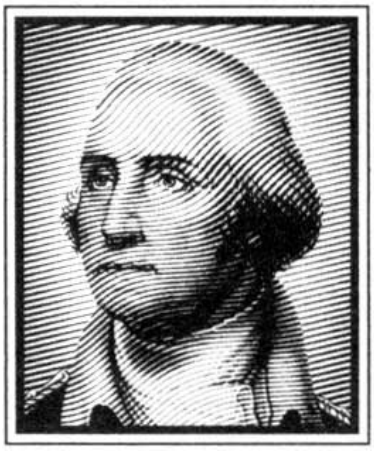

THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER

WASHINGTON DC

Cancer in the District of Columbia:

An Analysis of the Publicly Funded Health Care System and It's Impact on District Residents

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Executive Summary[1]

In 2010, 2,760 individuals received a new diagnosis of cancer in the District of Columbia. The District's residents have very high rates of insurance coverage and yet, DC ranked 6th highest in the nation for cancer deaths, third highest in the nation for colorectal cancer deaths, and first in the nation for deaths due to prostate, cervical, and breast cancers.

In order the explore the reasons for these troubling statistics The George Washington Cancer Institute and the School of Public Health and Health Services, Department of Health Policy began an effort to address this very significant public health issue. This paper was developed through a series of workgroup meetings organized by The George Washington University's Cancer Institute and the Department of Health Policy in the School of Public Health and Health Services and with generous contributions of time and information from individuals at the D.C. Department of Health (DOH), Department of Health Care Finance (DHCF), the D.C. Cancer Consortium, and cancer providers throughout the District.

The Workgroup has developed the following recommendations for policy-makers to consider:

- Improve reimbursement rates for providers of oncology services.
- Improve drug formularies for the Alliance and Medicaid programs to include commonly used and standard-of-care chemotherapy drugs.
- Improve chemotherapy drug reimbursement rates to at least levels sufficient to cover the cost of the drugs.
- Enforce the current managed care contracts to ensure the managed care contractors have sufficient numbers of oncology providers in their networks.
- Examine the fee-for-service program for adequate access to oncology providers.
- Include cancer and cancer survivorship in the Chronic Disease Collaborative.

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[1] This paper was written during 2010 and 2011 by staff of the G.W. Cancer Institute's Center for the Advancement of Cancer Survivorship, Navigation and Policy, including: Steven Patierno, PhD, Jennifer Leonard, JD MPH, Mandi Pratt Chapman, MA, Christina Cianflone, JD, Jennifer Lee, MD, Anna Stoto and Lucas Devine.

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- Eliminate unnecessary transitions for Medicaid enrollees between the managed care and fee-for-service programs.

- Provide adequate funding for cancer screenings and biopsies.

Introduction

This paper was developed through a series of workgroup meetings organized by The George Washington University's Cancer Institute and the Department of Health Policy in the School of Public Health and Health Services and with generous contributions of time and information from individuals at the D.C. Department of Health (DOH), Department of Health Care Finance (DHCF), the D.C. Cancer Consortium, and cancer providers throughout the District.

The workgroup, which included generous time contributions and data from DOH and DHCF staff, met to develop scenarios that exemplified common problems faced by District of Columbia residents who are diagnosed with cancer while insured by the District's Medicaid program or the D.C. Health Care Alliance program. The scenarios also, in certain circumstances, highlight the challenges in D.C.'s health care system as a whole, regardless of insurance status, and discuss how these challenges are exacerbated for the District's most vulnerable residents.

The goal of this paper is to start a dialogue on how to improve the health care system in a meaningful way. It goes without saying that reimbursement rates for oncology providers, hospitals, and the managed care organizations are a challenge for the District. However, the workgroup strongly believes that there are numerous administrative, structural, and practical changes that the District's Office of the Mayor, the administration, City Council, and health care providers could make to greatly improve the delivery of cancer care, and therefore survival, for its residents.

