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Highlights From ACCC's 16th Annual National Meeting

The Association of Community Cancer Centers held its 16th Annual National Meeting at the Hyatt Regency Washington March 21–24. Among the numerous seminars held during the four-day session were a special forum on issues affecting cancer care in the 1990s and symposia on new technology and chemoprevention. Following are a few of the highlights from the meeting.

Surveys Reveal Significant Reimbursement Problems

Two important surveys by the Gallup Organization and the General Accounting Office (GAO) reveal that medical oncologists are facing significant reimbursement denials for accepted cancer therapies.

The Gallup Survey

The Gallup Organization found, on the basis of 200 telephone interviews with physicians specializing in oncology, that 1 out of 8 cancer patients "never get the physician's preferred treatment due to reimbursement difficulties." The survey results, announced by Harry Cotugno, Ph.D., Vice President and Senior Study Director for Gallup, at the ACCC Annual Meeting, also found that 13 percent of the physicians said that 30 percent or more of their patients do not receive the treatment of choice because of reimbursement, while only 23 percent said all of their patients get the treatment of choice without reimbursement problems. And more than half (56 percent) of the oncologists surveyed in the national poll report that reimbursement is "very often" (17 percent) or "fairly often (39 percent) a problem in achieving treatment goals.

The survey also found that three out of four physicians report that reimbursement may be a barrier to enrolling patients in clinical trials. And two out of five oncologists report that reimbursement for patients in clinical trials has worsened in the past year. A majority (51 percent) of oncologists report that it is difficult to get patients to enroll in clinical trials. One-third of the oncologists surveyed believe that better cost coverage for treatments or better patient education would help encourage participation in clinical trials.

The GAO Survey

At the request of the Senate Committee on Labor and Human Resources, the General Accounting Office (GAO) undertook a study of the extent of off-label drug use, the extent of reimbursement problems oncologists are encountering, and the effect on the practice of oncologists. The responses of 680 oncologists and their specific treatment of more than 2,000 cancer patients revealed that 33.2 percent of the drugs prescribed by oncologists were for off-label uses. With regard to combination therapy, only 44 percent of all of the drugs prescribed in combination were all for on-label uses.

Mr. Laetz

The survey also found that "as the disease becomes less curable, off-label use increases," according to Thomas Laetz, Ph.D., Issue Area Manager-Program Evaluation, for the GAO. Speaking at an ACCC Annual Meeting session, Laetz said that about 50 percent of responding physicians are experiencing reimbursement problems for the off-label use of drugs; 45 percent are experiencing reimbursement problems for investigational agents; and 50 percent are having difficulty obtaining reimbursement for drugs administered on an outpatient basis.

Overall, Laetz says, three-quarters of the oncologists surveyed "thought denial rates were increasing," and 289 of the physicians had been denied reimbursement during the last 12 months. In addition, two-thirds of the oncologists said there was a increase in reimbursement delays.

The drugs for which oncologists were experiencing the greatest reimbursement difficulties were carboplatin for lung and ovarian cancers, cisplatin for lung cancer, etoposide for lung cancers and lymphomas, fluorouracil for colorectal cancers, and flutamide for prostate cancer.

Although, at *Oncology Issues* deadline, the GAO had not yet issued its recommendations, Laetz says implications of the survey could impact the use of authoritative drug compendia, the FDA supplemental labeling process, HCFA's policy of allowing carrier discretion in reimbursement decision, and societal decisions regarding palliative treatment and the prescribing of drugs for the deathly ill.

New Cancer Technologies In The Pipeline

A number of new antineoplastic drugs and biotechnologies should be available through clinical trials in the near future. According to Michael Grever, Acting Assistant Director, Development Technology Program, the NCI is "committed to discovering new antineoplastic drugs, analyzing dose-intensity in clinical trials, and improving tolerance to chemotherapy" with such agents as Growth Stimulating Colony Factor (GSCF).

According to Grever, drugs that should be approved soon include deoxycoformycin and fludarbine monophosphate for chronic lymphocytic leukemia. In addition, taxol is currently under study and achieving complete remissions in patients with melanoma, and lung and ovarian cancer. And, Grever said that anthrapyrazole for solid tumors, which is being used in Europe, should be available soon in U.S. trials.

According to Gregory Burke, M.D., Ph.D., Acting Division Director, Oncology and Pulmonary Drug Products, major efforts to speed up the approval of new cancer drugs at the FDA include the development of "strategies for dose escalation in phase I cancer drug studies, quality of life instruments for approving cancer drugs, decreased review of preclinical requirements, and the use of surro-

ACCC 1991–1992 Officers And Committee Chairs

The Association Officers for Fiscal Year 1991–1992 are: Lloyd K. Everson, M.D., Indiana Regional Cancer Center, Indianapolis, President; Robert T. Clarke, M.H.A., Memorial Medical Center, Springfield, IL, President-Elect; Carl Kardinal, M.D., Ochsner Clinic, New Orleans, LA, Treasurer; and Albert B. Einstein, Jr., M.D., Virginia Mason Cancer Center, Seattle, WA, Secretary.

