Bill as Introduced

HB 1642-FN – AS INTRODUCED

2012 SESSION

12-2789
01/05

HOUSE BILL ***1642-FN***

AN ACT relative to destination cancer hospitals.

SPONSORS: Rep. Garcia, Rock 4; Rep. Reagan, Rock 1; Rep. Stepanek, Hills 6; Rep. Azarian, Rock 4; Rep. Keane, Merr 13; Rep. O'Brien, Hills 4; Rep. Bettencourt, Rock 4; Rep. Katsakiores, Rock 5; Rep. Infantine, Hills 13

COMMITTEE: Health, Human Services and Elderly Affairs

ANALYSIS

This bill exempts destination cancer hospitals from the certificate of need process. This bill also requires the commissioner of the department of health and human services to submit a waiver pursuant to 42 C.F.R. section 433.68 for the purpose of waiving the Medicaid enhancement tax for such hospitals.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears ~~[in brackets and struckthrough.]~~
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

12-2789
01/05

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twelve

AN ACT relative to destination cancer hospitals.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Statement of Purpose. The general court, in an effort to improve the quality of health care and while identifying new economic growth opportunities for New Hampshire, makes the following findings:

I. In our current economic environment, the state needs to identify new ways to encourage job growth and economic expansion. This requires New Hampshire to find areas in which the state can become more competitive.

II. Health care is among the fastest growing industries both in New Hampshire and nationally and, with the changing demographics of both the state and the nation, will continue to expand greatly in the next decade.

III. New Hampshire is uniquely positioned to capture a significant share of this economic growth by becoming a destination for high quality specialty care.

IV. Having high end specialty care facilities in New Hampshire will benefit our residents, should they need this level of care.

V. The certificate of need process was designed to restrain the overbuilding of health care facilities for local usage, not to slow economic growth by limiting destination specialty care facilities.

2 New Paragraph; Certificate of Need; Definition Added. Amend RSA 151-C:2 by inserting after paragraph XV-a the following new paragraph:

XV-b. "Destination cancer hospital" means an institution with a licensed bed capacity of 50 or fewer which provides diagnostic, therapeutic, treatment, and rehabilitative care services to cancer inpatients and outpatients by or under the supervision of physicians, and whose proposed annual patient base is composed of a minimum of 65 percent of patients who reside outside of the state of New Hampshire.

3 Certificate of Need; Exemption Added. Amend RSA 151-C:13, I(h) and (i) to read as follows:

(h) Notwithstanding any other provision of this chapter, a skilled nursing facility distinct part unit established by Androscoggin Valley Hospital or Franklin Regional Hospital in order to qualify as a critical access hospital under 42 U.S.C. Section 1395i-4 and 42 C.F.R. Part 485, Subpart F; provided, that the number of beds in the skilled nursing facility distinct part unit shall not exceed the hospital's existing skilled nursing patient capacity. For purposes of this subparagraph, the term "existing skilled nursing patient capacity" means with respect to each month, the number of skilled nursing patient days for such month divided by the number of days in such month, and shall be the highest such number from the 12-month period ending immediately

prior to the filing of the federal request for approval of the distinct part unit; provided, however, that the number determined under this subparagraph shall not exceed 10 beds; [~~and~~]

(i) Acute care centers established, operated, or designated by the department pursuant to RSA 141-C:26; ***and***

(j) Destination cancer hospitals as defined in RSA 151-C:2, XV-b.

4 New Paragraph; Uncompensated Care Fund; Duties of Commissioner. Amend RSA 167:65 by inserting after paragraph II the following new paragraph:

II-a. Submit a waiver pursuant to the process outlined in 42 C.F.R. section 433.68 for the purpose of waiving RSA 84-A, Medicaid enhancement tax liability for destination hospitals as defined in RSA 151-C:2, XV-b.

5 Effective Date. This act shall take effect 60 days after its passage.

LBAO
12-2789
11/07/11

HB 1642-FN - FISCAL NOTE

AN ACT relative to destination cancer hospitals.

FISCAL IMPACT:

The Departments of Revenue Administration and Health and Human Services state this bill will have an indeterminable fiscal impact on state revenue and expenditures in FY 2012 and each year thereafter. There will be no fiscal impact on county or local revenue and expenditures.

METHODOLOGY:

The Department of Revenue Administration states the bill requires the Commissioner of the Department of Health and Human Services to submit a waiver request to the Center for Medicare and Medicaid Services (CMS) to exempt destination cancer hospitals from paying New Hampshire's Medicaid Enhancement Tax. The Department assumed such facilities may include existing facilities which qualify as destination cancer hospitals or new facilities established as a result of this legislation. The Department is not able to determine how many, if any, existing facilities would qualify or how many new facilities might be established meeting the definition of destination cancer hospitals and therefore cannot determine the fiscal impact. In addition, the Department suggested that the disparate treatment of hospitals may be unconstitutional. The Department states it could administer the provisions of the bill without additional resources.

The Department of Health and Human Services states that, in considering waiver requests, the CMS uses a specific test to measure the redistributive quality of a tax plan and this test relies on revenues generated by existing facilities. Since these entities may not yet exist, it is not possible to predict the outcome of a waiver request. In addition, the Department states this bill would exempt destination cancer hospitals from the certificate of need process and the associated administrative fee. The Department assumes these hospitals would be licensed by the State of New Hampshire but exempt from the certificated of need process.

Amendments

Rep. Reagan, Rock. 1
February 23, 2012
2012-1017h
01/04

Amendment to HB 1642-FN

Amend the title of the bill by replacing it with the following:

AN ACT relative to destination specialty hospitals.

Amend RSA 151-C:2, XV-b as inserted by section 2 of the bill by replacing it with the following:

XV-b. "Destination specialty hospital" means an institution with a licensed bed capacity of 50 or fewer which provides diagnostic, therapeutic, treatment, and rehabilitative care services to inpatients and outpatients by or under the supervision of physicians.

Amend RSA 151-C:13, I(j) as inserted by section 3 of the bill by replacing it with the following:

(j) Destination specialty hospitals as defined in RSA 151-C:2, XV-b.

Amend the bill by deleting section 4 and renumbering the original section 5 to read as 4.

2012-1017h

AMENDED ANALYSIS

This bill exempts destination specialty hospitals from the certificate of need process.

Speakers

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB 1642 Date 2-7-12

Committee Health, Human Services & Elderly Affairs

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
Rep. D. J. Bettencourt	Salem		Majority office	X	
Frederick m. Briccetti MD	Hopkinton	224-2556	New Hampshire oncology		X
Rep Sharon Nordgren	Hanover				X
Michael Keyes	Chester, NH				X
Susan Paschell	Concord		Harvard Pilgrim		X
Dan Li	EHS				X
Valerie Acres	Sheehan Phinney Capitol Group		Parkland medical Center		X
Lisa Hatch	DHHS	271-9408	DHHS	Provide info	
Tom Keane	Rep. Merrimack 13			X	
Rep Phyllis Katsakiores				X	
Rep Sharon Symonds	Seabrook			X	

Hearing Minutes

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

PUBLIC HEARING ON HB 1642-FN

BILL TITLE: relative to destination cancer hospitals.

DATE: February 7, 2012

LOB ROOM: 205 **Time Public Hearing Called to Order:** 10:30 AM

Time Adjourned: 11:45 AM

(please circle if present)

Committee Members: Reps. Reagan, Kotowski, Pilliod, McMahon, Barry, Millham, Case, Cusson, Cali, Donovan, Fredette, LeBrun, S. Schmidt, Ward, MacKay, Merrick, DiPentima, Harding and Deloge. Rosenwald & Blankenbeker

Bill Sponsors: Rep. Garcia, Rock 4; Rep. Reagan, Rock 1; Rep. Stepanek, Hills 6; Rep. Azarian, Rock 4; Rep. Keane, Merr 13, Rep. O'Brien, Hills 4; Rep. Bettencourt, Rock 4; Rep. Katsakiores, Rock 5; Rep. Infantine, Hills 13

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Rep. B.J. Bettencourt – introduced the bill and explained his involvement with this bill. He stated this bill is a bill that will produce jobs that are needed in this state along with a hospital that will expand choices in medical care that is highly needed. **Speaker William O'Brien** – spoke in favor of the bill. He explained the C.O.N. board and stated this new hospital would be a destination hospital that would provide high and medical treatment thatis highly needed. He asked for a study committee to look into bringing more specialty hospitals to this state. **Rep. Tom Keane** – spoke in favor of the bill. **Dr. Mark Israel and Dr. Acan Ha tford, of the Norris Cotton Cancer Center.** Both spoke against this bill. It was stated tl at reducing the patients numbers would be detrimental in the care received. Both doctors endors d the C.O.N. board. It was further stated no clinical trials have been produced by CC of America. **tep. Steven Cunningham** – spoke in support. **Patrick Clary, M.D.** – opposed the bill. **P. Travis HarKer, M.D., President of NH Medical Society** – spoke against the bill. He stated ie feared that bringing in this new hospital would be a determent to the state. **Thoma: Shelder , MD, a radiologic oncologist,** who also opposed the bill stated patients would still r ceive rac ology in present hospitals. **Rep. Marilinda Garcia, sponsor of the bill,** testified that 75 percen of patients would come from out of state.

Recessed to Thursday, February 9, 2012.

Respectfully subm tted J. Gail Barry

Rep. J. Gail Barry, C erk

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

PUBLIC HEARING ON HB 1642-FN

BILL TITLE: relative to destination cancer hospitals.

