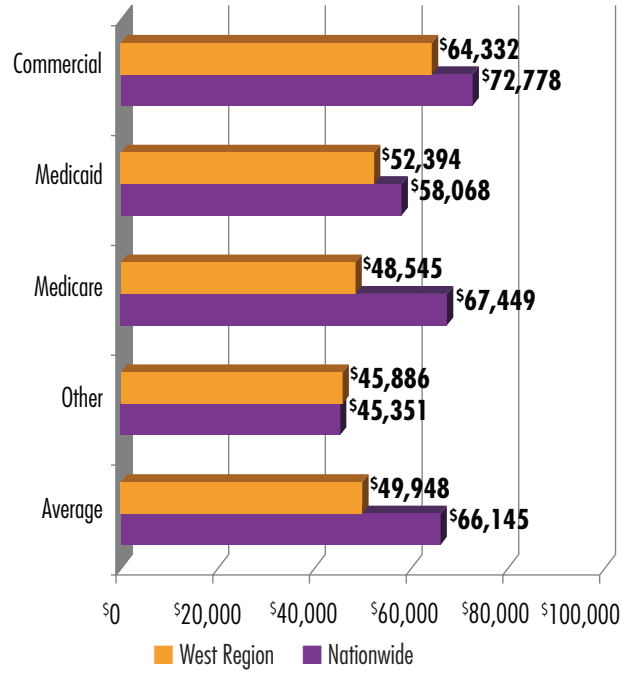
According to data from Charge Data Masters (CDM), 2009 total average charges for patients diagnosed with breast cancer were similar to those of 2008, both nationwide and in the West Region (Figure 5). The average charge to commercial payers, however, was up 25% in the West Region, to $64,332, and up 4% nationwide to $72,778. Medicare average charges were up 16% in the West Region, to $48,545, and down 3% nationwide to $67,449.

Increased charges in the West Region when commercial insurers or Medicare paid were offset by a 10% decline in the average charge for "other" payers in 2009.

Patients by Payer and Treatment Setting

Of the three major payers, commercial payers covered the largest portion of patients treated in physicians' offices and hospital outpatient settings in 2008 and 2009, in both the West Region and nationwide (Figure 6). Medicare covered the next largest portion, both in the West Region and nationwide.

Figure 5 Hospital Outpatient Average Charges for Patients with Breast Cancer, by Payer (CDM)



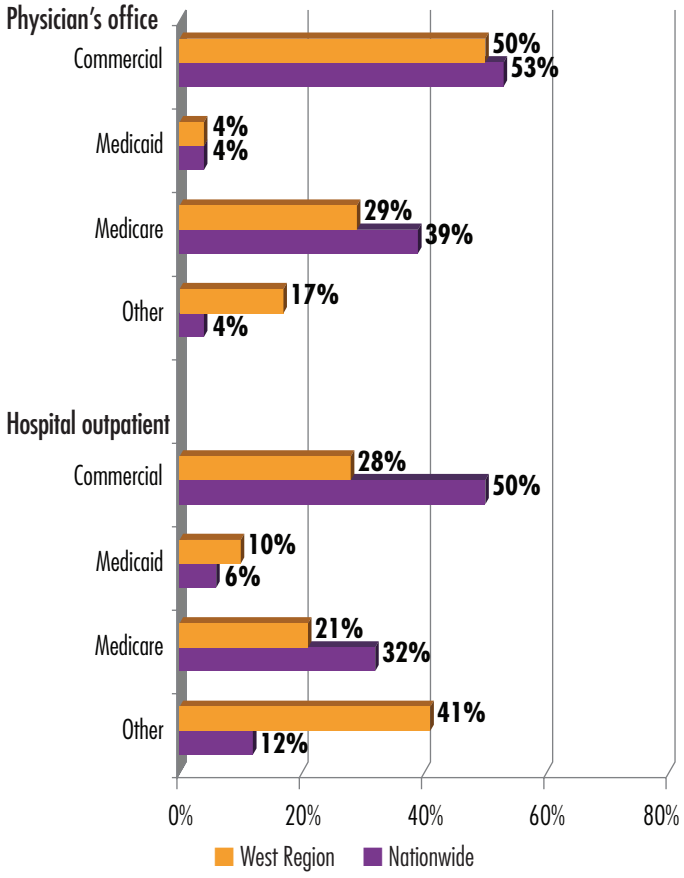
In the West Region in 2009, the "other" group, which includes government employee, military and railroad retirement plans as well as cash payers, had the highest percentage among all payers, 77%, of patients with early diagnoses seen in physicians' offices. Nationwide in 2009 only 4% of patients in physicians' offices had "other" as their payer type, compared to 17% in the West Region.

In 2009 the percentage of patients with breast cancer treated in physicians' offices and covered under Medicaid in the West Region was the same as nationwide (4%), but higher in the hospital outpatient setting in the West Region (10%), than nationwide (6%).

Compliance with NCCN Guidelines by Payer

The NCCN provides widely used guidelines for enhancing clinical decision-making, including recommendations for managing common symptoms experienced by patients with cancer. These guidelines include a set of early diagnostic steps for a number of cancers, including breast cancer, along with treatment recommendations that balance potential risks and benefits.

Figure 6 Patients with Breast Cancer by Treatment Setting and Payer



Chemotherapy and biologic treatments administered to breast cancer patients in physicians' offices are compared by payer type with those recommended in NCCN guidelines in Figure 7. Compliance with NCCN guidelines for all payer types in 2009 averaged 98% nationwide and in the West Region, both unchanged from 2008. Guideline compliance improved or was unchanged year-to-year for all payers nationwide, with the exception of Medicaid, which declined one percentage point. In the West Region, compliance declined one percentage point for commercial payers, Medicaid, and "other" payers, but increased one percentage point when Medicare was the payer.

Compliance with NCCN Guidelines by Treatment Setting

Nationwide, 98% of treatments in physicians' offices during 2009 were compliant with NCCN guidelines, unchanged from the previous year (Figure 8). In hospital outpatient settings only 87% of treatments were compliant, down from 94% in 2008.

Treatment Charges and Compliance with NCCN Guidelines

In hospital outpatient settings in 2009, noncompliance with NCCN guidelines for delivering care for breast cancer resulted in significantly elevated treatment charges nationwide, averaging $115,294 per patient, almost double the $58,784 charged for compliant care delivered in an outpatient setting (Figure 9). For care delivered in physicians' offices in 2009, however, per-patient charges for noncompliant care were reported as almost 40% lower than for compliant care ($15,446 and $24,864, respectively).

This difference may indicate the movement of the most complex/costly cases to hospital outpatient treatment settings. "The drop in the average charge for noncompliant breast cancer chemotherapy in physicians' offices may reflect retention of patients receiving noncompliant but less costly therapies," suggests Randy Vogenberg, PhD, RPh, principal, Institute for Integrated Healthcare. The impact on charges shown here, however, may be magnified because the number of treatments that fall outside NCCN guidelines is small in both treatment settings.

Figure 7 Breast Cancer Treatment Compliance with NCCN Guidelines in Physicians' Offices, by Payer

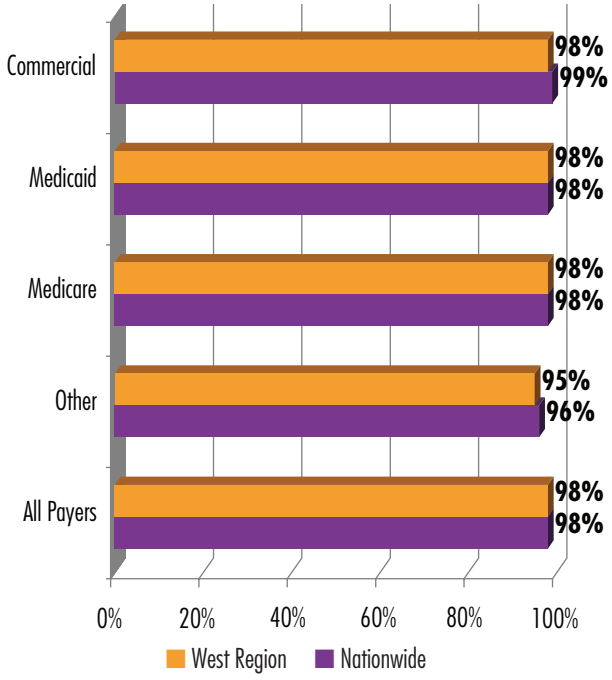


Figure 8 Breast Cancer Treatment Compliance with NCCN Guidelines, by Setting, Nationwide

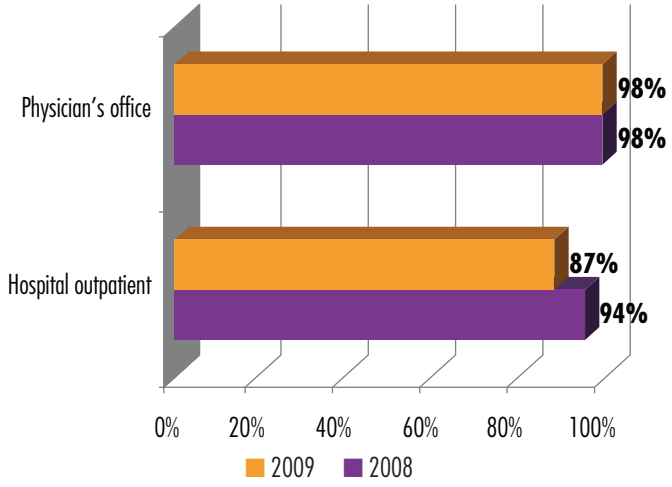
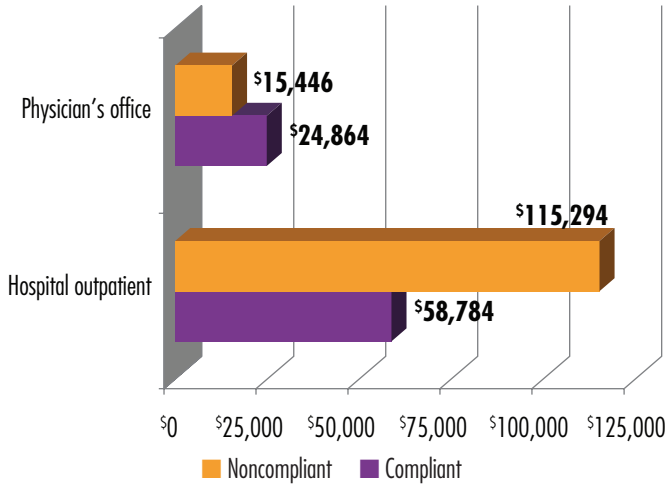


Figure 9 Average Charges for Breast Cancer Treatments, by NCCN Guideline Compliance, Nationwide

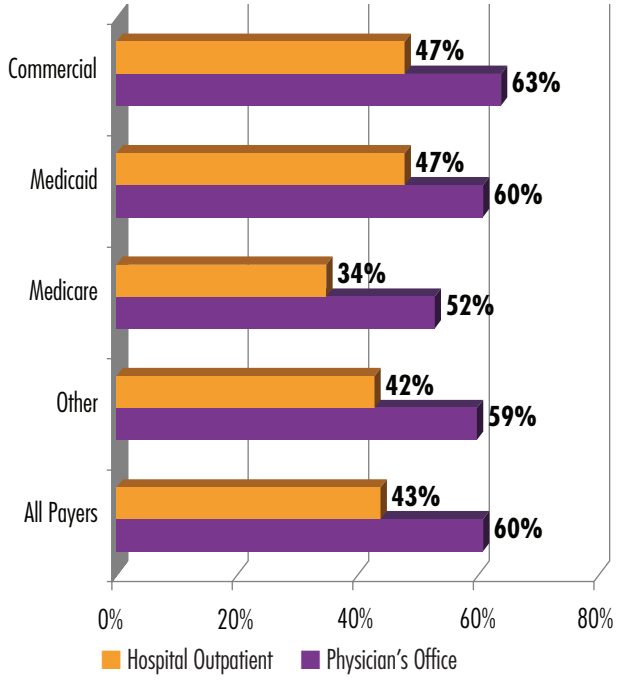


Use of the Top 5 Regimens

Nationwide, for breast cancer patients treated with chemotherapy and biologics in 2009, the five most prescribed treatment regimens accounted for 60% of treatments provided by physicians' offices (59% in 2008) and 43% (down from 63%) of treatments provided in outpatient hospital settings (Figure 10). The increased use in the hospital outpatient setting of treatments outside of the top regimens, treatments, which are typically more costly, may reflect successful efforts by physicians to shift more complex/challenging cases to hospital settings. While the percentage of use of the less costly top regimens remained similar from 2008 to 2009 in physicians' offices across payer types, it declined in hospital outpatient treatment settings by about 20 percentage points for each of the payer types examined, suggesting an increase in the number of more complex/challenging cases being treated.

"These data also reflect the decline of the buy-and-bill payment model," explains Vogenberg. "Physicians cannot finance the carrying costs of new, more expensive, therapies and have to move cases that require these treatments to hospital outpatient settings, or find new ways to address these cost challenges."

Figure 10 Breast Cancer Treatments Using Top 5 Regimens, by Setting and Payer, Nationwide



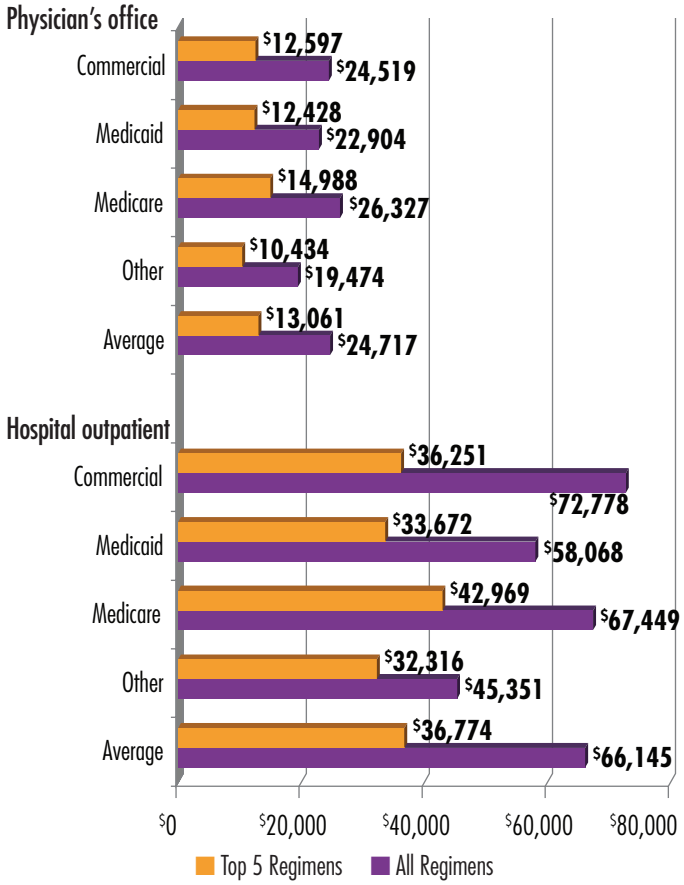
Treatment Charges for the Top 5 and All Regimens

Nationwide in 2009, average charges for treatment with all regimens were substantially higher than charges for the top five regimens in both physicians' offices (89% higher) and hospital outpatient settings, where they were 80% higher (Figure 11).

The 2009 average charge of $24,717 for all regimens in physician's offices was consistent year-to-year (down 1%), but in hospital outpatient settings the average charge for all regimens increased by $12,000 to $66,145 (up 22%). Year-to-year dollar changes were lower for the top regimens, which decreased about $1,000 to $13,061 (down 8%) in physicians' offices, and increased $12,000 to $36,774 (up 47%) in hospital outpatient settings.

Treatment in hospital outpatient settings, as previously noted, is typically associated with higher average charges than treatment delivered in physicians' offices. The large year-to-year increases in hospital charges, however, seem to indicate a shifting of complex/costly cases to this setting from physicians' offices.

Figure 11 Average Charges for Breast Cancer Regimens, by Setting and Payer, Nationwide



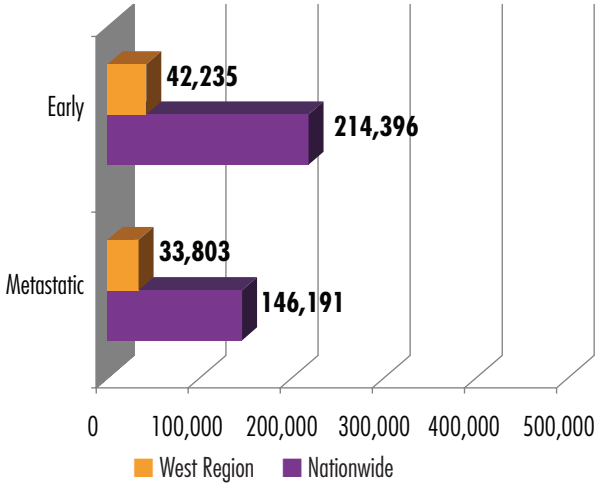
SDI Data on Patients with Colorectal Cancer

Colorectal cancer (cancer of the colon or rectum) is the third leading cause of cancer death for both men and women in the United States, with more than 140,000 new cases diagnosed each year.[2] The lifetime risk for men and women developing colorectal cancer is 1 in 20.[3] Approximately 39% of patients receive an early diagnosis (the disease is confined to the primary site) and among this group the 5-year survival rate relative to the general population is approximately 90%. The 5-year relative survival rate for the 37% of patients with regional lymph node involvement is almost 70%. For the 19% of patients diagnosed with late stage disease (the cancer has metastasized), the 5-year relative survival rate is below 12%.[3]

The National Comprehensive Cancer Network (NCCN) provides consensus-based treatment guidelines at their Web site (www.nccn.org) that can be used, along with a practicing physician's clinical judgment, to establish a treatment plan. Under the NCCN guidelines, the treatment for early stage localized colon or rectal cancer is surgical removal, followed by a minimum of 5 years of surveillance, including monitoring of carcinoembryonic antigen (CEA) levels and follow-up colonoscopies. At more advanced disease stages, radiation therapy and chemotherapy are introduced.

