FALL CONFERENCE HIGHLIGHTS

Summary: *The ACCC's Fall Leadership Conference, "Oncology Economics V: Can Cancer Programs Survive the 1980s," held September 22-24 in Boston, MA, focused on key issues of concern to cancer care providers, including Medicare payment for medical oncology and radiation oncology, avenues for cooperation between purchasers and providers of care, and the future of clinical research.*

Lack of DRG Volume Adjustment, Outlier Policy Pose Threat To Specialization

The health care spending spiral is going to continue, which will affect health care specialization and trigger the "dumping" of expensive, high-cost patients and services under the current DRG system, according to Stuart Altman, Ph.D., chairman of the Prospective Payment Assessment Commission (ProPAC) and Dean of the Heller School, Brandeis University, Boston.

In his keynote speech at the ACCC Fall Leadership Conference, Altman pointed to the "increased need for a volume adjustment" in the DRG system, which, at this time, is volume neutral. Under the current system, institutions receive the "same average payment for every patient, regardless of volume of patients seen." Even though specialization (or regionalization) "implies less cost and improved quality," and despite the "proof that both mortality and costs decrease as the number of procedures increases," Altman says that we haven't yet seen "serious specialization that places limits on the delivery system." To date, he contends, "managed care is a joke; a marketing activity that hasn't yet managed care. Access still reigns." As a result, Altman predicts that "40 to 50 percent differences between costs and charges" will prompt providers to "dump high-cost services as specialization increases and the pressure on cost builds."

Another problem under the DRG system that affects specialized centers is that the average cost for specialized services, such as burn care, exceeds average reimbursement, creating a disproportionate increase in high-cost patients or "outliers." "The DRG system is very tough in its approach to outliers," Altman says, because as the "outlier pool" increases, it requires "an equal reduction in other payments." There are "pressures on HCFA" to maintain what Altman calls an "arbitrary level" of outliers (6 percent of all Medicare beneficiaries). In actuality, however, a "much higher percentage—10 to 15 percent of all Medicare patients—fall within the outlier category," he says. And while Altman notes that an interim adjustment was made for burn patients, "it is difficult for government to create a differential reimbursement system by institution." One of the government's problems is defining what constitutes a specialty center. Altman also points out that it's a "regional problem, outliers are dominant in high-population areas." Furthermore, there is political jockeying among providers on the outlier issue. For instance, Altman notes that the American Hospital Association recently voted not to increase the outlier pool if it decreases payment to the average patient. As a result, Altman is "not sure how fast we will change the DRG system to come to grips with outliers."

Stuart Altman, M.D.

Meanwhile, "the implication of the current outlier policy is either that an institution's inefficient and should be penalized, or that patients should not be getting the level of service they currently are receiving—both of which I find difficult to swallow," Altman says. "We need a fair pricing system that doesn't discriminate against any particular patient or institution. No patient," he says, "ought to be identified as a clear winner or loser for an institution."

Another issue that ProPAC has been examining is the effect of the DRG system on the diffusion and use of high-cost technologies. Altman notes that for the first few years under DRGs, "there was no discernible effect" because the new system initially "increased hospital revenues by 10 to 20 percent." However, if the system continues to clamp down on costs, the suppression of new technology is a "potentially serious problem," he says. "We are a technology-driven society, but there has to be economic incentive for introducing technologies." We must be able to justify them as being "quality-enhancing"—an area in which Altman believes providers will face "much tougher calls." However, "if the introduction of new technologies is going to be slowed, that's not necessarily a bad thing," Altman says. "It won't be stopped," he claims, noting a current rate of increase of 20 percent.

In conclusion, Altman warned the audience that "DRG is not a transitional system; it's not going away." As a result, he advised providers that they must "learn about pricing; particularly in regard to technology," and they must "balance price and look at the effect of volume."

The Future of Clinical Research

Widespread payment denials are creating "a crisis in clinical research," says Karen H. Antman, M.D., Dana-Farber Cancer Institute, Boston, MA. Antman told conference participants that reimbursemnt denial for the patient care costs associated with clinical trials is "becoming a national problem, probably due to the reasonable goal of keeping down the costs of care," but, she warns, if such a policy continues, it will "basically shut down clinical trials."

