COMMUNITY ONCOLOGY ALLIANCE

GASCO ADMINISTRATORS' MEETING

News from the Commissioner

SGR, Sequester Cut, Payment Reform, Obamacare & Other Impacts to Oncology

Ted Okon

Hilton Head, NC

May 2, 2014

Don't Shoot the Commissioner!

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

I mean a complete dysfunctional mess!!!

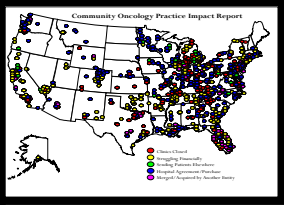
What You Need to Understand from My Presentation

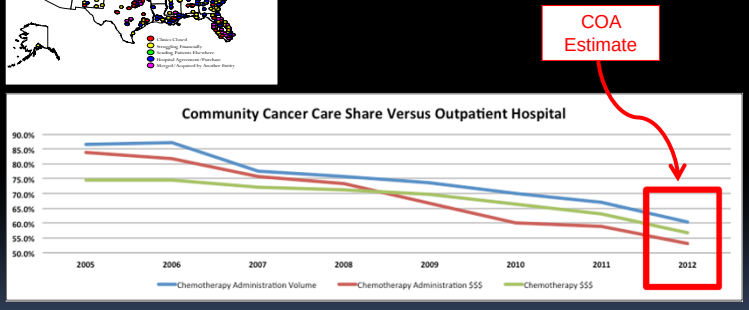
- Government's Medicare policy has had adverse, unintended consequences on cancer care
- Budget/debt battles on Capitol Hill have made a bad situation worse, especially with sequestration
- A new era of measuring quality and value is not coming but is here now in medical care
  - Oncology providers will be pressured to measure the quality and value of the care they provide, wherever they practice
  - *Even raw utilization data no longer hidden!*
- ACA/Obamacare is a big unknown for how it will impact medical care and the insurance market
  - Starting to see adverse impacts on cancer care
- *Oncology needs to lead, not be led!!!*

Medicare Reimbursement

- Medicare reimbursement for cancer care fundamentally changed in 2004-2005
  - Overall payments decreased
    - Services reimbursement (infusion services) increased
    - Drug reimbursement cut and fundamentally changed
      - ✓ Basis for reimbursement changed from AWP to ASP
- SGR has become a "sword of Damocles" hanging over the head of all private practice physicians
- Sequestration has cut all Medicare payments 2%, including the underlying cost of cancer drugs
- CMS cut payments for chemo administration, radiation treatment, diagnostic imaging, and pathology in 2014
- Medicare policy has had adverse, unintended consequences on all of cancer care, regardless of where it is delivered
  - Consolidation of cancer care
  - Drug shortages

Cancer Care Consolidation





Sources:
Community Oncology Practice Impact Report, Community Oncology Alliance, July 2013
Results of Analyses for Chemotherapy Administration Utilization and Chemotherapy Drug Utilization, 2005-2011 for Medicare Fee-for-Service Beneficiaries, The Moran Company, May 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?

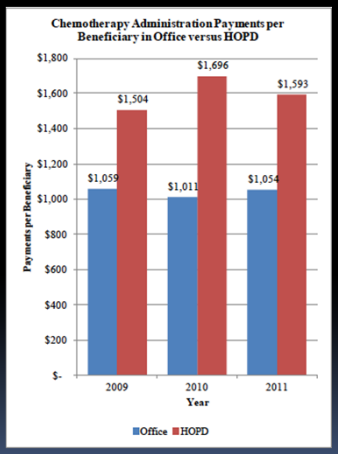
- Patients are falling through the "treatment cracks" in areas where facilities are closing
  - Especially true in rural areas where patients have to travel
- Consolidation results in higher costs directly for patients and insurers (Medicare and private payers)
  - Reports by Milliman, Avalere, ad Moran 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

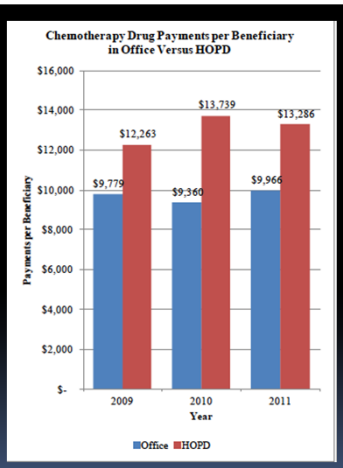
Cost of Consolidation: Milliman 2011 & Avalere 2012 Studies

- 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

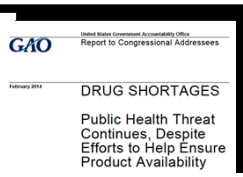
Cost of Consolidation: Milliman 2013 Private Pay Study