DATE: 2/7/2012

LOB ROOM: 205 **Time Public Hearing Called to Order:** 10:30AM

Time Adjourned:

(please circle if present)

Committee Members: Reps. Reagan, Kotowski, Pilliod, McMahon, Barry, Millham, Case, Cusson-Carr, Donovan, Fredette, LeBrun, S. Schmidt, Ward, MacKay, Merrick, DiPentima, Harding and Deloge. Rosenwald Blankenbeker

Bill Sponsors: Rep. Garcia, Rock 4; Rep. Reagan, Rock 1; Rep. Stepanek, Hills 6; Rep. Azarian, Rock 4; Rep. Keane, Merr 13, Rep. O'Brien, Hills 4; Rep. Bettencourt, Rock 4; Rep. Katsakiores, Rock 5; Rep. Infantine, Hills 13

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Rep Bettencourt introduced the bill and explained his involvement with this bill. He stated this bill is a bill that will produce jobs that are needed in the state along with a hospital that will expand choices in medical care that is highly needed.

Speaker O'Brien* spoke in favor of the bill. He explained the C.O.N board and stated this new hospital would be a destination hospital that would provide high end medical treatment that is highly needed. He asked for a study committee to look into bringing more specialty hospitals to this state.

Rep Keane* spoke in favor of the bill.

Dr Mark Israel* Dr Alan Hartford* of the Norris Cotton Cancer Ctr. Both spoke against this bill. It was stated that reducing the patients numbers would be detrimental in the care received. Both doctors endorsed the C.O.N board. It was further stated no clinical trials have been produced by CC of America.

Rep Cunningham* spoke in support.

Patrick Clary NH* opposed the bill.

HB 1642-FN

P. Travis Hanker M.D - Pres of NH Medical 2/7/2012
Society spoke against the bill. He stated he feared that bringing in this new hospital would be a detriment to the state.

Thomas Sheldon M.D. a radiologist oncologist who also opposed the bill stated patients would still receive radiology in present hospitals.

Rep. Garcia sponsor of the bill testified that 65% of patients would come from out of state.

Recessed to Thurs @ 9 AM

Reconvened 2/9/2012 9:03 AM

John O'Neil CEO AMI Maurice Mardmon MD
Cancer Centers of America - testified as to background and history of his company. It was stated cancer care should be for the patient and that is their goal. In the treatment of breast cancer one dose of radiation can be given @ the time of a lumpectomy and no other radiation is needed this was one example of treatment given @ the facility.

Though they do not accept medicaid funds they do help in finances for needy patients. They regard the C.O.N. a barrier to locating in N.H.

When questioned Mr. O'Neil stated that if a patient should have financial reverse they would arrange to care for them.

Donna Wolfendale a patient of CCA testified on her experience at the facility. A patient with Stage 4 pancreatic

cancer she tolerated extensive therapy and is hopeful for her recovery and grateful for the whole patient care that is given.

Andrew Eills # spoke in opposition to the bill. a lawyer who favors CON board he sees no reason why any group should be able to avoid the process. He stated it takes about 8 months for an acute care facility and does cost money.

Paula Rogers # Anthem Blue Cross feels we need an addition to the RSA to include specialty hospitals and she opposes the bill. As an insurer they would object to any waiver from the CON Board.

David Juvet # VP BAH opposes the bill

Glenn Wallace # Rath & Pegnatti opposed

Steve Ahnen # NH Hosp. Assoc. opposes objects to special rules for some

Jim Scott Colby - NH Medical Society opposed the bill & asked if there should be a set of rules for specialty hospitals.

Cynthia Currier - ~~CON staff~~ - Health Services Planning & Review explained CON.

Isabelle Selby DHHS gave provider information stated that an entity must be in place to receive a waiver.

10:36A

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS
RECONVENED, RECESSED FROM Feb. 7, 2012 at 11:45 AM
PUBLIC HEARING ON HB 1642

BILL TITLE: **relative to destination cancer hospitals.**

DATE: **February 9, 2012**

LOB ROOM: 205 **Time Public Hearing Called to Order:** 9:03 AM

Time Adjourned: 10:36 AM

(please circle if present)

Committee Members: Reps. Reagan, Kotowski, Pilliod, McMahon, Barry, Millham, Case, Blankenbeker, Cusson-Cail, Donovan, Fredette, LeBrun, S. Schmidt, Ward, MacKay, Merrick, DiPentima, Harding and Deloge.

Bill Sponsors: Rep. Garcia, Rock 4; Rep. Reagan, Rock 1; Rep. Stepanek, Hills 6; Rep. Azarian, Rock 4; Rep. Keane, Merr 13; Rep. O'Brien, Hills 4; Rep. Bettencourt, Rock 4; Rep. Katsakiores, Rock 5; Rep. Infantine, Hills 13

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.
John McNeil, CEO and Maurie Markman, MD, Cancer Centers of America – testified as to background and history of his company. It was stated cancer care should be for the patient and that is their goal. In the treatment of breast cancer, one dose of radiation can be given at the time of a lumpectomy and no other radiation is needed this was one example of treatment given at the facility. Though they do not accept Medicaid funds they do help in finances for needy patients. They regard the C.O.N. a barrier to locating in NH. When questioned, Mr. McNeil stated that if a patient should have financial reversals, they would arrange to care for them. **Donna Wolfendale, a patient of CCTA** – testified on her experience at the facility. A patient with Stage 4 pancreatic cancer, she tolerated extensive therapy and is hopeful for her recovery and grateful for the whole patient care that is given. **Andred Eills** – spoke in opposition to the bill. A lawyer who favors CON board, he sees no reason why any group should be able to avoid the process. He stated it takes about eight months for an acute care facility and does cost money. **Paula Rogers, Anthem Blue Cross** – feels we need an addition to the RSA to include specialty hospitals and she opposes the bill. As an insurer, they would object to any waiver from the CON Board. **David Juvet, VP, BIA** – opposes the bill. **Glenn Wallace, Rath Young & Pignatelli** – opposed. **Steve Amnen, NH Hospital Association** – opposed, objects to special rules for some. **Scott Colby, NH Medical Society,** opposed the bill and asked if there should be a set of rules for specialty hospitals. **Cynthia Currier, Health Services Planning & Review** – explained C.O.N. **Lisabn'tt Solsky, DHHS,** gave provider information stated that an entity must be in place to receive a waiver.

Respectfully submitted J. Gail Barry
Rep. J. Gail Barry, Clerk

Sub-Committee Minutes

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

SUBCOMMITTEE WORK SESSION ON HB 1642-FN

BILL TITLE: relative to destination cancer hospitals.

DATE: February 24, 2012

Subcommittee Members: Reps. Reagan, Kotowski, Pilliod, Barry, Millham, Cusson-Cail, Donovan, LeBrun, Schmidt, Ward, Merrick, DiPentima, Blaankenbeker, MacKay, and McMahon

Comments and Recommendations: Amendment 2012-0948 was introduced by Chairman Reagan. After discussion it was proposed that on line 9 after the work physician, a period would be inserted.

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,

Rep. Barry
Subcommittee Chairman/Clerk

9:31 AM
10:50AM

HB 1642-FN
2/24/2012
Work Session

Reagan Kolowski Pellish Barry Mullen Cushing Carl Donovan LeBrun S. Schmidt Ward Merrick DeSanctis Blankenbeker McKay McMahon

Amendment 2012-0948h was introduced by Chairman Reagan. After discussion it was proposed that on line 9 after the word physician, a period would be inserted.

"NOT ADOPTED"

Rep. Reagan, Rock. 1
February 21, 2012
2012-0948h
01/04

Amendment to HB 1642-FN

Amend the title of the bill by replacing it with the following:

AN ACT relative to destination specialty hospitals.

Amend RSA 151-C:2, XV-b as inserted by section 2 of the bill by replacing it with the following:

XV-b. "Destination specialty hospital" means an institution with a licensed bed capacity of 50 or fewer which provides diagnostic, therapeutic, treatment, and rehabilitative care services to inpatients and outpatients by or under the supervision of physicians, and whose proposed annual patient base is composed of a minimum of 65 percent of patients who reside outside of the state of New Hampshire.

Amend RSA 151-C:13, I(j) as inserted by section 3 of the bill by replacing it with the following:

(j) Destination specialty hospitals as defined in RSA 151-C:2, XV-b.

Amend the bill by deleting section 4 and renumbering the original section 5 to read as 4.

2012-0948h

AMENDED ANALYSIS

This bill exempts destination specialty hospitals from the certificate of need process.

Testimony

TESTIMONY OF SPEAKER WILLIAM O'BRIEN ON DESTINATION CANCER HOSPITAL LEGISLATION · HB 1642 · 2/7/2012

Good morning, Mr. Chairman and members of the committee. My name is Bill O'Brien and I represent Hillsborough District 4, including the towns of New Boston, Mont Vernon, Wilton, Lyndeborough and Temple.

I am here today in support of House Bill 1642, to allow a new definition of destination cancer hospitals here in New Hampshire. What this bill does is shift the very nature of health care treatment in our state.

Right now, the Certificate of Need, or CON, process was put in place because the legislature viewed health care as a zero-sum game. By that, they felt that there were a finite number of people in the state, and creating more facilities, they thought, would mean that these facilities would, in turn, drive up the costs they charged, to support the new buildings and staff involved.

While many would certainly view this process as anti-competitive, representing a government response to a government-caused market failure, a bigger, fundamental flaw in the CON setup is that it fails to consider that New Hampshire would ever be a state that could attract individuals to come here to receive care from beyond our borders. If we could make New Hampshire a destination for care, the idea of the zero-sum game would disappear and, for these destination facilities, the CON Board would simply be a relic used by entrenched hospitals to try to block competition.