Cancer in the District

As the nation is poised on the threshold of major health care reform, residents in the District of Columbia continue to experience one of the most compelling examples of the necessity for reform: a disaster for publicly insured residents needing treatment for cancer.

Approximately 11,700,000 people in the U.S. are dealing with cancer in a given year.[i] In 2010, there were 1,529,560 newly diagnosed cases of cancer in the United States. Of those newly diagnosed, lung cancer was the most common newly diagnosed form of cancer, followed closely by prostate and breast cancer. Cancer accounts for 1 in 4 deaths, second only to heart disease.[ii] Moreover, nearly 1 in every 20 adults have survived cancer, including 1 in 5 of adults over the age of sixty-five.[iii]

In the District, 2,760 individuals received a new diagnosis of cancer in 2010.[iv] Prostate, breast cancer, and lung cancer were the three most commonly diagnosed forms of cancer (in that order), followed by colorectal cancer, Non-Hodgkin Lymphoma, urinary bladder cancer, uterine cancer, melanoma, and leukemia.[v] From 2000-2005, DC ranked 6th highest in the nation for cancer deaths, third highest in the nation for colorectal cancer deaths, and first in the nation for deaths due to prostate, cervical, and breast cancers.[vi]

Much research has focused on the effect socioeconomic status and ethnicity have on cancer survival, demonstrating that African Americans, specifically African American women, in DC are twice as likely to die of their breast cancers than white women despite the same or higher rates of screening mammography. Similarly, Latinas have a rate of screening mammography only slightly lower than non-Hispanic white women, but they present at later stages of the disease, possibly due to cultural barriers.[vii] Such disparities indicate the existence of barriers and problems navigating the health-care system, both to find timely diagnostic services and to get comprehensive, high-quality care after diagnosis. Here in the District, cancer provides an unfortunate example of the impact of health care disparities and a structurally challenged publicly funded health care system, resulting in very significant barriers to accessing life-saving care.

Health Care Coverage and Delivery in the District

Insurance coverage also plays a key role in cancer treatment and survival. Overall, Medicare covers nearly 56% of patients diagnosed with cancer, 33% of patients with cancer are privately insured, 4% are insured by Medicaid, and 5% are uninsured.[viii] Of those individuals under sixty-five, the rate of private insurance coverage rises to 70% and Medicaid to 6%.[ix] Interestingly, expenditures related to cancer care vary depending upon the type of insurance coverage. For example, Medicare expenditures at a patient's first cancer event average $6,080; private insurance expenditures average $6,550; Medicaid expenditures average $5,943; and uninsured individuals' expenditures average only $3,606.[x]

District of Columbia residents are fortunate to enjoy one of the lowest un-insurance rates in the nation, due in large part to its D.C. Health Care Alliance program, and generous Medicaid coverage.[xi] The D.C. HealthCare Alliance, founded in 2001, was established as a result of the closure of the District's public hospital, D.C. General, and its six public primary care clinics. The D.C. Health Care Alliance program (Alliance), a locally funded health benefit program for residents with incomes up to 200% of the federal poverty level who are uninsured and not eligible for Medicaid, covers an additional 50,000 residents.[xii2] Because the Alliance is funded solely through local dollars, its benefit package and rates are not subject to Federal requirements and may be changed more easily and without outside approval.

The District's Medicaid program plays an enormous role in the health care system because Medicaid covers nearly 28% of all residents, compared to 19% nationally.[xiii] Eligible residents are either enrolled in a Medicaid managed care plan, currently Unison Health Plan, a part of the UnitedHealth Care, Inc., or Chartered Health Plan, a local managed care organization, or participate in the Medicaid fee-for-service program. There is also a separate program for children with special needs (i.e., CASSIP); Health Services for Children with Special Needs (HSCSN) is the District's

[2] This number was derived prior to the Department of Health Care Finance's submission of a State Plan Amendment to move a significant number of these individuals into the Medicaid program as a result of changes in eligibility under the Affordable Care Act.

current contractor for that program, which runs similar to a managed care organization.