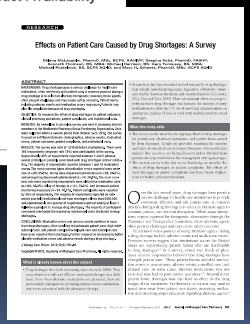
Cancer Type		POV	HOP	HOP/POV Episode Cost - Percent Higher in HOP	P Value
Metastatic	NSCLC	$82,849	$122,909	48.4%	< 0.001
	CRC	$122,300	$186,541	52.5%	< 0.001
	Breast	$115,308	$158,727	37.7%	< 0.001
Adjuvant	NSCLC	$44,769	$60,994	36.2%	< 0.01
	CRC	$79,058	$101,060	27.8%	< 0.001
	Breast	$57,809	$86,857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

- 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

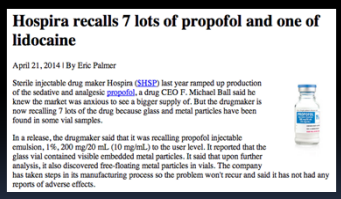




Source: GAO analysis of Utah Drug Information Services Database

Cause of Drug Shortages

- *Economics, economics, and more economics!!!*
- Medicare reimbursement changes (MMA) to ASP capped price increases and removed the floor from generic pricing
- Explosion of rebates and discounts required of generic manufacturers have created market disincentives to producing low-cost products.
  - Generic market has consolidated
  - Low margins hinder production/facilities reinvestment



Hospira recalls 7 lots of propofol and one of lidocaine

April 21, 2014 | By Eric Palmer

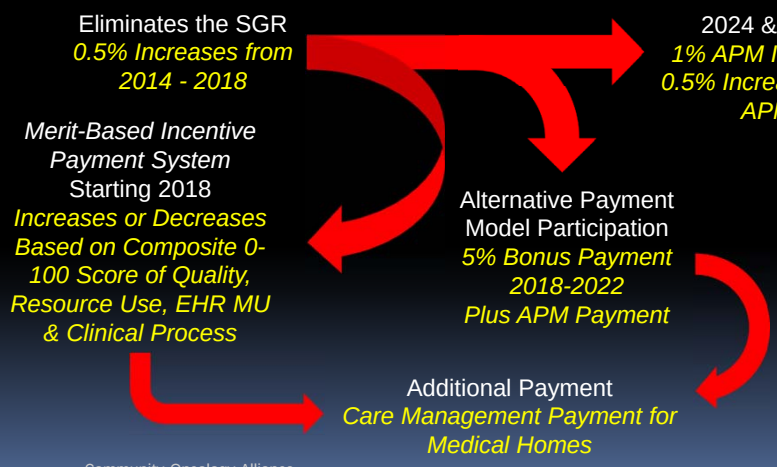
Sterile injectable drug maker Hospira (HSP) last year ramped up production of the sedative and analgesic propofol, a drug CEO F. Michael Ball said he knew the market was anxious to see a bigger supply of. But the drugmaker is now recalling 7 lots of the drug because glass and metal particles have been found in some vial samples.

In a release, the drugmaker said that it was recalling propofol injectable emulsion, 1%, 200 mg/20 mL (10 mg/mL) to the user level. It reported that the glass vial contained visible embedded metal particles. It said that upon further analysis, it also discovered free-floating metal particles in vials. The company has taken steps in its manufacturing process so the problem won't recur and said it has not had any reports of adverse effects.

The SGR Situation

- The sustainable growth rate (SGR) is the underlying formula for how all physicians under Medicare Part B are reimbursed for services
- Congress has agreed to an SGR bill on policy
  - *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 punted and passed yet another patch of the SGR
  - SGR will have to be addressed again in March 2015
- Problem now is increasing cost to fix the SGR and election year politics
- The fix, if ever passed, will move towards measuring quality and value (especially cost savings)

SGR Payment Reform in a Picture



Fight to Overturn Stark Exception

- Stark exception to "ancillary services" provided in MD offices allows for imaging, radiation treatment, labs, etc.
- President's budget would overturn Stark exception in most cases
- House legislation introduced by Representatives Speier, Titus, and McDermott
  - Promoting Integrity in Medicare Act of 2013 (H.R. 2914)
  - *"To prevent abusive billing of ancillary services to the Medicare program..."*
- ASTRO and others lobbying hard to overturn the Stark exception

ASTRO Intent Would Dismantle Integrated Community Practices

ASTRO
TARGETING CANCER CARE

Action Team Update

Sent from the desk of Colleen Lawton, MD, FASTRO

Immediate action needed!

Good morning,

Last month Congress introduced bicameral, bipartisan legislation to repeal Medicare's flawed Sustainable Growth Rate (SGR) formula -- H.R. 4015/S. 2000, the SGR Repeal and Medicare Pr Modernization Act of 2014. ASTRO strongly supports this historic legislation and we Michael R. Turner, Sen. Sherrod Brown, and Sen. Rob Portman to pass this legislati the current payment patch expires March 31, 2014 and a 24% Medicare payment cu including you!

