American Society of Clinical Oncology Policy Statement: Opportunities in the Patient Protection and Affordable Care Act to Reduce Cancer Care Disparities


ABSTRACT

Patients in specific vulnerable population groups suffer disproportionately from cancer. The elimination of cancer disparities is critically important for lessening the burden of cancer. The Patient Protection and Affordable Care Act provides both opportunities and challenges for addressing cancer care disparities and access to care. The American Society of Clinical Oncology (ASCO) advocates for policies that ensure access to cancer care for the underserved. Such policies include insurance reform and the reduction of economic barriers to quality health care. Building on ASCO’s prior statement on disparities in cancer care (2009), this article summarizes elements of the health care law that are relevant to cancer disparities and provides recommendations for addressing major provisions in the law. It outlines specific strategies to address insurance reform, access to care, quality of care, prevention and wellness, research on health care disparities, and diversity in the health care workforce. ASCO is committed to leading efforts toward the improvement of cancer care among the most vulnerable patients.

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INTRODUCTION

Years of research have led to the development of screening and treatment methods that have improved cancer survival in the United States. Although there has been a 14% decrease in mortality from all cancers combined from 1991 to 2004, not all segments of the American population have experienced this reduction in cancer mortality. Although multiple identifiable factors contribute to decreased access to quality health care, racial and ethnic minority groups have significant disparities in cancer outcomes, even after controlling for insurance and income. Racial and ethnic minorities consistently have poorer health as a consequence of other substantial obstacles to receiving care, including less access to state-of-the-art health care.

The 2002 Institute of Medicine report titled “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care” defines a “disparity” as a difference in treatment provided to members of different racial (or ethnic) groups that is not justified by the underlying health conditions or treatment preferences of patients. The American Society of Clinical Oncology (ASCO) follows the National Cancer Institute’s definition of “cancer health disparities” as “differences in the incidence, prevalence, mortality, and burden of cancer and related adverse health conditions that exist among specific population groups in the United States.” In 2006, Journal of Clinical Oncology published a special issue on cancer disparities to address cancer disparities from a broad perspective. In 2009, ASCO issued a policy statement highlighting the importance of eliminating disparities in cancer care and the need to provide meaningful opportunities for all Americans with cancer to secure health care coverage.

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA) as well as amendments to PPACA under the Health Care and Education Reconciliation Act of 2010. This legislation provides opportunities and challenges for addressing disparities in cancer care. PPACA has the potential to expand access to care and improve cancer care among vulnerable groups. However, PPACA alone will not solve the problem of cancer disparities but instead builds a new foundation for creating meaningful policy changes.

As the preeminent professional organization for cancer physicians and researchers, ASCO has a special responsibility to help identify the clinical needs of patients with cancer and to help lead efforts to ensure the elimination of disparities in patient outcomes involving the prevention, diagnosis, and...
treatment of cancer. In the following policy statement, we summarize the elements of the health care reform law that are potentially relevant to cancer health disparities, and we identify potential opportunities and challenges that lie ahead in addressing disparities in cancer care within the framework established under PPACA.

**INSURANCE REFORMS**

In 2008, there were an estimated 46.3 million uninsured Americans, equating 15% of the United States population, plus an additional 25 million underinsured Americans. Racial and ethnic minorities suffer disproportionately in terms of their rate of being underinsured. In 2008, an estimated 13% of whites were uninsured compared with 32% of Hispanics/Latinos, 21% of African Americans, and 28% of Native Americans/Alaskan natives. Lack of health insurance leads to lower rates of cancer screening and suboptimal cancer care. According to the Congressional Budget Office, PPACA is expected to expand health insurance coverage to 32 million individuals by 2019 through a variety of measures and would increase the proportion of legal nonelderly residents with insurance coverage from 83% currently to 94% when the law takes full effect.

**Elements of the Health Care Reform Law**

Medicaid (Sec. 2001). PPACA expands Medicaid to individuals with incomes up to 133% of the federal poverty level (FPL), thereby adding 16 million to 20 million individuals to the Medicaid roster. This roughly translates to a potential 59% reduction in the number of uninsured. Funding for this increased coverage is subsidized by the federal government starting at 100% in 2014 and decreasing to 90% by 2020. PPACA also standardizes Medicaid benefits by guaranteeing a minimum package of essential services.