The differences between the Alliance, Medicaid managed care, and Medicaid fee-for-service are significant. Along with different eligibility requirements, each of the programs has different benefit packages, drug formularies, provider networks, and administrative requirements. This can be challenging for providers from an operational perspective but is also difficult for residents who often bounce among programs as their eligibility changes. This will likely be exacerbated by the introduction of the health insurance exchange plans envisioned under the Affordable Care Act (ACA).[xiv]

The District's Medicaid and Alliance programs play an enormous role in cancer treatment locally for several reasons, including the numbers of residents enrolled in the programs and the health disparities that are experienced in the screening and treatment of those in the District's lowest socio-economic status. However, for a variety of financial and operational reasons, some private providers have begun to refuse to provide oncology services to the District's publicly insured residents--or do so only on a case-by-case basis--refusing to participate in the Medicaid and Alliance programs. These factors combined have resulted in significant delays in treatment and questionable quality of care for the city's most vulnerable cancer patients.

In many ways, the District is not unique. Oncology providers around the country have been strained by decreases in drug reimbursement rates and cuts to fee schedules due to state budgetary challenges. For example, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 reduced reimbursement rates for outpatient drugs quite significantly and created a new payment system for drugs based on average sales price.[xv] Nearly half of oncologists surveyed recently stated they were "under water" because drug reimbursement rates do not cover the cost of several commonly used "standard of care" chemotherapy drugs.[xvi]

States, too, are moving to restrict Medicaid enrollees' access to prescription drugs, including cancer drugs, as a means of controlling costs.[xvii] For example, Kentucky has recently announced it intends to require prior authorization for three cancer drugs due to the cost of the drugs.[xviii]

Locally, the District of Columbia's Department of Health Care Finance (DHCF) decreased mandatory physician reimbursement rates to 80% of the Medicare fee schedule, further straining providers' resources. While the District's providers may be experiencing challenges similar to those of their colleagues around the county, this only partially explains the obstacles facing District residents in need of or undergoing treatment for cancer in the city. Here, low reimbursement rates for

chemotherapy drugs and Medicare physician fees[3] exacerbate the structural barriers in the city's publicly financed oncology care system.

To further complicate the situation for cancer patients, the District's health care delivery system is complicated and disjointed. The District has eight acute care hospitals[xix], but its only public hospital, D.C. General Hospital closed in 2000. This left many publicly insured and uninsured residents to rely on United Medical Center (UMC- formerly Greater Southeast Community Hospital). The District, through the leadership of the City Council and DHCF, has made valiant efforts to sustain UMC's viability, though UMC is not structured or staffed to provide the full spectrum of clinical specialty services unique to oncology. Moreover, numerous press reports have alleged that UMC has had significant quality and budgetary issues and has been on the brink of closure several times.[xx] With United Medical Center's challenges and being the only hospital east of the river, Anacostia residents have been faced with additional challenge of access to services.

On the positive side, the D.C. Cancer Consortium has invested in a Citywide Patient Navigation Network (CPNN) administered by The George Washington University Cancer Institute comprised of 42 partners--including hospitals, clinics and community organizations—to assist cancer patients in the DC metropolitan region. This program provides patients with assistance in dealing with all aspects of their cancer care, including scheduling appointments, education about treatment, dealing with insurance issues, finding transportation, and seeking additional support. Research has demonstrated that patient navigation programs can be highly successful and helpful to patients by removing significant barriers to accessing care,[xxi] but this program relies on a good public partner. If coupled with a fully functioning delivery system and adequate rates, the CPNN program could make real and lasting improvements in patients' outcomes and quality of life.

It is clear that District residents face a fragmented delivery system given the lack of services east of the river, a lack of providers who accept Medicaid or Alliance patients, managed care plans that appear not to have sufficient numbers of in-network oncology providers, pharmacy benefit management systems and formularies that make it difficult for patients to access commonly utilized oncology drugs, and payment systems that force providers to risk losing money every time they accept a Medicaid managed care patient that could be retro-actively transitioned to Fee-for-Service.

