## **EPISODE 20:** **3 Trends That Can Change Cancer Care Forever: A 2-Part Podcast with Dr. Michael Kolodziej** August 2019

Karan Cushman: Welcome to [*The Precision Medicine Podcast*](https://www.interventioninsights.com/precisionmedicinepodcast)*,* sponsored by Trapelo. This is the podcast where experts come to discuss the problems oncologists, reference labs, and payers face, as precision medicine grows, and consider solutions for advancing the quality of patient-centered cancer care.

Jerome Madison: Welcome to the Precision Medicine Podcast sponsored by Trapelo. Today we have part two of our conversation with Dr. Michael Dr. Kolodziej, chief innovation officer of ADVI, and he's talking about the last two trends that he feels is going to change cancer care forever.

Jerome Madison: And those are payer reform and alternative payer models. Now, I want to just preface this episode for those of you who listen on a regular basis, there are some audio defects that you will see in the episode, but I want you to persist beyond those. Don't click off, because he delivers some truly special and insightful content on how payers are adopting precision medicine and what they can do to accelerate access to precision medicine for patients.

Jerome Madison: Truly great episode, I hope you enjoy. Take a listen.

Jerome Madison: Well, what you're saying is, a lot of what we're hearing from the market going out and speaking about utility of Trapelo, if we can eliminate prior authorization, which is a huge financial and administrative burden on both sides, that's doable. Now, we're talking about payer reform, which was the second trend that you spoke about in your keynote. I'm not sure if this is in the same category, but you spoke about mega mergers being blocked, and in early April, the Department of Justice ordered objections to be reviewed on the CVS Aetna merger that's supposedly already done. That's $70 billion on the line. So, is this a good or a bad thing, and what does this deal or no deal mean for the future of healthcare?

Dr. Kolodziej: So, in the spirit of transparency, I did work for Aetna, and part of my compensation was Aetna stock, which is now CVS stock, so let's just be clear on that. I don't consider myself conflicted on this, but I want to be transparent.

Jerome Madison: For sure.

Dr. Kolodziej: So, the Department of Justice initially blocked the horizontal mergers between Aetna and Humana, and then Anthem and CVS, and the grounds by which they blocked them was basically monopolistic tendencies in certain markets, so Aetna's interest in Humana, of course, was Humana's large Medicare Advantage business. Aetna's never really had a big Medicare advantage business, and it was quite attractive. Medicare Advantage, as you probably know, is one of the, if not the most rapidly growing insurance sector, and has been for the last several years. It's also quite lucrative for the health plan, so that's the Aetna CVS thing, and then the Humana Anthem thing was just to increase the footprint.

Dr. Kolodziej: So, the Department of Justice says you can't do that, and I think they were clearly markets where after the merger, there would have been... 75% of the market share was going to be Aetna Humana, so that I think was understood. Now, what we've seen is kind of less conventional, and more vertical type mergers, and the Aetna CVS deal, and the Cigna Express Scripts deal are good examples of that.

Dr. Kolodziej: Let's talk about Cigna Express first. You know, Cigna Express is pretty much improving your ability to do blocking and tackling, so Express, very large, very successful PBM. Cigna did not have really a pharmacy operations. By bringing them under the same roof, they were able to consolidate, integrate, multiple different components of the care spectrum. It just made total sense, and of course that went through.

Dr. Kolodziej: The Aetna CVS thing was that, because Aetna had a little pharmacy operation. Wasn't very big. Of course, CVS is a big pharmacy operation. That was a little bit of it, but I think the vision of the Aetna CVS merger was much, much greater than that, and I would say that the Aetna CVS... The vision, I believe, of the Aetna CVS thing, was to change the consumer experience around healthcare. And I don't know about your neighborhood, but in my neighborhood there's a lot of CVSs, and I think the idea that the health insurance company could become part of the provider spectrum, specifically through CVS, either through Minute Clinics, or some enhanced clinical offering, was really a lot of what drove that merger. Or acquisition, more precisely.

Dr. Kolodziej: Now, this whole business about administrative judge having heartburn that the Department of Justice didn't do enough due diligence to ensure there's no monopoly happening here, I think we should be aware that this has not really ever happened before, and whether or not there's any true teeth in this next set of hearings where we're going to hear what the AMA has to say, and this group, and that group, we'll see how that plays out. I think the Department of Justice says, "Listen, this was a fail safe mechanism, to make sure that really bad things don't happen. We believe we did a good job," and I think the Department of Justice will stand behind their perception on the ability to move this forward.

