Reducing Costs by Changing Behavior—Really?

I am fascinated by a study led by Lee Newcomer, MD, MHA, at UnitedHealthcare.¹ It was published last year, but I confess I didn't read it until I bumped into Dr. Newcomer at the NCCN 20th Annual Conference this past March and he told me the punch line. So I dove into the Internet and retrieved it so I could learn more.

Basically, it was a pretty bold experiment to see if bundled payments for episodes of treatment could reduce costs. Quality metrics were built in, but I'm not sure how much that factored into the results. The reasoning here was that if physicians got paid regardless of the treatment they selected, there would no longer be a financial incentive to treat, as exists now in community-based practices.

I liked the collaborative nature of this project. Five groups volunteered to be part of the experiment, and the physicians—together with UnitedHealthcare—developed more than 60 measures of quality and cost for the episodes of care that were chosen for the study. The physician groups met several times during the study to compare notes, and they discovered interesting differences in practice patterns. One example presented in the paper was of a group with a high hospital readmission rate. They realized that they were waiting too long to see patients after hospital discharge, so they changed their practice to see patients within 48 hours of discharge to fix this problem. That sounds like true quality improvement to me.

But the real kicker here was the resulting changes in cost of care and where those changes occurred. The overall 34% decrease in cost, as measured by standard billing charges tracked throughout the study period, may not have been surprising. But was this a result of lowered drug costs, as assumed at the start? No! Drug costs went up almost three-fold, whereas fee-for-service costs went down by about one-third. Go figure!

Let's back up. According to UnitedHealthcare data, drug costs and physician services each account for approximately 25% of the cost of care, and facility fees make up the balance. So if the real savings here was in fee-for-service charges, did that mean patients were seen less often than before the study? Did getting payment upfront dis-incentivize the physicians to keep a close watch on patients as they went through treatment? Or, because they were already paid, maybe they didn't feel as much need to submit a charge, or at least to submit the usual level 5 charge. Because patient satisfaction wasn't tracked and because they did not have adequate data to assess quality outcomes, we can only guess about this.

And why did drug costs soar? Did they model the projected costs adequately? Did new blockbuster drugs change the landscape during the study? The discussion in the publication doesn't begin to address the paradoxical rise in drug cost but merely reaffirms that the entire program had incentives built in to lower drug expenses.

So what did I like about this? I liked the fact that this was a collaborative program with much involvement on both sides. It was transparent, and data were freely shared. Quality metrics were incorporated, and even if that didn't yield much, it was a start. And physicians weren't tied to pathways or subject to unusual scrutiny for the choices they made. Further, I liked the fact that UnitedHealthcare was willing to publish their findings and let the rest of us learn something too.

Bundled payments for episodes of care will probably increase, and we need to be sure that we don't sacrifice quality as we adopt this form of payment. Even though I don't quite understand the results of this study and worry about the drop in fee-for-service charges, I commend UnitedHealthcare for attempting this and hope that what they learned can be leveraged in future larger initiatives that can reduce cost of care without compromising quality or patient satisfaction.

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Reference

1. Newcomer LN, Gould B, Page RD, et al. Changing physician incentives for affordable, quality cancer care: results of an episode payment model. *J Oncol Pract* 2014;10:322–326.