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ALSO IN THIS ISSUE

SP450

AACR

American Association
for Cancer Research*

FINDING CURES TOGETHER®

DISPARITIES DISCUSSIONS. The 15th American Association for Cancer Research (AACR) Conference on the Science of Cancer Health Disparities in Racial/Ethnic Minorities and the Medically Underserved covered links between neighborhood adversity and breast cancer and new data science devoted to disparities research. Addressing disparities in cancer care was a theme of the AACR Progress Report, **SP450-SP453**.



LIBUTTI



LICITRA

EXPERTS AT RUTGERS. A conference at Rutgers' Ernest Mario School of Pharmacy featured a

discussion on payment models with Steven K. Libutti, MD, FACS, director, Rutgers Cancer Institute of New Jersey, who spoke about the potential for bundled payments, and Edward Licitra, MD, PhD, chair and CEO of Astera Cancer Care, who reviewed advances under the Oncology Care Model, **SP424**.

FIVE YEARS OF CAR T-CELL THERAPY.

The FDA approved the first chimeric antigen receptor (CAR) T-cell therapy on August 30, 2017, and Bitu Fakhri, MD, of Stanford Medicine discusses how treatment for diffuse large B-cell lymphoma has never looked back, **SP429**.



FAKHRI



MOONSHOT UPDATE.

The National Comprehensive Cancer Network's fall policy summit featured an update on Cancer Moonshot 2.0 from the program's coordinator, Danielle Carnival, PhD, **SP449**.

NEW INDICATION.

FDA approves pemigatinib (Pemazyre, Incyte) for myeloid/lymphoid neoplasms with *FGFR1* rearrangement, **SP463**.



TECHNOLOGY

The Promise of Telehealth—A Cautionary Tale

Implications of Telehealth Use on the Future of Oncology Care

Neil Minkoff, MD; Joshua Greenblatt, BFA; and Yana Volman, MBA

EDITOR'S NOTE: This is the second installment of a 2-part series on the rise of telehealth during COVID-19 and its implications. Part I appeared on ajmc.com on September 15, 2022. See <https://bit.ly/3R3fMaV>

OPTIMIZING TELEHEALTH POST COVID-19 will be a balancing act. Despite its meteoric rise during the height of the pandemic, telehealth's application in complex, chronic, and/or life-threatening conditions may continue to present challenges.¹

Clear opportunities and advantages of telehealth for ambulatory patients or those in remote or rural areas are already evident. Providing diagnostic evaluations and follow-up consultations through virtual visits delivers value and efficiency. Easier and increased access to care may boost medication adherence, which can improve patient outcomes and potentially reduce the overall cost of care.

Many oncology practices embraced telehealth during COVID-19 as a cornerstone of safety for patients with cancer, many of whom are immunocompromised, only to discover added value. Beyond merely limiting unnecessary in-person patient visits to clinics, some practices report a more comprehensive and effective application of telehealth.



Many oncology practices embraced telehealth during the COVID-19 pandemic to protect immunocompromised patients, only to discover its added value.

CONTINUED ON SP486 »

PAYMENT MODELS

Wither the RO Model: Focusing on Access to Spread the Value of Radiation Therapy

Anne Hubbard, MBA

THE AMERICAN SOCIETY FOR RADIATION ONCOLOGY (ASTRO) has long advocated for an alternative payment model (APM) that recognizes the high-value care that radiation oncology provides to patients with cancer, and the society will continue to do so despite the indefinite delay of Medicare's Radiation Oncology (RO) Model announced in August.

Annual Medicare expenditures for radiation oncology services, both in the hospital outpatient setting and in the freestanding setting, equate to just over \$4 billion, which is significantly less than the more than the \$6 billion that CMS spends on just the top 3 cancer drugs.¹ Despite its high value in comparison to other oncology services, radiation oncology has experienced significant payment reductions in the Medicare Physician Fee Schedule resulting in a 27% cut between 2010 and 2019, when adjusted for utilization and inflation.²

CONTINUED ON SP489 »

PRECISION MEDICINE

At Last, Artificial Intelligence Is Transforming Cancer Drug Discovery and Development

Dietmar Berger, MD, PhD

AFTER SPENDING MORE THAN 3 decades as a hematology/oncology researcher and physician, it is invigorating to be living in and working through a "golden age" in cancer research.

