Managed Care & Medical Oncology: The Focus is on Value

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NCCN, managed care, medical oncology, comparative effectiveness, CER, health care reform, cancer care, cost of treatment, reimbursement, health insurance

Abstract
A previous NCCN Oncology Insights Report™ described the factors making cancer care a priority for managed care organizations (MCOs) and emerging trends in managing costs of cancer care. To better understand the concerns of MCOs and how they are addressing cancer costs and quality, NCCN interviewed senior physician executives from the 3 largest payors in the United States. The interviews provided insights into how these companies managed oncology care, with an emphasis on drugs and biologics. As a follow-up to the previous report, NCCN conducted additional interviews with medical executives from 10 MCOs between February and April 2010. The organizations represented in these interviews were Aetna, BlueCross BlueShield of Minnesota, BlueShield of Michigan, CareFirst BlueCross BlueShield, Empire BlueCross BlueShield, HealthNow, Humana, Independence Blue Cross, Priority Health, and UnitedHealthcare. Although this group is diverse, it does not constitute a representative cross-section of MCOs across the United States. NCCN interviewed these executives about the priority of cancer care management for their organizations and the strategies being used to address cost and quality of cancer care. The information garnered from these interviews was qualitative in nature. A separate quantitative analysis of trends in oncology managed care has already been published, and throughout this report, data from the 2009–2010 Genentech Oncology Trend Report are referenced to supplement findings from the NCCN interviews. (JNCCN 2010;8[Suppl 7]:S28–S37)

Background
The managed care industry includes national and regional health insurance plans along with self-insured employer plans. Most large MCOs offer 2 general categories of

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commercial policies: fully insured plans and administrative services for self-insured customers, commonly referred to as Administrative Services Only (ASO).

In a “fully insured” plan, the employer contracts with another organization, often an MCO, to assume financial responsibility for enrollees’ medical claims and all incurred administrative costs. Fully insured plans are more often chosen by small to mid-sized employers who do not want to assume too much financial risk. Insured plans are subject to oversight by insurance commissioners in each state where policies are sold. Depending on the state, insured plans may be required to include a specific set of benefits, such as coverage of second opinions, routine costs of care in clinical trials, and infertility treatments. To reduce their own financial risk, MCOs typically obtain reinsurance to cover very high-dollar claims for their insured plans. Reinsurance is insurance the MCO obtains through a reinsurer to cover losses that exceed a certain dollar amount. Reinsurance allows MCOs to pass along and spread out their risk, thus allowing them to assume more risk themselves.

ASO policies are more often purchased by larger employers who prefer to “self-insure” or “self-fund”; in other words, pay for plan participants’ medical expenses as these are incurred. Larger employers tend to be less concerned about financial risks because their larger size reduces the risk of a dramatic swing in medical expenses from year to year. Some self-insured plans bear the entire financial risk, but most insure against large individual or aggregate claims by purchasing stop-loss coverage. The stop-loss carrier becomes liable for losses that exceed predetermined limits, allowing the employer to avoid assuming 100% of the liability. Some self-insured employers contract with insurance carriers or third-party administrators (TPAs) for claims processing and other administrative services; other self-insured plans are self-administered. Self-insured plans are not subject to oversight by state insurance commissions; rather, they are governed by federal Employee Retirement Income Security Act (ERISA) legislation. Because ERISA imposes few specific benefit mandates, self-insured plans sometimes choose to exclude coverage for certain services; for example, they may have “experimental and investigational” or other language in their plan documents that excludes coverage of routine costs of care in clinical trials and off-label use of drugs. These exclusions can have important consequences for individuals being treated for cancer.

The policies of stop-loss carriers and reinsurers can also influence self-insured employers’ coverage policies. For example, when a self-insured plan has claims that have reached the dollar threshold at which they become the stop-loss carrier’s responsibility, the stop-loss carrier may refuse to cover claims for an enrollee who has been treated with off-label use of a drug or has participated in a clinical trial.

