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Oncology Care Access in the District of Columbia: An Overview and Needs Assessment

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ONCOLOGY CARE ACCESS IN DC: AN OVERVIEW AND NEEDS ASSESSMENT

Overview

Despite widespread health insurance coverage rates, District of Columbia (D.C.) residents battle significant cancer health inequalities, creating a tale of two cities when it comes to cancer care and outcomes. Patients, providers, payers, policymakers, community groups and hospitals face varied challenges in ensuring access to care for the highest-risk populations. The inaugural GW Cancer Institute DC Access to Care Summit on May 11, 2015 brings key stakeholders together to create strategies and potential solutions to address this long-standing problem. The following overview provides data specific to D.C. when available and national findings when D.C.-specific data is not available.

Background: What we know about Cancer Health Inequalities in DC and Nationally

- Cancer incidence in D.C. is 13% higher than the rest of the country¹ with marked cancer health disparities. D.C. whites have a 9.5% lower rate of cancer while African Americans have a 21.3% higher rate of cancer than their counterparts nationally.² African American cancer mortality rates in D.C. are 13.3% higher while whites are 34% lower than national averages.^{1,3}
- Nationally, factors influencing cancer health disparities include:
 - Disparities in education⁴, employment⁵ and income;⁶
 - Differences in incidence and mortality by race;⁷
 - Geographic barriers to treatment;⁸
 - Insurance type;^{9,10}
 - Varied health literacy;¹¹
 - Fragmentation and uncoordinated care when treatments require help from multiple clinicians;¹²
 - Greater complexity of medical care and support needs for Medicaid patients;¹³
 - Cultural beliefs that may impede diagnosis, understanding of disease and treatment completion;¹⁴
 - Disparities in the provision of supportive and psychosocial care to minority populations.^{15,16}
- National data suggests Medicaid patients are:
 - More likely to present with advanced cancer;¹⁷
 - Less likely to receive standard diagnostics;¹⁸
 - Less likely to receive standard treatments;^{19,20, 21}
 - Less likely to survive their disease.^{22,23,24}
- In D.C., 24% of the population relies on Medicaid and another 10% are uninsured.^{25,26}

Findings of the Needs Assessment

- Many disparities impacting access to timely, high-quality cancer care nationally are present in D.C.
- Rising overhead and falling reimbursement nationally has contributed to fewer oncologists accepting Medicaid patients, further burdening those who do.^{27,28}

¹ Data was not widely available for all racial and ethnic populations.

- A national perception of low reimbursement rates further discourages provider participation in Medicaid plans.^{29,30}
- Managed Care Organizations across the country have struggled to maintain profitability while maintaining benefits for health care services.³¹
- Hospitals face rising costs and current payment structures leave little incentive for separate providers to coordinate services, potentially leading to increased fragmentation.³²
- Community-based oncology practices are increasingly closing, merging with other practices or being acquired by larger hospital systems. The condensing of practices may hurt patients even more; competition among physician groups is needed to combat rising costs.³³
- Policymakers struggle to meet the needs of various stakeholders pushing for reform of the health care system.³⁴ The threat of major change to federal programs makes it difficult to know what to expect or how to plan.
- More D.C.-specific data is needed to better understand the impact of these findings at the local level.

Potential Solutions and Policy Recommendations

The May 11 Summit brings patients, payers, providers, community organizations and policymakers together to identify the most significant barriers to cancer care access in D.C. in order to begin developing potential solutions to overcome these challenges. Possible strategies might include:

