


What's Up With Drug Pricing?

Mark E. Thompson, M.D.
Medical Director for Public Policy, COA

Ohio Hematology Oncology Society Annual Meeting

October 11, 2019

Let's Frame the Issue

- Increasing drug prices for antineoplastic drugs are rapidly escalating and unsustainable
- New and more effective agents are expanding in use and expensive
- Consolidation in health care is rapidly occurring with increasing costs
- Cancer care is now moving from a localized service-based business to "BIG" business
- PBMs and rebates are driving up the costs of drugs
- 340B growth is driving up drug costs

Oncology Drug Cost Trends

- In 2018, two-thirds of the growth in U.S. oncology costs in the previous five years could be attributed to the uptake of innovative medicines launched since 2013 (2018 IQVIA)
- Oncology immunotherapy costs are projected to increase 231% from 2016 to 2021 (2018 Magellan)
- Oncology accounted for 35% of commercial medical pharmacy spend in 2016 (2018 Magellan)
- Commercial market per-member, per-year spend for oncology drugs increased by 18.1% from 2017 to 2018, making oncology the therapy class with greatest cost increase (2018 Express Scripts)
- Oncology agents accounted for 10 of the top 25 drugs by spend in the commercial medical benefit in 2017 (2018 Magellan)
- Oncology and oncology support accounted for 43% of the medical benefit drug per-member, per-month spend in the commercial market in 2017 (2018 Magellan)

Drug Prices/Costs in Perspective

- New drugs launched in the last five years now account for more than 20% of global oncology spending (2017 Quintiles)
- While total cancer care costs increased about 60% for commercially insured cancer patients between 2004 and 2014, spending on cytotoxic and biologic chemotherapies grew by 101% and 485% (2016 Milliman)
- *"Increased spending is the result of higher drug prices, greater use of high-priced drugs, and an increase in the proportion of chemotherapy infusions being done in hospital outpatient settings, which is generally more expensive than administering drugs in physicians' offices."* (President's Cancer Panel)

Here's the Environment!

- Health care is changing like never before
  - Consolidation = profound impact on cancer care
  - Lines blurring between insurer and providers, especially pharmacy
- Lowering prescription drug prices (and costs) has become a political and media agenda – like never before!
  - Drug prices and companies in the crosshairs of Trump Administration
  - Same holds true for Congress – both House (Democrat controlled) and Senate (Republican controlled)
- Need to score political victories can have a profound negative effect on cancer care
  - International Pricing Index (IPI) Model a perfect example
  - Giving insurers and PBMs more power to control medical decisions

Drug Prices in the Crosshairs

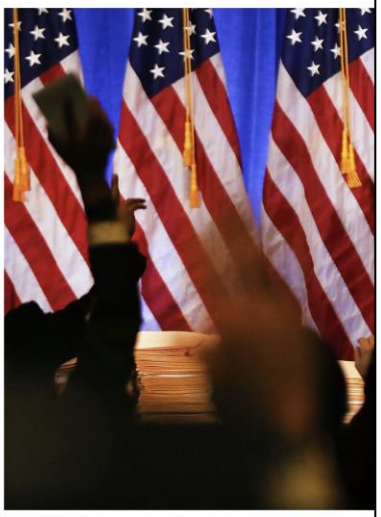
Trump Proposes to Lower Drug Prices by Basing Them on Other Countries' Costs

President Trump
and human servi

FIRST OPINION

Alex Azar: Why drug prices keep goin
up — and why they need to come dov

By ALEX M. AZAR II / JANUARY 29, 2019



POLITICS

It's not just Democrats: In dueling drug pricing hearings, at least some Republicans slam pharma, too

By LEV FACHER @levfacher and NICHOLAS FLORKO @NicholasFlorko / JANUARY 29, 2019

Drug Pricing in Am

Date: Tuesday, January 29, 2019
Time: 10:15 AM
Location: 215 Dirksen Senate Office

The New York Times

Trump Officials Move to Lower Drug Prices by Passing On Rebates to Patients

So What's Up in D.C. Regarding Drug Prices?

- There are currently more than 20 bills in Congress regarding drug pricing issues
- The President's Blueprint for drug pricing has influenced the environment
- The proposed IPI Model remains looming, yet not finalized
- Both Republicans and Democrats have an appetite to enact meaningful legislative fixes
- It is likely given the current D.C. climate that NOTHING of substance gets legislated this year

What Does the Legislation Look Like?

- S2543 - Prescription Drug Pricing Reduction Act of 2019 - Senate Finance proposal
- HR 3 - Lower Drug Costs Now Act of 2019 - House Democrat's proposal - May pass the House
- S1227- Prescription Pricing for the People Act of 2019 - Senate Judiciary Committee - everyone wants a piece
- REFUND Act of 2019 - Senators Portman & Durbin's Bill
- Various bills regarding PBM's and rebates

Politics Versus Reality

- Bipartisan interest in tackling drug prices
  - Progressive Dems want “Medicare For All” and complete negotiation of drug prices vs moderates
    - Ironic in that Republicans want to do something but split among Democrats may stop getting something done
- Democrats starting to spar with each other - that and ideological split makes moving forward tough
- Big focus right now among the Democrats is impeachment
  - Makes working with the Republicans harder
- The closer we get to 2020 – a major election year – Congress will likely grind to a halt

Where's the Drug Price Issue Going in D.C.?