Dr. Kolodziej: Yes, it's a lot of money. I think no one believes for a second that the whole thing is going to unwind. I think there could be a desire to have the combined organization divest itself of certain business units or something like that, but I don't see much happening from this. We'll see. We'll see. But truth of the matter is the Aetna CVS thing is so interesting to me, because as I said at my FLASCO talk, anybody who's had a kid wake up with an ear infection on a Saturday morning, and trying to find a pediatrics office open, man, that is really hard.

Dr. Kolodziej: Having the ability to go to a CVS, where there's let's say a nurse practitioner, who will see the patient, and prescribe the appropriate therapy, I think that's very attractive to a consumer. It certainly is attractive to me. Now, the question is, and this is a million-dollar question. Will this also become a mechanism for managing chronic illness? So, every payer in America have their eyes focused on diabetes. Why? Because diabetes costs a lot of money. I mean, it costs a lot of money to treat acutely, but also the cumulative effects and the development of chronic medical complications of diabetes, that's a big deal.

Dr. Kolodziej: Let's say you were able to use Minute Clinics to have diabetes educators, dieticians, any number of different healthcare professionals that might more actively and aggressively manage the chronic condition with the vision towards a better outcome down the line. That, to me, is fascinating, and I can even see ways that that could be implemented in oncology. So, we'll see how this plays out. I know people think I'm a little bit out there, because CVS is just a pharmacy and stuff, but I don't think Larry Merlo thinks CVS is just a pharmacy and stuff. I think CVS has much bigger plans for how they can address management of chronic care, because honestly, that's what where the money is, right?

Dr. Kolodziej: If you look at healthcare spending in America, it's not taking care of well people that costs the money. People who consume the most resources make up a very, very small part of the population, and that's been proven over and over again. And you can generate far more savings taking care of sick people effectively than taking care of well people, and I believe that's what this is all about.

Jerome Madison: Super interesting. Well, the fourth is... trend that you talked about, is something that you obviously have been pioneering work in, and that's creating alternative payer models. As we sit today, how many different models exist-

Dr. Kolodziej: Not enough.

Jerome Madison: I know that our audience is not just oncology-based physicians and industry people, but how many different models exist with the purpose of driving value-based care?

Dr. Kolodziej: What we have seen is that the vast majority of models that people are paying attention to are being driven by Medicare, and specifically an important, maybe the most important part of the ACA was the development of CMMI, the Medicare and Medicaid Innovation Center, and they were charged with looking at alternative payable models, and they've taken that very, very seriously. They have come under some criticism, and they certainly have undergone a lot of scrutiny, but they've done a lot of stuff in primary care, done a lot of stuff in hospital-based care. They did stuff with joint replacement, and then of course, now they've done the oncology care model, which is a medical home type model that looks at the ability to transform [inaudible 00:09:17] to reduce cost and improve quality.

Dr. Kolodziej: And you know, because cancer is a disease of aging, because for most oncology practices in America, about half [inaudible 00:09:26] patients are Medicare patients, they had the heft to really get in to practices that were motivated to change, practices that were motivated to pay attention [inaudible 00:09:36] quality, and really impact how things are done. Now, if we look at commercial payers, as opposed to Medicare, one of the biggest challenges is that all healthcare is local. But when I was at Aetna, and let's say I wanted to work with a practice, most practices would have [inaudible 00:09:56] cancer patients, [inaudible 00:09:58] and if that was the case, I often did not have enough valuable patients for my program.

Dr. Kolodziej: Medicare has tons of valuable patients, in every single practice [inaudible 00:10:06], so it's been really, really difficult for a lot of commercial pay, to get too excited about trying to build these programs. In fact, less than 1% of all people with a commercial insurance, less than 1% of Aetna or United beneficiaries actually have an oncology claim, a cancer claim. Less than 1%. That small number is responsible for, I don't know, 10 or 11% of total costs for health plan, so it's not that it's insignificant. It's just that there aren't that many members.

