United Healthcare, Five Oncology Practices Try Bundled Payments

By Merrill Goozner

The nation’s largest health insurer recently launched an experimental cancer care payment program that disconnects physician reimbursement from drug sales and encourages oncologists to follow standardized regimens.

The goal is not just to reduce costs—although United Healthcare (UHC) does hope that the pilot program will save money by reducing the overuse of expensive oncology drugs. The architects of the program also hope that the bundled, or “episode-of-care,” payment for a standardized treatment will improve outcomes and quality of care.

An episode of care under the plan, which was announced last October, is the treatment used for a specific stage of a certain cancer. UHC’s payment is based on actual drug costs plus a case management fee. The bundled payment does not include office visits, drug administration costs, radiation treatments, or lab tests, which will still be reimbursed on a fee-for-service basis.

The company expects that bundled payments and standardized regimens will reduce errors, remove incentives for deploying ineffective interventions, and ultimately generate information about which regimens worked best, according to Lee Newcomer, M.D., director of oncology at UHC.

Five community-based group practices with 158 oncologists based in Kansas City, Kan.; Atlanta; Memphis, Tenn.; Dallas-Fort Worth; and Dayton, Ohio are participating in the pilot project. The first enrolled in October 2009 and the fifth in the fall of 2010. The practices receive episode-of-care payments for 19 different stages and types of breast, lung, and colon cancer, the most common cancers in the United States.

Regimens and Payments

Before UHC determined the episode payments, each of the five groups chose one or two preferred regimens for each of the 19 conditions in the pilot. That step required nearly a year of analysis and debate within the five groups, since the care delivered by individual oncologists in most of the practices—while usually based on National Comprehensive Cancer Network (NCCN) guidelines—was all over the map. For instance, NCCN guidelines allow 14 different regimens for adjuvant chemotherapy after breast cancer surgery.

UHC based its payments on the difference between the previous physician fee schedule, which included a markup for drug reimbursement, and the drugs’ actual costs. Rather than reimbursing for drugs at the average sales price plus 6%, the insurer is paying exactly what the supplier charged the oncology practice. At the same time, UHC adds a case-management fee to the bundle to reflect the time and resources that oncologists spend talking with patients.

The company hopes to profit from lower costs under the new system; it will reduce costs, for instance, if physicians choose generic drugs over a branded version. That’s more likely to happen once the markup incentive is gone.

The insurer could also benefit from oncologists’ taking more time to engage patients and their families in the difficult decisions around heroic interventions near the end of life. “If they decide a patient is no longer responding to therapy and is too ill to get treatment, they still get the episode fee,” Newcomer said.

A recent Dartmouth Atlas of Health study showed wide variations across the country in use of chemotherapy, hospice, and palliative care in the last months of cancer patients’ lives.

Drawing Fire

The program, first announced at a June meeting of the Association of Community Cancer Centers, drew immediate fire from patient advocacy groups and some oncology groups. “Cheapest is not always best,” said Patricia J. Goldsmith, executive vice president of NCCN, in the American Society of Clinical Oncology’s ASCO Post. “We now have a system where there’s an incentive to get the most expensive medicine and deliver the largest dollar amount to the practice; let’s not have the pendulum swing [too far] the other way. . .”

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Newcomer rejected the charge. “These oncologists have far too much integrity to ever skimp on care,” he said. “Equally
important, the results are being measured for all the groups to compare.”

ASCO was cautiously supportive of the experiment. “This pilot program is a creative and clever attempt to solve a complex issue,” said Allen S. Lichter, M.D., CEO of ASCO. “The idea of separating payment for the medical care and attention we provide our patients from the drugs needed to treat their disease has been an idea that has long been worth exploring. We will be watching this pilot with interest.”

Creating Efficiencies

The five practices participating in the pilot hope that the program will help generate efficiencies and savings without stinting on care. “Doctors are like chefs in the kitchen,” said Roy Page, D.O., Ph.D., president and director of research at the Center for Cancer and Blood Disorders in Fort Worth, which oversees 19 physicians practicing in 11 clinics across North Texas. “One may pick one recipe, and another doctor may pick another recipe. It’s not that any are wrong. But if you can get all your doctors to agree that a certain recipe is a good standard of care, and everybody can be on board with treating with a
certain combination of drugs, it creates efficiencies in our pharmacy, in drug purchasing, and with nursing in the administration of therapy.”