- Systematically analyze Medicaid FFS and MCO provider networks to confirm whether listed oncologists 1) see pediatric- or adult-onset cancer patients, and 2) accept D.C. Medicaid (FFS or MCO) as first- or only second-level insurance. Revisit the process for updating Medicaid FFS and MCO provider networks to include information about patient type (pediatric versus adult) and first- or second-level coverage, as well as more accurate and immediately accessible information for patients and patient navigators.
- Establish oncology-specific Medicaid standards for access to care in D.C.
- Review reimbursement levels for cancer prevention, screening, diagnostics, treatment and chemotherapy to ensure providers are being reimbursed for costs. If D.C. Medicaid providers are being reimbursed at higher-than-national averages for services, educate providers about this fact. If chemotherapy, tobacco cessation, genetic counseling or other critical health care services are not routinely reimbursed or are reimbursed less than the cost of providing the service, recommend policy changes to align with evidence-based health care services needed by cancer patients.
- Create an education campaign updating health care providers on major changes to D.C. Medicaid that have reduced administrative burdens and payment issues in the last two years. Examine whether ongoing administrative burdens or payment obstacles remain.
- Consider new revenue or payment structures to incentivize a broader network of D.C. health care providers who accept Medicaid FFS and MCO as first-level payment for adult-onset cancer patients.
- Bundle provider payments for a variety of payers to support a comprehensive set of services for patients, including patient navigation, care coordination, health promotion, symptom management, palliative care, psychosocial support and long-term survivorship care planning.
- Utilize patient navigators, community health workers and other health care professionals to increase health literacy in D.C., particularly in at-risk communities in Wards 5, 7 and 8.
- Study at-risk populations and cancer outcomes in D.C., examining the influence of age, race, gender, sexual orientation, socioeconomic status, education and insurance type to inform more targeted interventions to improve access to care.

ONCOLOGY CARE ACCESS IN DC: AN OVERVIEW AND NEEDS ASSESSMENT

Washington, D.C. has made significant improvements in health care over the past several years. Despite this progress, cancer patients still face health disparities and struggle to access high-quality care which can impact survival. Patients, providers and policymakers have expressed challenges in accessing quality care for the highest-risk populations in D.C.; however, no formal complaints have been registered by patients or health care providers according to the D.C. Department of Health Care Finance (DHCF) and Medicaid Managed Care Organizations (MCO). The obstacles to accessing high-quality cancer care are varied and complex; and they cannot be remedied if the reasons are not well understood by all affected stakeholders. Solutions can only be reached with a common understanding of the landscape and broad participation across stakeholders. To build off of D.C.'s recent successes, it is important to understand these issues and work collaboratively to identify and implement strategies to improve access to care for D.C.'s highest-risk patients.

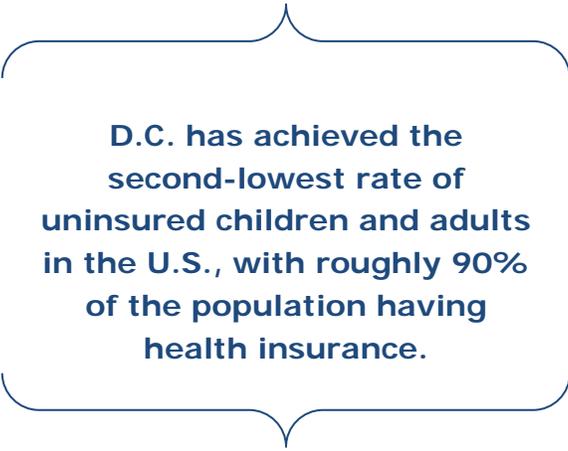
The following overview provides data specific to D.C., when available, and national findings when District-specific data is not available.

Successes in the District

Health and healthy living in Washington, D.C.

Compared with other states, D.C. has experienced some key health care successes. With its early implementation of the Affordable Care Act (ACA), D.C. has achieved the second-lowest rate of uninsured children and adults in the U.S.,³⁵ with approximately 90% of the population having health insurance in 2012.³⁶ D.C. has always been a strong supporter of the ACA, expanding Medicaid coverage early and providing an additional 35,000 residents with health insurance.³⁷ Health care in D.C. is also affordable for many residents. Out-of-pocket medical costs are lowest in D.C. compared with other states, with just 10% having high out-of-pocket medical costs relative to their annual household income.³⁸

D.C. has also made strides beyond increasing health insurance coverage rates and affordability. In 2012, more than 89% of residents had a routine check-up within the last 2 years.³⁹ In 2011, D.C. exceeded national cholesterol screening targets set by Healthy People 2020, with 83% of residents