The past 50 years have seen extraordinary strides in oncology treatment, leading to significant advances in patients' outlook and quality of life. However, as scientists we cannot ignore that most patients with advanced disease still face unacceptably low 5-year survival rates.¹

CONTINUED ON SP488 »

Wither The RO Model: Focusing on Access to Spread the Value of Radiation Therapy

ANNE HUBBARD, MBA

CONTINUED FROM COVER

This rate instability in recent years has resulted in practice consolidation, creating access to care issues that have an outsized impact on populations that experience health care disparities. CMS' continued efforts to shift more resources from specialty care to primary care mean that radiation oncology is likely to face additional cuts in coming years, necessitating a new payment model that ensures payment stability and safeguards patient access to state-of-the-art care.

ASTRO is committed to improving quality and reducing costs as part of a value-based payment model for radiation oncology, and this transition also presents a unique policy-based opportunity to improve outcomes for underserved populations. As designed, the RO Model does not provide sufficient resources to help minority, rural and other underserved populations overcome barriers to accessing and completing cancer treatment. In fact, the model's severe discount factors, waiver of the Advanced APM bonus on technical payments and onerous reporting requirements would exacerbate health disparities by causing disproportionate burden for practices who serve these populations. Future rulemaking can address these shortcomings; however, with a more reasonable payment methodology and the inclusion of wraparound services that help patients complete the cancer care this model was designed to support.

Jeopardizing Access to Care for Underserved Populations

Resource investment and interventions are necessary to address barriers facing patients from medical underserved populations to ensure that they have adequate access to treatment; otherwise, disparities in care will persist.

A Mayo Clinic analysis of the RO Model indicated that practices caring for patients from socioeconomically disadvantaged populations would face significant revenue reductions under the model, resulting in access to care issues for the communities they serve.³ According to the analysis, the RO Model base reimbursement rates for late-stage cancers were surprisingly lower than historical rates. Under the RO Model, this change would have resulted in a dramatic reduction in reimbursement for practices that treat patients with advanced cancers, which are disproportionately more prevalent among racial/ethnic minority and rural populations.

Decades of research have demonstrated that patients from racial/ethnic minority and rural populations are more likely than White patients to present with advanced-stage cancers, due largely to limited access to preventive services. For example, Black patients (12.3%) and Hispanic patients (10.5%) present with clinically advanced-stage prostate cancer more frequently than White patients (6.3%).⁴ Additionally, Black women are more likely than White women to receive a breast cancer diagnosis at an advanced stage of disease.⁵

Patients with late-stage cancers often receive palliative radiation therapy, which reduces pain and improves quality of life for patients with metastatic cancer. Despite this benefit, Black patients are 20% and 28% less likely to receive palliative radiation therapy for prostate and colorectal cancer, respectively, when compared with White patients.⁶

The RO Model in its current form would potentially exacerbate these health inequities for several reasons; for example, its

90-day bundle only recognizes/reimburses for 1 disease site, while patients with advanced cancers often have multiple sites of metastasis.⁷

Additionally, while cancer incidence and mortality rates in the US are declining, rural-urban differences in access and outcomes persist. Rural health care providers and their patients face many challenges in the delivery of care, such as limited availability of physicians and treatments, transportation barriers and financial issues. A recent study found that a substantial portion of the US population still suffers from poor geographic access to radiation therapy, with nearly 2% of the population (6 million people, 1 million of whom are aged 65 or older) living more than 50 miles from a radiation therapy facility.⁸ The authors recommend policies and technologies that aid geographically isolated populations to ensure no patient gets left behind, yet the RO Model would have done the opposite.

Radiation oncologists that provide care in rural communities or to underserved populations serve patients who are more likely to be covered by Medicare or Medicaid programs, rather than privately funded employer-based health plans. Due to this payer mix, this group of physicians typically has more limited financial resources than their peers in other areas.