This bill seeks to make New Hampshire a destination for cancer care. By requiring that any hospital that would apply for this new definition has to take at least 65% out of state patients, it would necessarily bring in new patients to increase the total amount of health care provided here. Therefore, this brings a new model of health care that the CON process was simply not designed to consider.

We often talk about the New Hampshire Advantage in terms of lower taxes and a more business friendly environment. While we think about companies like Fidelity and BAE locating here because of our competitive advantage, we often don't think about facilities that offer high-quality specialty health care here. In fact, our residents typically have to travel to Boston for high-end specialists. Why shouldn't we put ourselves in a position to have people from across the Northeast and even from other countries coming here, and helping our economy, to get their specialty care? Did we require Fidelity or BAE to go through a CON process before they brought their new business and new customers to New Hampshire? Why then, should we require a medical center bringing new business and new customers to New Hampshire to do so?

In fact, my only concern with this bill is that we are limiting it only to cancer specialty hospitals. While I think we should pass this bill, this committee should also consider adding a study committee to this legislation to look at the possibility of extending this treatment to other specialty areas, not just cancer.

What some people might not know is that New Hampshire already has a fully functional specialty hospital that treats many out of state patients. Hampstead Hospital is a 111-bed facility that cares for those with psychiatric and chemical dependencies, and does so quietly, while creating many jobs in Central Rockingham County.

One of the features of Hampstead Hospital is that it does not pay the Medicaid Enhancement Tax. It is for that reason that we added the second section of this legislation, which would direct DHHS to seek a waiver from the MET for hospitals that qualify under this new definition. This legislation seeks to deliver parity for cancer hospitals that we offer to other specialty hospitals.

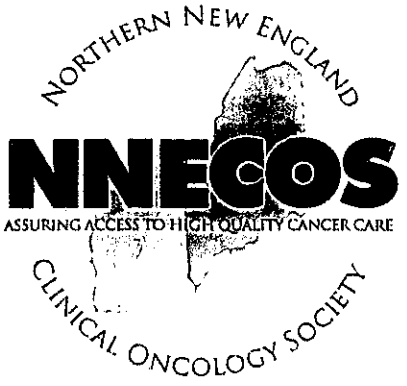
High-end specialty hospitals bring state-of-the-art levels of care to New Hampshire that is not available now, as well as numerous, high-paying jobs. There is no reason that New Hampshire cannot become home to numerous regional and national specialties, such as ear, nose and throat, burn treatment or sports medicine. These types of facilities will both grow our economy and bring new treatment option to the state, which our residents currently need to travel to receive.

House Bill 1642 begins this process by focusing on cancer treatment in New Hampshire. Let's begin this process to expand the New Hampshire Advantage and take a step to bringing jobs and high-level care to the Granite State and pass this legislation.

Thank you and I would be happy to answer questions.

Respectfully submitted,

William O'Brien
Speaker of the House



January 30, 2012

Dear Legislator,

We are writing you today in regards to New Hampshire House Bill 1642-FN, which exempts a "destination cancer hospital" from regulatory oversight and from supporting uncompensated care or Medicaid services.

The three signatories to this letter are Dr. Thomas Openshaw, an oncologist in Bangor, Maine and President of the Northern New England Clinical Oncology Society (NNECOS); Dr. Christian Thomas, an oncologist in Burlington Vermont and President-elect of NNECOS; and Dr. Denis Hammond, Immediate Past President of NNECOS. Dr. Hammond has been practicing hematology and oncology in New Hampshire for the past 33 years.

NNECOS was founded 15 years ago to "Assure the Availability and Access to High Quality Oncology Care in our Region. " NNECOS has over two hundred members in Maine, Vermont and New Hampshire who have committed themselves to this mission. Our national parent organization, The American Society of Clinical Oncology has over 30,000 members who also share these values and goals. In our office practices, as well as in our organizational activities, we support this mission by following national treatment guidelines so that unnecessary care or care that has not been proven scientifically to be useful is not ordered for patients. This helps control the cost of medical care by eliminating unwarranted health care expenditures. We promote rigorous quality improvement programs in our physician practices and in the hospitals of which we are members. We believe in making high quality and accountable cancer care available to patients in our communities. We promote programs of clinical cancer research that are approved by the National Cancer Institute so that our patients have access to the most advanced cancer care that is scientifically and ethically available. We are committed to providing care to every patient who seeks our help, regardless of their ability to pay. We promote community educational programs as well as participating in continuous professional education for all the members of our cancer care teams.

We are greatly concerned by the introduction of House Bill 1642-FN, seeking to facilitate the entry of a for profit cancer hospital into the State of New Hampshire. The bill seems to exempt these "destination cancer hospitals" from the certificate of need process. The rationale appears to be that investment in cancer care beds, equipment and services in New Hampshire should be permitted without regulation if you are a destination cancer center such as Cancer Treatment Centers of America (CTCA). We respectfully submit that this rationale is significantly flawed, and does not take into consideration important factors indicating that, rather than providing new and better opportunities, such an exception could actually serve to disrupt the existing infrastructure of oncology care in the region.

PO Box 643 • Sandown, NH 03873-0643
Direct Ph: 603.887.1948 • Direct Fax: 603.887.6049 • Email: info@nnecos.org • Web: www.nnecos.org

There are several arguments that are made, both in the bill and in the CTCA talking points. To take these points one at a time:

1. Future Employment: Collectively, the practices represented by NNECOS employ thousands of health care workers in New England dedicated to cancer care. Many of our practices are private and pay real estate tax and other taxes just like any other business. Yet our providers work within a fragile health care environment, comply with existing regulations and work towards implementing each state's plan for access to high quality cancer care. While CTCA would employ many people, many of these skilled professionals would come from existing health care providers within the state or region. This would not create jobs, but would just shift jobs. In fact we believe CTCA will drive jobs out of New Hampshire by harming existing hospitals and health care facilities. The New Hampshire legislature should help existing New Hampshire employers and providers maintain services and jobs not force them to eliminate such jobs.

2. Need for High Level Cancer Care: CTCA implies that it provides a level of cancer care not available in the state. The only way to determine the validity of this claim is to review the need for the alleged services. It is not at all clear that CTCA actually will provide any services that are different from those being provided efficiently and effectively already in New Hampshire and the region. Certainly, for the patients from New Hampshire and Massachusetts, CTCA cannot provide a model that ensures accountable and community based care and follow-up. We do not see that they care for patients with complex diseases such as acute leukemia. Their literature does not state that they perform bone marrow transplantation. They do not state that they are active in nationally sanctioned cancer research. They are not actively involved in professional education. We do not see that they are involved in community outreach to promote cancer prevention and early detection. Many of these vitally important activities are not funded by insurance or by governments, but the physicians and hospitals of New Hampshire and our region perform these functions because it is the right thing to do.

3. Need for New Buildings and Equipment in New Hampshire's Health Care Economy: Recently, due to rising health care costs in the region and nationally, hospitals have been challenged on the need for new infrastructure projects, beds, expensive equipment and additional services. Yet, this bill states that "The certificate of need process was designated to restrain overbuilding of health care facilities for local usage, not to slow the economic growth by limiting destination specialty care facilities." In CTCA's own literature they state that 35% of their patients would come from within New Hampshire. If there is a need for these additional and expensive services, surgical inpatient and outpatient operating rooms, high cost diagnostic and imaging equipment and beds to care for cancer patients in New Hampshire, CTCA should be required to defend that position publicly before the CON Board as any other New Hampshire provider, facility and hospital would.

4. Meeting the Need of Cancer Patients in New Hampshire: CTCA asserts that "with over 1,500 New Hampshire residents from the 3 largest counties being diagnosed each year (with cancer), there is clearly a need to increase access to treatment options." Additionally, we do not know of any data that substantiates the claim that the citizens of New Hampshire are being deprived of cancer care options because of lack of providers or facilities, certainly not in the counties that CTCA seems to target, Hillsborough, Merrimack and Rockingham. As far as we know there is no need for additional outpatient services within the target area, and there are competing hospitals throughout New Hampshire and Massachusetts already providing inpatient services. If CTCA believes there is such a need, CTCA should demonstrate it and meet the same regulatory requirements other providers have to meet.

5. The "Tipping Point"-Impact on Other Existing Care Providers: The assertion that CTCA would not compromise the care that other cancer care providers in the region give to patients is stated without any supporting evidence. According to HB 1642, destination cancer hospitals would be exempted from the requirement to treat patients who have Medicaid as their health care insurance. This would lead us to believe that only "private pay" individuals with more generous coverage options would have access to CTCA, and patients who are underinsured or uninsured would be left to be cared for by the state's existing health care providers. That type of "cherry-picking" will ultimately undermine the financial strength of the existing cancer care providers in the state, possibly causing them to down size or even close their doors all together. This would clearly be a detriment to the residents of New Hampshire as patients and would also harm the economy of the state and region as a whole.

6. A "New" Type of Care??: CTCA asserts that the cancer therapy it gives to its patients is different than that given at other health care facilities because it is "comprehensive" and "caring." We welcome our legislators to tour the many cancer care facilities existing in New Hampshire to witness what we do every day for our patients from New Hampshire and beyond. We would challenge CTCA to provide evidence for the assertion that other hospitals and providers in the region do not give comprehensive and caring cancer treatment. We have for years been committed, as cancer care providers in New England, to interdisciplinary and compassionate care for our patients. To undermine the careful and collaborative cancer care model that has been fostered by the existing cancer care providers in our region will have unintended consequences in Northern New England. This is particularly true for rural areas.