Newly-elected board members are: Ronald D. Deisher, M.A., The Cancer Institute, Kansas City, MO; John Feldmann, M.D., Mobile (AL) Infirmary Medical Center; J. Michael Ryan, M.D., Rice Memorial Hospital, Willmar, MN; and Connie Henke Yarbro, R.N., B.S.N., University of Missouri, Columbia, MO.

Newly-appointed Committee Chairs are: David K. King, M.D., Good Samaritan Medical Center, Phoenix, AZ, Ad Hoc Committee on Reimbursement; Carl Kardinal, M.D., Ochsner Clinic, New Orleans, LA, Ad Hoc Committee on Scientific Review; Donna Stover, R.N., B.S.N., Kalamazoo Community Hospital Oncology Program, MI, Ad Hoc Standards Committee; Diane Van Ostenberg, B.S., R.N., Grand Rapids (MI) Clinical Oncology Program, Bylaws Committee; James L. Wade, III, M.D., Decatur (IL) Memorial Hospital, Government Relations Committee; John Feldmann, M.D., Mobile (AL) Infirmary Medical Center, Membership Committee; and Michael Mohnsen, Mercy Medical Center, Cedar Rapids, IA, Program Committee. Members of the Nominating Committee are: Nancy Agee, Roanoke (VA) Memorial Hospitals; Paul N. Anderson, Cancer Center of Colorado Springs, CO; J. Gale Katterhagen, M.D., St. Joseph Medical Center, Burbank, CA; David K. King, M.D., Good Samaritan Hospital, Phoenix, AZ; and John W. Yarbro, M.D., Ph.D., University of Missouri, Columbia.'

Newly-appointed Special Interest Groups (SIG) Chairs are: Janene Centurione, Indiana Regional Cancer Center, Indianapolis, and Margaret Riley, St. Joseph's Hospital of Atlanta, GA, Co-Chairs, Administrator SIG; Albert B. Einstein, Jr., M.D., Virginia Mason Cancer Center, Seattle, WA, CCOP SIG; Robert Angeloni, Community Medical Center Foundation, Scranton, PA, Freestanding Cancer Center SIG; Dean Gesme, M.D., Mercy Medical Center, Cedar Rapids, IA, Medical Director SIG; and Catherine Harvey, R.N., Medical University of South Carolina, Charleston, Nursing SIG.

New ACCC Board members (left to right): John Feldmann, M.D.; Connie Henke Yarbro, R.N., M.S.N.; Ronald D. Deisher, M.A.; and J. Michael Ryan, M.D.

gate endpoints." In addition, Burke noted that since the Treatment IND rule was published in 1988, 12 INDs have been granted for cancer and AIDS' drugs.

FDA approval of GM-CSF and G-CSF took "328 days," according to Steven Gillis, Ph.D., President and Chief Operating Officer, Immunex Research and Development Corporation. And, "at least five human growth factors are in clinical trials," Gillis noted, including M-CSF, IL-1 and IL-2. According to Gillis, "oncology offers the biotechnology industry one of the largest opportunities for product development and clinical research."

"We are entering an exciting new era in cancer research," according to Emil Freireich, M.D., Professor of Medicine, The University of Texas Medical School. "Cytogenetics is helping to predict response rates and the quality of complete remissions," Freireich noted. "We are entering an era of cancer treatment on the basis of biologics, instead of the probability of remission." Nevertheless, Freireich is concerned about the "current state of clinical research." "After 20 years and the National Cancer Act, we "won't conquer cancer with only one billion per year [in funding]," Freireich contended. He warned that "the public will not tolerate the idea of no survival changes in breast cancer. Without a continual supply of innovative treatments, patients will go overseas for their treatment."

Moreover, "out of about 4,000 compounds screened annually, only five make it to phase I trials and only one is ultimately approved," said John F. Beary, III, M.D., Senior Vice President, Pharmaceutical Manufacturers Association. "In the opinion of many, FDA is an agency in crisis," Beary noted. "Manpower has decreased, the workload has increased, morale has declined, and the medical complexity of issues has increased." Beary contended that the "FDA needs a mission statement that balances safety with the timely approval of drugs."

Nevertheless, the state of cancer treatment has made some incredible advances, according to Emil Frei, III, M.D., Director and Physician-In-Chief, Dana Farber Cancer Institute. Dr. Frei, recipient of ACCC's clinical research award, noted that "at the time the clinical center at NCI opened, in 1955, people didn't believe chemotherapy was worth research." And, Frei, recalled, it wasn't until 1972 that we "recognized that if we wanted to cure different cancers, we needed interdisciplinary treatment." Moreover, when Frei and his colleagues designed the first randomized trials, acute lymphocytic leukemia killed 100 percent of patients in two to three weeks. Now, however, we have a 70 to 80 percent cure rate. "We not only found out we could cure the disease, but the technology was transferred out into the community."