The data in Figures 12-17 include patients diagnosed with colorectal cancer in 2009, without regard to their treatment regimen. Figures 18-22 include data on chemotherapy and biologic treatments delivered in physicians' offices and hospital outpatient settings in 2009. Comparisons are made between national averages and those of the West Region. The accompanying text describes changes from 2008 to 2009.

Figure 12 Number of Patients with a Diagnosis of Colorectal Cancer Seen in Physicians' Offices



Treatment in Physicians' Offices

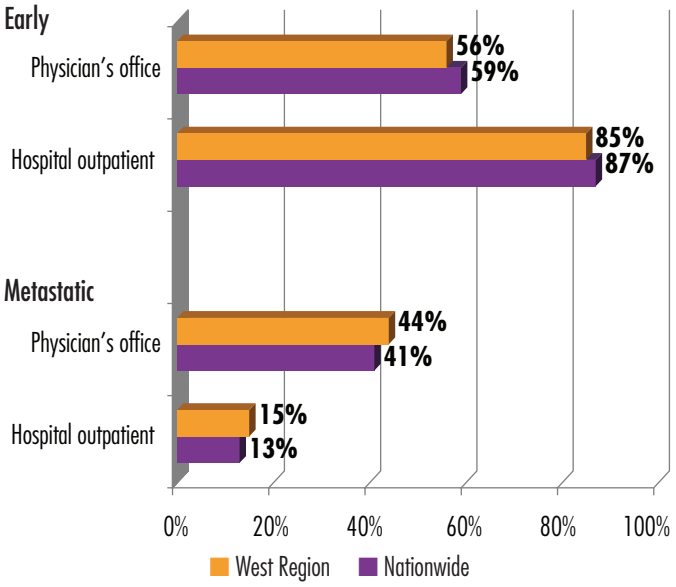
SDI reports that more than 360,000 persons diagnosed with colorectal cancer were seen in physicians' offices nationwide during 2009, a 2% increase over 2008 (Figure 12). The West Region accounted for more than 75,000 colorectal cancer patients seen in physicians' offices in 2009, up 3% from 2008 and representing 21% of the nationwide total in both 2008 and 2009.

Treatment by Setting and Cancer Stage

In 2009, almost 340,000 patients diagnosed with colorectal cancer were treated in hospital outpatient settings nationwide (Figure 13). Among this group, 87% were diagnosed at an early stage, while 13% were diagnosed with metastatic disease, an improvement over the previous year's early/metastatic proportions of 84% to 16%. In the West Region, the percentage of hospital outpatients with early diagnoses was 85%, the lowest proportion of the five regions. The West Region accounted for 15% of colorectal cancer patients treated in hospital outpatient settings nationwide in 2008 and 2009.

In 2009 in physicians' offices in the West Region, 56% of colorectal cancer patients treated were diagnosed at an early stage, while 44% were diagnosed with metastatic disease. Nationwide in physicians' offices, 60% were diagnosed early in 2008, and 59% in 2009. The West Region accounted for 21% of colorectal cancer patients treated in physicians' offices in both 2008 and 2009.

Figure 13 Patients Diagnosed with Colorectal Cancer by Disease Stage and Treatment Setting

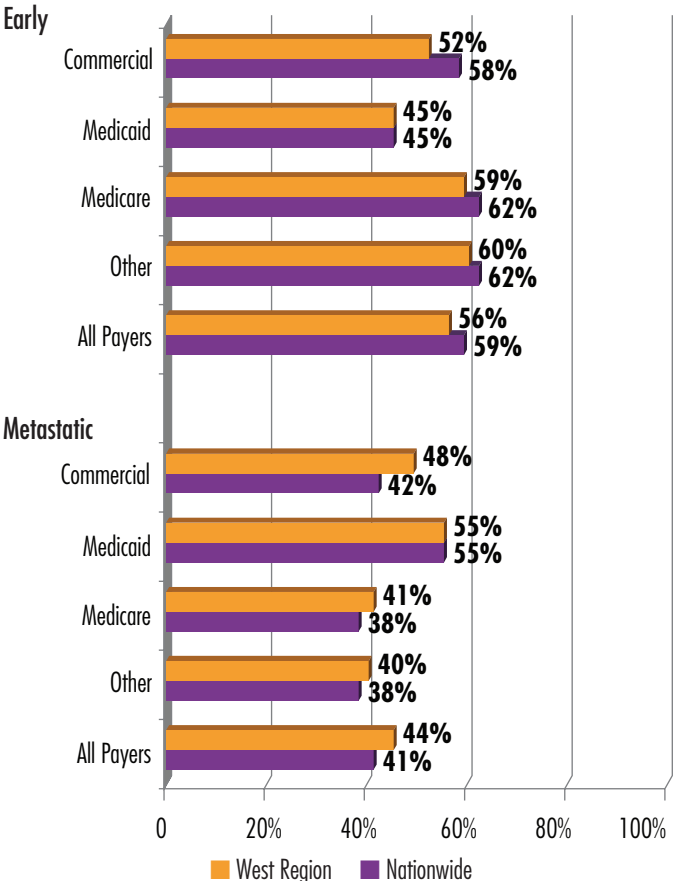


Patients in Physicians' Offices by Disease Stage and Payer Type

Nationwide in 2009, 62% of Medicare patients treated in physicians' offices received an early-stage colorectal cancer diagnosis (unchanged from 2008). This compares with 58% of commercially insured patients (also unchanged from 2008).

In the West Region in 2009, 59% of Medicare patients treated in physicians' offices received an early-stage diagnosis (58% in 2008), compared with 52% of commercially insured patients (unchanged from 2008). When Medicaid was the payer, only 45% of patients treated in physicians' offices received an early diagnosis nationwide or in the West Region during 2009.

Figure 14 Patients with Colorectal Cancer Seen in Physicians' Offices, by Disease Stage and Payer



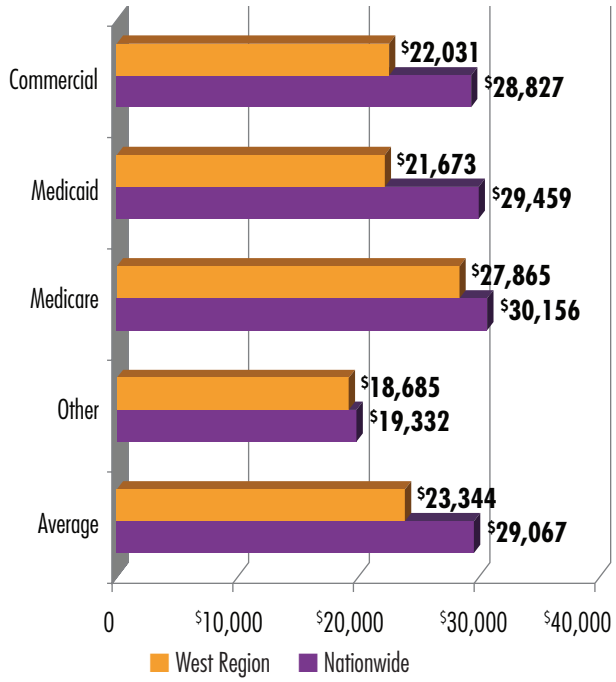
Average Charges in Physicians' Offices, by Payer

Nationwide, the average charge for treatment of colorectal cancer patients in physicians' offices was $29,067 in 2009, down 8% from the 2008 average of $31,674 (Figure 15). In the West Region the average charge in 2009 was $23,344, down 13% from the 2008 charge of $26,936.

The decline in the average charge in the West Region was led by Medicaid, whose average charge for treatment in a physician's office decreased 20%, to $21,673. The average charge to commercial payers decreased 14% in both the West Region and nationwide, to $28,827 and $22,031, respectively.

"Figure 15 shows that commercial health plans have been the most effective of the payers at driving down physicians' charges on a national basis, although some regional variations persist," says Randy Vogenberg, PhD, RPh, principal, Institute for Integrated Healthcare. "The result of lower authorized fees for physicians' services is often the movement of complex and costly cases to the hospital outpatient setting."

Figure 15 Physician's Office Average Charges for Patients with Colorectal Cancer, by Payer



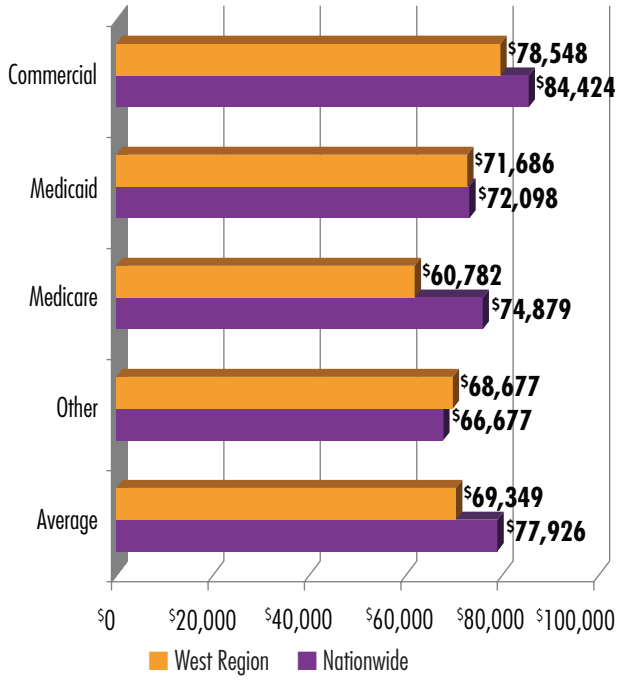
Hospital Outpatient Charges

According to hospital outpatient data from Charge Data Masters (CDM), 2009 total average hospital outpatient charges for patients diagnosed with colorectal cancer were similar to 2008 charges both nationwide and in the West Region (Figure 16). The average charge to patients insured by commercial payers increased 2% nationwide to $84,424, but increased 14% in the West Region to $78,548. Medicare average charges dropped 5% in the West Region, to $60,782, and decreased 1% nationwide to $74,879. Medicaid 2009 CDM average hospital outpatient charges decreased 4% nationwide to $72,098, and declined 2% in the West Region to $71,686.

Patients by Treatment Setting and Payer

Medicare covered the largest portion (50%) of colorectal cancer patients treated in physicians' offices nationwide in 2009 (Figure 17). In the hospital outpatient setting, Medicare and commercial payers each covered 35% of colorectal cancer patients in 2009. In the West Region in 2009, the "other" payer group, which includes government employee, military and railroad retirement plans as well as cash payers, covered 45% of patients in hospital outpatient settings, a higher percentage than either Medicare (29%) or commercial payers (21%).

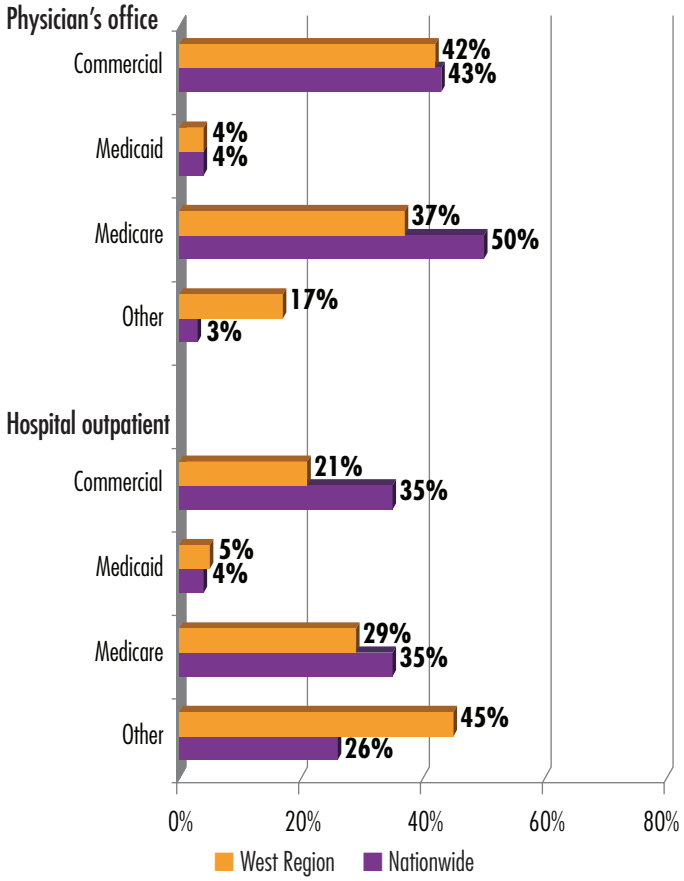
Figure 16 Hospital Outpatient Average Charges for Patients with Colorectal Cancer, by Payer (CDM)



Compliance with NCCN Guidelines by Payer

Treatments administered to colorectal cancer patients in physicians' offices were compared with the most commonly accepted guidelines for cancer care to determine compliance in the delivery of care. Compliance with NCCN practice guidelines for patients covered under Medicare and commercial insurance in 2009 increased over 2008 both in the West Region and nationwide. Nationwide, when a commercial insurer was the payer, NCCN compliance averaged 30% in 2009 (up from 22%), while compliance when Medicare was the payer was 38% (up from 31%). In the West Region, NCCN compliance was 25% (up from 22%) when a commercial insurer paid, and 34% (up from 32%) when Medicare paid.

Figure 17 Patients with Colorectal Cancer by Treatment Setting and Payer



Compliance with NCCN Guidelines by Treatment Setting

Nationwide, only 33% of treatments in physicians' offices during 2009 were compliant with NCCN guidelines, although this was up 7 percentage points from 2008. In hospital outpatient venues 36% of treatments were compliant, which was up 6 percentage points from 2008 (Figure 19).

"With colorectal cancer it can be difficult to have high compliance because of the wide variation in patients entering treatment as well as approved therapy limitations in the marketplace," says Vogenberg. "Still, compliance with NCCN guidelines increased as more health insurers promoted the use of these and other national guidelines to their physician networks. In fact, the relative gaps in compliance between the physician's office and hospital outpatient settings closed significantly within a one year period, confirming a rapid dissemination of information along with incorporation of treatment guidelines into regular practice."

Treatment Charges and Compliance with NCCN Guidelines

Year-to-year changes in average treatment charges suggest that more complex/costly colorectal cancer cases may have been moved from physicians' offices to the hospital outpatient setting. A result of this shift was that the average charge for delivery of care in the hospital outpatient treatment setting increased substantially in 2009, regardless of compliance with NCCN guidelines (Figure 20). The average charge for noncompliant treatment in this setting was up almost $32,000 (58%) to $89,300.

The average charge for treatment that complied with NCCN guidelines in the hospital outpatient setting increased by almost $11,000 (23%) to $57,387. For care delivered in physicians' offices, the average charge for noncompliant treatment was down 2% to $19,901, while the average charge for compliant treatment was down 6% to $33,595.

"We see that the result of lower fees for physicians' services is the shifting of complex and costly cases to the hospital outpatient setting," notes Vogenberg. "In Figure 20, the reduced charges for both compliant and non-compliant treatment suggests that physicians' offices may be retaining patients receiving non-compliant but less costly treatment."

