Incentive-Based Oncology: Unintended Consequences?

Recently, WellPoint, the largest private payer for health care, announced a new program. The company has outlined designated treatment pathways for cancer and indicated that it will pay physicians an incentive payment of $350 per month per patient treated on a designated pathway. At first, I didn’t think too much about this. After all, physicians already receive extra payments for quality metrics. But the more I thought about it, the more concerned I became. The monthly amount per patient doesn’t seem like a lot, but multiply it by the number of patients receiving active treatment under the care of a busy oncologist, and it gets into real money. This could easily become an important business strategy for a busy office-based practice.

WellPoint’s argument for doing this is simple. They want to rein in the cost of cancer care, which is largely driven by expensive drugs, especially newer oncology drugs, that can cost up to $15,000 per month. Some drugs are even more expensive. Ipilimumab, approved for the treatment of malignant melanoma, costs approximately $230,000 for 4 treatments. By some estimates, costs for new cancer therapies are increasing at the rate of 25% a year. There is no doubt that we can’t continue to sustain this rate and that something must be done. But is WellPoint’s approach the right one?

It’s ironic that just as science is beginning to drive us closer to precision medicine and personalized care, programs are emerging that urge us, even pay us, to stick to a cookie-cutter approach. Arguably, because of evidence-based medicine, that’s probably the right choice for most patients. But exceptions and outliers always exist. Every day we see patients with certain comorbidities or disease features for whom deviation from a treatment guideline makes sense. Will oncologists be reluctant to make these decisions because of an adverse effect on payments? That remains to be seen.

WellPoint’s medical director for oncology, Jennifer Malin, MD, PhD, was quoted in the AIS Report as saying that this approach will also minimize variation in the quality of care. WellPoint estimates that up to one-third of patients treated with chemotherapy do not receive treatment consistent with current medical evidence and best practices. I don’t dispute the data and, if true, believe it’s a sad statement about the delivery of cancer care.

Despite this, mortality rates in some of the most common malignancies, especially breast cancer, continue to decline, partly because of improved treatment. So we must be doing something right, although if WellPoint is correct, we could be doing it even better. Paying doctors to get it right seems wrong, though. Quality improvement programs and self-assessment report cards within practices might accomplish the same thing.

I also agree that oncologists need to be conscious of cost and—as best one can assess it—value. Putting economic models for treatments in place that take into account all the ancillary and downstream costs (eg, management of toxicity), seems like a pretty important thing to do. But we don’t hear much about that.

Every action can have unintended consequences. One of the things I am most worried about with this incentive model is the impact on clinical trials. Clinical trials don’t appear to be part of the pathway program. The percentage of patients on clinical trials is already extremely small. Will this program and others like it erode that further? I would argue that improved survival rates in cancer have resulted directly from clinical trials. After all, that’s how we make new drugs available to patients. Will oncologists be reluctant to make these decisions because of an adverse effect on payments? That remains to be seen.

WellPoint’s experiment will be important to watch. They will be rolling it out in 6 states and limiting the program to breast, lung, and colorectal cancers. I hope WellPoint will be transparent—sharing data about conformance with pathways, cost savings, and, most importantly, patient outcomes. Further, I sincerely hope this doesn’t result in a decrease in clinical trial accrual. That’s something we really can’t afford!

Reference