Additionally, we urge you to tell your Members of Congress to help offset some of $1 SGR repeal by closing the physician self - referral loophole for radiation therapy. Inc the ASTRO-supported "Promoting Integrity in Medicare Act (PIMA) of 2013" in the would represent sound policy that protects patients and generates substantial saving dollars over 10 years to help pay for this important legislation. We know Congress is self-referral loophole as part of the SGR package, and we need your voice to seal th

Click "Immediate action needed" above to send an email your representative expres the SGR fix bill, H.R. 4015/S. 2000, and urging them to include the PIMA language t cost of the bill.

ASTRO is working hard to get the message of support to Congress, but we now nee team members to send the message directly. Now is the time to act! Congress is nc fixing the SGR and closing the self-referral loophole, so please tell your members of

ASTRO
TARGETING CANCER CARE

Official Statement
FOR IMMEDIATE REVIEW

Contact: Michelle Kirkwood
703-286-1600
michellek@astro.org

ASTRO applauds new CBO estimate demonstrating that ending self-referral abuse would save Medicare more than $3 billion

Fairfax, Va. April 17, 2014 — The Congressional Budget Office (CBO) today released a new assessment of the significant costs associated with physician self-referral abuse, estimating that closing the self-referral law's loophole would save Medicare approximately $3.4 billion over a 10-year budget window. CBO's new savings estimate—nearly double its previous estimate—adds additional weight to the existing mountain of evidence that the in-office ancillary services (IOAS) loophole results in potentially inappropriate patient care and substantial costs to the Medicare program.

Medicare Sequester

- Medicare sequester is a 2% across-the-board capped cut on all Medicare fee-for-service drugs and services
  - MA plans largely *wrongly* passing along the sequester cut
- Obama administration says it has no authority to stop application of the sequester cut to Medicare payments for cancer drugs
  - In reality, administration has actually exempted portions of Obamacare from sequestration
- H.R. 1416 (Congresswoman Ellmers/110 cosponsors) would stop application of the sequester cut to Part B drug reimbursement
- High awareness on Capitol Hill of the sequester and impact on community oncology practices/patients
- Needs more pressure to move bill to the House floor

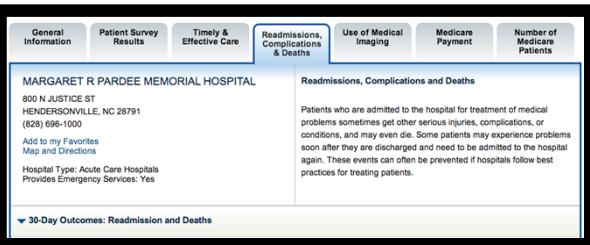
Virtual Hill Day to Stop the Sequester

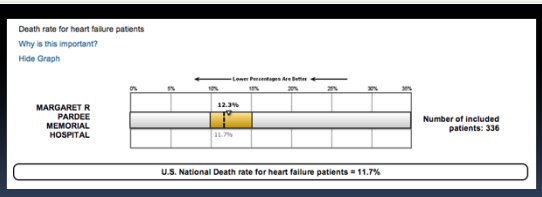
- Grassroots (*that's you!*) outreach to Representatives (House) on May 7th & 8th
- Calls and emails to health staff, general office, and other contacts — *including members themselves*
- Message
  - Cosponsor H.R. 1416
  - Stop applying the sequester cut to cancer drugs
- COA will provide talking points, materials, and Hill contacts
- Oncologists and administrators on Capitol Hill May 1st meeting with Congresswoman Ellmers and others
- Act if you want to stop the sequester — *it won't stop by itself!*

Medicare Clearly Moving Towards Payment for Value & Quality

- Medicare has already moved to "scorecards"
  - PQRS
  - 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
- *Now even releasing raw data!*

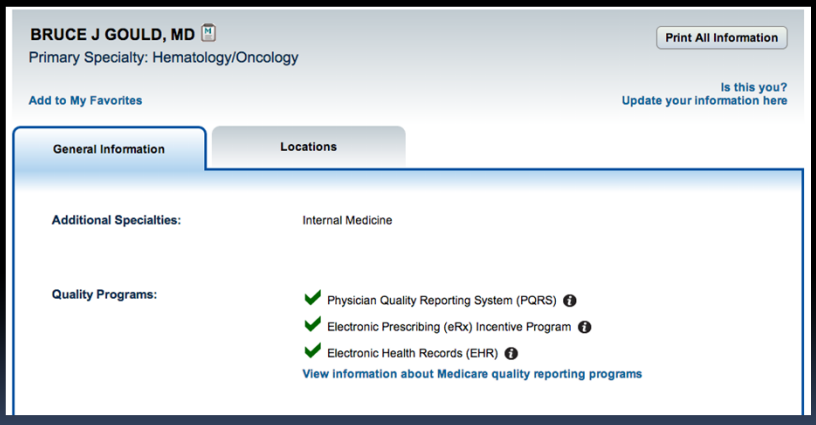
Hospital Compare





Source: http://www.hospitalcompare.hhs.gov/

Physician Compare



Source: http://www.medicare.gov/find-a-doctor/provider-search.aspx

Medicare Raw Data Release

BRUCE J. GOULD MD

Location	MARIETTA, GA.
Specialty / Facility Type	Hematology/Oncology
Total Medicare payments in 2012	$308,420.89

