Health Care Reform and Its Implications for the Academic Cancer Center

As I assume has been the case for other readers, I have watched the development of the Patient Protection and Affordable Care Act (PPACA) with genuine hope that it might mend the gaping holes in our health care safety net by insuring the uninsured, providing access and insurance coverage for patients seeking enrollment on clinical trials, expanding coverage for cancer prevention services, addressing the problem of escalating health care expenses, maintaining funding for cancer research, and beginning to address the looming health care workforce shortages. My initial optimism is now tempered with caution and concern that not all of these goals will be addressed and that implementation of PPACA will bring a mixture of beneficial and deleterious consequences for academic cancer centers (ACCs).

As I write this, several alternatives concerning the fate of the PPACA seem possible. At minimum, it is likely to undergo significant modification by Congress or the Supreme Court. Depending on the outcome of the 2012 election, new legislation could overturn the PPACA or replace it with an alternative plan.

Since nearly every section of the PPACA legislation could have some impact on ACCs, a comprehensive analysis of the possible changes is beyond the scope of this commentary. Rather than just list the more significant elements of the PPACA that could affect ACCs, I will offer thoughts on how some of the components of the bill might interact to strengthen or undermine our mission.

Will Expanding Demand and Shrinking Reimbursement Undermine the Mission?

If implemented as written, PPACA will add 32 million people to the ranks of the insured and will provide full payment for preventive care and wellness services. These changes should encourage increased reliance on primary care providers to access the health care system and wider use of recommended cancer screening services, and are likely to increase demand for early-stage cancer treatment services. Although the PPACA adds to the number of primary care residency training positions and enhances primary care reimbursement, it does not provide a solution for the current and projected shortage of oncology specialists. Adding the service needs of an additional 32 million insured patients to an already stressed system will certainly exacerbate an already serious workforce shortage.

At a time when Medicare is approaching insolvency and state Medicaid rolls and budgets are already overtaxed, the PPACA will be funded through reduced Medicare expenditures and will expand Medicaid enrollment to provide insurance for low-income populations. With reimbursement from these public insurance programs already low, hospital and physician reimbursements for cancer services are likely to be further reduced under the PPACA. With or without a universal mandate, commercial insurance companies will need to offer coverage plans that are more broadly affordable, and providers will experience increasing pressure to control costs. As safety-net providers of last resort, academic medical centers and ACCs could be overloaded with patients whose insurance plans provide limited reimbursement. They may not have sufficient offsetting income from patients with more favorable insurance coverage to both subsidize care costs for the marginally insured and support their academic mission.

If unaddressed, these forces have the potential to merge into a “perfect storm,” wherein ACCs are inundated with patients needing care, reimbursements for necessary oncology services are reduced, marginal income needed to support academic

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.
enterprises is jeopardized, and ACCs will not be able to train and retain enough oncology specialists to meet the incoming demand.

**Will ACCs Be Able to Adapt to Value-Based Reimbursement Models?**

Although some can argue that the PPACA does not sufficiently alter the basic incentives and forces that are causing the continuing escalation of medical costs, it does incorporate provisions aimed at enhancing quality and reducing cost. These provisions are based on the proposition that the value of services purchased through publicly funded insurance programs can be increased. As mandated by the PPACA, the Center for Medicare and Medicaid Innovation (CMMI) has been established to guide such initiatives.

CMMI is establishing a number of value-based purchasing models that may be particularly important for ACCs. The bundled payment initiative seeks to encourage improved coordination and quality of care by establishing a single payment for an array of services that may include hospital services and post-acute care. Although bundled payment models for cancer care can prove to be difficult to administer the need to integrate multiple therapeutic modalities and apply guideline-compliant treatment makes this an area in which such models may encourage quality enhancement and yield substantial savings. ACCs have experience in this area through developing case rates for various services, including bone marrow transplantation, stereotactic radiosurgery, and robotic surgical procedures. Ten years ago, Roswell Park Cancer Institute developed a comprehensive case rate for multimodality treatment of early-stage breast cancer and implemented it collaboratively with community oncologists. We standardized care and used the most cost-effective drugs to deliver care compliant with the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines). Savings were divided equally between providers and payers. Although the cost and complexity associated with fiscal accounting were significant, we were able to achieve a very high level of compliance with treatment guidelines and to return a substantial bonus based on the savings achieved. Unfortunately, the program was discontinued, primarily because the accounting requirements were not readily adaptable to existing information systems. Based on this experience, however, I am optimistic that the use of innovative compensation models can encourage community-wide care standardization and reduce unnecessary cost.

The PPACA also encourages the development of new models for the organization and funding of health care delivery that are aimed at increasing care coordination and reducing unnecessary expenditures through encouraging population-based risk sharing. The accountable care organization (ACO) model waives restrictions to allow physician groups, hospitals, and other providers to plan and standardize care for a regional Medicare population. If quality metrics are met, the participants receive a share in the savings that are achieved.