Also, reimbursement rates must be improved in order to secure the participation of more providers of high-quality cancer care. However, there are also structural changes that can be accomplished without rate increases that can also improve the quality of cancer care. The purpose of the following scenarios is to describe

[3] Medicare physician fee schedules play an important role because DHCF has previously based its Medicaid fee-for-services physician fee schedule on either a percentage of or equal to Medicare's physician fee schedule.

common situations encountered by District residents and note the challenges presented by each. We conclude with a summary of the information and recommendations for change.

Case Scenario One

A 48-year old Hispanic woman, Ana, living in Columbia Heights uses a community health center located in her neighborhood as her regular source of care (when she seeks it). She rarely seeks care for herself but brings her two children to the health center for check ups and when they are sick. One day, during a neighborhood health fair, she is approached by a community outreach worker who asks whether she has had a mammogram. A mobile mammography van is offering them free at the health fair so she obtains one, never having had one in the past.

Following the mammogram, Ana is informed there is a suspicious finding on her mammogram. The staff tells her she must get a diagnostic mammography at a local hospital. When the diagnostic mammography confirms the findings of the mobile mammogram, she must then get a biopsy to determine whether she has cancer. Ana works for a small business that does not offer health insurance and she has never sought Medicaid coverage for herself. The staff tells her she will qualify for Medicaid in the District if she has breast cancer, provided she has proper documentation of Medicaid's other eligibility requirements. However, if she does not, she will not be eligible for Medicaid and the Alliance does not have corresponding eligibility or coverage requirements.

The community health center staff calls several local surgeons to try to assist Ana in arranging a biopsy. The staff explains that Ana will qualify for Medicaid once a biopsy confirms she has breast cancer. However, because the cost of the biopsy is not covered retroactively by Medicaid, and Ana does not have any other source of insurance, it is very difficult to arrange for a biopsy. After several weeks, the health center staff, with the help of Project WISH[4], is able to find a surgeon who will do the biopsy for a reduced rate with funding from Project WISH. The biopsy confirms that Ana has breast cancer, at which point she is able to qualify for Medicaid coverage.

The District's Income Maintenance Administration (IMA) enrolls Ana and asks her to choose a health plan. She does, but it takes three weeks for her to obtain all of her information from her plan and choose a Primary Care Provider (PCP). She chooses her community health center as her PCP. Ana must now schedule an appointment with her PCP to obtain a referral to a surgeon in the plan's network. Because the surgeon who did the biopsy does not participate in Ana's health plan, she must

[4] Project WISH is a breast and cervical screening program operated by the D.C. Department of Health with funding from the CDC. Additional information about the program can be found at: http://dchealth.dc.gov/doh/cwp/view,a,1373,q,582368,dohNav_GID,1801,dohNav,%7C33183%7C33184%7C.asp

arrange for the results of the biopsy to be sent to her PCP and her new surgeon prior to scheduling an appoint. This entire process takes nearly two months.

Issues Identified:

1. In accordance with the Breast and Cervical Cancer Prevention and Treatment Act of 2000,[5][xxii] a woman qualifies for Medicaid once she has breast cancer but she can't get the coverage until the cancer is confirmed by a medical professional. This cannot happen until she has a biopsy, which many providers believe is not covered.

2. Once a woman qualifies for Medicaid, it may take several weeks before she is able to enroll in the program and obtain the care she needs. This is not unique to cancer care but the consequences for someone diagnosed with cancer can be devastating.

Case Scenario Two

A thirty-two year old, African American mother of two, Deborah, living in the Petworth neighborhood of D.C. finds a lump in her breast. Deborah schedules an appointment with her family physician at a local community health center. At that visit, the family practice physician confirms that a lump can be felt and refers the woman to a surgeon for follow up. Because Deborah is enrolled in the District's Medicaid managed care program, the D.C. Healthy Families Program, she is a member of Chartered Health Plan[6] and has coverage for specialty care (with appropriate referrals), mammograms, and biopsies.

