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Testimony on:

NEW YORK STATE MEDICAID PAYMENT CUTS TO CANCER CARE

New York State Senate

Committee on Health

Albany, New York

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Chairman Hannon and members of the New York State Senate Committee on Health — We thank you for the opportunity to share our views on the adverse impact that Medicaid payment cuts will have on patients with cancer in New York State who are covered under Medicare and are also eligible for Medicaid.

I am the executive director of the Community Oncology Alliance, a non-profit, national organization dedicated to serving patients and providers in the community oncology setting, where close to 70% of Americans with cancer are treated. After my initial remarks on this critical issue, I will hand this testimony over to Maryann Roefaro, who is the chief executive officer of a large community oncology practice in New York that serves patients with cancer in the greater Syracuse area.

Recent changes to the State of New York's Medicaid reimbursement policy for patients dually-eligible for Medicare and Medicaid will hurt community oncology practices and the patients with cancer they serve. Specifically, we are concerned with the budget-cutting policy that Medicaid is now no longer reimbursing partial Medicare Part B coinsurance amounts when the Medicare payment exceeds the Medicaid fee for that service. Medicare covers 80% of the reimbursement rates it sets for cancer care, with patients responsible for the remaining 20%. For those individuals covered by Medicare, who are also eligible for Medicaid, it is Medicaid that is supposed to cover the 20% coinsurance. That is the issue — although New York Medicaid relented in not cutting payments for the 20% Medicare coinsurance for cancer drugs, it is now substantially cutting payments for the administration of chemotherapy and other vital services

provided to the most vulnerable patients with cancer — seniors and those disabled individuals covered by Medicare.

As background on this issue, community oncology practices like Maryann's have faced many devastating payment cuts at both the state and federal levels, such as the automatic Medicare budget sequestration cut in 2013. These cuts have slowly pushed more practices to close or to be acquired by hospitals, consolidating the cancer care delivery system significantly. Over the last eight years nearly 40% of New York State's community oncology practices have closed clinics or have been acquired by hospitals.[1]

The problem is that as community oncology practices close, patients have to go to hospitals for care they could be receiving in the community setting. Patients that have been receiving treatment from the same practice — in some cases for years — face dangerous gaps in their care when they are displaced to the hospital setting. Furthermore, many studies have demonstrated that hospital-based cancer care is 153% more expensive than in the community setting.[2]

The consolidation of cancer care, in New York State and across the country, is already creating stresses on the nations' cancer care delivery system, with patients being displaced and costs increasing as cancer care is absorbed into large hospital systems. Now, New York Medicaid is adding to the stresses by paying a fraction of the 20% Medicare coinsurance for dual-eligible individuals.

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[1] Community Oncology Alliance *"Practice Impact Report: The Changing Landscape of Cancer Care."* http://www.communityoncology.org/pdfs/Community_Oncology_Practice_Impact_Report_10-21-14F.pdf

[2] Milliman *"Comparing Episode of Cancer Care Costs in Different Settings. An Actuarial Analysis of Patients Receiving Chemotherapy."* www.communityoncology.org/UserFiles/Milliman_SiteCostofCancerStudy_2013.pdf.

As it is, community oncology practices are reimbursed by Medicare for just 57% of the costs related to chemotherapy administration and related critical services. Additionally, many other services are not reimbursed at all, such as psychosocial counseling, care coordination, supportive care, telephone support, and financial counseling.[3]

Community oncology practices simply cannot absorb additional payment cuts. They either have to send patients to hospitals or eventually close or merge into large hospital systems, in which case all patients end up being billed under the more expensive hospital setting. Taxpayers end up paying the price when that happens.

Representatives from community oncology practices across New York State — from Long Island, Queens, Brooklyn, Syracuse, Albany and beyond — are here today to say that this Medicaid policy change is extremely shortsighted. While it might save money in the short run, there is no question that costs for cancer care to New York State Medicaid and the federal Medicare program will go up dramatically.

Tragically, it is the most vulnerable patients — seniors and those with disabilities — who get caught in the policy cross hairs. And when I get too caught up in policy it is my wife the oncology nurse who reminds me what cancer care is about — people battling a dreaded disease.

Recently, President Obama and Vice President Biden launched a moonshot to cure cancer. We commend them for that and know that New York oncologists have and will

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[3] Avalere Health *"Providing High Quality Care in Community Oncology Practices: An Assessment of Infusion Services and Their Associated Costs."* http://www.communityoncology.org/pdfs/avalere-coa-components-of-care-study-final-report.pdf

continue to contribute greatly to that effort. But as we prepare for that battle tomorrow we cannot forget the Americans, especially the most vulnerable New Yorkers, facing misguided public policy that threatens their cancer treatment today.

I now will hand this testimony over to Maryann Roefaro of Hematology-Oncology Associates of Central New York.

As Ted introduced, I run a large, independent community oncology practice that since 1982 has been serving people in the greater Syracuse area and beyond who have cancer or hematologic disease. We have a team of sixteen specialists, in four clinic locations, in the area of oncology and hematology, as well as a professional clinical staff of advanced-practice nurses, specialized oncology nurses, and ancillary professionals.

