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Toward Accountable Cancer Care

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Cancer accounts for over 500 000 deaths and nearly \$ 125 billion in medical costs annually, second only to heart disease. While interventions arising from the Affordable Care Act aim to improve care quality and reduce cost growth for patients with heart disease, reforms directed toward cancer care have received comparatively little attention.

Research and innovation have led to measurable improvements in survival and quality of life for patients with cancer. Treatment now often resembles the management of chronic disease, incorporating both acute in-patient and longitudinal outpatient care. However, the delivery of cancer care is inherently multispecialty and multisetting medical care that easily produces fragmentation, generating high costs and care variability.

Achieving accountable cancer care will require tailored payment and delivery system reform. Surgical, medical, and radiation oncology cancer specialists “quarterback” complex, interdisciplinary cancer care and symptom management. Their roles change and evolve with treatment phase, and most specialists do not provide the full scope of primary care services. Primary care providers (PCPs) continue to manage the comorbid illnesses of cancer patients, and over half of PCPs counsel patients on cancer treatment decisions involving major procedures.¹ This unsteady balance of patient care does not fit neatly into current concepts of accountable care organizations or medical homes, which focus on primary and preventive care, or medical neighborhoods.

Under the traditional fee-for-service system, cancer specialists are economically incentivized to deliver more care, be it surgeries, chemotherapies, or radiation fractions, rather than evidence-based care.² Fee-for-service payments also do not encourage better symptom management or care coordination among cancer specialists and between cancer specialists and PCPs. Uncoordinated cancer care results in overuse of unnecessary—and underuse of necessary—tests and treatments, avoidable hospitalizations, and gaps in the management of comorbid illness.

Three principles of reform should drive accountable cancer care. First, accountable cancer care should align provider incentives toward patient-centered, coordinated care among cancer specialists and PCPs. It is imperative that accountable cancer care move beyond fee-

for-service payment, separating cancer specialists' incomes from treatment choices. Second, accountable cancer care should foster guideline-concordant care. Third, accountable cancer care should provide feedback to patients, providers, and payers through population-based performance measurement of care quality, outcomes, and costs. Federally supported state cancer registries can help address the requirements of accountable cancer care but must be both expanded and upgraded to provide near real-time ascertainment of quality metrics, risk-adjusted outcomes, and costs.

CANCER CARE GROUPS

To meet the goals of accountable cancer care, we propose the establishment of Cancer Care Groups (CCGs), formalizing the multidisciplinary ethos of tumor boards. Cancer specialists would voluntarily establish CCGs with panels of surgical, radiation, and medical oncologists providing comprehensive cancer care throughout the arc of patients' progressive cancer care needs and coordinating care with PCPs and palliative care specialists.

Accountable cancer care should link guideline-concordant care to shared savings from bundled payments.³ The few cancer bundles have been proposed only within narrowly defined episodes of chemotherapy administration, limiting their potential to induce better symptom management and coordinated care.^{4,5} Rather, CCGs should be compensated under a bundled payment system, receiving a single payment for each patient according to the diagnosis and stage of disease, risk adjusted for factors like disease severity and comorbid illnesses, and adjusted for local cost of living.

For prevalent cancers, clinical guidelines recommend consensus-approved equivalently effective tests and treatments that can be used to price the bundle of medical services and duration of therapy. A reference point for the initial risk-adjusted payment would be the 50th percentile cost of guideline-concordant care for all patients nationally with that diagnosis and stage of cancer. The bundle would include costs of surgery, chemotherapy, irradiation, symptom management, and management of comorbid illness through care coordination with PCPs.

For many cancers, especially adjuvant therapy for common cancers, establishing the initial treatment service bundle will be straightforward. For other cancers, establishing the initial bundle will be challenging because of the large selection of available and acceptable, but disparate, treatments. For patients with meta-static disease, the bundle should promote early coordination with palliative care specialists.⁶

This bundled payment approach will reduce cost growth through incentives for cancer specialists to discontinue unnecessary or discretionary tests and therapies and to shift to lower-cost but still equivalent therapies. To promote integration and care coordination between cancer specialists and PCPs, a coordination payment could be shared between the CCGs and PCPs, derived from savings associated with reductions in uncoordinated care and avoidable emergency department visits and hospitalizations. Coordination payments will reduce mismanagement of symptoms, comorbid illnesses, and care transitions.

Performance measurement would be a key aspect of evaluating and paying CCGs. To promote high-quality care and to avoid skimping on necessary care, CCGs will be evaluated on the extent to which they provide cancer care that is consistent with professionally established guidelines, such as those published by the National Comprehensive Cancer Network. To promote improved outcomes, CCGs will be evaluated on the extent to which they fall short of, meet, or exceed risk-adjusted disease control and treatment-related complication benchmarks. Bonus payments—or withheld payments—should occur for CCGs demonstrating above-average—or below-average—quality and outcomes.

BARRIERS AND BENEFITS

Substantial barriers to fundamental reform exist, as do many uncertainties. The regulatory and legal structure to allow for shared savings to be distributed among unaffiliated cancer specialists and PCPs has yet to be established. Formal contractual relationships among cancer specialists to establish CCGs and between CCGs and PCPs (or medical homes) will facilitate coordination and shared savings, but CCGs may raise anti-trust or anti-kickback concerns. Some malignancies have a winding rather than linear treatment course that complicates bundled payment formation. Today's electronic medical record systems minimally facilitate integration, coordination, and performance feedback among physician practice groups and hospitals. At least initially, CCGs will be established in larger, often urban, health care markets, where investments in interoperability and data analytics are feasible. But over this decade, with greater experience, CCGs should be expanded to smaller markets.

Patients and cancer specialists may also mistakenly associate CCGs with the failed capitation efforts of the 1990s, where the focus was to reduce physician and hospital payment rates. However, there are clear differences.⁷ First, under the model we propose, patients and cancer specialists may choose among equivalent, guideline-concordant tests and treatments, not care as defined by payers. To insulate against bias in guidelines, CCGs might group together to establish independent boards, with representatives of the National Cancer Institute or the Patient-Centered Outcomes Research Institute, to review proposed bundles, ensuring inclusion of all appropriate treatment approaches, regardless of cost.⁴ Second, patients are not locked into care arrangements with specific CCGs. By retaining patient choice of providers, this model promotes natural competition among CCGs for patients based on performance. Third, rather than cutting physician payments across the board, CCGs reward cancer specialists and PCPs for delivering high-quality cancer care and reducing cost growth. Fourth, under the diagnosis-based bundled payment model, few services would not be captured by the episode, restricting the potential for cost shifting. Fifth, CCGs would be an optimal structure to introduce, test, and evaluate new cancer treatments, to be facilitated by pass-through payments as needed, and allowing for observational comparisons of real-world effectiveness.

CONCLUSIONS

The CCG represents a new structural and payment-reform vehicle that has the potential to drive toward accountable cancer care. Implementing the initial pilots necessary to demonstrate the feasibility of CCGs will require strong resolve and collaborative effort on the part of patients, cancer specialists, PCPs, and public and commercial payers. We must move forward to assure that cancer care of the highest quality is available to cancer patients while minimizing crippling cost growth.

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