NEW PROJECTS & MODELS

Panel Moderator: Laura Long, MD
President, The Long View, PC
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MODERATOR: LAURA LONG, MD

• Horizon BCBS, New Jersey
  – Lili Brillstein, Director, Episodes of Care, Horizon BCBS of New Jersey
  – Edward Licitra, MD, PhD, Medical Oncologist, Regional Cancer Care Associates, LLC

• BCBS of South Carolina
  – Rene Frick, Senior Director, Innovations and Partnerships, BCBS of South Carolina
  – Kashap Patel, MD, Carolina Blood and Cancer Care Associates

• Sentara Healthcare, Virginia
  – George Leidig, Director, Provider Contracting and Reimbursement, Optima Health Plan
  – Karen Mercier, State Manager of Managed Care Contracting, Virginia Oncology Assoc.

• Mercer, Illinois
  – Sandra Kuhn, LCSW, MSW, Principal, Mercer

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Oncology Episodes of Care

Episodes of Care (EOC) • Full spectrum of health care services related to and delivered for a specific medical condition, illness, procedure or health care event during a defined time period.

Primary Goals: Standardize & Optimize Care and Cost of Care
• Compare like patients and like outcomes, study variation in utilization and cost of care
• EOC stratification/bundles allows for like patients to be grouped together (apples to apples comparison)

“Standard” EOC vs Oncology EOC
• “Standard” EOC Algorithms – Stratification based on claims
• Oncology – COTA - Stratification based on clinical criteria

Benefits
• Allows for more precise stratification of members and episodes
• Includes clinical and claims/cost information
• Disease state considered
• Precise ability to compare truly like patients with like disease
• Not just apples to apples – Honeycrisp to Honeycrisp,

Macoun to Macoun...

Proprietary and Confidential

Clincially Relevant Factors

| ICD 9 Code | 174.9 |
| ICD 10 Code | C50.11 |
| Therapy Type | Adjunct |
| Age | 49 |
| Tumor Size | 3.5cm |
| Nodal Involvement | No |
| Estrogen Receptor | Positive |
| Progesterone Receptor | Positive |
| Her2 | Negative |
| OncotypeDX | 12 |

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Utilized a comprehensive, multi-faceted, patient-centered approach

• Incorporated targeted pathways to assure delivery of evidence based care
• Improved access with implementation/expansion of “after hours/weekend” coverage and available services to decrease admissions, ER visits and improve patient satisfaction
• Leveraged technology to reduce administrative burden and provide relevant clinical information at the point of care
Utilized a comprehensive, multi-faceted, patient-centered approach, continued...

- Involve practice care manager to visit admitted patients and develop care plan and transition services
- Enhanced end of life planning by developing a family conference model including ancillary care providers as needed (psychologist, social worker, etc.)
- Support survivorship programs to enhance surveillance for recurrence and secondary cancers as well as improve physical and emotional recovery

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Stage 1:
Initial Discussions
Rationalized Drug Rates

Stage 2:
Graduated Discussion
Quality Improvement Components

Stage 3:
Discussion Going Forward
Prospective vs. Retrospective

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EMPLOYER TRENDS INNOVATIONS IN ONCOLOGY CARE

• Key cost driver:
  – Oncology is often leading diagnostic category for high cost claimants
    - Impacts member quality of life, productivity and employer spend

• Employers challenged with “what to do”:
  – Episodic vs longitudinal care differences
  – Information about quality/outcomes not widely available – diagnostic and therapeutic
  – Emphasis on solutions that don’t emphasize quality and social supports

• Most common emerging “solutions” include COEs, regional value based care arrangements and expert second opinion programs

• Increasing focus is on member experience:
  - Evolving efforts toward packaging education, programming, social supports
  - Innovations in technology introducing direct to member solutions

MARKET POSITIONING INNOVATIONS IN ONCOLOGY CARE

• Employers will need more information and solutions
  – Where should program focus be? Evidence based practices, emerging technologies, palliative care?
  – How has care evolved over time?
    - Are there opportunities to move care to lower cost settings without sacrificing quality?
  – What value based contracting opportunities exist?
    - What should employers look at in their own data to determine gaps?
    - Are health plans the only source for value based contracting?
  – How is care coordinated and integrated for purposes of value based arrangements?
    - For example, bundled payments and role of COE and community providers?
    - What are the determinants of an integrated approach – chemotherapy, technology etc…
    - Local vs. best in class?
  – Address employer concerns about fraud? Unnecessary treatments, misdiagnosis?
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