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Resource and Reimbursement Barriers to Comprehensive Cancer Care (CCC) Delivery: An Association of Community Cancer Centers (ACCC) Survey Research Analysis

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ACCC
Association of Community Cancer Centers

Background

- Comprehensive cancer care (CCC) is:
  - Recommended in guidelines
  - Required by accreditation bodies
  - Essential for high-quality cancer management
- Barriers prevent consistent access to and delivery of CCC
  - Barriers, such as insufficient reimbursement and lack of specialist staff
  - Particularly in supportive oncology services
- Community programs have limited access to philanthropy and similar funding
- ACCC conducted a representative survey of its member programs to:
  - Elucidate capacity and barriers to CCC
  - Inform policy and value-based payment reform

Comprehensive Cancer Care Service	Standard or Guideline
Distress/emotional/psychosocial support care	CoCStandard 5.2; ASCO 2014; NCCN DIS
Financial needs counseling and navigation	NCCN DIS-23
Fertility preservation consult	NCCN BINV-C
Nutritional consult	CoCStandard 4.7; NCCN FT-6, NCCN PAL-13
Clinical pharmacy services	NCCN OAO-I
Providing patients with a written multi-modality cancer care plan at diagnosis	OCM; NAM-IOM 2011 and 2013 "Information in a CancerCare Plan"
Anticancer therapy education (chemo education)	CoC; QOPI
Genetic counseling	CoCStandard 4.4; NCCN BR/OV-1
Oncology clinical trials	CoCStandard 9.1; ASCO and NCCN best practice
Image recovery (e.g. hair loss, wigs, skin care)	NCCN AYAO-6
Patient Navigation	CoC ; NAPBC Standard 2.2
Addressing practical needs (e.g., transportation)	NCCN DIS-23
Addressing family needs (e.g. child or elder care)	NCCN DIS-23
Advance Care Directive and Power of Attorney	NCCN PAL-29
Spiritual services	NCCN PAL, NCCN DIS-25
Dermatology consult for skin-related symptoms	NCCN FEV-10; NCCN ICI-DERM-1
Palliative care services	CoCStandard 4.5; QOPI 43; NCCN PAL-7
Hospice	NCCN PAL-27
Dedicated pain management	NCCN PAIN-1
Caregiver support	NCCN DIS-23
Vaccination during flu season	NCCN INF-7
Dental consult and care before select high risk systemictherapies such as bisphosphonates	ADA '08; American Dental Association MouthHealthy™
Bone health, (eg., DEXA scan)	NCCN BINV-16
Smoking cessation	NCCN SC-1
Survivorship planning	CoCStandard 4.8; ASCO survivorship; NCCN SURV-1
Prehab/Rehab and physical therapy services	CoCStandard 4.6; NCCN FT-7
Integrative oncology, e.g., acupuncture, massage	NCCN MS-15

Methods

- Survey development methodology included:
  - Item generation with expert review
  - Iterative piloting and cognitive interviews
- Online survey was piloted at the 2018 ACCC Annual Meeting and sent to member programs via email
- Final survey included 22 questions on:
  - Availability
  - Reimbursement/funding
  - Patient payment for 27/standard guideline indicated comprehensive supportive services
- Analyses were conducted with simple frequencies and SAS

Results

- 172 of 704 ACCC member programs responded and completed the survey as of October 7, 2019
- Respondent program demographics:
  - 39% are Safety-net providers with a significant level of care to uninsured, Medicaid, and other vulnerable populations
  - 28% of programs participate in The Center for Medicare and Medicaid Services Oncology Care Model (OCM)
  - Geographical locations: 22% rural, 27% suburban, 51% urban
  - Annual adult new cancer patients: 500 or less: 22%, 501-1000: 28%, 1001-1500: 20%, 1501 or greater: 29%
- Insurance coverage types:
  - Medicaid 11%, Medicaid primary with supplemental/secondary insurance 37%, Medicare only 19%, Dual Medicare/Medicaid 5%, Commercial private payer 23%, Uninsured 3%, Charity Care 2%

Respondent Commission on Cancer (CoC) cancer program categories	
Academic Comprehensive Cancer Program (ACAD)	10%
Community Cancer Program (CCP)	24%
Comprehensive Community Cancer Program (CCCP)	38%
Free Standing Cancer Center Program (FCCP)	1%
Hospital Associate Cancer Program (HACP)	3%
Integrated Network Cancer Program (INCP)	8%
NCI-Designated Network Cancer Program (NCIN)	8%
NCI-Designated Comprehensive Cancer Center Program (NCIP)	4%
Physician Practice	4%

Results

- Deficits in reimbursement are partially compensated patient out-of-pocket payments, grants, and donatio
- Of the 27 comprehensive cancer services:
  - For 8 of the services, 20% cancer programs report no billi code
  - For 10 additional services, over 50% of cancer programs re no code
- Most centers needing more staff in:
  - Psychology (61%)
  - Social Work (60%)
  - Navigation (59%)
  - Nutrition (57%)
  - Palliative Care (56%)
  - Genetic Counseling (52%)
  - Financial Counseling (53%)
- Gaps were observed regardless of region or practice type

n varies from 17 to 172	Is this service offered at your cancer program?	To what degree does revenue generated or total funding allocated at your cancer program cover the total needs of your population for each service?		If you bill for this service, what is the reason for gaps in reimbursement?	
		≤50% cost covered by reimbursement	≤74% cost covered by reimbursement	Reimbursed but not sufficiently	Rarely or never get paid for service
Distress management	92%	33%	44%	43%	22%
Fertility preservation*	42%	47%	47%	43%	0%
Genetic counseling	77%	29%	44%	66%	11%
Patient navigation	92%	33%	51%	9%	73%
Palliative care	79%	33%	54%	52%	2%
Survivorship care planning	86%	34%	49%	46%	22%
Nutrition consults	90%	37%	55%	35%	35%

Conclusions

- There is a lack of sufficient staffing, reimbursement, and budget to provide Comprehensive Cancer Care across the U.S.
- Oncology care models and reimbursement policies must include Comprehensive Cancer Care services to optimize delivery of care
- Over 50% of the cancer programs reported that 10 services have no coding and 8 services have limited or underutilized coding
  - Important to provide adequate services
  - Survey responses demonstrated that programs are not getting reimbursed adequately and, in some cases, can't offer services

Conclusions

- The analysis is not complete
  - We are collecting additional responses to the survey
- There is a need to estimate the costs of providing these essential services to include:
  - Appropriate use of codes currently available
  - Codes should be used routinely by centers
  - Calculate costs for services not currently reimbursed to develop uniform strategies for payment reform
- Cancer care centers will need to generate data to inform their true personnel requirements and costs of such with development of external partnerships to systematically link patients with services they cannot provide