Dr. Kolodziej: So, I would say United did a lot of very interesting stuff over the years. Lee gets a lot of credit for being innovative. He developed what he called a bundle or episode-based model, in which a limited number of fairly common malignancies-

Jerome Madison: Wow.

Dr. Kolodziej: ... were managed in a program, where practices that agreed to participate, agreed to improve the care of the patients, and be paid by a methodology in which they received a flat sum of money for a period of active treatment. As opposed to the current system, in which practices are paid for service basis. That is every time you see a patient, you submit a bill, you give chemo therapy, you submit a bill. That was not the model Lee put in. The model was, "Look, we'll pay for [inaudible 00:11:24] drugs at cost, and we're going to give you management fee. It's going to take care of all the stuff, and we'll see how you're doing. If you pay attention, if you save money, I'll give you some more." And he did it with, I think it was seven practices, and the initial report, which has been published and extensively discussed, showed significant savings.

Dr. Kolodziej: Now, I have some personal criticisms of the study, but that said, it got people very, very excited. United has subsequently expanded that program. They have not achieved the same degree of success with the second wave of practices, but that sort of bundled, episode-based payment is one innovative approach.

Dr. Kolodziej: At Aetna, I did an oncology medical home type model. Very similar what the OCM did. The payment was a little different, but it was the same kind of goal. Just recently, Humana announced a similar model. The oncology model of care, I think they called it, and they're basically doing the same thing. Look, pay attention how you're taking care of the patient, do a good job, we're going to compare, we're going to give you a little extra money to help you deliver enhanced services, and then we're going to measure how much it cost before and after. Talked to my friend Bryan Loy at Humana, and they'd been careful to select practices that they think are capable of doing this, and again, practices that are in markets where Humana has enough of a footprint that they can actually measure something.

Dr. Kolodziej: Anthem has another program altogether, and I would say that Anthem's program, which is really a Pathways type program, is a model that I think we're going to see more and more of here in the near future. So, what did Anthem do? Anthem said, "Look, we're going to focus only on the drug costs. We're only interested in the drug cost, and we know that there are many different ways to treat a patient, with same or similar outcomes, so what we're going to do is we're going to make a list of what we consider to be the value-based choices for [inaudible 00:13:08], and [inaudible 00:13:09] on a patient level basis with that value-based decision choices, we will give you a management fee. We'll give you some extra money. If you don't, we'll pay for it, but you don't get the extra money. In addition, if you play through this, play ball with us through this model, we'll make prior auth really easy for you. It's going to shoot right through."

Dr. Kolodziej: So, Anthem, which is in 14 states, has deployed this program in 14 states. We don't have any real cost results yet from it, but I think what we're seeing now is an enhanced interest by many payers in the adoption of Pathways type programs. It's almost impossible for an oncologist to believe that there was a time before NCCN guidelines. Just goes to show you how old I am, but NCCN guidelines changed everything. They really did change everything, because what NCCN guidelines did was they developed a very disciplined, very transparent, very reproducible methodology, by which experts evaluated the best available evidence, to determine appropriate treatment for patients with various malignancies. They did a tremendous service to America. Again, America.

Dr. Kolodziej: And so payers ultimately, all of them ultimately just basically said, "If you're doing something NCCN says is okay, it's good enough for us. We like it." Now, when we looked at the NCCN guidelines when I was at U.S. Oncology, we said, "All right, these are all okay, but some of them probably, some treatment choices are probably better than others," and NCCN does call that out, incidentally, and some of them are like way more expensive than others. So, what if we put together a program by which we formally evaluated what NCCN had put out there, and chose the treatments that we thought really had the best evidence, either of efficacy or reduced toxicity, and then we kind of looked at it through a cost lens.

Dr. Kolodziej: So, a pathway is a value-based distillation of evidence-based treatment options. Now, there's no such thing as a Pathway, the process by which pathways are developed are fairly comparable across the board. There's been expansion and contraction of companies that do pathway development, but I think we're going to see increased interest in pathways, and the reason we're going to see increased interest in pathways is the oncology care model did one really, really important thing for oncology in the U.S., and that is it showed people where the dollars were being spent. Unbelievable. Why unbelievable? Because we were living under this impression, false impression, that, "Oh, drugs made up about 20 or 25% of the cost of care." That is absolutely false. It is categorically incorrect.