**Focus on Cancer Treatment Costs and Quality of Care to Maximize Value**

Value in cancer care can be defined as cost divided by benefit. In that sense, MCOs are not solely focused on the amount spent in absolute terms, but rather what they, their customers, and their members receive for the money they spend on benefits. Likewise, employers are increasingly cost-conscious and many are challenged to maintain quality health benefits in the face of a weak economy and the inexorable rise in medical expenses. Finally, consumers fortunate enough to have health insurance sometimes face crippling costs for health insurance premiums and out-of-pocket expenses, while the estimated 15% of Americans who lack health insurance face overwhelming financial exposure when dealing with a serious illness.

In the NCCN interviews, cancer was typically ranked among the top 5 clinical priorities for MCOs because of cost. Likewise, the GOTR also found that MCOs ranked the management of cancer number 4 in priority, behind chronic illnesses such as diabetes, cardiovascular disease, and asthma. Although cancer is not the most frequently diagnosed condition, it represents a disproportionate share of costs, typically approximately 12% of total medical expenses for all conditions and is rising rapidly. MCOs are especially concerned about the rising costs of drugs and biologics and costs deriving from new diagnostic approaches, such as PET and the expanded uses for these technologies. During an NCCN interview, one physician executive cited an “emergent need” to do something about reducing “avoidable costs.” Another described oncology as “one of the essential conditions to manage.”

However, cost is not the only concern. Understanding what represents appropriate, evidence-based care and finding ways to reduce inappropriate variability in care are also top priorities. The focus on value means that MCOs are looking hard at both cost
This represents concern about both what is good for consumers and what is good for the bottom line. One managed care executive described a “triple aim” philosophy that seeks to find an ideal balance of positive patient experiences, optimal outcomes, and reduction in cost. For this executive, “variability means there is opportunity for improvement.”

Medical expenses related to cancer care for a nonelderly population with commercial insurance continue to rise, with current expenditures in the area of $312.00 per member per year (PMPY). Cancer drugs alone are expected to represent $21.58 PMPY and are expected to increase at a rate of 24% to 25% and reach $33.50 PMPY by 2012. In fact, over the next 3 years, PMPY costs for cancer drugs are expected to increase by 92.6%, based on increased prevalence, increase in unit cost, and the availability of new, more costly drugs.

Although cancer cost trends vary from one MCO to another, the trends are inexorably upward. The rate of increase in cancer medical expenses for one large MCO is approximately 20%, a rate that far exceeds the 9% overall rate of increase for the market basket of medical costs. As one executive stated, “The trend is alarming.”

The GOTR reported a growth rate in cancer expenditures between 10% and 20% for medical and pharmacy benefits. In 2008, total cancer expenditures grew by approximately 10% for medical benefits and 14% for pharmacy benefits, whereas drug-only cancer expenditures increased by 12% and 17% for medical and pharmacy benefits, respectively. These numbers are expected to be similar for 2009 and highlight the concern that the cost of oncology drugs is rising faster than total cancer costs for both medical and pharmacy benefits. The growth of spending for oncology drugs has caught the attention of managed care companies, who are seeking to control and manage the increase in cancer care costs.

Managed Care Strategies
Based on the NCCN interviews, cost-saving strategies are primarily aimed at physicians and hospitals, with aggressive contracting continuing to be the cornerstone of cost-containment. Consideration of new reimbursement models, such as episode-based payments intended to reduce financial incentives for the use of more costly drugs, are in the early stages and likely to receive more attention in the next few years. Influencing the behavior of plan participants is a secondary focus. A third strategy involves coverage policies related to certain kinds of cancer drugs.

Consumer Engagement
“Consumer engagement” is being emphasized more than ever as one strategy to improve health and health care outcomes and reduce costs. Consumer-directed strategies are more common in relation to general health and wellness, and chronic conditions such as diabetes and asthma. Fully insured plans are limited in the strategies they can use because they operate under state insurance oversight; for example, they can’t offer to reduce premiums or provide financial incentives for healthy behaviors. The alternative is to increase awareness of healthy behaviors and the risks associated with unhealthy choices.

