

THE DEBATE OVER EPISODE-BASED PAYMENTS IN ONCOLOGY

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CAN THIS SYSTEM REPLACE BUY AND BILL?

– By Paul Watson –



In a reformed healthcare system, will oncologists be paid by the episode?

The current economic downturn has only added more fuel to the fire in the debate over universal healthcare and provider payment reform. As the Obama administration is now turning its attention to this debate, many analysts and legislators are expressing disdain over the fee-for-service model—a system they see as rewarding volume and intensity of service rather than the quality and clinical value of those services. As a result, it seems there is an increasing number of experts who are considering the implementation of the episode-based payment system as a replacement for the fee-for-service model; however, there is also increasing speculation from opponents about how such an approach might work in oncology, or if it can work at all when it comes to replacing buy and bill. Interestingly, it is not the Centers for Medicare and Medicaid Services (CMS) that is testing the efficacy of an episode-based payment system in oncology, but rather United Healthcare, a private payer. This fact alone may highlight the vast savings potential insurers see in such a payment model.

Testing Grounds for a New System

According to Stuart Gutterman, MD, Senior Program Director of the Commonwealth Fund's Program on Medicare's Future, "The fee-for-service payment system is the wrong way to go. Bundled payment is simply a way to encourage providers to take broader responsibility for the care that their patients get and also rewards them for doing that." The Commonwealth Fund is a private foundation that supports independent research on healthcare issues and offers grants to improve healthcare practice and policy.

Under an episode-based payment model, hospitals or healthcare professionals receive a single fixed payment that covers the entire hospitalization episode for the patient. This payment ostensibly covers all the costs associated with the patient's treatment (i.e., blood tests, chemotherapy, nurse visits, follow-up care, etc). The fixed payment may be adjusted for severity of illness or revised until a clinical outcome is achieved. Providers whose costs exceed the average payment would be financially penalized whereas providers whose costs fell far below the average would profit handsomely. As a result, healthcare professionals have an incentive to provide the best quality care at the lowest possible price.

Although President Obama's Recovery Act included \$1.1 billion for comparative effectiveness research (and his budget touched on bundled payment models for Medicare reimbursement) there may be little political motivation in Congress to implement payment methods, based on comparative effectiveness research, especially since meaningful outcomes in oncology will not be documented for some time.

As such, episode-based payments may provide CMS a roundabout way of implementing "least costly alternative" reimbursement strategies by proxy and physicians may choose less expensive drugs that are clinically equivalent to treat their patients in order to keep their expenses low.

Compelling Yet Controversial

Experts like Trish Goldsmith, Executive Vice President and COO of the National Comprehensive Cancer Network (NCCN) and Lee Newcomer, MD, Senior Vice President of Oncology at United Healthcare are divided over the merits of instituting an industry-wide episode-based payment model in oncology. Both agree that the fee-for-service model needs revision, though Goldsmith sees bundled payments as too simplistic a system for the convoluted nature of cancer care, and paradoxically, too complex administratively to execute efficiently at the office.

Goldsmith stated that an episode-based payment system is an excellent idea in theory, "but, I just don't see a broad, quick uptake of that system because of the administrative complexities and the huge risk and variability associated with the technologies, drugs, and biologics used to treat cancer."



Trish Goldsmith,
Executive Vice President
and COO, National
Comprehensive Cancer
Network

She noted that several years ago, one of NCCN's member institutions, Roswell Park Cancer Institute in Buffalo NY, entered into an episode-based payment contract with their local Blues plan. "The project lasted for about two years and while both parties were satisfied with it, it was an administrative nightmare and just too difficult to implement and maintain."

On the other hand, Newcomer believes that medical oncologists may come to embrace episode-based payments and all its attendant complexities, especially when the alternative may be lower reimbursements. According to him, many commercial payers have or are expected to [cont. on pg 10 >>](#)

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incorporate CMS's ASP+ 6% reimbursement policy in order to significantly lower drug costs. "Everybody on the commercial side is trying to get [ASP+ 6%]...and that's not a very pretty picture for medical oncology," he said.

Another dilemma facing insurers is the lack of a workable algorithm that can be applied across all cancers. According to Lee Blansett, MBA, Senior Vice President at MattsonJack DaVinci, "The very large degree of variability among cancer types means that you'll never achieve the economies of scale that you get in 'simpler' diseases like asthma, hypertension and so forth."

Despite these reservations, however, the buzz around episode-based payments has been building in recent months, most likely due to their great cost savings potential. Peter B. Bach MD, MAPP, Associate Attending Physician at Memorial Sloan-Kettering Cancer Center and a former Senior Advisor to the Director of CMS, used Medicare expenditures from the Office of the Actuary to illustrate that spending on Part B drugs—a category dominated by cancer drugs—rose from \$3 billion in 1997 to \$11 billion in 2004, an increase of 267% (*NEJM*. 2009;360(6):626-633). He further estimated that episode-based payments, albeit in fields other than cancer, have saved Medicare and private payers \$18 billion over the last decade.