Figure 18 Colorectal Cancer Treatment Compliance with NCCN Guidelines in Physicians' Offices, by Payer

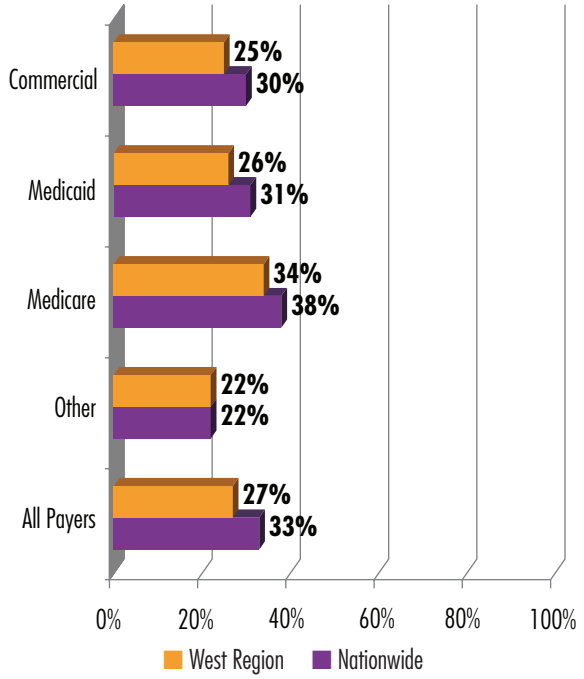


Figure 19 Colorectal Cancer Treatment Compliance with NCCN Guidelines, by Setting, Nationwide

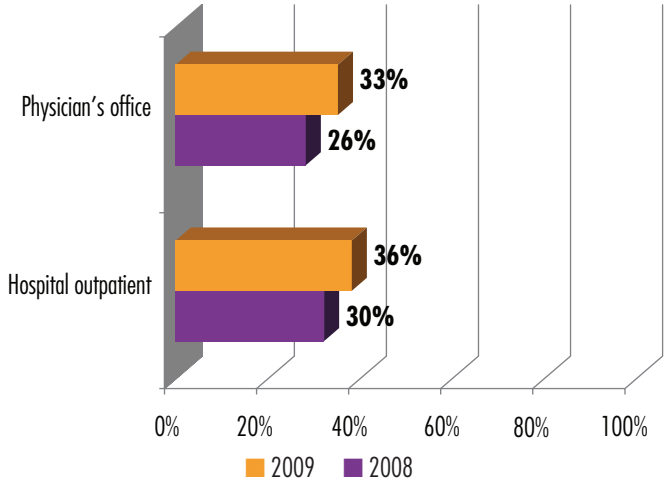
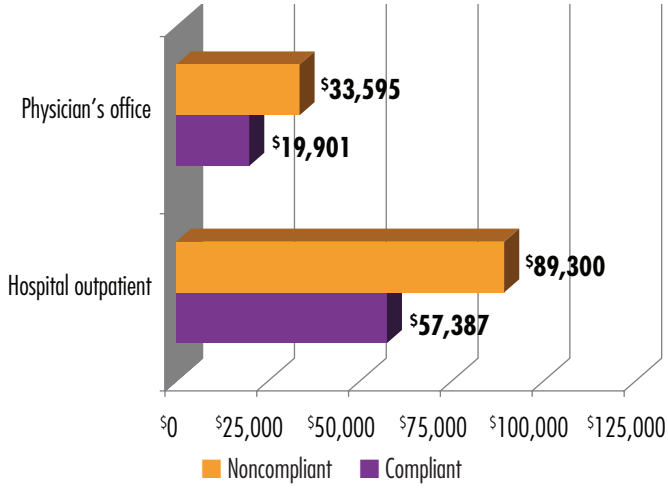


Figure 20 Average Charges for Colorectal Cancer Treatments, by NCCN Guideline Compliance, Nationwide



Use of the Top 5 Regimens

Nationwide, for colorectal cancer patients receiving chemotherapy or biologic treatments in 2009, the five most prescribed treatment regimens accounted for 63% of treatments provided by physicians' offices (unchanged from 2008) and 74% of treatments provided in outpatient hospital settings (down from 82% in 2008) (Figure 21). The stable percentage of use of the top regimens year-to-year in physicians' offices coupled with the decline in the percentage of use of these regimens in the hospital outpatient treatment setting suggests an increase in the percentage of more complex cases being treated in the hospital outpatient setting.

Treatment Charges for the Top 5 and All Regimens

Nationwide for all payers, the average charge for treatment in physicians' offices with all regimens was $29,067 in 2009, down from $31,674 in 2008 (Figure 22). This was in part due to a drop in charges for the top regimens in physicians' offices during the 2008-2009 period. In hospital outpatient settings the average charge for treatment with all regimens was $77,926, up substantially from $41,256 in 2008. This suggests that more complex/costly cases are being shifted from physicians' offices to hospital outpatient settings.

By payer type, year-to-year increases in treatment charges to commercial payers were generally lower than increases in charges to Medicare. From 2008 to 2009, average charges to commercial payers for treatment with all regimens in physicians' offices decreased from $33,591 to $28,827 (down 14%); for Medicare the average charge decreased from $30,573 to $30,156 (down 1%). For treatments in hospital outpatient settings, the average charge to commercial payers increased 46% to $92,315 for the top 5 regimens, and increased 57% to $84,424 for all regimens. Although these were the highest charges to any payer in the hospital outpatient setting, the 57% year-to-year increase in the average charge for all regimens to commercial payers is modest compared to the 182% increase in the average charge for all regimens when Medicare paid.

Treatment in hospital outpatient settings is typically associated with higher average charges than treatment delivered in physicians' offices. During 2009, the average charge per patient receiving treatments in the outpatient setting was $77,926 for all regimens, more than two and a half times the $29,067 charged for treatment in physicians' offices. The average top regimen charge per patient was $73,718 in outpatient settings, more than double the average treatment charge of $32,989 in physicians' offices.

Figure 21 Colorectal Cancer Treatments Using Top 5 Regimens, by Setting and Payer, Nationwide

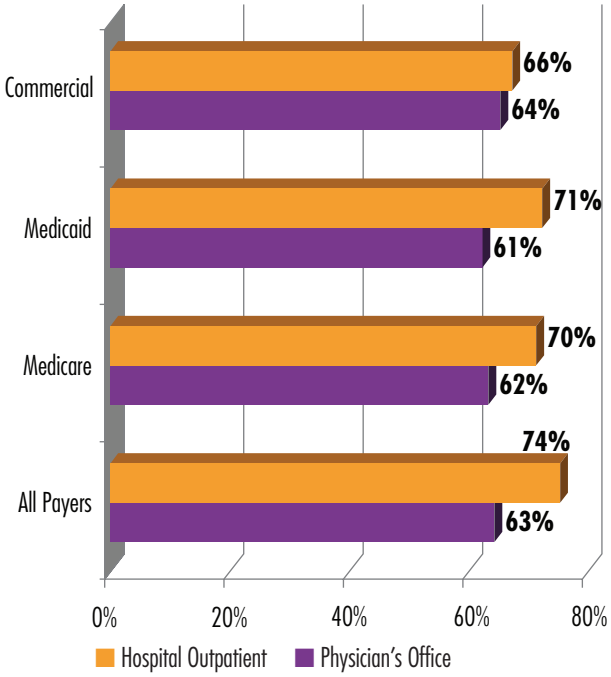
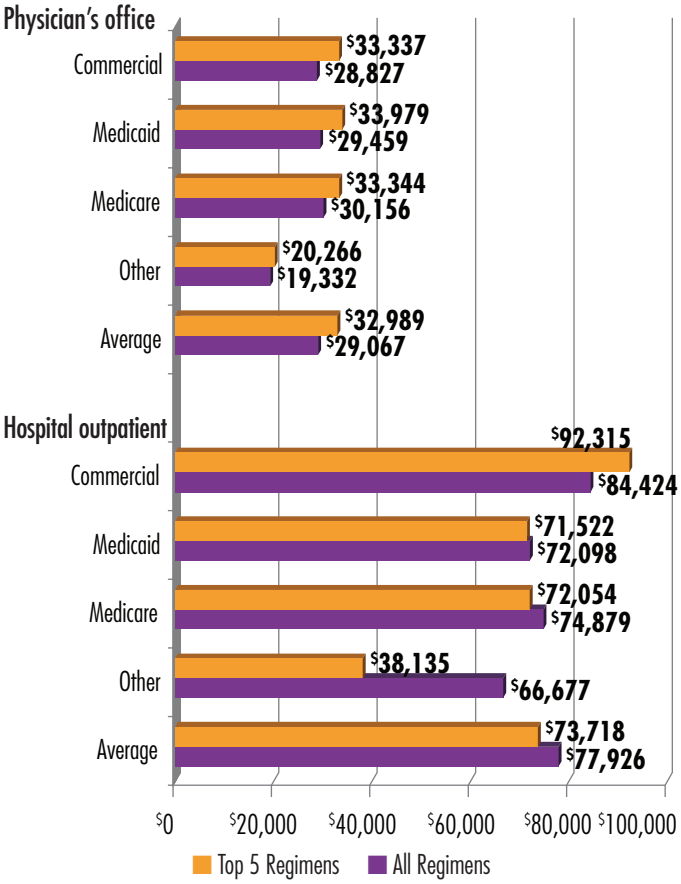


Figure 22 Average Charges for Colorectal Cancer Regimens, by Setting and Payer, Nationwide



SDI Data on Patients with Prostate Cancer

Prostate cancer currently affects more than 2 million men in the United States, and it is estimated that 1 in 6 men will be diagnosed with prostate cancer during his lifetime.[4] The incidence and cost of treating the condition are expected to increase as the US male population ages and new treatment options become available. Diagnosis can be challenging because it typically requires regular monitoring of a man's prostate-specific antigen (PSA) level. Additionally, early symptoms, such as frequent urination, can be ignored or minimized by those affected. In early disease, men receive a single diagnosis of prostate cancer; in metastatic disease, men receive both a primary and secondary cancer diagnosis.

The National Comprehensive Cancer Network (NCCN) provides consensus-based treatment guidelines at their Web site (www.nccn.org) that can be used, along with a practicing physician's clinical judgment, to establish a treatment plan. Under NCCN guidelines, men who receive an early diagnosis and have localized disease may initially follow an active surveillance regimen with PSA levels checked as often as every 6 months, and digital rectal exams (DRE) as frequently as every 12 months. If the disease progresses but remains localized, radiation therapy (RT) may be introduced to the treatment regimen. If the disease advances locally or metastasizes, patients may be given androgen deprivation therapy (ADT). Patients with metastatic disease are treated with systemic chemotherapy agents along with palliative RT and encouraged to explore clinical trials. As shown later in this report, because a higher percentage of patients are diagnosed at an early stage and treated with RT, the use of chemotherapy for metastatic disease is less common. During 2009, less than 3% of prostate cancer patients visiting physicians' offices and less than 1% of prostate cancer patients treated in the hospital outpatient setting received chemotherapy.

The data in Figures 23-28 include patients diagnosed with prostate cancer in 2009, without regard to their treatment regimen. Figures 29-33 include data on chemotherapy and biologic treatments delivered in physicians' offices and hospital outpatient settings in 2009. Comparisons are made between national averages and those of the West Region. The accompanying text describes changes from 2008 to 2009.

Treatment in Physicians' Offices

SDI reports that almost 860,000 men who were diagnosed with prostate cancer were seen in physicians' offices nationwide during 2009, an increase of 2% over 2008 (Figure 23). The West Region accounted for more than 180,000 patients seen in physicians' offices in 2009, up 1% from 2008, and 21% of the nationwide total.

Treatment by Setting and Cancer Stage

In 2009, almost 840,000 men who were diagnosed with prostate cancer were treated in hospital outpatient settings nationwide (Figure 24). Among this group, 96% were diagnosed at an early stage, while 4% were diagnosed with metastatic disease; the ratio was unchanged from 2008. In the West Region in 2009, 94% of patients

Figure 23 Number of Patients with a Diagnosis of Prostate Cancer Seen in Physicians' Offices

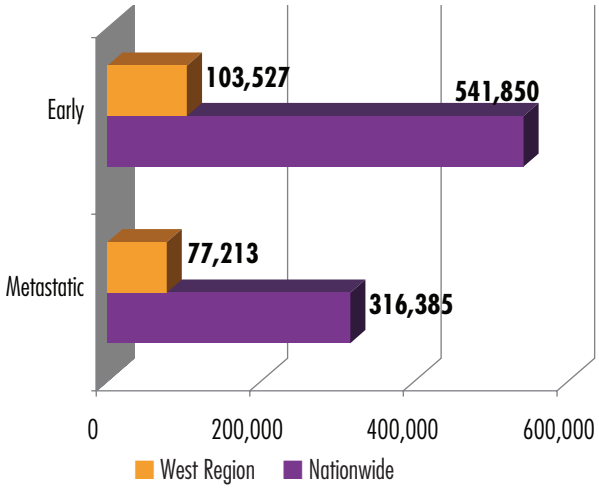
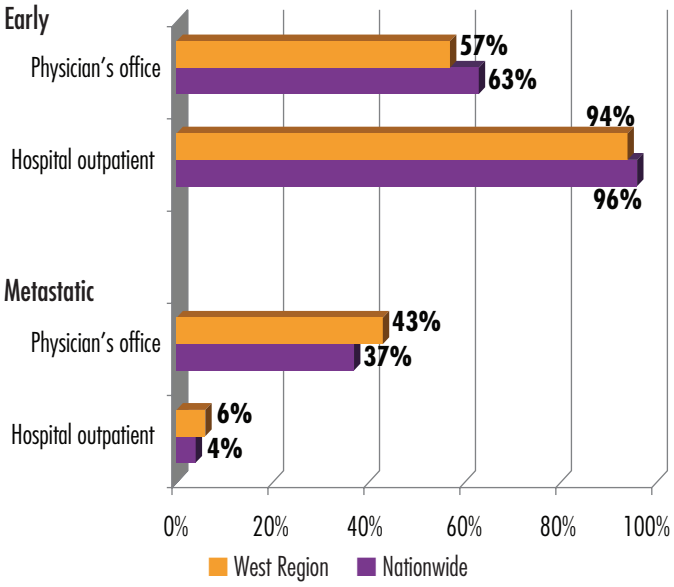


Figure 24 Patients Diagnosed with Prostate Cancer by Disease Stage and Treatment Setting

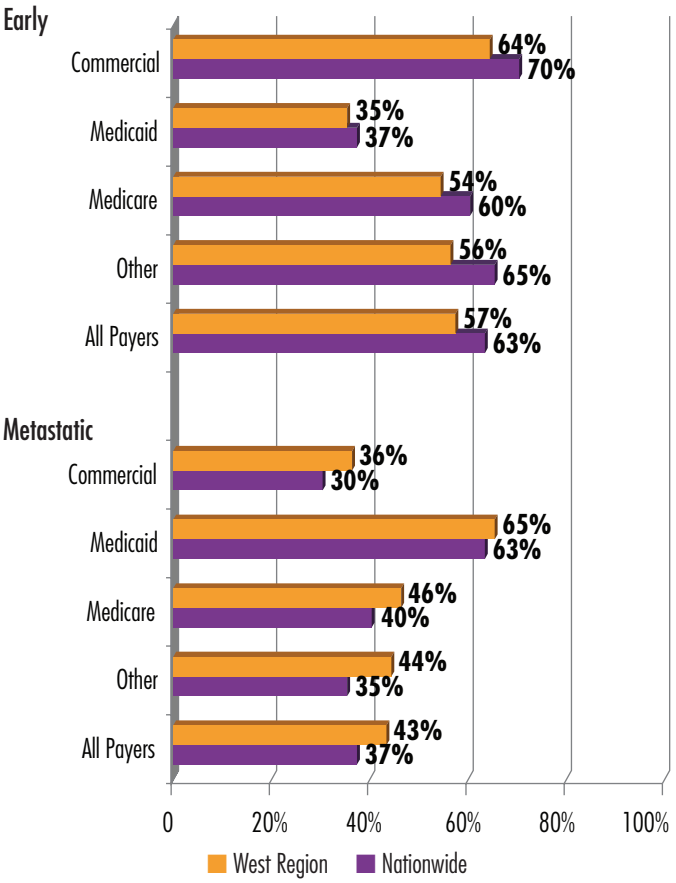


treated in hospital outpatient settings were diagnosed at an early stage (unchanged from 2008). This was the lowest percentage of patients with early diagnoses treated in the hospital outpatient setting of any region in 2008 or 2009.

In physicians' offices nationwide in 2009 and in 2008, 63% of prostate cancer patients were diagnosed at an early stage while 37% were diagnosed with metastatic disease. In 2009, 57% of West Region prostate cancer patients seen in physicians' offices were diagnosed at an early stage (unchanged from 2008). This was the lowest percentage of patients with early diagnoses treated in physicians' offices of any region in 2008 or 2009.

"Owing to increased screening for cancer in men overall, the rate of prostate cancer diagnoses has been inching upwards," says Randy Vogenberg, PhD, RPh, principal at the Institute for Integrated Healthcare. "This has been especially true in hospital owned settings where affiliated physicians have steadily increased screening rates."

Figure 25 Patients with Prostate Cancer Seen in Physicians' Offices, by Disease Stage and Payer



In both 2008 and 2009, the West Region accounted for 21% of nationwide prostate cancer cases seen in physicians' offices. The West Region also accounted for 14% of prostate cancer patients treated in hospital outpatient settings nationwide during 2009, up from 13% in 2008.