Self-funded employers can use a broader range of incentives, including both “carrot” and “stick” approaches. One MCO executive noted that the self-funded space serves as a laboratory for trying out new strategies. In fact, many employers already offer incentives for completing a Health Risk Assessment, exercising, or quitting smoking, such as reducing participants’ premiums, subsidizing gym memberships, or giving small gifts or cash rewards. However, some use penalties, such as charging higher premi-
ums for smokers. Whether these incentives and disincentives will have the desired impact on behavior or reduce medical expenditures remains to be seen.

An increasing number of MCOs provide support services for their enrollees who have cancer. At a minimum, MCOs offer basic information through a 24/7 “nurseline” program, which relies on patients or caregivers to call in. Case management/disease management programs generally involve one-on-one counseling by a nurse. These programs provide services customized to the individual’s needs and offer more in-depth information; they generally rely on making outbound calls to individuals identified from medical claims.

Many of the MCOs interviewed provide some type of complex case management program staffed by nurses who offer information and ongoing support to individuals with complex cancers or who have incurred high costs and/or had multiple emergency room visits or hospital admissions. These programs typically find individuals by mining claims data. Relying primarily on claims data to find people with cancer is problematic, however, because there can be a lag of several months between diagnosis and initial treatment, receipt of the claim, identifying the individual, and making the outbound call. Therefore, these programs often do not find people until they are well along in treatment, when there is less opportunity to have a positive impact. These programs may or may not use nurses with cancer experience. More often the emphasis is on having generalist nurses who take a “whole person” approach by addressing a range of health conditions, including cancer.

One aspect of case management for patients with cancer is an increasing emphasis on options for terminally ill patients. It is generally perceived that increasing hospice participation is an opportunity to both do the right thing for patients and reduce medical expenses. However, most MCOs handle this issue with a light touch, presumably to avoid the appearance that their motivation is financial. One MCO has established a program that reimburses physicians for engaging in advance care planning discussions early in the course of treatment and encouraging completion of an advance directive. Another health plan is participating in an advance care planning program called “honoring choices.”

Cancer-specific case management programs are offered by a few MCOs and by at least 2 disease management companies that contract with health plans, employers, TPAs, and government entities. The scope and structure of these programs vary widely. The most common elements include educating and empowering patients, providing treatment decision support, working with the patient and treating physician to reduce emergency room visits and unscheduled admissions, coordinating care among providers, and addressing end of life issues. Feedback from consumers who have participated in these programs is consistently very positive. Analytic techniques for proving financial savings from cancer case management programs are not well established, and proving that they yield savings continues to be a challenge. In light of increased emphasis on value, the absence of convincing financial savings data may be an impediment to broader adoption of these programs.

Provider Designation

Designation programs are common in transplantation and often used to rate facilities and/or physicians in other areas, such as bariatric surgery, cardiac care, and orthopedics. Designation programs in oncology are more complicated to design and implement, and are much less common. In contrast to designation programs for other conditions, few efforts are being made to direct patients to designated providers for cancer care.

The two existing provider designation programs in cancer are based on cancer center or facility-based programs, rather than individual physicians. In 2009, the Blue Cross Blue Shield Association rolled out its Blue Distinction Centers for Complex and Rare Cancers, and is developing Blue Distinction models for other cancers. These programs are offered to Blue Cross and Blue Shield plans. Although participation in Blue Distinction programs is voluntary for each plan, most have elected to participate.

OptumHealth launched Cancer Resource Services, the first cancer “centers of excellence” program, in 2002. The Cancer Support Program, a cancer-specific case management program that incorporates the centers of excellence program, is also available. These programs are offered to self-funded employers, health plans, TPAs, and other organizations.

Provider Engagement Strategies

If consumer engagement is increasing, so too is “provider engagement.” Aggressive contracting with physicians and hospitals remains a baseline strategy
for controlling costs. Increasingly, though, collaborative engagement efforts are being used to engender physician buy-in.