The Fort Worth-based group chose its preferred regimens from best-practice guidelines produced by the University of Pittsburgh Medical Center. The Texas group expanded its efforts to standardize practice beyond the 19 conditions targeted for the pilot project. For example, NCCN guidelines for multiple myeloma offer at least seven possible drug combinations for first-line treatment. On the basis of the Pittsburgh recommendations, the group chose two. That decision required prolonged discussions among its physicians. In the end, each agreed to start patients on one of the two regimens, but he or she wasn’t locked into that choice should an individual patient’s needs demand change.

“As much as we’d like to be congruent with our therapies, we know as our patients go through their journey with cancer that there’s always that 15%–20% of patients whose journey is unique,” said Page. “There may be excess toxicities or more rapid progression where you need to make changes in the regimen. That’s understood. [But] if you can create more consistency and congruency within the practice, realizing that will hold true for 80%–85% of patients, then you can create efficiencies by reducing the cost of health care and increasing patient safety.”

For nearly a decade, the Kansas City Cancer Center in Overland Park, Kan., whose 34 oncologists are affiliated with US Oncology, has been using “clinical pathways” for treating cancer. US Oncology had already been working with Aetna to encourage its affiliated practice to follow these pathways, although Aetna hasn’t yet linked reimbursement to adherence. “We were primed to participate in this [UHC] program because we had a fairly well-distilled list of choices for treating patients based on scientific evidence,” said Marcus Neubauer, M.D., who directs the center. “It wasn’t a stretch to get our doctors to participate.”

One factor motivating the participating groups is the rising financial burden on patients. The latest cancer drugs can cost tens of thousands of dollars for a course of treatment and usually require a 20% copayment, which many can’t afford. IMS Health, a market research firm, reports that chemotherapy drug sales in the U.S. quadrupled, to more than $20 billion, over the past decade.

“The cost of cancer care is rising at a pace that is unsustainable,” said Neubauer. “We ought to be part of the solution. We’re not going to sacrifice quality of care. But you still can focus on cutting costs when possible. Not everything has to be the most expensive therapy.” Once the groups opted for standardization, they quickly realized that NCCN guidelines would be of no use in making their decisions. “NCCN guidelines are very broad, to the point where I could tell a payer that I follow the guidelines—and he has no idea how we treat patients in our practice,” Neubauer said. “There are 20 different ways to treat lung cancer [by] using NCCN guidelines.” He said US Oncology tries to distill one or two or three treatment programs for a certain stage of disease and expects doctors to use those regimens for that disease, unless using something outside that clinical pathway is in the patient’s best interest.

Comparing Outcomes

The final phase of the pilot project—comparing costs and outcomes at the five sites—could become controversial. None of the sites knows which regimen the other four sites chose for the 19 different diagnoses that bundled payments cover. Newcomer emphasizes that comparing outcomes is an important part of the program, with the implication that future coverage decisions could be based on the results: “We built the pilot with the idea that eventually we will be able to expand it,” he said. “If we see changes in the practices that lead to better results like fewer complications and less hospitalization, then we’ll move forward. And since they’ll be doing different regimens, we might discover that one or the other has better outcomes.”

Persuading oncologists to adopt common standards could be a hard sell. Some question whether the numbers of patients in this pilot program will be large enough to yield the data needed to draw such conclusions: “As far as outcomes, progression and survival, that stuff will be meaningless with the numbers we’re reporting,” said Page. “These [standard] regimens are all evidence-based medicine where clinical trials have proven it is best of care. It’s meaningless to draw conclusions when we’re reporting numbers in the hundreds.”

Newcomer sees it differently. Collecting data on costs and outcomes from the five practices will provide “a good observational study,” he said. “We should be able to compare results between groups and get valid differences.”

The groups plan to meet in late fall 2011 to compare first-year results.