

Tulane-led study evaluates Medicare payment model for cancer treatment

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The cost of cancer care is rapidly increasing. The National Institutes of Health estimates the yearly cost of treating the disease is more than \$158 billion. A new study led by a Tulane University researcher recently analyzed a payment and delivery model for Medicare patients undergoing cancer treatment to see if the pilot program changed care management decisions and reduced costs in some cancers. The [results](#) are published in *JAMA Network Open*.

“Cancer is a multibillion-dollar line item for Medicare,” says study author Brigham Walker, a research assistant professor in the Department of Health and Policy Management at Tulane School of Public Health and Tropical Medicine. “I think that it’s essential to have the ability to tell whether these initiatives are working to make sure that public expenditures are well-allocated and well-spent.”

Walker and his team looked at how the Oncology Care Model (OCM) impacted cancer costs. The OCM sought to drive care coordination, navigation, and treatment guidelines adherence for chemotherapy-based care. To achieve this, the model introduced two new forms of payment incentives: a \$160 per beneficiary Monthly Enhanced Oncology Services payment for each six-month episode of cancer treatment beginning with chemotherapy, and a Performance-Based Payment (PBP) predicated on cost efficiency. The PBP is based on an expected target cost to treat a cancer patient. For example, a treatment episode that was projected to cost \$30,000 but where the actual price tag came out to \$25,000 would result in a performance-based payment of up to the \$5,000 in savings achieved.

Walker evaluated two years of physician office-based data from 2015-2017, one year both before and after the launch of the OCM, to compare the differences between participating and nonparticipating practices.

The study found the first year of the program resulted in lower physician-administered drug use in prostate cancer, lower drug costs in lung and prostate cancer, fewer visits for patients with breast or colon cancer and lower office-based costs in all cancers analyzed. However, these potential savings were offset by the administrative costs of implanting the new model.

It is important to review the care choices and associated costs of these pilot programs, Walker said. “Without these kinds of programs, we’ll just remain at the status quo,” he said. “Without evaluation research like this, though, we won’t know what kind of progress has been made towards reducing costs and improving quality.”

Walker is continuing his research on this model, including how the OCM may have spillover effects into the non-Medicare population that does not have the same incentive structures in place, and how the OCM may have affected care in the longer-term (where prior research suggests that the savings effects may increase). This research overall can inform health insurer policy design and the choices that caregivers make when deciding which models in which to participate.