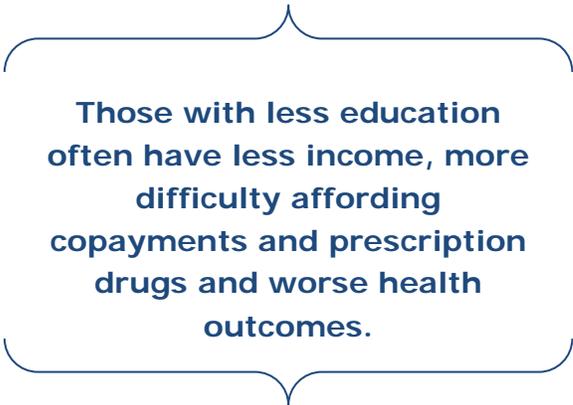
D.C. has achieved the second-lowest rate of uninsured children and adults in the U.S., with roughly 90% of the population having health insurance.

receiving cholesterol screening within the past 5 years.⁴⁰ Nearly 28% of residents met aerobic activity guidelines set by the Centers for Disease Control (CDC) (goal is 32.2%), and 81% exercised within the last 30 days (goal is 82.6%).⁴¹ Furthermore, 34.1% of residents consumed at least 2 fruits per day (goal is 35.6%), and 16.3% ate at least 3 vegetables each day (goal is 19.6%).⁴² These factors along with D.C.'s high number of parks and recreation centers; percentage of residents using public transportation, bicycling or walking to work; availability of farmers markets and low death rates for diabetes and cardiovascular disease, led D.C. to be ranked the healthiest city in the nation by the American College of Sports Medicine.⁴³

A Tale of Two Cities: Inequalities in D.C.

The differences between Wards in D.C.

Despite its many advantages, D.C. is a tale of two cities due to significant differences in demographics that are associated with health inequality.^{44,45} Nationally, factors impacting cancer health disparities include education,⁴⁶ income,⁴⁷ employment,⁴⁸ race,⁴⁹ geographic barriers⁵⁰ and transportation issues,^{51,52} insurance type,⁵³ fragmentation in care,⁵⁴ health literacy⁵⁵ and cultural differences⁵⁶ between patients and providers. Many of these factors are well-documented in D.C. Differences across these factors are most profound when comparing demographics by Ward. While most D.C. residents have graduated



Those with less education often have less income, more difficulty affording copayments and prescription drugs and worse health outcomes.

from high school, differences in rates of college education are clear: 82% of Ward 3 residents have a Bachelor's degree or higher, as compared to 17% of Ward 7 residents and just 10% of Ward 8 residents.⁵⁷ National studies suggest that even with the same access to health care, those with less education tend to have worse health outcomes than those with more education.⁵⁸ Those with less education tend to have lower

incomes to afford copayments and prescription drugs, and they are more likely to live in low-income neighborhoods and lack community resources such as healthy food or primary care providers.⁵⁹

Inequalities in average incomes and unemployment rates are also clearly divided between Wards; unemployment rates have remained firmly in the double-digits for Wards 5, 7 and 8 since November 2008.⁶⁰ Inequalities are also manifest in disparate average family incomes by Ward and percentage of individuals living in poverty.⁶¹ From 2007-2011, only 7.9% of Ward 3 residents lived in poverty.⁶² The

average family income during those years was \$240,044.⁶³ Comparatively, 36% of Ward 8 residents lived in poverty during the same period, and the average family income was \$43,255.⁶⁴ These disparities leave many D.C. residents challenged to access and pay for vital health care services.

The ability to take time off of work for screening, diagnostic services, treatment and survivorship care also impacts those seeking cancer care. Of 22 wealthy nations, the U.S. is the only one that does not guarantee paid time off for illness.⁶⁵ Approximately 41% of employers nationally offer an average of 9 paid days to manage illness or other issues in addition to vacation time.⁶⁶ When it comes to taking time off to manage their

cancer care, patients working in the public sector are better off than patients working in the private sector: Public sector employers provide 5 times the assistance of private sector employers.⁶⁷ Furthermore, large organizations offer 7 times more assistance than smaller organizations.⁶⁸ Employment issues for cancer patients can include job loss, an undesired change in work situation, issues with coworkers and diminished work capacity,⁶⁹ all of which can impact one's ability to access care.