Health insurance exchanges (Sec. 1311, Sec. 1401). By 2014, health insurance exchanges must be established in all states. These exchanges are designed to provide an opportunity for individuals or small businesses to shop for health insurance. PPACA provides credits and premium subsidies to low-income US citizens (up to 400% of the FPL) who are not eligible for Medicaid so they can purchase insurance through these exchanges.

Elimination of coverage barriers (Sec. 1101, Sec. 2704, Sec. 2711, Sec. 2714). PPACA prohibits insurers from denying coverage to children with pre-existing medical conditions and allows young adults up to age 26 years to remain on their parents’ health plans. Starting in 2014, all insurers will have to accept all applicants, irrespective of pre-existing conditions, and renew coverage. The law prohibits canceling coverage, eliminates the lifetime amount insurance will pay for certain conditions, and restricts annual limits. Until Medicaid expansion and state exchanges begin in 2014, the law creates federally subsidized state high-risk pools for those with pre-existing conditions. This provision is particularly relevant to cancer disparities because racial and ethnic minorities suffer disproportionately from pre-existing conditions.

Concurrent care for children (Sec. 2302). Children with cancer, particularly those who are uninsured, are one of the most vulnerable and underserved groups within the oncology community. In the United States, approximately 10% of children are uninsured. Cancer is the leading cause of death by disease among 1- to 14-year-olds in the United States. In aggregate, childhood cancer is the sixth most common cancer in the United States. PPACA allows payment for services provided to children eligible for Medicaid who have voluntarily elected to receive hospice services, without foregoing coverage of and payment for other services that are related to the treatment of the child’s cancer.

**Challenges and Opportunities**

The Congressional Budget Office estimates that 23 million individuals will still be uninsured by 2019. Despite the provisions in the Health Care Reform Law, decreased access to quality cancer care will remain the most significant obstacle for vulnerable populations. A major concern with respect to the expansion of Medicaid is that participation of health care providers in Medicaid is in jeopardy, particularly in states that are economically poorer. Some health care providers may be unable to accept additional Medicaid patients because of low reimbursement levels, leading to lower access to health care. Currently, some states are reporting more cuts in Medicaid payments, further reducing the value of this coverage. The law provides for increased reimbursement under Medicaid (to Medicare rates) for primary care services for a limited number of years and for bonus payments for primary care and major surgical services performed in Health Professional Shortage Areas, also for a limited number of years. Neither of these provisions, however, would apply to care for patients with cancer.

Even more concerning is that there is convincing evidence that adult patients with cancer who are covered by Medicaid have poor clinical outcomes similar to those of uninsured patients. Therefore, Medicaid expansion would not necessarily be expected to improve cancer outcomes among vulnerable populations as the system currently stands. Given the anticipated expansion in the Medicaid population, the quality of care under the Medicaid program may be further compromised. Although it is preferable to provide uninsured patients with some kind of insurance, it is unlikely that simply expanding the Medicaid program in its current form will lead to substantial improvements in patient outcomes.

Also of great concern is inadequate reimbursement under the Medicaid program. Given the longstanding concern that current Medicaid coverage does not significantly improve individuals’ access to quality cancer care, policy makers should consider ways to improve coverage for Medicaid patients. Lower Medicaid reimbursement is particularly problematic in pediatric cancer centers that are mandated to provide a high level of care for all pediatric patients with cancer, regardless of insurance status. One approach would be to provide reimbursement at Medicare rates to those providers who care for all adults and children who are diagnosed with cancer and are enrolled in the Medicaid program. Such increased reimbursement is already provided on a temporary basis for primary care services in PPACA. Another strategy would be to allow individuals who are diagnosed with cancer and enrolled in Medicaid to have immediate, presumptive eligibility under Medicare. Although Medicare reimbursement itself is inadequate for cancer services and drugs, such a safeguard would represent an improvement compared with the current Medicaid policy for these vulnerable populations.

Recognizing that the primary goal of health care reform is to improve access to care for all Americans, ASCO is committed to ensuring that all people with cancer, particularly the underserved, have access to high-quality care. The legislation does not address the
cumulative effect of multiple cuts under Medicare to oncology reimbursement over the past years, and the law also creates mechanisms for potential new cuts in the future. For this reason, ASCO urges the US Department of Health and Human Services (HHS) to stop making Medicare reimbursement cuts to cancer care. ASCO conducted a poll in June 2010 and found that nearly one third of respondents indicated that they would be forced to accept fewer Medicare patients to their practice because of these cuts.

