Importance for Cancer Patients and the Medicare Program

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11/17/15
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Site Neutrality & Medicare Payments for Cancer Care

- Payment site neutrality is about paying for the same service provided to Medicare patients whether in physician offices or outpatient hospital facilities
  - Substantial payment gap between independent community cancer clinics and hospital outpatient cancer facilities

- Real consequences of a lack of Medicare site payment parity
  - Medicare pays more for cancer care in the hospital outpatient setting
  - Seniors covered by Medicare pay more in the hospital outpatient setting
  - Causing a dramatic shift in cancer care to the more expensive hospital setting
Hospital Outpatient Setting More Expensive

- Milliman 2011 study on Medicare costs by site-of-service
  - $6,500 annualized higher chemo treatment costs in outpatient hospital cancer facilities versus independent 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 hospital cancer facilities versus independent community cancer clinics
  - 24% higher on average in in outpatient hospital cancer facilities

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

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Hospital Outpatient Setting More Expensive

Source: Cost Differences in Cancer Care Across Settings, The Moran Company, August 2013
Consolidation of Cancer Care

Community Oncology Cancer Care Impact Map

2010

Community Oncology Practice Impact Report

2014

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75.1% of hospital acquisitions of community cancer clinics were by existing 340B hospitals (2012-2014)
Medicare Spending on Cancer Care: Shift of Spending by Site Dramatic & Increasing

Source: Medicare Data; Study in Progress, November 2015
“Push” and “Pull” Causing Consolidation

**Push**
- Declining Payment for Cancer Care
- Administrative Burdens: Physicians forced to do more paperwork than treat patients
- Obstacles to Patient Care: Medicare and insurance company requirements

**Pull**
- Hospital Hardball Tactics: Cut off referrals to oncologists
  - Hospitals get higher payments for identical services, such as administering chemotherapy
  - 340B Drug Discounts

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**Same Service: Different Payments**

<table>
<thead>
<tr>
<th>Service</th>
<th>Community Cancer Clinic</th>
<th>Outpatient Hospital Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Hour Chemotherapy Administration</td>
<td>$136</td>
<td>$288</td>
</tr>
<tr>
<td>Facility Fee</td>
<td>$0</td>
<td>$102</td>
</tr>
<tr>
<td>Total Payment</td>
<td>$136</td>
<td>$390</td>
</tr>
</tbody>
</table>

Additionally, hospitals are reimbursed for 65% of uncollected Medicare patient copays AND patient “outliers” (cases where a specific cost threshold is exceeded).
“The financial incentive to maximize Medicare revenues through the prescribing of more or more expensive drugs at 340B hospitals also raises concerns… Not only does excess spending on Part B drugs increase the burden on both taxpayers and beneficiaries who finance the program through their premiums, it also has direct financial effects on beneficiaries who are responsible for 20 percent of the Medicare payment for their Part B drugs. Furthermore, this incentive to prescribe these drugs raises potential concerns about the appropriateness of the health care provided to Medicare Part B beneficiaries.”
340B Hospitals Cost Medicare 52% More

340B similar to old Medicare reimbursement system based on AWP (average wholesale price)

Reimbursement rate fixed to hospitals but actual drug costs discounted 30-50%
  - Margin spread said to subsidize other services under/not reimbursed
  - 340B discounts provide huge financial incentives for hospitals to generate more oncology revenue
    - $1.2-2 million per oncologist
  - 340B margin spread fuels the use of more cancer drugs and more expensive drugs in hospitals
Hospitals with Special Medicare Exemption

Seattle Cancer Care Alliance
Seattle, WA
PPS exemption effective in 1985

The Ohio State University Comprehensive Cancer Center – James
Columbus, OH
PPS exemption effective in 1991

Roswell Park Cancer Institute
Buffalo, NY
PPS exemption effective in 1986

Dana-Farber Cancer Institute
Boston, MA
PPS exemption effective in 1985

Memorial Sloan Kettering Cancer Center
New York, NY
PPS exemption effective in 1996

Fox Chase Cancer Center
Philadelphia, PA
PPS exemption effective in 1984

Moffitt Cancer Center
Tampa, FL
PPS exemption effective in 1999

University of Southern California Norris Comprehensive Cancer Center
Los Angeles, CA
PPS exemption effective in 1984

MD Anderson Cancer Center
Houston, TX
PPS exemption effective in 1984

Sylvester Comprehensive Cancer Center
Miami, FL
PPS exemption effective in 1991

Source: Centers for Medicare & Medicaid Services; Map Resources (map) | GAO-15-199

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# PCHs Significantly Upcharge Over Medicare

Table 7: Estimated Additional Medicare Fee-for-Service Outpatient Payment at Prospective Payment System (PPS)-Exempt Cancer Hospitals (PCH) After Application of Payment Adjustment for Selected Service Categories, 2012

<table>
<thead>
<tr>
<th>PCH</th>
<th>Level 2 hospital clinic visits</th>
<th>Level V drug administration</th>
<th>Intensity-modulated radiation therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Hope</td>
<td>$10</td>
<td>$30</td>
<td>$66</td>
</tr>
<tr>
<td>Dana-Farber Cancer Institute</td>
<td>37</td>
<td>108</td>
<td>233</td>
</tr>
<tr>
<td>Fox Chase Cancer Center</td>
<td>16</td>
<td>45</td>
<td>100</td>
</tr>
<tr>
<td>MD Anderson Cancer Center</td>
<td>37</td>
<td>106</td>
<td>233</td>
</tr>
<tr>
<td>Memorial Sloan Kettering Cancer Center</td>
<td>38</td>
<td>111</td>
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<tr>
<td>Moffitt Cancer Center</td>
<td>15</td>
<td>44</td>
<td>96</td>
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<tr>
<td>The Ohio State University Comprehensive Cancer Center – James</td>
<td>25</td>
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<tr>
<td>Roswell Park Cancer Institute</td>
<td>13</td>
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<td>82</td>
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<tr>
<td>Seattle Cancer Care Alliance</td>
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<tr>
<td>Sylvester Comprehensive Cancer Center</td>
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<td>29</td>
<td>64</td>
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<tr>
<td>University of Southern California Norris Comprehensive Cancer Center</td>
<td>22</td>
<td>84</td>
<td>141</td>
</tr>
</tbody>
</table>

“Because Medicare’s payment methodology for PCHs lacks strong incentives for cost containment, it has the potential to result in substantially higher total Medicare expenditures. If, in 2012, PCH beneficiaries had received inpatient and outpatient services at nearby PPS teaching hospitals—and the forgone outpatient adjustments were returned to the Supplementary Medical Insurance Trust Fund—Medicare may have realized annual savings of almost $0.5 billion. **Until Medicare pays PCHs to at least, in part, encourage efficiency, Medicare remains at risk for overspending.**”
Site Neutral Payments for Cancer Care

- Patients and Medicare pay more for cancer care in the outpatient hospital setting

- Hospitals have huge financial incentives to purchase independent community oncology clinics
  - Higher payments for services, such as chemotherapy administration
  - 340B drug discounts

- Hospital arguments that higher payments (and drug discounts) subsidize emergency departments unfounded and not fair to patients
  - Increases copays and Part B premiums

- Site neutral payment provision in the bipartisan budget bill is a critical first step to stop the consolidation of cancer care and control costs
Thank You!

Jeff Vacirca, MD