Racial and ethnic inequalities in cancer incidence and mortality are prevalent in the U.S. and in D.C. Despite having higher incidence of cancer, African Americans and the poor are more likely to receive lower-quality care than whites and wealthier individuals.^{70,71} Although national cancer mortality rates have declined, African-Americans have a much higher mortality rate than whites across many cancer

Cancer incidence in D.C. is 13% higher than the national average, but whites have a 9.5% lower incidence and African Americans have a 21.3% higher incidence of cancer compared to their counterparts nationally.

types.⁷² Cancer incidence in D.C. is 13% higher than the rest of the country,⁷³ and disparities are particularly pronounced between races. For example, in D.C., whites have a 9.5% lower rate but African Americans have a 21.3% higher rate of cancer than their counterparts nationally.⁷⁴ Cancer mortality rates are also much higher in D.C. for some races than others.⁷⁵ The mortality rate for African Americans in D.C. is 13.3% higher than the national average, while whites are

Of 22 wealthy nations, the U.S. is the only one that does not guarantee paid sick leave.

34% less likely to die of cancer in D.C. than their national counterparts.⁷⁶ In D.C., African-Americans are more likely to live in Wards 5, 7 and 8.⁷⁷ Hispanic populations are higher in Wards 1, 2 and 4. Whites and Asian populations are more likely to live in Wards 2, 3 and 6.⁷⁸

Geographic barriers can also be significant obstacles in accessing care.⁷⁹ Of the 6 major hospitals systems and oncology treatment sites in D.C., only one is located in a Ward with marked economic, educational and employment inequities. For those who do not live near a treatment center, transportation to clinics may present a significant issue.

Transportation has been cited as an issue, especially for Latino patients accessing cancer care in D.C.^{80,81}

African Americans are 13.3% more likely to die and whites are 34% less likely to die from cancer in D.C. than their counterparts nationally.

Medicaid and Medicaid Outcomes

In D.C., Medicaid covers 24% of the population (153,600 residents) and another 10% are uninsured.^{82,83} Kaiser Family Foundation research found that, overall, having Medicaid is better than not

In D.C., 24% of the population relies on Medicaid and 10% are uninsured.

being insured; and beneficiaries have comparable preventive and primary care access.⁸⁴ However, specialists are less likely to accept Medicaid and there is variation in performance between health systems.⁸⁵ Furthermore, Medicaid can do little about the varying complexity of patient health care needs or geographic

barriers to care.⁸⁶

Treatment and Survival of Medicaid Patients Nationally

Nationally, those dependent on Medicaid have worse cancer outcomes than their privately insured peers, even when access to care is the same.⁸⁷ Studies suggest that Medicaid patients are less likely to survive their cancer than privately insured patients.⁸⁸ One study showed that roughly 84% of privately insured patients with lymphoma survived their cancer, as compared to 71% of Medicaid patients.^{89,90} Even when controlling for demographic information, stage at diagnosis and treatment modality, patients with Medicaid coverage or no coverage at all were less likely to survive cancer than privately insured patients.⁹¹

Outcome disparities may be due, in part, to differences in time of presentation and services provided for these patients.⁹² For example, individuals covered by Medicaid are less likely to have their Hodgkin Lymphoma caught at an earlier and more treatable phase,^{93,94} and patients with Medicaid coverage or who were uninsured are also more likely to present with advanced-stage disease.⁹⁵ Medicaid patients are also less likely to receive medically advanced diagnostic techniques for breast cancer: One study found that only 47% of women insured by Medicaid or Medicare received breast Magnetic Resonance Imaging (MRI), compared to 81% of privately insured patients.⁹⁶ Furthermore, while 81% of privately insured patients received an image-guided core needle biopsy, only 25% of Medicaid or Medicare patients received this test.⁹⁷ Outcome disparities may also be due to the fact that Medicaid patients are more likely to have other challenges, such as lack of transportation, lack of social support, limited financial resources and comorbidities that contribute to more advanced disease, inadequate treatment and, ultimately, worse survival.⁹⁸ While these data are not D.C. specific, the data suggests that simply providing health insurance may not necessarily lead to improved health outcomes.⁹⁹