Why are insurers no longer covering the costs of clinical research? Although insurance companies still are "covering the majority of patients, coverage is arbitrary," Antman says. Although marginal, long-standing treatment regimens are "routinely compensated," many insurers are covering investigational treatment simply because "they aren't aware that the treatment is experimental," Antman notes. In addition, coverage largely depends on the "definition of investigational care," which can vary from non-FDA approved therapy to non-FDA approved dosages, treatment schedules, or indications."

Who will pay for clinical research if insurers won't? According to Antman, "there are currently no other viable options." A sufficient increase in research grants through the National Cancer Institute to cover such costs would require "an enormous increase in the budget of the National Institutes of Health," she says, noting that it costs approximately $200,000 to treat each patient on a clinical trial. Antman also believes that it is "unreasonable to expect the pharmaceutical industry, which already pays for research and development and, in many cases, the research laboratory costs for new therapies, to also pay patient care costs." As a result, if insurers continue to refuse payment, "only the affluent will be able to afford clinical trial treatment."

Is investigational care cost effective? "The truth is, sometimes it is and sometimes it isn't," Antman says. But a system that allows "insurers to make medical decisions regarding patient care is totally inappropriate." And, Antman charges, the current shift in reimbursement policy "equates investigational care with no treatment."

Are there potential solutions to the problem? "We must get legislators to insist that Medicare patients are paid for investigational care," Antman contends, noting that by pointing out the "human costs" of such a reimbursement stance, providers will be more "effective in dealing with legislators." She also says that we need to convince insurers to use "efficacy versus investigational or non-investigational as the criteria for payment." However, she warns, "if third-party payors do accept such a criteria for payment," we will need "rigorous safeguards" against unorthodox treatments, such as laetrile. Studies will have to be "well designed, have a firm scientific foundation, represent important advances in cancer treatment, and have an ethical basis," she says.

Karen Antman, M.D.

Antman also suggests that perhaps providers should support the use of the NCI's PDQ as the standard for payment of clinical research—a suggestion that met with resistance from some meeting participants who question the wisdom of a policy that puts NCI in a position of passing judgment on all U.S. clinical research. Other participants point out that such a policy might be too restrictive, noting that not all current protocols are included in PDQ. In fact, PDQ only requires approval for trials taking place at more than six institutions. Protocols at fewer institutions or with less than 100 patients enrolled are not reviewed by NCI. However, Antman pointed out that there would be "nothing to prevent providers from beginning to seek NCI approval of such protocols."

ACCC Honors SWOG Chairman For Excellence In Clinical Research

At a special awards luncheon during the Fall Leadership Conference, the ACCC honored Charles A. Coltman, Jr., M.D., for "Outstanding Achievement in Clinical Research." Dr. Coltman is a professor of medicine at the University of Texas Health Science Center, San Antonio, TX, and chairman and principal investigator for the Southwest Oncology Group.

ACCC President King presents award to Dr. Coltman.

During the award presentation, Dr. Coltman was lauded by ACCC President, David K. King, M.D., for his "significant contributions to community cancer research over the past 25 years." At the time that the CCOP program was being developed, Dr. King said, "Dr. Coltman immediately embraced the concept of clinical trials in the community. He was instrumental in organizing SWOG's participation in the CCOP program, and in helping to devise a quality control program."

Dr. Coltman accepted the award on behalf of "SWOG and its participating physicians in private practice who have made a success of our group." Coltman pointed out that participating private physicians "accounted for 43 percent of the new patients enrolled in SWOG clinical trials in 1987—the largest accrual of any cooperative group in the country."

Coltman also commended private practitioners participating in SWOG protocols for their delivery of high-quality patient care. For instance, a study of 3,000 SWOG patients found that over 13,380 cycles of treatment, participating physicians provided the correct dosage 90.67 percent of the time. Such a high percentage is "unheard of in clinical trials," Coltman said. He also noted that patients treated by private, commmunity-based physicians had "better response and survival rates" than those treated at member institutions in university settings. And, he added, studies show that the differences in responses and survival rates for private practitioners' patients "cannot be accounted for on the basis of patient mix." In short, he said, "quality is conformance to standards, which are protocols, and the adherence of private practitioners to the protocols is uncanny."