The strategy most often mentioned is collaborative development of clinical pathways programs, tracking physician practice against guidelines or pathways, and reporting back to physicians on how they compare with their peers. Pay for Performance initiatives in cancer remain uncommon, although some respondents consider pathways programs to be a Pay for Performance model. Recognition and rewards for participating in quality initiatives, such as the American Society of Clinical Oncology’s (ASCO) Quality Oncology Practice Initiative may receive additional compensation. Oncologists who achieve a specified level of pathway compliance are very limited.

**Treatment Guidelines and Pathways**

Based on NCCN interviews, the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) and NCCN Drugs & Biologics Compendium, (NCCN Compendium) are widely used by MCOs as the primary source for evidence-based information on cancer treatment. Several respondents stated that NCCN resources are used along with other clinical guidelines and/or their own review of evidence. Aetna, UnitedHealthcare, and 20 Blue Cross Blue Shield plans across the country rely on the NCCN Compendium as a primary source for determining coverage for off-label use of drugs in cancer care.

Since 2009, interest has been increasing in reducing variation in care through defining limited treatment pathways. Several organizations offer oncology pathway programs to MCOs. Most interview participants believe that financial incentives too often influence treatment choice. Strategies to equalize incentives are being sought so that physicians choose the best treatment without considering the revenue implications. Several MCOs now offer pathway programs that identify “preferred” options: either a single-treatment option per condition or a subset of treatment options per condition. These programs are often developed in a specific health plan market in collaboration with participating oncologists. Oncologists who achieve a specified level of pathway compliance may receive additional compensation.

NCCN is currently participating in a quality improvement initiative with UnitedHealthcare and Ingenix in which oncologists contribute clinical staging information to United’s cancer registry using a “cancer status form.” Participation is voluntary and intended to provide feedback to participating oncologists about how their actual practice compares with NCCN Guidelines recommendations for treatment of breast, colon, and lung cancers. More than 700 oncologists have chosen to participate. The result is physician-specific “Impact Intelligence Oncology Management” reports that combine the clinical information supplied by the oncologist with UnitedHealthcare claims data. Aggregate data are also reported.

**Chemotherapy, Pharmacy Benefits, Pharmacy Benefit Management Companies, and Specialty Pharmacy Programs**

Advances in technology resulting in complex and expensive biologics and targeted therapies have made the management of oncology drugs a priority for MCOs. Drug coverage policy developed by an MCO’s Pharmacy and Therapeutics committee (or other equivalent committee) may use clinical guidelines and pathways as part of their process. According to the GOTR, most MCOs (87%) used the NCCN Guidelines. Other guidelines used included those developed by ASCO (58%) and US Oncology (19%). Interestingly, MCOs reported that inclusion of a drug in a published guideline was an important factor when considering drug coverage policy, second only to whether the drug is FDA-approved.

Another area receiving attention is the setting for chemotherapy administration. During the interviews, it was identified that in general, chemotherapy administered in the physician office costs less than chemotherapy administered in the hospital outpatient setting. The GOTR identified that almost half of oncologists (49%) have referred patients to the hospital for treatment if there is “significant loss of drug revenue.”

Few programs are in place today to influence the location of treatment. One MCO executive stated that they are “spending too much on chemotherapy in the hospital outpatient setting,” and are not actively working on this issue yet, but that “it’s coming.” Another stated that they want to make treatment setting revenue-neutral so that physicians do not need to consider sending “unprofitable patients” to a hospital infusion center, when care in the office setting is more cost-effective. The importance of this issue seems to vary significantly among the MCOs interviewed, with some being very concerned and others stating that it is not an issue.