These disparities extend beyond screening and diagnostic services. In one study, about 35% of Medicaid patients with lymphoma received radiation treatment compared with 43% of privately insured patients.^{100,101} Patients with Medicaid coverage or who were uninsured were also less likely to undergo surgery or radiation treatment for non-metastatic disease.¹⁰² Again, while these data are not D.C.-specific, given the proportion of those reliant on Medicaid and anecdotal evidence regarding fragmentation of services in D.C., it is reasonable to assume that Medicaid patients face screening, diagnostic and treatment barriers that are more severe than those faced by privately-insured patients.

Access, Health Literacy and Cultural Barriers

The impact on access and treatment

Despite D.C. having the highest number of oncologists per geographic area, with 15.3 oncologists for every 100,000 people, one obstacle to receiving quality care is provider accessibility.¹⁰³ Nationally, the average is 3.8 oncologists for every 100,000 people. Maryland has 6.6 oncologists per 100,000 individuals and Virginia has 2.4-3.2.¹⁰⁴ Despite the availability of oncologists, however, many of these physicians do not accept Medicaid (See box



**D.C. has the highest
oncologists per capita in the
U.S.**



Assessing Oncologists who Take Medicaid as First-Line Insurance in D.C.

To determine the number of oncologists accepting Medicaid as a primary insurance, GW Cancer Institute staff reviewed provider networks available online or provided by the Department of Health Care Finance and the Managed Care Organizations (MCOs). To determine the number of oncologists accepting Medicaid Fee-For-Service (FFS), staff reviewed the online provider database of 100 oncologists in D.C. who accept Medicaid available on the Department of Health Care Finance website. Oncologists were identified as those who designated hematology and oncology as their primary specialty. Of those 100 providers, 29 were listed outside of D.C., in Maryland, Virginia or North Carolina. Another 11 were pediatric oncologists only accepting patients up to age 21. During follow-up calls, 8 only accepted Medicaid FFS as a secondary insurance. Five treatment sites were counted as oncologists, and 1 oncologist was listed twice. The GW Cancer Institute staff found a total of 46 oncologists in D.C. accepting Medicaid FFS as a primary insurance for adult cancer patients.

This process was repeated for each MCO serving adult populations. An analysis identified a total of 16 adult oncologists in D.C. accepting Trusted Health Plan as primary insurance. A review of AmeriHealth D.C.'s network found 1 adult oncologist who accepts AmeriHealth D.C. as primary insurance. A total of 27 adult oncologists in D.C. accept Medstar Family Choice as primary insurance.

It is important to note that some, but not all, providers overlap. Based on this research, only 1 oncologist in D.C. accepts all Medicaid FFS and MCO plans.

NOTE: Research conducted April 14-16, 2015.

on left). While we don't have D.C.-specific data, on average, only 11.4% of oncologists nationwide accepted Medicaid coverage in 2013.¹⁰⁵

Health literacy is also an important factor in patient outcomes. Even when patients receive cancer screening, that screening may be ineffective for patients with low health literacy.¹⁰⁶ These patients may be diagnosed at a later stage, and they may not understand treatment options.¹⁰⁷ For patients with low health literacy, informed consent documents may be too complex and patients may not make optimal choices about their treatment.¹⁰⁸ Low health literacy impacts incidence, mortality and quality of life; yet, only 12% of the population has a proficient level of health literacy.¹⁰⁹ Older adults, immigrants, minorities and low-income individuals are most likely to have poorer health status and use less preventive care due to low health literacy.¹¹⁰

In the U.S., only 12% of the population is health literate.