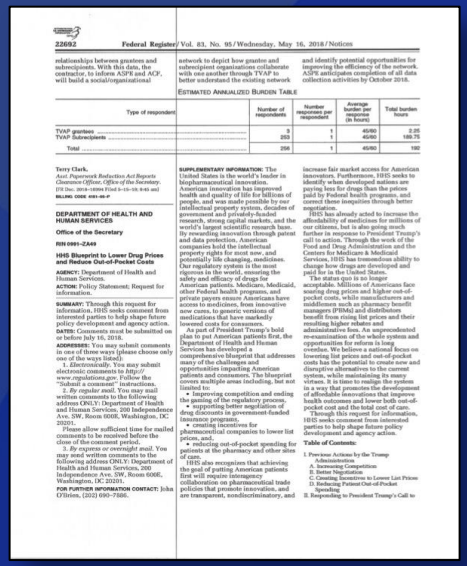
- Trump wants a "win" on drug prices and doesn't care about policy. Democrats want a "win" as well. Neither want to credit the other in this space.
  - So, HHS Sec. Azar needs a win on drug prices
- Medicare Part B is in the crosshairs again – a theme that never quits
  - Giving MA plans ability to implement "fail-first" (step therapy) and formularies
  - Using "mandatory" demos under the Medicare "Innovation Center" to change reimbursement
  - Proposed taking away protected classes (cancer is one of six protected classes)
    - But backed away from it!
- Recently passed (out of committee) Senate Finance drug pricing bill puts price inflation caps on Part B and D drugs, among other provisions
- Speaker Pelosi's HR 3 drug pricing Bill in the House also has caps
- Putting HUGE pressure on pharma companies
  - Both the administration and entire Congress
- Look for drug prices to be a HUGE election year issue

Trump Blueprint on Drug Prices

- Covered virtually every area of drug pricing, except for direct government negotiation of drug prices in Medicare
- Posed 132 questions asking input on many aspects of drug pricing
- Regardless of media and political portrayal, most comprehensive blueprint ever

Blueprint Goals

- Increase drug competition
  - Speed generic, biosimilar, and brand approvals
- Fix “global freeloading”
- Change Medicare Part B
  - Move Part B drugs to Part D
  - Revive the Competitive Acquisition Program (CAP)
- Fix 340B
  - Move reimbursement closer to true drug acquisition cost
  - Tie 340B to charity care
- Reimburse physician practices and hospitals the same
- Address PBM situation, especially rebates
- Facilitate manufacturer value-based contracting
- Drug price transparency



22692 Federal Register / Vol. 83, No. 95 / Wednesday, May 16, 2018 / Notices

relationships between grantees and subrecipients. With this data, the contractor, to inform ASPE and ACF, will build a social/organizational network to depict how grantee and subrecipient organizations collaborate with one another through TVAP to better understand the existing network and identify potential opportunities for improving the efficiency of the network. ASPE anticipates completion of all data collection activities by October 2018.

ESTIMATED ANNUALIZED BURDEN TABLE

Type of respondent	Number of respondents	Number responses per respondent	Average burden per response (in hours)	Total burden hours
TVAP grantees	3	1	40/60	2.25
TVAP Subrecipients	253	1	40/60	185.75
Total	256	1	40/60	190

Terry Clark,
Acct Paperwork Reduction Act Reports Clearance Officer, Office of the Secretary.
[FR Doc. 2018–10886 Filed 5–15–18; 8:45 am]
BILLING CODE 4151–05–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

RIN 0991–ZA49

HHS Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs

AGENCY: Department of Health and Human Services.

ACTION: Policy Statement; Request for information.

SUMMARY: Through this request for information, HHS seeks comment from interested parties to help shape future policy development and agency action.

DATES: Comments must be submitted on or before July 16, 2018.

ADDRESSES: You may submit comments in one of three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments to *http://www.regulations.gov.* Follow the instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Department of Health and Human Services, 200 Independence Ave. SW, Room 606E, Washington, DC 20201.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Department of Health and Human Services, 200 Independence Ave. SW, Room 606E, Washington, DC 20201.

FOR FURTHER INFORMATION CONTACT: John O'Brien, (202) 690–7886.

SUPPLEMENTARY INFORMATION: The United States is the world's leader in biopharmaceutical innovation. Medicines have dramatically improved health and quality of life for billions of people, and was made possible by our intellectual property system, decades of government and privately-funded research, strong capital markets, and the world's largest scientific research base. By rewarding innovation through patent and data protection, American companies hold the intellectual property rights for most new, and potentially life changing, medicines. Our regulatory system is the most efficient and effective in ensuring the safety and efficacy of drugs for American patients. Medicare, Medicaid, other Federal health programs, and private payers ensure Americans have access to medicines, from innovative new cures, to generic versions of medications that have markedly lowered costs for consumers.

As part of President Trump's bold plan to put American patients first, the Department of Health and Human Services has developed a comprehensive blueprint that addresses many of the challenges and opportunities impacting American patients and consumers. The blueprint covers multiple areas including, but not limited to:

- Improving competition and ending the gaming of the regulatory process;
- supporting better negotiation of drug prices in government-funded insurance programs;
- creating incentives for pharmaceutical companies to lower list prices, and;
- reducing out-of-pocket spending for patients at the pharmacy and other sites of care.

HHS also recognizes that achieving the goal of putting American patients first will require interagency collaboration on pharmaceutical trade policies that promote innovation, and are transparent, nondiscriminatory, and increase fair market access for American innovators. Furthermore, HHS seeks to identify when developed nations are paying far less than the prices paid by Federal health programs, and correct these inequities through better negotiation.

HHS has already acted to increase the affordability of medicines for millions of our citizens, but is also going much further in response to President Trump's call to action. Through the work of the Food and Drug Administration and the Centers for Medicare & Medicaid Services, HHS has tremendous ability to change how drugs are developed and paid for by Federal health programs.

The status quo is no longer acceptable. Millions of Americans face soaring drug prices and higher out-of-pocket costs, while manufacturers and middlemen such as pharmacy benefit managers (PBMs) and distributors benefit from rising list prices and their resulting higher rebates and administrative fees. An unprecedented re-examination of the whole system and disruptive alternatives is therefore urgent. We believe a renewed focus on lowering list prices and out-of-pocket costs has the potential to create new and disruptive alternatives to the current system, while maintaining its many virtues. It is time to realign the system in a way that promotes the development of affordable innovations that improve health outcomes and lower both out-of-pocket cost and the total cost of care.

Through this request for information, HHS seeks comment from interested parties to help shape future policy development and agency action.

Table of Contents:

I. Previous Actions by the Trump Administration
A. Increasing Competition
B. Better Negotiation
C. Creating Incentives to Lower List Prices
D. Reducing Patient Out-of-Pocket Spending
II. Responding to President Trump's Call to

Where's the IPI Model?

- Waiting for the final rule from CMS/HHS
  - CMS/HHS moved it to OMB for a "possible" August 2019 release of the proposed rule that never came to be
  - Some speculate it may not be released anytime soon, or at all
    - Lots of pushback on the indexing of drugs to international prices (can it even be operationalized?)
    - Apparently, not a lot of takers on CAP (at least in a version that doesn't totally disrupt providers' operations)
    - ASP flat add-on fee being looked at by Congress, possibly as part of bipartisan drug pricing legislation, however the recent Senate Finance package failed to tackle this piece

IPI Model: What's Wrong?