In the area of health insurance exchanges, ASCO urges the federal government to recommend and promote best practices for exchanges that will encourage the elimination of disparities in cancer care. Moreover, ASCO recommends that states exercise their discretion to go beyond the minimum federal requirements in protecting their citizens from experiencing disparities in health care.

Elements of the Health Care Reform Law

Community health centers (Sec. 10503, Sec. 5313). Community health centers (CHCs) serve an estimated one in three low-income people and one in four low-income minority residents.17 PPACA increases funding for CHCs to allow for nearly a doubling of the number of patients seen by the centers over the next 5 years. Grants are also authorized through the Centers for Disease Control and Prevention (CDC) to support community health workers. Eligible entities include hospitals, federally qualified health centers, and other public or nonprofit entities. Collaborations between CHCs and academic institutions are encouraged. The goals of these funds are to educate, guide, and provide outreach regarding health problems prevalent in underserved populations, to determine effective strategies for promoting positive behaviors, and to improve enrollment in health insurance.

Community-based collaborative care networks (Sec. 10333). PPACA authorizes grants to support community-based collaborative care networks. These networks are required to be a consortium of health care providers with a joint governance structure that provides comprehensive coordinated and integrated health care services for low-income populations and would include a safety-net hospital. Grant funds could be used to assist low-income individuals, provide case management and care management, perform health outreach, and provide direct patient care services.

Community health teams and medical homes (Sec. 3502, Sec. 2703). Under this program, the Secretary of HHS will provide grants for entities to create health teams that include an interdisciplinary, interprofessional team of health care providers. These teams would include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, and behavioral and mental health care providers. The purpose of these teams would be to work with primary care providers to provide integrated community-based care for their patients. Similarly, the medical home would allow states, under Medicaid, to make medical assistance payments at an enhanced federal match to a team of health professionals who provide a comprehensive set of medical services, including care coordination for patients with chronic conditions.

Pediatric Accountable Care Organization Demonstration Project (Sec. 2706). Under this program, the Secretary of HHS authorizes a participating state to allow providers of pediatric medical care who meet specified requirements to be recognized as an accountable care organization (ACO) for the purpose of receiving specified incentive payments. Participating states would be required to establish an annual minimum level of savings in expenditures for items and services covered under Medicaid and the Children’s Health Insurance Program (CHIP) that would need to be achieved by an ACO for the ACO to receive an incentive payment. ACOs that meet the performance guidelines established by the Secretary and achieve savings greater than the annual minimal savings level established by the state would receive an incentive payment.

Cultural competence (Sec. 5307). PPACA directs the Secretary of HHS to support the development of curricula for cultural competency programs. PPACA also directs the Secretary of HHS to collaborate with health professional societies, licensing and accreditation entities, and other experts. The goals of this provision are to evaluate adoption and implementation of cultural competency curricula and to facilitate inclusion of these competency measures in quality measurement systems as appropriate.

Linguistic competence (Sec. 2715). Effective in 2012, health plans are expressly required to present their summary of benefits and appeals processes in a culturally and linguistically sensitive manner. Summaries must be written in plain language so they can be understood by those with limited English proficiency.

Coverage for patients enrolling in clinical trials (Sec. 2709, Sec. 10103). PPACA prohibits health insurers from denying coverage of certain routine costs associated with clinical trial participation and from discriminating against patients who are participating in clinical trials. This is particularly relevant to cancer disparities because racial and ethnic minority participation rates in cancer clinical trials are disproportionately low.18,19 This provision aims to improve clinical trial enrollment by removing an economic barrier to participation.

Challenges and Opportunities

The PPACA moves in the right direction by substantially increasing funding for CHCs, which have served as the model for community-based health care for the last 40 to 50 years; however, the CHC model has been limited to date in its ability to ensure meaningful access to specialty care. This is especially problematic in cancer care in which a disconnect between diagnosis and treatment can be deadly. Specifically, between 69% and 79% of CHCs that do not have affiliations with hospitals for referrals to specialists report problems with obtaining specialty care for their Medicaid fee-for-service patients.20 ASCO urges Congress to consider reimbursing, at the enhanced Medicare rate, any specialist who formally agrees to take on the care of any cancer patient diagnosed at a federally qualified health center.