High-cost oral drugs, which are typically covered under the pharmacy benefit rather than the medi-
some self-funded employers are trying this approach. by the respondents for their insured populations, but drugs unaffordable for many patients. the payor’s financial risk, this approach makes these 50% coinsurance. Although the intent is to reduce insurance, with higher tiers sometimes having up to copayment, the patient is responsible for paying co macy benefit, so that instead of having a specified are sometimes placed in a “higher tier” on the phar oncology, multiple sclerosis, and other conditions are increasingly covered under the pharmacy benefit rather than the medical benefit. High-cost drugs for oncology, multiple sclerosis, and other conditions are sometimes placed in a “higher tier” on the pharmacy benefit, so that instead of having a specified copayment, the patient is responsible for paying co-insurance, with higher tiers sometimes having up to 50% co-insurance. Although the intent is to reduce the payor’s financial risk, this approach makes these drugs unaffordable for many patients.

High co-insurance strategies are not being used by the respondents for their insured populations, but some self-funded employers are trying this approach. One medical director stated, “[We] intentionally did not put oncology drugs in tiers 4 or 5. We do not want that financial burden on the patient so they will be unable to pay for their drugs.”

Nevertheless, significant concern exists about the rising costs of drugs and the number of new drugs and biologics in the pipeline. Some of these drugs are extremely expensive while providing only modest incremental improvements in survival. One respondent seemed conflicted about incorporating more cost-sensitivity into treatment decisions. The negative impact of coinsurance for high-cost drugs was acknowledged, while observing that cost often is not considered at all when the physician and patient discuss treatment options. Finding the appropriate balance will continue to be challenging.

MCOs look to PBMs and SPs to help control costs through purchasing arrangements, home delivery programs, and other strategies. Several respondents also use the SP vendor to counsel patients. Counseling is provided by having pharmacists contact patients by telephone to make sure they understand how to take their drugs, understand possible side effects, and refill their prescriptions in a timely manner. This approach has been effective in increasing drug compliance. One MCO executive reported that this approach resulted in a 25% improvement in compliance. Although improved compliance led to somewhat higher drug expenses, it also resulted in a reduction in medical expense that was several times larger than the increase in drug costs.

Attempts to require oncologists to order infusion drugs from MCO-designated sources, often referred to as “brown bagging,” largely seems to be a thing of the past, at least among the respondents. One executive indicated this approach was tried but soon discontinued because of strong physician resistance, and another noted it had been considered but rejected for the same reason.

Notification and Prior Authorization

Although administrative requirements sometimes seem to be growing exponentially, most respondents articulated a genuine desire to strike the best possible balance and avoid overburdening physicians. All of the respondents use a radiology benefit management company, either internal or vendor-provided, for notification or prior authorization of certain types of diagnostic radiology services. Use of notification or prior authorization for radiation
therapy is much less common. Notification and prior authorization are also widely used for chemotherapy, but only for a subset of high-cost cancer drugs. One national MCO reported they do not require notification or prior authorization for any treatment that is included in the NCCN Compendium with category 1, 2A, or 2B level of evidence. However, many commercial plans (approximately 50%) require evidence that a patient’s laboratory values are within a specified range before certain drugs will be covered. Additionally, approximately 44% require that therapy with a preferred drug fail before a different one will be covered.

Looking Into the Crystal Ball

Recognizing that oncology is now a priority target for managed care, MCOs are expected to develop and implement specific strategies to ensure they receive value for their money. The top 2 strategies identified in the GOTR are increasing utilization management controls (such as prior authorization) and encouraging the use of less-costly specific drugs when clinically appropriate.

Additionally, NCCN asked respondents about strategies they currently use or expect to implement within the next 2 years to address cancer costs and quality. The most frequently mentioned strategies were:

- Increased use of guidelines or pathways programs
- Equalizing financial incentives for choosing a treatment
- Focus on evidence-based care, with more frequent peer-to-peer calls if needed
- More emphasis on advance care planning and making informed end of life choices, including providing better education and counseling to increase hospice enrollment and earlier hospice enrollment
- Using case management programs to address gaps in care and knowledge
- Educating and empowering patients to participate in collaborative decision-making with their physicians
- More aggressive contracting, especially average sales price pricing for drugs
- Ensuring appropriate use of diagnostic radiology services
- Increased use of SP programs to ensure appropriate use of drugs and patient compliance with the drug regimen
- Quality of care initiatives
- Evaluating the potential for episode reimbursement model

Ultimately, how MCOs will address oncology care in the future is uncertain in light of rapid changes in cancer care, a fragile economy, and pending health care reform.