7. Marketing or Reality?: Again CTCA makes the claim that they have the ability to treat "advanced stages of cancer when many other hospitals lack the protocol and treatment programs to do so." This is simply untrue. Every hospital that we work with in the state and across the region adheres to established treatment guidelines that are formulated for the care of not only advanced stage cancer, but for every stage of cancer. CTCA focuses only on treating patients with the most advanced stages of cancer who require the most expensive care. They are not helping to prevent cancers or to detect cancers at the early stages when lives can be saved and when the money spent will have the most impact on the health of the public at large.

In summary, the cancer care professionals of Northern New England have sought for decades to provide high quality, low cost and high value cancer care close to home. Facilitating the arrival of a cancer care provider into New Hampshire that will only see the wealthiest patients who utilize the most expensive services, without careful review of our current health care needs, will not serve the interests of the citizens of New Hampshire or our region. The CTCA hospital system does not publicly support the goals that are endorsed by NNECOS, by our parent organization, the American Society of Clinical Oncology, or by any other nationally recognized cancer care organizations. There is no reason why such a new, out of state provider should be granted special treatment, especially given the years of dedicated service our existing cancer care providers have committed to in New Hampshire and in our region for many years.

Thank you for your attention to our concerns.

Sincerely,

Thomas Openshaw, MD
207-973-7478

Christian Thomas, MD
802-655-3400

Denis B. Hammond, MD
603-622-6484

CONCORD HOSPITAL
Payson Center for Cancer Care
JIM & MARIANNE COOK RADIATION ONCOLOGY DEPARTMENT

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House Health Human Services and Elderly Affairs Committee

HB 1642, relative to destination cancer hospitals.
February 7, 2012
Testimony

Good morning Mr. Chairman and members of the Committee. My name is Dr. Tom Sheldon and I'm a Board-certified radiation oncologist with Radiation Oncology Associates, and am Medical Director of radiation oncology at the Payson Center for Cancer Care at Concord Hospital. I have been practicing in New Hampshire since 1986.

Cancer Treatment Centers of America has proposed that they offer unique and important cancer care services not available in the region. That is not true. Specifically, in radiation oncology they would plan to install a model of equipment called Tomotherapy. New Hampshire has similar but more versatile equipment in Londonderry and Nashua. More precise equipment, when needed, is available in Manchester, Dover, and Lebanon. They would not fill any gaps in our regional cancer services.

In my 25 years practicing in NH, radiation oncology services have grown at a good pace as the state has grown and our population has aged. The competitive CON process has worked well. The departments are of uniform high quality, busy and efficient. We work hard to make sure that patients are treated close to home, and freely send patients between centers to keep them close to their families and community. If specialty services make referral to another center necessary, we do not hesitate to send them. We have achieved a balance between cooperation and healthy competition among cancer centers in NH. This has been accomplished in very few parts of the country, and we should be proud of this. A patient and family anxious about a cancer diagnosis should not be faced with differing claims from cancer centers, particularly when the motive is profit.

Any new cancer services in NH should only be available through the same competitive regulatory processes. This will hold them to the same high standards that the other cancer centers in NH have achieved.

HB 1642 - relative to destination cancer hospitals

Testimony Presented by: Patrick Clary, MD

February 7, 2012

I have practiced medicine in New Hampshire since 1987, first as a family doctor, then as a specialist in hospice and palliative medicine. I have been Board Certified in Hospice and Palliative Medicine since 1999, and have practiced Hospice and Palliative Medicine full time since 2004. I remain Board Certified in Family Practice as well.

Palliative Medicine is the most recently recognized subspecialty of medicine, focusing on matching patient's goals to appropriate treatments in the setting of advanced illness. In 2009, 2010 and 2011 I was named a "leading physician" in this specialty by the annual poll of New Hampshire physicians conducted by New Hampshire Magazine. I am the Director of Palliative Medicine at Exeter Hospital, the Medical Director of Rockingham VNA Hospice, and the Medical Director of Riverside Rest Home, Strafford County's public nursing home. I have long been an active member of the New Hampshire Medical Society, served in the past as President of the NH Hospice and Palliative Care Organization, continue to participate in four institutional ethics committees, and am part of the New Hampshire Health Care Decisions Coalition. In these roles I have always worked to improve end of life care in our state. I plan to die here so my efforts are not entirely altruistic. As a hospice medical director and palliative care consultant I have helped take care of more than ten thousand New Hampshire citizens as they have neared death. My views come from this work do not necessarily represent those of Exeter Hospital, Rockingham VNA Hospice, Riverside Rest Home, the Medical Society, the Hospice Organization or the Health Care Decisions Coalition.

I do not intend to talk about the threat a specialized cancer center which refuses to care for the indigent poses to our current cancer centers and hospitals, which take all comers, nor about net jobs likely to be lost, or the constitutional principle that laws should apply equally to all. I do not intend to talk about the ethical issue of basing treatment on a patient's ability to pay, or the likely increase in procedures and costs to the people of our state resulting from an end run around the certificate of need process. This is no time for a "hail Mary" pass. There are folks here much better qualified to discuss administrative issues than I am.

What I do want to talk about is the experience of caring for patients here after they have been abandoned by the CTCA, the quality of care offered at these centers, and to share the concerns I have based on these experiences.

I don't think "abandoned" is too strong a term: patients have been transferred to my care in ambulances with no information beyond a single page form after being told they have "failed" therapy, accused of parental neglect because they became to ill to provide planned supervision for visiting children. CTCA' mission statement claims "we never

stop searching for and providing powerful and innovative therapies to heal the whole person, improve quality of life and restore hope." In my experience CTCA mistakes chemotherapy for hope; it is true that CTCA patients tend to receive aggressive treatments until days from death. The "integrative therapy" and "investigational" approaches this group also promises are code words for "unproven," in my experience. The promise then for those who have advanced cancer is that they will no longer have to fly to Mexico for therapies that don't work – they will be able to get them a short drive from Manchester Airport.

The last thing our state needs is a for-profit institution specializing in advanced cancer. While I am old enough to remember when Hodgkins disease was a death sentence, and I applaud the advances in treatment that have made some cancers such as Hodgkins essentially curable, other cancers still predictably cause death when they reach advanced stages. Honest talk is better than promises of impossible cures when patients reach those stages: planning appropriate treatment to manage symptoms and maintain quality of life, working with institutions and caregivers to allow them to spend precious time with family members at home. This is the hospice and palliative care approach to advanced cancer, what hospices and palliative care clinicians now offer in collaboration with colleagues at cancer centers across out state now, something I have never experienced with CTCA.

In fact current medical literature suggests that patients with advanced cancer not only experience higher quality of life, fewer distressing symptoms, and less depression with the palliative approach to care, they also experienced longer survival. Specifically I refer you to the September 23rd 2010 issue of the New England Journal of Medicine for an article titled "Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer," which I will provide for the chair. I would be happy to respond to any questions you might have.

Dartmouth-Hitchcock
NORRIS COTTON
CANCER CENTER

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Lebanon, NH 03756

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February 7, 2012

Hon. John M. Reagan
Chair, House Health and Human Services Committee

Re: House Bill 1642, relative to destination cancer hospitals

Dear Chairman Reagan:

Mark A. Israel, MD, director of the Norris Cotton Cancer Center in Lebanon, and Alan C. Hartford, MD, PhD, section chief of radiation oncology at Norris Cotton Cancer Center, offer the following written testimony in conjunction with their appearance before the committee in opposition to House Bill 1642.

Norris Cotton Cancer Center is one of the nation's premier facilities for cancer treatment and research. It is one of only 40 National Cancer Institute-designated Comprehensive Cancer Centers in the United States – joining the ranks of pre-eminent cancer treatment and research institutions such as Dana Farber Cancer Institute in Boston, the M.D. Anderson Cancer Center in Houston, Memorial Sloan-Kettering Cancer Center in New York, and the Fred Hutchinson Cancer Research Center in Seattle – and is the only NCI Comprehensive Cancer Center in northern New England.

Our opposition to this bill is based on two primary beliefs:

- The need for world-class, comprehensive cancer care for the citizens of New Hampshire is already being met by Norris Cotton and other providers.

- The regulatory process now in place for the development of health care facilities in New Hampshire serves the state well, and any new health care facility should be held to the same regulatory standards as all other healthcare providers in the state.

New Hampshire's cancer needs are complex, and are currently being met an extremely high level.

Care at the Norris Cotton Cancer Center is coordinated through multidisciplinary clinical oncology teams. Each team brings together physicians, specialty nurses, and other professionals who evaluate individual cases and set standards for treatment. The teams pay particular attention to preventing disfigurement, controlling symptoms, eliminating pain, and coping with the emotional distress caused by cancer.

The Norris Cotton Cancer Center provides a positive environment for treatment, cure, and recovery for patients with all forms of cancer. Patients receive technologically advanced cancer treatments and access to clinical trials of new treatments. Each patient is seen as an individual, and a specific treatment plan is developed by specialists who work directly with the patient, family, and referring physician. The Cancer Center is also a leader in improving the comfort and quality of life of patients.

In addition to the clinical care we offer, about 250 active research projects are part of the Norris Cotton's quest to cure cancer, understand its causes, and promote ways to prevent cancer before it starts. These projects are led by 135 cancer research scientists supported by more than $68 million in grants each year from federal and other sources.

Norris Cotton is a world leader in cancer prevention and control research, seeking to identify nutritional, environmental, and lifestyle factors that may cause cancer. We help patients understand their cancer risk and work to prevent cancer-causing behaviors, such as tobacco use by children.