- Indexing U.S. drug prices to foreign prices sounds great on paper, but how do you really do it without other countries playing games?
  - Problem comparing other countries' net prices to U.S. list prices
  - More cancer drugs available here than in any other country

- CAP- a big problem
  - It would fundamentally change how cancer patients get their drugs
  - It would change from just-in-time delivery of chemotherapy to ordering and waiting for chemotherapy from some middleman

- Changing cancer drug reimbursement would put even more pressure on community oncology practices, forcing more closures and consolidation into hospitals

“Old School” Strategies/Tactics Not Working

- Using middlemen – PBMs, insurers, etc. – to “manage” cancer care drug spending through centralized decision making and rationing
  - Prior authorizations
  - Formularies
  - “Fail-first” step therapy
  - Copayment tiers
- Largely focused on drugs, leaves out other drivers of cancer care costs
- Not patient-centric and not focused on value (quality delivered for the cost)

Let's Look at Some Drivers of Drug Pricing

- Health care consolidation
- Pharmacy Benefit Managers (PBMs)
- 340B Drug Pricing Program

Cancer is Big Business!

HEALTH

Big Pharma's Go-To Defense of So
Doesn't Add Up

Just how expensive do prescrip
research?

AMA Journal of Ethics
Illuminating the Art of Medicine

≡ TIME

HOSPITALS

The Profit Of Prestigious Cancer Care

rman Jun 21, 2019

orporatization of hospital systems

THE WALL STREET JOURNAL.

Home World U.S. Politics Economy Business Tech Markets Opinion Life & Arts Real Estate WSJ. Magazine

BUSINESS | HEALTH CARE | HEALTH

General Atlantic Takes Majority Stake in OneOncology, a Startup for Running Cancer-Doctor Practices

$200 million deal by private-equity firm is latest sign investors see opportunity in the health-services sector

Bill Ford, chief executive officer of General Atlantic. The private-equity firm earlier this year
of chronically ill patients at their homes. PHOTO: VICTOR J. BLUE/BLOOMBERG NEWS

HEALTH • FLATIRON HEALTH

Why Drug Giant Roche's $1.9 Billion Deal to Buy Data Startup Flatiron Health Matters

Pharmaceutical Middlemen, Not Patients, Profit Off New Cancer Treatments

re preventing some Americans from taking life-saving drugs. Just look
re than 50% of patients with the highest out-of-pockets costs abandon
red to only 10% of patients with the lowest costs, according to a recent

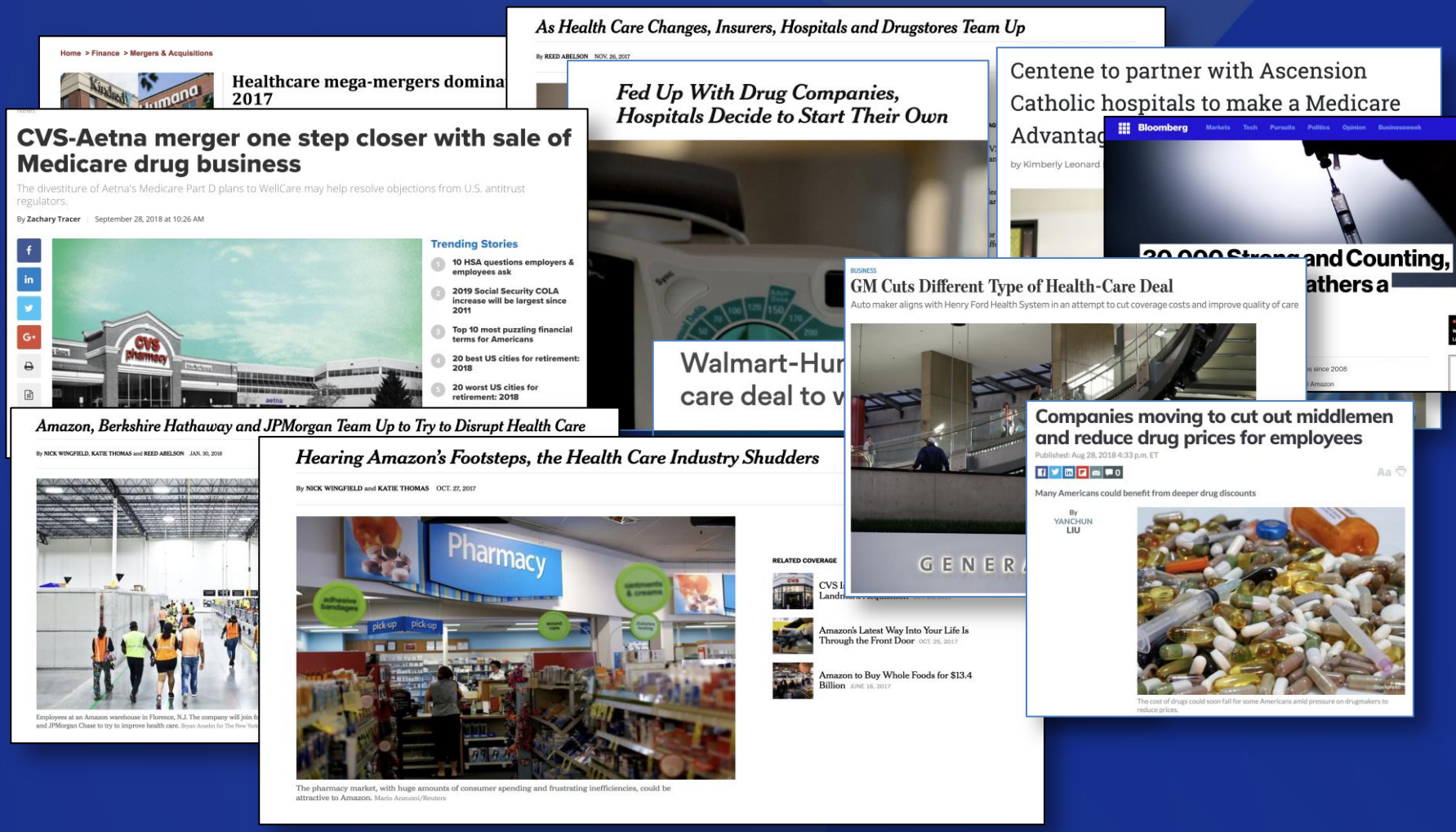
MAJOR INDICES
S&P 500 (MES)
NASDAQ-100 (MNQ)
RUSSELL 2000 (M2K)
DOW JONES INDUSTRIAL AVERAGE (MYM)

These steep out-of-pocket prices are often thanks to the bloated middlemen who control the drug supply chain. These middlemen, known as pharmacy benefit managers (PBMs), burden patients with high drug costs. And they're ill-equipped to deliver the next generation of targeted therapies.