Procedure (Code)	Number performed	Average payment per procedure	Total payments for procedure
Injection, pegfilgrastim 6mg (J2505-O)	39	$2,192.83	$85,520.37
Denosumab injection (J0897-O)	4,080	$11.50	$46,920.00
Office/outpatient visit est (99214-O)	345	$78.29	$27,010.05
Darbepoetin alfa, non-esrd (J0881-O)	9,140	$2.61	$23,855.40
Office/outpatient visit est (99213-O)	362	$50.78	$18,382.36
Chemo iv infusion 1 hr (96413-O)	149	$107.14	$15,963.86
Palonosetron hcl (J2469-O)	860	$14.77	$12,702.20
Complete cbc w/auto diff wbc (85025-O)	842	$10.96	$9,228.32
Subsequent hospital care (99232-F)	160	$54.41	$8,705.60
Initial hospital care (99223-F)	54	$150.71	$8,138.34

Source: Wall Street Journal and Centers for Medicare & Medicaid Services

Medicare Raw Data Release

Matching Providers

You searched for providers that match the following criteria:

First name is **Bruce**
Last name / organization's name is **Gould**
Located in **GA**

Bruce J Gould, MD
340 KENNESTONE HOSPITAL BLVD
MARIETTA, GA
NPI: 1326042706
Provider Type: Hematology/Oncology
Entity Type: Individual

Bruce J Gould, MD
340 KENNESTONE HOSPITAL BLVD
MARIETTA, GA
NPI: 1326042706
Provider Type: Hematology/Oncology
Entity Type: Individual

CPT copyright 2011 American Medical Association. All Right Reserved.

Routine venipuncture
HCPCS Code: 36415
Place of Service: Office

Number of Services	Number of Beneficiaries	Average Submitted Charge	Average Medicare Allowed Amount	Average Medicare Payment
691	262	$21	$3	$2.89

Complete cbc w/auto diff wbc
HCPCS Code: 85025
Place of Service: Office

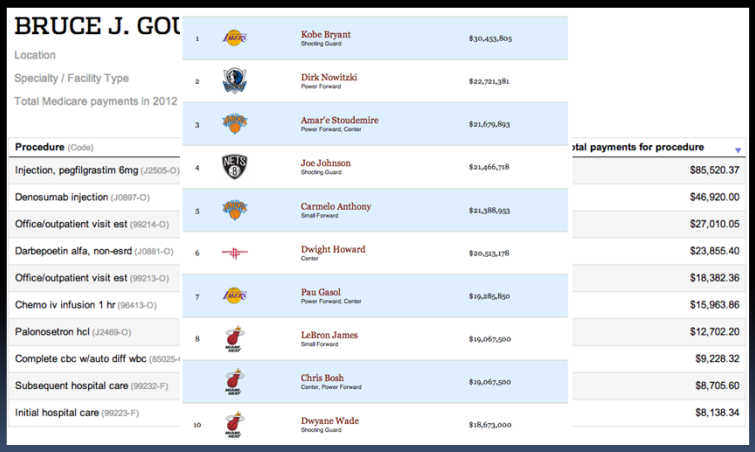
Number of Services	Number of Beneficiaries	Average Submitted Charge	Average Medicare Allowed Amount	Average Medicare Payment
842	281	$36	$11.02	$10.96

Prothrombin time
HCPCS Code: 85610
Place of Service: Office

Number of Services	Number of Beneficiaries	Average Submitted Charge	Average Medicare Allowed Amount	Average Medicare Payment
148	37	$31	$5.56	$5.53