As currently defined, the community health teams and health homes center around the primary care physicians, including obstetricians and gynecologists. This offers a tremendous opportunity to develop a comprehensive coordinated strategy to reduce cancer incidence by improving cancer screening and helping individuals implement behavioral and lifestyle changes. It does less to ensure the coordination of care once a cancer diagnosis is made. Specifically, it is unclear whether a cancer-specific community health team under the guidance of a medical oncologist would be allowed. Given the unique care requirements for patients with cancer, ASCO believes that any form of integrated community care should allow for cancer-centered services under the direction of oncology professionals.
Another anticipated issue is that some of the most vulnerable Americans, particularly those with limited English proficiency, may not enroll in health insurance programs because of linguistic challenges and complex application procedures. The experience in Massachusetts may demonstrate the importance of removing language barriers. On July 1, 2007, a new statewide health insurance program was created in Massachusetts to provide subsidized health coverage for individuals below 300% of the FPL. All Massachusetts state residents were required to purchase health insurance coverage. However, 3 years later, about one third of the estimated 650,000 people who were previously uninsured remained uninsured.21,22 One of the potential reasons for persistent underenrollment is that individuals with limited English proficiency are less able to complete the application processes to obtain insurance coverage. ASCO recommends that adequate funding be made available to assist individuals applying for health insurance coverage.

Protecting access to clinical trials coverage is critical for addressing disparities in cancer care. In oncology, clinical trials provide a fundamental access point to care for many patients. In addition, there is a paucity of scientific data involving racial and ethnic minorities, and increasing participation rates in clinical trials is a critical step in acquiring such data. The new clinical trials regulations expressly require plans to take affirmative steps to ensure that all patients have meaningful access to clinical trials that are ethically designed and approved by institutional review boards and to show that administrative burdens are not used to create barriers to cancer care for anyone who might benefit from participation in a clinical trial. As PPACA is currently written, additional action from policy makers may be necessary to ensure that Medicaid patients are afforded the same protections for participation in clinical trials that apply to other individuals. In addition, because administrative barriers are likely to harm minority and underserved populations the most, health insurance plans should be required to document the steps they take to ensure that members of racial, ethnic, and low-income groups have meaningful access to clinical trials.

Challenges and Opportunities

Although improving quality of care will most certainly benefit minority patients who are often cared for in facilities with lower-than-average quality, such initiatives must be careful to not further weaken the efforts of providers who are struggling to care for these patients in a strained resource environment unless the tools are provided for them to improve their quality. Similarly, provisions such as penalties for increased readmission rates must take into account the reduced social support and high rates of comorbidities that are often seen in patients living in impoverished conditions, both of which may lead to higher-than-anticipated readmission rates. Reduced outpatient medical care services and the greater level of comorbidities among patients from underserved populations can also affect readmission rates and are important factors in determining risk-adjusted readmission rates. ASCO recommends that quality improvement efforts be conducted in such a way that providers caring for underserved patients are not penalized.

ASCO strongly supports the efforts underway to develop a strategy to improve quality, affordability, and access to care for patients and communities. In developing a national strategy to improve the quality of health care, ASCO recommends that quality improvement programs be patient centered. Any meaningful system for quality enhancement must address the different modes and locations of care. With respect to a quality improvement system, we can maximize the impact of our quality improvement initiatives by focusing on settings that have the most patient encounters. A critical function for quality systems is to examine and address disparities in health care. Clinical registries that include data from community-based settings can provide insight into the underlying causes of health care disparities and can point to possible strategies for addressing them.

In addition, ASCO recommends that in developing a national strategy to improve health care quality, policy makers recognize the important role that professional societies can play in promoting quality of care. ASCO’s national data-driven quality improvement program and clinical registry, the Quality Oncology Practice Initiative (QOPI), was launched in 2006 and includes nearly 700 oncology practices (representing more than 1,000 practice sites), which enables QOPI to serve as a significant and robust clinical registry and quality improvement system for ambulatory cancer care in the United States. QOPI provides an optimal platform for promoting quality of care in the diagnosis, treatment, and prevention of cancer while also providing a unique clinical registry for scientific and health services research involving patients with cancer. As a clinical registry, QOPI now contains well over 100,000 patient records. QOPI also provides a model for addressing quality improvement in other complex combinations of diseases that require highly specialized care.