In concert with this research, our scientists are developing new drugs to stop cancers in the very earliest stages of growth. Our search for more effective ways to diagnose breast cancer includes devising new screening technologies. A growing area of research is directed at improving the quality of life for people with cancer.

Along with this statement, we are attaching some data outlining the breadth and depth of services provided by Norris Cotton Cancer Center. There are, or course, other providers in the state, including Dana Farber, the Lahey Center for Oncology & Hematology, and others, which only adds to the capacity available in New Hampshire.

Support the existing Certificate of Need (CON) process

Our additional point of opposition to this bill stems from our strong belief in the regulatory processes currently in place for needs assessment and planning for facilities that provide care. The current Certificate of Need process, under which all New Hampshire health care providers are bound, takes into account the present, but also looks toward the future, anticipating both the demand for services and the supply of those services. On a level playing field, all participants are involved in the process, ensuring that a comprehensive approach to health care is maintained.

Advocates for this legislation have suggested that this project could create as many as 500 new jobs and $500 million in economic impact. While these kinds of promises are enticing in the current economic environment, we believe that such claims further argue for the thorough review process and validation that the CON provides. Additionally, we believe that HB 1642 unfairly tilts the playing field by allowing certain providers an exemption from the comprehensive process that has served the state well over time, and will have far-reaching consequences by addressing only narrowly defined needs and excluding certain payor groups – particularly those most in need of high-quality, comprehensive, coordinated cancer care. By excluding the poor (Medicaid patients), exempted applicants could not only avoid all the additional health and social issues that burden the poorest segment of our population, but also burden the remaining providers that accept all comers – thereby upsetting the delicate balance the CON process is designed to maintain.

In short, any measure that circumvents or bypasses the current process ignores the complexity of treating diseases like cancer and the need for a comprehensive, coordinated approach to the planning and provision of care for those diseases. The impact will be felt in the health care industry, but more importantly, by the citizens of New Hampshire. If any provider, for-profit or non-profit, believes in the care they plan to offer care in New Hampshire, they should be willing and able to go through the process in which all other providers in the state participate.

We hope the committee will find HB 1642 to be inconsistent with quality health care in New Hampshire, and will vote inexpedient to legislate.

Respectfully submitted,

Mark A. Israel, MD
Director, Norris Cotton Cancer Center

Alan C. Hartford, MD, PhD
Section Chief, Radiation Oncology, Norris Cotton Cancer Center

ABOUT THE NORRIS COTTON CANCER CENTER

Breadth of Services:

- 17 clinic locations providing hematology/oncology services and 2 providing radiation oncology services. NCCC-Nashua, N.H. opened January 2012 and Newport, Vt. outreach clinic begins service in February 2012
- Regional NCCC clinics in Vermont at St. Johnsbury and in New Hampshire at main locations in Keene, Manchester, Rochester, and Nashua
- 15 NCCC medical oncologists based in locations other than Lebanon, N.H.
- Leadership of a regional cancer consortium of University of Massachusetts, University of Vermont, and Jackson Laboratories in Maine

Patient Care:

- More than 5,200 new cancer diagnoses each year
- More than 31,000 patients served each year
- More than 75,000 visits to NCCC outpatient clinics each year
- 17 disease-specific Clinical Oncology Groups integrating major modalities of care: surgery, oncology, medical oncology, radiation oncology
- Comprehensive multidisciplinary cancer care in interdisciplinary clinics
- 14 disease-specific Tumor Boards convene each week
- Six Survivorship Clinics treat cancer survivors' ongoing concerns
- 54 bone marrow transplants in 2011
- Patient Supportive Services Program and telephone support groups funded at $275,000 primarily by philanthropy
- Familial Cancer Program provides genetic counseling
- Regional Cancer Prevention Office
- NCCC holds the NH State Tumor Registry contract
- Clinical research accruals occur at St. Johnsbury, Keene, Manchester, and are expected at Nashua

Programs unique to NCCC:

- Interdisciplinary cancer programs in Breast, Thoracic, Head & Neck, Endocrine, Gastrointestinal/Pancreas, Genitourinary/Prostate, Gynecologic Oncology, Pediatric Oncology, Neuro-Oncology/Brain Tumor, Melanoma, and Lymphoma/Leukemia
- 9 Hematology/Oncology Fellows

Harvard Pilgrim Health Care

February 7, 2012

John M. Reagan, Chairman

Health, Human Services and Elderly Affairs

House of Representatives

Room 205, Legislative Office Building

Concord, NH

Re: HB 1642 An Act relative to destination cancer hospitals

Dear Chairman Reagan,

I am writing on behalf of Harvard Pilgrim Health Care of New England ("Harvard Pilgrim") to express our deep concern with HB 1642, an Act relative to destination cancer hospitals. HB 1642 essentially establishes an uneven playing field in the hospital community by defining a new category of hospitals "Destination cancer hospital" and exempting these hospitals from Certificate of Need cost evaluations. Moreover, the bill also requires the Commissioner of the Department of Health and Human Services to submit a waiver request to the Center for Medicare and Medicaid Services (CMS) to exempt destination cancer hospitals from paying New Hampshire's Medicaid Enhancement Tax.

Harvard Pilgrim is concerned about this bill for several reasons. While the Certificate of Need ("CON") process is an imperfect process for stemming the rising cost of health care, it does serve the purpose of weighing and making explicit the costs and benefits of new construction, added or increased operating costs, and the introduction of new technologies. The State of New Hampshire may determine through the CON process that the advantages of constructing a destination cancer hospital outweigh any added costs to the healthcare system or unnecessary duplication of existing services, but without the CON process, an objective determination isn't possible. In addition, while HB 1642 clearly states that it views a destination cancer hospital as a growth engine for the state, it doesn't appear to take into account the negative impact this new type of cancer facility could have on existing cancer services in New Hampshire. To the extent it has the impact of destabilizing or eliminating existing cancer services in the state, even though such services provide quality care, it can actually result in the loss of jobs in communities where the local hospitals have to eliminate those services. Finally, there is nothing in the bill to require the destination cancer hospital to coordinate care for its cancer patients with their local primary care providers, rehabilitation or skilled nursing facilities, home health services or hospice care. This flies in the face of efforts to develop medical homes and increase care coordination as a way to improve the quality of care, reduce costs and increase patient satisfaction.

Thank you for this opportunity to present our concerns with HB 1642 and we urge the Committee to find it inexpedient to legislate.

Sincerely,

Beth Roberts

Vice President, Regional Markets

Representative Marilinda Garcia – Testimony for HB 1642, "relative to destination cancer hospitals"

The overarching goal of this legislation is to develop the NH economy, create jobs and to make NH a magnet for those seeking high-quality, specialized health care.

Key Provisions:

- Waives Medicaid Enhancement Tax
- Exempts destination cancer hospitals from the CON process
- Under definition, 65% of patients must come from out of state

This legislation would allow specialty cancer treatment centers, such as CTCA, to be exempt from the certificate of need process. Despite what the opposition has been asserting, this provision is not a special favor – this is a necessity. Under the current CON law, which was designed to restrain the overbuilding of healthcare facilities for acute care and local usage, a facility like CTCA need not apply. Specialty cancer treatment centers, or boutique hospitals providing a specific service, do not meet the requirements mandated under the CON law, therefore it would be unnecessary and self-defeating for them to apply for it in the first place. NH needs a new designation for a unique class of hospitals to be allowed and encouraged to build in the state – my legislation seeks to accomplish this.

There has been a lot of concern voiced about possible replication of services that already exist in NH. I submit that that concern is immaterial to the legislation at hand. At each of the other 6 CTCAs in the country, approximately 70% of the patients at the facility come from outside the state in which it is located. My provision requires 65% of patients to come from out of state.

NH citizens may in fact be adequately served by the cancer care available in the state, I'm not questioning the work of NH hospitals. Instead, my question is: How many cancer patients come to NH from another state specifically to seek unique, comprehensive care? My legislation seeks to change the conception of NH – I want NH to become a destination state for those seeking specialty health care, while also increasing the cancer care options for NH citizens.

Cancer Treatment Centers of America is an example of such specialty health care with a singular focus on the provision of individualized, integrative cancer care. It is a comprehensive model that provides everything from diagnostics to treatment to aftercare – all under one roof. By combining expertise in traditional cancer treatments with complementary therapies, it is an alternative approach focused on treating the whole person, not just the disease. [List on page 38/39 of the Outcomes doc.]

My legislation would waive the Medicaid Enhancement Tax for a simple reason – Cancer Treatment Centers of America accepts an insurance payer-mix that does not include Medicaid. Additionally, as a for-profit organization, CTCA would pay business taxes that other NH hospitals do not pay. This one

center will have an estimated 500M impact and create approximately 500 jobs in the first 5 years of its entry to the state. Those who travel to NH to receive specialized treatment at a facility such as this often come with family, which boosts revenue from retail and lodging, as well as bringing co-morbidities that are tended to at other NH hospitals.

Any organization that is seeking to invest millions of their own dollars into the continuation of a growth initiative that, by virtue of its success in 6 other states has demonstrable value to its customers, who in this case are cancer patients, is an organization I want to encourage to locate in NH. Again, this legislation seeks to achieve that goal.

That concludes my remarks. Thank you for your time – I'd be happy to take any questions.

Sincerely,

Rep. Marilinda Garcia

District 4 Rockingham County

Salem/Windham

State of New Hampshire House of Representatives

Hon. Steven L. Cunningham, O.D. ~ Sullivan County, District 2

State-Federal Relations and
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Room 203, Legislative Office Building
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February 7, 2012

RE: HB 1642

Chairman, Honorable Committee Members:

The free enterprise system has served our country well. We generally have just the right number of pizza joints in any given communtiy. If we have too many, the most poorly run will go out of business. As it should.