Source: Centers for Medicare & Medicaid Services

Some Perspective



BRUCE J. GOU

Location

Specialty / Facility Type

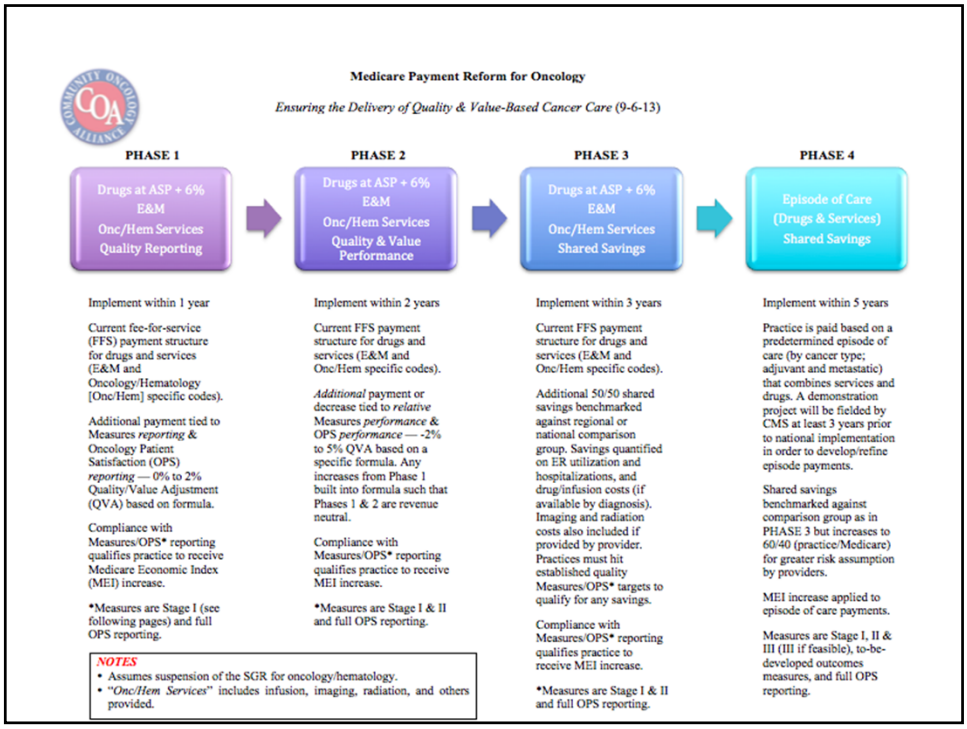
Total Medicare payments in 2012

Procedure (Code)	tal payments for procedure
Injection, pegfilgrastim 6mg (J2505-O)	$85,520.37
Denosumab injection (J0897-O)	$46,920.00
Office/outpatient visit est (99214-O)	$27,010.05
Darbepoetin alfa, non-esrd (J0881-O)	$23,855.40
Office/outpatient visit est (99213-O)	$18,382.36
Chemo iv infusion 1 hr (96413-O)	$15,963.86
Palonosetron hcl (J2469-O)	$12,702.20
Complete cbc w/auto diff wbc (85025-I	$9,228.32
Subsequent hospital care (99232-F)	$8,705.60
Initial hospital care (99223-F)	$8,138.34

1	Kobe Bryant, Shooting Guard	$30,453,805	
2	Dirk Nowitzki, Power Forward	$22,721,381	
3	Amar'e Stoudemire, Power Forward, Center	$21,679,893	
4	Joe Johnson, Shooting Guard	$21,466,718	
5	Carmelo Anthony, Small Forward	$21,388,953	
6	Dwight Howard, Center	$20,513,178	
7	Pau Gasol, Power Forward, Center	$19,285,850	
8	LeBron James, Small Forward	$19,067,500	
	Chris Bosh, Center, Power Forward	$19,067,500	
10	Dwyane Wade, Shooting Guard	$18,673,000	

Required Aspects of Oncology Payment Reform

- Starts with measured quality
  - Quality of the care delivered
  - Patient experience (satisfaction)
- Adds measured value
  - Quality for cost expended
- Includes evidence-based medicine
- Incentivizes cost reduction/containment
  - *Not at the expense of quality patient care!*
- Works in concert to improve clinical and financial outcomes



Medicare Payment Reform for Oncology

Ensuring the Delivery of Quality & Value-Based Cancer Care (9-6-13)

PHASE 1	PHASE 2	PHASE 3	PHASE 4
Drugs at ASP + 6% E&M Onc/Hem Services Quality Reporting	Drugs at ASP + 6% E&M Onc/Hem Services Quality & Value Performance	Drugs at ASP + 6% E&M Onc/Hem Services Shared Savings	Episode of Care (Drugs & Services) Shared Savings
Implement within 1 year	Implement within 2 years	Implement within 3 years	Implement within 5 years
Current fee-for-service (FFS) payment structure for drugs and services (E&M and Oncology/Hematology [Onc/Hem] specific codes).	Current FFS payment structure for drugs and services (E&M and Onc/Hem specific codes).	Current FFS payment structure for drugs and services (E&M and Onc/Hem specific codes).	Practice is paid based on a predetermined episode of care (by cancer type; adjuvant and metastatic) that combines services and drugs. A demonstration project will be fielded by CMS at least 3 years prior to national implementation in order to develop/refine episode payments.
Additional payment tied to Measures *reporting* & Oncology Patient Satisfaction (OPS) *reporting* — 0% to 2% Quality/Value Adjustment (QVA) based on formula.	*Additional* payment or decrease tied to *relative* Measures *performance* & OPS *performance* — -2% to 5% QVA based on a specific formula. Any increases from Phase 1 built into formula such that Phases 1 & 2 are revenue neutral.	Additional 50/50 shared savings benchmarked against regional or national comparison group. Savings quantified on ER utilization and hospitalizations, and drug/infusion costs (if available by diagnosis). Imaging and radiation costs also included if provided by provider. Practices must hit established quality Measures/OPS• targets to qualify for any savings.	Shared savings benchmarked against comparison group as in PHASE 3 but increases to 60/40 (practice/Medicare) for greater risk assumption by providers.
Compliance with Measures/OPS• reporting qualifies practice to receive Medicare Economic Index (MEI) increase.	Compliance with Measures/OPS• reporting qualifies practice to receive MEI increase.	Compliance with Measures/OPS• reporting qualifies practice to receive MEI increase.	MEI increase applied to episode of care payments.
•Measures are Stage I (see following pages) and full OPS reporting.	•Measures are Stage I & II and full OPS reporting.	•Measures are Stage I & II and full OPS reporting.	Measures are Stage I, II & III (III if feasible), to-be-developed outcomes measures, and full OPS reporting.

