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Medical News & Perspectives

ASCO Calls for Medicaid Reform to Improve Cancer Care for Beneficiaries

Rita Rubin, MA

State Medicaid programs must strengthen and expand access to high-quality cancer care for patients with low incomes, according to a new policy statement from the American Society of Clinical Oncology (ASCO).

About a fifth of the US population, or 67.9 million individuals, is enrolled in Medicaid, and an estimated 2.1 million of them either have cancer or have previously been treated for it, according to the ASCO statement (<http://bit.ly/1z64gyS>).

"The program's shortcomings mean that major gains in cancer treatment and prevention are still too far out of reach for many Americans," ASCO president Peter Yu, MD, a medical oncologist and hematologist and director of cancer research at Palo Alto Medical Foundation, said in November during a webcast in which he and 2 of the policy statement authors discussed it with journalists.

Published studies about the effect of Medicaid coverage on cancer diagnosis, treatment, and outcomes have been mixed, ASCO says. Some research has shown that, compared with privately insured individuals, Medicaid beneficiaries were more likely to be diagnosed with cancer at stage III or stage IV instead of stage I. Medicaid beneficiaries are approximately 3 times more likely to be diagnosed at a later stage with cancers that can be diagnosed early through appropriate screening, such as breast cancer and mela-

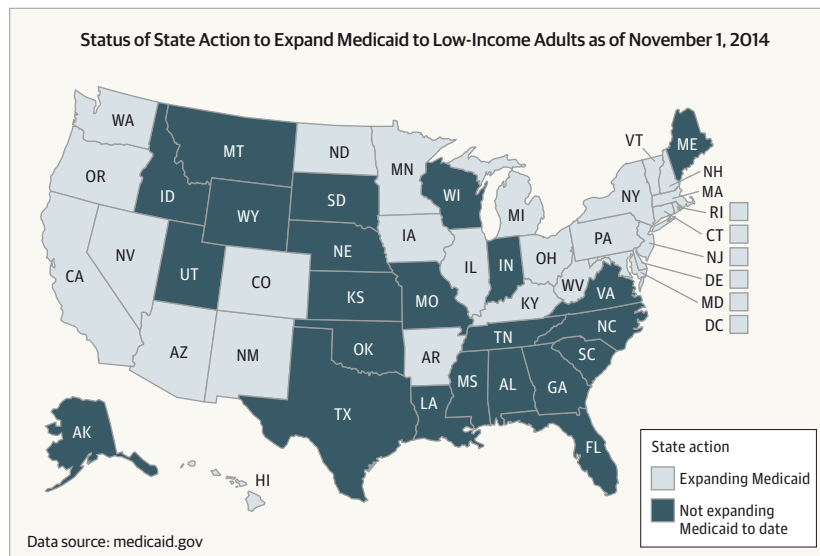
noma, according to ASCO, citing information from an analysis of data from the National Cancer Database (Halpern MT et al. *Lancet Oncol.* 2008;9:222-231).

"In some geographic areas, we have patients who are screened but have difficulty accessing treatment," Shelley Fuld Nasso, MPP, chief executive officer of the National Coalition for Cancer Survivorship, said during the ASCO webcast.

After accounting for potential confounders, however, some studies have reported similar treatment patterns and outcomes among patients with cancer who had

Medicaid and private insurance, while uninsured patients were significantly more likely to be diagnosed with advanced cancer, according to ASCO.

ASCO is calling on every state to expand Medicaid or provide comparable alternatives. Under the Affordable Care Act (ACA), the federal government is paying states the entire cost for 3 years—2014 through 2016—of expanding Medicaid coverage to all adults younger than 65 years who earn up to 133% of the federal poverty level. To be eligible for Medicaid, an individual could make up to \$16 105 a year, a family of



Several of the most populous states with larger underserved populations are not expanding Medicaid.

four, \$32 913, according to HealthCare.gov. By 2020, the federal government's share of Medicaid expansion costs would decrease to 90%.

As of mid-December, 27 states and the District of Columbia had decided to expand Medicaid, but some of the most populous states, including Texas and Florida, had not, leaving an estimated 40 000 individuals with cancer only limited access to care, according to ASCO. Although the number of

Raising Medicaid reimbursement for all physician services. Medicaid should pay the same as Medicare, according to ASCO.