Futurist Predicts Significant Changes in Health Care

Russell C. Coile, Jr., president, the Health Forecasting Group, Alameda, CA, challenged conference participants to anticipate the driving trends that will influence future possibilities as an integral part of good management. The future, he says, should be thought of as a "resource that should be managed in the same way that you manage budgets, patients, and human resources." Some of the trends that Coile believes providers will have to contend with include:

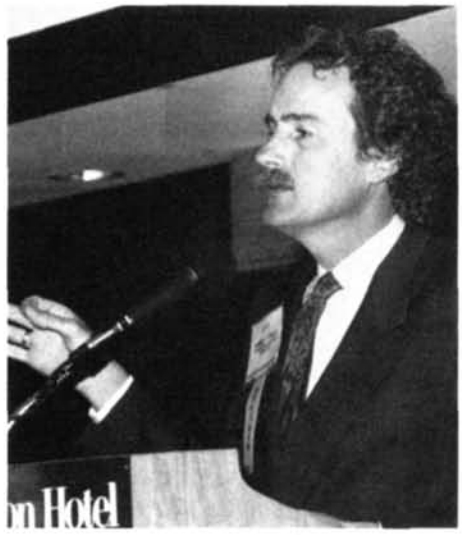
• **Severe labor shortages between now and the year 2000.** Coile says that we can expect "only a 20 percent increase in the work force over the next 20 years"—a result of the baby boom being followed by a baby bust—unless the United States "reopens its borders to immigration."

• **Double-digit health care inflation in 1989.** We are already moving in this direction, according to Coile, who notes that during the first two quarters of 1988, the medical component of the GNP inceased 7.9 percent; however, the hospital component rose 11.1 percent—rises that Coile attributes to wage increases.

• **Health care will account for a larger percentage of the GNP.** Health care is the "pac-man" of the gross national product, Coile says, noting that the "growth rates that are being seen in health care would delight people in any other industry." Even the Health Care Financing Administration has predicted that "health care will account for 15 percent of the gross national product (GNP) by the year 2000"—a prediction that Coile believes will be true as early as 1995 if current growth rates continue.

• **A rise in inpatient occupancy rates.** "We are already seeing modest increases," Coile says, "which are and will be driven by the aging of America and the increased complexity of inpatient cases. Coile also predicts inpatient bed shortages, due to AIDS and the fact that there has been "no major infusion of new beds since the 1970s."

• **Half of the population of each state will be enrolled in managed care plans.** Coile believes that managed care will "dominate tomorrow's health care landscape." In California, he says, 70 percent of the population is already enrolled in managed care plans, with particularly large enrollment increases in PPOs versus



Russell Coile

HMOs. In addition, 66 percent of General Motors employees are currently enrolled in managed care plans, and HCFA is looking for demonstration sites for Medicare PPOs.

• **Buyer cartels in every part of the country.** Coile predicts cartel growth will be a result of "purchasers becoming increasingly well informed about the health care industry and starting to exercise their clout." Coile also predicts that "fee bundling is just beginning," saying that its "both a problem and an opportunity." Along those same lines, Coile predicts more "aggressive pricing by purchasers. Purchasers will be shopping for oncology services as they currently are for mental health services." And, he says, providers can expect more purchasers to be soliciting bidding on package prices.

• Competition on the basis of quality of care. "We live in a disclosure fishbowl, and the light is getting brighter," according to Coile. "Buyers are measuring outcomes much more closely," and they are "already shifting to quality versus price as the basis of purchasing decisions," he says, noting that Prudential Insurance Company recently issued a list of preferred providers by service.

• **Three out of four hospitals** will fall below the line of profit. It's been predicted that one out of every two hospitals will lose money this year, according to Coile, and he believes that number will rise to three out of every four hospitals in 1989. "The average hospital is limping by on the arbitrage earned on investments and, as they begin to spend their reserves, more hospitals will fall below the line of profit," Coile says.

• **Mandated health insurance legislation.** Coile predicts that there is "a good chance" that such legislation will be enacted within the next two years, because it is "budget neutral" legislation; employers will bear the cost.

• **No more than 5 to 10 health care management companies.** Kaiser will be one of those systems, according to Coile; the rest will be insurance companies. "We will see insurance companies becoming managed care companies with private networks of preferred providers."

• **Oncology will be a major market in the 1990s.** Cancer care will be a major market niche opportunity in the 1990s, according to Coile, but he warns that "pricing that care will be difficult."

• **Cancer HMOs.** Such an arrangement will be an opportunity, Coile says, because it will place cancer care providers at full financial risk, which also means that they will decide what areas in which to provide treatment and what new technologies to adopt.

