

Oregon Health Evidence Review Commission (HERC)

***How do we implement cost effective cancer treatment
in patients with short life expectancy with a limited
budget?***

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History of Medicaid

- Part of Great Society Legislation passed in 1965
 - Goal is to provide basic health care for most vulnerable in our society:
 - Children
 - Pregnant women
 - Most poor
 - Disabled
 - Operated by the states
 - Different rules depending on state priorities
 - Jointly funded by the state and federal governments
 - Up to 50% of money comes from CMS
 - Strings are attached
 - Money from other joint federal/state programs often blended in
 - Childrens' Health Insurance Program (CHIP)
 - Eligibility requirements set by the state

History of Oregon Health Plan

The story of Coby Howard

- Seven year old boy with Acute Leukemia diagnosed 1987
- Eligible for coverage by Oregon Medicaid
- Legislation passed before his diagnosis eliminated funding for marrow transplants for Oregon Medicaid patients
- Coby died before fund raising could cover cost of transplant
- Legislation subsequently introduced to return funding for transplants
 - Opposed by John Kitzhaber (state senator, ER physician)
 - Legislation ultimately failed
- In the aftermath a reorganization of funding priorities proposed, ultimately labeled Oregon Health Plan

Oregon Health Plan Goals



- Goal is health rather than insurance
- Public input important in prioritizing values that drive the plan
- **Budget constraints to be met by reducing benefits rather than cutting people or reducing payments below cost of delivering care**
- Prioritize coverage by using best evidence of clinical effectiveness
- Maintain integrity of prioritization by prohibiting legislative changes (i.e. legislators only set global budget, not specific coverage priorities)
- Expand coverage to a larger population of working poor by funding only most effective therapies
 - No guarantee for coverage for all standard therapies***

Prioritized List of Services



- Developed originally by consensus based on expert opinion
- Overseen by Oregon Health Services Commission
- Condition/Treatment Pairs comprise the list
 - ICD-9 Code paired with CPT code for given condition
 - Example: Coarctation of Aorta (line 50)
 - ICD-9 747.10
 - CPT 33720
- Total lines: 679 (GASTROINTESTINAL CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY)
- Funding Line: 502 or higher (CYSTS OF BARTHOLIN'S GLAND AND VULVA)

List Reorganization

Occurred in 2006 as a result of many years of incremental changes that resulted in inconsistencies

Categories of illness developed and prioritized:

1. Maternity and newborn care
2. Primary and secondary prevention
3. Chronic disease management
4. Reproductive services
5. Comfort care
6. Fatal Conditions with focus on cure or disease modifications
7. Nonfatal conditions focus on cure or disease modification
8. Self limiting conditions
9. Inconsequential care

What About Cancer Diagnoses?

Almost all are in covered lines:

- ALL (childhood) line 101,
- AML (transplants) line 102
- Testicular cancer line 123
- Hodgkin's lymphoma line 125
- Cervical cancer line 144
- Colon Cancer line 167
- NHL line 170
- Breast cancer line 197
- Myeloma line 198

Caveat: Treatments covered when given with essentially curative intent only.

Bar for cure rate set low (>5% five year survival)

What About Cancer Treatments that Don't Cure the Patient?



- Not covered in original plan design
- Implementation not consistent however:
 - No codes for curable versus incurable cancer
 - Bigger fish to fry
 - Not worth the hassle (deny 5FU/LV for colon cancer?)
 - Incurable cancer not a big cost in a plan covering many pregnant women and poor children

Cancer Costs in 2000 and beyond



- Routinely in top 5 on most health plan cost rankings
- Costs escalating at unsustainable rate
- Increasing evidence of high costs in last six months of life
- With most OHP patients now on managed care plans, health plan medical directors asked Oregon Health Service Commission clarify intent on treatment of cancer near end of life
- Issues like this in the prioritized list are addressed via practice guidelines

HSC Subcommittee



Recommendations regarding Palliative Care

- Palliation is always a covered service
- Palliative care questions should be separated from questions on use of chemo in terminal patients, especially when chemo goal is to extend life
- Palliative care is always covered whether patient's illness is terminal or not
- Patients with terminal illness considering chemo should have palliative care consult whenever possible

HSC Subcommittee Recommendations regarding Chemo in Incurable Disease



Guideline Note 12

- Least effective spending is in situations where most MDs would agree the patient is unlikely to benefit
- Evidence shows patients with limited reserve (poor performance status) do not benefit in most situations (or they were intentionally excluded from trials we might use to justify coverage)
- Tiered approach to coverage depending on life expectancy
- This was an expansion of benefits compared to previous list

When we spend money here unwisely, result is that somebody else (people with curable cancer, kids, pregnant women) are not covered at all

Guideline Note 12

Original version



Treatment with intent to prolong survival is not a covered service for patients with any of the following:

- Median survival of less than 6 months with or without treatment,
- Median survival with treatment of 6-12 months when the treatment is expected to improve median survival by less than 50%,
- Median survival with treatment of more than 12 months when the treatment is expected to improve median survival by less than 30%
- Poor prognosis with treatment, due to limited physical reserve or the ability to withstand treatment regimen, as indicated by low performance status

Note: If median survival with treatment >24 months, guideline does not apply

Challenges with Guideline Note 12

- Challenges with implementation
 - Not every situation has a randomized controlled clinical trial
 - Increasing use of progression free survival by FDA in approving drugs for use in patients with terminal illness
 - Crossover effects in many trials obscure the published outcomes on overall survival
- Affordable Care Act
 - Treatment decisions can't be based on life expectancy
 - Expansion of Medicaid with new federal dollars allows coverage of more patients
 - But expectation is that savings from more effective care delivery will offset less federal money in the future

Revision to Guideline Note 12



- Cancer is a complex group of diseases with treatments that vary depending on the specific subtype of cancer and the patient's unique medical and social situation.
- Goals of appropriate cancer therapy can vary from intent to cure, disease burden reduction, disease stabilization and control of symptoms.
- Cancer care must always take place in the context of the patient's support systems, overall health, and core values.
- Patients should have access to appropriate peer-reviewed clinical trials of cancer therapies.
- A comprehensive multidisciplinary approach to treatment should be offered including palliative care services (see Statement of Intent 1, Palliative Care).

Revision to Guideline Note 12 (continued)



Treatment with intent to prolong survival is **not** a covered service

1. For patients who have progressive metastatic cancer with severe co-morbidities unrelated to the cancer that result in significant impairment in two or more major organ systems which would affect efficacy and/or toxicity of therapy;

OR

2. A continued decline in spite of best available therapy with a non reversible KPS or Palliative Performance score of <50% or with ECOG PS of 3 or higher which are not due to a pre-existing disability.

Revision to Guideline Note 12 (continued)



Treatment with intent to relieve symptoms or improve quality of life is a covered service as outlined in Statement of Intent 1, Palliative Care.

To qualify for treatment coverage, the cancer patient must:

1. Have a documented discussion about treatment goals, treatment prognosis and the side effects, and knowledge of the realistic expectations of treatment efficacy. This discussion may take place with the patient's oncologist, primary care provider, or other health care provider, but preferably in a collaborative interdisciplinary care coordination discussion.
2. Treatment must be provided via evidence-driven pathways (such as NCCN, ASCO, ASH, ASBMT, or NIH Guidelines) when available.

Lessons Learned

1. The discussion is colored by strong emotions
2. Consensus on value definition lacking
3. Published evidence not always structured in a helpful manner
4. Heme malignancies are a different animal
5. Making physicians state their case is helpful
6. The discussion did bring the community together in some respects.
7. Creative approaches to palliative care and treatment pathways are a more effective approach