Deborah is able to easily locate a number of surgeons and radiologists on her health plan's website and schedule an appointment. She makes an appointment with a surgeon, who is able to see her within a month. Deborah arrives at the surgeon's office without having called her health plan (and not aware that she should have done so), so she does not have the appropriate pre-certification documents or referral. The surgeon is unwilling to do the biopsy without the plan's preauthorization because it is unlikely the claim will be paid by the plan without the appropriate documentation. The office staff tries to reach the health plan's staff for a pre-authorization while the patient is in the office but the plan does not have sufficient staff in place to arrange the authorization. Deborah leaves the office, re-scheduling the appointment for two weeks later in order to ensure sufficient time for the surgeon's office to assist her with her pre-authorization paperwork.

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[5] This is an optional Medicaid eligibility category. All 50 states and the District of Columbia have elected this option. Women without documentation of citizenship or legal residence for five or more years cannot qualify under this category of eligibility and the Alliance does not have a corresponding eligibility category.

[6] There are two managed care organizations that participate in the D.C. Healthy Families (i.e., Medicaid managed care) program: Chartered Health Plan and Unison Health Plan. The reference here to Chartered is not intended to focus on Chartered but rather to use the name as a representative of a Medicaid MCO in the District.

Once Deborah obtains the biopsy and the presence of a mass is confirmed, the surgeon tells the woman she must return to her primary care provider for a referral. Her PCP, in turn, tells Deborah she must go to a medical oncologist. Deborah attempts to find an oncologist through her health plan website but not a single oncology provider is listed on her health plan's website within 10 miles of her home. Her primary care provider attempts to call local oncology providers to find treatment for Deborah, without success. After some time, Deborah contacts her health plan. The health plan's staff works to negotiate a single case agreement with a local oncology provider. This process takes several weeks and results in critical delays in treatment.

Issues Identified:

1. There is a critical shortage of oncology providers willing to accept Medicaid patients. Providers attribute this to two factors: low reimbursement rates for oncology providers and below-cost reimbursement rates for chemotherapy drugs.

2. As part of their efforts, the workgroup queried the current Medicaid and Alliance MCOs' provider network databases and found *not a single oncology provider listed* for either Unison or Chartered. This means that either the plans' websites do not contain accurate information or the plans do not have in-network oncology providers. These are both clear violations of the MCOs' contracts with DHCF.[xxiii]

3. Even if the Medicaid MCOs are willing, and able, to negotiate single case agreements with oncology providers, these agreements take time to negotiate. These agreements also raise serious questions regarding quality of care issues. Moreover, primary care providers or other types of providers are largely unaware of this option and do not pursue it, also leading to significant delays.

Case Scenario Three

A fifty-year old man, Abe, with colorectal cancer is being treated through a single case agreement with an oncologist at a District of Columbia multi-specialty practice that includes oncology services. He is enrolled in Unison Health Plan (UHP), where the staff has been assisting him with arranging his care. About three months into his extensive treatment regiment, Abe is transitioned out of the Medicaid managed care program, disenrolled from UHP, and enrolled in the Fee-for-Service (FFS) system. This change occurs because his condition now prevents him from working so he qualifies for SSI benefits.

Once Abe is disenrolled from the managed care program, Abe must find a new oncology provider because the FFS network is different from the current Medicaid managed care plans' provider networks. Several of the District's multi-specialty practices and oncology providers do not accept Medicaid FFS due to the low reimbursement rates and administrative challenges. This is particularly challenging

for Abe because DHCF does not have case managers to assist Medicaid FFS beneficiaries in coordinating their care or finding a provider. This transition could cause critical delays in his treatment. In most cases, the local oncology providers continue patients' course of treatment, however, they do so without knowing whether they will be paid for the treatment or at what rate.