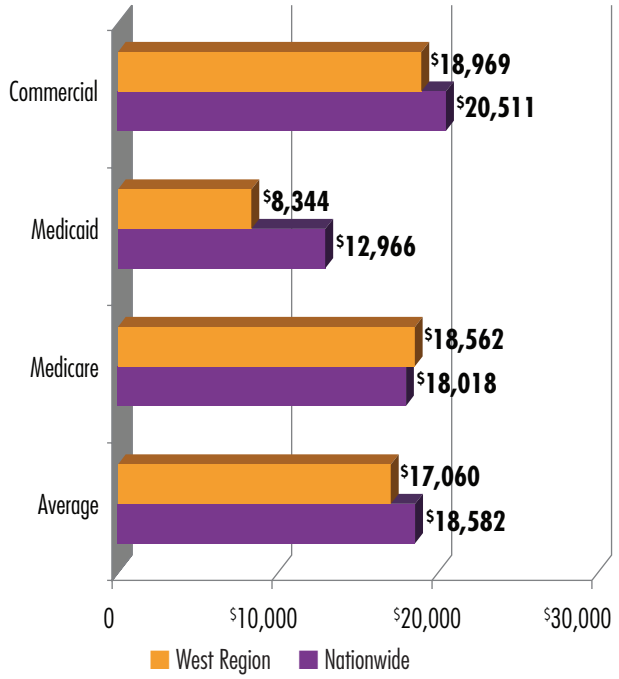
Patients in Physicians' Offices by Disease Stage and Payer Type

Among men seen in physicians' offices, both nationwide and in the West Region, commercially insured patients had consistently higher rates of early prostate cancer diagnoses than those covered by Medicare or, most notably, Medicaid (Figure 25).

Nationwide in 2009, 70% of commercially insured patients treated in physicians' offices received an early-stage prostate cancer diagnosis (unchanged from 2008), compared with 60% of Medicare patients (61% in 2008). Also nationwide in 2009, only 37% of Medicaid patients were diagnosed early (down from 39% in 2008).

In the West Region in 2009, 64% of commercially insured patients treated in physicians' offices received an early-stage diagnosis (61% in 2008), compared with 54% of Medicare patients (58% in 2008). Only 35% of Medicaid patients in this treatment setting received an early diagnosis (up from 25% in 2008). The percentage of change

Figure 26 Physician's Office Average Charges for Patients with Prostate Cancer, by Payer



for Medicaid may be magnified by the small base of prostate cancer patients involved; Medicaid patients accounted for only 1% of patients seen in physicians' offices both in the West Region and nationwide during 2008 and 2009.

Average Charge in Physicians' Offices, by Payer

Nationwide, the average charge per patient for prostate cancer treatment in physicians' offices was $18,582 in 2009, up 2% from the 2008 average of $18,236 (Figure 26). In the West Region the average charge in 2009 was $17,060, up 4% from the 2008 charge of $16,393.

In the West Region the increase in the average charge for patients treated in physicians' offices was led by Medicaid, for which the average charge increased 19% to $8,344. The average charge to Medicare increased by 16% to $18,562 from 2008 to 2009. The average charge to commercial payers in the West Region declined 2% in 2009, to $18,969. When the payer was "other" the average charge declined 15% to $11,699, but "other" payers only accounted for 3% of patients treated in physicians' offices in the West Region in 2009.

Hospital Outpatient Charges

According to hospital outpatient data from Charge Data Masters (CDM), 2009 total average hospital outpatient charges for patients diagnosed with prostate cancer were similar to 2008 averages both nationwide and in the West Region (Figure 27). However, the average charge to patients insured by commercial payers was up 8% nationwide to $48,090 and up 102% in the West Region to $54,505. Medicare average charges were up 56% in the West Region to $33,692 and up 4% nationwide to $40,936. Medicaid 2009 CDM average hospital outpatient charges were up 4% nationwide to $36,772, but down 18% in the West Region to $43,319. Charges when "other" payers paid were down 37% nationwide to $24,048 and down 25% in the West Region to $28,264.

Patients by Payer and Treatment Setting

Of the three major payers, Medicare covered the largest portion of prostate cancer patients treated in physicians' offices (about two-thirds) or hospital outpatient settings (about half) in both 2008 and 2009, nationwide (Figure 28).

Figure 27 Hospital Outpatient Average Charges for Patients with Prostate Cancer, by Payer (CDM)

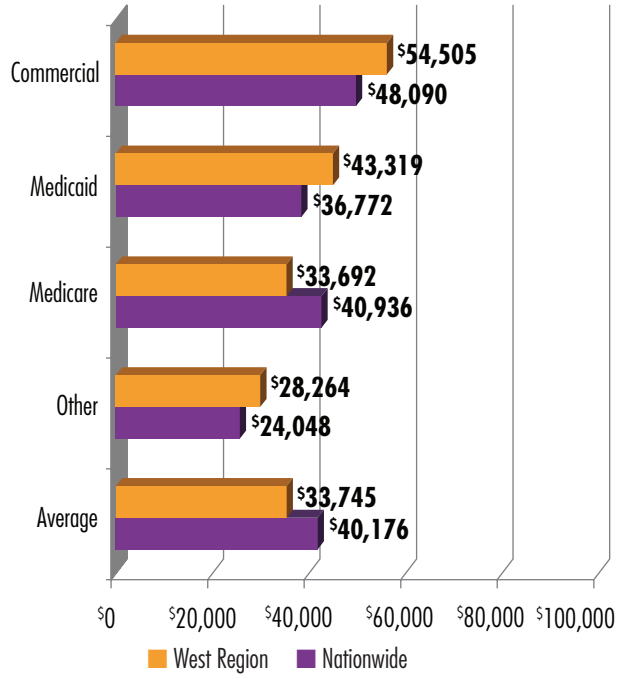
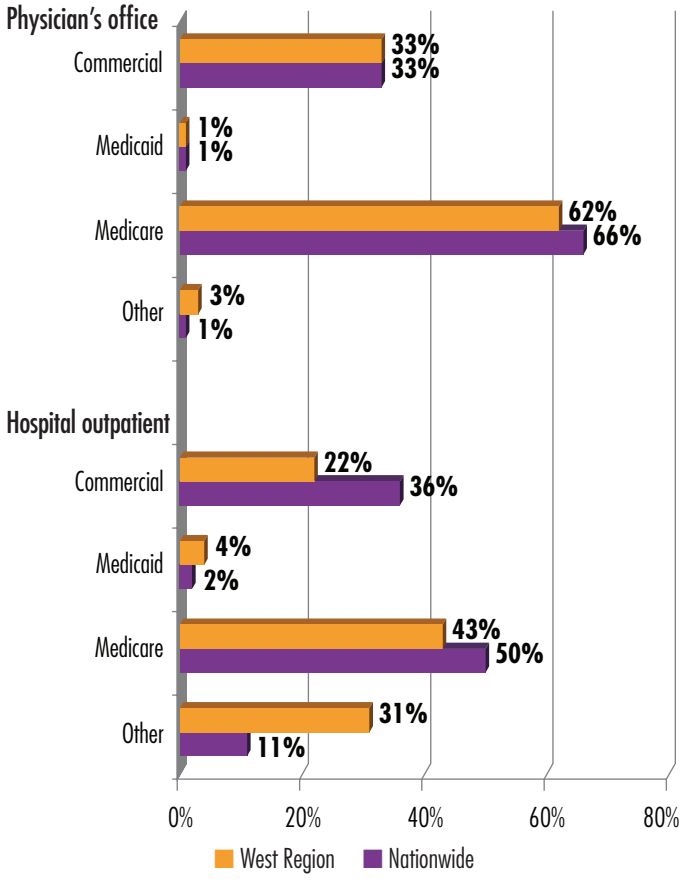


Figure 28 Patients with Prostate Cancer by Treatment Setting and Payer



In physicians' offices in 2009, commercially insured patients accounted for almost all of the rest, both nationwide and in the West Region, except for 1% covered by Medicaid and the 3% covered by "other" payers in the West Region ("other" accounted for 1% nationwide).

In the hospital outpatient setting in 2009 commercial payers were the second-largest payer for prostate cancer patients nationwide, covering 36% of patients. In the West Region, however, commercial payers were the third-largest with 22%, behind "other" payers which covered 31% of prostate cancer patients in this setting. The "other" payer group includes government employee, military and railroad retirement plans as well as cash payers.

Compliance with NCCN Practice Guidelines by Payer

Chemotherapy and biologic treatments administered to prostate cancer patients in physicians' offices were compared with the most commonly accepted guidelines. Compliance with NCCN guidelines for all payers averaged 32% nationwide in 2009 (down from 34% in 2008), and 30% in the West Region (31% in 2008) (Figure 29).

Nationwide and in the West Region, treatments for prostate cancer patients covered by Medicare had the highest compliance levels in 2009: 50% in the West Region (48% in 2008) and 48% nationwide (49% in 2008). The relatively high rate of guideline compliance for care covered by Medicare is because Medicare will pay for treatments detailed in five compendia, one of which is NCCN, but will not pre-approve other care plans. Thus, physicians may be more likely to limit treatment to approved compendia when Medicare is the payer, explains Dawn Holcombe, MBA, president, DGH Consulting.

Compliance with NCCN Guidelines by Treatment Setting

Nationwide, only 32% of treatments for prostate cancer in physicians' offices during 2009 were compliant with NCCN guidelines (34% in 2008). In hospital outpatient settings, 66% of treatments were compliant (65% in 2008) (Figure 30).

Figure 29 Prostate Cancer Treatment Compliance with NCCN Guidelines in Physicians' Offices, by Payer

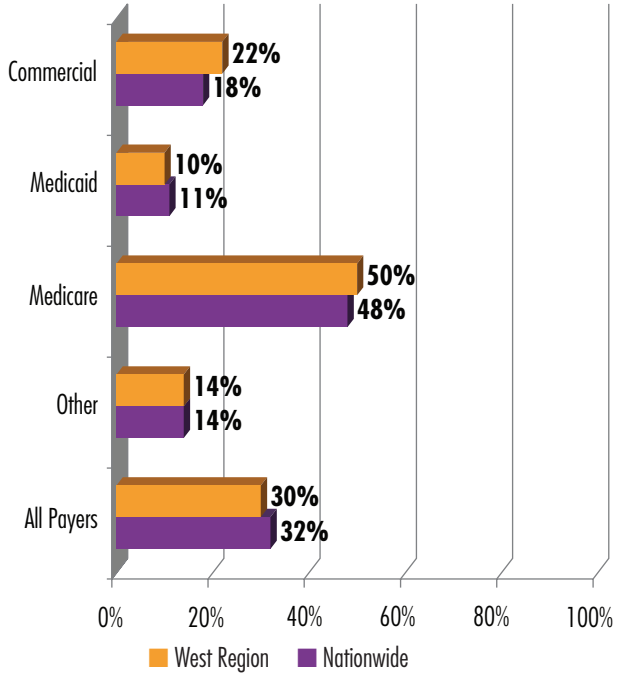


Figure 30 Prostate Cancer Treatment Compliance with NCCN Guidelines, by Setting, Nationwide

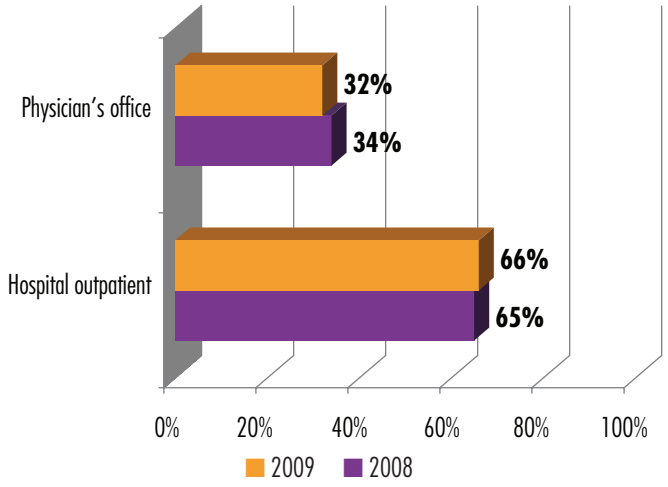
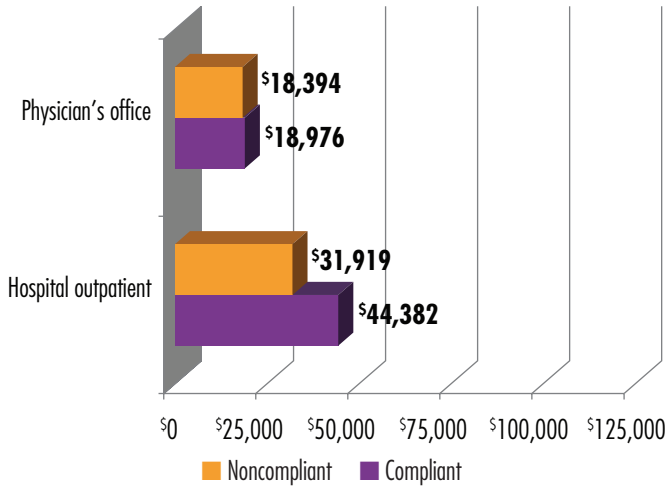


Figure 31 Average Charges for Prostate Cancer Treatments, by NCCN Guideline Compliance, Nationwide



Treatment Charges and Compliance with NCCN Guidelines

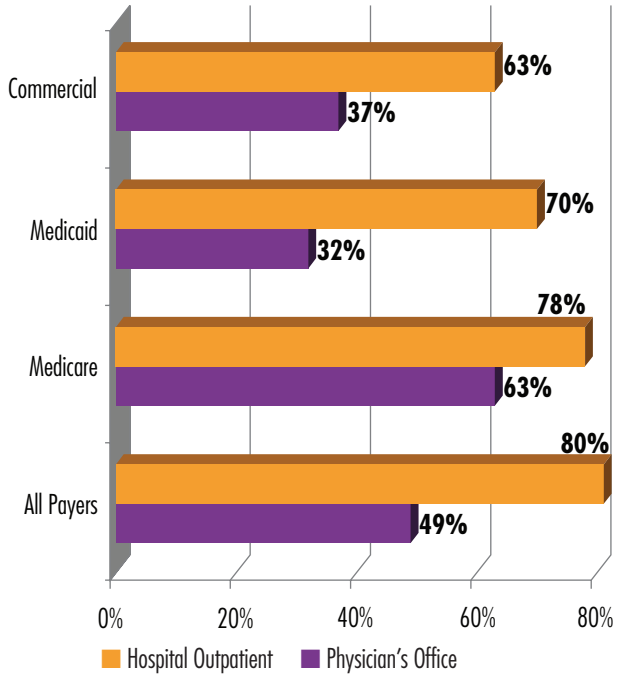
Nationwide in 2009, noncompliance with NCCN guidelines for hospital outpatient care for prostate cancer was associated with reduced treatment charges, averaging $31,919 per patient, $12,463 lower than the $44,382 charged for compliant care delivered in the hospital outpatient setting (Figure 31). These charges were still significantly higher than charges for either compliant or non-compliant care in the physician office setting. The lower average charges in the outpatient setting for non-compliant treatment are surprising, given that non-compliant care is usually associated with more complex cases and higher charges.

For care delivered in physicians' offices in 2009, noncompliant per-patient charges were similar to those for compliant care ($18,394 and $18,976, respectively).

Use of the Top 5 Regimens

Nationwide, for prostate cancer patients receiving chemotherapy and biologic treatment in 2009, the top five most prescribed treatment regimens accounted for 49% of chemotherapy treatments provided by physicians' offices (50% in 2008) and 80% of chemotherapy treatments provided in outpatient hospital settings (93% in 2008) (Figure 32). While the percentage of use of the top regimens remained consistent from 2008 to 2009 in physicians' offices, the decline in the hospital outpatient treatment setting suggests an increase in the percentage of more complex cases being treated in that setting.

Figure 32 Prostate Cancer Treatments Using Top 5 Regimens, by Setting and Payer, Nationwide

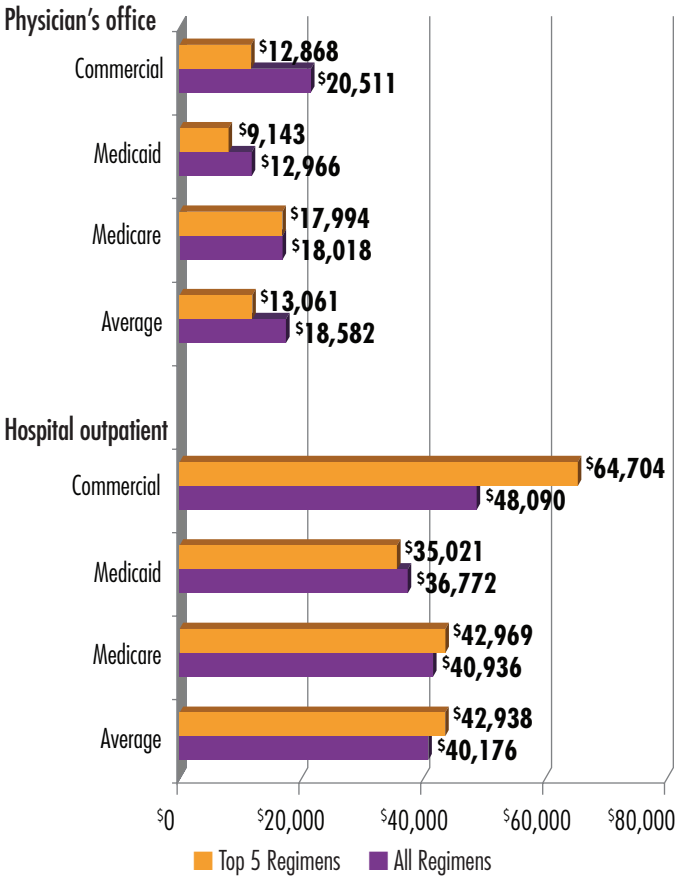


Treatment Charges for Top 5 and All Regimens

Nationwide, the average charge for treatment of prostate cancer in physicians' offices for all regimens was $18,582 in 2009, 42% higher than the average charge for the top regimens in this setting (Figure 33). The average charge for treatment for all regimens was higher than that for the top regimens in physicians' offices in 2008 as well, although only by 8%. From 2008 to 2009, the 10% increase in the average charge to hospital outpatients for all regimen treatments suggests a successful transfer of more costly cases to this treatment setting from physicians' offices.

