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2026 Access Pulse Check: Evolving Controls in Oncology

Part 3: The Provider Pull

This paper is Part 3 of Hayden's 2026 Oncology Access Pulse Check series and examines how oncology practices are responding to mounting economic pressure.

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In the prior installment of this oncology tug-of-war series, we examined how payers are responding to mounting oncology cost pressure by pulling harder on a growing set of access and utilization strings. But payers are not the only focal point of control in oncology. Oncology practices, a catchall term we will use to represent academic institutions, integrated delivery networks, scaled community settings, and traditional community settings, have also evolved in the face of increasingly efficacious, complex, and expensive therapies. We will focus specifically on evolutions and anticipated behaviors related to economic capture and mechanisms of control exerted on choice of therapeutics to narrow our scope.

While the practice types can vary in their size, patient mix, and capabilities, one important throughline emerged in our panel interviews: a focus on capturing and protecting practice economics. The reason for the focus is different across practices – a rural community may need to capture economics for survival, an academic may need to capture economics to support less lucrative non-oncology care, an IDN or scaled community practice may need to capture economics to satisfy growth requirements of their owner or integrating entities.

Increasing Economic Focus at Oncology Practices

PROVIDER TYPE	PERSPECTIVE
Academic Organization	"The 340B program was originally designed for hospitals that had no resources. My facility, an academic medical center should have never had access to this program, but we do. And we've expanded it to the point where it's embedded as part of our budget and without it our outpatient pharmacy would run at a loss. If that program goes away, we will not run an outpatient pharmacy, infusion center, or specialty pharmacy. We are keeping that money hand over fist because we're losing money everywhere else."
Scaled Community Organization	"Our revenue is generated by buy-and-bill. Changing the structure of how we get paid — ASP +6%, reimbursement changes, authorization — creates a lot of uncertainty. That's why we've had to move to a business strategy with multiple streams of revenue."
Traditional Community Organization	"Our mindset used to be to find the most efficient value-based models and try to also pursue a win-win with lower priced drugs with better margin. But now our focus is needing to drive towards financial margin whenever possible."

This increasing need for economics has naturally created an incentive for practices to use the drugs that offer a greater financial opportunity. Therapeutics can generate wildly different net cost recoveries depending on list price, means of acquisition, patient coverage, and other factors. The graphic below illustrates the financial outcomes for a practice that administers an oral therapy for EGFR-mutated lung cancer dispensed by in-office pharmacy vs. an infused therapy acquired via buy-and-bill.

Net Cost Recovery Potential by Acquisition Channel

Illustrative HCP-Administered Therapeutic

IV acquired via buy and bill	
Monthly WAC[1]	**$30,000**
Medicare reimbursement[2]	$30,846
Medicare NCR per month[3]	**$846**

Commercial reimbursement[4]	$32,010
Commercial NCR per month[3]	**$2,010**

Illustrative Oral Therapeutic

Oral dispensed via in-office pharmacy	
Monthly WAC[1]	**$16,000**
DIR fees	$19,200
PBM reimbursement[5]	$14,784
DIR fees	$1,182
Medicare NCR per month[3]	**$(2,398)**

AWP	$19,200
PBM reimbursement[5]	$14,784
Commercial NCR per month	**$(1,216)**

Assumptions: 1 Assumes ASP is 97% of WAC; 2 Medicare reimbursement is 106% of ASP; 3 No purchasing discounts; 4 Commercial reimbursement is 110% of ASP; 5 PBM reimbursement 77% of AWP ($19,200); 6 Medicare DIR fees 8% of PBM reimbursement

It is important to approach this discussion with appropriate nuance – provider practices, by and large, are committed to delivering the appropriate care to patients. We are not suggesting otherwise. What we *are* suggesting is that the economic criteria are becoming even more important to the survival and viability of many of these practices, so that they can continue to see patients at all.

There are largely two opportunities for practices to influence the therapies used by their physicians: pathway development (practice recommendations for what drugs should be used, when), and pathway steering (how practices enforce adherence to those pathways).

Pathway Development

Pathways help inform prescribing and sequencing of therapies and are often tied to treatment recommendations within an organization's electronic health record (EHR) and order set system. Most are based on evidence-based guidelines like NCCN, therapeutic toxicity, and increasingly, economics associated with therapeutic use. P&T decision-making is influenced by both clinical stakeholders (e.g., physicians) and operational administrators (e.g., pharmacy administrators, practice administrators, financial roles). Pathway adoption has been accelerated in part by the continued acquisition or aggregation activity of practice networks like US Oncology; as these entities assimilate formerly independent practices, they often implement their internal pathway solutions.