Our mission is simple — provide the highest level of quality care in a healing environment for the mind, body, and spirit of patients dealing with cancer and blood disorders. Our goal is to offer the highest level, state of the art technology and treatments, while meeting the emotional needs of our patients and their families. In taking care of the whole patient we provide the array of critical cancer diagnostic and treatment services in a highly coordinated, efficient but friendly environment. Our services include the administration of chemotherapy, biologics, and related cancer drugs, diagnostic imaging, radiation therapy, and specialty drug pharmacy.

We are extremely concerned with the payment cuts that Medicaid is now implementing for our patients dually covered by Medicare and Medicaid. As Ted has described, our

practice has felt the brunt of cut after cut to cancer care, including the blunt ax of the Medicare sequestration cut. These types of cuts have real impact on the cancer care system in each of your districts. For example, our practice has had to close a clinic facility and simply cannot absorb any more cuts.

The most recent Medicaid cuts are unsustainable. Community oncology practices with small populations of patients who only have Medicaid coverage accept losses in order to provide care to the needy. However, for many of us, dual-eligible Medicare and Medicaid patients represent a large part — upwards of close to 30% — of the Medicare populations we serve and this new policy will hurt tremendously. For four of the practices joining me in this room today, losses from just this new Medicaid policy are estimated to be over $235,000 a year. That may not sound much to you considering a budget that is in the billions of dollars — but it will have an incredible impact on the ability of cancer care providers in New York to continue operating.

The services impacted by these cuts are critical to patient care and safety. For example, the skilled nurses that administer chemotherapy and care for patients while they receive treatment fall under the latest Medicaid cuts. They are essential to patient care, monitoring for dangerous complications and ensuring good treatment outcomes. In the short term, these cuts will cause practices like ours to cut back skilled nursing care and similar key oncology administrative services, which is a shortsighted way to achieve quick savings. Or in the end being forced to send these patients to hospitals for treatment. The problem in our case is that the hospital simply cannot absorb our patients.

I underscore what Ted related from my vantage point of running an oncology practice and keeping it viable. As a business person, I understand this is about budgets and finances. However, fundamentally it is about the people I watch every day fighting a terrible, often devastating disease. I watch them struggle with treatment, their own finances, and simply putting one foot in front of another as they fight cancer. These Medicaid cuts will have a devastating impact on the most vulnerable of these patients.

If you do not believe me, look at recent studies documenting that patients who are dual-eligible for Medicare and Medicaid face significant disparities in outcomes and quality of cancer care. They are diagnosed at more advanced stages of disease, have lower 5-year survival rates, receive lower quality of care, and have poorer outcomes than persons with insurance from other sources.[4] I call your attention to a recently published study by the University of California Davis, which we have referenced in our testimony. As an example, cancer patients in California who are dual-eligible for Medicare and Medicaid had the lowest proportions of recommended treatment of breast cancer with radiotherapy and of colon cancer along with chemotherapy. In short, dual-eligible patients end up being treated like second-class citizens. That is simply not right.

As if the Medicaid cuts being implemented now are not bad enough, New York Medicaid has indicated the cuts are retroactive from July 1, 2015. Practices will be required to refund — and yes, I underscore the word "refund" — portions of reimbursements provided by Medicaid since July 1, 2015. This will be devastating to community oncology practices.

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[4] California Cancer Reporting and Epidemiologic Surveillance Program, Institute for Population Health Improvement, University of California Davis *"Disparities in Stage at Diagnosis, Survival, and Quality of Cancer Care in California by Source of Health Insurance."* https://www.ucdmc.ucdavis.edu/iphi/resources/1117737_CancerHI_100615.pdf

We met with New York Medicaid last December and they listened to the facts we provided. But they said they are unable to do anything. We implore the Senate to help us in this dire situation. We are not just asking to stop additional payment cuts but to mandate Medicaid to work with practices across the state on Medicaid oncology payment reform. Community oncology practices like ours have been leading the way in real payment reform, working with national insurance companies like Aetna, UnitedHealthcare, and even Medicare in reducing costs of cancer care while increasing quality. Just recently, our practice received accreditation as an Oncology Medical Home from the Commission on Cancer, which is an exciting new model of cancer care delivery and associated payment reform.

Given the special nature of cancer care, the devastating impact of the disease, and the vulnerable dual-eligible population involved, we ask for a carve-out of cancer care services from the Medicaid cuts, including suspension of the retroactive payments back to Medicaid. This will actually end up saving the state money, as well as Medicare, by keeping cancer care from migrating further to the more expensive hospital setting. This way our practices can work with New York Medicaid in devising innovative solutions that provide quality, efficient cancer care to the dual-eligible Medicare and Medicaid population.

Please, let's work together for our patients — the New Yorkers you represent — not to mindlessly cut cancer care to the most vulnerable but to improve it for generations to come.

Thank you for listening and we would be happy to answer any questions.