Treatment in hospital outpatient settings is typically associated with higher average charges than treatment delivered in physicians' offices, as held true in 2009. The average charge per patient receiving treatments in the outpatient setting was $40,176 for all regimens, more than double the $18,582 charged for treatment in physicians' offices. The average top regimen charge per patient was $42,938 in outpatient settings, more than three times the charge for top regimen treatment in physicians' offices.

Figure 33 Average Charges for Prostate Cancer Regimens, by Setting and Payer, Nationwide



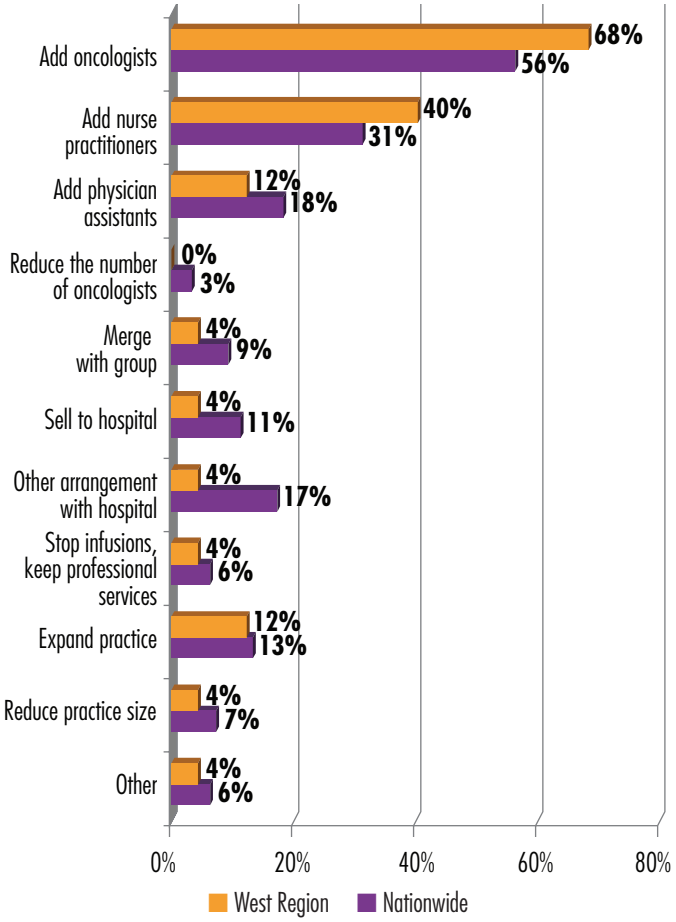
Oncology Practice Survey Findings

Physicians are under increasing financial pressure to improve business operations and satisfy the needs of payers for oncology management programs that address cost concerns. Practices are seeking operational affiliations/mergers/collaborations and clinical management enhancements, with the expectation that such changes will better position them for negotiations and relationships with key payers.

A total of 165 oncology physicians (93%) and administrators (7%) nationwide responded to the survey. Of these, 28, or 17%, are in the West Region. More than half of all practices are groups of five or fewer physicians (64 % in the West Region, 66% nationwide).

Proportionately more West Region practices are considering changes than practices nationwide; just 4% in the West Region reported merging with another medical group, selling to a hospital, or developing some other collaborative hospital arrangement. West Region practices more often anticipated adding oncologists and adding nurse practitioners (Figure 34).

Figure 34 Potential Changes to Practice



Commitment to Patient Care

Responses concerning payer and patient care policies demonstrate that oncologists' commitment to patient care and to preserving access to services and care in their offices exceeds their focus on the business of care delivery. Almost half of practices (43% in the West Region and 49% nationwide) report that they now see more patients than a year ago. In the same time period, more than half of practices in the West Region (57%) and nationwide (52%) report decreasing net profit. Despite these strains, half of practices in the West Region and 58% nationwide indicated, when asked how they would respond to proposed Medicare reimbursement cuts of as much as 20% to 30%, that they would continue to treat Medicare patients as usual. Nearly one third of oncologists nationwide (31%) and in the West Region (32%) say they may need to identify alternative sites of service for Medicare patients, such as hospitals, which would prove more costly to Medicare and private insurers. Practices in the West Region (63%) report that they are slightly less likely to refer some patients to a hospital-based infusion center than practices nationwide (69%).

Practices also report that patients are choosing to delay or cancel care due to costs of treatment. One-third of West Region practices report that 11% or more of patients have requested changes in their care plan (32% of practices nationwide) or stopped taking oral medications early due to financial costs (39% in the West Region and 45% nationwide).

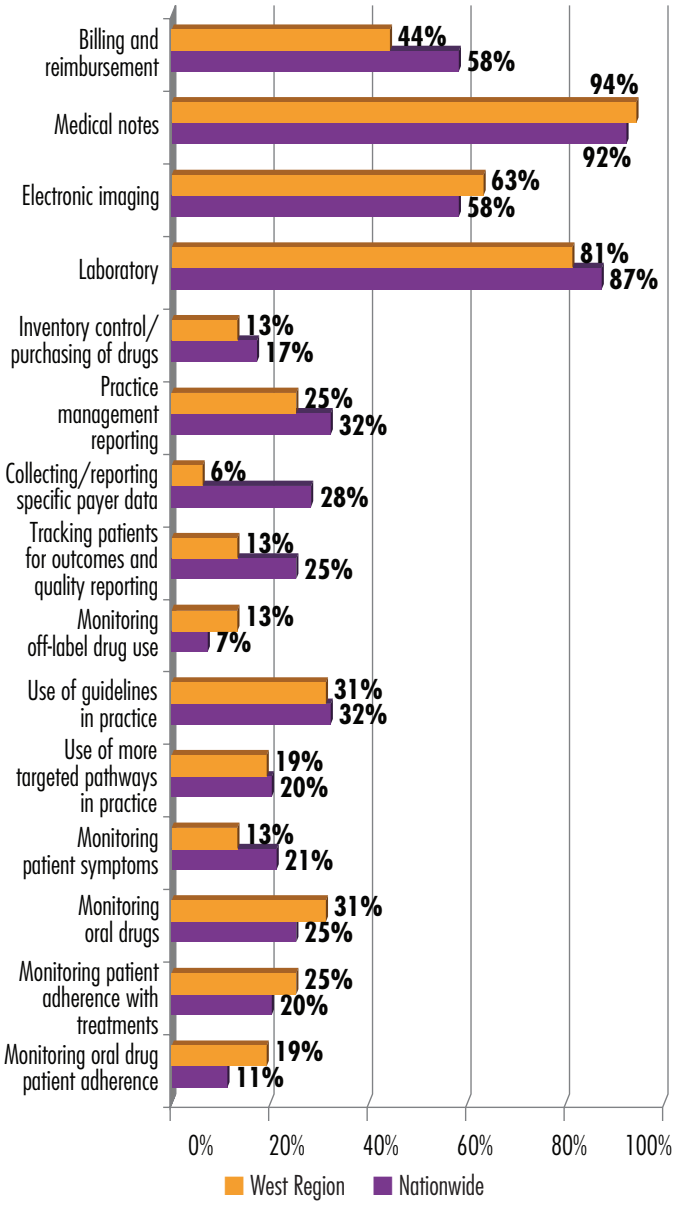
Use of Electronic Medical Records (EMRs)

More than half (54%) of practices in the West Region report using an EMR system, significantly more than practices nationwide (44%) and the highest proportion among all regions surveyed. There is considerable variation in the type of system used, but more West Region practices (27%), and practices nationwide (28%), report using a hospital provided/based system than any other single oncology-specific EMR. Only 15% of West Region practices indicate that the practice is hospital-owned, less than the 20% reported nationwide.

It is a lengthy process to select, install and implement an EMR. West Region practices report that they have not yet fully implemented an EMR at about half (13%) the rate of practices nationwide (22%). Another 44% of West Region practices have had an EMR for two years or less (29% for practices nationwide).

Even when EMRs are fully implemented, they are being used primarily to automate routine processes rather than to improve patient outcomes and practice management. When the 44% of all survey respondents with EMRs indicate how they use their systems, more than half of reported applications are for billing, medical notes, electronic imaging, and laboratory results (Figure 35).

Figure 35 EMR Utilization



Far more practices (61%) in the West Region than nationwide (49%) report that they do not collect data through their EMR or electronic order entry system (EOES). Of those that do, none of practices in the West Region and just 9% nationwide have been able to sell their data or gain preferential reimbursement consideration.

Use of Practice Guidelines

Guidelines for the delivery of medically recognized standards of practice are widely accepted and followed. More than half of all practices nationwide (56%-59%) and West Region practices (61%-67%) encourage their use in colorectal, NSC lung, breast, prostate, and head and neck cancers.

Respondents are most likely to use as a reference the National Comprehensive Cancer Network (NCCN) Guidelines (92% in the West Region and 89% nationwide). Far fewer practices in the West Region monitor compliance to guidelines or pathways (25%) than nationwide (35%). Of those practices that do monitor compliance, practices in the West Region report that 75% monitor compliance every three months and 13% every six months, but none monitor annually, while 37% of practices nationwide monitor compliance every three months, 16% every 6 months and 26% annually.

Only 25% of practices in the West Region and nationwide report guideline integration into an EMR. While 38% in the West Region and 33% nationwide track compliance, not one practice in the West Region and only 4% nationwide report receiving rewards for guideline compliance.

Use of Specialty Pharmacies

While oncology practices do accept specialty pharmacy drugs in their practice, such utilization occurs only under specific situations, eg, for selected drugs, or for specific payers under limited circumstances. The majority of practices do not accept drugs from specialty pharmacies when shipped directly to the patient (54% in the West Region, 63% nationwide), but about half will allow some specialty pharmacy drugs to be shipped directly to the practice (46% in the West Region, and 50% nationwide). More than three quarters (79%) of practices in the West Region and 75% of practices nationwide state that they would not accept drugs from a specialty pharmacy without a signed liability waiver.

Half of practices in the West Region and 45% nationwide use specialty pharmacy drugs because the commercial payer requires it, and 58% in the West Region (49% nationwide) do so because of inadequate drug reimbursement margins

or reimbursement rates too low to support buy and bill. Nationwide, 34% of practices and 46% in the West Region report using specialty pharmacies for 5% or less of their total drug orders for oral drugs; for injectable drugs, two thirds (66%) nationwide and 54% in the West Region report ordering 5% or less from specialty pharmacies.

Oncology Management Programs

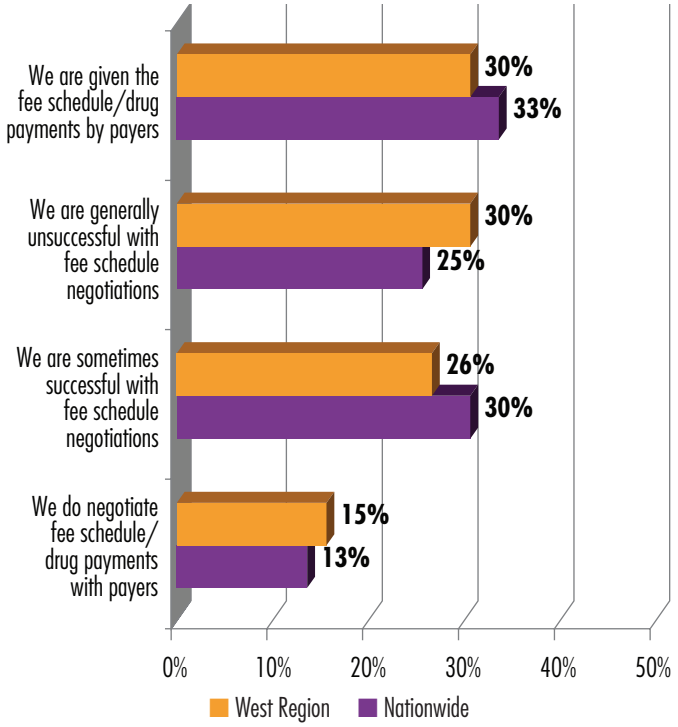
Respondents were asked to cite oncology management programs already in place or that could be developed and presented to payers. West Region practices were most likely to have already implemented symptom management, survivorship and end of life programs and patient education, and to have the greatest interest in developing pathways, preferred treatment regimens, and review of oncology treatments over certain dollar thresholds.

Reimbursement Issues

Oncologists see a growing chasm between Medicare payment policy and what they deem to be acceptable reimbursement rates. Respondents were asked to estimate what rate of payment for professional services by private payers (in relation to current Medicare rates for professional services) would approximately cover their non-drug costs of care delivery if private payer drug reimbursement rates were set at cost or Medicare rates. West Region practices indicated either 200% over Medicare rates (67%), or 50% over Medicare rates (33%) would be adequate. All other brackets received 0% response in the West Region. Nationwide, practices estimated adequate rates as follows: 3% for current Medicare rates; 19% for Medicare rates plus <50%; 22% for 50% over; 14% for 100% over; 19% for 150% over; and 23% for 200% plus over Medicare rates.

Oncology practices report a distinct lack of success in creating effective contracts with payers (Figure 36). Many oncology practices lack basic information concerning the profitability of working with specific plans. Far fewer practices in the West Region (18%) than nationwide (32%) feel their contracts with the majority of managed care plans are profitable. The contracts are considered unprofitable by 29% in the West Region and 26% nationwide. The largest response, 54% in the West Region, the highest in all regions, and 42% nationwide, was "don't know."

Figure 36 Practice-Payer Fee Negotiations



The costs of oncology drugs and their handling constitute the largest component of the costs of running an oncology practice, yet only 46% of practices in the West Region and 53% nationwide report having taken steps to identify potential losses for specific oncology infusion therapies. When asked what they would do in cases where delivery of a medication would result in a revenue loss, most West Region practices would refer the patient to the more costly hospital setting, use an alternative medication if one exists, or absorb the loss. (Figure 37).

In the face of increasing fiscal and operational challenges, practices are turning to a variety of options to increase practice revenues. The most popular choices are tightening controls on coding and documentation (50% and 43% respectively in the West Region, and 60% and 56% respectively nationwide), and participating in federal performance programs and e-prescribing (25% and 25% respectively in the West Region and 18% and 20% respectively nationwide). More than a quarter in the West Region (29%) and 20% nationwide have made no changes.

