Evaluation of payer-initiated oncology clinical pathways: Utilization trends, development, and barriers to implementation

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Background

- In the context of numerous product launches and rising costs in oncology, payers are increasingly interested in ensuring consistent and cost-effective care in this disease area
- Payer-initiated oncology clinical pathways (OCPs) allow payers to manage oncology spend while providing value-based care[1]
- The first OCPs were implemented over 10 years ago, and prior research has shown expansion in the use of clinical pathways among payers and providers across other therapeutic areas[2,3]
  - In 2016, 58% of oncology practices reported use of OCPs, which was 42% higher than in 2014[4,5]
- More recent trends in utilization and design of OCPs initiated and developed by payers are less clear
- There is a need to characterize the current development and utilization of payer-initiated OCPs to understand the extent to which OCPs still influence access to oncology treatments

Objectives

- To assess current trends in OCP utilization among United States (US) payers
- To identify the driving factors that influence development and uptake of OCPs
- To understand barriers to adoption of OCPs

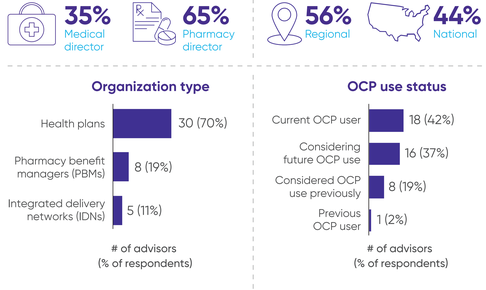
Methods

- An electronic payer survey containing multiple-choice, open-ended, and Likert scale-rating questions was fielded in November 2020 to Xcenda's Managed Care Network (MCN)
- MCN is a proprietary research panel of over 160 healthcare executives, medical and pharmacy directors, and other experienced individuals in managed care
- All survey respondents were required to have a general understanding of payer-initiated OCPs and be involved in managing medical policies for oncology products within their respective organizations

Respondent demographics

- A total of 43 advisors from Xcenda's MCN completed the survey (**Figure 1**)

Figure 1. Respondent demographics (N=43)



Results

Current users of OCPs (n=18)

OCP landscape among current users

- Of the 18 represented organizations currently using OCPs, the majority (83%) stated that their organizations plan to continue using OCPs over the next 5 years
- Improving patient outcomes was rated as the most important reason for adopting OCPs, followed by reducing variations in oncology care and improving overall quality of care (**Figure 2**); other rationales for adopting OCPs included leveraging combined expertise across care teams, minimizing off-label use of oncology medications, and maintaining formulary adherence
- Medical directors (89%) and oncology providers (83%) were the most common stakeholders involved in the development of OCPs; group purchasing organizations, manufacturers, and patients were not involved in the development of any OCPs represented by this group of advisors
- The most impactful challenges during OCP implementation were difficulty integrating OCPs with electronic health records (EHRs) or other clinical decision support tools and unknown return on investment associated with OCPs; other barriers cited by advisors included misaligned incentives for OCP adoption, lack of timely OCP updates, and difficult training and rollout of OCPs for staff members

Development of OCPs

- When determining which cancer types to include in OCPs, the cost of medications used to treat the cancer type was the most influential factor, followed by prevalence of the cancer type within the plan population and total cost of care associated with treating the cancer type (**Figure 3**)
- Anticancer medications, supportive care medications, and diagnostics are the most common components included in OCPs (**Figure 4**)
- All surveyed organizations consider efficacy of treatment when developing OCPs, and some consider additional factors such as those related to cost; impact on patient productivity and caregivers were not considered in the development of OCPs represented by this group of advisors (**Figure 5**)
- Clinical guidelines and peer-reviewed literature are the most influential sources of evidence used during OCP development, though all evidence types presented in the survey were on average at least somewhat influential to the development of OCPs (**Figure 6**)

Figure 2. Reasons for adopting OCPs

Reason	Average importance score
Improve patient outcomes	4.6
Reduce variations in oncology care	4.4
Improve overall quality of care	4.3
Decrease total costs of care	4.1
Decrease costs associated with anticancer medications	3.9
Improve overall patient satisfaction	3.7
Increase patient adherence	3.6
Decrease costs associated with other anticancer treatments*	3.4
Decrease costs associated with supportive care therapies	3.4

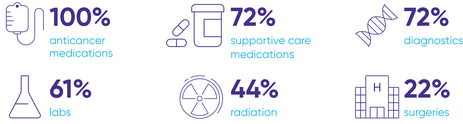
* eg, radiotherapy, surgery.
N=18
Q5. Please evaluate the following reasons your organization had for adopting OCPs in terms of their importance. 1 = not at all important; 2 = not very important; 3 = somewhat important; 4 = very important; 5 = extremely important.