The growing number of patients diagnosed with and surviving cancer, advances in diagnostic methods and earlier screening, the need for adjuvant and multi-modal therapies and the shortage of skilled cancer care professionals compound gaps and inequalities in cancer care.¹¹¹ Providing care that is

coherent and linked, the result of good information flow, good interpersonal skills and good coordination of care is challenging.¹¹² Often, preventive and early detection services, palliative care and psychosocial supports are inadequately provided and hospice referrals come too late.¹¹³ Cancer patients may receive fragmented and uncoordinated care as treatments require help from multiple clinicians.¹¹⁴

More than one-third of the city's residents live in Wards 5, 7 and 8, which have the most pronounced disparities;¹¹⁵ residents in these Wards have the lowest level of educational attainment,¹¹⁶ the highest level of poverty¹¹⁷ and live farther from major hospitals and treatment sites in D.C. Along with anecdotal evidence in D.C., the national data suggest these individuals are at risk of having inadequate access to timely, high-quality cancer care.

In D.C., more sites provide cancer screening than treatment. Even fewer sites take Medicaid as first-line insurance.

In D.C., there are more sites providing cancer screening than there are providing cancer treatment and even less who take Medicaid as first-line insurance. A total of 15 sites were identified by GW Cancer Institute staff as providing some type of cancer screening. Of those sites, 6 provide cancer treatment. Five of those 15 sites provide cancer treatment to patients with any type of Medicaid as their primary insurance.² While free-standing screening clinics

provide a critical service to patients, patients often have to receive services at multiple clinics across D.C., risking potential fragmentation in care.

Cultural differences between patients and providers may impact a patient's ability to receive quality care. Many providers lack a complete understanding of the complex relationship between cultural beliefs and cancer care.¹¹⁸

Several factors may impact a patient's or family's health practices and status, including age, education, income, family structure, gender, wealth, being foreign or U.S.-born, immigrant status and/or social and historical experience with discrimination.¹¹⁹ These factors, as well as cultural beliefs, attitudes and behaviors related to prevention, screening, relationships with

Groups of color have the least confidence they will receive quality health care and are less likely to have home care and supportive care services.

² Based on 2013 Rand Report and online searches. See Anhang, R., Blanchard, J., Harris, R., Ruder, T., & Gresenz, C. (2013). Monitoring Cancer Outcomes across the Continuum: Data Synthesis and Analysis for the District of Columbia. *Rand Health*, for more information.

providers and adherence to treatment are linked to patient outcomes.¹²⁰ While a provider showing genuine interest in a patient improves the patient-provider connection, language barriers and previous experience of discrimination in the health care system may negatively impact this connection.¹²¹ Providers may be unaware that, nationally, groups of color have the least confidence that they will receive quality care from providers¹²² and are less likely to have home assistance and supportive services.¹²³ Many continue to work and care for others during their cancer treatment due to cultural and/or socioeconomic factors.¹²⁴ Additionally, psychosocial and supportive care services are often not offered or distributed equally.¹²⁵

Challenges for Providers

In addition to challenges that patients face in accessing timely, high-quality care across the cancer continuum, national data describe challenges for health care providers, Medicaid agencies, Medicaid Managed Care Organizations, hospitals, community-based oncology programs and policymakers. Although D.C.-specific data on many of these issues is currently unavailable, it is needed to better understand and address the issues described at the local level.

Rising Overhead and Falling Reimbursement

While patients face significant challenges in accessing care, many oncologists face challenges in providing it. Oncologists and clinical practices are caught in the middle as public and private payers reduce reimbursement rates in an attempt to decrease costs of cancer care at the same time that overhead costs for physicians and practices are increasing.¹²⁶ Many oncologists cannot afford to absorb falling revenues, particularly with escalating costs such as implementing electronic health records.¹²⁷ While innovative payment models that incorporate quality into payment metrics are being tested, historically oncologists have been paid based on the number, not the quality, of services they deliver.¹²⁸ A system that values quantity over quality can result in more services and higher spending that does not necessarily result in better health outcomes.¹²⁹ If payments are perceived as too low, physicians are further discouraged from seeing patients for whom care will not be adequately reimbursed.¹³⁰

One issue that has been cited among physicians is that doctors lose money on Medicaid patients because the reimbursement rate is much lower than commercial health plans or Medicare.¹³¹ As fewer physicians accept Medicaid, the millions of new enrollees seeking care are further straining those who do. While the ACA temporarily increased Medicaid payments, the boost did not apply to specialists such as oncologists.¹³² Doctors may also be reluctant to accept Medicaid because of issues related to cost and

payment. When asked about the most significant challenges they face in their practice, more than 24% of practices nationally cited costs, and over 21% cited payer-related issues.¹³³ In the past, D.C. Medicaid payers have had difficulty providing payment on time.^{134,135,136} Anecdotal evidence from D.C. patient navigators indicates that payment delays have, at least on some occasions, resulted in D.C. Medicaid patients having to stop necessary treatment.