• **A possible end to the Medicare DRG system of reimbursement.** Coile believes that a distinctly possible alternative to the DRG system will be a decision by Congress to spend "x" dollars on health care, divided by the number of beneficiaries, and leave it up to providers how to manage care, putting providers at full financial risk. "This is a manifold opportunity for efficient providers," Coile maintains, "because it allows them to fully manage their costs."

• **Significant increases in the number of physician managers.** According to Coile, a managed care environment requires "the active collaboration of the medical staff," which is accomplished by "placing physicians in positions of fundamental power."

• **Increased private regulation.** Although Coile says wage, price, or cost controls are possible, he is more concerned about private regulation, which he predicted will be "more extensive as purchasers better understand how the health care system works."

• **Patient compliance will be increasingly important.** Coile points out that in a managed care evironment, patients who do not comply with treatment will be costly. As a result, "compliance management is a management opportunity of the future," he says.

Medicare Payment Reform Will Impact Radiation Therapy Services

The new fee schedules for a relative value scale (rvs) payment system for radiologists' services will have a profound effect on such fundamental decisions as whether or not to build a free-standing center, according to Diane Millman, attorney at law, McDermott, Will & Emery, Washington, DC.

Millman believes that the move to a relative value scale system is a move toward "mandatory assignment," explaining that the rvs rules call for a "cap on actual physician charges, even for physicians who don't accept assignment."

Even though the change to an rvs-based system is due to go into effect on January 1, 1989, Millman reports that no-one has any idea what the new fee schedules will look like. "HCFA missed its August 1 date for reporting to Congress," Millman reports. However, HCFA's request for "an amendment that would delay the January 1 implementation date was denied."

Even though the fee schedules have not yet been released, many experts are questioning the accuracy of the 1986 charge data HCFA may use as the basis for the fee schedules, Millman says. In fact, the American College of Radiology "conducted its own fee survey of radiologists and created its own fee schedules," Millman says. "The question is, whose data will be used?" It also is not known how HCFA will deal with the "difference between hospital and office-based physician fees." That's an important issue, Millman says, "because 40 percent of the global fee is attributed to the professional component and 60 percent to the technical component. Yet it is unclear if that difference will be reflected in HCFA's rvs. It may even vary from code to code, based on historical data," she says.

The effect of such "unknowns" on determining whether services should be hospital-based or freestanding remain "up in the air" until the fee schedules are released. However, once HCFA does release the data, Millman advises providers to compare their costs on a per procedure basis with the new fee schedules. "If your costs are higher, you may want to organize the venture as a hospital-based center." Providers should also examine state licensing laws which, according to Millman, vary from state to state and will affect whether an off-site center can be licensed as part of the hospital. The Federal Register notice that finally provides HCFA's fee schedules will be an "important report for both FCCs and hospital-based centers."

In the area of medical oncology, Millman says that drug reimbursement will be "extremely limited" under the new outpatient drug amendment to the Medicare Catastrophic Coverage Act. "HCFA will be in the position of designating what are covered and noncovered drugs," she warns. In addition, she says that the amendment will be "extremely costly, requiring special computers in all participating pharmacies."

Diane Millman, with ACCC Executive Director Lee Mortenson

Legislators are also becoming increasingly concerned about physician ownership of entities to which they refer patients. According to Millman, Rep. Pete Stark (D-CA) has introduced a bill that "essentially will preclude such arrangements in a wide variety of areas," included diagnostic and therapeutic radiology facilities. This is a "serious policy issue," Millman says. And although she believes that, in its current form, Stark's bill is "too controversial" to be enacted, it does signal Congress' increasing concern about utilization and ethical issues related to joint ventures.

Coping With The Nursing Shortage

The American Medical Association's proposal to establish a new category of health care provider, a Registered Care Technologist (RCT), to ease the nursing shortage has come under fire by the Oncology Nursing Society. According to Margaret Irwin, RN, MN, Allegheny General Hospital, Pittsburgh, "training a person for nine months is not going to solve the need for highly-skilled nursing." Furthermore, Irwin says that as the proposal currently exists, it "constitutes delegated medical practice," which requires actual physician supervision of the RCTs. And, finally, she believes it will further fragment the delivery of care and actually reduce nurses' time at the bedside.

