

### ***The Impact of Health Care Reform on Academic Cancer Centers***

Much of the discussion regarding health care reform and its implications for cancer care delivery has focused on community oncology practice, with far less attention being paid to the impact on academic cancer centers and the patients they serve. As currently conceived and implemented, health care reform does not provide much consideration of the mission of academic cancer centers. For example, financial incentives and organizational innovations—such as accountable care organizations—may prove beneficial for the health care system as a whole, but may actually be detrimental to academic cancer centers.

Academic cancer centers have a unique mission that places them at a disadvantage when low cost of care becomes the key priority. Unlike many community hospitals and medical groups, academic cancer centers are responsible both for educating new physicians and making groundbreaking research discoveries. Training and research are costly and their impacts are not always immediately measurable. An investment in a medical student's experience today might result in a skilled practitioner or clinical investigator decades hence. Researchers have shown that financial incentives aimed at improving health care quality and lowering health care costs may have the unintended consequence of harming organizations with special missions and/or special patient populations, such as academic cancer centers. Therefore, it has been suggested that special consideration should be given to academic cancer centers in regards to implementing certain aspects of health care reform.

The Physician Payments Sunshine Act, or “Sunshine Act,” passed as part of the Patient Protection and Affordable Care Act in 2010. This law is designed to bring transparency to financial relationships between physicians and teaching hospitals and the pharmaceutical industry. The Sunshine Act requires manufacturers of pharmaceutical drugs and devices, as well as group purchasing organizations, to report payments or transfers of value to a physician or teaching hospital, whether made directly or indirectly through a third party. Transfers of value include such items as research payments, travel, honoraria and speaking fees, meals, and educational items such as textbooks and journal reprints.

There are many interactions between physicians and manufacturers that benefit patients and advance the art and science of medicine. These interactions often drive innovation, discovery, and changes in medical practice that may promote better patient outcomes. The Sunshine Act transparency reports provide patients and the public with information on the financial interactions of physicians and industry. While scrutinized that the content of such reports are detrimental if taken out of context, the congressional sponsors of the ACA have stated that the Sunshine Act is not designed to stop, chill, or call into question beneficial interactions between physicians and industry, but to ensure that they are transparent.

On July 10, 2014, the National Comprehensive Cancer Network® (NCCN®) hosted the NCCN Policy Summit: *The Impact of Health Cancer Reform on Academic Cancer Centers* at The Westin Arlington Gateway in Arlington, Virginia. The intent of the summit was to examine the impact of the Sunshine Act on academic physicians, as well as to provide a forum for stakeholders to discuss the impact of current health care reform efforts on academic cancer centers. Among the topics to be considered were shift in site of care, narrow networks, and the cost and quality of care delivered at academic cancer centers.

Robert W. Carlson, MD, Chief Executive Officer of NCCN, opened the policy summit by welcoming the attendees and setting the stage for discussion by providing some basic information on academic medical centers. Academic medical centers in the United States combine clinical services, medical education, and research activities and train 80,000 resident physicians each year. There are 141 medical schools in the U.S. with approximately 400 affiliated hospitals. While academic medical centers account for only six percent of hospitals in the U.S., it is estimated they deliver up to 25% of clinical care in the country, including 40% of the charity care and the vast majority of highly specialized services, such as comprehensive cancer care, trauma centers, and burn units. These centers also conduct nearly half of the external research that is funded by the National Institutes of Health.

Dr. Carlson closed by enumerating a number of current threats to academic cancer centers. These include decreased federal funding for medical education and research, decreased venture capitalism, narrow networks offered in health insurance exchanges, expanding Medicare and Medicaid populations and the corresponding lower reimbursement, a shift in payment models, and the demonstration of value.