Another recent analysis demonstrates that there would have been a significant disparity between urban and rural RO Model participants' capacity to deliver high-value treatments such as stereotactic radiation and brachytherapy.⁹ According to the study, rural practices under the model would be less likely to have technology that supports shorter, more cost-effective radiation treatment regimens for patients. Additionally, a report last year from the Government Accountability Office stated that providers in rural, shortage, or medically underserved areas face financial, technology, and other challenges in transitioning to APMs. These include barriers related to capital to finance the upfront costs of the transition, purchasing electronic health record technology and acquiring the data analysis necessary to comply with the reporting requirements.¹⁰ Cuts, in lieu of investments, are likely to further disadvantage rural clinics and their patients.

Finally, radiation oncologists that provide care in rural communities or to underserved populations serve patients who are more likely to be covered by Medicare or Medicaid programs, rather than privately funded employer-based health plans. Due to this payer mix, this group of physicians typically has more limited financial resources than their peers in other areas. This financial reality makes it difficult to invest in the resources necessary to participate in value-based payment programs. »



Anne Hubbard, MBA, is director of Health Policy, American Society for Radiation Oncology (ASTRO).

Addressing Disparities Through Health Equity Achievement in Radiation Therapy (HEART)

ASTRO recommended numerous reforms to the RO Model including the establishment of a Health Equity Achievement in Radiation Therapy (HEART) scoring methodology based on social determinants of health that would trigger a payment for wrap-around services to address healthcare disparities.

HEART payments could support services that are not currently billable, such as:

- 24/7 triage for patient needs
- Patient care navigation
- Coordination of care and communication with other care providers engaged in the patient's treatment
- Documented survivorship plan developed in coordination with the patient and other care providers and issued upon completion of treatment.

Symptom management clinics or triage units established in oncology settings have proven to be successful at reducing costs and ensuring patients have access to resources that improve their quality of life during their treatment. These units are typically run by nurse care managers that meet with patients during regular clinic visits to assess symptoms associated with radiation therapy and provide guidance regarding self-management, as well as treatment follow up. A University of North Carolina Chapel Hill study demonstrated significant savings associated with the implementation of a symptom management program leading to reduced unnecessary emergency department visits and inpatient admissions.¹¹ Programs such as this are currently not reimbursable—and therefore difficult for smaller practices to establish—yet they have a substantial impact on the patient's quality of life and the cost of care.

A similar initiative pursued by Cone Health, a regional multihospital health system in Greensboro, North Carolina, created a transportation hub to remove barriers to treatment by identifying patients at risk for not pursuing or completing treatment through the establishment of a real-time registry managed by care navigators.¹²

Implementing the program flattened the gap in treatment completion rates for early-stage breast and lung cancer between Black and White patients, and it improved completion rates for all patients. After the intervention, treatment was completed by 88.4% of Black patients and 89.5% of White patients, up from 79.8% and 87.3% before the wrap-around services were implemented. Survival rates also rose for both Black and white patients, and the historical gap in survival between the groups was eliminated. A HEART payment could support initiatives such as these to ensure that patients from underserved populations can achieve improved health outcomes.

Transportation barriers are particularly salient for radiation oncology, given that radiation therapy treatments often require daily clinic visits lasting several weeks and interruptions can negatively impact the ability to control disease progression. A recent study indicated that regions with the least access to radiation therapy are disproportionately rural and have older populations that are more likely to be uninsured, placing these patients at higher risk for not securing adequate care.⁸

Data associated with episodes that include a HEART payment could be collected and used to determine the effectiveness of HEART interventions. By learning more about what drives disparities and which interventions are most effective at closing gaps, radiation oncology teams and patients can actively work together to reduce health disparities. Additionally, meaningful quality measures can be established to measure treatment interruptions, completion of the radiation therapy episode of care and duration of treatments.

Despite the evidence supporting these reasonable modifications to improve the RO Model, CMS ignored concerns from radiation oncology stakeholders about the model's impact on health disparities. ASTRO continues to believe that radiation oncology represents a unique opportunity to address health disparities and establish stable payment for high-value radiation oncology services. We will continue to work toward achieving these goals. ♦

AUTHOR INFORMATION

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