Trying Something New: Episode Payments for Cancer Therapy

By Lee N. Newcomer, MD, MHA

My recent personal experiences illustrate the current issues for health care delivery. Last spring, a driver behind me was blinded by the early morning sun, and she did not see that I had stopped at a stop sign. It only took four hours after the rear-end collision for me to develop the aches and pains of a minor whiplash injury. My internist was booked, so I accepted an alternative appointment with a new physician who was one year out of residency. My exam was normal except for a neck spasm. My new physician wrote a prescription for some pain medication and a muscle relaxant. Then he began scheduling a magnetic resonance imaging (MRI) scan of the neck.

"Give me a moment," I asked. "Isn't my exam normal?"

"Yes," he said.

"Do you really think I have any pathology in my neck based on the history and exam?"

"No," he said.

He then explained that he was being cautious; he did not want to miss anything. I told him what I do for a living and explained that I was more than willing to take the meds, rest, and wait to see whether I improved. If I did not get better, I said I would return for the MRI. We developed a plan for follow-up and shook hands on the agreement.

As I left, he turned the tables on me: "You do realize," he said, "that you insurers pay me more to do the MRI than to have this discussion."

Misaligned payment incentives for technology and inadequate payment for discussion and planning encourage physicians to do more rather than less. Even the overrated threat of malpractice is illustrated in this example. In addition, this young physician did not have a forum in which to compare results and costs with his peers, so any quality improvement was left to his ingenuity.

The same issues are exaggerated in medical oncology in which an old payment system has created strong and perverse incentives for care. Medical oncologists evaluate patients with cancer to determine the extent of the disease and then recommend therapy. Treatment options for cancer include surgery, radiation therapy, chemotherapy, or combinations of those three. If chemotherapy is recommended, the medical oncologist administers those drugs in his office. Medical oncologists purchase chemotherapy drugs at wholesale prices from manufacturers and then bill the payer at retail prices. This payment system originated in the 1960s when few chemotherapy drugs were available and their costs were minimal. However, as more drugs were discovered and as the cost of those drugs increased, a major shift occurred in medical oncology economics. Today, the profit margin from these drug sales accounts for approximately 65% of a medical oncology practice's income. These profits are essential to cover the overhead of the community oncology office.

The current system does have benefits. The administrative overhead of a dedicated oncology clinic is usually much lower than alternatives in outpatient hospital-based clinics, so they can offer these services for a lower cost. Unpublished UnitedHealthcare (UHC) data show that private offices also use fewer ancillary services for a cancer episode compared with hospital-based outpatient clinics. Combining those two factors—cost and use—has a startling impact. At UHC, the total cost of care for a patient actively on chemotherapy is approximately two times more expensive if the patient is treated in a hospital outpatient clinic than if that patient is treated in a community oncology office.

Unfortunately, there were excesses when profit margins were high. Medicare responded to this problem by lowering chemotherapy reimbursement levels to approximate cost. Using a calculation called Average Sales Price, the federal government pays a 6% margin on its calculated acquisition cost for each drug. But like any new payment system, unintended consequences quickly emerged. Even with a fixed margin, the net profit on an expensive drug is higher than that of a low-cost drug. Many generic drugs yielded margins that measured in the pennies whereas new, branded products could generate hundreds of dollars by using the same 6% margin. Not surprisingly, physicians increased the use of expensive chemotherapy drugs. Using Medicare data, Harvard researchers showed that a medical oncologist would prescribe the most expensive regimen when there were multiple choices of therapy.[1] This incentive has significant implications for total cost. The study noted that each dollar of incremental profit for the medical practice cost Medicare an additional $23 for drug expenditures. With the Medicare decrease in payment, practices started shifting patients to hospital facilities for treatment or shifting their losses to private payers. Private insurers began experiencing inflation trends of 15% annually for cancer care after the Medicare payment change.

A new payment system is needed. When UHC began developing a new pilot payment program to correct the existing problems, it had three objectives: (1) separate the oncologist's income from drug sales, (2) retain the medical oncologists' personal incomes at current levels, and (3) create an objective performance measurement system that becomes the basis for future payment increases. The pilot started with five volunteer medical oncology groups. Each medical group agreed to two key requirements to participate. They chose a standard chemotherapy regimen for each of 19 clinical presentations in breast, colon, and lung cancer, and they agreed to participate in a joint performance review with the other participating oncology groups.

Once the groups selected their regimens, UHC calculated the profit margin amount of money each group would make on drug profits for each of the 19 clinical presentations by using the differ-

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ence between the group's current fee schedule and the drug costs. A case management fee was added to this amount, and the amount became the patient care episode fee. This new episode fee would be paid on the first day when the patient would receive care from the group. Drugs were reimbursed at cost. The medical group was free to change their drug regimens at any time, but the episode payment would not change. Office visits, chemotherapy administration codes, and other ancillary services—like laboratory tests—were paid on a fee-for-service basis. Adjuvant treatment episode fees were single payments that covered the time period of the adjuvant regimen. Episode fees for patients with metastatic disease would renew every 4 months, even if the patient elected not to receive additional chemotherapy. UHC is gathering data for clinical and cost profiles of each clinical category. These data are shared openly with all five groups. Measurements include complication rates, relapse rates, pain control admissions, and total medical costs. Because each group is treating its patients with a consistent regimen, the pilot creates a comparative effectiveness analysis that allows all of us to identify best practices. If and when a best practice is identified, it is UHC's expectation that groups will transition care to that practice.

This novel approach accomplishes several important goals. Drug selection is based on best practices rather than income maximization. Oncologists will be able to compare their performance with that of other groups and adopt best practices. UHC anticipates that use of medications with minimal responses will diminish, because physicians will not see any improvement in their clinical performance as they compare data. This program does not penalize the oncologist for participating, because current income is preserved. This method does not address the new drug pricing by pharmaceutical manufacturers. Neither UHC nor the physician community can negotiate effectively when new, single-source drugs are approved for use, because there are no alternatives. In addition, price increases on existing drugs from manufacturers are not addressed.

A second personal experience illustrates why something must be done differently. My son's roommate—a nursing student at the University of Nevada—called me last weekend; she needed help diagnosing a rash for one of her friends. The young nurse was convinced it was the target rash of Lyme disease. Using her cell phone camera, she sent me a photo that could have been used as an illustration in a medical textbook. I gave her my opinion and told her that her friend needed medical care that day. That was when I found out that the patient did not have medical insurance. Although the friend had graduated with a college degree, she was subsisting on three different part-time, minimum-wage jobs; none of the jobs offered insurance, and she could not afford the premium if she was going to pay rent, buy food, and put gasoline in her car.

Health care coverage is simply unaffordable for too many people. It will only become affordable with radical changes in payment incentives and the elimination of care that does not really matter. The UHC pilot may help, and it may not; it is an experiment. My wish is to see hundreds of experiments in the next five years. Only through change are we going to find solutions that work.

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Reference

1. Jacobson M, O'Malley AJ, Earle CC, et al: Does reimbursement influence chemotherapy treatment for cancer patients? Health Aff (Millwood) 25:437-443, 2006

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