Legislative Update

*What’s Impacting Cancer Care?*

Ted Okon
Orlando, Florida
April 5, 2014
Don’t Shoot the Messenger!

Washington, DC — Capitol Hill and 1600 Pennsylvania Avenue — is an unmitigated disaster.

I mean a complete dysfunctional mess!!!
What You Need to Understand from My Presentation

- Government’s Medicare policy has had adverse, unintended consequences on all of cancer care.
- Budget/debt battles on Capitol Hill have made a bad situation worse, especially with sequestration.
- Medicare is ushering in a new era of measuring quality and value in medical care.
  - Oncology providers will be pressured to measure the quality and value of the care they provide, wherever they practice.
- ACA/Obamacare is turning the insurance market upside down.
  - For the better or worse?
  - Starting to see adverse impacts on cancer care.
- The cancer community needs to lead cancer care forward and advocate for it; not let the policymakers in Washington, DC destroy it!
Medicare Payment for Cancer Care

- Medicare payment for cancer care fundamentally changed in 2004-2005
  - Put enormous pressure on community oncology practices
  - Medicare has inordinate influence and leverage because it pays for approximately 50% of all cancer care in the United States

- The government has been cutting Medicare’s payment for cancer care since the system was changed in 2004-2005
  - Cuts to administering chemotherapy, imaging, radiation treatment, and certain lab tests

- Congress can’t fix the broken Medicare payment system (SGR, docfix)
  - It has patched the system 17 times in the last 10 years at enormous waste to us (the taxpayers)

- Medicare policy has had adverse, unintended consequences on all of cancer care
  - Consolidation of cancer care
  - Drug shortages
Cancer Care Consolidation

Community Oncology Practice Impact Report, Community Oncology Alliance, July 2013
Consolidation Over the Last 6 Years

- 1,338 clinics/practices impacted
  - 288 clinics closed
  - 407 practices struggling financially
  - 43 practices sending ALL patients elsewhere for treatment
  - 469 practices acquired by hospitals or have a PSA agreement
  - 131 practices merged or acquired

- Over past 16 months since report issued July 2013...
  - 20% increase in clinics closed
  - 20% increase in hospital acquisitions/agreements
Why is Consolidation a Problem?

- Patients are falling through the “treatment cracks” in areas where facilities are closing
  - Especially true in rural areas where patients have to travel
- Consolidation results in higher costs directly for patients and insurers (Medicare and private payers)
  - Reports by Milliman, Avalere, ad Moran document higher costs
- This is a blind experiment on the cancer care delivery system
  - We have no idea of how cancer patients will be impacted long term
Cost of Consolidation: Milliman 2011 & Avalere 2012 Studies

- Milliman 2011 study on Medicare costs by site-of-service
  - $6,500 annualized higher chemo treatment costs in outpatient hospitals versus MD community cancer clinics
  - $650 annualized higher out-of-pocket costs for Medicare beneficiaries

- Avalere 2012 on private payer costs by site-of-service
  - Up to 76% higher chemo treatment costs in outpatient hospitals versus clinics
  - 24% higher on average in outpatient hospitals

Sources:
Site of Service Cost Differences for Medicare Patients Receiving Chemotherapy, Milliman, October 2011
Total Cost of Cancer Care by Site of Service: Physician Office vs Outpatient Hospital, Avalere, March 2012
Cost of Consolidation: Moran 2013 Study

Source: *Cost Differences in Cancer Care Across Settings*, The Moran Company, August 2013
Cost of Consolidation: Milliman 2013 Private Pay Study

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>POV</th>
<th>HOP</th>
<th>HOP/POV Episode Cost - Percent Higher in HOP</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metastatic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSCLC</td>
<td>$82,849</td>
<td>$122,909</td>
<td>48.4%</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>CRC</td>
<td>$122,300</td>
<td>$186,541</td>
<td>52.5%</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Breast</td>
<td>$115,308</td>
<td>$158,727</td>
<td>37.7%</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Adjuvant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSCLC</td>
<td>$44,769</td>
<td>$60,994</td>
<td>36.2%</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>CRC</td>
<td>$79,058</td>
<td>$101,060</td>
<td>27.8%</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Breast</td>
<td>$57,809</td>
<td>$86,857</td>
<td>50.2%</td>
<td>&lt; 0.001</td>
</tr>
</tbody>
</table>

- Study found “significantly higher per-episode cost for chemotherapy drugs, radiation oncology, imaging (CT, MRI and PET scans) and laboratory services” in outpatient hospitals.

Source: *Comparing Episode of Cancer Care Costs in Different Settings: An Actuarial Analysis of Patients Receiving Chemotherapy*, Milliman, August 2013
Drug Shortages

- Most of the important drugs in short supply are low-cost generic, injectable drugs
  - Shortages started with cancer drugs several years ago
- You hear about a lot of quality manufacturing problems in the press as causing drug shortages
- The real, underlying reason is economic!!!
  - The Medicare pricing system puts downward pressure on generic drugs administered in MD offices, such as community cancer clinics
  - Low prices, combined with increasing discounts mandated by the government, are making the generic injectable make unprofitable
    - We have fewer numbers of manufacturers
    - Lower profits mean less investment in manufacturing plants and equipment
      ✓ Rundown production facilities = quality problems
Drug Shortages

Source: GAO analysis of Utah Drug Information Services Database

Community Oncology Alliance
The SGR Situation

- The sustainable growth rate (SGR) is the underlying formula for how all physicians under Medicare Part B are reimbursed for services
  - *It’s BROKEN!!!*