Elements of the Health Care Reform Law

**National strategy to improve health care quality (Sec. 3011).** The Secretary of HHS is authorized to establish, through a collaborative process, a strategy to develop and test several measures to improve the quality of care being delivered. Reducing health care disparities is identified as a specific goal in developing these measures.

**Hospital Value-Based Purchasing Program (Sec. 3001).** Hospitals will be required to collect quality data for several indications such as acute myocardial infarction and hospital-acquired infections, and both incentive and penalty payments will be put in place through Medicare. In addition, specific penalties are put in place for hospitals with a larger than expected number of readmissions.

**Physician Quality Reporting System (Sec. 3002, Sec. 3007, Sec. 10327).** As with hospitals, physicians will be required to report quality data, and such information will be made public to allow for comparison. In addition, reduced Medicare payments are authorized for physicians who fail to meet reporting requirements or who fail to meet quality standards.

Elements of the Health Care Reform Law

**PREVENTION AND WELLNESS**

Early detection of cancer through adherence to recommended screening examinations leads to decreased mortality from most cancers. Racial and ethnic minorities experience lower rates of cancer screening and are more often diagnosed at more advanced stages of cancer.1

PPACA contains provisions for improving prevention and wellness care. It requires all health plans to cover preventive services that
receive an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF). These treatments must be covered with no deductibles or copays and with no maximums allowed. A list of many of the USPSTF recommendations relevant to cancer management is provided in Table 1.23

Table 1. USPSTF Grade A and B Recommendations Covered Under PPACA23

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Grade</th>
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<tbody>
<tr>
<td>Women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing</td>
<td>B</td>
</tr>
<tr>
<td>Biennial screening mammography for women age 50 to 74 years</td>
<td>B</td>
</tr>
<tr>
<td>Discussion of chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention</td>
<td>B</td>
</tr>
<tr>
<td>Screening for cervical cancer in women who have been sexually active and have a cervix</td>
<td>A</td>
</tr>
<tr>
<td>Screening for colorectal cancer by using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years</td>
<td>A</td>
</tr>
<tr>
<td>Screening all adults for tobacco use and providing tobacco cessation interventions for those who use tobacco products</td>
<td>A</td>
</tr>
<tr>
<td>Screening all pregnant women for tobacco use and providing augmented pregnancy-tailored counseling to those who smoke</td>
<td>A</td>
</tr>
</tbody>
</table>

Abbreviations: PPACA, Patient Protection and Affordable Care Act; USPSTF, United States Preventive Services Task Force.

Challenges and Opportunities

Although PPACA mandates that insurers cover preventive services receiving an A or B rating from the USPSTF without deductibles or copays, PPACA does not expressly require insurers to cover follow-up testing of abnormalities found during a cancer screening examination. For example, if a colonic polyp is found during a colonoscopy or if an abnormal breast mass is found during a screening mammogram, PPACA does not specifically require insurers to cover follow-up diagnostic examinations and biopsies. Similarly, insurers are mandated to cover genetic counseling of women with a high risk of having a BRCA mutation, but it is unclear whether they will be required to cover the cost of genetic testing in these high-risk patients. Since these tests may continue to be cost prohibitive for people with low incomes, individuals in vulnerable populations may continue to have lower rates of cancer screening. ASCO recommends that insurers be required to cover appropriate follow-up testing, without deductibles or copays, of abnormalities found during covered cancer screening services.

An additional concern is that, although USPSTF cancer screening recommendations are evidence-based, there is currently scant evidence about optimal cancer screening strategies for ethnically diverse populations. For example, it is well established that despite having a lower incidence of breast cancer, black women are more likely than white women to die of the disease. One significant reason is that breast cancers in young premenopausal black women are more likely to have unfavorable biologic characteristics, including higher proportions of estrogen receptor–negative tumors and high-grade tumors. Biennial mammography after age 50 would not be expected to improve this situation. ASCO recommends that health services–based research efforts to determine optimal cancer screening recommendations for diverse populations be supported. Results of such research would inform organizations such as the USPSTF when they issue comprehensive cancer screening recommendations.