Growth is not exclusively driven by these acquisitions, however; independent organizations facing the need to streamline treatment decisions and support burdened practice administrators who are responsible for operational updates have led to the growth and adoption of other third-party services like ClinicalPath or Flatiron Assist. They have proven to be an invaluable tool as providers and administrative teams navigate sustained high levels of FDA approvals and a rapidly expanding clinical universe.

There is a universal sense among our panel that pathway utilization will increase, and that pathways will prioritize economics and net cost recovery. As with payers, increasing clinical options with comparable efficacy and tolerability gives leeway to prioritize other factors. Some EHRs already include indicators of economic favorability visible to physicians (stoplights with green/yellow/red, a scale of 1-5-dollar signs are notable examples) that can help guide decisions. Outside of economic weighting, we may begin to see payer coverage as a pathway factor – practices may discourage the use of agents that face burdensome requirements or site-of-care redirects as payers become more controlling.

> [On Pathways] When we first started off, we did maybe our top 5 diagnoses. Now those have become even more robust… it's gone from like 5 indications to maybe 25 indications in our health system.
>
> – Practice Manager, Academic Organization

The increasing use of pathways has important implications for manufacturers. More favorable placement means higher visibility, easier selection, and potentially streamlined ordering and administration processes for patients. A cottage industry of consulting services (including us at Hayden) has emerged to develop pathway placement, practice engagement, and contracting strategies. The importance of favorable pathway placement is doubly important as we expect pathway steering, the second lever of control, to become more prevalent and more severe.

Pathway Steering

Pathway development establishes recommendations for treatment choices across practices. Pathway steering is the behavior by which practices ensure adherence to those recommendations. Steering exists along a continuum, ranging from soft EMR-embedded suggestions to more directive approaches such as automatic population of preferred agents or restricted order sets. In some cases, HCPs may face financial penalties (i.e., reduced bonuses) for diverging from pathway recommendations. Although these penalties remain relatively uncommon today, growing financial pressures are likely to drive more institutions to manage in this manner.

> We decided to add on a 10% bonus being tied to 85% compliance with our internal pathway.
>
> – Practice Manager, Academic Organization

> They've [our doctors] always been in this private practice model and sometimes we need to make decisions based on the financial aspects of the medications. And for the most part, our employee physicians are on board with it. They understand that we've got to remain as viable as possible.
>
> – Pharmacy Manager, Traditional Community Organization

The use of steering does not fall cleanly along practice type lines – we have encountered independent community practices (often perceived to be less economically focused) with rigid steering behaviors and private-equity owned scaled clinics (often perceived to be highly economically focused) that defer almost entirely to physician preference. This introduces significant complexity for manufacturers – it is hard to develop a high-level and generalized practice engagement strategy. Strategies must evaluate and mitigate risks at the local level to ensure appropriate access,

> [On Steering] Not so much. I mean because we're a physician owned practice, we control how we practice... we never restrict a physician's ability to prescribe a particular drug. That's one of the great things about being in a community practice which is we maintain autonomy over the clinical decisions.
>
> – Oncologist, Scaled Community Organization

and unfortunately there are no publicly available data sets that detail practice-level steering like MMIT or Fingertip Formulary for payer controls.

As with pathway adoption, our panel universally expects steering to become more common and more severe given the economic need and increasing clinical optionality as new brands and biosimilars launch. This will likely include lower triggers for corrective practice action (e.g., applying physician consequences at 75% adherence vs. 85% adherence) and more restrictive corrective actions (e.g., 20% of an HCP's EOY bonus is subject to pathway penalties vs. 10%). In some cases, we may begin to see payer-style choice of therapy controls. We have encountered anecdotal situations where practice pharmacies are prevented from dispensing scripts for certain CDK4/6 and BTKi therapies given comparable clinical profiles and economic dynamics.

There may be natural limits to the amount of control practices can wield. Already we have encountered anecdotal reports of primary care physicians, often the first line of triage, hesitating to refer patients to specific oncology sites of care because of their steering practices. Enhanced practice steering, or even outright control, may look like payer white bagging mandates: something that looks good on paper, but does not translate well to reality.

