

Bundled Payments Come to Cancer Care

Joe Cantlupe, for HealthLeaders Media , March 11, 2013

This article appears in the January/February 2013 issue of [HealthLeaders](#) magazine.

When UnitedHealthcare first met two years ago with five oncology medical groups that volunteered to participate in a bundled payment program designed to reduce costs for cancer care, there was definitely uncertainty, but "nobody came into this kicking and screaming," says Lee Newcomer, MD, an oncologist and vice president of oncology for UnitedHealthcare, a Minnetonka, Minn.-based health benefits company with 2012 revenues (through September 30) of nearly \$77 billion and earnings from operations exceeding \$6 billion.

"Everyone knew the world of healthcare had to change," Newcomer says. "Everyone was eager to try something new."

Their target: to evaluate 19 clinical scenarios for breast, colon, and lung cancer and identify the best practices for the care of those patients. Each group selected the chemotherapy it believed was the best and agreed to participate in measurement of those results.

As the five physician groups evaluated their chemotherapy selections for early-stage breast cancer, the cost of treatment proposed varied greatly, Newcomer says. There was also a wide variation in the number of imaging tests physicians believed they needed to evaluate relapsed patients with breast, colon, or lung cancer.

"Clearly some groups are doing far more radiology studies than others and getting the same results," Newcomer says. UnitedHealthcare and the physicians worked on "standardizing the tests to decrease utilization."

As time went on, the physicians and insurer worked to minimize variations of care, reaching agreements for breast, colon, and lung cancers. Physicians receive an up-front payment for the episode that is equal to the drug margins they used to receive from their previous fee schedule. Fee-for-service vanished, but the drugs are always reimbursed at cost, even if changes are made. It was only November 2010, and UnitedHealthcare was testing the bundled episode payment approach with five medical oncology groups for more than 430 patients.

Bundling is one of the new payment models being scrutinized across the country as a way to get a handle on skyrocketing service line costs, including those for oncology programs. These models, which include accountable care organizations, have a twist: Providers and insurers are teaming up instead of facing off. Under the bundling initiatives, payments are made for multiple services under what is termed an episode of care for a patient. Instead of a surgical procedure generating multiple claims from many providers, the entire team is compensated with a bundled payment with the thought that such a move would provide incentives for more efficient care. Medicare now makes separate payments to providers for services, leading to what CMS has called "fragmented care" with minimal coordination.

Under a bundled savings program, there is an incentive for providers to share in any savings, and it can increase physicians' payments with improved patient outcomes. Physicians "have the opportunity to be paid more for the work they do taking care of patients," Newcomer says. In addition, he says physicians have a "chance to mold and influence a new payment model."

Establishing the bundling program is a complicated structure, and UnitedHealthcare learned a lesson the hard way. While the insurance leaders believed they could quickly tally outcome measures, it didn't turn out that way. "It takes a large number of patients to identify a statistical difference," Newcomer says, referring to oncology patients whose treatment costs were included in the bundling. "Cancer costs can vary by 100% routinely, and detecting a difference among those wide swings means that we needed nearly 700 patients before we could begin the analysis," he adds.

The Northwest Georgia Oncology Centers physicians are among the groups working with UnitedHealthcare on the episode of care payment plan, says Bruce J. Gould, MD, medical director of the organization, which has 10 treatment centers and more than 20 physicians; he also is a staff physician at WellStar Kennestone Hospital in Marietta, Ga. Gould acknowledges that there are risks involved for physicians in the bundling package.

"If a patient ends up in the hospital, we don't get charges for our services for that hospital care," Gould says. He remains adamant, however, that physicians in the practice will make profits in the shared savings, though results may be long term. "We're in the transition from fee-for-service to one in which we get paid for global care, which is taking ownership of the cost of caring for those patients."