Having worked in our medical community in private practice, in a government facility, on the state optometry board, and having been a co-founder of a PPO, I can tell you that one of the big problems with our entire medical care industry is the absence of the free enterprise system.

Please encourage initiative and excellence by removing the certificate of need for a least one sector and forwarding HB 1642 as ought to pass.

Thank you,

Steven Cunningham, O.D.
New Hampshire State Representative

TESTIMONY OF REPRESENTATIVE THOMAS KEANE ON DESTINATION CANCER HOSPITAL LEGISLATION
·HB 1642 · 2/7/2012

Good morning, Mr. Chairman and members of the committee. My name is Tom Keane and I represent Merrimack 13, including the towns of Bow and Dunbarton.

I am here today in support of House Bill 1642, to allow a new definition of destination cancer hospitals here in New Hampshire. I want to talk about how this bill will provide a new option and I believe an improved standard of care for New Hampshire patients who have been diagnosed with cancer.

I will focus on the combined experience of myself as a cancer survivor, that of my mother who did not survive and half a dozen of my constituents who are in various stages of treatment for cancer.

The Cancer Treatment Centers of America provide patients the opportunity to receive the latest in diagnosis and treatment care but so do many fine regional cancer centers.

What is different about CTCA is their singular focus on cancer and most out standing is their unbending focus on the needs of their patients.

As a patient it was frustrating to wait weeks for an appointment with various specialists only to find out that there was little coordination of care. The fear that strikes every person who suspects a diagnosis of cancer requires rapid access to evaluation and the development of a comprehensive multi-disciplined treatment plan. The coordination of these two factors, is often not currently available.

It has been my experience that patient centered care is also missing from the current choices for treatment. By patient centered care I mean a top to bottom staff commitment to make the patient the focus of service provision. On a visit to one of the centers I saw a new patient and their spouse walk through the front door looking confused about where to go. The was a person cleaning who stopped what they were doing and not only offered to answer their question but dropped what they were doing to personally walk the patient to the admissions office. It was my experience that the philosophy of patient's first permeated the entire staff at the facility I visited.

I ask the committee to vote OTP on HB 1642.

Thank you for your time and service to the citizens of New Hampshire.

New Hampshire Hospital Association

HOUSE HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS COMMITTEE

February 7, 2012

HB 1642-FN, An Act relative to destination cancer hospitals

Testimony

Good morning Mr. Chairman and members of the Committee. My name is Steve Ahnen, and I am the president of the New Hampshire Hospital Association, representing the state's 32 acute care community, rehabilitation and specialty hospitals.

The New Hampshire Hospital Association and our members strongly believe that comprehensive, compassionate cancer care services should be available for the patients and communities they serve here in New Hampshire. In fact, New Hampshire and the broader New England region are home to some of this country's leading oncology providers, including the Norris Cotton Cancer Center at Dartmouth-Hitchcock Medical Center in Lebanon and affiliated sites around the state, the Payson Center for Cancer Care at Concord Hospital, Elliot Regional Cancer Center, New Hampshire Oncology Hematology, Exeter Hospital Center for Cancer Care, Portsmouth Regional Hospital Hematology and Oncology Center, The Oncology Center at St. Joseph Hospital, Nashua Regional Cancer Center, Seacoast Cancer Center at Wentworth-Douglass Hospital, The Memorial Hospital/Maine Medical Center, The Lahey Center for Oncology and Hematology at Parkland Medical Center, Dana-Farber/New Hampshire Oncology-Hematology, and the numerous providers just to our south in Boston (see attached list and map of oncology services currently offered in New Hampshire). These providers work collaboratively to provide the highest level of care to patients suffering from cancer, as well as conduct important research to develop treatments and improve the lives of those suffering from this dreaded disease.

The Norris Cotton Cancer Center (situated at 4 regional locations and 8 affiliated hospitals in New Hampshire) is one of only 40 cancer centers in the country to have earned the National Cancer Institute's Comprehensive Cancer Center designation. This designation means that the Norris Cotton Cancer Center: 1) treats all types of cancers using a multi-disciplinary team-based approach; 2) conducts all three major types of cancer research—

basic cancer research, clinical cancer research, and cancer prevention and control research; and 3) demonstrates professional and public education and dissemination of clinical and public health advances into the communities it serves.

Hospitals in New Hampshire do not, as some have suggested, fear the entrance to the market of a new health care provider, such as the Cancer Treatment Centers of America (CTCA). Hospitals in New Hampshire operate in a market environment and must compete within the existing rules, including the state's certificate of need (CON) laws and regulations. The CON laws and regulations have been part of the legal and regulatory environment for many years in New Hampshire and every hospital is subject to them. The CON process is structured to ensure ***"that all new institutional health care services be offered or developed in a manner which avoids unnecessary duplication, contains or reduces increases in the cost of delivering services, and promotes rational allocation of health care resources in the state."***

HB 1642 would circumvent that process for the establishment of a "destination cancer hospital" that CTCA is seeking to create here in New Hampshire. While proponents of this legislation claim that this is simply creating more competition in the health care marketplace, it is actually anti-competitive. No other hospital or health care provider in New Hampshire would enjoy this regulatory "free pass," but would be required to go through the CON process to demonstrate the need for a new institutional health care facility. At a time of restrained health care resources, we should not through regulatory actions do things that will increase the cost of health care, damage our state's existing health care providers and infrastructure, or create special exceptions to the rules that do not benefit the patients and communities of New Hampshire.

The CON process is designed to be fair and ensure that any institutional health care services provide the highest quality of care that is available to the citizens of our state, as well as to promote collaboration among health care providers to provide better care and to manage the increase in health care costs. By going through the CON process, projects that don't stand up to regulatory scrutiny are withdrawn, and worthy projects are further improved and strengthened as different aspects of the project are examined.

Among other requirements, applicants for a CON must demonstrate:

- the portion of **need** professed that is not currently being met;
- **accessibility** of the proposed service to the population in the service area, including accessibility to **Medicaid** patients;
- how the proposed project is projected to affect the proposed service area in terms of: **utilization, patient charges, market share, physician referral patterns, and personnel services;**
- how the proposed project will impact other providers on their continued ability to maintain quality services; provide essential community services; provide emergency services; and provide charity care; and

- the degree to which the proposed project will be accessible to persons who are medically underserviced, including, but not limited to, persons with a disability and indigent persons.

In fact, just a few years ago, another out-of-state hospital chain approached NH officials about building a new hospital in New Hampshire. **Specialty Hospitals of America** (SHA) wanted to build a Long Term Acute Care Hospital (LTACH) in NH. SHA learned it must comply with the state's CON requirements as provided in the law and requested that standards for this new service be developed. Thus, the CON Board established standards for LTACH services to include defining the requirement to demonstrate the need for the service. Once the standards for review were adopted, any interested provider – not just Specialty Hospitals of America – would be invited to compete to bring this new service to New Hampshire. Because of changes in federal Medicare reimbursement for LTACH providers, SHA later decided not to pursue development in NH.

If a destination cancer hospital is a viable project, the citizens of our state deserve to have the project vetted to ensure the best possible result, not the least of which is quality care without increasing cost. Exempting this or any other facility from the CON process opens the door to creating excess service capacity thereby increasing costs.

New Hampshire's hospitals treat all patients without regard to their ability to pay. HB 1642 would appear to exempt the Cancer Treatment Centers of America (CTCA) facility from treating patients diagnosed with cancer who are either uninsured or on Medicaid. While it is true that New Hampshire's Medicaid reimbursement rates to hospitals are the lowest in the nation, hovering at or below 50 percent of the actual cost of providing services to Medicaid patients, exempting CTCA from the requirement to treat Medicaid patients is not consistent with existing public policy that applies to every other hospital in New Hampshire—and is simply not right.

By not requiring this new cancer facility to provide services to Medicaid or uninsured patients, the State of New Hampshire is by public policy endorsing the ability of this provider to "cherry pick" only the most profitable patients. That will have a devastating effect on other providers in the state who operate under a very different set of rules, which dictate that they serve all patients, including those on Medicaid and the uninsured. Hospitals in New Hampshire continue to suffer from the effects of the state budget adopted last year that cut over $250 million in Medicaid payments to hospitals. The vast majority of these cuts came through changes to the state's Medicaid Enhancement Tax (MET) and Disproportionate Share Hospital (DSH) payment program. HB 1642's exemption for this new destination cancer hospital of requirements to pay the Medicaid Enhancement Tax is deplorable and would only serve to harm New Hampshire's community hospitals further.

While CTCA claims that "only 35 percent" of in-state residents would be treated by this new "destination cancer hospital," it is very clear that CTCA intends to treat only those patients who are well insured. That will only serve to weaken New Hampshire's community hospitals by pulling out those patients who have private insurance and leaving fewer

privately insured patients and those who are uninsured or on Medicaid in our local community hospitals. National research by the Medicare Payment Advisory Commission (MedPAC) has demonstrated that limited service providers, such as CTCA, routinely treat better-insured patients and have higher profits than community hospitals. They admit fewer, if any, Medicaid patients and are associated with significantly higher utilization growth. Health trends analysis has shown that growth of limited service providers, like CTCA, comes at the expense of community hospitals.