Additional Provider Evolutions

We see practices developing new mechanisms to capture economics beyond just increased control as well. Economic need is a powerful evolutionary stimulant – combine it with a sense that the go-go days of buy-and-bill NCR and outpatient reimbursement could be coming to an end as payers search for ways to cut costs, and you have a recipe for change. We have highlighted several evolutions we believe could necessitate a change in strategic approach for manufacturers through the end of the 2020s.

Increasing Self-Dispense Behavior

Self-dispensing, when in-house practice pharmacies purchase drugs from specialty distributors and seek payer reimbursement, is not a new practice. What is new is urgency and increasing prevalence. Smaller practices are increasingly willing to self-dispense, even if that introduces administrative burden and therapy initiation risks. Self-dispensing revenues account for an increasing proportion of revenues at large practices.

> The molecular targeted drugs in the oral setting, especially our specialty pharmacy, has just continued to balloon and expand. I don't think that bubble's going to pop.
>
> – Pharmacy Manager, Traditional Community Organization

Beyond just economics, this allows for greater dosing flexibility and rapid dose adjustments. Cancer care is already multidisciplinary and logistically complex, requiring close coordination between multiple clinical, logistical, and administrative roles. Adding external dispensing or additional administrative handoffs introduces further friction and risk into an already strained dynamic; this is something practices are possibly unwilling to take on given the severity of disease and the consequences of delays in care. Keeping dispensing in-house offers greater control, predictability, and continuity across the care continuum.

For manufacturers, this has implications for pharmacy network, distribution, and practice/GPO contracting decisions. Making sure practices can acquire and dispense therapies seamlessly and without losing money on each script is likely to become even more important.

High-Science Care at Community Practices

Historically, oncology group segmentation has been characterized by a relatively simple distinction between academic centers as "high-science" settings and community practices as "low-science." That line is becoming blurred, as many community sites invest in infrastructure, staffing, and clinical sophistication that allow them to manage more complex therapies in-house.

Community practices are adjusting to the safety and monitoring requirements of oncology therapeutics like bispecific antibodies, ADCs, and even CAR-T in some cases. While some expect to continue referring out these patients for treatment, others are building protocols for the acquisition, dispensing, and use of these therapies in-house. This is an exciting development; bringing advanced care closer to patients could help reduce barriers to access like travel and hotel stays.

For manufacturers, this could have significant implications for practice engagement and patient support. Rural or geographically isolated community practices often have different administrative abilities and serve a different patient population versus large academic hospitals, IDNs, or large scaled community practices. A one-size-fits-all approach is unlikely to be successful; understanding how to best engage with the practices and their patients can ensure access success.

> **[On Cell & Gene Therapies] Right now you have a technology that gets locked into academic centers and it's a losing financial proposition for the payers. And they are trying to find a way to get it to the community setting and we are motivated to do that too. We just have to do it in a way that fits within our resources and ability to implement it within our structure.**
>
> – Oncologist, Scaled Community Organization

In sum, these developments reflect a provider community that is not a passive recipient of payer policy, but rather an active participant in the oncology tug-of-war. As economic pressure intensifies and clinical optionality expands, practices are increasingly using pathways, steering, and operational investments to protect sustainability and retain influence over therapeutic decision making. In the final section of this paper, we will zoom out and look ahead. We examine the major developments on the horizon that may further shift this balance – and consider how emerging scientific, economic, and policy forces could reshape the tug-of-war itself as oncology moves toward the end of the decade.

About the Author

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Sam is a principal at Hayden Consulting Group and leads the Hayden Oncology practice group. He has a decade of consulting experience and helps clients navigate access and commercial challenges. For questions or to talk oncology access, please email Sam at smcmeley@haydencg.com

Further Reading

This paper is part of Hayden's 2026 Oncology Access Pulse Check series.

Explore the full series:

- **The Complete Report: Evolving Controls in Oncology**
- **Part 1: The Oncology Tug-of-War**
- **Part 2: The Payer Push**
- **Part 3: The Provider Pull**
- **Part 4: Forces That May Shift the Balance**

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Hayden Consulting Group, a BGB Group Company, is a strategy and analytics consulting firm that partners with life sciences companies to untangle access complexity, uncover deep insights, and unlock commercial success. Our team of leaders is connected by a common thread – to redefine how the life sciences industry thinks about access. Placing access at the forefront of decision-making is critical to ease the process for patients and their providers to obtain clinically necessary therapies. We're excited to lead the way, driving Access Forward.

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