Does Value Mean Quality? The Payer's Perspective

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Status Quo Is Unsustainable

Without major changes to the US health care system, the average cost of the health insurance premium and out-of-pocket costs for a family will equal the median household income in 2018.¹ The cost of cancer care is approximately 6% of overall US health care costs and is projected to be \$173 billion in 2020, a 39% increase from 2010, assuming costs increase at 2% per year.^{2,3} However, with the current trend for cancer drugs at 27%, cancer care likely will consume a greater share of health-care resources in the future.

True Innovation Versus Pseudoinnovation

Increased spending on health care has contributed to advances in the diagnosis and treatment of cancer that have resulted in significant improvements in health outcomes.⁴ Survival rates for childhood cancer now approach 80%. Chronic myelogenous leukemia has in fact become a chronic disease. Cervical cancer can be prevented with a vaccine. However, many new drugs or technologies, although more costly, do not provide meaningful improvements in survival or quality of life, leading them to be dubbed “pseudoinnovations.”⁵

Are We Getting Good Value in Oncology?

Ultimately, the goal of all health care is to improve patient health outcomes. In this context, value is defined as the patient health outcomes achieved per dollar spent.⁶ This seemingly simple definition integrates quality, safety, patient centeredness, and cost containment.⁴ As the costs of new therapies increase in oncology, there has been considerable debate about whether improvements in median survival of 1 to 2 months at a cost of \$50,000 to \$100,000 are a good value.^{7,8} Although the high cost of new cancer therapies draws headlines, improving the quality, safety, and patient centeredness of care will arguably have a greater impact on value.

Unnecessary Care Is Not Good Quality Care

Although most quality assessment has focused on underuse of recommended care, a growing body of evidence suggests that many patients receive health care services that they do not need. For example, Hillner et al⁹ found that nearly half of patients with cancer who received a positron emission tomography-computed tomography (PET-CT) received a body CT scan in 30 days prior and 23% had a CT scan in the 30 days after. Although there may be clinical circumstances in which an additional imaging study is needed to clarify a finding that was not

definitive on the first study, it is unlikely for this to be the case in almost three quarters of patients undergoing a PET-CT. Treatment of prostate cancer is another example where questions of overuse have been raised. Jacobs et al reported that the overall rate of radiation treatment increased 10% after the introduction of intensity-modulated radiation therapy (IMRT), and a greater proportion of men who received IMRT had low-risk tumors and would be less likely to benefit from any treatment.³ Although the magnitude of overuse is not known, these data suggest that some men with prostate cancer are receiving unnecessary treatment. Unnecessary care not only increases the costs to the patient and their payer (usually their employer or Medicare),¹⁰ it also places patients at risk of adverse events. In addition, unnecessary care exacts an often overlooked cost in terms of patient and caregiver time.^{11,12} Given the burden associated with unnecessary care, which by definition offers no tangible health benefit, it fails to meet the expectation that care be patient centered and cannot be considered good quality care.

Patient-centered care improves quality and value. A cornerstone of patient-centered care is shared decision making.¹³ The Institute of Medicine recommends providing patients and their families with a written treatment plan with explicitly stated goals of care in order to facilitate shared decision making.⁸ Decision aids that provide a specific and personalized focus on options and outcomes for patients contemplating a treatment decision are another approach that can increase patients' involvement and improve their knowledge and realistic perception of outcomes.¹⁴ Decision aids have the potential to reduce costs as patients who participate in shared decision making often choose more conservative treatment than do patients who do not use decision aids.^{15,16}

Quality of life is another outcome that is extremely important to patients and often undervalued by the health care system. Symptoms related to both the disease and treatment are highly prevalent among patients with cancer.¹⁷⁻²⁰ Hospitalizations for symptoms and chemotherapy-related toxicity are common,²¹⁻²³ and the limited data on the quality of symptom management suggest that there are opportunities to improve supportive care.^{24,25} Interventions to improve symptom management ranging from routine screening for symptoms to telephonic support from nurses show promise for improving patients' symptom control and quality of life²⁶⁻²⁸ and potentially decreasing emergency room visits and hospitalizations.²⁹

Re-engineering for value-based, patient-centered cancer care. Although oncology practices have always focused on delivering high quality cancer care, improving quality through value-

based patient centered care will likely require some re-engineering of current delivery models. One approach that is being pilot tested by several practices is the oncology medical home, modeled after the patient-centered medical homes being used in primary care.^{30,31} Although the pilot oncology medical homes vary in many aspects of their implementation, three characteristics are common to all. First, these practices have adopted, and track their adherence to, treatment pathways. Treatment pathways generally identify a subset of regimens recommended in guidelines with the goal of further reducing unwarranted variation in care and cost.^{32,33} As with a guideline, it is expected that some patients will not be candidates for one of the pathway regimens, and so adherence to the pathway is not expected to be 100%. Second, oncology medical homes implement processes to improve coordination of care and symptom management. Either through proactive outreach or through a “hotline,” oncology nurses provide telephonic management of patients undergoing active treatment, bringing patients into the office for urgent visits when they have unrelenting toxicity or symptoms. Preliminary data suggest that this telephone support by oncology nurses decreases the need for emergency room visits and hospitalizations,³⁴ but more important, it promises to improve patients’ quality of life and their experience of care.³⁵⁻³⁷ Third, in an oncology medical home, palliative care is integrated alongside cancer-directed therapy for patients with advanced disease. By using tools like the Palliative Care Needs Assessment Tool, practices can systematically assess patients’ palliative care needs, addressing those such as symptom management within the practice, and referring patients to specialty consultation or to hospice when they require more intensive palliative care.³⁸ Although the oncology medical home model will continue to evolve over time, it provides a useful framework for re-envisioning cancer care delivery.

Re-engineering oncology care will require that approaches to reimbursement evolve, moving from payment primarily for delivery of chemotherapy to models that reward innovation in oncology practices.³⁹ Initial efforts at WellPoint have included increases in chemotherapy administration fees and a higher

margin paid to practices on lower cost generic drugs. As we look to further support efforts to improve the quality and value of cancer care going forward, we are developing new approaches to reimburse practices for treatment planning and care coordination for an episode of care, as well as reward adoption of treatment pathways and high-quality care.

Does value mean quality? If we are to sustain true innovation and continue to improve on the gains of the last half century in improving patient outcomes, quality cancer care needs to be high value care. It is up to the clinicians at the bedside who are actually providing cancer care to determine how best to achieve the desired outcomes for individual patients. Health plans can support these efforts by aligning reimbursement to support clinicians who provide value-based, patient-centered care.

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