The supply chain is complex. Drug makers
ly to patients. Instead, they sell to PBMs, which are hired by health
ces. PBMs process the majority of prescriptions in America and decide
over.

more like corporate titans on the stock exchanges than the charities

Health Care Consolidation



The Site of Cancer Care Matters

PROGNOSIS PROFITS

Prices soar as hospitals dominate cancer market

AMES ALEXANDER, KAREN GARLOCH & JOSEPH NEFF - AALEXANDER@CHARLOTTEOBSERVER.COM
KGARLOCH@CHARLOTTEOBSERVER.COM
APRIL 22, 2015 12:14 AM, UPDATED APRIL 23, 2

Large nonprofit hospitals in No
drugs at a time when they are c
Observer and The News & Obs

The newspapers found hospital
over cost. Some markups are fa

It's happening as hospitals incr
more – sometimes much more

Asked about the findings, hosp
more for some services to mak
shifting.

HEALTH CARE > Posted 4:00 AM | Updated at 8:05 AM

Across Maine, prices for the
often staggeringly different

Low patient volumes and scarce competition among prov
for health care in the U.S.

BY J. CRAIG ANDERSON STAFF WRITER

Share

COSTS & SPENDING

By Zack Cooper, Stuart Craig, Martin Gaynor, Nir J. Harish, Harlan M. Krumholz, and John Van Reenen

Hospital Prices Grew Substantially Faster Than Physician Prices For

The New York Times

THE NEW HEALTH CARE

Hospital Mergers Improve Health? Evidence Shows the Opposite

The claim was that larger organizations would be able to harness economies of scale and offer better care.

By Austin Frakt

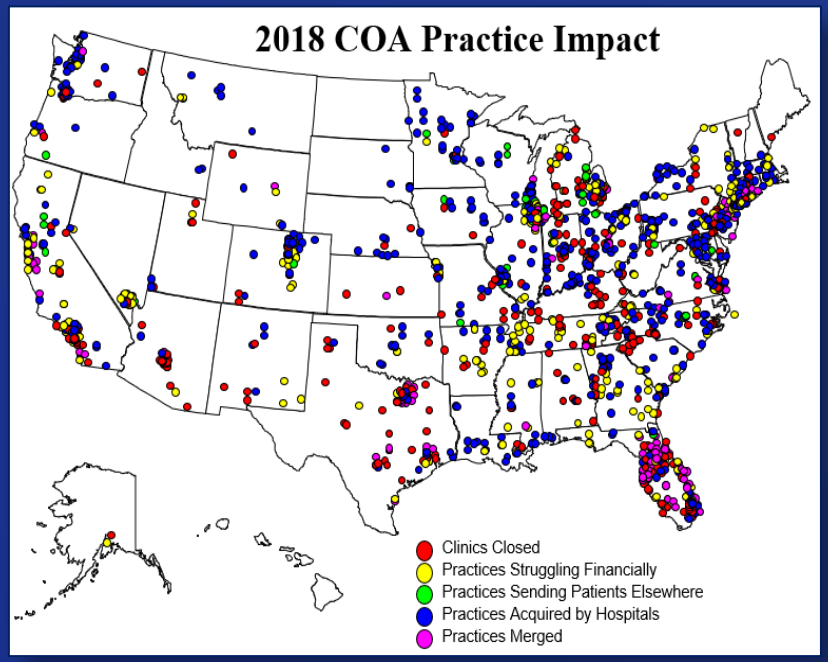
Feb. 11, 2019

Many things affect your health. Genetics. Lifestyle. Modern medicine. The environment in which you live and work.

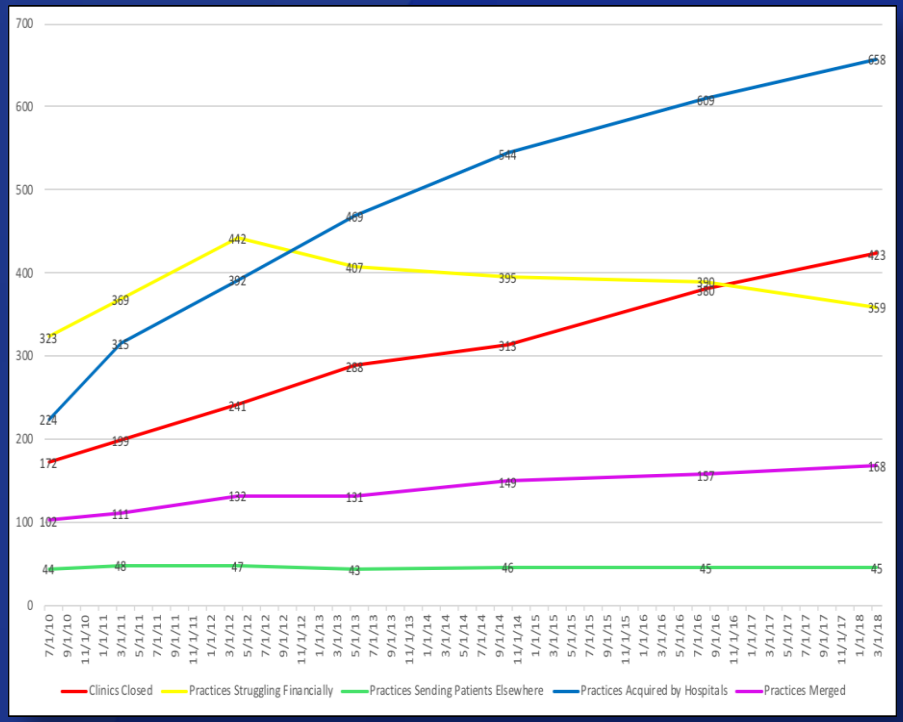
But although we rarely consider it, the degree of competition among health care organizations does so as well.