Medicaid, Managed Care Organizations and Cancer Care

Limited participating providers

Anecdotal evidence in D.C. suggests provider networks for Medicaid patients are more limited than published networks would suggest. An informal review by George Washington University Cancer Institute staff conducted between April 14-16, 2015 revealed that publicly available FFS and MCO networks had outdated and incorrect information listed. Importantly, changes to providers willing to accept Medicaid combined with shifting alignment of providers with various hospital systems and networks may make it difficult for Medicaid Managed Care Organizations (MCOs) to keep information accurate and current.

Furthermore, Medicaid beneficiaries can only receive chemotherapy from a handful of providers at the District's 7 Commission on Cancer-accredited cancer programs,¹³⁷ most of which are not geographically close to where the highest-risk populations are likely to live. According to the Department of Health and Human Services Office of the Inspector General (OIG), all states with Medicaid MCOs must have access to care standards to ensure responsiveness of provider networks to its enrollees.¹³⁸ The most common types of standards relate to distance or time traveled to see a provider, appointment access within a delimited timeframe and the provider-to-enrollee ratio. In D.C., a primary care provider is required to be within 30 minutes travel time by public transportation or within 5 miles of an enrollee (L. Walker, personal communication, April 15, 2015). There is disagreement regarding whether there are standards for specialty care in D.C. The OIG report indicates that there are no standards, but verbal reports from the Department of Health Care Finance indicate that contracts do enforce standards.

D.C. patient navigators have noted that payment delays have, in some cases, resulted in D.C. Medicaid patients having to stop necessary treatment.

Actual Medicaid contracts were not available for review in this analysis. In D.C., there is a 30-day standard for access to an appointment with a primary care or specialty care provider for routine care; however,

there are no time-driven standards for urgent care (L. Walker, personal communication, April 15, 2015). Unlike many other states, D.C. has no provider-per-enrollee standard for specialists based on the OIG report.¹³⁹

Cost constraints

Nationally, MCOs have struggled to maintain profitability while maintaining benefits for health care services.¹⁴⁰ Although MCOs have the potential to significantly improve access to health care and outcomes for the Medicaid population, this is only possible if payments are set at an appropriate level.¹⁴¹ Whether reimbursement in D.C. is set at a sufficient level is unknown and requires further research. While we are not certain that this is a primary issue in D.C., at a national level insufficient funding provided to MCOs encourage low payments to providers, further prohibiting clinicians from providing care to Medicaid patients.¹⁴² Thus reimbursement issues are a concern for all stakeholders – including patients, providers and health plans. The national perception is that if the payment is too low, providers will be unable to deliver quality care, no matter how reliable the payment method is.¹⁴³ More research needs to be done to assess whether level of reimbursement and historical issues of nonpayment by former MCOs are primary reasons for oncologists being resistant to take Medicaid as first-line health insurance in D.C.

Hospitals and Community-Based Oncology

Growing health care costs

From 1970-2005 the U.S. had an 8.3% increase in the percentage of the gross domestic product (GDP) spent on health care, the highest of all Organization for Economic Cooperation and Development (OECD) countries.¹⁴⁴ Even though spending is highest in the U.S., there are fewer physicians, nurses, hospital beds, doctors' visits and hospital days than the median OECD country.¹⁴⁵ One reason may be that providers, laboratories and hospitals are all paid separately for their services, leaving little incentive for separate providers to coordinate services.¹⁴⁶ Competition among different physician groups is necessary to combat rising costs and provide patients with options.¹⁴⁷ While collaborative and innovative arrangements may improve quality and reduce costs, those goals can only be achieved when there is healthy competition in the marketplace – collaboration and competition may be opposing goals that result in less coordinated care.¹⁴⁸