While Abe struggles with his challenges related to arranging and managing his own care, DHCF begins the process of recouping Abe's monthly capitation payments from UHP because his FFS designation is retroactive back to the time of his diagnosis. As DHCF does this, UHP then seeks to recoup its payments from the provider, who must then re-bill DHCF, creating long delays in payment, significantly lower reimbursement rates, and an added administrative and financial burden on the provider. Perhaps most importantly, because the health plans' formularies differ significantly from the FFS formulary, the oncologist may be forced to choose to change a patient's course of treatment or assume the cost of very expensive cancer drugs, along with the administration costs of the drugs. Alternatively, the provider may need to work with a different pharmacy benefits manager (PBM) that requires different authorization procedures or places restrictions on how or when the drugs may be delivered, resulting in delays in treatment.

Issues Identified:

1. DHCF's re-classification of managed care enrollees as FFS beneficiaries when the enrollee becomes disabled to his/her cancer care causes very significant disruptions in care due to the different provider networks utilized by the MCOs and the FFS program. The disruptions in care are compounded because the FFS system does not provide case managers, so the most vulnerable Medicaid beneficiaries are essentially left completely on their own to try to navigate the transition, as well as their on-going care.

2. DHCF's practice of recouping capitation payments from providers for the retroactive program changes (i.e., from managed care to FFS) is extremely harmful to the delivery system for oncology services. Importantly, after DHCF recoups the payments, the MCOs recoup from the providers. This often takes place after several months of treatment, when the providers have already established a course of treatment and provided very expensive oncology drugs that are not covered by FFS or are covered at much lower rates. This means the oncology providers essentially lose thousands of dollars on every course of treatment and must shoulder a significant increased administrative burden. This destabilizes the system and forces providers to refuse to take Medicaid patients due to the unpredictability of the timing and amount of reimbursement.

3. The differing drug formularies create significant challenges for both patients and providers. For patients, this information can be extremely confusing and can result in delays as providers attempt to navigate different Pharmacy Benefit Manager (PBM) requirements. Providers, on the other hand, may have to assume the cost of

the treatment if they choose to complete a patient's course of treatment. Due to the high cost of the drugs, this loss can be several thousand dollars for each patient.

Summary of the Gaps in Oncology Care for District Residents

The case scenarios highlight a number of gaps in care and coverage for the Districts' residents, namely:

- Reimbursement rates for pharmaceuticals are too low and are often below the actual cost of the drug and without payment for the providers and staff (e.g., technicians and nurses) necessary to administer the drugs.

- DHCF's policy of transitioning Medicaid enrollees between managed care and fee-for-service systems is unnecessary and extremely burdensome for providers, causing many of them to discontinue treatment of Medicaid and Alliance members.

- The lack of case management or other assistance in the fee-for-service program means that patients are left without any assistance, other than the patient navigator program discussed above, funded through the D.C. Cancer Consortium and administered through the G.W. Cancer Institute.

- Reimbursement rates for physician services are too low to support the ancillary providers such as nurses, pharmacy technicians, and social workers who are essential to providing high quality oncology care. Furthermore, in a situation where they are most needed, reimbursement for nutrition counseling is low, difficult to obtain or not available.

- There is a critical lack of access to providers in the Medicaid fee-for-service program. This forces DHCF to negotiate single case agreements (or one-time provider agreements) with providers for each case. This prevents DHCF from engaging in any meaningful quality-of-care monitoring or surveillance.

- The Medicaid managed care contractors do not have adequate numbers of oncology providers in their networks. As noted above, a search of the provider directories has failed to turn up even a single in-network oncologist. Even if this is the result of inaccurate provider directories it is a very real barrier for patients. This situation is unacceptable and a flagrant violation of their contracts.

- There is a lack of access to providers in the Alliance program. Low rates have resulted in providers exiting the program, which results in single-case agreement negotiations by the MCOs at best, and a lack of access at worst.

- There are significant problems with the managed care drug formularies. The Alliance program's formulary is out-of-date and does not include several widely used drugs. But also, according to local oncology providers, the procedures the MCOs put in place to approve drugs, including some that are on formulary, require multiple denials as the MCOs attempt to enroll the member in a patient assistance program through the pharmaceutical companies. The pharmaceutical companies typically require two denials. This process can take 4 months and hours of staff time, and, shockingly, during this period, the patient is left without chemotherapy or anti-nausea drugs. Some providers do not participate in the Medicaid or Alliance program as a result of these administrative obstacles to securing critical drugs needed to provide appropriate, standard of care, services.