Given these facts, if Medicare and payers were to pursue episode-based payments in a subset of cancer care scenarios, the financial incentives for providers might be profound. However, the idea that Congress has the political willpower necessary to launch such a system in oncology—a field replete with its very own idiosyncratic complexities and ethical conundrums—is presumptuous, at best. If enough reputable institutions were to compile compelling evidence attesting to this payment model's efficacy in cancer care, legislators may be willing to execute some trial programs in oncology.

Three Players Enter the Playing Field

An increasing number of private healthcare insurers and nonprofit organizations are experimenting with episode-based payment models (also known as prospective payments, bundled payments, or case-rate payments) to help offset the high costs of physician services. The most notable example of a private insurer experimenting with this model in oncology—and at present, the sole example—is United Healthcare, which is currently conducting

pilot programs in colon, breast, and lung cancers at six of its group practices across the country.

Two additional institutions diligently working towards the wide-scale dissemination of such a payment model—with an eye towards oncology in the future—are Prometheus Payment Inc., a nonprofit corporation piloting episode-based payment programs in cardiology, diabetes and orthopedics; and Geisinger Health System, an integrated delivery system experimenting with episode-based payments in elective coronary artery bypass grafting (CABG).

United Healthcare: Piloting the Way

United Healthcare's pilot program focuses on three specific cancers (colon, breast, and lung), which are then divided into 20 different categories based on staging data and genetic markers. According to Newcomer, the categories developed for this pilot program were closely modeled after coding found in the Physician Voluntary Reporting Program, which was created by CMS in 2006 to help capture data about the quality of care provided to Medicare beneficiaries.



Lee Newcomer, MD
Senior Vice President,
United Healthcare

"We wanted to begin paying oncologists for the care they were giving their patients and get them away from their dependency on selling drugs to fund their clinics," said Newcomer.

Six groups will be participating in the pilot program and will design their own treatment algorithms. United Healthcare will then calculate a single-fixed payment for the clinical situation being treated, taking into account such things as drug pricing, hospital care, case-management fees, and follow-up care. The episode-based payment for an adjuvant case will cover the time period a patient receives adjuvant chemotherapy, whereas the payment for metastatic disease will be renewed every four months. The drugs will be paid at cost.

Newcomer explained that when a physician enters this program "they're going to be making the same amount of money that they would have made under the old fee-for-service program and they'll be able to raise patient-care fees based on their performance." As the pilot program progresses, the six groups will meet to compare perfor-

mance results, at which point, a potential best practice will emerge. If one of the groups is achieving better results at a lower cost, or fewer hospitalizations and complications, then the team as a whole will consider switching to that group's successful treatment algorithm. Newcomer is optimistic that any administrative difficulties will be quickly remedied and that the six groups will be able to report on their progress in a year's time.

Prometheus: Unbound from Fee for Service

Formed in 2006 by Robert Galvin MD, Director of Global Health Care at General Electric, Prometheus Payment Incorporated is a nonprofit corporation working towards the wide-scale dissemination of episode-based payments. Funded in part by the Commonwealth Fund and the Robert Wood Johnson Foundation, Prometheus is currently piloting programs in diabetes, cardiology, and orthopedics, with hopes of expanding into oncology.

At Prometheus, evidence-based case payment rates for a specific condition are developed on the basis of best clinical practice guidelines rather than current patterns of care, the latter of which may reflect high rates of misuse and variation. Called the Prometheus Payment® model, this form of episode-based payment includes risk adjustment and a warranty for care in the case of complications, as well as performance incentives for cost efficiency and quality of care.

Geisinger Integrated Delivery System

Whereas the episode-based payment systems being piloted by United Healthcare and Prometheus were initiated by a private payer and nonprofit, respectively, Geisinger's system was doctor-hospital initiated. Founded in 1915, Geisinger is a physician-led integrated healthcare delivery system located in Danville, Pennsylvania.

Their ProvenCare payment system, which was initially created for elective CABG, includes the costs associated with pre-operative care, all surgical services in-between, and 90 days of follow-up care. The episode

price is based on the cost of routine services plus an amount equal to half the average cost of complications.

"When we priced this model, we did a two-year look-back at the complication and readmission rates," explained Ron Paulus MD, MBA, Chief Technology and Innovation Officer at Geisinger. "We decided to bundle half that amount into the fixed price. So the buyer got a 50% discount on the historical complication/readmission rate, the hospital-slash-doctors had locked in 50% of this rate. If they could improve more than 50% on complications they made that extra money."

Recently, the Geisinger ProvenCare system has expanded into angioplasty, total hip replacement, cataract surgery, perinatal care, and bariatric surgery, which present considerably less complications than oncology.

The Missing Algorithm

Extending these types of systems into oncology will be accompanied by all the difficulties inherent in such a complicated field of medicine, especially while maintaining high quality of care for cancer patients. "It's not impossible, but it's much harder than cataract surgery or CABG," said Paulus. Like Newcomer and Gosfield, Paulus believes a strongly defined algorithm is necessary for bundled payments to make sense in oncology as "It's hard to bundle [for example] every permutation of breast cancer," he said.