Although the new legislation generally refers to prevention without any modification, the language suggests a focus on primary, population-level prevention. However, preventive services are critically important not only for the general population but also for cancer survivors and individuals at increased risk for developing cancer. ASCO urges policy makers to ensure that the scope of preventive services supported and advanced under PPACA includes the specific needs of cancer survivors and individuals at increased risk for cancer.

It is clear that PPACA’s provisions renew the focus on cancer prevention by emphasizing screening and renew the overall focus on health and wellness in the general population. What remains less clear is how these provisions, once implemented, will affect the growing number of individuals who have already been diagnosed with cancer and are at increased risk for developing secondary cancers and other diseases, which can occur as a result of cancer treatment, genetic predisposition, and/or lifestyle factors. Oncologists currently use a range of risk reduction strategies. Strategies for follow-up care for cancer survivors must be tailored to the individual, include referrals to appropriate subspecialists, and incorporate a summary of treatment and an outline of recommended monitoring and follow-up care. Adequate coverage and reimbursement for the development of cancer care plans and treatment summaries are necessary so that oncologists can facilitate the coordination of care in a manner described and endorsed by the Institute of Medicine’s National Cancer Policy Board.24

Finally, PPACA lacks a clear commitment to improving cancer survivorship care. The increasing number of cancer survivors increases the need for coordinated care for cancer survivors. ASCO calls for incorporating survivorship care plans into the standard care of patients with cancer and cancer survivors. ASCO has included treatment plans and summaries in QOPI. The Commission on Cancer, a multidisciplinary program of the American College of Surgeons, plans to implement a new accreditation standard of survivorship care plans effective in 2012. However, these unfunded initiatives will create financial challenges to physician practices. ASCO supports the Comprehensive Cancer Care Improvement Act, which would require a survivorship care plan and insurance reimbursement for its completion. If passed, the Act would establish Medicare payment for the development of a cancer care plan and the communication of that plan to the individual patient, establish reimbursement for the development of a treatment summary outlining follow-up care for survivors, and authorize a Medicare demonstration project to evaluate the cost and effectiveness of delivering comprehensive cancer care without limits that apply to hospice benefits.
**Elements of the Health Care Reform Law**

Data collection (Sec. 3101, Sec. 4302, Sec. 1946). Currently, health disparities research is hampered by the lack of reliable patient self-reported race and ethnicity data. Sample surveys are often of insufficient size to ensure reliable estimates for small racial and ethnic subpopulations. By 2012, PPACA requires that any federally funded public health and health care programs contain self-reported data on five items that are relevant to cancer disparities: race, ethnicity, sex, primary language, and disability. Geographic data at the lowest level (state, local, or institutional) should also be collected if such data can be aggregated. The Office of Management and Budget (OMB) standards will be used, at a minimum, for race and ethnicity measures and to develop standards for measurement of sex, primary language, and disability status. Some of the goals of this provision are to identify locations where individuals with disabilities access care, determine the number of providers with accessible facilities and equipment to meet the needs of individuals with disabilities, and assess training in disability awareness and patient care.

**National Center on Minority Health and Health Disparities and Office of Minority Health (Sec. 1707A, Sec. 10334).** PPACA redesignates the National Center on Minority Health and Health Disparities (NCMHHD) to status as an “Institute,” charging it with planning and coordinating all health disparity research within the National Institutes of Health. The law also moves the Office of Minority Health from the Public Health Service to the Office of the Secretary of HHS and establishes parallel offices in several HHS agencies, including the CDC, the US Food and Drug Administration (FDA), and the Agency for Healthcare Research and Quality (AHRQ).

**Patient-Centered Outcomes Research Institute (PCORI; Sec. 6301).** This nonprofit, nongovernmental entity is established to promote comparative effectiveness research by identifying research priorities, establishing a research agenda, and providing funding to conduct research that targets outcome differences in racial, ethnic, and sex subpopulations.

**Center for Medicare and Medicaid Innovation (Sec. 3021).** The purpose of the Center for Medicare and Medicaid Innovation (CMI) is to test innovative payment and service delivery models to reduce Medicare and Medicaid program expenditures while improving quality of care. The focus is to be on defined populations with deficits in care that lead to poor clinical outcomes or potentially avoidable expenditures.