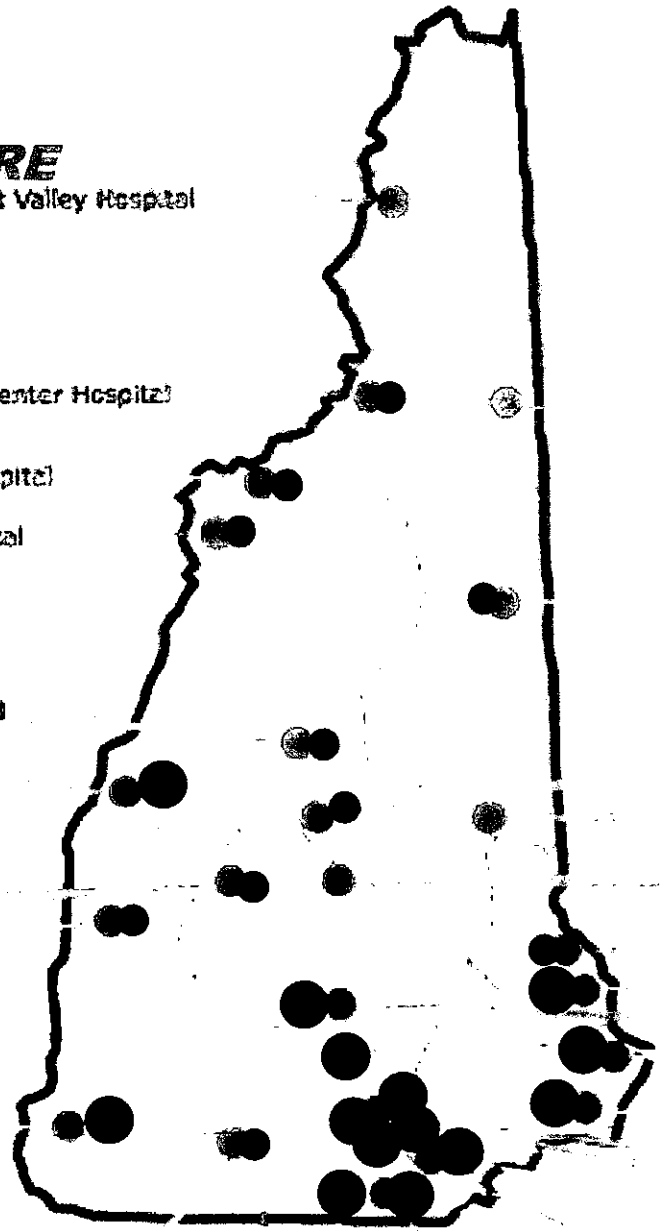
Despite the tough economic climate over the past few years, New Hampshire's hospitals are economic anchors in communities all across the state. They make significant contributions to our communities by not only providing high quality health care, but as employers who provide jobs and benefits, as well as economic activity that drives growth for businesses and families to locate in New Hampshire. That should be our focus. Policies that can harm the economic strength and vitality of one of New Hampshire's most important sectors should be rejected.

Finally, hospitals, doctors, nurses and other caregivers in New Hampshire work hard to collaborate and partner with one another to improve care and best serve the patients and communities of New Hampshire. HB 1642 would seek to upend that sense of collaboration by jumping over the current legal and regulatory process and bringing in a new, out-of-state provider. We do not know the Cancer Treatment Centers of America well, but we do know that they have not yet demonstrated their interest or commitment to the health care community in New Hampshire. I am not aware of any providers in New Hampshire that have been contacted by CTCA officials. And it would appear that this legislation seeks to isolate CTCA from other providers in the state. That is not the kind of collaborative culture that exists in this state or that studies show produce high quality health care.

Mr. Chairman and members of the Committee, we strongly urge you to find HB 1642 inexpedient to legislate. There is a structure and process currently in place to review the need for any new institutional health care service, including those that CTCA seeks to provide. If those services are necessary and fulfill an unmet need here in New Hampshire, they will be approved. If it is found that these services, however, are not needed, they will not be approved and New Hampshire will avoid the unnecessary duplication of services and the added costs associated with them.

Thank you for your time and I would be happy to answer your questions.

ONCOLOGY SERVICES IN NEW HAMPSHIRE



Upper Connecticut Valley Hospital

Weeks Medical Center Hospital

Androscoggin Valley Hospital

Littleton Regional Hospital

Cottage Hospital

The Memorial Hospital

Speare Memorial Hospital

Mary Hitchcock Memorial Hospital

Lakes Region General Hospital

Huggins Hospital

Alice Peck Day Memorial Hospital

Franklin Regional Hospital

New London Hospital

Valley Regional Hospital

Frisbie Memorial Hospital

Wentworth-Douglass Hospital

Concord Hospital

Portsmouth Regional Hospital

The Cheshire Medical Center

Exeter Hospital

Catholic Medical Center

Elliot Hospital

Parkland Medical Center

Monadnock Community Hospital

St. Joseph Hospital

Southern NH Medical Center

ONCOLOGY SERVICES IN NEW HAMPSHIRE

Derry
The Lahey Center for Oncology & Hematology at Parkland Medical Center

Londonderry
Dana-Farber/New Hampshire Oncology-Hematology
Elliot Regional Cancer Center

Nashua
Norris Cotton Cancer Care Nashua
Nashua Regional Cancer Center
The Oncology Center at St. Joseph Hospital

Manchester
Elliot Regional Cancer Center
Norris Cotton Cancer Center at Catholic Medical Center

Hooksett
New Hampshire Oncology Hematology

Concord
Concord Hospital Payson Center for Cancer Care

Exeter
Exeter Hospital Center for Cancer Care

Portsmouth
Portsmouth Regional Hospital Hematology & Oncology Center

Dover
Seacoast Cancer Center at Wentworth-Douglass Hospital

Rochester
Frisbie Hospital Center for Cancer Care/ Norris Cotton Cancer Center

Laconia
LRGHealthcare/New Hampshire Oncology Hematology

Peterborough
Monadnock Community Hospital/Norris Cotton Cancer Center

Keene
Dartmouth-Hitchcock Norris Cotton Cancer Center

Claremont
Valley Regional Hospital/Norris Cotton Cancer Center

New London
New London Hospita/Norris Cotton Cancer Center

Lebanon
Dartmouth-Hitchcock Norris Cotton Cancer Center

Plymouth
Speare Memorial Hospita/Norris Cotton Cancer Center

Littleton
Littleton Regional Hospital/Norris Cotton Cancer Center

Woodsville
Cottage Hospital/Norris Cotton Cancer Center

Lancaster
Weeks Medical Center/ Norris Cotton Cancer Center

North Conway
Memorial Hospital/Maine Medical Center

February 7, 2012

Business and Industry Association
New Hampshire's Statewide Chamber of Commerce

HB 1642 FN

Testimony of David A. Juvet

Business & Industry Association of New Hampshire

February 7, 2012

Dear Mr. Chairman, and members of the Health, Human Services $ Elderly Affairs Committee, my name is David Juvet and I am senior vice president of the Business & Industry Association, New Hampshire's statewide chamber of commerce. We are here today in opposition to HB 1642 FN because we don't believe that creating an unlevel playing field, and unfair competition is the best way to spur the economy and job growth in New Hampshire.

Having said this, I would like to take just a moment to thank the prime sponsor and co-sponsors for focusing on economic growth. I believe their hearts are in the right place, but HB 1642 doesn't work. At its essence HB 1642 is trying to lure a single employer to this state to provide services that are already generally available by carving out exemptions to current laws that apply to that industry. Obviously this gives the employer economic advantages that are not shared by those other employers already in New Hampshire who provide those services.

Mr. Chairman, we stand ready to work with the legislature to foster job growth and improve New Hampshire's economy, but unfortunately HB 1642 sets a bad precedent. Carving out exemptions to entice a company into the state is not in the best interest of employers already here. By design it creates an unlevel playing field and results in unfair competition for employers already in New Hampshire. **We respectfully ask that you find HB 1642 FN inexpedient to legislate.**

I would be happy to answer any questions from the committee.

Frederick M. Bricetti, MD
Partner, New Hampshire Oncology and Hematology
Medical Director, Dana-Farber Cancer Institute of Londonderry
Payson Cancer Center
250 Pleasant St.
Concord, NH

HB 1642 COMMENTS

To Chairman Reagan and committee members:

My name is Dr. Fred Briccetti, and I am a partner in New Hampshire Oncology Hematology (NHOH), the largest private oncology group in New Hampshire. We employ 12 physicians and more than 100 staff in clinics in Concord, Hooksett, Laconia, Exeter and Londonderry. Our Londonderry site is a satellite facility of the renowned Dana-Farber Cancer Institute, and all our physicians are on staff at Dana-Farber. The partnerships we maintain within the existing regional cancer treatment network allow us to provide comprehensive oncology care to our patients, which has been our core mission for 35 years. This includes everything from making available cutting edge treatments and clinical research, educating the public and general medical community on cancer treatments, and providing psychological and spiritual support to patients and families. We provide access to oncology care for ALL citizens, not just those with generous insurance coverage. We pay federal and state business taxes as well as local real estate taxes.

My NHOH partners and I ask the committee to consider two important questions: 1) Are the oncology needs of the people of New Hampshire currently being met? And 2) Should CTCA be permitted to circumvent the Certificate of Need (CON) process that has served the state well and that we and other local institutions have abided by? We would answer, "Yes," the oncology needs of New Hampshire residents are being fully met and need no augmentation, and "No," the legislature should not vote to exempt CTCA from the CON process.