### ***The Physician Payments Sunshine Act – Keynote Addresses***

Anita Griner, MBA, PMP, Centers for Medicare and Medicaid Services (CMS), started the session by covering the intent, basics, and implementation of the Physician Payments Sunshine Act. CMS is the federal agency charged with implementing this law, which it has dubbed “Open Payments.” Ms. Griner explained that collaborations between physicians and the medical industry can have both positive and negative aspects. On the positive side, they can promote the discovery and development of new technologies that improve health and/or lower costs. On the negative side, such collaborations have the potential to influence professional judgment and create opportunities for unintended consequences, including conflicts of interest. CMS views its role as a neutral party responsible for creating transparency and providing information to consumers that is understandable, palatable, and contextualized. Ms. Griner explained the genesis of the Sunshine Act in the ACA and provided definitions of applicable manufacturers, group purchasing organizations, and covered recipients, as well as what types of payments must be reported. She also described the reporting, review, and dispute processes and indicated that there are multiple resources available to assist all who are impacted by this law. These resources include a series of tutorial videos, fact sheets and user guides, two continuing education modules for physicians, a live help desk, and mobile applications. They can be accessed at <https://go.cms.gov/openpayments>.

F. Marc Stewart, MD, Seattle Cancer Care Alliance, followed and presented general background on conflict of interest and unintended consequences and concerns around the Sunshine Act. Dr. Stewart described the basic tenets of the physician-industry relationship. He noted that academia performs a majority of basic medical research, as industry view such activities as risky, but once the basic science is established, industry is able to carry the development much faster than academia. This is the basis of much collaboration. Dr. Stewart noted that all parties must recognize and manage the tensions associated with ethical conduct and self-interest, including career advancement and profit.

Dr. Stewart touched upon the financial incentives and drivers for industry and physicians. Oncology is a growing area of health care spending, and both industry and physicians stand to benefit from increased spending. Industry engages physicians in a multitude of ways, including speaking engagements, research trials, and lectures.

Dr. Stewart then questioned whether the Sunshine Act will actually provide transparency and change or if it is just another “bureaucratic obstacle.” He noted that the information reported as a result of the Sunshine Act does not in and of itself say whether undue influence has occurred. It merely reports that there is a financial relationship between parties. He also remarked that analyses of state-based Sunshine laws revealed little effect on the prescribing practices of doctors or prescription drug expenditures.

Dr. Stewart then noted five concerns or possible unintended consequences relative to the Sunshine Act. These include the collection of too much irrelevant information; whether consumers will have the ability to correctly understand and interpret reported information; whether there is really a relationship, or just the illusion of a relationship (e.g., transparency versus translucency); the possible inhibition of collaboration between academia and industry; and the potential addition of more cost to the health care system.

Dr. Stewart summed up his presentation by noting that, in his opinion, the Sunshine Act in its current form brings translucency—not transparency—to industry-physician relationships and also brings many unintended consequences. He stated that substantial progress has already been made with self-declared policies for managing conflict of interest and enforcement of relevant laws. He suggested three potential options for moving forward, including modifying the Act, determining if the Act works, or repealing it. He ended by noting that whatever happens, the vast majority of physicians and pharmaceutical professionals will continue to dedicate their lives to improving patient care.

### ***The Physician Payments Sunshine Act Roundtable***

The keynote addresses were followed by a roundtable discussion that included Matt Farber, MA, Association of Community Cancer Centers; Ms. Griner; Diedre Meehan, JD, Johnson & Johnson; Jon Retzlaff, MBA, MPA, American Association for Cancer Research; Samuel Silver, MD, PhD, University of Michigan Comprehensive Cancer Center and American Society of Hematology; Dr. Stewart; and Andrew Zelenetz, MD, PhD, Memorial Sloan Kettering Cancer Center. The panel was moderated by Clifford Goodman, PhD, The Lewin Group, and covered issues raised by the keynote speakers, including use of Sunshine Act data by patients, the ability of the system to identify and remove outliers, and whether the Sunshine Act will or should change physician behavior.