Irwin provided some statistics on the extent of the current shortage, including:

- Nursing vacancy rates increased from 4.4 percent in 1983 to 11.3 percent in 1987. At the same time, the demand for RNs increased, particularly in the acute care area where the number of required nurses per 100 patients has risen from 86 in 1984 to 96 in 1986. Irwin attributes much of the increased demand to case mix index changes, noting that hospitals are seeing "more acutely ill patients."
- The nursing shortage is not related to acute care nurses seeking positions in other areas of care, such as home health. Irwin says that more nurses are working in acute care settings than in clinic settings. For instance, from 1977 through 1984, the percentage of nurses in acute care increased from 62 percent to 68 percent, while the percentage in other settings decreased, e.g., extended care (8.3 percent to 7.7 percent), community care (7.7 to 6.8 percent), and nonclinical (managerial) settings (13.7 percent to 10.8 percent).

The shortage shows no immediate sign of easing up. Irwin says that RN programs have experienced "extreme declines" in enrollments. For instance, 250,000 students were enrolled in nursing programs in 1983, compared to less than 200,000 in 1986. In short, Irwin says that many potential nurses are entering other professions. In addition, the eligible pool of high school students is declining.

To solve the shortage, Irwin suggests taking into account such studies as the American Nurses Foundation's study of hospitals that have good recruitment/retention statistics. ANF found that magnet hospitals promote shared governance, provide salary and job security, encourage a spirit of cooperation and teamwork, provide social and recognition programs for nurses, encourage physician collaboration, and instill in nurses the belief that they are valued by the organization.

Purchasers/Providers Discuss Cost/Quality Issues

A select panel of health care purchasers and providers discussed their concerns and priorities, at a special session during the ACCC leadership conference. Paul Anderson, M.D., director of the Cancer Center of Colorado Springs, Inc., and moderator of the panel discussion, noted that "providers are hopeful that they can shift the debate from cost to quality." A recent survey of health care coalitions, reported by Gaylen Young, director of the Office of Health Coalitions and Private Sector Initiatives of the American Hospital Association, lends support to that hope. According to Young, quality of care is currently coalitions' number one priority. Ten years ago, when the first coalitions were created, the focus was on cost containment. "By 1980, membership in coalitions had expanded to include not only hospitals and physicians, but labor unions and employers, and they broadened their agenda to cover not only cost, but quality of care," Young notes.

Young contends that "there must be a greater understanding between the buyers and sellers of health care." Providers must be able to convince purchasers that they are buying quality care which, according to Young, "purchasers want every bit as much as providers."

George Ligotke, medical cost manager for Hewlett Packard in Colorado, presented the perspective of a large, self-insured company. In Northern Colorado alone, Hewlett Packard is spending $14 million per year on medical costs for 15,000 beneficiaries. At this point in time, Ligotke notes that cancer care accounted for 5.5 percent of the company's medical claims in 1987. However, during the first half of 1988, Ligotke says, that percentage has already risen to 8.2 percent; the equivalent of $562,000 in medical costs.

Ligotke warned participants that cancer care has been viewed by purchasers as an "apple pie and motherhood issue" and, as a result, it's been low on most employers' cost priority lists. However, that is unlikely to remain true. To counter any future constraints on payment, Ligotke advised providers to actively communicate with purchasers. "Discuss new technologies with them; provide tours of your facilities; keep them informed about treatment modalities, costs, and outcomes; seek cohesion among yourselves on treatment modalities; and network wherever possible," he said.

NCI staff recently met with members of the national Blue Cross and Blue Shield Association about clinical research reimbursement problems, according to Robert Wittes, M.D., associate director for Cancer Therapy Evaluation at the NCI. "Blue Cross is now interested in this problem," and plans to include it on the agenda of its fall meeting of medical directors," Wittes says. On the other hand, HCFA's position on investigational treatment has been "that it's not reasonable and necessary and, therefore, can't be reimbursed under Medicare criteria." However, NCI is also meeting with HCFA staff on this issue.

Gaylen Young

Regarding the use of FDA-approved drugs for off-label indications, Wittes points out that HCFA's policy is to leave such payment decisions to the "discretion of contractors." Nevertheless, he notes that "HCFA has declined to pay for an FDA-approved indication purely on the basis of cost."

Robert Wittes, M.D.

ACCC executive director Lee Mortenson noted that the need for new health care policies affecting pharmaceutical reimbursement. First, we need a "national policy on clinical research." We must influence national health policymakers and educate them about the limits being placed on such research. Second, he advocated that organizations such as ACCC work with insurance intermediaries about policies that affect research and technology.

George Ligotke

Third, he emphasized the need to discuss insurance coverage with purchasers, pointing out gaps in coverage and a need for national standards. ■

Lee Mortenson

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