ANCO COMMENTS SENT TO JENNIFER MALIN, M.D.,
ANTHEM BLUE CROSS MEDICAL DIRECTOR FOR ONCOLOGY

Thank you very much for presenting and discussing the *Wellpoint Cancer Care Quality Program Treatment Pathways* with the ANCO *Board of Directors* on June 18. The *Board* has a number of comments and concerns that it wishes to communicate to you regarding the *Pathways*. The purpose of this e-mail is to present these comments and concerns to you and to continue the discussion of the *Program*.

In summary, ANCO understands that *Wellpoint's* stated goal in developing its *Cancer Care Quality Program Treatment Pathways* is to ensure access to quality and affordable cancer care and reduce unwarranted variation in the quality and cost of the cancer care provided to its beneficiaries. ANCO shares *Wellpoint's* goal of ensuring access to quality cancer care and acknowledges that any variation in cancer care that may occur impacts quality and cost. Providers have not been good at managing healthcare costs and certainly are partially responsible for a substantial amount of suboptimal spending. However, ANCO is concerned that *Wellpoint's Pathways* sacrifice access to effective cancer treatment regimens in the interest of savings to the payer and that its manner of developing its *Pathways* presents both methodological, logistical, clinical, and ethical problems. Wellpoint's approach is not a good solution the the problem.

ANCO understands that *Wellpoint's Pathways* were developed in a manner that follows their P&T process using an internal team of oncologists and pharmacists. Data regarding clinical effectiveness, toxicity, and cost for cancer treatment regimens were reviewed by the internal team which then recommended a number of preferred *Pathways* for breast, colorectal, and non-small cell lung cancer. These recommendations were then reviewed by a national board of external advisors prior to adoption. What is unclear is how these parameters (i.e., effectiveness, toxicity, and cost) were prioritized.

ANCO is extremely concerned that neither the data used in the

internal analyses nor the names of the external advisors reviewing the recommendations of the internal team are public. You emphasized during your presentation to the *Board* that *Wellpoint* did not adopt any set of existing pathways due to their lack of transparency. We do not find that *Wellpoint's* process is any more transparent. The *Program's* lack of transparency results in methodological, logistical, clinical, and ethical problems, as follows:

1. From a methodological perspective, *Wellpoint's* lack of transparency does not allow any peer or independent review of the data or its analysis to be conducted to ensure that the *Pathways* reflect a balanced, but prioritized, consideration of clinical effectiveness, toxicity, and cost. This is especially important given that the *Pathways* restrict clinical treatment choices. Providers cannot answer the very important question: How do I know that the *Pathway* provides the highest quality for the least cost (i.e., the best value)? They may suspect that the *Pathways* sacrifice quality for cost given *Wellpoint's* interest in reducing costs.

2. From a logistical perspective, your providers will view with suspicion these *Pathways* since neither they nor their representatives at their professional organizations were consulted, involved in, or can review the background for selecting the *Pathways* to treat their patients. Adoption of the *Program* will be hindered as a result. Providers will suspect that the *Pathways* were driven more by cost savings for the payer than by best value (i.e., highest quality for least cost) for the patient. And, providers will deeply resist following pathways they suspect of being developed in this matter.

3. From an ethical perspective, most providers, and many payers, follow the NCCN *Guidelines*. Your *Pathways* narrow the choices offered to providers by the *Guidelines.* This presents an ethical dilemma to the providers when planning treatments for patients—do they choose the best possible treatment for the patient that is included in the *Guidelines* or the one that is recommended by *Wellpoint* for a direct (i.e., per patient per month) and potential long-term (i.e., continued contracting) financial incentive? And, this financial incentive (and ethical challenge) is present for both the

payer (i.e., for *Wellpoint* through the savings generated by the use of less expensive drugs for which *Wellpoint* may have possibly contracted for with manufacturers for rebates). As a result, both payer and provider are placed both into serious conflicts of interest between their wallets and their patients best interests. *Wellpoint* and its physicians choosing financially-driven pathways will be perceived as being motivated by much more serious financial incentives to both (just as acceptance of a pen with a logo from a pharmaceutical company is perceived as incentivizing clinical choices by some). Will *Wellpoint* and its physicians be subject to Sunshine Act-like disclosures of what savings are accrued and funds are received by practicing medicine according to the *Pathways*? Finally, the financial incentive (i.e., per patient per month management fee for each beneficiary on *Pathway*) is a perverse and implied threat to physicians who do not comply with the pathways to the payer's satisfaction. It would only be fair to providers for them to know what compliance data will be collected and what analyses will be conducted with regard to the *Pathways*. For example, will providers be ranked as to their compliance with the *Pathways?* Will their future inclusion in networks be impacted by their compliance? Will future contract fee schedules be similarly determined? If providers do not follow the *Pathways* sufficiently, are they exposing themselves to the risk of being shut out of any potential preferred networks? Only with answers to these questions can providers make an informed choice as to their participation in your *Program* (after they are reassured that the *Pathways* fairly reflect quality cancer care).

4. From the clinical perspective, several of our *Board* members are subject matter experts on breast, colorectal, and non-small cell lung cancer. None of them were consulted in the development of these pathways. In general, they feel that *Wellpoint's Pathways* are out of step with both clinical practice and other guideline programs and that they reflect a selective analysis of the potential toxicities involved in using some regimens. In some cases, (e.g., lung) new drugs included in the NCCN *Guidelines* are absent from the *Pathway*? More generally, ANCO is concerned with the implied limitation to the lines of active treatment in *Wellpoint's Pathways* and with the absence of clinical trials as being "on pathway." Many other pathways programs

have encouraged early cessation of active care regardless of patient or physician wishes and evidence in support of continuing care. Similarly, there is a de facto incentive ***not*** to enroll a *Wellpoint* patient into a clinical trial given the financial incentive to enroll patients on a *Pathway*. As to your statement that "most control arms in clinical trials" will be on pathway, a provider should never know whether a patient is enrolled in the control or experimental arm of a randomized clinical trial. This will disrupt the ability to offer patients clinical trials.

ANCO has announced to its membership that *Wellpoint* intends to implement these *Pathways* in California in November 2014. We have further asked them to review and comment on the *Pathways* available at www.cancercarequalityprogram.com. We will collect their commentary and share it with you. Similarly, we will keep ASCO and our sister state societies informed as to your *Pathways* program and its implementation in California.

Finally, ANCO shall neither endorse nor encourage participation in *Wellpoint's* program.

Once again, thank you for presenting the *Pathways* to the ANCO *Board* and for considering our comments