Markets for both hospitals and physicians have become more concentrated in recent years. Although higher prices are the consequences most often discussed, such consolidation can also result in worse health care. Studies show that rates of mortality and of major health setbacks grow when competition falls.

Cancer Care Consolidating



1,654 clinics and/or practices closed, acquired by hospitals, merged, report financial struggles from 2008-2018

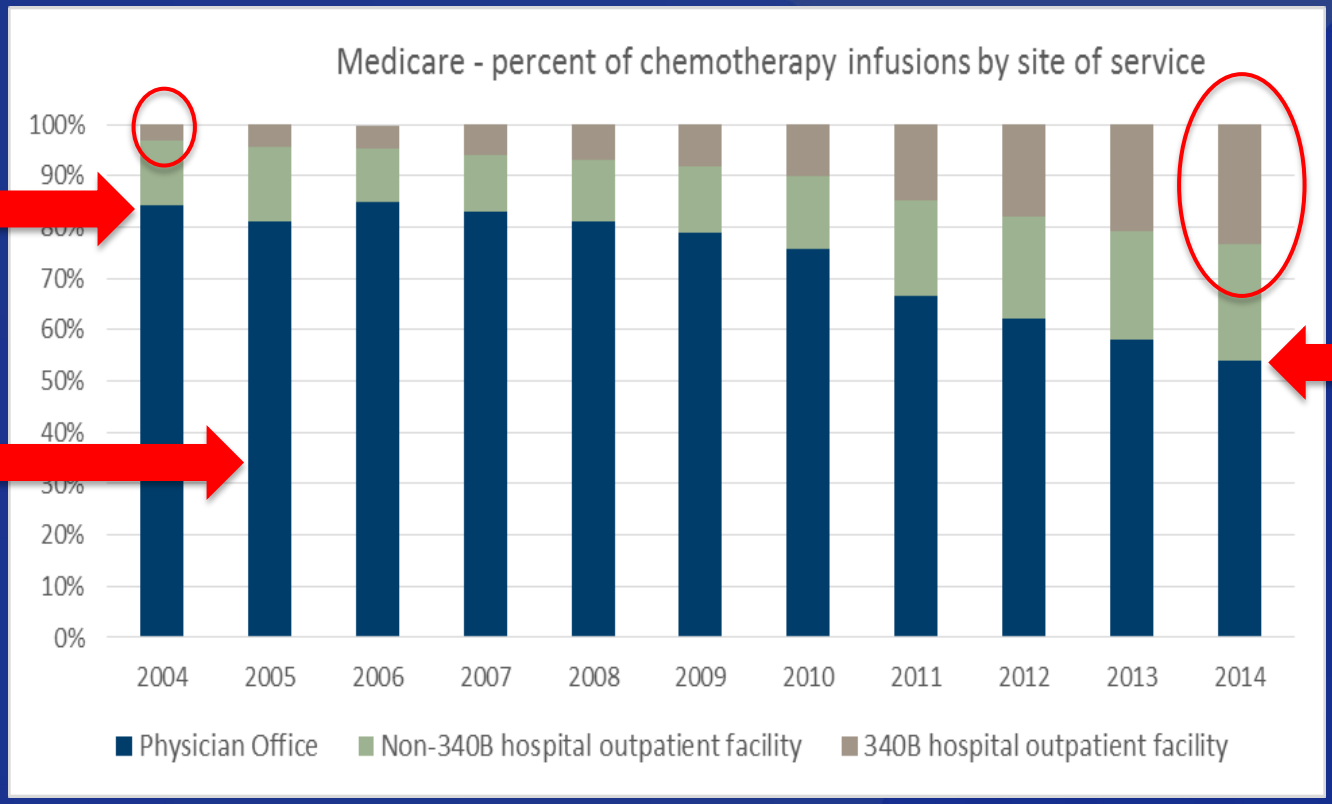


- 11.3% increase in closings, 8% increase in consolidations since 2016 report
- Full report: CommunityOncology.org

Shifting Site of Cancer Care Delivery

84%

MMA



54%

- Percent of chemotherapy administered in community oncology practices decreased from 84.2% to 54.1%
- Percent of chemotherapy administered in 340B hospitals increased from 3.0% to 23.1% (670% increase)
  - 340B hospitals account for 50.3% of all hospital outpatient chemotherapy administrations

Source: *Cost Drivers of Cancer Care: A Retrospective Analysis of Medicare and Commercially Insured Population Claim Data 2004-2014*, Milliman, April 2016

The PBM Problem

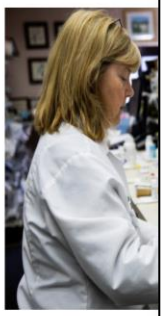
- PBMs have a vested interest to use the most profitable drug for them, even if it's the highest priced drug
  - Rebates are based on drug list prices (higher the better)
  - DIR fees (and similar pharmacy concessions) are based on drug list prices (the higher the better)
  - Documented increasing gap between list and true net drug prices
- Problem is that rebates (and pharmacy concessions) may not be passed onto payers and beneficiaries (paying off of list prices)
- PBMs increasingly narrowing networks and requiring use of corporate specialty/mail pharmacies
  - Delays, denials, mistakes & waste increasing

The PBM Problem (continued)

PBMs driving up drug and insurance prices, critics

Pharmacy benefit managers under scrutiny for their role

HEALTH :: by CHRISTOPH



Marion Bradley, 57, filling a p
is the lead pharmacist and co-

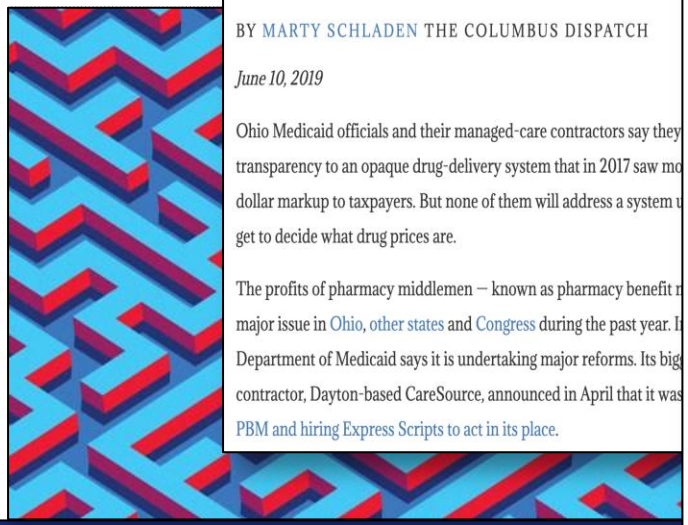
choose what drugs are
determine co-pays for
and decide how much

