

Rising Costs of Cancer Care

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“Unsustainable Cancer Costs” read a Bloomberg News headline last month. The news story quoted an expert panel assembled by The Lancet Oncology medical journal, saying, "Cancer treatment costs are rising at such a rapid rate that they threaten to become 'unsustainable' even for rich countries."¹ Cancer care costs, estimated in 2009 to be \$286B worldwide (1/2 of which are pegged to cancer treatment, with another 50% calculated as “lost production”) could not be sustained at that level. The Bloomberg story attributes the rise to the world population aging (leading to more cancer cases, as the century unfolds), higher costs for drugs and new technologies, and to “overuse of tests and expensive diagnostics.”²

Long a source of concern, cancer care costs are related to the cost per case and to the multiplier effect caused by the increasing number of cancer patients predicted as the US and world populations age. Dubbed the “Silver Tsunami” by some social scientists and economists, the facts show a marked increase in the number (and percentage) of US individuals 65 and older.

- The number of people 65 and older in the US will double between 2010 and 2050;³
- US population is expected to grow by 19% between 2010 and 2030;
- However, cancer patient volume is expected to increase 45%, or more.⁴

Cancer care costs span the scope of inpatient and outpatient services, and are not limited, as some believe, to the costs associated with directly treating patients with chemotherapy, radiation oncology, and surgery. For example, a recent JAMA study reported that diagnostic imaging accounts for over 10% of **ALL** cancer care costs. Furthermore, diagnostic imaging costs for cancer patients grew between 1%-5% per year between 1999 and 2006. Moreover, diagnostic imaging costs, as a portion of a cancer patient’s overall cost of treatment, increased from 5.1% in 1999 to 10.3% by 2006.⁵

¹ Bloomberg news (accessioned online Sept 27, 2011 at 2:44 pm). Cancer Cost Swells, Risks Becoming ‘Unsustainable,’ Lancet Says By Kristen Hallam - Sep 26, 2011 5:58 AM CT <http://www.bloomberg.com/news/2011-09-26/cancer-cost-swells-risks-becoming-unsustainable-lancet-says.html>

² Bloomberg news (accessioned online Sept 27, 2011 at 2:44 pm). Cancer Cost Swells, Risks Becoming ‘Unsustainable,’ Lancet Says By Kristen Hallam - Sep 26, 2011 5:58 AM CT <http://www.bloomberg.com/news/2011-09-26/cancer-cost-swells-risks-becoming-unsustainable-lancet-says.html>

³ UAB New Archive (accessioned online Oct. 13, 2011 at 5:18). Beware the silver tsunami” – the boomers turn 65 in 2011. <http://main.uab.edu/Sites/MediaRelations/articles/82818>

⁴ Smith BD, Smith GL, Hurria A, Hortobagyi G, Buchholz TA. Future of Cancer Incidence in the United States: Burdens Upon an Aging, Changing Nation. Journal of Clinical Oncology 2009; Vol 27 No 17: 2758-2765

⁵ Dinan MA, Curtis LH, Hammil BC, Patz, EF, Abernethy AP, Shea AM, Schulman KA. Changes in the use of Diagnostic Imaging Among Medicare Beneficiaries with Cancer, 1999-2006. JAMA 2010; Vol 303 Number 16 1625-1631

Clinical and technological advances on the horizon add hope for cancer patients while concomitantly adding associated cost to the system. Clinicians expect their near-term future treatment arsenals to include personalized treatments specific to a certain patient, rather than a certain type of cancer; more targeted therapies; less invasive (but not necessarily less expensive) procedures; increased screening; and patients requesting more support services (such as patient navigators and complementary medicine therapies). Add to this, the realities of health care payment reform, and the mix could become volatile – with institutions, and cancer programs, dealing with reduced payments per patient and increased patient numbers. It could be the old saw, “making up the loss through volume”.

Experts and healthcare observers note other factors leading to the current increase in cancer care costs include reimbursement models that affect doctors’ incentives for using certain treatments or diagnostic procedures. While experts exhort “patients, insurers, policymakers, drug companies and the health industry . . . to work together to lower costs without compromising care,”⁶ expect the real work to control costs to land on cancer center leaders, oncologists (across all modalities), and staff.

Specifically, expect cancer care reimbursement to occupy a prominent position on payors’ radar screens. Most importantly, CMS (as the major payor for cancer care) will no doubt, redouble their scrutiny of costs. Payment recovery auditors are becoming more aggressive in pursuing intended or non-intended overpayments for all services, but could potentially focus on cancer care services. The Recovery Audit Programs (such as CMS or OIG) post their findings on their websites. For example, in 2010 in one region, over \$1 million dollars was recovered related to IV chemotherapy infusion.⁷

As a cancer program administrator, leader or clinician, the upcoming patient influx, coupled with granular level interest in cancer services costs requires each institution take steps to ensure their programs rest on solid financial foundations. While quality cancer care is the ultimate goal, without appropriate revenue, quality could be at risk. It is inherent on the cancer program leaders (both administrative and physician) to determine where cost is occurring and if there are ways to safely reduce cost or ensure appropriate revenue.

Steps to take could include:

1. Accurately calculating the costs of cancer care (by tumor site and stage, by physician(s), by modality and diagnostics). Most programs can “estimate” their costs of care, but few have rigorously calculated their institution’s exact costs.
2. Benchmark your institution’s costs to national averages.

⁶ Bloomberg news (accessioned online Sept 27, 2011 at 2:44 pm). Cancer Cost Swells, Risks Becoming ‘Unsustainable,’ Lancet Says By Kristen Hallam - Sep 26, 2011 5:58 AM CT <http://www.bloomberg.com/news/2011-09-26/cancer-cost-swells-risks-becoming-unsustainable-lancet-says.html>

⁷ <https://www.cms.gov/Recovery-Audit-Program/Downloads/FY2010ReportCongress.pdf>

3. Work with affiliated physicians to define “best care” – is it guidelines’ based; is there wide latitude for individual physician choice (of drug, of surgical procedure, of f/u care, etc.); is it based on comparative effectiveness research? Drill down what this institution’s physicians define as measurable clinical quality. For these decisions may guide cost/benefit ratio discussions that could affect reimbursement incentives your physicians may respond to.
4. Determine which functional departments delivering care to your cancer patients add the most costs to the total cancer patient final bill. And monitor this particular department’s costs to determine if they are rising or remaining stable.
5. Operate with exquisite revenue cycle monitoring. Now is not the time to “leave money on the table”, or to neglect to re-bill for denied charges. Conduct audits to ensure the physicians, their staffs, and the institutional departments are billing and receiving revenue for *all provided* services. And remain hyper vigilant that coders and billers comply with all relevant billing regulations.
6. Consider partnering with community agencies, practitioners, and groups to broaden the cancer program’s supportive care services, without taking on development and operations costs. Off load those to the partner, and enable the partner to charge for them, as the community economy will bear.