The Transformation of Healthcare in Private Practice Oncology

A Roundtable Discussion with

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With federal healthcare reform enacted and the cost of care escalating, community oncologists are challenged not only to remain up-to-date on clinical research but also to find new ways to cover their patients' expenses and their own operating costs. In this discussion, editor-in-chief Mark Krasna, a surgical oncologist, asks the experts what community practices can expect in 2010. Although this is a politically charged area, our panel focuses on the practical aspects of delivering the highest quality of care.

Mark Krasna (MK): Besides those changes legislated at the national level through the Patient Protection and Affordable Care Act, are there trends of healthcare reform already taking hold in the private sector?

Michael Blau (MB): There are some common aspects between the legislative level and the private-payer sector. The concepts of value purchasing, cost containment, a new value proposition dealing with medically unnecessary services, bundled pricing and episodes of care, and/or shared cost-savings with providers are all trends that are occurring in the private sector regardless of whether they are legislated or mandated as part of healthcare reform. Currently, there are demonstration projects, and pilot projects in these areas by private payers.

Ronald Barkley (RB): For providers, the questions are: Where do they fit in a consolidating industry, and what do they need to do to be prepared? The wheels are already in motion, and as Michael said, private sector healthcare plans have already commenced the dialogue with providers to explore methods of payment that are different from the manner in which providers are reimbursed today. I believe we have enough data to manage and predict true costs. Even with a condition with great variability like cancer, we have enough of a database to be able to understand our costs and to be in the position to experiment with more longitudinal care pricing with bundles of care. This pricing would make it easier to manage and probably reduce costs from a standpoint of the redundancy of personnel and systems we need to have in place to handle claims for the multitude of drugs, treatments, and imaging procedures. For providers, being able to know in advance that they will receive—for example, $50,000 for a defined cancer site and stage—would be a good place to start.

Currently, I’m only aware of one major payer, UnitedHealthcare, that is offering a bundle-of-care approach, meaning, as I understand the program, it is paying a budgeted rate for a particular episode of care based on diagnosis, staging, and anticipated cost. Costs are based on historic information by group, so effectively UnitedHealthcare pays the amount of money it thinks a provider would receive for treating this episode of care in a standard way pursuant to the expected protocol using the anticipated drugs. The company, however, pays the money upfront and expects the provider to stay within this budget. This is the spend that you’re going to get to treat this episode of care. Unless something changes, unless there is a different diagnosis, that’s all the money you will get.

I suppose what I am saying is “no good deed goes unpunished.” Let’s use as an example a group that is optimally efficient, one that has already instituted protocols and has guarded against redundant or unnecessary services. It provides the most efficient care for oncology and its clinicians always do the right thing. So for a set episode-of-care payment, any variability in cost, for example, if the drug prices go up (new drugs come on the market, existing drugs get reprinted), if labor costs go up, if overhead costs go up, during any of the care period, the practice is responsible for those costs. Assuming that the payer gave the practice the correct amount to begin with, the only way the group can make up the differential is by reducing the costs, that is, by rationalizing the amount of care or the amount of drug or the amount of input into the treatment.

Jessica Turgon (JT): Oncology as a service line within a community is one of the cardiac care models. If we look at the changes in the cardiac service line and draw parallels to oncology, the changes cardiologists have been facing regarding bundled reimbursement for their ancillary services have led to an increasing trend in the marketplace for cardiologists to be employed by hospitals or to work with hospitals in a more integrated fashion than ever before. No one was employing cardiologists 3 or 4 years ago. Now, everyone is employing cardiologists. So it’s interesting to draw a parallel to cancer and think through what a bundled case rate would do to an oncology service line if it’s targeted toward outpatient services. How much of the testing payments would be included in that type of bundled rate? How will community oncologists be affected?

Time will tell whether that trend continues, what types of ancillary care of their patients in our community should be the same standard of care whether these patients go to the practice setting or the hospital setting.

MK: When you look at the overall landscape of healthcare and you look at the greatest challenge being stressed at the national level, that of the uninsured—whether that number is 10 million or 40 million—how do you foresee that the new state-based American Health Benefit Exchanges will affect the delivery of care?

MB: Let me go back and reframe this question a little differently. In healthcare reform today, we have expanded coverage to many of the uninsured. That said, the question becomes: How are they going to access care? The answer, I think, may be in ways that make the problem of the underinsured more acute for the following reasons.