"Ultimately," he adds, "this plays to our strength. We have always tried to be thoughtful to patients who would likely benefit from it and no more. Some doctors will give chemotherapy to the bitter end. However, most stakeholders agree substantial cost savings can be realized by more appropriate use of chemotherapy at end-of-life care. They are in the minority, but it's there. With this we are trying to solve the problem of out-of-control cancer care costs and not be part of the problem."

Indeed, the cost of cancer care continues to skyrocket, in part because of more costly advanced treatments being used, according to the National Institutes of Health. Medical costs for cancer are anticipated to reach \$158 billion in 2020, an increase of 27% over 2010, the NIH states.

The Congressional Budget Office projects that bundling hospital and postacute care for Medicare patients alone would reduce federal spending by \$19 billion, from 2010 to 2019, according to the Commonwealth Fund. Bundling appeared several years ago in cardiology care and then moved to hip replacement, obesity, and other medical services. UnitedHealthcare says it was the first insurer to become involved in bundled payments for oncology care. The Centers for Medicare & Medicaid Services has begun partnering with providers through a bundled payments initiative.

In another team effort involving an insurer and providers, Florida Blue (formerly Blue Cross Blue Shield of Florida) is coordinating an accountable care organization shared savings plan with Baptist Health South Florida in Coral Gables, and Advanced Medical Specialties, a Miami-based oncology group, which consists of 17 physician practices. Florida Blue, based in Jacksonville, serves 15.5 million people in 16 states through affiliated companies. While the project is directed toward shared savings, the plan includes shared risk for a defined oncology population.

The importance lies in "establishing and solidifying relationships with medical staff and payers," says Ralph Lawson, executive vice president and CFO for Baptist Health South Florida, a 1,738-licensed-bed system that includes seven hospitals. Lawson is also national chairman for the Healthcare Financial Management Association.

Lawson describes it as a shared-savings arrangement because participating providers "are coordinating care for this defined oncology population with the goals of increasing quality and efficiency while reducing costs and unnecessary services."

"We started with oncology because we are fortunate to work with a premier oncology group in the South Florida area that has worked with Baptist Health for many years," Lawson says.

In another partnership, Blue Cross Blue Shield of Michigan and the University of Michigan are examining various funding sources, including bundling, as physicians evaluate cost efficiency in other oncology programs, such as prostate cancer, says David C. Miller, MD, MPH, assistant professor in the department of urology at the University of Michigan's Center for Healthcare Outcomes and Policy.

The project has initiated dozens of urology practices to evaluate prostate-related cancer services to improve evaluation of data and assess outcomes, Miller says.

That's why a partnership between providers and insurers is crucial, he says.

Success key No. 1: Evaluating drug costs

When a new breast cancer drug, pertuzumab, was approved by the FDA, physicians in UnitedHealthcare's bundling program added the medicine to their regimens based on promising results from clinical trials; the cost for the new regimen was approximately \$180,000 for a course of therapy covering an 18-month period for each patient. The medication was, indeed, costly, but the physicians agreed it would set the stage for better outcomes. In addition, UnitedHealthcare pays for the cost of the drug, so physicians are not at risk for the expense. However, physicians do not make more money for using the more expensive medication, as they would in a fee-for-service payment model.

UnitedHealthcare calculated the drug margin for each selected regimen by subtracting the average sales price—the price determined by Medicare—from the group's usual reimbursement for the drug using the existing fee schedule. To determine the episode payment, UnitedHealthcare asked physician groups to identify the chemotherapy program that it thought would be best practice for the oncology programs, Newcomer says. The discussions were not always smooth. Not every member of the group used the same regimen, and they had to come to a consensus for the program."

When new evidence requires changing an episode's chemotherapy to a more expensive drug, the drug cost is reimbursed by UnitedHealthcare to the physician and the episode payment is not increased. "They don't get paid any more money now that they are using the drug," Newcomer says. "In the old system, the physicians would have made a lot more money, but that doesn't happen in this program. Everyone knows the drug profit model is going away and this model offers a unique way to increase physician payments."