Currently, the state Medicaid programs vary widely in what they pay physicians. In his analysis of 2007 Medicaid data, Halpern found that the median payment to primary care providers for an office visit was \$37—about half that of the average Medicare rate of \$73. At least a third of

ASCO members have decided they can't afford to care for Medicaid patients, lead author Blase Polite,

MD, MPP, said at the November webcast. "We believe that Medicaid rates should be moved up for all specialties to the Medicare payment," said Polite, an assistant professor of medicine at the University of Chicago and chair of the ASCO health disparities advisory group. "We are not trying to single out cancer here."

Reforming the 340B Drug Pricing Program so that it provides an incentive for providers to care for uninsured and underinsured individuals and Medicaid beneficiaries, which was its original intent, ASCO says.

Under this program, drug makers must provide outpatient drugs at greatly reduced prices to eligible safety-net providers, such as hospitals that serve a disproportionate share of Medicaid and Medicare beneficiaries.

Extending clinical trial protections in the ACA to Medicaid beneficiaries.

The ACA requires group health plans and individual or group health insurance products to cover routine patient care costs, such as physician visits and laboratory tests, associated with approved clinical trials. However, Medicaid was not specifically included in this requirement. Patients from racial and ethnic minority groups, who are already underrepresented in clinical trials, are overrepresented in the Medicaid program, so this oversight will further hamper research into their potentially different responses to or tolerance of treatment, ASCO says.

Allowing oncology practices to be designated as "medical homes."

As a medical home, oncology practices would receive monthly Medicaid payments to coordinate cancer patients' care in addition to traditional fee-for-service payments. For now, only primary care facilities can be designated as a medical home, but ASCO says that the services that define it, such as care coordination and aggressive management of chronic conditions, are the same as required by patients with cancer. "Fragmented care is a very, very important issue," says Siran Koroukian, PhD, an associate professor of epidemiology and biostatistics at Case Western Reserve School of Medicine, whose research was cited by the policy statement (Koroukian SM et al. *Cancer*. 2012;118[17]:4271-4279). The Medicaid population is more likely to have mental illness and other comorbidities, Koroukian says. "It's a very complex population with very complex needs."

Tying states' flexibility in running Medicaid with the need to meet predefined cancer quality outcomes for Medicaid patients. If they fail to meet those outcomes, the federal government would intervene.

Requiring coverage for genetic testing for patients at high risk for an inherited cancer risk syndrome.

ASCO's recommendations would all undoubtedly lead to improved care of Medicaid patients, but Congress is unlikely to add provisions to increase the cost and the scope of the ACA, says Lindsay Sabik, PhD, an assistant professor of health care policy and research at Virginia Commonwealth University.

"The states that have chosen to expand are states where they generally are more generous to begin with in terms of their Medicaid programs," says Sabik, lead author of a recent study of state Medicaid expansion decisions and disparities in women's cancer screening (Sabik LM et al. *Am J Prev Med*. doi:10.1016/j.amepre.2014.08.015 [published online October 29, 2014]). "States that have chosen not to expand have larger underserved populations."

But given the large and growing Medicaid population, even small improvements, such as increasing payments for visits to doctors' offices, could lead to better cancer outcomes, ASCO's Halpern says. ■

"We believe that Medicaid rates should be moved up for all specialties to the Medicare payment,"—Blase Polite, MD, MPP

beneficiaries in the expansion states jumped 22% over the past year, nonexpansion states saw an increase of only 5%, says Michael Halpern, MD, PhD, MPH, a senior fellow in health services research at RTI International and a coauthor of the ASCO policy statement.

Other steps ASCO says are needed to ensure that Medicaid patients receive the same level of cancer care as privately insured patients include the following:

- Eliminating differences in coverage between people who enrolled in Medicaid before and after the ACA.

For now, those who enrolled before the ACA tend to have more limited benefits. For example, the ACA mandates eliminating copays for cancer screening and diagnostic follow-up only for Medicaid beneficiaries newly eligible under expansion of the program but not for people who were already enrolled. In an analysis of 2007 Medicaid data, Halpern found that copayments, no matter how small, were linked to a lower likelihood of screening colonoscopy and Pap tests. Getting rid of copayments would be an "easy and important step" toward improving Medicaid beneficiaries' access to screening, he says.

- Adding coverage for oral cancer drugs. Medicaid typically covers all or nearly all of the cost of intravenous cancer drugs administered in physicians' offices or clinics. But beneficiaries might be responsible for paying up to 20% of the cost of oral chemotherapy, now a mainstay of cancer care.