Figure 37 When Use of a Drug Will Result in Revenue Loss

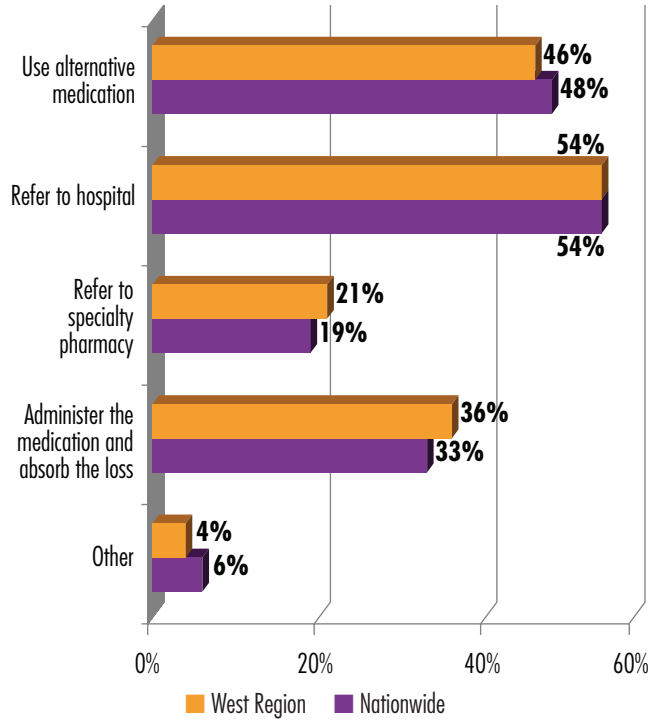
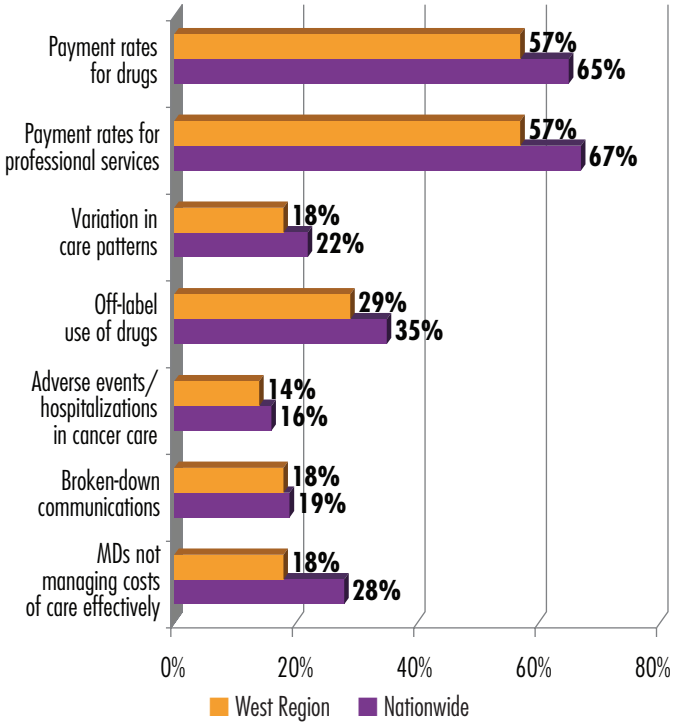
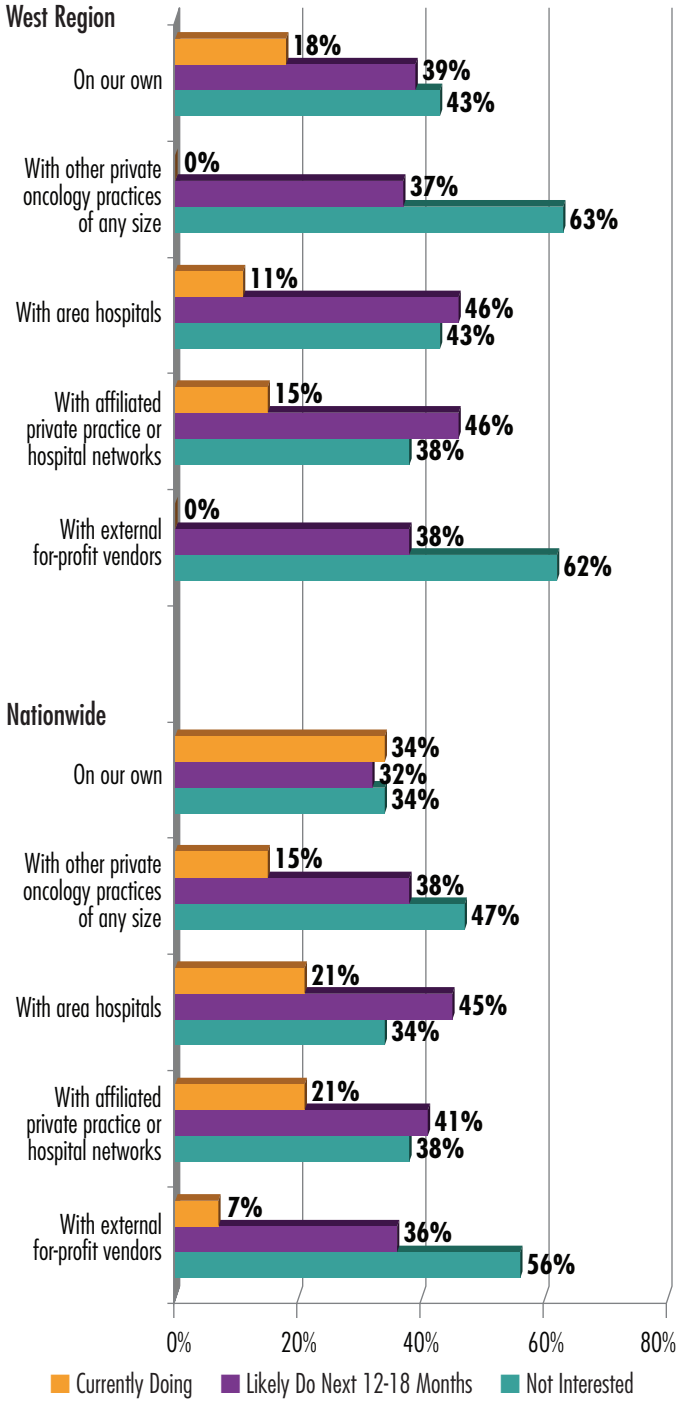


Figure 38 Issues Affecting Provider-Payer Relations



The most commonly reported reimbursement rate (54%) in the West Region for drugs in the physician practice is average sales price (ASP) plus 6%. Another 13% (for each range) reported rates of ASP plus 0%-5% and ASP plus 7%-12% as well as AWP minus 15% or less. Twenty-nine percent of West Region respondents did not know their current reimbursement rates. For practices nationwide, 43% report ASP plus 6%, and 27% report

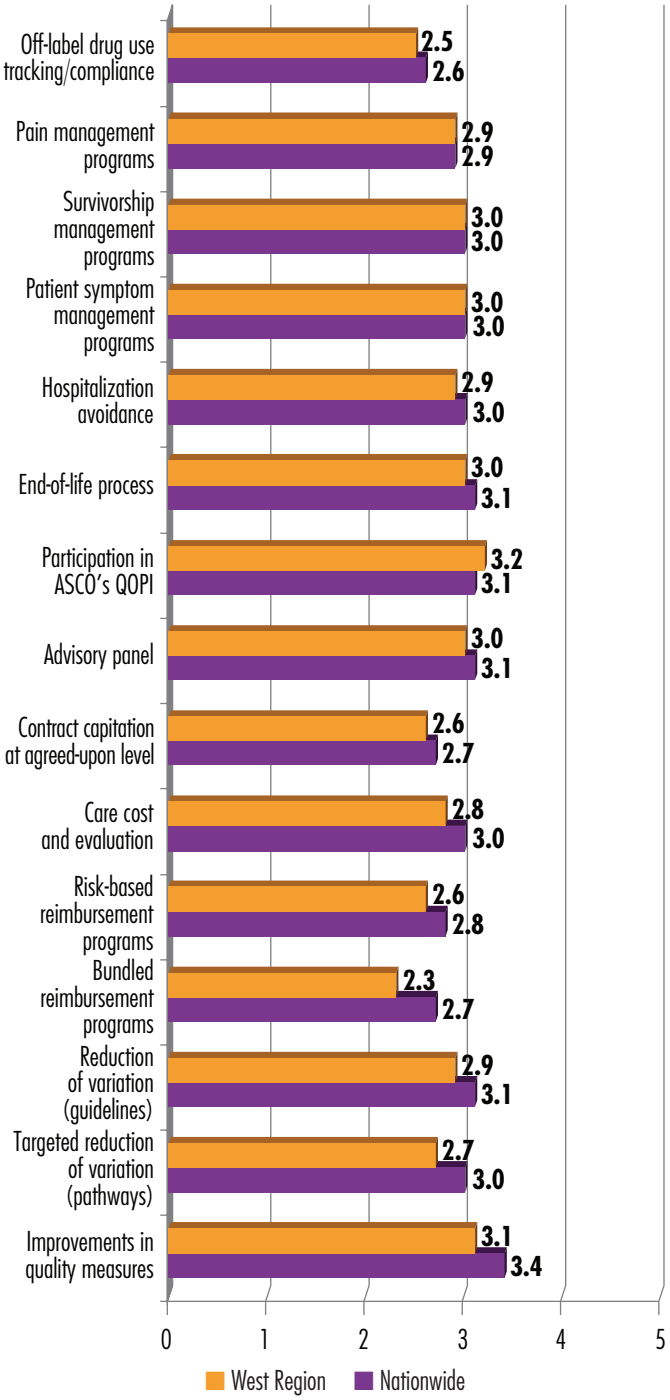
Figure 39 Oncology Practice Interest in Payer Programs



ASP plus 0%-5%. Other rates reported by practices nationwide are ASP plus 0%-5% (27%), ASP plus 7%-12% (14%), ASP plus 13%-18% (7%), ASP plus 19%-25% (5%), ASP plus 26% and higher (7%), while only 7% of practices nationwide reported any AWP based pricing, and 21% did not know.

Figure 40 Practice-Payer Collaboration Options

1 = Not at all interested; 2 = Slightly interested; 3 = Neutral, 4 = Moderately interested; 5 = Extremely interested



Practice – Payer Relations

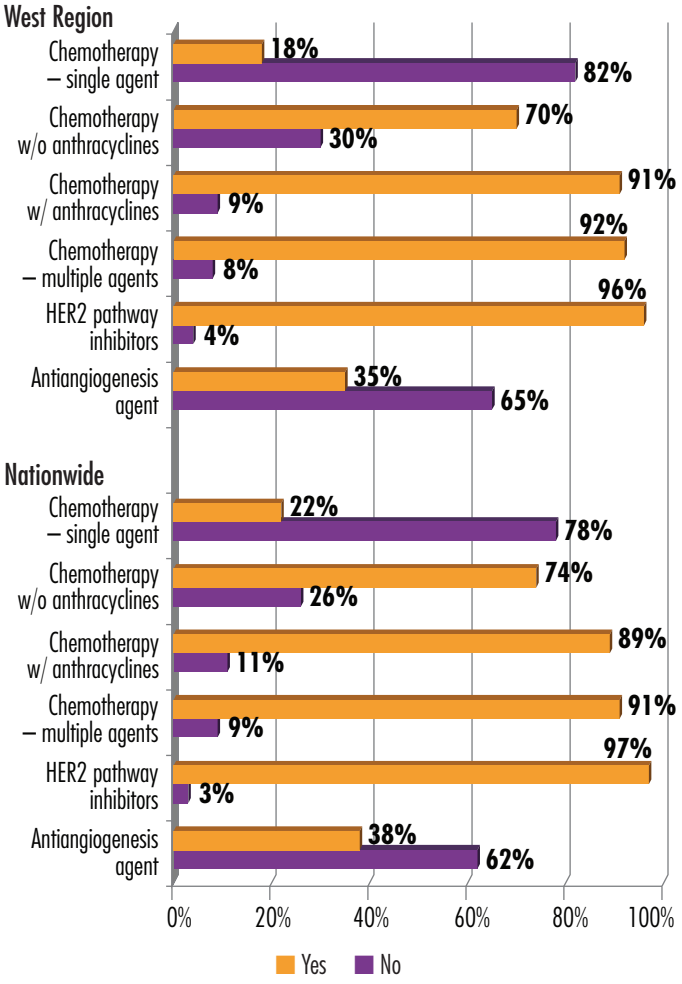
More than two-thirds (70%) of West Region practices and practices nationwide (68%) state that their relationship with payers goes no further than annual contracting.

For West Region physicians and all physicians nationwide, the most sensitive issue affecting current and future relations with payers is payment rates for professional services and payment rates for drugs (Figure 38).

Collaborative Prospects

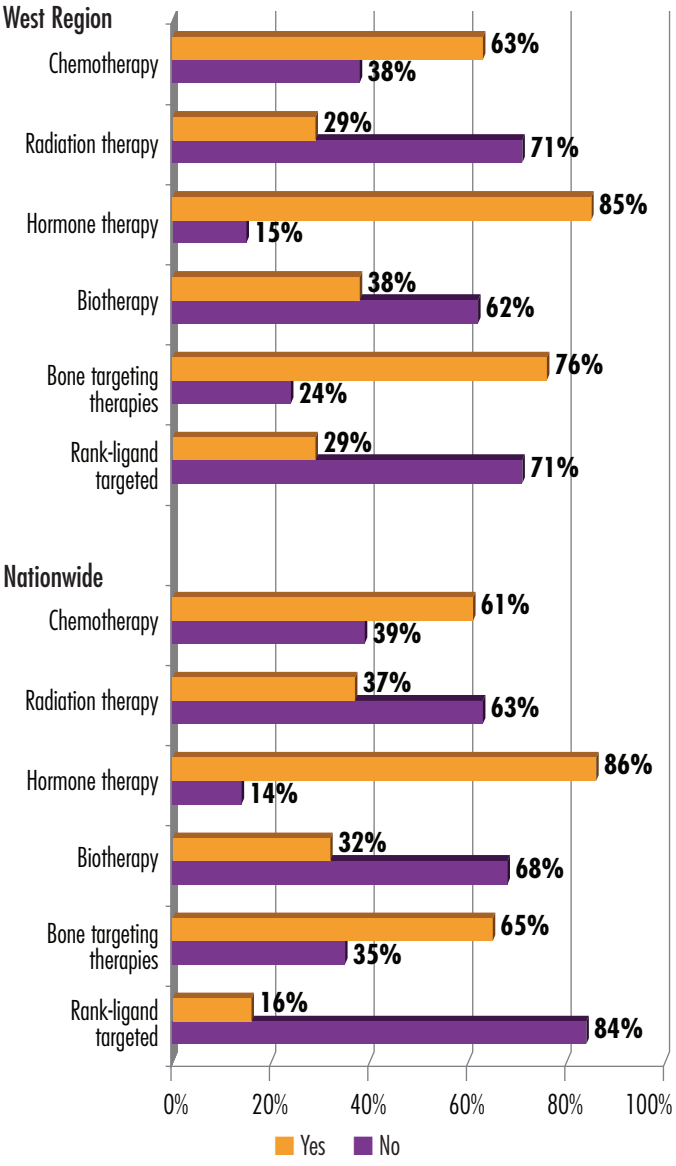
When asked about collaborating with other care providers in exploring key payer programs related to oncology, West Region practices show a lower interest (57% combining currently doing and likely to do) in working with area hospitals than do practices nationwide (66%). West Region practices indicate less interest (62%) than practices nationwide (56%) in working with external for-profit vendors that seek to aggregate oncology practices for payer negotiations (Figure 39).

Figure 41 Adjuvant Treatment for Breast Cancer



Practices are also looking at programmatic collaborations and innovative programs with payers. All practices show the most interest in improvements in quality measures programs, ASCO's QOPI measures, patient symptom and survivorship management programs, advisory panels, and end-of-life process (Figure 40).

Figure 42 Breast Cancer Treatment for Patients with Positive Hormone Receptor Findings and Metastatic Disease



Breast Cancer Treatment

Treatment of cancer is complex, usually involving more than one drug. When asked about adjuvant treatment generally followed for breast cancer patients, practices clearly show a trend toward chemotherapy with multiple agents (92% in the West Region and 91% nationwide) and for chemotherapy with anthracyclines (91% in the West Region and 89% nationwide) (Figure 41). If the patient is HER2 positive, treatment also is most likely to include HER2 inhibitors (96% and 97%, respectively).

Most physicians indicate that if they have patients with positive hormone receptor findings and metastatic disease, they generally continue to treat for the life of the patient (70%, West Region; 74% nationwide).

Choices for treatment of breast cancer patients with recurrent metastatic disease vary by treatment and region (Figure 42).

Most physicians in the West Region and nationwide consider introducing discussion of palliative care with breast cancer patients by stage IV or at the third line of therapy.

Figure 43 Patients Treated for Localized Prostate Cancer at Respondent's Hospital or Center

Radical nerve sparing prostatectomy				
West Region	40%	32%	24%	4%
Nationwide	58%	23%	16%	3%
Laparoscopic prostatectomy				
West Region	61%	26%	9%	4%
Nationwide	60%	30%	9%	2%
Robotic prostatectomy				
West Region	58%	33%	4%	4%
Nationwide	56%	25%	13%	5%
Brachytherapy				
West Region	58%	42%	0%	0%
Nationwide	47%	39%	13%	2%
Conformal RT				
West Region	54%	33%	8%	4%
Nationwide	52%	34%	12%	2%
IMRT				
West Region	52%	30%	13%	4%
Nationwide	44%	31%	19%	5%

0%–25% 26%–50% 51%–75% 76%–100%

Prostate Cancer Treatment

Oncology physicians report variations in treatment choices for patients with localized prostate cancer (Figure 43). Patients are more likely to receive radical nerve sparing prostatectomy in the West Region (40% reporting 0%-25% occurrence) than nationwide (58% reporting 0%–25% occurrence).

Physician choices for treatment of prostate cancer in the West Region are generally consistent with choices nationwide (Figure 44).

When asked if they currently had patients receiving immunotherapy for metastatic, hormone-refractory prostate cancer, 73% in the West Region said no, as did 76% nationwide. When asked if physicians expected to have such patients in the next twelve months, fewer practices in the West Region (29%) responded in the affirmative than nationwide (37%).

The responses of physicians, when asked about expectations for trends in therapeutic medication volume for stage IV prostate cancer patients, reveal variation in expectations for individual treatment options between the West Region and nationwide.