- Congress actually agreed to a bill on how to eliminate the SGR and replace it with Medicare payment reform
  - *SGR Repeal and Medicare Provider Payment Modernization Act of 2014*
  - This means both parties in the House and Senate agreed to repealing the SGR and phasing in real payment reform

- The problem is Congress can’t agree on how to pay for the policy
  - CBO estimated that policy costs $138-180 billion over 10 years

- So, for the 17th time, Congress puncted and passed yet another patch of the SGR
  - SGR will have to be addressed again in March 2015

- The fix, if ever passed, will move towards measuring quality and value (especially cost savings)
Medicare Clearly Moving Towards Payment for Value & Quality

- Medicare has already moved to “scorecards”
  - PQRS (old PQRI)
  - Accountable Care Organizations
  - Hospital Compare
    - Hospital Value-Based Purchasing Payment Modifier
  - Physician Compare
    - Physician Value-Based Purchasing Payment Modifier
  - Quality & Resource Use Reports
  - Medicare Advantage Star Ratings
  - EHR Meaningful Use
## Hospital Compare

### Margaret R. Pardee Memorial Hospital

**Address:**
800 N Justice St
Hendersonville, NC 28791
(828) 696-1000

**Hospital Type:** Acute Care Hospitals
Provides Emergency Services: Yes

**Readmissions, Complications, and Deaths**

Patients who are admitted to the hospital for treatment of medical problems sometimes get other serious injuries, complications, or conditions, and may even die. Some patients may experience problems soon after they are discharged and need to be admitted to the hospital again. These events can often be prevented if hospitals follow best practices for treating patients.

**30-Day Outcomes: Readmission and Deaths**

**Death rate for heart failure patients**

**Why is this important?**

Hide Graph

**Margaret R. Pardee Memorial Hospital**

- **Death Rate:** 2.7%
- **Number of Included Patients:** 336

**U.S. National Death Rate for Heart Failure Patients:** 11.7%

Physician Compare

DAVID EAGLE
Primary Specialty: Hematology/Oncology

Add to My Favorites

Is this you? Update your information here

General Information

Quality Programs:
- Physician Quality Reporting System (PQRS)
- Electronic Prescribing (eRx) Incentive Program
- Electronic Health Records (EHR)

View information about Medicare quality reporting programs

COA Leading the Way in Payment Reform for Cancer Care

- Development of the Oncology Medical Home
  - *Total focus on the patient***!

- Quality measurements relating to cancer care
  - Includes patient satisfaction tool specific to cancer care

- Value measurements relating to cost effectiveness
  - Reducing hospitalizations & ER visits

- Evidence-based medicine to ensure optimal treatment
Affordable Care Act = Obamacare

- Signed into law on March 23, 2010
- Has created over 11,000 pages of new regulations
- Starting the major roll-out year this year
  - Make or break year in many respects
- Just starting to see the good, bad, and ugly impact on cancer care
Enrollment Statistics

<table>
<thead>
<tr>
<th>Paid Premiums</th>
<th>Current Population</th>
<th>As of</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>40.2%</td>
<td>208.9%</td>
</tr>
<tr>
<td>74,199</td>
<td>200,865</td>
<td>7,822,000</td>
</tr>
</tbody>
</table>

Source: Foundation for Government Accountability; Department of Health and Human Services
Enrollment Statistics (continued)

Financial assistance

Individuals below a certain income level who purchase a plan through the marketplace may qualify for financial assistance from the government.

- 18% Financial assistance
- 82% No financial assistance

Source: U.S. Department of Health and Human Services
Data current as of February 1, 2014
Enrollment Statistics (continued)

Source: Washington Post; Department of Health and Human Services
Obamacare Good for Cancer Care

- Payment help for more cancer patients in need but can’t afford treatment
- Annual and lifetime caps and preexisting condition obstacles removed
- Private insurers can’t block cancer patients from participating in clinical trials by not paying for standard-of-care
- Preventative cancer services paid for genetic counseling, mammography screenings, and chemoprevention counseling
- Preventative services paid for, with no patient copayment, breast cancer drugs such as tamoxifen and raloxifene
Obamacare Bad and Ugly for Cancer Care

- **The Bad**
  - Of the 24-34 million Americans to be covered by insurance, 50% or more will be covered by Medicaid
    - Medicaid programs will come under tremendous pressure to keep Medicaid solvent going forward
    - Medicaid will be forced to restrict treatment/drugs
  - Employers cutting costs ahead of 2014 by eliminating insurance or cost shifting to employees
    - Will more than likely leave MORE cancer patients underinsured

- **The Ugly**
  - Independent Payment Advisory Board (IPAB) is the equivalent of the SGR on steroids
  - Insurers cutting providers out of networks
  - Insurers are already ratcheting down provider reimbursement
    - Milliman study found wide variation in formularies coverage
      - Most cover thalidomide but few cover pomalidomide
Exchange Problems Surfacing for Cancer Care & Oncology Providers

- Oncology providers across the country are being excluded (out of network) from exchange plans
  - Includes NCCN systems and community practices
  - Especially true with bronze and silver plans
- If out-of-network and treating an exchange patient, there is no treatment $$$ cap as there is in-network
- If practice treating a patient who has a plan but does not (or stops) paying premium, practice on the hook for bad debt after first month
- Ratcheting down of reimbursement
- Formularies
Thank You!

Ted Okon
tokon@COAcancer.org
Twitter @TedOkonCOA

www.CommunityOncology.org
www.COAadvocacy.org (CPAN)

www.facebook.com/CommunityOncologyAlliance