Potential Impact of Health Care Reform

MCOs are not the only stakeholders focused on increasing value and quality in health care; the current administration and Congress are also. On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act, into law, with subsequent changes made by the passage of the Health Care and Education Reconciliation Act of 2010. Many elements of health reform focus on increasing value within the health care system, with value often equated with health outcomes achieved per dollar spent. Through putting greater emphasis on value and quality, savings can be achieved while also improving outcomes. Much of the health care legislation focuses on key areas for improving quality and value, including restructuring the care delivery system and developing alternative reimbursement systems. These areas, along with several other initiatives that emphasize value, are discussed.

Health Care Delivery Systems

For individuals who have complex diseases such as cancer, coordinated delivery of health care services can be difficult to manage for both physicians and patients. Two reasons the cost of treating complex diseases is increasing is the duplication of tests and other services and fragmentation of care. The Patient Protection and Affordable Care Act (PPACA) introduces accountable care organizations (ACOs) on a voluntary basis for Medicare beneficiaries by directing the Secretary of Health and Human Services (HHS) to develop a Medicare Shared Savings Program. The purpose of this program is to encourage investment in infrastructure and redesigned care processes to achieve high-quality and efficient service delivery that will reduce the growth of expenditures and improve health outcomes. The Medicare Payment Advisory Committee has
defined an ACO as a group of physicians (possibly including a hospital) that assumes responsibility for annual Medicare spending for a defined patient population. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries (not fewer than 5000 individuals), have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. The PPACA provides for implementation of the Medicare Shared Savings Program by January 1, 2012, with multi-year ACO agreements spanning 3 to 5 years. ACOs can promote accountability for a patient population and coordinate and integrate items and services, and reward physician practices and other organizational models for quality and efficiency. ACOs would require hospitals and doctors to work closely together and share financial risk and potential rewards.

Reimbursement Systems

Most health care in the United States is billed and paid for on a fee-for-service basis. For Medicare in 2008, $172.8 billion (72%) of all Part A dollars were spent on fee-for-service payments, compared with $141 billion (60.6%) of Part B dollars. In the fee-for-service payment model, doctors and other providers receive payment for each service. Critics of fee-for-service argue that this model encourages physicians to adopt new technologies and order more tests and procedures to increase their revenue stream. Physicians are not rewarded for spending time with patients but rather for giving more treatment. As President Obama said, “Our reimbursement structure rewards procedures and the use of technology but not time spent with patients or coordinating care.”

The PPACA establishes a national Medicare pilot program to develop and evaluate bundled payments for acute inpatient hospital services, physician services, outpatient hospital services, and post–acute care services for an episode of care that begins 3 days before a hospitalization and spans 30 days after discharge. The episode-of-care or bundled payment system involves reimbursement to providers based on expected costs for a clinically defined episode of care. It is a middle-ground between fee-for-service reimbursement, in which each service is billed and paid separately, and capitation payments, in which the provider or provider group receives a lump sum, usually prospectively, to provide all needed care for an individual. Advocates of bundled payments note that this system discourages unnecessary care, encourages coordination across providers, and could potentially improve quality.

The Medicare pilot program will be focused on up to 8 medical conditions to be selected by the Secretary of HHS, and quality measures will be developed in consultation with the Agency for Healthcare Research and Quality. If the pilot program achieves its stated goals of maintaining or improving quality and reducing spending, Medicare will develop a plan for expanding the pilot. The pilot program will be established by January 1, 2013, and, if appropriate, will be expanded by January 1, 2016.

To further explore different payment structures, the PPACA establishes the Center for Medicare and Medicaid Innovation (CMI) within the Centers for Medicare & Medicaid Services (CMS). CMI is charged with testing, evaluating, and expanding different payment structures and methodologies to reduce program expenditures in Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP) while maintaining or improving quality of care. CMS will be looking for innovative models that promote broad payment and practice reform in primary care, support care coordination for the chronically ill, and use geriatric assessments and comprehensive care plans to coordinate care, among many other goals. Payment reform models that improve quality and reduce the rate of growth in costs could be expanded throughout Medicare, Medicaid, and CHIP. This program is effective January 1, 2011.