Figure 44 Treatment of Prostate Cancer by Stage

Stage 1,2 surgically treated adjuvant					
West Region	53%	18%	29%	0%	0%
Nationwide	60%	14%	25%	0%	1%
Stage 1,2 RT treated adjuvant					
West Region	57%	26%	17%	0%	0%
Nationwide	52%	20%	25%	2%	1%
Recurrent/metastatic first line therapy					
West Region	42%	22%	29%	2%	4%
Nationwide	37%	21%	31%	7%	4%
Hormone refractory therapy					
West Region	26%	13%	16%	32%	13%
Nationwide	24%	17%	17%	23%	18%

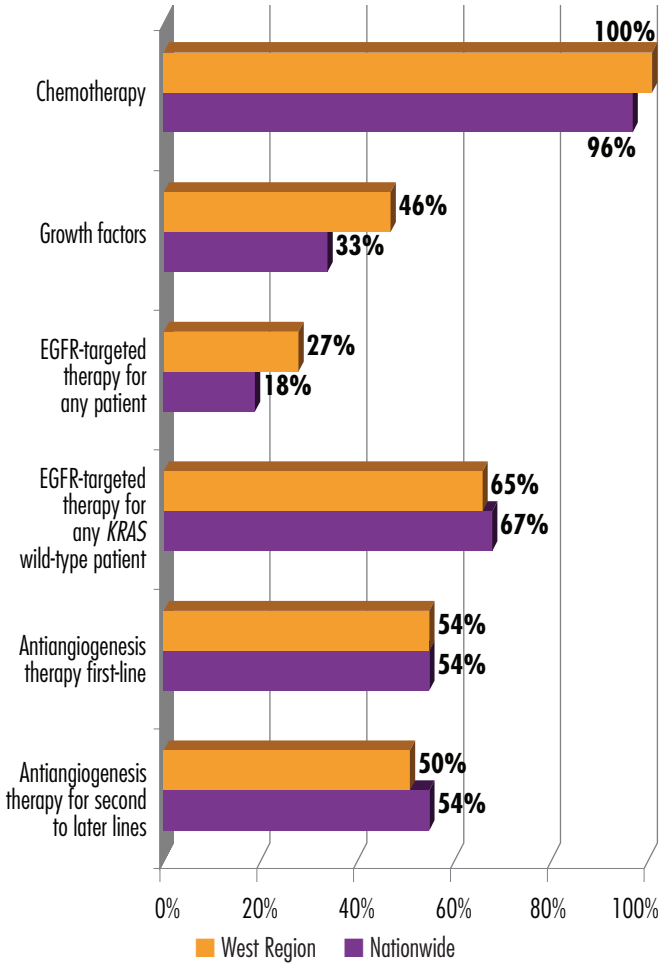
LHRH ADT Anti-androgen Immunotherapy Antiangiogenesis

Colorectal Cancer Treatment

Chemotherapy is the most frequent treatment choice for colorectal cancer patients in the West Region and nationwide (Figure 45).

More than three-quarters of oncologists (84% in the West Region, 77% nationwide) agree that introducing discussion of palliative care is appropriate with stage IV colorectal cancer patients.

Figure 45 Preferred Treatments for Colorectal Cancer Patients



Managed Care Survey Findings

Health plans are seeking more information in order to make better-informed decisions concerning coverage and patient management, placing greater emphasis on access to data, such as obtaining and interpreting lab values. A related trend is the growing emergence of companion diagnostic use in guiding and supporting treatment decisions.

Health plans are also seeking ways to reduce costs associated with the delivery of cancer care by encouraging but not mandating use of specialty pharmacy for oral and self-injectable oncology agents. In this effort they are moving cautiously so as not to antagonize oncologists with whom they seek to maintain good relationships.

A total of 123 health plans and managed care organizations responded to the survey. Of these, 34 (28%) are West Region plans; 18 (15%) are plans with national coverage. For only this section of the report, three sets of responses are presented: those from plans in the West Region; responses from plans with national coverage; and responses from all plans nationwide, representing all five geographic regions.

Preferred Care Settings

The preferred cancer care treatment locations for plans with national coverage are freestanding infusion clinics (Figure 46). For West Region plans, the community physician's office is favored. Least preferred for all plan types are retail pharmacy infusion facilities.

Medical and Pharmacy Benefits

Among West Region plans, 76% are actively managing cancer care in their medical and pharmacy benefits plans compared with about two-thirds of other plan types.

For West Region plans, all plans nationwide, and plans with national coverage, injectable/infused drugs make up the greatest proportion of cancer spend under the medical benefit (36%, 32%, and 31%, respectively). Hospital services are a significant component (22%, 26%, and 29%, respectively) for all plan types. More than half of all plans nationwide (60%) and plans with national coverage (72%) expect to see increased spending on injectable/infused drugs, and also on oral drugs (60% and 59%, respectively) under the medical benefit in the next year. For West Region plans predictions for changes in spending on injectables and orals are more evenly split between increasing (47% for injectables and 50% for orals) and no change (44% for both).

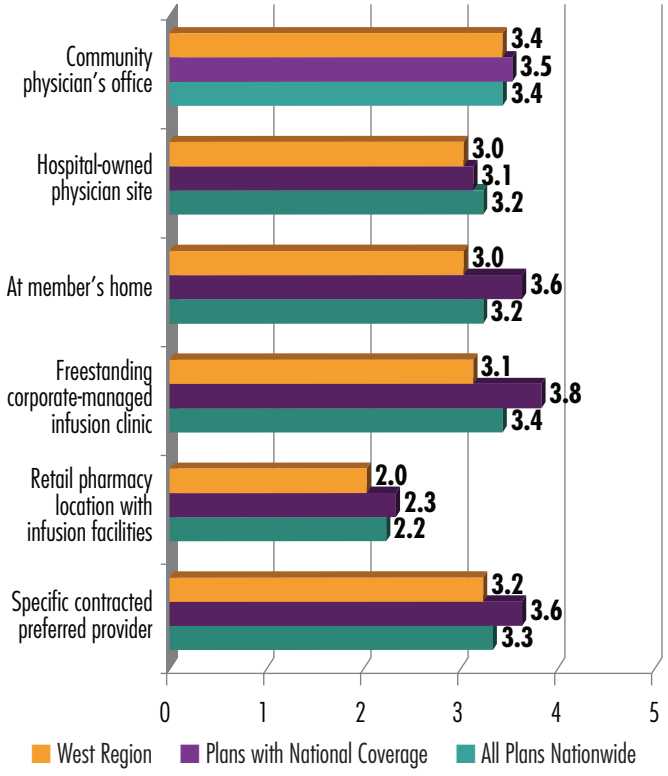
Oral drugs account for 53% of the pharmacy benefit cancer spend for West Region plans, 50% for all plans nationwide and 59% for plans with national coverage. Significantly more of all plan types expect the portion allocated to oral drugs under the pharmacy benefit to increase over the next year than expect the proportion of injectable/infused drugs to increase.

Plans with national coverage (56%) report that employers are expressing greater concern or desire for a role in determining oncology reimbursement policy, compared with 46% of all plans nationwide and 41% of West Region plans. Select clients are expressing concerns but are allowing plans to determine specifics.

Specialty Pharmacy

West Region plans lead other plan types in allowing physicians to determine the best source of injectable/infused drugs for their patients (Figure 47). Use of a preferred specialty pharmacy in oncology is still optional with many plans that indicate they will not force this requirement in the next 12 to 18 months.

Figure 46 Preferred Cancer Care Settings
Scale of 1–5: 1 = least preferred; 5 = most preferred



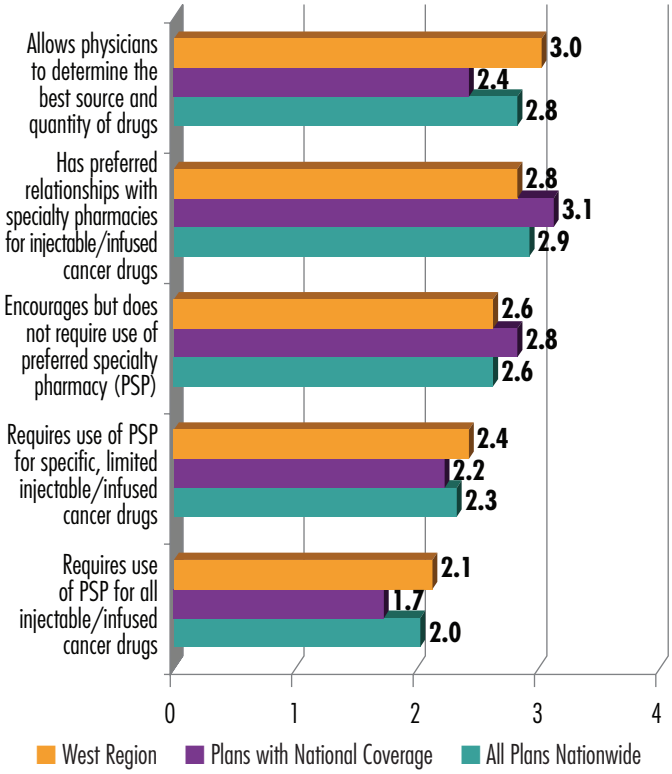
All plan types favor having preferred relationships with one or more specialty pharmacies to obtain oral cancer drugs (Figure 48).

Access to Data

Plans are seeking more information in order to make better-informed decisions concerning coverage and patient management. Of plans that require prior authorization for cancer drugs or treatments, most review physician notes along with lab tests to determine results within certain parameters.

Plans with national coverage (84%) are more likely to have a medical policy regarding approved coverage of cancer treatments than are West Region plans (78%) and all plans nationwide (75%). The policy is most often applied by drug under plans with national coverage (44%) and all plans nationwide (33%). West Region plan responses were split between applied by drug and applied by ICD-9 disease classification (24% each).

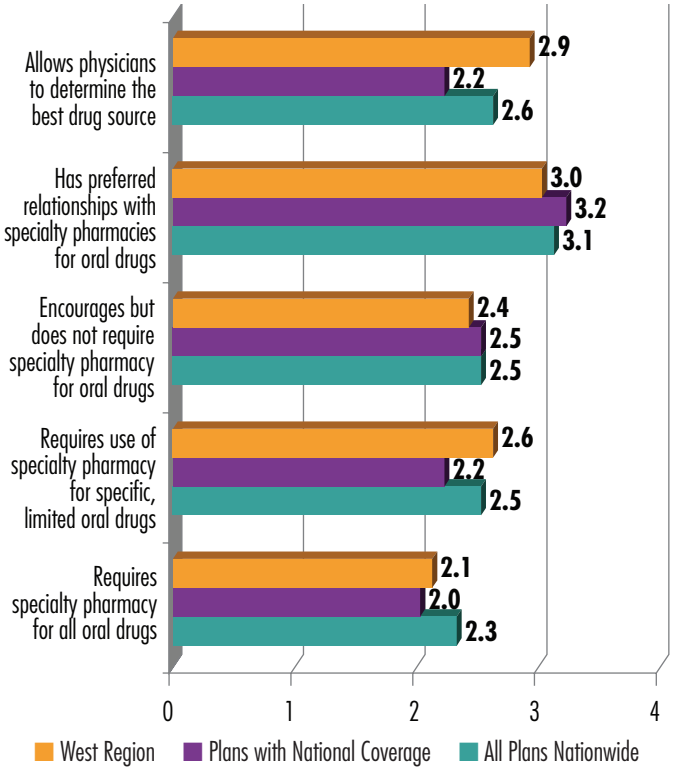
Figure 47 Policies for Acquiring Injectable/Infused Drugs
1 = Will not do; 2 = Considering doing in next 12–18 months; 3 = Will do within the next 12–18 months; 4 = Currently doing



Plans rely on many different information sources on oncology treatments to determine coverage policy. For all plans nationwide and plans with national coverage the top information source is FDA labeling (78% and 83% respectively). Also preferred by all plans nationwide are NCCN Guidelines (76%) and NCCN Compendia (70%). Sources favored by West Region plans are NCCN Guidelines (83%) and FDA labeling (79%). Plans with national coverage also favor NCCN Compendia (78%), NCCN Guidelines (78%), and US Pharmacopeia Drug Information (72%).

"The variety and use of multiple sources demonstrates the difficulty as well as the complexity for plans in managing oncology treatments," observes Randy Vogenberg, PhD, RPh, principal, Institute for Integrated Healthcare.

Figure 48 Policies for Acquiring Oral Drugs
1 = Will not do; 2 = Considering doing in next 12–18 months; 3 = Will do within the next 12–18 months; 4 = Currently doing



Disease Stage Data

Nearly three-quarters (74%) of West Region plans review disease stage data on members with cancer, the highest rate among all regions, compared with 54% of all plans nationwide and 67% of plans with national coverage. Plans with national coverage most often review disease stage data by requiring staging information on prior authorization forms (39%) while all plans nationwide and West Region plans request and review medical records (27% and 47% respectively). These disease stage data are not retained and tracked by most respondents.

"Disease stage data offers plans the opportunity to engage oncologists in a discussion around alignment of incentives and the creation of pathways," says Maria Lopes, MD, chief medical officer, AMC Health. "In late stage disease, where treatment options produce marginal benefit in overall survival and may not improve quality of life, engaging patients and their families around such treatment options using pathways can significantly reduce costs and variability in care. Pathways incorporate evidence-based treatment and may include biomarkers as well as supportive care treatments."

"The lack of health IT penetration across all providers complicates efforts of plans in seeking more detailed and accurate staging data," adds Vogenberg.

Reimbursement Formulas

The most commonly used reimbursement rate for office-administered oncology drugs under the medical benefit in the non-Medicare setting for plans with national coverage (37%), and all plans nationwide (22%) is average sales price (ASP) plus 6%. For West Region plans, reimbursement rates are more variable; ASP plus 6% and ASP plus 7%-12% are most common (18% each). Over half of all plan types, including 62% of West Region plans, did not adjust professional fees in conjunction with a move to ASP-based reimbursement.

Just 38% of West Region plans see Medicare rates as sufficient reimbursement for professional services compared with 44% of both plans with national coverage and all plans nationwide. Similar proportions of West Region plans regard 50% over Medicare rates as fair (35%), as do 44% of plans with national coverage and 38% of all plans nationwide.

Reimbursement pricing of cancer products utilizes a publicly available basis (such as ASP or AWP), according 68% of West Region plans, 78% of plans with national coverage, and 72% of all plans nationwide. Modifications of specific drug rates to incentivize physicians or to promote use within medical policy is reported by 56%, 51%, and 56% of plans, respectively.

Oncology Care Management

Of oncology management strategies, plans with national coverage are most likely over time to favor enforcement of strict laboratory value thresholds as a prerequisite for product access (2.9 out of a possible 4.0). That strategy was rated 2.8 by West Region plans, behind differential prior authorization rules to direct physicians to a preferred agent within a therapeutic class (2.9), and step therapy (3.0). Only a few plans expect to introduce a separate benefit design for oncology therapies.

Oncology management services are being strongly considered by plans for the next 12 months (at rates between 89% and 100%), most often with internal staff (53% of West Region plans, 50% of plans with national coverage, and 56% of all plans nationwide) or specific oncology providers (41%, 31%, and 35% respectively), rather than with an external oncology management vendor (6%, 19%, and 9%, respectively).

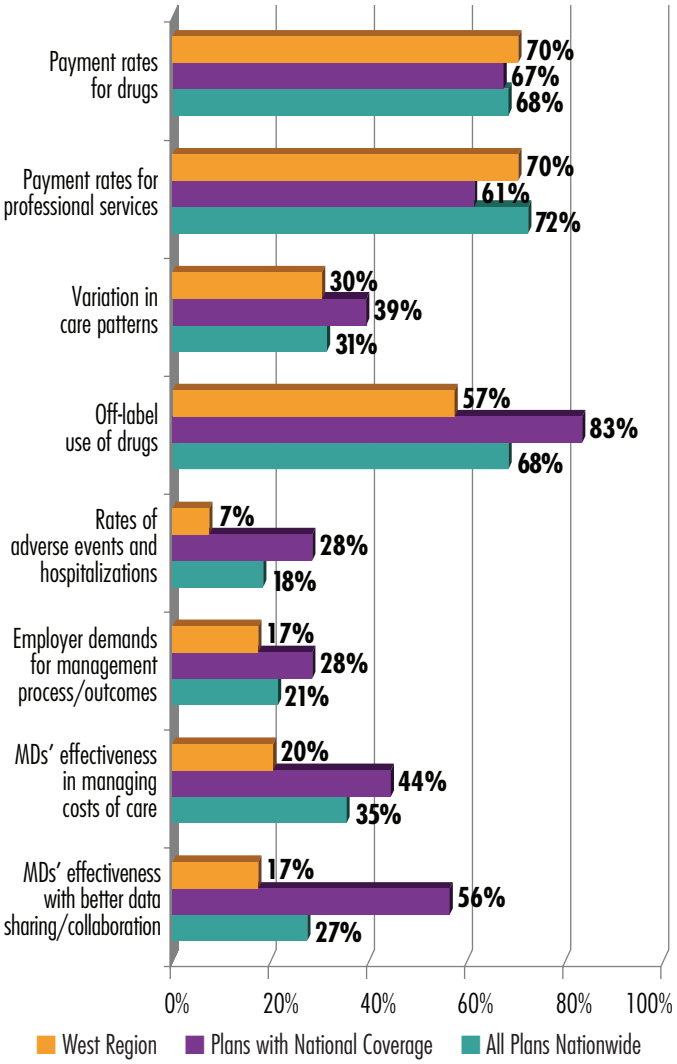
All plans nationwide favor mandatory prior authorization (60%) and use of guidelines (50%), with higher proportions for West Region plans (82%, 65%, respectively). Most other types of oncology management, including pathways and symptom management, are used predominantly on a voluntary basis.