HEALTH

Invisible Middlemen Are Slowing Do Health Care

Nurses spend 16 hours c
patients suffer as they w

OLGA KHAZAN APR 9, 2019



Drug middlemen name own prices
methodology goes unchallenged

BY MARTY SCHLADEN THE COLUMBUS DISPATCH

June 10, 2019

Ohio Medicaid officials and their managed-care contractors say they
transparency to an opaque drug-delivery system that in 2017 saw mo
dollar markup to taxpayers. But none of them will address a system u
get to decide what drug prices are.

The profits of pharmacy middlemen – known as pharmacy benefit r
major issue in Ohio, other states and Congress during the past year. I
Department of Medicaid says it is undertaking major reforms. Its big
contractor, Dayton-based CareSource, announced in April that it was
PBM and hiring Express Scripts to act in its place.

UnitedHealthcare Network Bulletin May 2019 Table of Contents

Front & Center

Updates to Requirements for Specialty Medical Injectable Drugs for UnitedHealthcare Commercial and Community Plan

We're making some updates to our requirements for certain specialty medications for many of our UnitedHealthcare commercial and Community Plan members. These requirements are important to provide our members access to care that's medically appropriate as we work toward the Triple Aim of improving health care services, health outcomes and overall cost of care. These requirements will apply whether members are new to therapy or have already been receiving these medications.

What's Changing for UnitedHealthcare Community Plan

Spravato™ has been added to the **Review at Launch Drug List** for UnitedHealthcare Community Plan. This list is located at UHCprovider.com/stateplicies- protocols/ commmedicaid-policies/medicaid-co unity-st e-policies.html through the *Review at Launch f New Market Medications* drug policy.

What's Changing for UnitedHealthcare Commercial and Community Plan Members

Clinical Policy and Prior Authorization Updates

Effective July 1, 2019, our White Blood Cell Colony Stimulating Factors medical drug policy will be updated to include preferred product coverage criteria. Preferred product language will be added as follows:

- Use of Neulasta® and Neulasta® vial prior to the use of Fulphila™ and Udenyca™

In addition to the preferred product changes to the drug policy, UnitedHealthcare commercial plans will be expanding the current prior authorization requirements on these medications to include use for any diagnosis:

- Neulasta Onpro/Neulasta, Fulphila, and Udenyca currently require prior authorization when used to treat a cancer diagnosis.
- On July 1, 2019, for UnitedHealthcare commercial plans (including affiliated plans for Oxford, UMR and Neighborhood Health Partnership) use of these medications for all diagnoses will require prior authorization with this policy change.
- On Aug. 1, 2019, for UnitedHealthcare affiliate plans UnitedHealthcare of the Mid-Atlantic and UnitedHealthcare of the River Valley, use of these medications for all diagnoses will require prior authorization.

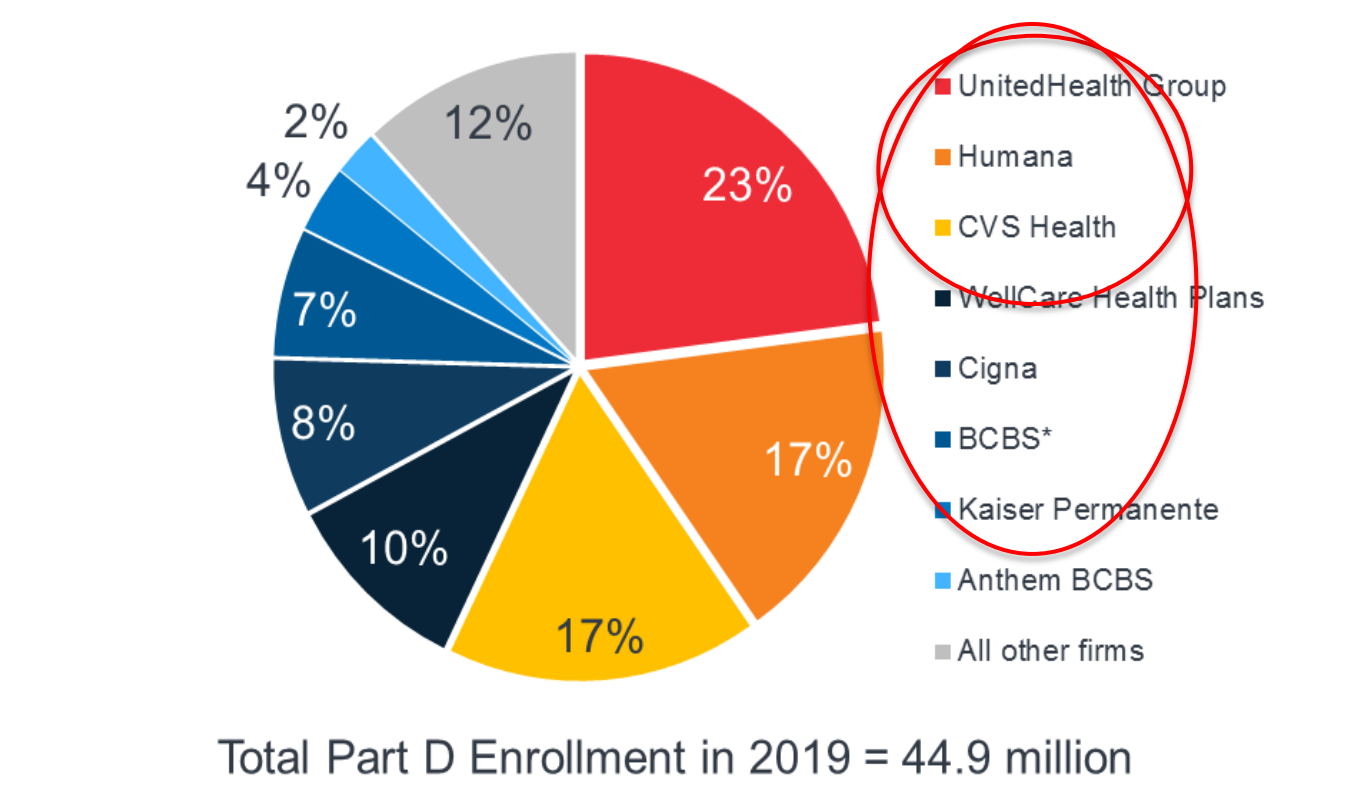
For both UnitedHealthcare commercial and Community Plan members, current authorizations will be honored through their end date. Upon authorization renewal, the updated policy will apply. Care providers are encouraged to begin using the preferred Colony Stimulating Factor products.