**Challenges and Opportunities**

The data collection requirement is a step forward in gathering more meaningful information about race, ethnicity, and language, because these variables may not be accurate proxies for cancer outcomes disparities. However, sufficiently granular standards for data collection are lacking at this time. Currently, OMB standards list only five races (black or African American, white, Asian, American Indian or Alaskan native, and Hawaiian or Pacific Islander) and two ethnicities (Hispanic/Latino or non-Hispanic/Latino). These racial and ethnic categories are not always sufficiently descriptive to target interventions most effectively, and more granular population data are needed. Improving data collection will enhance important research resources such as the Surveillance, Epidemiology and End Result (SEER) -Medicare database leading to more accurate health services research. Additional guidance will be needed from the Secretary of HHS regarding moving beyond OMB guidelines, which might include studies to evaluate incorporating ancestral markers into the definition of racial or ethnic definitions. ASCO recommends that Congress work with ASCO and its QOPI program on collecting the data necessary to address cancer disparities and address the issues of how we capture data on race and ethnicity and of how we determine what data must be collected to make meaningful cancer evaluations.

The significance of elevating the NCMHHD to Institute status and increasing the authority and visibility of the Assistant Secretary for Minority Health cannot be minimized in terms of elevating health disparity research to a national priority and approaching the health disparity issue in a more coordinated fashion. Similarly, the creation of the PCORI holds great promise for conducting effectiveness studies of procedures and treatments with a focus on potential differential effectiveness in patient subgroups. However, the ultimate success of many of these efforts will rest on how well they are actually funded by Congress and how funds are allocated by the Secretary of HHS. The current law is essentially silent on these issues. ASCO urges Congress and the Administration to ensure that the newly designated and newly created offices have the resources and influence to help eliminate disparities in cancer care. In addition, ASCO urges these offices to work directly with ASCO and its QOPI program on practical steps for addressing disparities in cancer care and developing objective data. ASCO is committed to increasing prioritization of public and private research on cancer care disparities. To the extent that comparative effectiveness research provides a unique and important opportunity to collect data on real-world practices, ASCO urges the PCORI to support studies that evaluate relative disparities in care based on race, ethnicity, sex, and income status. In the context of limited resources going forward, it is important for Congress and the Administration to maintain a commitment to funding these efforts in a comprehensive and timely manner. ASCO will work with the newly elevated National Institute on Minority Health and Health Disparities and the PCORI to identify and prioritize research that specifically addresses solutions to reduce cancer disparities. For its part, ASCO funds grants and awards in health disparities research through ASCO’s Conquer Cancer Foundation and integrates health disparities research into scientific sessions of its Annual Meeting.

As a new center, the CMI will be vulnerable to strategies aimed at limiting funding to implement elements of PPACA. Given its broad mandate, there is no guarantee that the CMI will embrace bold proposals to transform the current payment models. We hope all members of Congress will see this as a golden opportunity to inject innovation into Medicare and Medicaid payment models and that the CMI sees this as an opportunity to embrace bold proposals. ASCO believes that cancer-specific innovative payment models focused on reducing disparities in cancer outcomes should receive high priority from the CMI, and ASCO hopes to work with CMI to create and test such models.
Elements of the Health Care Reform Law

PPACA expands initiatives to increase racial and ethnic diversity in health care professions. Grants of at least $250,000 annually are authorized to recruit individuals from underrepresented, disadvantaged, or rural backgrounds into the health professions; to develop and implement strategies to foster community-based training and education with an emphasis on primary care in underserved areas; to facilitate community-based field placements or preceptorships; to conduct interdisciplinary training involving an array of health professionals; to deliver or facilitate continuing education for health professionals with an emphasis on individuals who provide care in underserved areas and for health disparity populations; to propose and implement outcomes measurement and evaluation strategies; and to establish a youth public health program to recruit high school students into health careers (with a focus on public health careers).