NOTES
- Assumes suspension of the SGR for oncology/hematology.
- *"Onc/Hem Services"* includes infusion, imaging, radiation, and others provided.

COA Payment Reform Model

- Phase 1 (Year 1)
  - Pay-for-reporting on an initial subset of quality/value measures
    - Includes patient satisfaction
  - Allows providers to make investments to enhance quality/value processes
- Phase 2 (Year 2)
  - Pay-for-performance on an expanded set of measures
  - Benchmarked to regional/national results
  - Can go negative for inferior results
- Phase 3 (Year 3)
  - Moves to 50/50 shared savings
    - Must also hit an expanded set of quality measures
- Phase 4 (Year 5)
  - Possibly moves to hybrid shared savings and episode-of-care
    - Must first collect data for episodes and pilot

Patient Care Measures
% of cancer patients that received a treatment plan prior to the administration of chemotherapy.
% of cancer patients with documented clinical or pathologic staging prior to initiation of first course of treatment.
% of chemotherapy treatments that have adhered to NCCN guidelines or pathways.
Antiemetic drugs given appropriately with highly emetogenic chemotherapy treatments.
% of cancer patients undergoing treatment with a chemotherapy regimen with a 20% or more risk of developing neutropenia and also received GCSF/white cell growth factor.
New Measures
Appropriate use of advanced imaging for early stage prostate cancer patients.
Presence of patient performance status prior to treatment.
Resource Utilization
of emergency room visits per chemotherapy patient per year.
of hospital admissions per chemotherapy patient per year.
Survivorship
% of cancer patients that received a survivorship plan within X days after the completion of chemotherapy.
% of chemotherapy patients that received psycho/social screening and received measurable interventions as a result of the psycho/social screening.

Survivorship
Survival rates of stage I through IV breast cancer patients.
Survival rates of stage I through IV colorectal cancer patients.
Survival rates of stage I through IV NSC lung cancer patients.
End of Life
% of patients that have Stage IV disease that have end-of-life care discussions documented.
Average # of days under hospice care (home or inpatient) at time of death.
% of patient deaths where the patient died in an acute care setting.
A measurement of chemotherapy given near end of life.

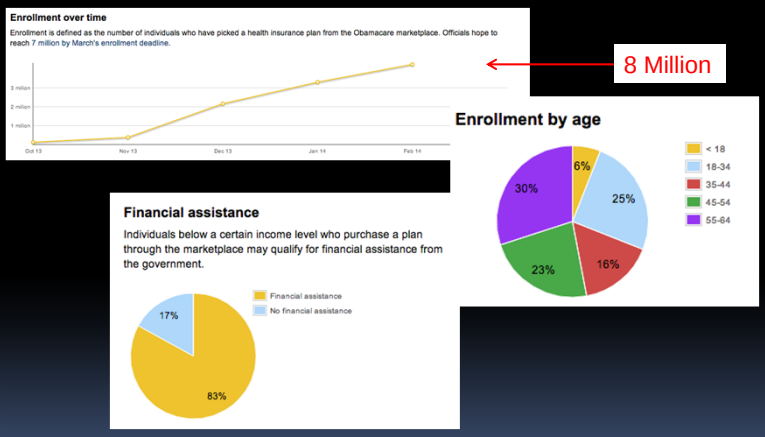
Status of COA Payment Reform Efforts

- Tied to the COA *Oncology Medical Home Initiative*
- Have been working with the congressional committee staff (3 committees) as they have developed SGR payment reform legislation
- Have been working with private payers
- Working with the Commission on Cancer on OMH accreditation
  - *Come Home* practices (7) and 3 others serving as pilot sites
- Submitted a CMMI grant for a demonstration project on Phases 1-3
  - Model, assumptions, and financials blessed by actuarial analysis (Milliman)
- Meetings next week to advance payment reform legislation
  - We can't wait for SGR fix and payment reform — *if it ever happens*