If you administer any of these medications without first completing the notification/prior authorization process, the claim may be denied. Members can't be billed for services denied due to failure to complete the notification/prior authorization process.

8 | For more information, call 877-842-3210 or visit UHCprovider.com.

PREV NEXT

Consolidation in Medicare Part D



- Three companies control almost 60% of Medicare Part D
- Six companies control over 80% of Part D

Source: KFF analysis of Centers for Medicare & Medicaid Services 2019 Part D plan files

PBMs Impacting Real Lives

LOCAL

Cancer patients are being denied drugs, even with doctor prescriptions and good insurance

BY CARMEN GEORGE

AUGUST 02, 2019 06:40 AM, UPDATED AUGUST 0

Cancer patient Norma Smith and husband Ro
Specialty Pharmacy in trying to secure proper

Smith's story is "an example of how bad things can get" for cancer patients who require different medications than what pharmacy benefit managers consider standard protocol.

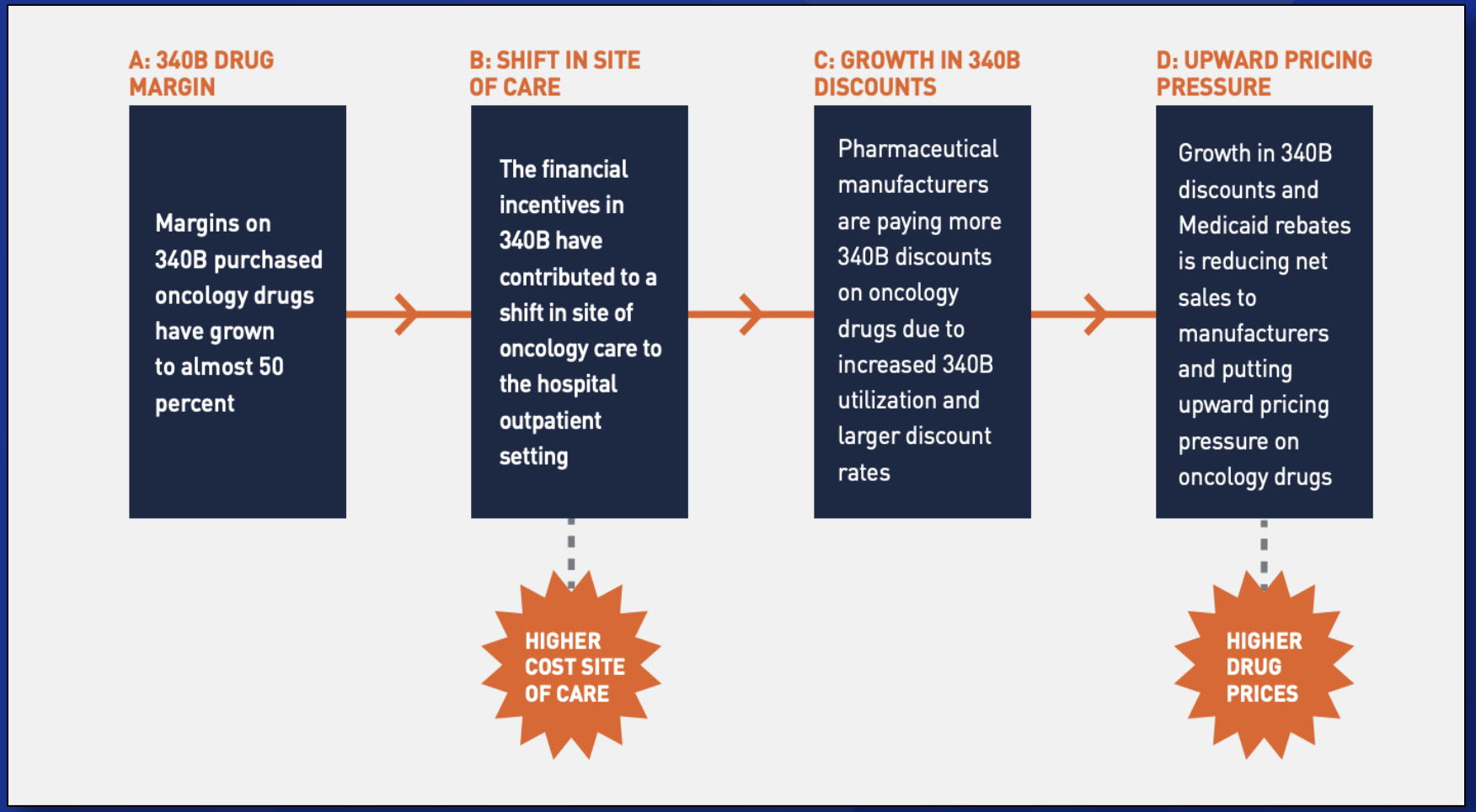
"My husband would call and be on the phone for five and six hours trying to advocate for me," Smith said, "trying to find out how he could work the system so he could get the needed drug for me so that I would live.

"I'm a human being. I'm not a used car. I have feelings. I'm a person. I want to live. I want to spend time with my grandchildren. I want to quilt. I want to do things. I want to live."