Title VII Diversity Programs Reauthorized by Sec. 5401 and Sec. 5402 of PPACA

ASCO is committed to working with stakeholders to carry out programs aimed at enhancing the supply of minority physicians and to improve the training of the oncology workforce to meet the needs of racially and ethnically diverse patients with cancer. The ASCO Diversity in Oncology Initiative, funded by Susan G. Komen for the Cure, is designed to facilitate the recruitment and retention of individuals from populations underrepresented in medicine to careers in oncology. This initiative offers awards for clinical oncology or clinical research oncology rotation for medical students and travel awards for residents who are from populations underrepresented in medicine as well as loan repayment for oncologists or oncology fellows who agree to practice oncology in a medically underserved region of the United States. Within the context of limited resources going forward, it is important for Congress and the Administration to maintain a commitment to funding health care workforce diversity efforts in a comprehensive and timely manner.

Table 2. Title VII Diversity Programs Reauthorized by Sec. 5401 and Sec. 5402 of PPACA

<table>
<thead>
<tr>
<th>Program</th>
<th>Funding Details</th>
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<tbody>
<tr>
<td>Centers of Excellence</td>
<td>$50 million authorized for each fiscal year from 2010 to 2015 and such sums in subsequent years</td>
</tr>
<tr>
<td>Formula for funding allocations updated</td>
<td></td>
</tr>
<tr>
<td>Health Careers Opportunity Program</td>
<td>$60 million authorized for fiscal year 2010 and such sums for each fiscal year from 2011 to 2014</td>
</tr>
<tr>
<td>Scholarships for Disadvantaged Students</td>
<td>$51 million authorized for fiscal year 2010 and such sums for each fiscal year from 2011 to 2014</td>
</tr>
<tr>
<td>Faculty Loan Repayment Program</td>
<td>$5 million authorized for each fiscal year from 2010 to 2014</td>
</tr>
<tr>
<td>Maximum award increased from $20,000 to $30,000</td>
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For those unfamiliar with the lexicon of legislative language, there are two words or phrases that must be understood: “authorize” and “the Secretary shall . . . .” The word authorize must be understood in juxtaposition to the word “appropriate.” Congress can authorize that a sum of money be spent on an initiative over a defined period of time (as occurs multiple times throughout this legislation); however, this does not actually obligate Congress to spend this money. Every year Congress determines how much should be spent for the following 12 months. These authorized provisions are considered but may or may not be funded. In the context of constrained financing, ASCO urges Congress to remain committed to ensuring that we address disparities in cancer care.

The phrase “the Secretary shall . . . .” means that the details of implementation are left to the Secretary of HHS who accomplishes this through the regulatory process by issuing what are called rules and allowing public comment on these rules. This means that the actual details of much of this legislation remain to be specified. This phrase is used numerous times in PPACA. ASCO is committed to working with stakeholders in the interpretation of the health care reform law. Government agencies, state exchanges, and private plans should all work with ASCO and its QOPI program to apply the new law to individuals with cancer in a way that eliminates disparities in care. ASCO has special expertise and an interest in working with stakeholders.

In addition, numerous advisory boards and commissions are established under PPACA, some with very little authority and others with a great deal of authority to influence national health policy involving disparities. The composition and work of these commissions will need to be monitored closely as this process moves forward.
The elimination of disparities should be a primary focus of every advisory board established under the law. Objective measures that provide a sufficiently granular understanding of cancer care should be used throughout the health care system.

Finally, much of the administrative work of setting up the insurance exchanges and increasing Medicaid enrollment will fall to the states. The difficult financial situations faced by many states as well as opposition to PPACA by many state legislators and governors have implications for implementation of these elements of the law.

**CONCLUSION**

PPACA has the potential to provide a springboard for significant steps forward in reducing disparities in cancer care. This comprehensive legislation may meaningfully change clinical outcomes among the most vulnerable Americans diagnosed with cancer. However, despite the law’s many relevant and well-meaning provisions, it has serious limitations. Given the current fiscal climate in the United States, the sustainability of PPACA remains in question. The feasibility of its programs also remains to be seen. The wording of the law is vague and open to different interpretations. It is important to realize that PPACA provides a new foundation for making real progress in the elimination of disparities in cancer care. Table 3 provides a summary of the recommendations set forth by ASCO. Given the current constrained budget environment and political environment, ongoing efforts are being made within ASCO to prioritize these recommendations.

This policy statement is not a blanket endorsement of the health care reform law. We recognize that ASCO comprises a diverse membership of oncology providers and patients with differing opinions on many issues related to cancer care. However, ASCO recognizes that providing quality care to all patients with cancer, regardless of their...
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