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In the News

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ACCC'S PRESENTATION TO THE NCAB

On February 26, 1997, then-ACCC President-Elect James L. Wade III, M.D., presented results of the Association's "Barriers to Care" survey at the 101st Meeting of the National Cancer Advisory Board (NCAB) in Bethesda, Md. The survey was distributed to 2,000 oncologists across the country; 329 responses were received. Results are based on 322 responses.

The survey sought to:

- study the perceived impact of managed care on medical oncologists' ability to deliver care
- determine if denied payments affect the clinical judgment of oncologists
- determine if certain types of treatments are no longer offered in practices heavily affected by managed care.

According to Wade, results of the survey show that 72 percent of responding physicians had active managed care contracts in 1995. Mean contribution of managed care revenue to total practice revenue was 24.9 percent—a significant contribution to medical oncology services at the community level.

Physicians who responded to the survey noted that 80 percent of their managed care contracts require prior authorization for services. Sixty-six percent of contracts impose a gatekeeper to monitor utilization, which can hinder patient access to clinical trials and other treatment.

Wade reported that 37 percent of total respondents reported insurer denial of patient participation in a clinical trial. As a result, a large number of medical oncologists (77.3 percent) acknowledged hesitating to place a patient enrolled in a managed care plan on a clinical trial because of a previous reimbursement denial.

Wade reported to the NCAB that physician hesitation is not limited to clinical trials and appears to be driven by payer type. Slightly more than 87 percent of oncologists hesitated to prescribe a bone marrow transplant for a patient enrolled in a managed care plan. That number decreases in half when patients are covered by either commercial insurance (41.5 percent), Medicare (39.5 percent), or capitated (38.5 percent) plans.

The contrast is even greater when medical oncologists are asked about their behavior in prescribing new, "expensive chemotherapy." Fifty-three percent of physicians hesitated to prescribe this treatment to patients enrolled in managed care plans, while only 13 percent of medical oncologists hesitated with patients covered by commercial insurance.

More than 50 percent of practices reported adding staff to help with the increased paperwork and communications required with managed care plans. And 55 percent of practices experienced difficulty reaching plans to clarify coverage. Interestingly enough, said Wade, 43 percent of physicians assume the burden of personally handling managed care appeals.

Immediately following Wade's NCAB presentation, Harold Freeman, M.D., member of the President's Cancer Panel, delivered his annual address. The President's Cancer Panel was created in 1971 to notify the President of any problems or barriers to the National Cancer Program. Freeman summarized results of the Cancer Panel's year-long study of the impact of managed care on the National Cancer Program.

In 1996 members of the Panel visited various parts of the nation to hear first-hand testimony to determine how recent changes in health care delivery have impacted the National Cancer Program. In the course of these meetings the Panel heard compelling testimony from a diverse set of constituents, including physicians and other providers of health care, patients, academic medical centers, government officials, and representatives of the pharmaceutical and biotechnical industries as well as representatives of managed care organizations. Freeman conceded that first-hand testimony can never substitute for scientific data. However, he did emphasize that anecdotes heard repeatedly from people throughout various parts of the country shed substantial light on managed care's increasing influence. "For the last several years the topic of managed health care has dominated the collective conscience of our nation," he stated.

Freeman organized the Panel's preliminary findings into several categories of managed care impact, including:

- funding of clinical cancer research studies
- patient access to clinical trials and clinical care
- managed care policies on physicians and institutions participating in clinical research
- education and training of future clinical researchers.
- the pharmaceutical and biotechnical industry's contribution to clinical research.

Clinical research. Historical sources of funding are shifting or disappearing, and there seems to be no replacement on the horizon. Restrictive managed care policies include: limiting health services utilization, negotiating provider contracts that may not cover providers' costs, capitating cost, and denying reimbursement for certain services that are provided with research initiatives. The Panel found that a managed care company may deny payment for care of a cancer patient if research is considered a part of the treatment, despite the likelihood that the care would have to be given in some form anyway.

In the experience of those who testified before the Panel, the for-profit managed care organizations have been unwilling to commit resources for health care

research and development, despite what may be seen as possible benefits. In light of this finding, support was virtually unanimous among those who testified for policies that would require all beneficiaries of clinical cancer care, managed care organizations as well as the government, to share in paying for research and education costs.

Patient access. Freeman reported that the Panel heard testimony suggesting managed care organizations are impeding access to trials by:

- denying reimbursement for clinical trial costs, including standard patient care costs associated with the trial.
- referring patients away from certain institutions of choice, either because treatment can be performed less expensively in a community setting or because the institution is not in the plan's network.
- requiring more paperwork and administration that may delay or disqualify a patient from entering a trial.
- shifting patients to generalists rather than to medical oncologists.

Managed care organizations appear to perceive that costs of trial-related patient care are higher than costs of conventional therapies. Concern was expressed to the Panel, according to Freeman, that trials may become skewed toward those that are more easily financed, such as shorter outpatient trials or studies that enroll only those patients with the financial and intellectual ability to navigate the health care system. In addition, important scientific questions may be disregarded. In one case, a trial was designed using a lower dosage, requiring less inpatient time and thus less difficulty in obtaining reimbursement, although the higher dose had been shown to produce a better result.

Concerns over access issues extend beyond clinical trials to concern that managed care is negatively impacting patients' access to supportive cancer care services, such as pain relief, symptom control, psychosocial care, and hospice care.

Freeman noted that the Panel is expected to deliver its final report on these findings to the White House in March 1997.

A DAY OF HOPE AND HUGS

On June 1, 1997, 650 communities throughout the United States will be celebrating the tenth annual National Cancer Survivors Day. The world's largest cancer survivor event will be a day filled with picnics and parades, concerts and carnivals, tree plantings, and camaraderie. For information on the celebration in your area, call the National Cancer Survivors Day Foundation at 615-794-3006.

STANDARDS FOR CANCER PROGRAMS

Your May/June 1997 *Oncology Issues* arrives with a special supplement: the new revision of ACCC's *Standards for Cancer Programs*. Among the changes are new chapters on ethics and pain management.

Kudos to the 1996-97 Ad Hoc Committee on Standards, which included Nancy A. Nowak, M.A., Chair; Edward L. Braud, M.D., Ronald D. Deisher, M.A.; Brian E. McCagh, C.H.E.; and Margaret A. Riley, M.N., R.N., C.N.A.A. Thanks also to SmithKline Beecham Oncology, whose generous educational grant allowed publication and distribution of this important document.