All Bundled Up!

This is going to be interesting, but we knew it was coming. Ever since the passage of the Affordable Care Act, health economists were predicting it. Large health maintenance organizations are looking forward to it. Community oncologists are worried about it.

What am I talking about? Bundled payments for cancer care! For the first time, UnitedHealthcare will be implementing a bundled payment system for comprehensive cancer care delivered to patients at MD Anderson Cancer Center with newly diagnosed head and neck cancer.¹ It's a pilot project with some customization, and approximately 150 patients will be enrolled.

Bundled payments aren't exactly new. In the oncology world, we've had bundled payments for bone marrow transplants for years. Contracts are based on a case rate, with some allowance for outliers, and each hospital negotiates its own contract with the payer. This form of bundled payment is more straightforward because it involves an episode of care and a fairly uniform set of providers at each hospital-based organization.

Payments for oncology care in solid tumors get a lot more tricky. Unless the patient is receiving care in a health maintenance organization, he or she probably sees multiple providers over time in different organizations. For many patients covered by Medicare or other private payers, the medical and radiation oncologists may be community-based, surgery is performed in the hospital, and ancillary care can theoretically be provided anywhere. How does a bundled payment work then?

I can think of a lot of good things related to bundled payments. For one thing, administrative costs would be streamlined. Since you would receive one payment for a given diagnosis, there would be no need for authorizations or individualized billing. This would cut costs for both the insurer and the provider, and would have a positive impact on improving the process of delivering patient care. However, an organization would most certainly want to keep track of charges (and cost, which I know is not the same thing) as a foundation for future contracts. Bundled payments would also encourage better coordination among providers in different specialties, so I think interdisciplinary care would be reinforced. Finally, especially in rare and aggressive tumors, bundled payments may encourage patients to seek care in selected Centers of Excellence.

But I can also think of a few threats. Unless bundled payments can be operationalized across multiple sites of care, medical and radiation oncologists in community-based practices will have difficulty participating. The tendency for these physicians to migrate to hospital-based positions will increase. Hopefully, if this happens, patients will still have ready access to providers and will experience the same level of concierge-based care that our current system affords.

Another issue to be grappled with is how to build in the right amount of flexibility to account for the use of newly approved drugs that often come with a hefty price tag. A good example would be for patients with malignant melanoma. Care for these patients has been changing quickly and dramatically because of newly available agents. How does a bundled payment system allow for rapid adoption of life-prolonging drugs and technical advances?

I'm sure someone out there has answers to my questions. If you are reading this, please weigh in. And in the meantime, I think we should all play close attention to this new initiative with UnitedHealthcare and MD Anderson Cancer Center. I think we'll learn a lot.

Reference

1. Mathews AW. UnitedHealthcare tests a flat rate for cancer treatment. The Wall Street Journal. Available at <http://www.wsj.com/articles/unitedhealthcare-tests-a-flat-rate-for-cancer-treatment-1418619661>. Accessed on January 21, 2015.

Margaret Tempero, MD

Dr. Tempero is a Professor of Medicine and Director of the UCSF Pancreas Center, and the editor-in-chief of *JNCCN*. Her research career has focused on pancreatic ductal adenocarcinoma especially in the area of investigational therapeutics.

Dr. Tempero has served on the ASCO Board of Directors and as ASCO President. She co-directed the AACR/ASCO Methods in Clinical Cancer Research and taught this course and similar courses in Europe and Australia. She was founding Chair of the NCI Clinical Oncology Study Section (CONC) and served as a member and chair of the NCI Board of Scientific Counselors Subcommittee A. She is on the External Advisory Boards of the Pancreas SPOREs at Mayo Clinic and at UAB/Minnesota and the GI SPORE at the University of Arizona. She is, or has been, on the Scientific Advisory Boards of the Lustgarten Foundation, the Pancreatic Cancer Action Network, the V Foundation, The Alberta Canada Cancer Board, and the EORTC. She served as a member of the Oncology Drug Advisory Committee for the FDA. She has served as Deputy Director and Interim Director for the UNMC Eppley Cancer Center. She is Chief Emeritus of the Division of Medical Oncology at UCSF and served as Deputy Director and Director of Research Programs at the UCSF Helen Diller Family Comprehensive Cancer Center.

The ideas and viewpoints expressed in this editorial are those of the author and do not necessarily represent any policy, position, or program of NCCN.