Cancer Research 'Short-Changed': Rep. Durbin

The area of funding for cancer research has been "shortchanged" for the past 10 or more years, according to Richard J.

Durbin (D–IL). Durbin, the keynote speaker at the ACCC Congressional Breakfast, stressed the importance of "investing in basic science." The "area of cancer prevention and control is particularly important," he said. Nevertheless, "we have seen slow increases in such funding," he said, vowing to try and improve this year's 5.5 percent increase in funding. "Health research not only saves lives, but it saves money," Durbin said. For example, he pointed to the antineoplastic drug, cisplatin, which results in a "savings of $109 million each year versus a $56 million investment over 17 years by the National Cancer Institute."

Key RBRVS Issues Yet To Be Resolved

The final regulations governing the implementation of Medicare's Resource Based Relative Value Scale (RBRVS) of payment for physicians will be published in early October of this year, according to Charles Booth, Director, Office of Payment Policy, the Health Care Financing Administration (HCFA). Nevertheless, Booth noted that "clearly, a number of issues must be dealt with prior to implementation of the system in January 1992." For instance, HCFA has yet to determine how the system will reflect geographic variations in practice expenses and in malpractice costs. However, Booth predicted that HCFA will "probably continue to use Medicare's historical localities, at least for the first year of RBRVS. Early recommendations are to count most states as one payment locality, but to break up 10 to 15 states by metropolitan statistical localities." HCFA must submit its recommendations for geographic adjustments to Congress in July of this year.

Mr. Booth

Booth also noted that "it is necessary to better define visit codes, especially in view of "the disparity in the interpretation of CPT codes." To that end, the American Medical Association (AMA) has been developing, for almost two years, "a new series of evaluation and management (visit) codes to meet the requirements of RBRVS," according to Barry Eisenberg, Director, Division of Health Programs, AMA.

Noting that "management codes represent 35 percent of Part B Medicare billing," Eisenberg said that the AMA has been conducting extensive pilot tests of proposed new codes. The new codes will place "more emphasis on the problem the physician is dealing with and the complexity and degree of counseling," Eisenberg said. The sites of service will remain the same, but follow-up consultations "will be radically changed," he said. In the pilot tests, physicians in four states were asked to assign current and proposed new codes to patient visits.

However, Eisenberg said that it has yet to be decided if the new codes will include a time factor. He explained that the physicians participating in the pilot tests had "strong diversities of view on whether or not a time factor should be included. Their concern was how time is to be defined." The resolution of that issue, Eisenberg said, will "depend on empirical results of the pilot study," which, at the time of the ACCC Annual Meeting, were still in progress. But Eisenberg is confident that "we can achieve a better system;" one that ensures that physicians are paid "fairly and accurately" and one that decreases "nonuniformity and the consequent burden on physicians and office staff."

Reliance On 'Pure' Cancer DRGs Can Short-change Oncology Programs

The 45 "pure" cancer DRGs "may not be capable of identifying cancer as a primary diagnosis," said Marsha Prater, Product Line Administrator for Oncology at Memorial Medical Center, Springfield, IL. When the hospital assigned 14 additional DRGs to the oncology product line, they accounted for an additional 2.4 percent of total hospital admissions, a 3.9 percent increase in total patient days, and increased oncology's share of total hospital net revenue by 4 percent.

Other cancer programs also need "to examine the relationship between ICD-9 codes and the DRGs that tend to be closely associated with those codes," Prater contended, noting that "as much as 20 percent of the total oncology line of hospitals can be missed by using DRGs alone." In those cases where management did not find a close relationship between the ICD-9 codes and DRGs, "we examined physician practice patterns and, in an interactive process involving management, decided the placement of those DRGs to a specific product line," Prater explained.

Ms. Prater

Four of those DRGs (49, 167, 334, and 353) fell within a "90 to 100 percent concordance range," Prater said. An additional four DRGs (191, 149, 233, and 148) had a concordance range of "40 to 49 percent," but it was still clear that "oncologists were treating more of these admissions than the physicians associated with the other product lines," Prater explained. However, other DRGs, such as 75 and 77, which were "split between pulmonary medicine and oncology," were cases in which "the interactive management process came into play," Prater said.

"The oncology product line, as now defined by 59 DRGS, more accurately reflects physician practice patterns at the hospital, and we are capturing oncology patients with the same accuracy as ICD-9 codes," Prater said. Marsha Fountain, the Program Manager for Oncology at Harris Methodist Fort Worth (TX), said that including "DRGs that are traditionally left out of the cancer product line" increased the oncology program's contributions to the hospital from $1.5 million to almost $3 million." According to Fountain, "36.4 percent of our cancer admissions fell outside of the 45 traditional cancer DRGs. Clearly, we experienced better reimbursement and less bad debt for the DRGs that are traditionally left out of the cancer product line."

Fountain stressed the importance of having computer systems that allow cancer program administrators to "manipulate data a number of ways. I can analyze the data by payor, admitting physician, inpatient and outpatient services, length-of-stay, total charges, costs, etc. That is the kind of sophistication you need to truly manage your product line." ■