Abstract #31

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

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BACKGROUND

Comprehensive cancer care (CCC) delivery is recommended in guidelines, required by accreditation bodies, and essential for high-quality cancer management. Barriers such as insufficient reimbursement and lack of specialist staff, prevent consistent access to and delivery of CCC, particularly supportive oncology services.

Challenges persist in community programs, where access to philanthropy and similar funding is limited. ACCC conducted a representative survey of its member programs to elucidate capacity and barriers to CCC delivery in the community setting in order to inform policy and value-based payment reform.

METHODS

Survey development methodology included item generation with expert review, iterative piloting and cognitive interviews to achieve content and internal validity. An online survey was piloted at the 2018 ACCC Annual Meeting and sent to member programs via email. The final survey included 22 sets of questions on availability, reimbursement/funding and patient payment for 27 standard/guideline indicated comprehensive supportive services, see table below. Analyses were conducted with simple frequencies and SAS.

Comprehensive Cancer Care Service	Standard or Guideline
Distress/emotional/psychosocial support care	CoC Standard 5.2; ASCO 2014; NCCN DIS
Financial needs counseling and navigation	NCCN DIS-23
Fertility preservation consult	NCCN BINV-C
Nutritional consult	CoC Standard 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 Cancer Care Plan"
Anticancer therapy education (chemo education)	CoC; QOPI
Genetic counseling	CoC Standard 4.4; NCCN BR/OV-1
Oncology clinical trials	CoC Standard 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	CoC Standard 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 systemic therapies such as bisphosphonates	ADA '08; American Dental Association Mouth Healthy™
Bone health, (eg., DEXA scan)	NCCN BINV-16
Smoking cessation	NCCN SC-1
Survivorship planning	CoC Standard 4.8; ASCO survivorship; NCCN SURV-1
Prehab/Rehab and physical therapy services	CoC Standard 4.6; NCCN FT-7
Integrative oncology, e.g., acupuncture, massage	NCCN MS-15

CONCLUSIONS

There is a lack of sufficient staffing, reimbursement, and budget to provide comprehensive cancer care across the United States, regardless of region or practice type.

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 essential services have no coding and that 8 services have limited or underutilized coding. This is important to provide adequate care. The survey responses demonstrated that programs are not getting reimbursed adequately and, in some cases, can't offer services.

Additional analyses will be completed, including further comparison according to service, payer mix, reimbursement, and staff/resources providing said service(s).

There is a need to estimate the costs of providing these essential services. When doing so, the appropriate use of available billing codes should be considered. Costs of services not currently reimbursed should also be factored in when developing uniform strategies for payment reform.

Cancer care centers will also need to generate data to inform their true personnel requirements to provide said essential services. External partnerships may need to be developed to systematically link patients with services they cannot provide as a component of their comprehensive care plan for each patient.

For more information and to download this poster: https://www.accc-cancer.org/projects/comprehensive-cancer-care-survey/comp/abstract-31-resource-and-reimbursement-barriers-to-care-delivery-at-asco-qcs

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RESULTS: 204 of 704 ACCC member programs responded as of 03.25.20.

Respondent Program Demographics:

- 42% are Safety-net providers with a significant level of care to uninsured, Medicaid and other vulnerable populations.
- 33% 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%

Respondent Commission on Cancer (CoC) cancer program categories	
Academic Comprehensive Cancer Program (ACAD)	9.5%
Community Cancer Program (CCP)	22%
Comprehensive Community Cancer Program (CCCP)	42%
Free Standing Cancer Center Program (FCCP)	1%
Hospital Associate Cancer Program (HACP)	4%
Integrated Network Cancer Program (INCP)	7.5%
NCI-Designated Network Cancer Program (NCIN)	7.5%
NCI-Designated Comprehensive Cancer Center Program (NCIP)	3%
Physician Practice	3.5%

Insurance Coverage Types: Medicaid 17%, Medicare primary with supplemental/secondary insurance 18%, Medicare only 15%, Dual Medicare/Medicaid 11%, Commercial private payer 17%, Uninsured 13%, Charity Care 9%.

Screening: Formal screening of comprehensive care needs for patients by respondent cancer programs was under 40% for: palliative care, physical therapy/prehab/rehab, family needs, vaccines (flu), fertility, dental, bone health; under 60% for: smoking cessation, advance care directives, spiritual needs, addressing practical needs, nutrition needs; under 80% for treatment side effects, pain management needs, fatigue and financial needs. For distress/emotional/psychosocial support screening the rate was 92%.

Cost and Reimbursement: Despite a high proportion of programs offering supportive oncology services, gaps between cost and reimbursement were present for all (Table).

n varies from 28 to 200	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/never get paid for service
Distress management	95%	33%	50%	42%	21%
Fertility preservation*	44%	35%	52%	32%	4%
Genetic counseling	65%	27%	39%	63%	8%
Patient navigation	94%	36%	51%	20%	65%
Palliative care	84%	28%	50%	52%	1%
Survivorship care planning	90%	36%	52%	45%	27%

Fertility preservation was not offered on site for over 70% of the responding member programs

Deficits in reimbursement are partially compensated by patient out-of-pocket payments, grants and donations. Of the 27 comprehensive cancer care services, for 8 of the services over 20% cancer programs reported no billing code, and for 10 additional services over 50% of cancer programs report no code.

Staffing: Most centers report needing more staff in psychology (61%), social work (60%), navigation (59%), nutrition (57%), palliative care (56%), financial counseling (53%), and genetic counseling (52%). Gaps were observed regardless of region or practice type.