Plan-Provider Relationships

For plans with national coverage, the most sensitive issue that may affect current or future relations with oncology providers is off-label use of drugs (83%) (Figure 49). For West Region plans, payment rates for drugs and payment rates for professional services are tied (70%).

"The top three concerns identified as the pressure points with providers focus on cost and misalignment of incentives," says Lopes. "As profit margins erode on drugs, site of care and controlling appropriate use of treatments remain focal points as payers address escalating costs and the industry evolves into a better understanding of accountable care through alignment of incentives between payers and treating physicians," she adds.

Figure 49 Issues Affecting Provider Relations

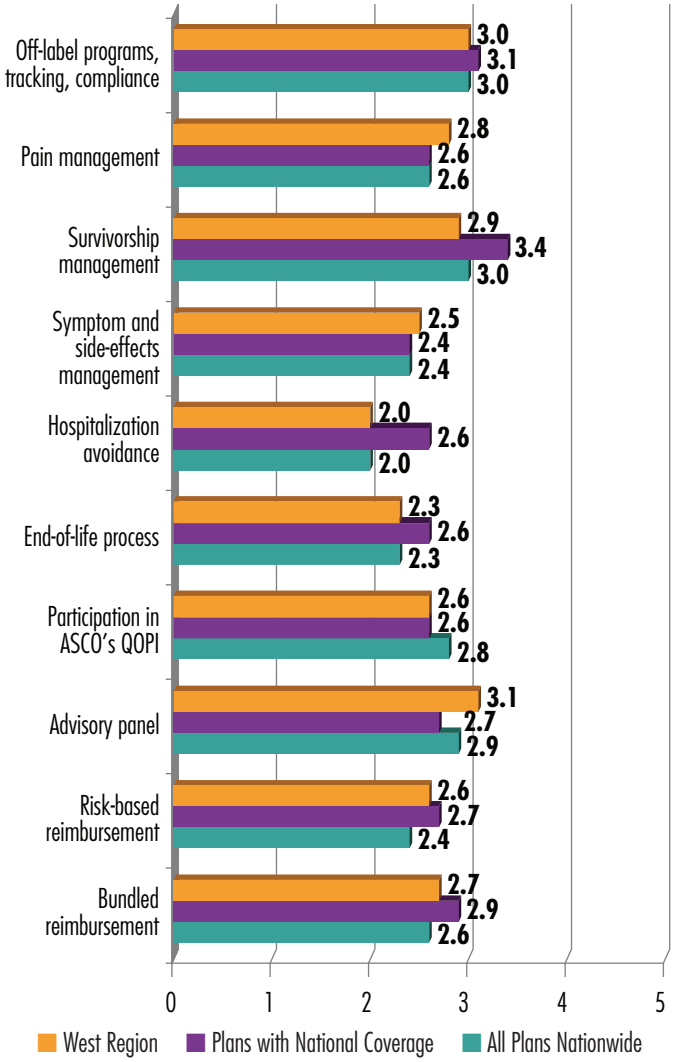


Interest in Collaboration

West Region plans (44% currently doing) and all plans nationwide (45%) are more likely to contract with hospital-based oncology practices than plans with national coverage (18%). Plans with national coverage are generally not interested in contracting with private practices of fewer than 20 oncologists.

Plans with national coverage show the most interest in collaborating with providers on survivorship management programs (Figure 50). West Region plans seek oncologists to serve on advisory panels.

Figure 50 Interest in Collaboration with Oncology Practices or Centers by Program Type
Scale of 1–5: 1 = little or no interest; 5 = extremely interested



Breast Cancer Treatment

Asked about approval of various adjuvant treatments of breast cancer, all plans nationwide and West Region plans tend to respond that they have no specific policy; plans with national coverage are significantly more likely than other plan types to "approve treatment if prior authorization requirements are met" (Figure 51).

Most plans will approve treatment for patients with positive hormone findings for the life of the patient (75% of West Region plans, 67% of plans with national coverage, and 79% of all plans nationwide).

Policies for treatment for breast cancer patients with recurrent metastatic disease vary by treatment and region (Figure 52).

Figure 51 Policy for Adjuvant Treatment of Breast Cancer

Chemotherapy with anthracyclines					
West Region	0%	30%	9%	24%	36%
Plans with National Coverage	0%	53%	6%	12%	29%
All Plans Nationwide	0%	29%	8%	23%	40%
Chemotherapy without anthracyclines					
West Region	0%	33%	6%	24%	36%
Plans with National Coverage	6%	47%	6%	12%	29%
All Plans Nationwide	1%	27%	9%	23%	40%
If HER2+, HER2 pathway inhibitors					
West Region	3%	36%	12%	15%	33%
Plans with National Coverage	0%	71%	6%	6%	18%
All Plans Nationwide	1%	35%	9%	20%	34%
HER2 pathway inhibitors					
West Region	3%	36%	12%	15%	33%
Plans with National Coverage	0%	71%	6%	6%	18%
All Plans Nationwide	1%	34%	10%	20%	35%
Antiangiogenesis agent					
West Region	0%	45%	21%	6%	27%
Plans with National Coverage	0%	65%	6%	6%	24%
All Plans Nationwide	0%	39%	15%	13%	34%

Do not approve treatment
Approve treatment if prior authorization requirements are met
Pending treatment for medical review before approval
Approve treatment without prior authorization or medical review
No specific policy

Figure 52 Policy for Treatment of Recurrent Metastatic Breast Cancer

Chemotherapy					
West Region	0%	40%	13%	27%	20%
Plans with National Coverage	0%	47%	18%	12%	24%
All Plans Nationwide	0%	31%	12%	22%	35%
Radiation therapy					
West Region	0%	37%	10%	27%	27%
Plans with National Coverage	0%	35%	18%	12%	35%
All Plans Nationwide	0%	27%	11%	24%	37%
Biotherapy					
West Region	7%	23%	20%	17%	33%
Plans with National Coverage	6%	29%	24%	6%	35%
All Plans Nationwide	6%	19%	18%	12%	46%
Bone targeting therapies					
West Region	0%	37%	20%	20%	23%
Plans with National Coverage	0%	35%	24%	12%	29%
All Plans Nationwide	1%	29%	16%	15%	39%
Rank-ligand targeted therapies					
West Region	0%	43%	20%	10%	27%
Plans with National Coverage	0%	41%	18%	6%	35%
All Plans Nationwide	1%	30%	14%	11%	44%

Do not approve treatment
Approve treatment if prior authorization requirements are met
Pending treatment for medical review before approval
Approve treatment without prior authorization or medical review
No specific policy

Approximately three-quarters of all plan types indicate that they would like to see physicians introduce discussion of palliative care with breast cancer patients whose disease has progressed to stage III or in whom cancer has recurred.

Prostate Cancer Treatment

The most frequent response of all plan types regarding approval of treatment options for prostate cancer is that they have no specific policy. Where policies are in place, most plans with national coverage require prior authorization.

Plans are more likely to have a specific policy for authorization of treatment of stage III or IV prostate cancer (Figure 54). All plan types tend to rely most on prior authorization.

Most plans (77% of West Region plans, 71% of plans with national coverage, and 74% of all plans nationwide) cover the use of vaccines/immunotherapy for patients with stage IV metastatic, hormone-refractory prostate cancer.

Figure 53 Policy for Treatment of Early-Stage Prostate Cancer

Radical nerve sparing prostatectomy					
West Region	0%	21%	10%	34%	34%
Plans with National Coverage	0%	35%	24%	6%	35%
All Plans Nationwide	2%	25%	12%	21%	39%
Laparoscopic prostatectomy					
West Region	0%	21%	14%	31%	34%
Plans with National Coverage	0%	35%	24%	6%	35%
All Plans Nationwide	0%	24%	15%	21%	39%
Robotic prostatectomy					
West Region	10%	21%	10%	24%	34%
Plans with National Coverage	0%	35%	24%	6%	35%
All Plans Nationwide	7%	21%	13%	19%	41%
Brachytherapy					
West Region	3%	21%	17%	21%	38%
Plans with National Coverage	0%	35%	24%	6%	35%
All Plans Nationwide	2%	22%	17%	17%	42%
Conformal RT					
West Region	0%	21%	17%	17%	45%
Plans with National Coverage	0%	29%	24%	6%	41%
All Plans Nationwide	1%	20%	17%	16%	46%
IMRT					
West Region	0%	21%	21%	10%	48%
Plans with National Coverage	0%	29%	29%	6%	35%
All Plans Nationwide	1%	21%	21%	13%	44%
Antiangiogenesis drugs					
West Region	7%	34%	17%	10%	31%
Plans with National Coverage	0%	47%	18%	6%	29%
All Plans Nationwide	2%	29%	19%	14%	36%

Figure 53 Policy for Treatment of Early-Stage Prostate Cancer (cont.)

Biologics/immunotherapy					
West Region	3%	41%	10%	14%	31%
Plans with National Coverage	0%	47%	18%	6%	29%
All Plans Nationwide	4%	29%	14%	17%	36%
Chemotherapy					
West Region	0%	24%	14%	28%	34%
Plans with National Coverage	0%	47%	18%	12%	24%
All Plans Nationwide	0%	27%	13%	27%	33%
Anthracycline chemotherapy					
West Region	0%	21%	14%	24%	41%
Plans with National Coverage	0%	47%	12%	12%	29%
All Plans Nationwide	0%	25%	14%	22%	40%
ADT agents, including LHRH					
West Region	0%	34%	14%	14%	38%
Plans with National Coverage	0%	47%	18%	6%	29%
All Plans Nationwide	0%	31%	17%	15%	37%
Antiandrogen					
West Region	0%	31%	10%	17%	41%
Plans with National Coverage	0%	53%	12%	12%	24%
All Plans Nationwide	0%	29%	12%	21%	38%
Generic antiandrogens or ADT agents					
West Region	3%	34%	10%	14%	38%
Plans with National Coverage	0%	47%	18%	12%	24%
All Plans Nationwide	1%	29%	10%	20%	40%

- Do not approve treatment
- Approve treatment if prior authorization requirements are met
- Pending treatment for medical review before approval
- Approve treatment without prior authorization or medical review
- No specific policy

Figure 54 Policy for Treatment of Late-Stage Prostate Cancer

Antiangiogenesis drugs					
West Region	10%	40%	7%	17%	27%
Plans with National Coverage	0%	47%	24%	6%	24%
All Plans Nationwide	3%	30%	15%	18%	35%
Biologics/immunotherapy					
West Region	7%	50%	7%	13%	23%
Plans with National Coverage	0%	47%	18%	12%	24%
All Plans Nationwide	3%	36%	11%	18%	32%
Chemotherapy					
West Region	0%	33%	7%	27%	33%
Plans with National Coverage	0%	41%	18%	18%	24%
All Plans Nationwide	0%	30%	9%	26%	35%
Anthracycline chemotherapy					
West Region	0%	24%	10%	24%	41%
Plans with National Coverage	0%	35%	18%	18%	29%
All Plans Nationwide	0%	24%	11%	23%	41%
ADT agents, including LHRH					
West Region	0%	37%	10%	17%	37%
Plans with National Coverage	0%	41%	18%	12%	29%
All Plans Nationwide	1%	29%	14%	19%	38%
Antiandrogen					
West Region	0%	33%	10%	17%	40%
Plans with National Coverage	0%	41%	18%	18%	24%
All Plans Nationwide	0%	29%	12%	20%	39%
Generic antiandrogens or ADT agents					
West Region	3%	37%	10%	10%	40%
Plans with National Coverage	0%	41%	18%	18%	24%
All Plans Nationwide	1%	29%	12%	19%	40%

Do not approve treatment
Approve treatment if prior authorization requirements are met
Pending treatment for medical review before approval
Approve treatment without prior authorization or medical review
No specific policy

Colorectal Cancer Treatment

Treatment policies for colorectal cancer patients are generally consistent across all plan types, although plans with national coverage tend to require prior authorization regardless of treatment (Figure 55).

A majority of health plans agree that stage III is an appropriate time for physicians to discuss palliative care with colorectal cancer patients; responses range from 90% for West Region plans to 81% of plans with national coverage and 75% of all plans nationwide. About three-quarters of all plan types agree that recurring disease is also an indicator for physicians to discuss palliative care options with patients.

Figure 55 Policy for Treatment of Colorectal Cancer Patients

Chemotherapy					
West Region	0%	37%	13%	30%	20%
Plans with National Coverage	0%	56%	11%	11%	22%
All Plans Nationwide	0%	32%	9%	27%	32%
Growth factors					
West Region	0%	37%	13%	23%	27%
Plans with National Coverage	0%	61%	11%	11%	17%
All Plans Nationwide	0%	40%	12%	19%	30%
EGFR-targeted therapy for any patient					
West Region	0%	43%	20%	10%	27%
Plans with National Coverage	0%	56%	17%	6%	22%
All Plans Nationwide	1%	36%	15%	15%	33%
EGFR-targeted therapy for *KRAS* patient					
West Region	0%	43%	23%	7%	27%
Plans with National Coverage	0%	56%	17%	6%	22%
All Plans Nationwide	1%	35%	17%	13%	35%
Antiangiogenesis therapy first-line					
West Region	0%	47%	13%	17%	20%
Plans with National Coverage	0%	50%	17%	6%	28%
All Plans Nationwide	3%	33%	11%	19%	35%
Antiangiogenesis therapy later lines					
West Region	0%	50%	17%	13%	20%
Plans with National Coverage	0%	50%	17%	6%	28%
All Plans Nationwide	2%	33%	15%	17%	34%

Do not approve treatment
Approve treatment if prior authorization requirements are met
Pending treatment for medical review before approval
Approve treatment without prior authorization or medical review
No specific policy

Conclusions

These conclusions are based on findings from the SDI analyses of breast cancer, prostate cancer and colorectal cancer treatments; the survey of oncology practices; and the survey of health plan executives.

- Patients covered under Medicaid face challenges in accessing adequate and timely cancer care regardless of cancer type or region. Medicaid patients with treatable disease have the lowest percentages of early stage breast cancer, colorectal cancer, and prostate cancer diagnoses in all five regions.
- Both West Region practices and West Region plans cite payment rates for drugs as a sensitive issue in their relationship, tied with payment rates for professional services. For plans with national coverage, the top concern is off-label use of drugs. Practices and plans nationwide agree that the most sensitive issue is payment rates for professional services. Oncologists have seen a growing distance between Medicare payment policy and what they deem to be acceptable reimbursement rates. Historically, private payers have used Medicare policies and payment rates as a basis for private reimbursement. Thirty-eight percent of West Region plans see current Medicare rates for professional services as sufficient on which to base private plan rates, but not a single West Region practice agrees. A much narrower gap exists between West Region plans (35%) and West Region practices (33%) that favor reimbursement at 50% over Medicare rates.
- Oncology practices are primarily focused on care delivery. However, they also need to more actively manage the business side of their practices and their relationships with health plans. Perhaps because of their smaller average size, West Region practices are slightly less successful than practices nationwide in negotiating plan contracts.
- Despite facing financial strains due to proposed Medicare reimbursement cuts of 20% to 30%, more than half of practices say they will continue to treat Medicare patients as usual. Another third expect to refer such patients to hospital-based infusion centers, which would likely prove more costly to both public and private insurers. Policymakers need to guard against unintended consequences of cost containment measures.
- More strategic use of technology could facilitate the use of clinical data and care outcomes. EMRs remain underutilized for improving patient outcomes and practice management. Incorporation of guidelines into EMRs could encourage their use and improve monitoring of compliance.
- Coverage policies of specific therapies for breast cancer patients of plans with national coverage tend to be more formalized and restrictive than those of both regional plans and all plans nationwide. Plan coverage policies and procedures for prior authorization can have a significant impact on access to care and on which therapies are prescribed.
- While plans and practices agree on the need to discuss palliative care with breast cancer patients once patients reach stage IV, there is no such consensus for colorectal cancer. Plans favor such discussions with stage III colorectal cancer patients but oncologists would wait until stage IV.
- Physicians show more interest in collaborating with plans than plans do in collaborating with practices. For all practices and plans nationwide, using a scale of 1 to 5, physician interest in all programs ranged from 2.6 to 3.4 while plan interest ranged from 2.0 to 3.0. Several programs garnered high interest from both practices and plans, suggesting likely areas for collaboration. These include survivorship management programs (3.0 for both), advisory panel (3.1, 2.9, respectively), and participation in the American Society of Clinical Oncology's QOPI (3.1, 2.8, respectively). Collaborative efforts could promote innovation and lead to new reimbursement models.
- Nationwide, it appears that part of the impact of health care payers' efforts to drive down cost has been movement in the treatment of complex/costly breast cancer, colorectal cancer, and prostate cancer cases from physicians' offices to hospital outpatient settings. The impact of this apparent shift is significant for payers, given the consistently higher cost of treatment in a hospital outpatient setting.
- Changes in public and private payer payment models combined with higher medication costs have reduced profitability for many oncology practices. Practices that cannot finance the carrying costs of new, more costly, therapies may have to move cases that require these treatments to hospital outpatient settings, or find new ways to ensure the continued economic viability of their practices.

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Thank you to the National Association of Managed Care Physicians for its assistance.

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