Reduced competition

Competition is decreasing rapidly, however, as more and more community oncology practices are closing, merging or being acquired by corporations.¹⁴⁹ Since the first national report from the Community Oncology Alliance, covering 2008-2010, 313 community oncology clinics have closed, 395 practices are struggling financially, 46 practices are sending all Medicare patients elsewhere for treatment, 544 practices have been acquired by hospitals and 149 practices have merged or been acquired by a corporate entity other than a hospital.¹⁵⁰ This translates into an 82% increase in clinics closed.¹⁵¹ The Community Oncology Practice Report also found a 46% increase in the number of practices merged or acquired, and a 143% increase in practices acquired by a hospital.¹⁵²

Across the U.S., hospitals are trying to increase their market share to increase profits, but this may be detrimental to the community.¹⁵³ An increase in market share may lead to an increase in total health care spending in the community.¹⁵⁴ In fact, hospitals represent the largest share of total health care costs.¹⁵⁵ They are also the largest contributor to growing costs.¹⁵⁶

Institutions that have historically cared for high-risk, low-income cancer patients may have to turn patients away for reasons that are not well-studied, but may include financial viability of operations or inability of providers to see the volume of patients demanding care. Variability in payer reimbursement for organizations participating in the discounted drug purchasing program, the 340B Drug Pricing Program, versus non-340B hospitals, the overall resources available at different institutions and patient demand for services may also contribute to the confusion in finding a permanent solution to unreliable access to specialist oncology care.

Politics and Cancer

Politicians may be supportive of improvements in cancer care, particularly in payment reforms and increased access to care, but disagreements among voters and competing issues can slow efforts for reform. Generational differences among voters may impact politicians' focus; older voters care much more about foreign policy and immigration, while younger voters are more focused on the economy and environmental issues.¹⁵⁷ Even among so-called voting blocks, such as retired voters, generational divides exist. Younger members, aged 50-64 are unhappy with the choices they are faced with in the private insurance market. Older members aged 65 and up are angry over proposals to expand Medicaid coverage to adults in the 50-64 age group.¹⁵⁸

Continued attempts to overturn key aspects of the Affordable Care Act make it difficult for states, health plans and patients to know what to expect or how to plan. On March 4, 2015 the Supreme Court heard arguments about the legality of the health care subsidies provided by the federal government in 34 states that have decided not to create their own exchanges.¹⁵⁹ If this provision of the ACA is overturned, more than 5 million enrollees could lose critical support needed to pay for health insurance.¹⁶⁰

Conclusion

Washington, D.C. has made tremendous progress to become the healthiest city in America. Yet, there are significant cancer outcome inequalities for residents. Many factors identified as impacting disparities nationally are well-documented in D.C. Differences in educational attainment,¹⁶¹ employment,¹⁶² income,¹⁶³ race,¹⁶⁴ geographic barriers¹⁶⁵ and transportation issues,^{166,167} insurance type¹⁶⁸ and fragmentation¹⁶⁹ may all contribute to cancer disparities in D.C. and should be studied further. Issues such as health literacy^{170,171} and cultural differences¹⁷² between patients and providers should also be explored.

Other issues to consider include challenges for health care providers, health plans, hospitals, outpatient clinical sites and policymakers. This needs assessment identified national concerns about rising costs for providers and care sites as well as the lack of incentives to provide coordinated care and better services for all patients.^{173,174} Reimbursement levels were cited in many national studies as problematic for providers and practices and were cited as a reason why many oncologists nationally do not accept Medicaid patients:^{175,176,177} whether or not this is true for D.C. requires further investigation. An analysis conducted by GW Cancer Institute staff found that in D.C., Medicaid FFS and MCO networks are more limited than published networks suggest.

To better understand the issues impacting patients and D.C., more local data is needed on each of these issues. The inaugural Access to Care Summit on May 11, 2015 will bring payers, providers, safety-net organizations, community organizations and patients together to identify gaps and collaboratively create strategies to move toward greater equity in access to quality cancer care.

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