Interview with Oncology Business Review (OBR) and Ben Jones, Vice President, Government Relations and Public Policy, McKesson Specialty Health at the COA Annual Meeting

Q: What is one hot policy topic that is impacting the delivery of quality cancer care today?

Jones: The top issue in cancer care – as it should be across the health care spectrum – is protecting access to quality care in the community setting. Unfortunately, barriers to access often exist through a culmination of multiple factors that make it difficult for many highly efficient community-based providers to keep their doors open.

From Part B drug payment reductions, disparity in reimbursement across sites of care, ambiguous fees and restrictions from PBMs to various other drivers of consolidation that allow hospitals to have a distinct advantage over physician practices – policies that have long contributed to these barriers need to be refocused and aimed at protecting access to high-quality community cancer care.

Day in and day out, community oncology providers are asked to do more, get paid less and navigate an increasingly complex regulatory environment – all while being reimbursed only a percentage of what hospitals are paid for delivering the same care – this must change, and we are working hard to ensure that it does.

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Ironically, these headwinds have intensified at the precise time that CMS and commercial payers are leaning on community providers as they explore efforts to drive value.

Q: What is your perspective on the shift in site of care and non-site neutral payments? Consolidation? How do we stop this trend?

Jones: Ten years ago, well over 80% of cancer care was delivered in the community setting. Today it is closer to 50%. This shift results in patients traveling longer for care that is often fragmented, less convenient, and more expensive.

Simply put, access to care is at severe risk due to the unlevel playing field in the provider community that often disadvantages physician offices. It is simply unsustainable to pay different rates for the EXACT same service depending on where the service is rendered. Especially when that rate is twice as high, as is the case with chemotherapy administration.

This higher payment rate for hospitals is on top of other built in advantages hospitals enjoy that are meant to cover purported overhead costs, like partial reimbursement for uncollectable bad debt, significant tax breaks, and at times, mandated drug discounts.

These perverse advantages incentivize the acquisition of physician offices. A move that often involves little more than changing the sign on the front door, but results in increased costs for the patients and payers.

Luckily, Congress took steps to address this unlevel playing field by requiring any new off-campus hospital outpatient department (HOPD) to bill under physician rates starting January 1, 2017.

We are actively meeting with congressional champions to expand this policy so that all outpatient care is treated and paid on a truly level playing field.

Q: With all the legislative changes being proposed, how are they going to impact the cancer patient experience? Especially with costs and if the American Healthcare Act is passed, with the pre-existing stipulation for cancer patients?

Jones: While the path forward on AHCA is not clear, it is likely to undergo a fair amount of changes from its current version before proceeding along the legislative process. With that said, at this point there are three principle issues of interest in the AHCA for cancer patients and providers: changes to pre-existing conditions and lifetime limits, relaxing of essential health benefits requirements, and changes to Medicaid coverage.

As everyone would agree, the Affordable Care Act dramatically reshaped the insurance market and overall healthcare delivery system in the United States. Many cancer patients became newly insured and many more were relieved that the pre-existing conditions provisions allowed them to move between plans/employers more easily. Many states also used the ACA as an opportunity to expand their Medicaid coverage and benefits.

With each of these provisions now facing an uncertain fate and potential adjustment, it will be vitally important for cancer patients and providers to remain engaged in the process to ensure that any changes are undertaken with an understanding of the impact to the cancer community. To echo former Vice President Joe Biden on his new cancer initiative “the only nonpartisan thing we have left out there is the fight against cancer.”

Q: On a local level, how can practices get a voice on local issues that is as effective as hospitals?

Jones: It is often unrealistic for community practices to match the level of engagement and activity of local hospitals – who are oftentimes the largest employer in a given locale. However, the passion of a community provider and his/her colleagues carries an enormous amount of political capital.

The key is to establish a relationship with your local policy makers and media outlets before you need them. These folks need to know who you are and what you are doing to help the community survive and thrive. Have an occasional open house. Invite your local elected officials for a tour or meet n’ greet.

Once you establish that relationship – grow it. Don’t let an opportunity pass to lend your support for local initiatives or offer insight into policy impacts. This relationship building is critical when it comes time to seek their support for your own federal/state priorities.

Don’t forget, all politics is local. Although cliché, it is just as pertinent now as it ever was.