Think about how the uninsured are going to access insurance under the healthcare reform system. The plan (effective January 1, 2014) creates a health benefit exchange where low-income, uninsured patients (133% to 400% of the poverty level) can purchase an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law health savings account limits ($5950/individual and $11,900/family in 2010), and is not more extensive than the typical employer plan.

These will be relatively low-cost policies, because the insurance companies will design them as low-cost policies and because they will be competing for the business of this pool of patients. This will be through a bid process sponsored by the exchange. This will drive

We will probably see value-based purchasing, capped rates, episodes of care, and stricter medical necessity guidelines and clinical protocols for oncology.

—Michael L. Blau, JD
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—Ronald Barkley, MS, JD

Unless anyone has any comments regarding those two general questions, we will move on to what’s happening in the private sector and how those providers and payers are dealing with these issues.

RB: Just a couple of comments on cost, and then I’ll talk about episodes of care. Mike discussed the idea that for the uninsured insurance cooperatives, insurance pools will need to deal with premium reductions and affordable premiums and arrive at reduced cost. In these discussions, it is useful to clarify what we mean by “cost.” From an insurance perspective, the definition of cost is what the insurance company has to pay; it does not mean the true cost. Translated, that means whatever the mechanics of addressing the population under insurance, it comes back to the reality that there is only so far you can reduce true costs regardless of the insurance viewpoint of cost.

Now I’ll comment on the underinsured, which will lead us to the discussion on episodic payment. A good example of a situation providers deal with on a daily basis is that of a cancer patient with Medicare who does not have a supplemental policy to Medicare. In medical oncology alone, a regimen may run $80,000 to $100,000, and for a patient with 80% coverage from Medicare, the 20% out-of-pocket is not covered by a Medicare supplemental policy simply may not be affordable. That would be maybe $20,000 to $40,000 out-of-pocket because they didn’t have a Medicare supplemental policy. That creates a real dilemma for physicians working in private practice regarding what to do with these patients. I am seeing an unfortunate trend. Some practices are making it a policy that they cannot afford to treat Medicare patients who do not have a Medicare supplement and sending these patients for treatment elsewhere.

MK: How are guidelines and quality measures going to affect the cost of care? Other than episodes of care, by instituting guidelines or quality measures, are we going to be able to cut cost of care and will it have a significant impact?

RB: Guideline-based pathways are an opportunity to reduce variability in treatment and variability in costs for care. They are better positioned to have budget predictability, so that you can start to understand what is possible under a different payment model, bundled rates or otherwise.

After providers agree to certain pathways and eliminate or have an internal review process for outliers from the pathways, they have the opportunity to understand where the costs are really coming from and start to talk about efficacy of different drugs and procedures. Guideline-based pathways, in my experience, don’t automatically reduce costs. They open the dialogue for reducing variability and starting to understand the costs of taking different actions.

MB: I think that is correct, but we have to look at it with at least two different lenses. Looking through the lens of providers, clinical protocols generally are being adopted for quality-consistency purposes, not for cost-containment purposes, and, to the extent that they do result in efficiencies, providers are looking at pathways as a way to get bonus payments. They are saying, “We are doing the right thing, we are adopting a clinical protocol, we are getting rid of the variability, we have a better mousetrap and payers should reward us for that by giving us another 5% or whatever for adopting the protocol, following it, documenting it, and showing that we are improving quality.”

It’s not clear in that equation whether there is cost savings for the system. It’s just another way of getting paid.

From the payers’ perspective, it’s a very different ball game. Payers are saying that to the extent the industry can forge either a national consensus or a consensus among the payer’s oncology advisory board about what is the cost-effective approach to care, it should be imposed on oncology providers to wring out cost savings. For example, in a specific case, the payer’s stance may be that once there is determination and documentation of cancer staging, intention of care, and diagnosis of a site-specific cancer, only a prespecified (less expensive) drug regimen or radiation therapy regimen will be covered and paid.

We are now beginning to see carve-out companies starting to manage the oncology spend and cost on behalf of payers. And those companies are developing relatively sophisticated clinical...
The focus of IT reform is meaningful use and e-prescribing. A lot of effort and dollars have been exerted in implementing this small piece of stimulus. It will be interesting to see if that improves efficiencies in the long term.

—Jessica Turgon