Affordable Care Act = Obamacare

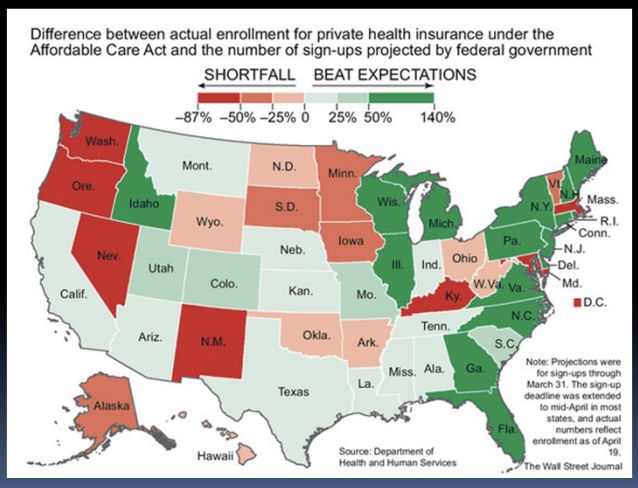
- Signed into law on March 23, 2010
- Has created over 11,000 pages of new regulations
- Starting the major roll-out year in 2014
  - Make or break year in many respects
- Just starting to see the good, bad, and ugly impact on cancer care

Enrollment Statistics

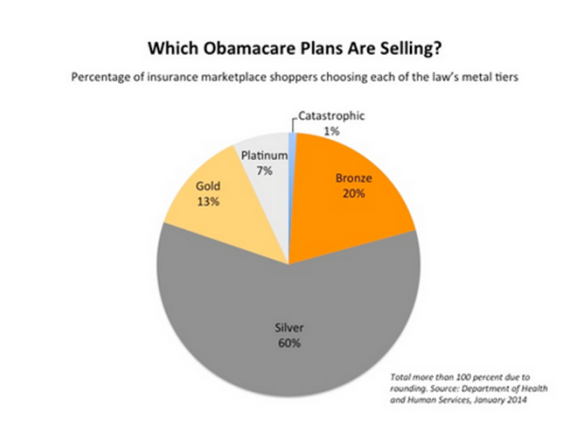


Source: Department of Health and Human Services

Enrollment Statistics



Enrollment Statistics (*continued*)



Source: Washington Post; Department of Health and Human Services

In Exchange for Lower Premiums, Deductibles Are High in Bronze and Silver Plans

AVERAGE STATISTICS FOR 84 PLANS IN SAMPLE

Metal Level	# Plans	Average Premium for 27-Year-Old Nonsmoker	Average Global[1] Deductible	Average Drug Deductible	Average Global[1,3] OOP Maximum
Bronze[4]	15	$181	$5,607	N/A[2]	$6,260
Silver[4]	69	$258	$2,630	$657	$6,052

- **Silver** plan premiums range from $139 to $418, and **bronze** plan premiums range from $125 to $230 for a 27-year-old nonsmoker
- Only 2 of 69 **silver** plans analyzed had separate drug OOP maximums; no **bronze** plans did (although most were HDHPs)
- 10 plans in the sample are **HDHPs**, where the global deductible is equal to the global OOP maximum
- Very few plans reduced OOP maximums—just 3 plans had OOP maximums below $5,000, another 14 between $5,000 and $6,000

HDHP = High-Deductible Health Plan OOP = Out-of-Pocket
1. Both medical AND drug costs count toward global deductible or out-of-pocket maximum.
2. None of the 15 bronze plans in the sample set had *separate* drug deductibles.
3. None of the 15 bronze plans in the sample set had *separate* drug out-of-pocket maximum and only 2 silver plans in the sample had such maximum.
4. 10 plans in the sample (9 bronze and 1 silver) are high deductible plans with no cost sharing for individual services given the plan structure. These plans are excluded from statistics on cost sharing by tier on future slides.
Source: Avalere Health PlanScape,™ a proprietary analysis of exchange plan features. Data as of October 31, 2013.

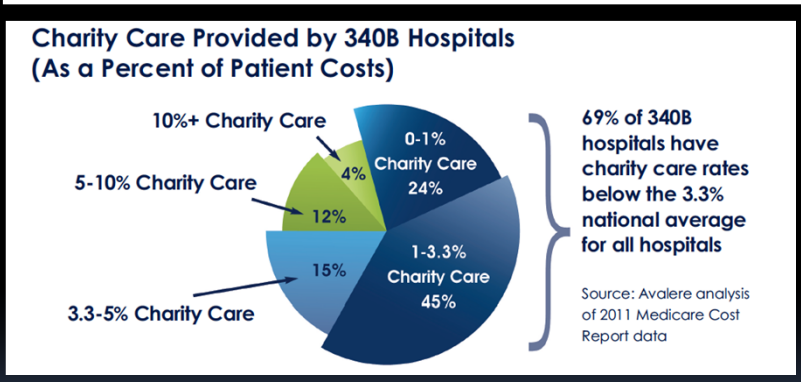
Exchange Problems Surfacing for Cancer Care & Oncology Providers

- Oncology providers across the country are being excluded (out of network) from exchange plans
  - 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