The five medical groups involved in the UnitedHealthcare program used docetaxel and cyclophosphamide chemotherapy for early-stage breast cancer, yet costs of treatment varied by 100% among the groups, Newcomer says. The cost for drugs in the regimen would range from \$9,000 to \$22,000, he adds.

When new evidence requires changing an episode's chemotherapy regimen to a more expensive drug, the physician's episode payment is not increased.

Coordination and quality of care are just as important to evaluate as the drug costs, Newcomer says. Over the past several years, physicians and UnitedHealthcare's oncology group discussed how to assess the value for each scenario using more than 60 measures, such as survival, complication rates, and total cost.

The current bundling system differs drastically from what Newcomer described as the "buy-and-bill" scenario, in which oncologists earned the difference between what they paid for chemotherapy drugs and the amount they billed insurers.

Before the bundling program was implemented, there was discouragement "of lower-cost generic medications, even if the clinical results are similar,"

Newcomer says. "All of us are struggling to change behaviors to get better outcomes."

Success key No. 2: Physician involvement

A key for success in the episode of care model relies on physician involvement and providing quality care. Everyone agrees this one will be tricky.

Medical groups may change their regimens at any time, but the episode payment will not be adjusted for new drug selections. Each physician identifies eligible patients during the initial consultation, and his or her office registers the patient with UnitedHealthcare under its program.

"We're taking on some of the ownership of the cost of care for those patients," says Gould of the Northwest Georgia Oncology Centers. "We're transitioning from fee-for-service to one in which we are paid for global care of the patient," Gould adds. The Northwest Georgia Oncology Center is part of the UnitedHealthcare episode of care pilot project.

Gould is excited about the prospects for the bundled payment program that impacts the 21 medical oncologists at Northwest Georgia Oncology Centers because, he insists, the payments are wrapped around value.

Physicians can increase their episode payments by improving their results, through either improving patients' survival or decreasing the total cost of care, Gould says.

Physician involvement is essential to get the project going, says Leonard Kalman, MD, chairman of the board of managers for Advanced Medical Specialties of Miami, an oncology practice involved in an accountable care program with a Florida hospital and insurer.

"What's in it for the oncologist?" Kalman asks. "You have to buy the proposition that's where the payers want to move, including Medicare and Medicaid, so you better get on the bus, otherwise you will be left behind. That's the motivation."

"Risk does scare some people, but it also represents a potential opportunity. So we need to get comfortable managing a population," Kalman says. "If you can manage costs while maintaining quality, it's very possible that you will attract more patients."

Success key No. 3: Coordination

Prostate cancer care is expensive and highly variable in terms of quality and cost-efficiency, both in the hospital and at physician practices.

Urology practices provide most prostate cancer-related services, but they often lack data regarding quality of care in their practices. And even when the data is available, few physicians understand how to make changes to make improvements, according to the University of Michigan's Miller.

Recognizing these concerns, urologists from throughout the state of Michigan and Blue Cross Blue Shield of Michigan have partnered to create the Michigan Urological Surgery Improvement Collaborative.

The group includes a consortium of urology practices—representing about 60%-70% of all urologists in Michigan—to initiate coordinated care, says Miller. "In prostate cancer, there has been a fair amount of variation in care that has been well documented," he says. "It's a very expensive condition."

Miller says it's important that systems build guidelines to potentially reduce unnecessary testing of men with low risk of cancer. In a study, Miller said that in 2010 surgeons collected uniform data for men with newly diagnosed prostate cancer. Of 215 men having prostate cancer, 43% underwent testing, but only 9% of those were positive for the disease.

The MUSIC program has initiated guidelines to reduce unnecessary testing, Miller says. "We may be able to improve practice patterns and avoid many radiographic tests in low-risk patients," he says. At the same time, the work may "optimize the use of appropriate radiographic staging evaluations among men with a higher risk of cancers."