Dr. Goodman started the discussion by asking the panelists if the Sunshine Act is necessary. Many thought the Act is well-intentioned and there is value in a national program to collect conflict of interest information, but that modifications to the current program are needed. Others said it was not needed, noting limitations and concerns, including cost (both financial and time), transparency, proper contextualization of data, timing with other data releases, and the ability of patients to understand the data reported.

Ms. Griner explained that CMS put much thought and research into what data elements should be collected. CMS, she noted, is making efforts to remain flexible and understand who the stakeholders are and what they need. She also addressed the issue of contextualization by noting that industry can submit contextual information for every single transfer of value. CMS has a disclaimer on the report that notes that the reporting of information does not imply unethical conduct. Ms. Griner also noted the need for professional organizations and patient groups to help physicians and consumers have open dialogues about the Sunshine Act.

The next topic discussed was the impact of the Sunshine Act on physicians. Dr. Silver noted that some younger physicians want “squeaky clean score sheets” and are unwilling to participate in activities that have any link to industry, including continuing medical education (CME). He said that innovation requires the mixing of different perspectives and that, if people become afraid to mix, the impact will be huge. He also said that physicians are already responsible for reporting potential conflicts of interest to other entities, including their own institutions and federal grantors. Mr. Farber commented that some community physicians are turning away industry representatives and, in turn, are not getting key clinical information or patient assistance information.

Ms. Meehan spoke about the impact of the Sunshine Act on industry. The Sunshine Act has created a tremendous amount of administrative and IT work for industry, and, while large companies like Johnson & Johnson are equipped to handle Sunshine Act reporting, small companies may struggle with it. Ms. Meehan observed that reporting of indirect payments is more challenging and companies are being cautious as they are liable for accurate information.

Dr. Goodman challenged the panel as to whether the Sunshine Act goes overboard in collecting too much data, asking whether so much information is needed to catch the “bad guy”? Ms. Griner explained

that finding the balance between identifying the bad guys and encouraging relationships that breed innovation is complicated and CMS will be open to evolving the requirements and policy over time.

The panel deliberated the impact of the Sunshine Act on innovation. Currently the impact is unknown, but Dr. Zelenetz worried that some physicians may be fearful to collaborate with industry on clinical research, because, hypothetically, they could end up on the cover of *The New York Times* if a reporter analyzes the data, but does not understand the context of a large research grant. Ms. Meehan reported that she has had to alter how contracts are signed with clinicians to perform research.

Conversation then turned to how patients and consumers will utilize Sunshine Act information. The panelists were unsure what patients will do with the data and whether they will understand the context of transactions. Several panelists questioned whether the average patient with cancer will even care about the data. Some patients may look favorably upon a physician who works closely with industry; others may not. It was suggested that physicians could take a proactive approach with patients and let them know about any relationships with manufacturers of prescribed drugs.

Dr. Goodman asked the panel to define what success will look like for the Sunshine Act. “Is success the number of hits to the website? Changes in physician behavior?” he asked. Ms. Griner opined that, in the eyes of legislators, success will be a positive impact on the cost of care, while, for CMS, success will be the smooth implementation of the law including accurate and timely information. Dr. Zelenetz suggested that success would be the elimination of outliers.

The panel came to an end as Dr. Goodman asked how patients should utilize Sunshine Act data. Panelists responded that physicians should be forthcoming with disclosures, Sunshine Act data should be used in conjunction with other data to create a holistic picture, and patients should ask questions of their physicians. Dr. Zelenetz said that he would emphasize that this data reflects his main mission to educate patients and physicians and conduct research.

### ***Effects of ACA on Academic Cancer Centers - Keynote Addresses***

Kavita Patel, MD, The Brookings Institution, started the afternoon session by presenting background on the ACA, including its implementation timeline and the patchwork effect of both Medicaid expansion and insurance exchanges. She commented that “we never really thought this many states would depend

on a federally-facilitated exchange,” and that this large dependence on the federal government may have been the partial cause of some of the problems with the Healthcare.gov web site.