340B

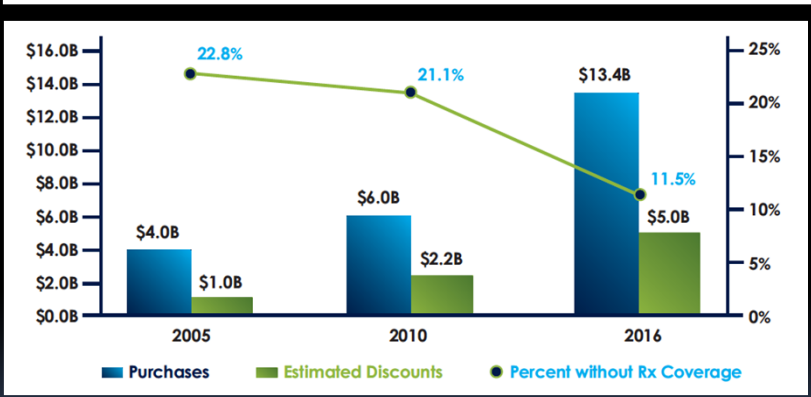
- Government drug discount program intended to cover indigent patients falling through the cracks
- Controversial because scope of the program growing rapidly and question if 340B is living up to original intent
  - Avalere study on 340B and indigent coverage
  - OIG 2014 Work Plan contains 3 340B studies
    - Contract pharmacies
    - Drug cost (less 340b discounts) versus reimbursement
    - Manufacturer discounts
- Increasing focus in DC
  - Growth of 304b
    - Estimated 1/3 hospitals are 340b and growing
  - Program abuses

340B Study Results Recently Released



Source: *Unfilled Expectations: An analysis of charity care provided by 340B hospitals*, AIR 340B, March 2014.

340B Study Results (*continued*)



Source: *Unfilled Expectations: An analysis of charity care provided by 340B hospitals*, AIR 340B, March 2014.

Site-of-Service Payment Parity

- Increasing focus of growing disparity between hospitals and physician offices for providing identical services
  - Medicare
    - MedPAC report
    - Rogers/Matsui bill (H.R. 2869) to create Medicare payment parity for cancer care services
  - Private Payers
    - Highmark announcement to create payment parity

Site Payment Parity on the Radar Screen

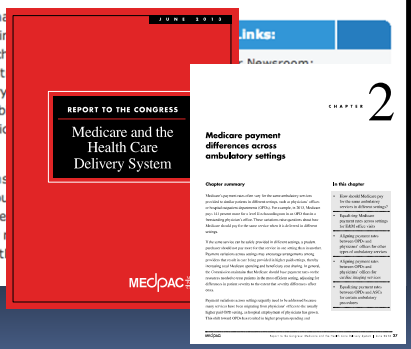
PRESS RELEASE: FEB. 26, 2014

Highmark Inc.

Highmark announces plan to restore more rational payments for cancer care

PITTSBURGH (Feb. 26, 2014) — Beginning April 1, 2014, Highma
rational payments for cancer care in western Pennsylvania by elir
the cost of certain oncology-related services, including infusion ch
The dramatic increase in the cost of infusion chemotherapy treat
occurring in western Pennsylvania and other parts of the country
and large hospitals purchase physician oncology practices, then b
chemotherapy services as a higher-cost hospital outpatient servic
treatment continues to be provided in a physician office.

"Because of this practice, many cancer patients in western Penns
more for their infusion chemotherapy treatments than they shou
care improvements," said William Winkenwerder Jr, M.D., preside
Highmark Health. "We feel a responsibility to take action for our
estimate that this billing change will save our community more t
quality of cancer care."



COA Legislative Focus

- SGR Fix Legislation
  - Advance payment reform that works for community oncology
- Medicare Sequester Relief
  - Including stopping unauthorized MA cuts
- Prompt Pay Solution
- Medicare Fee Schedule Cuts
  - Unwarranted cuts
  - Site-of-Service payment parity
  - Reimbursement special issues (e.g., radiopharmaceuticals)
- 340B Program Fixes

Community Oncology 2.0

- Help practices become Oncology Medical Homes
- Promote payment reform that works for community oncology
  - Universally-accepted quality and value measures
    - Includes patient satisfaction tool
  - Medicare and private pay
- Unite oncology to leverage solutions to pressing problems impeding quality cancer care
  - Consolidation
  - Drug shortages
  - Obamacare issues

Parting Wisdom

"*This is where they fought the battle of Gettysburg. Fifty thousand men died right here on this field, fighting the same fight that we are still fighting among ourselves today. This green field right here, painted red, bubblin' with the blood of young boys. Smoke and hot lead pouring right through their bodies. Listen to their souls, men. I killed my brother with malice in my heart. Hatred destroyed my family. You listen, and you take a lesson from the dead. If we don't come together right now on this hallowed ground, we too will be destroyed, just like they were. I don't care if you like each other or not, but you will respect each other. And maybe... I don't know, maybe we'll learn to play this game like men*"

Coach Herman Boone, *Remember The Titans*

Thank You!

Ted Okon
tokon@COAcancer.org
Twitter @TedOkonCOA

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

www.facebook.com/CommunityOncologyAlliance