OHC
SPECIALISTS IN CANCER AND BLOOD DISORDERS

December 6, 2023

House Insurance Committee
Ohio House of Representatives
77 S High St
Columbus, OH 43215

Support for HB 156: Regards Physician Administered Drugs

Honorable Chairman Lampton, Vice-Chair Barhorst, Ranking Member Miranda, and Members of the House Insurance Committee,

My name is Randy Drosick and I am a medical oncologist, hematologist, and Practice President at Oncology Hematology Care (OHC) in Cincinnati. I come to you this morning on behalf of my colleagues, our partners, and our patients to speak in support of HB 156 which would protect Ohio cancer patients from suffering under mandatory white bagging policies.

Oncology Hematology Care, or OHC as we call it, is an independent, physician-led practice that delivers leading-edge technology and treatment options to cancer patients in the greater Cincinnati area. As one of the largest independent adult cancer practices in the nation, we have provided accessible and affordable cancer care to patients of all economic backgrounds in our community for nearly 40 years. OHC is our region's premier source of treatment for nearly every form of adult cancer and complex blood disorder. At OHC, our core value is to ensure that our patients receive the right care at the right time and in the right place. In our lengthy experience, when this goal is achieved, patient outcomes improve, quality of care is preserved, and unnecessary care costs are avoided. That is why when our practice experiences the threat of policies like white bagging that exist solely to cut line-item drug costs without examining the larger picture, we must speak out.

As the President of OHC, one of my main roles is to guide practice performance while delivering high quality, high value cancer care to the over 25,000 patients we treat annually. As a part of that charge, I spend a significant amount of time working with OHC care teams to ensure that our patients have safe, timely, and affordable access to life saving medications in the physician office setting. That includes standing firm when it comes to health plan attempts to impose policies like white bagging on our patients. At a high level, white bagging is when a patient is required to access their infused medications through an off-site specialty pharmacy instead of through the inventory available on-site at their infusion clinic. These policies are intended to save payers money by reducing the cost of the medication to the plan itself; however, these supposed savings come with the tradeoffs of diminishing quality of care overall, significant liability for the practice, and poorer patient outcomes.

It is the negative impact on patient outcomes that concerns my colleagues and I not only from a clinical perspective but also from the perspective of being responsible stewards of our health care system. There is a consensus among think tanks[1], government agencies[2], and major consulting firms[3] alike that the future model for keeping specialty health care high quality yet affordable is not through care fragmentation but through value-based reimbursement programs. Value based programs tie the amount that health care providers earn from their services to the results that they deliver for their patients. These programs are required to use five key outcomes-based metrics to determine success:

1. Efficiency & Effectiveness;
2. Timeliness & Ease of Access;
3. Safety;
4. Focus on the Patient; and
5. Equitability.[4]

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[1] Value-Based Care: What It Is, and Why It's Needed | Commonwealth Fund
[2] Fighting healthcare rocketing costs with value-based medicine: the case of stroke management - PMC (nih.gov);
[3] Investing in the new era of value-based care | McKinsey;
[4] 5 Quality Measures That Matter for Value-Based Care (managedhealthcareexecutive.com)

Considering that CMS has committed 100% of Medicare plans and the majority of Medicaid plans to transition to value based payment structures by 2030[5], these five metrics are on track to be some of the most important indicators for a clinical practice to pay attention to when evaluating new policies & protocols. With that in mind, it makes sense to use these metrics as a rubric to analyze white bagging. And when we do that, we find that white bagging policies fail every quality metric, every time.

For as long as I have been a practicing oncologist, physician-ownership of an infusion drug inventory has been the standard practice for community cancer care. This is done through a closed-supply distribution system that ensures the product arrives safely and on time. We manage the drug through our on-site inventory and, when a patient arrives for treatment, bloodwork is completed. If needed, I am able to adjust their treatment for that day based on the patient's disease progression, comorbidities, or weight variation, as well as the drug's toxicity and side effects. Under the current system, we prepare infusion drugs on-site to the exact specifications of each individual patients' needs. As a result, we are able to immediately dispense a safe and appropriate dose to the patient as soon as the drug is mixed. For the patient, this is not only the most convenient and secure method, but it is also the most cost-effective method of accessing care because treatments delivered in this way are covered under their medical benefit. Under the medical benefit, patients merely pay for the cost-sharing associated with the service provided instead of shouldering an additional cost of a separate co-pay relative to the cost of the drug itself.

However, under white bagging policies, I would be required to order the excluded drugs from a designated specialty pharmacy in advance of the patient's arrival for scheduled treatment. Patients often require multiple infusion drugs in combination with each other for each treatment regimen, so it would not be out of the question to have to coordinate with many different pharmacies for in order to access all medications prescribed. The specialty pharmacies purchase the drug from a manufacturer, prepare the drug according to my earlier requested dose, and then ship it to my office for administration. The supply chain is outside of my control, possibly leading to delayed, damaged, contaminated, or even counterfeit shipments that my office would have no record of. Upon arrival of the drug to my office, I would have to maintain this drug in a separate inventory from my normal drug supply, which creates added infrastructure cost and administrative burden. Beyond that, if my patient arrives for treatment and I believe her dose needs to be adjusted, I must send her home and re-order the drug from the specialty pharmacy for a different date. The unused, white-bagged drug cannot be re-dispensed or used for another patient, so it now becomes waste. Above and beyond all the administrative burden, safety issues, and waste, the delays in patient care could result in disease progression. Overall, this is leads to poor quality outcomes when compared to patients who did not experience white bagging with no direct benefit for the patient.

Undergoing cancer treatment is already a stressful time for patients. At this time, patients should be focused on getting well while eliminating any additional complications from delayed, ineffective, or unnecessarily costly treatment. And instead of worrying over the quality and timely arrival of pre-mixed drugs in my infusion clinic, I should be able to focus on helping my patients get better. For these reasons, we respectfully request support of HB 156 so that myself and other physicians providing specialized care in the State of Ohio can continue to serve our patients safely, efficiently, and effectively. On behalf of OHC and the patients that we care for I thank you for your leadership on this issue and look forward to working with the committee throughout this process. Thank you for your time.

Sincerely,

Randy Drosick, MD
Practice President
Oncology Hematology Care

[5] Value-Based Payments & CMS's Vision For 2030 | RTI Health Advance