Comparative Effectiveness Research

Although payors currently use coverage policies and reimbursement models to control costs and use, comparative effectiveness research (CER) may be looked to in the future as an additional means of controlling costs and utilization and improving quality. The nature of cancer and the breadth of disease states within the oncology field have unique and nuanced implications for how CER might be carried out, applied, and interpreted. Application of CER within oncology requires full understanding and careful consideration of its potential consequences for all stakeholders, especially for patients and their oppor-
tunity for improved quality of life. Availability of and access to appropriate drugs, devices, procedures, and techniques are essential for patients with serious and life-threatening or terminal illness. Furthermore, the implications of policy decisions and processes for the advancement and development of innovative technologies must be carefully considered when any new policy paradigm is implemented.

The PPACA establishes the non-profit Patient-Centered Outcomes Research Institute (PCORI), overseen by the Board of Governors.\(^\text{17}\) The Government Accountability Office has responsibility for appointing members to the Board of Governors. The Board must include 3 individuals representing patients and health care consumers and 5 individuals representing health care professionals or institutions. The PCORI will conduct, support, and synthesize research with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically. Money to run the PCORI comes from the Patient-Centered Outcomes Research Trust Fund, which will be funded in part through fees (starting in policy year ending after September 30, 2012) imposed on insurers of health plans and employer sponsors of self-insured health plans. The legislation also clearly states that findings from CER may not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment, or be used to deny coverage.

To address CER in oncology, NCCN introduced the NCCN Comparative Therapeutic Index™ (CTI) as an analytic method for near-term comparative effectiveness analyses of existing data.\(^\text{18}\) The NCCN CER Work Group provided recommendations for development of a strategy for incorporating CER into the NCCN Guidelines process through the use of the CTI that will be used to compare different treatment options. Development of the CTI will be an evidence-based, systematic, comprehensive, and transparent process using explicit criteria for evaluating and then comparing the risks-versus-benefits of different treatment options recommended in the NCCN Guidelines. The effectiveness and toxicity variables used in the CTI model are based on the evaluation of available scientific data (including CER studies) integrated with the expert judgment of leading oncologists.

### Other Value/Quality Initiatives in Health Reform

- The PPACA establishes a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extend the Medicare Physician Quality Reporting Initiative beyond 2010.\(^\text{19}\) Quality measures would include a minimum of 5 indicators, including acute myocardial infarction, heart failure, pneumonia, certain surgical procedures, and health care–associated infections. Implementation of value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers also will be considered.

- To improve care coordination for dual eligibles, CMS is creating the Federal Coordinated Health Care Office.\(^\text{20}\) This office has the goal of more effectively integrating Medicare and Medicaid benefits and improving coordination between the federal government and states to improve access to and quality of care and services for dual eligibles.

- The PPACA calls for the development of a national quality improvement strategy.\(^\text{21}\) Priorities include improving the delivery of health care services, population health, and patient health outcomes. That national strategy is due to Congress by January 1, 2011, and must create processes for the development of quality measures involving input from multiple stakeholders.

### Conclusions

Substantial disagreement exists among the diverse set of stakeholders—payors, health care providers, consumers, and policymakers—about how to reform health care in the United States. All agree that health care outcomes should be better, especially in light of the growing share of the gross domestic product spent on health care in the United States. Although health care reform coming out of Washington will have a profound impact on what happens, progress may be slow and uneven because of the complexities of legislation and rule-making. It is certain, however, that private-sector health insurance will continue to have a central role in health care for years to come. Because private-sector MCOs and self-insured employers are able to act quickly, they are likely to lead the charge toward obtaining greater value in cancer
Non-profit organizations like NCCN will also continue to play a major role in creating a new model for cancer care in the 21st century.

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