# Achieving Accountable Cancer Care

By Michael L. Blau, Esq.

A national consensus is emerging that the rate of growth in healthcare spending is no longer sustainable. Employers and patients are chaffing at rising healthcare costs, which are crowding out other important federal and state budgetary priorities, and are causing an increasing number of medical bankruptcies. Oncology is responsible for its fair share of these costs, accounting for up to 10% of all healthcare expenditures by some estimates. Moreover, oncology costs are growing faster than many other healthcare components because of expensive new drugs, expensive new molecular diagnostics, and expensive new robotic and therapeutic technologies. It has gotten to the point that some patients are more afraid of their out-of-pocket costs of cancer care than they are of their disease.



Perhaps not surprisingly, in this era of renewed cost consciousness, some of those oncology expenses are being called into question. A serious re-examination is underway of the variability of prescribed cancer treatments, and of potential overutilization of oncologic imaging, chemotherapy, radiation therapy and surgery—particularly where evidence-based medicine results are lacking, and different approaches result in widely different costs.

In addition, there is always the third rail issue of the cost of end of life care—which, as a nation, we need to be able to address in a less politically charged manner. A recent study titled, "Benchmarks for Value in Cancer Care" identifies significant opportunities to reduce costs for cancer patients, particularly for those receiving chemotherapy. The authors suggest that there are substantial cost savings to be attained by using cost-effective treatment guidelines to reduce avoidable hospital admissions and ER visits, and decrease the cost of futile care during the last 30 days of life (*JOP*. 2011;7:301-6).

Against this backdrop, payers have been experimenting with new payment methodologies that are designed to reduce the trend in healthcare spending. The Affordable Care Act (ACA), which envisions a sea change in the way that healthcare services will be rendered, including oncology services, has provisions for transforming Medicare and Medicaid payments from fee for service to "value-based" purchasing. ACA also authorizes the new Medicare Shared Savings and Pioneer ACO programs, as well as demonstration programs and pilot projects to test shared savings, bundled payments, episodes of care, pay for performance, partial or full capitation, and other provider risk-sharing arrangements.

Instead of paying for volume, Medicare and other payers are moving toward basing payments on compliance with clinical pathways, quality and cost-effectiveness protocols, use of electronic health information technology, quality reporting, transparency, and the results of outcomes and comparative effectiveness research. In addition, healthcare providers are being asked to assume an increasing amount of financial risk for the cost of care they provide. ACA calls for patient centered, population health management. In doing this, it encourages future patient care to be delivered by multi-disciplinary teams of providers, and coordinates care across a continuum of facilities, through new organizational structures such as Accountable Care Organizations (ACOs), Patient-Centered Medical Homes, and other integrated care organizations.

Some of the critical questions that need to be answered about the role community oncology will play within these new organizations include: Will oncology stakeholders be the owners and drivers of these organizations, or will they become vendors to someone else's delivery system? Will oncology providers come under added pressure from their own colleagues to reduce utilization as the cost of oncology care becomes a shared financial risk with other providers? How will they assure themselves that they will receive their fair share of the healthcare dollar? And, what are the implications of these new payment methodologies for the economics of oncology service delivery, and most importantly, for quality patient care?

Truly, there is a sense of urgency to transform our healthcare system, and the resulting pace of strategic planning is breeding uncertainty and anxiety about disruptive changes that may lie ahead for many parts of our system, including community oncology. Some will resist change; and some will embrace change. There are those who will bury their heads in the sand for as long as possible; and there are those who will experiment with new arrangements—and will discover novel approaches to architecting multi-disciplinary care across provider types and sites of care.

Recognizing that the conditions that have led to healthcare reform—the unsustainable rising costs of healthcare—are not going away, government payers, private insurers, and integrated provider organizations will be undeterred in proceeding to hold oncology providers increasingly accountable for the cost and quality of the care they provide. Thus, oncology providers should heed the call and prepare to be engaged, and actively participate in designing the new care processes that will enable the delivery of more efficient and effective cancer care, and also to define the future of our healthcare system.

Through active engagement, community oncology practices may discover ways to blaze new trails to success. Those trails may lead to new information technologies—such as specialty EMRs with automated clinical pathways, clinical decision support, predictive testing, payer coverage rules engines, precertification ability, quality reporting, coding, claims submission, and CPOE—that are interfaced and interoperable with other IT systems. These information technologies may provide new ways to identify, generate, and share cost savings with payers; identify new ways to provide evidenced-based care to patients; and provide the foundation for outcomes and comparative effectiveness research.

The trails may also lead to leadership in new organizations, like oncology Medical Homes, oncology "supergroups", oncology-specific risk based IPAs, oncology-centric multi-specialty groups, and other integrated care organizations that will provide a laboratory for experimenting with new payment and care delivery models. Or, they may lead to new models of collaboration with providers and payers or with new businesses that are not yet on anyone's radar screen.

The future is for those who make it; and the time is now to develop and test the business models that will define future success for community-based oncology.

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FDA approval decisions pending in June 2012 for important pipeline cancer drugs include Merck/Ariad's Taltorvic® (ridaforolimus) for sarcoma [June 5] and Roche/Genentech's pertuzumab for HER2-positive metastatic breast cancer [June 8]. *(TheStreet, 5/2/12)*

Researchers just reported that nearly half of American men 75 and older continue to be screened for prostate cancer despite official recommendations against doing so. *(ABC News, 4/24/12)*