Dr. Patel discussed implementation challenges, including website woes, policy cancellations, and a lower-than-expected enrollment rate, along with an older-than-anticipated enrollment mix. She touched on the effects of Medicaid expansion and narrow networks on academic cancer centers, noting that narrow networks can be found in both private insurance plans and plans offered through the federal and state exchanges. Dr. Patel mentioned an Associated Press article from March 2014 that surveyed NCCN Member Institutions about their inclusion in health exchanges and reported that only four out of 19 respondents were included in all exchange plans offered in their region.

Dr. Patel highlighted several areas of the ACA where she believes there will be major changes in the near future. These include the 340B Drug Discount Program, the Medicare payment system, diagnostic testing, and quality measurement. She predicted that the traditional fee-for-service model will become less prevalent and the reimbursement model for academic oncology will switch to a combination of medical homes, episodic type payments, and accountable care arrangements.

Following Dr. Patel, Tim Ferris, MD, MPH, Massachusetts General Hospital Cancer Center, focused on national spending on cancer care and the rising costs of delivering cancer care. Dr. Ferris covered drivers of cost growth, such as the increasing incidence of cancer due to an aging population, greater utilization of services, introduction of high cost therapies, and the shift of care from physician offices to hospital outpatient departments. He stated that accountable care organizations (ACOs) are, in fact, slowing the rate of rise in health care spending, but cancer costs are rising faster than all other health care services. He suggested three possibilities for how increased costs in oncology might be addressed in the future:

- Efficiencies in cancer care will be found that allow the rate of cancer care spending to grow without increasing total health care costs (i.e., grow at  $\frac{1}{2}$  its current growth rate); OR
- Efficiencies found in other health care provision will be used to subsidize the cost of cancer care;  
OR
- The new high-cost therapies for cancer care will have to be financed separately from other health care financing.

Dr. Ferris talked about the implications of increasing health care costs for physicians, recommending that the focus be on keeping health care cost increases as close to the rate of general inflation as possible. One potential solution is to assume some financial risk for the costs of care in the form of shared saving models (ACOs), bundled payments, and global payments. Dr. Ferris noted that both physicians and health systems must develop tactics that will be successful under any payment model.

Dr. Ferris then described programs at Massachusetts General Hospital Cancer Center that are addressing quality and cost, highlighting the risk contracts the institution has with the Medicare, Medicaid, commercial, and self-insured service lines. Dr. Ferris spoke briefly about the wide range of population health management (PHM) programs in place and focused on a Medicare demonstration project that dealt with complex care management in which hospitalization rates and emergency room visits were reduced while creating cost savings of 7.1%. Several PHM programs in the oncology space were also mentioned.

### ***Effects of ACA on Academic Cancer Centers Roundtable***

The keynote addresses were followed by a roundtable discussion that included Christian Downs, JD, MHA, Association of Community Cancer Centers; Dr. Ferris; Louis Jacques, MD, ADVI; Terry Langbaum, MAS, The Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins; Donald Liss, MD, Independence Blue Cross; Dr. Patel; Caroline Pearson, Avalere Health; Brian Rosen, JD, The Leukemia and Lymphoma Society; and Julie Anne Wolfson, MD, MSHS, City of Hope Comprehensive Cancer Center. The panel moderator, Dr. Goodman, started the roundtable discussion by delineating six topics he hoped the conversation would address. These were: narrow networks, state exchanges, patient composition, value added to cancer centers, the 340B drug program and the future survival of academic cancer centers.