Figure 3. Considerations when selecting cancer types for OCP inclusion

Consideration	Average importance score
High cost of medications used to treat cancer type	4.3
High prevalence of cancer type within the payer's covered population	4.2
High total cost of care associated with cancer type	4.2
High variability in treatment patterns for cancer type	4.1
Perceived suboptimal management of cancer type	3.6

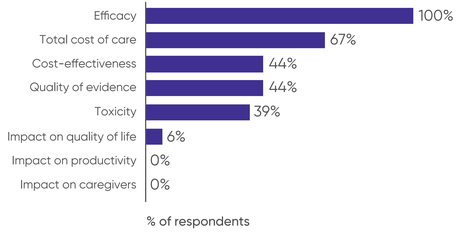
N=18
Q9. Please evaluate the following factors in terms of their importance in determining how your organization chooses which cancer types to include in OCPs. 1 = not at all important; 2 = not very important; 3 = somewhat important; 4 = very important; 5 = extremely important.

Figure 4. Components of care included in OCPs



% of respondents
N=18.
Q8. Which of the following components are incorporated in your organization's OCPs? Please select all that apply.

Figure 5. Factors influencing OCP design



N=18
Q11. Please select the top 3 factors that are most influential when designing OCPs at your organization.

Figure 6. Sources of evidence used in OCP development

Evidence source	Average influence score
Clinical guidelines	4.5
Peer-reviewed literature	4.5
Systematic literature reviews	4.2
Consensus guidelines	4.1
Value assessment frameworks	4.0
Payer organization's medical policies	3.9
Expert recommendations	3.7
Real-world evidence	3.6
Drug compendia	3.6
Economic analyses	3.4
Health technology assessments	3.2

N=18
Q12. Please evaluate the following sources of evidence in terms of their influence on the development of your organization's OCPs. 1 = not at all influential; 2 = not very influential; 3 = somewhat influential; 4 = very influential; 5 = extremely influential.

Non-users of OCPs (n=25)

OCP landscape among non-users

- Of the 25 respondents who do not currently use OCPs, around half (56%) stated that their organization last evaluated OCPs within the past 2 to 3 years
- The majority (88%) of these respondents stated that their organization's interest in OCPs has stayed the same or increased over the past 5 years
- The majority (60%) of respondents stated that their organizations were at least somewhat likely to implement an OCP within the next 5 years (**Figure 7**)

Figure 7. Likelihood of implementing OCPs in the next 5 years

N=25
Q24. What is the likelihood that your organization will implement OCPs within the next 5 years? 1 = not at all likely; 2 = not very likely; 3 = somewhat likely; 4 = very likely; 5 = extremely likely.

Considerations for future OCP implementation among non-users

- When asked about reasons for not implementing OCPs, advisors responded that unwillingness of their organizations to limit provider choice, potential administrative burden for payers, and pushback from providers were the top factors that have deterred their organizations from implementing OCPs (**Figure 8**)
- The top factors that influenced whether payer organizations would implement an OCP within the next 5 years were potential return on investment (78%), the ability to measure outcomes associated with OCPs (50%), and buy-in from oncology providers (44%)

Figure 8. Reasons for not implementing OCPs

Factor	Average influence score
Unwillingness to limit provider choice	4.2
Administrative burden for payers	4.0
Pushback from providers	3.8
Lack of ability to measure outcomes	3.6
Administrative burden for providers	3.4
Potential lack of return on investment	3.4
Workflow disruption for providers	3.1
Potential lack of clinical benefit	3.1
Limited EHR interoperability	2.8
Lack of interest in or awareness of OCPs	2.5

N=25
Q28. How influential were the following factors in your organization's inclination not to implement OCPs? 1 = not at all influential; 2 = not very influential; 3 = somewhat influential; 4 = very influential; 5 = extremely influential.

Limitations

- Survey results were descriptive in nature and based on a small number of respondents; thus, they may not be generalizable to all payer organizations or payer types
- Because all respondents voluntarily completed the survey, voluntary response bias may exist, and survey results may over-represent organizations with higher interest in implementing strategies to manage oncology treatments and spend

Conclusions

- OCPs continue to be a method that payers utilize or are interested in adopting to ensure high-value care in the oncology space
- Improving patient outcomes and controlling total cost of care within the oncology space are driving forces behind the utilization of OCPs by payers
- The development of OCPs is a multi-disciplinary effort; several stakeholders play a key role in the development of OCPs, including medical directors from payer organizations and oncology providers
- Manufacturers do not play a direct role in OCP development; however, some sources of evidence used to inform OCP design (eg, peer-reviewed literature, value assessment frameworks) may require manufacturer participation and engagement
- It is important for developers of OCPs to remain current on the body of evidence available for oncology treatments to inform OCP design and provide optimal access to oncology care

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