- There is much confusion amongst providers and patients regarding whether screening services and biopsies are covered services for Medicaid and Alliance members.

Recommendations

Improve Reimbursement Rates

It goes without saying that the District must improve reimbursement rates for its Fee-for-Service program providers. Additionally, for its managed care contractors (i.e., for the Medicaid managed care and Alliance programs), DHCF should ensure the contractors are paying sufficient rates to oncology providers including, at a minimum, covering the cost of oncology drugs and the services necessary to administer the drugs. As it stands, District residents are at the mercy of DHCF to negotiate an agreement with a single provider to avoid disruption in service or in fact no service at all. This is a band-aid on a broken system, and with improved reimbursement rates, providers are more likely to treat patients who participate in the fee-for-service and managed care public programs.

Improve Drug Formularies

Similar to CMS's policy under the Medicare program and those of private insurers such as United Heathcare, the DHCF should, at a minimum, consider requiring coverage under the Medicaid and Alliance programs for drugs in the American Hospital Formulary Service-Drug Information, the US Pharmacopoeia-Drug Information, and the National Comprehensive Cancer Network (NCCN) Compendium, including for indications validated in the peer reviewed literature.

Washington DC residents have some of the most significant cancer health disparities in the nation. By providing adequate coverage for drugs, DCHF could send a message to its publically insured cancer patients that regardless of their socioeconomic status, coverage for their drugs is comparable with drugs in national formularies and that their survival is a priority for the District.

Enforce the Current Managed Care Contracts

Simply stated, DHCF should enforce the requirements under its existing managed care contracts. Specifically, Sections C.6 and C.7 of the Medicaid managed care contract require the contractors to provide information to enrollees about its provider network[xxiv] and maintain accurate websites.[xxv] Also, Section C.9.2 states clear requirements about provider network adequacy. Finally, Section C.9.3.4 mandates the plans adhere to appointment time standards.

Perhaps if other administrative issues were streamlined, DHCF's staff would be better able to ensure the information presented to plan participants was accurate and available. DHCF's careful monitoring and enforcement of these requirements could greatly improve enrollees' ability to find a provider and start treatment in a timely manner.

Examine the Fee-For-Service Program for Network Adequacy

Similar to the managed care program, beneficiaries in the fee-for-service program lack access to oncology providers. DHCF's Office of Accountability should query whether the fee-for-service program continues to lack even a single participating Medical Oncologist or Surgical Oncologist and, if so, devise a plan for rectifying this as soon as possible.

Include Cancer and Cancer Survivorship in the Chronic Care Collaborative

DHCF's collaboratives have been considered by the community to be successful for numerous reasons. DHCF should include cancer in the Chronic Care Collaborative in order to focus attention on this issue and to work with the various providers and MCOs to eliminate the significant barriers to oncology services.

Eliminate Transitions

Providers state that DHCF's policy to transition Medicaid managed care enrollees to the Fee-for-Service system creates disruptions in care as providers must obtain new authorizations for existing care plans. There is also no way to overstate the administrative barrier these transitions create for providers. Because DHCF recoups the MCO contractors' capitation payments when DHCF moves an enrollee into FFS, the MCOs then recoup the payments from the providers. Providers must then bill DHCF directly, at different rates, with different formularies, and in accordance with different procedures. Anecdotally, oncology providers say this alone makes serving Medicaid beneficiaries- both managed care and FFS- too costly and too great of a risk. DHCF can remedy this through a State Plan Amendment that allows the MCOs to retain enrollees, even when they become disabled, or, at a minimum, allows the MCOs to retain the capitation payment prior to the actual move to FFS, protecting both the MCOs and providers from payment claw-backs and rebilling requirements.