Dr. Kolodziej: It is true that at the beginning of the OCM, it was about 40 to 45%. It is true that as of today, it's more like 60%, and the payers look at it and they say, "Look, we can reduce hospitalizations, that's great for everybody. We can reduce ER utilization, that's great for everybody. But as Willie Sutton said, the bank is where the money is, so let's go for the money." And the payers, they believe that. They believe we have to have a solution for the high costs of drugs, and pathways are a solution for the high cost of drugs, and so I know for a fact that United is in the process of looking at pathways process. Cigna is in the process of looking at a pathways process. Aetna's in the process of looking at a pathways process. Pathways... We will see, I'm quite certain, the emergence, reemergence of pathways as a way to promote value-based prescribing behavior.

Dr. Kolodziej: And I think, and again, I've been working in this space for 10 years, and believe me, in a lot of things in medicine, there's a right time and right place for everything. 10 years ago, people looked at us like we were insane. We are no longer perceived as insane. I think the idea of pathways as being something that people can actually... Well, I don't know if embrace is the right word. That may be a little bit strong. Can accept as a way to promote, and reward, value-based care, I believe is something we will see continue to evolve, and then really emerge in a widespread way on the clinic oncology scene.

Jerome Madison: Well, you said there's not enough models that exist. You certainly just listed for us several, and you just... I really appreciate you bringing your insights to this, and kind of a behind the curtain look at the way payers are approaching this, and the different possibilities, so we really appreciate you coming on and sharing your insights. Very, very valuable information for our audience. Thank you for being a guest on the Precision Medicine Podcast.

Dr. Kolodziej: Jerome, it's been my pleasure. Thank you very much.

Jerome Madison: Absolutely. We want to thank Dr. Michael Dr. Kolodziej, of course, all of our listeners for joining us today. We hope you'll tune in for the next episode of the Precision Medicine Podcast. Dr. Dr. Kolodziej, can you give them your social media? Are you on Twitter? Where can they reach you if they want you to come speak about this, or get in touch with you at some of your consulting?

Dr. Kolodziej: Yeah, probably the easiest way is just through the ADVI website. I'm not allowed to use Twitter. That would be a dangerous weapon in my hands, so I don't do that.

Jerome Madison: I think you'd be a very good Twitter follow. For those of you out there who want the full transcripts of today's episode, you can get them at precisionmedicinepodcast.com, and you can also follow us on Twitter, at PMPbyTrapelo. That's Precision Medicine Podcast, PMP, by Trapelo. If you enjoyed this episode, you probably know someone else who would too, so please tell them. They'll thank you, and so will we.

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A person wearing a suit and tie smiling and looking at the camera

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**About Our Guest: Dr. Michael Kolodziej**   
**Vice President and Chief Innovation Officer, ADVI Health**

Dr. Kolodziej attended college and medical school at Washington University in St. Louis, where he was Phi Beta Kappa and Alpha Omega Alpha. He completed internal medicine and hematology-oncology training at the University of Pennsylvania in Philadelphia, and, after completing training, joined the faculty at the University of Oklahoma School of Medicine where he was an associate professor.

1998, Dr. Kolodziej joined New York Oncology and was a partner in the practice until December 2012. He was an active member and executive on the of the U.S. Oncology Pharmacy and Therapeutics committee from 2002-2011 and chairman from 2004-2011. He served as Medical Director for Oncology Services for U.S. Oncology from 2007-2011. In this role, he helped direct the implementation of the USON clinical pathways initiative, the integration of the USON EMR into this program, and the development of the USON disease management and advanced care planning programs, now known as Innovent Oncology.

Dr. Kolodziej became National Medical Director of Oncology Solutions at Aetna in 2013. While there, he directed Aetna’s oncology delivery reform pilots and was the architect of the Aetna Oncology Medical Home program. He was also active in Aetna’s pharmacy policy, condition analysis, and genetics subcommittees.

In 2016, Dr. Kolodziej accepted a position as National Medical Director of Managed Care Strategy at Flatiron Health, where he applied the core tech and data capabilities of Flatiron to facilitate practice transformation and success in alternative payment models. He joined ADVI in 2017.

Dr. Kolodziej is a Fellow of the American College of Physicians, and he has published and spoken extensively on payment reform, personalized medicine, and practice care delivery transformation in oncology.