WELLPOINT RESPONDS TO ANCO's COMMENTS

Thank you again for taking the time to meet with us to learn about Anthem's Cancer Care Quality Program and the Wellpoint Cancer Treatment Pathways as well as your subsequent email. We very much appreciate the ongoing dialogue with ANCO.

I would like to clarify what I think may have been some misconceptions about the Cancer Care Quality Program based upon some of the questions raised in your recent email.

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.

There appears to be a misunderstanding regarding the objectives of the Cancer Care Quality Program. The Cancer Treatment Pathways do not restrict a physician's medical judgment about the best treatment option for a patient. Treatments that are not on Pathway will continue to be reviewed just as they are today against Anthem's clinical criteria and services will be adjudicated according to the terms of the benefit plan.

We are in complete agreement with ANCO regarding the importance of transparency. The Pathways are available at www.cancercarequalityprogram.com and can be accessed by anyone via the internet. The data used to evaluate the regimens included in the Pathways and those regimens not selected for Pathways are obtained from the published literature and the publically reported

Average Sales Price (available on the CMS website), all of which is in the public domain. As stated during the telephone call, we are willing to share our detailed evidence summaries of the peer reviewed literature upon request. Please also recall that we already shared these data summaries with the ANCO Board of Directors immediately following our initial discussion on June 18th.

WellPoint Cancer Treatment Pathways are selected from therapies recommended by national guidelines on the basis of the following, and prioritized accordingly:

- *Clinical benefit (efficacy)*
- *Side-effects (toxicity), especially those that lead to hospitalizations or impact quality of life*
- *Strength of national guideline recommendations*
- *Cost*

Our highest priority is quality of care, and quality is not sacrificed for cost in the Pathways.

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.

We recognize that it is critical for Anthem to have a collaborative relationship with the providers in our network in order to help ensure that our members have access to quality care. We would welcome the opportunity to collaborate with ASCO in the development of Pathways and have encouraged ASCO to develop pathways that could be adopted by programs such as ours.

We have solicited feedback regarding our Cancer Care Quality Program from ASCO as well as the local oncology specialty societies, including ANCO's sister society in Southern California MOASC. MOASC is very enthusiastic about the program and has requested that Anthem move up the implementation date for California from the currently planned date in November 2014. We launched the Program in the Midwest and Georgia just two weeks ago and our current estimate is that even at this early stage we have over 80% of our in-network providers participating in the Program.

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? …. 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.

Again, as stated above, there appears to be a misunderstanding regarding the objectives of the Cancer Care Quality Program. The Cancer Treatment Pathways do not restrict a physician's medical judgment about the best treatment option for a patient. Treatments that are not on Pathway will continue to be reviewed just as they are today against Anthem's clinical criteria and services will be adjudicated according to the terms of the benefit plan.

You are correct that, by definition, since Pathways foster improved quality of care by decreasing unwarranted variation in care, they include a subset of the regimens recommended in most guidelines. Pathways are widely accepted as a component in managing oncology treatment quality and costs. More specific than

guidelines, pathways identify treatments selected based on effectiveness, favorable toxicity profiles, and cost. Over half of practices responding to ASCO's 2010 National Practice Benchmark report that they regularly use pathways in patient care. Organizations such as US Oncology that have implemented pathways have found that survival outcomes are equivalent for patients treated on and off pathway, while overall costs decrease substantially for patients treated on pathway. WellPoint's Cancer Treatment Pathways are aligned with NCCN, ASCO, and other evidence-based clinical guidelines.

The current approach to reimbursing cancer care includes many perverse incentives, most notable being that both a practice's financial viability and oncologist's personal income is enhanced when they prescribe chemotherapy – even when not warranted – as well as when prescribing a more expensive therapy. The additional reimbursement for treatment planning and care coordination that practices which participate may be eligible for when selecting a Pathway regimen was developed to help mitigate this existing financial incentive. For example, 4 cycles of bevacizumab+pemetrexed+carboplatin costs $64,988 at ASP+6%, and a practice would net $3,900 profit for prescribing this regimen. In contrast, 4 cycles of bevacizumab+ paclitaxel+ carboplatin costs $39,770 at ASP+6%, resulting in a profit of $2,386 for the practice. With the $350 monthly additional reimbursement for the latter regimen since it is considered a WellPoint Pathway, the practice would net $3,486, which is close, but still not as much net revenue as the more expensive, but equally effective regimen. We recognize that most oncologists are not selecting regimens based on their potential profit; however the current system raises many ethical dilemmas for the treating physician. We hope that oncologists, whether or not they choose to participate in the Anthem Cancer Care Quality Program, disclose all potential financial conflicts of interest to their patients, including the margin that their practice or institution makes from treatments that they administer, diagnostic tests performed, fees received to enroll patients on industry

sponsored clinical trials, pay for performance programs, shared savings programs, as well the reimbursement from using a pathway regimen.

(continued) …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).

Data being collected by the program is entered through the web portal by the practices themselves. A practice's adherence to Pathways compared with other practices in Anthem's network will be reported back to the practice on the portal as well. We plan to develop quarterly reports of Pathway adherence and other quality measures (such as hospitalizations due to treatment toxicity) to share with practices that in turn, may use this data to implement any of their own quality improvement programs. If, over time, these measures are to be used in pay for performance programs or other initiatives, participating network practices will be informed by Anthem about these initiatives in advance of their implementation.

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.

We encourage any clinical experts or other clinicians to provide feedback on the WellPoint Pathways at cancer.quality@wellpoint.com. We are fortunate to have a group of ten highly qualified external advisors who support our Pathway development process with their expertise, representing both academic and community practices across the United States. Five of our external advisors are from NCI-designated cancer centers and two of them practice in California. Over half of our external advisors have served on national advisory panels sponsored by ASCO and NQF and others.

Pathways are reviewed quarterly and new therapies may be added if those therapies are determined to be favorable in terms of effectiveness, toxicity and cost at that time. Since treatments that are not on Pathway will continue to be reviewed against Anthem clinical criteria and services will be adjudicated according to the terms of the benefit plan just as they are today, the Cancer Care Quality Program is not a barrier to prescribing a newly approved therapy for a patient when appropriate.

While we recognize that some other pathway programs have limits on lines of therapy, the Anthem Cancer Care Quality Program does not limit lines of therapy. All Pathways in the metastatic setting are established for first or second and "subsequent lines of therapy." While it may be possible to exhaust the options available to a patient, that unfortunately reflects the reality of the finite number of treatments for cancers with a poor prognosis and is not a result of the program. Additionally, an oncologist may recommend a third, fourth or beyond line of therapy regardless of whether an option exists on Pathway, and as stated above, the services will continue to be reviewed and adjudicated as they are today.

Since most institutions participating in clinical trials receive fees for enrolling patients in clinical trials as well as fulfilling other important institutional objectives and their research mission, it seems difficult to envision how a $350 payment would undermine the clinical trial programs at leading academic institutions or community practice research sites. Services for "usual care" as part of a clinical trial will continue to be adjudicated according to the terms of the benefit plan and applicable law, as they are today. If the "usual care" includes cancer treatment that is not being provided by the study sponsor, and the regimen is on Pathway, then the practice may still be eligible for additional reimbursement for treatment planning and care coordination through S0353 or S0354.

Thank you again for the opportunity to share our program with you and the feedback. We would welcome the opportunity to present information about Anthem's Cancer Care Quality Program to your members, either in person or as a webinar, and continue this dialogue.