In addition to the administrative burden and disruption of service, when cancer patients transition from an MCO to FFS plans, they lose a key member of their healthcare team, the case manager. This role is critical to help the underserved in

the District receive timely care. While the city-wide patient navigation network is helping to ensure these patients are not lost in the system, the network's funding is in jeopardy during these difficult budgetary times and DHCF does not have a "back up" case management system available for FFS beneficiaries.

Eliminate Unnecessary Obstacles to Pharmaceuticals

Restricted formularies are only one of the obstacles facing oncology patients and providers. Each of the three current managed care organizations, Chartered Health Plan, Unison Health Plan, and Health Services for Children with Special Needs,[xxvi] not only have different formularies, but also different pre-authorization procedures and operating procedures. For example, one of the MCOs requires that patients apply for the indigent pharmaceutical programs prior to authorizing specific drugs, increasing the paperwork burden for patients and providers and delaying treatment.

Having a myriad of administrative and operating procedures for pharmaceutical coverage, coupled with already low reimbursement rates for services, contributes to providers' unwillingness to participate in the public managed care programs, leaving residents with few options for care and drug coverage. Cancer patients are also likely to suffer unnecessary pain and discomfort, increased burden of side effects of treatment with proper ancillary drug coverage, and lack of access to adequate drugs by a lack of consistency among plans.

Provide funding for screening and biopsies

The confusion regarding coverage for screening services and biopsies should be clarified and the services paid for should be clear to plan participants and providers. As it currently stands, providers, patients, and navigators are faced with a time-consuming administrative burden trying to determine a payment source for screening and diagnostic services. At a minimum, DHCF and DOH could clarify this payment source and educate providers in the city about how to obtain payment.

Conclusion

The District, like many other jurisdictions, is facing extraordinary budget challenges. It also has a health care system that is fragmented and lacking a high-quality public hospital. These pressures adversely – and disproportionately- affect cancer patients in the city. Fortunately, many of the problems with the oncology delivery and payment system can be resolved without a financial impact. Rather, a series of operational and policy changes can greatly improve the care for the District's cancer patients. We strongly encourage policy makers to consider the changes discussed above.

[i] See, American Cancer Society, http://www.cancer.org/cancer/cancerbasics/cancer-prevalence
[ii] Thorpe, K. and Howard, D., *Health Insurance and Spending Among Cancer Patients*, Health Affairs, September 2003 10.1377 pg. 189.
[iii] Morbidity and Morality Report, Centers for Disease Control and Prevention, March 11, 2011 60(09);269-272.
[iv] American Cancer Society, Surveillance and Health Policy Research, 2010.
[v] American Cancer Society, Surveillance and Health Policy Research, 2010.
[vi] American Cancer Society, *South Atlantic Division Facts and Figures 2008.*
[vii] Hoffman, H. et al, *Having Health Insurance Does Not Eliminate Race/Ethnicity-Associated Delays in Breast Cancer Diagnosis in the District of Columbia*, Cancer, August 2011, vol. 117 pg. 3824-3832.
[viii] Thorpe, K. and Howard, D., *Health Insurance and Spending Among Cancer Patients*, Health Affairs, September 2003 10.1377 pg. 189.
[ix] Thorpe, K. and Howard, D., *Health Insurance and Spending Among Cancer Patients*, Health Affairs, September 2003 10.1377 pg. 189.
[x] Thorpe, K. and Howard, D., *Health Insurance and Spending Among Cancer Patients*, Health Affairs, September 2003 10.1377 pg. 189.
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[xii] Meyer, J. et al., *Expanding Health Coverage in the District of Columbia: D.C.'s Shift from Providing Services to Subsidizing Individuals and Its Continuing Challenges in Promoting Health*, 1999-2009, Brookings Institution, December 2010.
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[xxiii] See, Sections C.9.2 and C.9.3.

[xxiv] See, Section C.6.6.

[xxv] See, Section C.7.6.

[xxvi] Health Services for Children with Special Needs (HSCSN) coordinates the health, social, and education services for the Supplemental Security Income (SSI) and SSI-eligible children of Washington, DC.