Matrix ACCs that participate in an ACO by virtue of being incorporated in a comprehensive hospital system would be expected to meet organizational quality standards that might include, for example, greater involvement of primary care physicians in planning and delivering care, use of evidence-based guidelines for diagnostic testing and treatment, greater patient involvement in decision-making, and use of electronic health records. Although adopting the ACO model could accrue benefit to patients and caregivers through enhanced coordination of care, system-wide quality initiatives, and data systems for monitoring treatment outcomes, ACO success in the academic medical environment will require a substantial change in the traditional departmental culture and in the criteria for academic achievement and compensation. The ACO model could pose challenges for ACCs, especially for the 11 prospective-payment system–exempt, free-standing centers, since they are precluded from establishing an ACO. Although participating patients may receive care outside their ACO, participating physicians—by virtue of working in a hospital or health system organized as an ACO—could conceivably be reluctant to refer patients to an ACO if cancer services are otherwise available within their ACO. One could also imagine circumstances in which commercial insurance companies emulate the ACO model and establish an expectation for ACO participation as a prerequisite for a hospital or a physician group to participate in a coverage network. That could restrict access to ACCs.

**How Will The PPACA Impact Clinical Research?**

Certain PPACA provisions could work to improve the quality of clinical trials and enhance trial enrollment. It is well recognized that the quality of clinical trials and our ability to generalize and apply results can be jeopardized by disparate inclusion of various racial and age groups. A number of the groups that are underrepresented in clinical trials are those that lack insurance coverage, including economically disadvantaged racial minorities, young adults, and the unemployed. By providing insurance coverage for 32 million previously uninsured individuals, allowing extended coverage of young adults through parental insurance plans, and allowing those with pre-existing medical conditions to obtain insurance, the
PPACA may encourage a more balanced representation of these groups in clinical trials and an overall increase in trial enrollment.

Denial of coverage for clinical trials by insurance plans, particularly self-insured employer plans that operate under Employee Retirement Income Security Act (ERISA) regulations, has become an increasingly serious problem in many parts of the country. These denials are apparently based on the unproven assumption that enrollment on a trial adds to costs borne by the payer. The PPACA mandates that by 2014 all public and private insurance plans must provide reimbursement for the standard care costs associated with trial participation. An unfortunate limitation is that self-insured plans that do not currently cover patients on trials can be “grandfathered” and can continue to deny coverage for patients seeking to enroll on trials after 2014. Enrollees in such grandfathered plans may face continued denial for trial costs not covered by sponsors until they enroll in a different plan.4

As was highlighted by the Institute of Medicine (IOM), a large fraction of health care costs in the United States is attributed to care that is ineffective or not cost-effective.5 The IOM has recognized that, although available evidence is not always used in formulating treatment recommendations, in some areas of oncologic practice, trials have not been conducted and high-level evidence does not exist. To address this deficit, the PPACA has already established a new agency, the Patient-Centered Outcomes Research Institute (PCORI), to guide and administer comparative effectiveness research (CER) grants “to assist consumers, clinicians, purchasers, and policy makers to make informed decisions that will improve health care at both the individual and population levels.” That the results of CER should be used to develop evidence-based guidelines where they are needed seems relatively obvious; however, with a seeming nod to political realities, section 1182(c)(1) specifically limits use of CER for determining whether care is cost-effective or for determining Medicare coverage policy unless the determinations are subject to transparent review and assessment of their impact on populations.4 Although this provision was rooted in the unfortunate debate over whether CER might be used by “death panels” to withhold life-prolonging care, it may reduce the value of CER as a tool for optimizing care. Although the concept of developing evidence-based guidelines based on CER has considerable appeal, we must also recognize that CER has significant limitations and it should not be viewed as a substitute for randomized trials.7

Finally, an exceedingly important question not explicitly addressed by the PPACA is how the evidence that underpins medical decision-making is translated into coherent practice guidelines for physicians and patients. National policy makers should consider establishing an expanded version of the NCCN model for developing and maintaining contemporaneous and comprehensive cancer treatment guidelines for physicians, with companion guidelines for patients, and establishing a national system for maintaining guidelines that apply broadly to medical practice. NCCN Guidelines are built on high-level evidence when such evidence exists, and are informed by lower-level evidence, CER data, and expert opinion when high-level evidence is unavailable. These guidelines are becoming the world-wide “gold standard” guiding oncology practice, are widely used by payers to make coverage determinations, and are increasingly relied on by patients. This is a wheel that does not need to be invented or fixed; through adding a few more wheels to the NCCN framework, we could build a vehicle to transport the best available evidence from trials and CER into the best possible care for the public we serve. Such a system would go a long way toward addressing the need for evidence-based standardization of care, as has been recognized by the IOM, and could guide efforts to simultaneously bend the cost curve and enhance quality. Ideally, such a system would need an ongoing source of funding free from any perceptions of conflict of interest. The payback would be huge.

In conclusion, I beg the readers’ understanding that there will be changes to the PPACA that are beyond the limited acuity of my crystal ball, forgiveness for any significant omissions on my part, and tolerance for any real or perceived political bias that has crept in.

References
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