Dr. Goodman started the discussion by asking the panelists about the extent of network exclusions and the threats they pose. Ms. Pearson explained that one of the driving forces behind narrow networks is the need for health plans to keep their costs low in order to attract and enroll customers. Another issue she mentioned is the problem that arises for patients when their physician participates in a particular plan, but a hospital or facility where the physician works does not. Mr. Rosen spoke about a study the Leukemia & Lymphoma Society commissioned to study benefit design, premiums, and network adequacy of qualified health plans in California, Florida, Michigan, New Jersey, New York, Texas, and

Washington. The study revealed that very few of the National Cancer Institute (NCI) designated cancer centers in these states were participating in qualified health plans, creating gaps for patients.

Dr. Goodman then asked Dr. Liss how Independence Blue Cross (IBC) approached network development. Dr. Liss explained that IBC convened focus groups of consumers to learn what was important to them, and that price clearly emerged as the top priority in regard to choosing a plan on the exchange. Given that finding, IBC's approach was to establish a tiered network that includes varying levels of coinsurance, copayments, and deductibles depending on the physician or facility selected by the patient. Ms. Langbaum questioned the composition of the focus groups used by IBC, pointing out that younger and/or healthier people are generally more focused on cost than what their insurance actually covers, whereas those who have been ill previously or have had experience with health insurance tend to look more carefully at what is actually covered, convenience of providers, and outcomes. Panelists mentioned two additional aspects of networks that are important to patients – geographical access and availability of subspecialists.

Dr. Jacques observed that all cancer cases are not uniformly complicated, and they do not all need to be treated in an academic cancer center. However, he stated, it is important that access to academic cancer centers is available when it is warranted.

Dr. Goodman then steered the conversation toward the definition of quality and how academic cancer centers, in particular, could demonstrate value. Dr. Liss commented that he would like to see more patient-centered outcomes to help define quality, while Ms. Langbaum said that value could be found in academic cancer center specialization, such as certain complex surgical procedures done in high volume centers or radiologists who read scans for one particular type of cancer all day long. She also stated that while many academic cancer centers have data that show improved survival, they are reluctant to share it. Dr. Wolfson described her recently published [study](#) that examined survival rates and access for 70,000 patients with breast, cervical, colorectal, gastric, hepatobiliary, lung, oral, or pancreatic cancers treated in Los Angeles County between 1998 and 2008. The study found improved five-year survival rates for patients treated at NCI-designated comprehensive cancer centers along with decreased risk of mortality compared to patients treated at community hospitals.

Dr. Ferris suggested there is a need for greater transparency around quality data so that comparisons can be made. Dr. Liss reminded the audience that value is in the eye of the beholder. One patient may value outcomes while another values convenience. He also addressed how difficult it is to engage patients in using quality data for decision-making. Dr. Patel spoke about two companies, Castlight and Flatiron, both of which work with data in the health care space and are able to collect, analyze, and lead their customers to make decisions based on quality and value.

In response to an audience inquiry, Dr. Ferris elaborated on justification of higher cost care at academic medical centers, explaining that such institutions do many things that other medical centers do not, including conducting research, teaching, and innovating. He also said that, in proportion to their numbers, they have a higher market share of patients, which increases costs. Additionally, he said, academic medical centers are usually the providers of services that are valued by society, such as burn units and child psychiatry, but are not as highly valued by current payment systems, resulting in cross-subsidization of other services by oncology. It was also noted that many consumers choose their health plans when they are healthy and not thinking about specialized services they might need in the future, so they are not focused on whether their plan includes an academic health center. Ms. Langbaum commented on the importance of training oncologists for the future and how the value of that teaching and research can be measured as part of the higher costs of academic medical centers. Ms. Pearson suggested we need a system that allows patients access to academic centers when they need them.

Dr. Goodman closed the panel discussion by asking what academic medical centers will look like in 2020 following health care reform efforts. Panelists responded that academic centers will be more integrated with the community practices, cancer care will be carved out, Medicare fee-for-service will be gone, there will be consolidation to large integrated delivery systems, large provider entities will assume risk, value-based contracting will be more prevalent, and there will be a balance between academic and community centers.