The 340B Problem

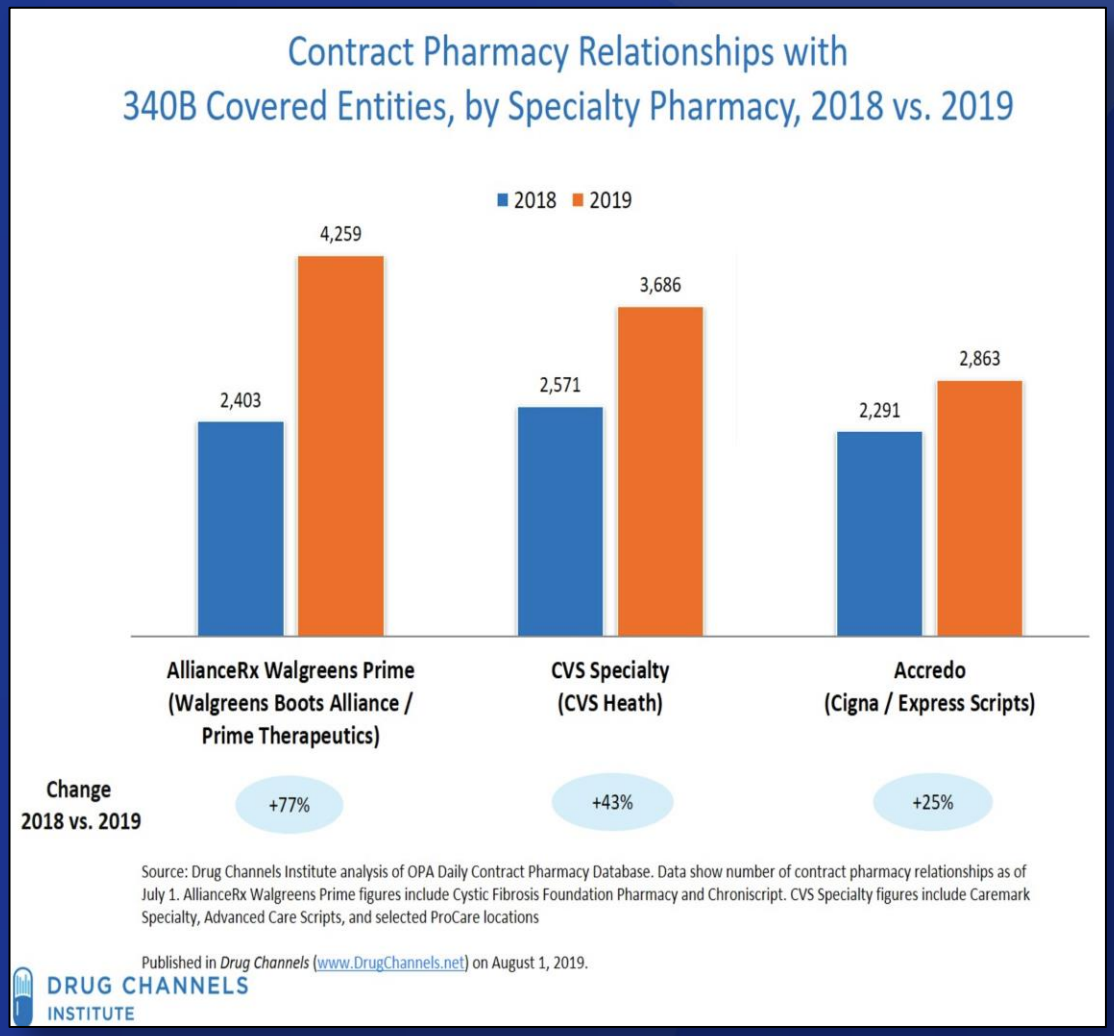
- About one-third of all outpatient volume for certain types of cancer treatments is now at 340B hospitals (2017 Berkely Research Group)
  - 30% of Medicare Part B reimbursements were at 340B hospitals in 2017 (2017 Berkely Research Group)
  - In 2017, 340B covered entities purchased more than $19 billion in drugs, a 114% increase since 2014 (2017 Berkely Research Group)
- 340B discounts increasing in both scope and magnitude
  - Incentives for 340B hospitals to consolidate cancer care to the more expensive setting
    - Drives up the cost of cancer care
  - Pharma/bio companies' factor 340B discounts into launch prices
    - Discounts are so large in scope and magnitude that they fuel drug prices
  - Discounts don’t typically get passed on to patients or shared with payers

340B: Higher Cancer Care & Drug Costs



Source: *The Oncology Drug Marketplace: Trends in Discounting and Site of Care,* Berkeley Research Group, December 2017

PBMs More Active in 340B Covered Entities



340B: Increasing Scope & Magnitude

Source: *340B Program Purchases Reach $24.3 Billion—7+% of the Pharma Market—As Hospitals' Charity Care Fluctuates,* Drug Channels, May 2019

What Happens Overall in 2019?

- PROBABLY NOTHING of substance in 2019!!!
- Likelihood of more bills relating to drug pricing/costs passing Congress
  - Not likely given the current environment and focus on impeachment
- There is increasing focus by Congress on PBMs
  - More bills coming but not clear what can pass
  - Think greater focus will be at the state level which could influence federal policy

The closer we get to 2020 – a major election year Congress will likely grind to a halt

COA's Efforts

- Detailed meetings with CMS & HHS
  - Pushing back on IPI Model
  - Providing alternatives
- Working with Congress to fix PBM problems
- Suing the government over the sequester to drug reimbursement
- Working hard on oncology payment reform
- Only advocacy organization solely devoted to community based cancer care

COA's Efforts (cont'd)

- PBM Abuses Campaign (www.PBMAbuses.org)
- OCM 2.0 CMMI demonstration project
- Continued advocacy on key issues
- Regularly scheduled Hill Days as well as ad hoc days when needed
- Creation of a standing Government Affairs and Policy Committee
- Creation of Position Statements to highlight COA's position on key issues - available on COA's website (CommunityOncology.org)

COA's Efforts (cont'd)

- Comment letters on MPFS, HOPPS, Mandatory Radiation Oncology Payment Model
- Comments on "Patients over Paperwork" RFI
- Community Oncology Pharmacy Association (COPA)
- Continued Advocacy track through COA Patient Advocacy Network (CPAN)
- Senate Finance Committee Bill and patient assistance programs advocacy

Thanks!

- Mark E. Thompson, M.D.
  - Medical Director of Public Policy
  - Community Oncology Alliance (COA)
  - Cell: (614) 561-7972
  - Email: mthompson@COAcancer.org
  - Web: www.CommunityOncology.org