Independent Oncology Practices in the COVID-19 Era—Does US Cancer Care Need a Bailout?

The coronavirus disease 2019 (COVID-19) pandemic has exposed the fragility of US cancer care. Though half of US oncology practices are independent, these mostly physician-owned practices, sometimes the only cancer care providers in their communities, often struggled financially even before the pandemic. Today, with COVID-19 expected to result in at least 19 million people becoming uninsured or transitioning to Medicaid and national guidelines recommending careful consideration or delay of cancer treatment, outpatient cancer visits are at half of prepandemic levels, and chemotherapy administration is down 13%. This is slashing revenue for oncology practices. While oncology-specific data are not available, US labor statistics showed that physicians’ offices eliminated 240,000 jobs in April alone. As financial pressures put some independent practices on the verge of collapse, patients’ access to cancer care could be threatened. In this Viewpoint, we detail the particular risks confronting independent oncology practices and offer 3 solutions to mitigate those risks: identify practices crucial to preserving cancer care access; promote their short-term stability; and pivot toward a system that adequately pays for comprehensive cancer care services.

Pandemic-driven revenue declines have exacerbated a number of preexisting stressors for independent practices. They were already confronted with growing expenses, rising cancer care complexity, and a reimbursement system that inadequately covers the time and resources needed to provide comprehensive care. Meanwhile, this same reimbursement system has made it difficult for practices to compete with the hospitals that have increasingly acquired them. Under “buy and bill,” oncologists purchase infused or injected cancer drugs at one price and are reimbursed by insurers at a higher price. The difference between the 2 prices is their margin. Though cancer drug administration represents two-thirds of oncologists’ Medicare revenue and half of their commercial reimbursements, margins differ by setting. Half of hospitals obtain significant discounts through the 340B drug pricing program and may also have greater leverage with which to negotiate higher reimbursements. While hospital costs may be higher and their care for underinsured or uninsured populations more prominent, hospital margins are also greater under the 340B program. For independent practices, their relative ability to cross-subsidize otherwise under-reimbursed services with treatment-based revenue is limited, and it is increasingly attractive for hospitals to acquire them. Between 2007 and 2017, hospital and health system ownership of oncology practices increased from 20% to 54%. Oncology is now the most vertically integrated specialty.

With COVID-19 expected to affect oncology care for at least 18 months, revenue reductions may result in many independent practices closing or selling to larger organizations to access capital. While enhanced coordination with larger centers may facilitate access to the subspecialized care considered increasingly necessary in today’s complex treatment landscape, large-scale closings or acquisitions would have long-term disadvantages for several reasons. First, underlying national trends suggest that greater numbers of patients needing cancer care will strain future capacity. Loss of independent practices will exacerbate this. Second, closures will force some already underserved patients to travel further for oncology care. This may delay care as well as increase hospitalization rates, intensive care unit utilization, and spending. Third, accelerating vertical integration may also increase spending and reduce affordability.

In the context of the current demand shock in oncology, ensuring the short-term solvency of independent practices is critical to preserving patients’ access to cancer care. This will require several temporary changes that go beyond the aid generally available through relief legislation. We propose 3 solutions.

First, we should identify practices whose closure or acquisition is most likely to impair affordable access to cancer care. While not the only factors, 3 key identifiers of critical access practices (CAPs) could be: (1) caring for underserved populations, including patients newly uninsured or transitioning to Medicaid; (2) being located in a geographically underserved area; and (3) competing in a highly consolidated market. Failure of the first 2 types of practices would have obvious access implications. They may also be at higher risk of failure. Practices already caring for the uninsured and patients covered by Medicaid will have lower operating margins with which to absorb COVID-19–driven losses. Those newly doing so will face acute revenue declines for which they may be unprepared. Potentially less obvious, but important, is that support for practices competing in highly integrated markets might avoid further consolidation and prevent detrimental effects on affordability and spending. Measures of consolidation are considered when regulatory bodies decide whether to approve mergers. These same principles could be adapted to select practices for relief measures.

Second, Congress could stabilize these practices’ finances by reducing the capital expenditures required for drug acquisition. One mechanism would be to temporarily extend 340B pricing to independent practices that cannot currently qualify. Though admittedly provocative, an extension targeted at CAPs might even be consistent with the 340B program’s goal of improving access for the un-
derserved. Under usual circumstances, Congress would be unlikely to enact an expansion of covered entities, but such a radical proposal should at least be considered as an emergency measure to reduce practices’ expenditures and increase their revenue.

Third, independent practices should be adequately reimbursed for the time, effort, and expertise necessary to provide high-quality, complex, and patient-centered oncology care. Alternative payment models have recognized that shared decision-making, care coordination, and advanced care planning are undervalued. As the pandemic increases the complexity of treatment decisions and monitoring, these services are more important than ever. In recognition of this, the Oncology Care Model’s capitated Monthly Enhanced Oncology Services payment could be extended to any independent oncology practice that agrees to meet its enhanced services requirements, and commercial payers could establish similar payments. Because capitated payment rates were determined based on the estimated cost to deliver the required services, payments would need to be increased, likely substantially, to provide fee-for-service-independent revenue during the pandemic. To assist practices not equipped to immediately meet all requirements, the Centers for Medicare & Medicaid Services and commercial payers could consider a tiered payment system, a structure suggested in some proposed alternative payment models. Payment rates could be tied to both the proportion of services offered and a practice’s CAP designation.

Our proposed changes may encounter a number of stakeholder objections. First, an expansion of 340B pricing would be controversial. But this measure would be temporary, and the ongoing policy debate about 340B pricing’s pros and cons can be resumed after the crisis. Second, COVID-19’s widespread disruption has resulted in competition for relief funding. Though many individuals and organizations will require support in the coming months, the specific challenges faced by independent oncology practices outlined here warrant consideration. Finally, how to implement capitated payments remains disputed. This debate will not be settled during the crisis. Yet temporary, pandemic-driven innovations could still inform post-COVID-19 policy changes. Offering practices flexibility during the crisis while soliciting ongoing feedback and rapidly iterating might provide valuable insight into these measures’ barriers to implementation and their intended and unintended consequences.

The coming months will be difficult for patients with cancer and the independent practices that care for them. The solutions we propose, some of which would have been considered unacceptable just months ago, could provide needed capital at a crucial time to stabilize independent oncology practices. They could also begin to fundamentally realign the structure of oncology reimbursement in the US to better provide high-quality, affordable, and patient-centered cancer care.

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REFERENCES