Despite the logistical difficulties of extending the ProvenCare concept into oncology, rudimentary discussions are currently taking place that may pave the way forward for just such an expansion of services. According to Thanjavur S. Ravikumar, MD, the surgical co-chair of the oncology service line at Geisinger Health System and previously the chief of surgical oncology at Robert Woods Johnson University Hospital, "Cancer is not one disease you lump into one model. It may have different models with each model standing on its own, and consisting of two or three different buckets."

For highly lethal cancers such as esophageal, pancreatic, and liver, where treatment options are extremely variable and clinical efficacy difficult to gauge, Ravikumar advocates a value-driven approach to bundled payments that includes incentivizing medical oncologists for main- [cont. on pg 12 >>](#)

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taining the best quality of life for the patients. “If more and more surgeries, chemotherapy, or radiation is not found to be effective in the last six months of life, then quality of life should be put into the equation.”

It is highly unlikely; however, that providers and patients would willingly embrace such a revised equation. “Cancer shines a spotlight on the problem that we have in the US with end-of-life care,” said Meredith B. Rosenthal, PhD, an Assistant Professor of Health Economics and Policy at the Harvard School of Public Health, and a former consultant at Prometheus. “It’s a place that is very hard for policy makers to step into because it’s so highly charged.”

Consequently, medical oncologists and cancer patients may feel unfairly restrained in their treatment options. “The largest incentive for an oncologist will be the freedom to treat a patient in what he or she feels is the most appropriate manner,” said Blansett. “One stage IV patient might feel that anything other than palliative care is unnecessary since the odds of obtaining a long-term remission or cure is low; another [patient] may feel that it is necessary to try everything possible.”

And therein lays one of the many quandaries facing Congress when debating payment reform in oncology.

Will CMS Follow Suit?

Private payers are much more likely to adopt controversial policies if CMS has already implemented them, but ironically enough, it is the providers, payers, and nonprofits who must establish a workable episode-based payment model if Medicare is to push forward in oncology. If CMS is to begin experimenting more broadly with bundled payments, it will likely involve more manageable conditions such as diabetes, hip replacements, pregnancy, and asthma care, or acute surgical interventions.

Blansett doesn’t see episode-base payments ever truly taking off at CMS while Trish Goldsmith doesn’t see episode-based payments ever truly taking off in oncology. “Although there are some pilot projects out there now, I don’t think either the provider or payer is in a good place administratively to be able to implement, and functionally bill and collect on a global pricing model,” she said.

Goldsmith cited her experience contracting global episode-based payments for transplant care as further evidence of the difficulties awaiting oncology should it

embrace bundled payments. “For a number of years, episode-based payments have been done for both solid organ and stem cell transplantations. There’s still a great deal of frustration on the part of payers and providers about the actual mechanics of billing and collecting. Payers have a lot of experience with episode-based payments in transplantation. If it was easily exportable to other kinds of care, they would already have done that.”

Conclusion

If episode-based payments have the potential to drive down spending—then that may incentivize the conservation of resources and the choice of certain drugs based on price. In order to be a valuable innovation, perhaps episode-based payments wouldn’t have to be used for all patient types. For example, treatment protocols are fairly well developed and evidence-based for breast cancer. Cancers such as colon, metastatic lung, advanced prostate, chronic myeloid leukemia, and non-Hodgkin’s lymphoma might be amenable to an episode-based payment model, given the level of evidence to support such an approach in these cancers.

Should episode-based payments one day become de rigueur in oncology, manufacturers will most likely be subjected to comparative effectiveness by proxy. One of the ideas Bach expressed of episode-based payments is to shift the make-up of winners and losers, and he imagines that manufacturers who can garner market share by offering products that are as equally effective as their competitors, but at a lower price, will benefit.

Newcomer thinks episode-based payments will make pharma more accountable for their results. “It’s one thing to do a clinical trial where all of the patients can leap tall buildings and run a mile in five minutes, but they’re not the kind of patients that walk into a community oncology office,” he said. United Healthcare, he informed, is going to have real results to look at— meaning that they may find that a drug does well in a clinical trial but does not perform well in a real-world setting. And, if oncologists see that kind of data they may choose not to use that drug; on the other hand, the exact opposite may occur. Should United Healthcare’s pilot program prove beneficial to oncologists and patients alike, the insurance industry is likely to quickly adopt their methods...moreover, maybe even Medicare. **PW**

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Date	Company	Product	Event
July 11, 2009	Centocor Oncology Research, LP (Behring & Johnson)	Yervoy® (Ipilimumab HCl)	ODAC meeting to discuss 2) NDA for Yervoy's approved brand name, proposed indications in combination with Docil for treatment of relapsed ovarian cancer, and 3) sNDA for Docil, for intravenous infusion, proposed indication in combination with docetaxel for locally advanced or metastatic breast cancer, for patients who have received prior anthracycline treatment.
July '09	Beigene Sciences International, Inc.	Onviva™ (formerly known as NINA™)	BSI's shares jumped on June 13 after it announced that approval of Onviva, a treatment for "breakthrough" pain is open.

OBR RADAR

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