Success key No. 4: Accountable care organizations

At least 16% of total Florida Blue's medical expenses over a year's period were linked to cancer care. Those figures prompted the insurer to team up with Baptist Health South Florida and Advanced Medical Specialties, the medical group, to initiate an oncology ACO.

The collaboration focuses on six of the most common forms of cancer: leukemia, lymphoma, breast cancer, lung cancer, colorectal cancer, and male and female genitourinary cancers. All told, they represent 80% of all cancer types in Florida. An early examination of data "shows trends in a good direction" for cost savings, Lawson says.

"This is an ACO-like shared savings arrangement," Lawson says. "It is ACO-like from the standpoint that participating providers are coordinating care for this defined oncology population with the goals of increasing quality and efficiency while reducing cost and unnecessary services," he says.

Baptist Health will assume the risk for cost of care. "We found cancer care has complexities unlike some of the other service lines," he says. All parties agreed that collaboration was necessary to cut costs, says Lawson. To carry out effective coordination, it was also important that senior leadership in each of the three organizations was engaged in setting strategy, he adds. Negotiations were sensitive because the parties felt they were breaking new ground, including the need to divulge financial information.

"To attempt to make an impact on the cost of care, it is important to understand the complete picture—services rendered, patterns of care, ED frequency, etc.," he says. "The only way to build the complete picture is for all three parties to share clinical and financial information. This requires a new level of disclosure and transparency among parties that are typically on opposing or competing sides and must now learn to work together toward shared goals.

"Florida Blue is very much a partner in setting and achieving these goals. Part of the initial phase of this program was the formation of several subgroups and task forces. It is the only way to ensure that, with so many moving parts, nothing falls through the cracks," Lawson says.

"The clinical subgroup is tasked with identifying opportunities along the continuum of care," Lawson adds. "Patients are often bombarded by duplication efforts, information-related material, advanced directive documentation, and reminders. By simply coordinating some of these efforts, the patient's experience is positively impacted and resources from duplicative areas can be directed to more beneficial use."

Jonathan Gavras, MD, chief medical officer and senior vice president at Florida Blue, also says that all parties were present together throughout the process. "Cancer costs have been an issue throughout the U.S. and particularly in Florida for a long time," Gavras says. "For three months, we ground through the analysis of data. We shared information with each other that we never would have shared before."

Team meetings among the groups are held to "review data and maintain adherence to time frames and initiatives," Lawson adds. The task force includes three members from all parties in the transaction and shares all the "available data concerning the cancer patients treated at Baptist Health."

Baptist Health's and Advanced Medical Specialties' information technology teams are also working diligently on the development of appropriate and compliant processes to achieve more real-time sharing of target population information. This would be a breakthrough for emergency visits to Baptist Health facilities, so cancer patients can avoid duplication of care or unnecessary diagnostic testing, according to Lawson.

"You have to have a lot of trust developed," Gavras adds.

Indeed, trust-building counts in every aspect of payment-bundling for cancer service lines.

Reprint HLR0213-7

This article appears in the January/February 2013 issue of [HealthLeaders](#) magazine.

Joe Cantlupe is a senior editor with HealthLeaders Media Online.



[Back](#)

Copyright © HealthleadersMedia, 2013

**Care coordination
is the No. 1
organizational challenge
of healthcare executives.**



ANALYTICS
From Big Insights
to Big Breakthroughs

CLICK FOR ON-DEMAND
VIRTUAL CONFERENCE



THE POWER TO KNOW.

INDUSTRY SURVEY
HEALTHLEADERS MEDIA 2013

**National Winner:
Best Original Research
2012**

DOWNLOAD THE FREE REPORT

Supported by **CONIFER**
HEALTH SOLUTIONS®

90% of Healthcare Leaders Will Pursue a Population Health Strategy. Find Out How They Are Preparing...