CTCA implies that it will provide a new type of treatment and a level of care not currently available in the state. We have seen no evidence to support this claim. We feel that the level of care currently available in New Hampshire exceeds that offered by CTCA. The local partnerships and cooperation we currently maintain allows our patients to take advantage of the expertise of cutting-edge care without having to sacrifice the comfort and convenience of receiving their care close to home. Patients with malignancies that require a higher level of care than can be provided at the community level have the option of being treated at Dartmouth-Hitchcock Medical Center, or being referred to one of the Boston teaching hospitals.

CTCA claims that it will create jobs in New Hampshire. We doubt this claim. It is more likely that most of these jobs will merely shift from existing practices. Furthermore, CTCA will hurt existing cancer care facilities by "cherry-picking" their patients, thereby undermining the financial stability of our lower-cost institutions. This will threaten the jobs of the health care workers these institutions currently employ.

Finally, the Certificate of Need process was put in place by the New Hampshire Legislature to make sure that new facilities and expensive medical services are actually needed in the state. Exempting CTCA from the review that is required of other oncology providers gives them an unfair advantage. CTCA offers nothing that justifies such an advantage.

Testimony of Andrew B. Eills, Esq. delivered to the House Health, Human Services and Elderly Affairs Committee regarding HB 1642, relative to destination cancer hospitals, February 9, 2012.

Good morning, Mr. Chair, and Members of the Committee. I appreciate very much the opportunity to speak with you today. I am testifying against this bill. I am testifying today here as a "citizen/lawyer."

I have two distinct comments. They concern 1) a brief description of the benefits to the public of the process of Certificate of Need review, and 2) the competitive process for applications for Certificates of Need.

1. With regard to the process for CON, I have practiced before the Board for over 15 years. I have been involved with Certificate of Need applications, the rulemaking process of the Board, and issues concerning whether the Board itself has jurisdiction over particular providers. I can say with absolute confidence that the CON process requires healthcare providers -- be they independent providers with particular equipment or hospitals -- to examine their own projects in a disciplined manner and to demonstrate to the public the need for the particular project. It results in an internal analysis of the capital expenditures required and the most efficient and beneficial way to spend those funds. But perhaps more importantly, this analysis benefits the public because it focuses on quality and cost. The CON process results in health care providers actively being able to justify with great certainty the need for their projects. The public has the opportunity to comment on how health care resources will be expended. There is no other process in New Hampshire that results in this benefit to the public.

2. The second point is that a competitive process for applications exists in the statute governing CON applications. Indeed, not all Certificate of Need applications are granted. In fact, I have been involved with several applications that were competitive. In each case, each separate party understood that a particular need identified by the Board could only be filled by one provider. In these instances, the parties presented competing applications to the Board and the public. The Board, based upon the evidence provided by the parties and public comment, and based upon the statute and particular criteria enunciated in the Board's administrative rules, chose the party that would best fill the need for the service.

HB 1642 would not result in any of the benefits that I have described to you. In fact, it would allow one particular company to avoid any public comment and the competitive process that has worked in other instances before the Board.

Thank you. I would be pleased to answer any questions you may have.

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Concord, NH 03301
(603) 545-6126
aeills@haslaw.com

#50531978

Maurie Markman, MD – Senior Vice President of Clinical Affairs & National Director of Medical Oncology

Dr. Markman is a member of numerous professional organizations, including, but not limited to: the American College of Physicians, the American Society of Clinical Oncology, the American Association for Cancer Research, the American Medical Association, the American Society of Hematology, the American Society of Internal Medicine, the International Gynecologic Cancer Society, and the Society of Gynecologic Oncologists.

Dedicated to finding new and innovative ways to treat cancer, Dr. Markman has published more than 250 peer-reviewed manuscripts, and more than 600 review articles, editorials, book chapters, letters and abstracts. He has also written or co-edited 10 books and served as an editorial board member on over 30 journals. He is currently the Editor in Chief of *Current Oncology Reports*.

Dr. Markman is regularly listed as one of the "Best Doctors in America" by Best Doctors, Inc., and one of "America's Top Doctors" by Castle Connelly Medical Ltd. In 1999 he was recognized as the Lee and Jerome Burkons Research Chair in Oncology by the Cleveland Clinic.

Early in his career, a mentor reminded Dr. Maurie Markman to approach the practice of medicine as a "people's doctor." This advice resonated with Dr. Markman, and he continues to carry it with him as he treats patients today.

A nationally-renowned oncologist, Dr. Markman is the Vice President of Patient Oncology Services and National Director of Medical Oncology at Cancer Treatment Centers of America (CTCA).

"From the beginning of my career, I recognized the importance of practicing medicine as a 'people's doctor,'" says Dr. Markman. "All of my research and work has been motivated by the thought of giving patients every option to beat their disease."

Dr. Markman has more than 20 years of experience in cancer treatment and gynecologic research at some of the country's most recognized facilities. In June 2011, he received the esteemed American Society of Clinical Oncology (ASCO) Statesman Award. Presented annually, the Statesman Award recognizes individual ASCO members who have shown extraordinary volunteer service, dedication and commitment to ASCO, their hospital community and the patients they serve for at least 20 years.

Most recently, Dr. Markman served as the Vice President for Clinical Research and Chairman of the Department of Gynecologic Medical Oncology at M.D. Anderson Cancer Center in Houston, Texas. Prior to that, Dr. Markman spent 11 years as Chairman of the Department of Hematology/Oncology and Director of the Taussig Cancer Center at the Cleveland Clinic Foundation. He also spent five years as Vice Chairman of the Department of Medicine at Memorial Sloan-Kettering Cancer Center in New York. A Diplomate of the American Board of Internal Medicine, Dr. Markman is board certified in internal medicine, medical oncology and hematology. He also holds a Certificate of Advanced Study in Bioethics from the Department of Philosophy at Cleveland State University.

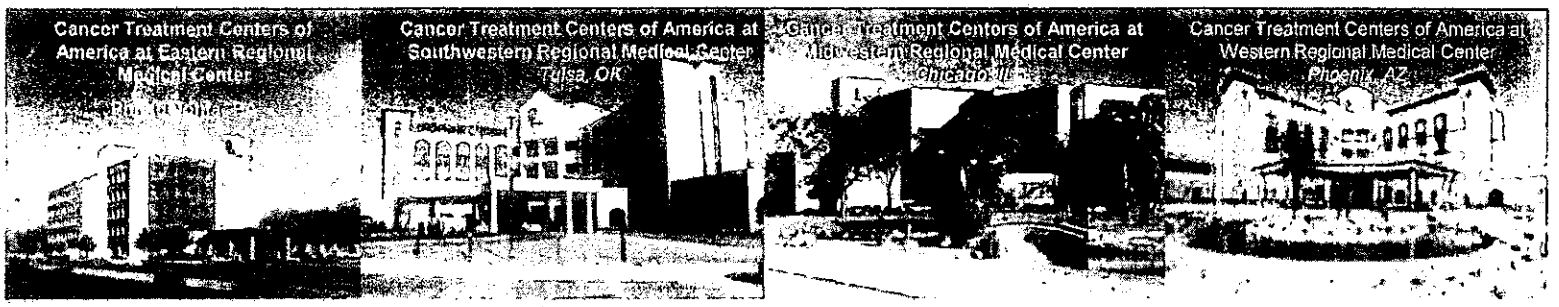
Dr. Markman began his undergraduate education at the University of Southern California, where he earned a bachelor's degree in Biology and graduated summa cum laude. He went on to earn a medical degree from New York University School of Medicine.

Following medical school, Dr. Markman completed an internship and residency in internal medicine at Bellevue Hospital-New York University Medical Center, where he was named Chief Resident in his final year. He then completed fellowship training in hematology and oncology at both the National Cancer Institute and Johns Hopkins University in Maryland. He also holds a master's degree in health policy and management from New York University Graduate School of Public Administration.

He is widely regarded for his knowledge and expertise as a practicing clinical oncologist and is frequently asked to be a visiting professor and guest lecturer at universities and medical schools across the country.

Dr. Markman joined CTCA in September 2010. In addition to his national role within the organization, he also serves patients as a medical oncologist at CTCA at Eastern Regional Medical Center.

Dr. Markman says he was drawn to CTCA by the hospital's patient-centered approach to cancer care and philosophy of treating the whole person, not just the disease. At CTCA, he treats patients as part of the Patient Empowered Care® model. This model gives patients more time and greater access to their dedicated care team, ensuring more responsive, personalized care.



Cancer Treatment Centers of America®

Winning the fight against cancer, every day.®

The CTCA Mission

CTCA is the home of integrative and compassionate cancer care.

We never stop searching for and providing powerful and innovative therapies to heal the whole person, improve quality of life and restore hope.

The CTCA Promise

You and your healing are at the center of our hearts, minds and actions every day.

We rally our team around you, delivering compassionate, integrative cancer care for your body, mind and spirit.

We offer clear information, powerful and thorough treatment options, all based on your needs.

We honor your courage, respect your decisions, and offer to share your journey of healing and hope.

Cancer Treatment Centers of America

Cancer Treatment Centers of America (CTCA) Model Overview:

- CTCA is a privately held network of cancer treatment hospitals and outpatient oncology clinics with locations in Zion, Illinois; Tulsa, Oklahoma; Philadelphia, Pennsylvania; Goodyear, Arizona and Seattle, Washington. Our newest facility, which will be located in Newnan, Georgia, is expected to open in September of 2012.
- CTCA treats more than 5,000 new and returning patients each year, has a nurse-to-patient ratio of 1 to 6, and has over 130 guest rooms for patients and families(an average of 25 guest rooms for new facility).
- CTCA has more than 1,500 doctors and clinical professionals.
- CTCA's growth initiative will place hospitals within 300 miles of approximately 80% of the U.S. population.

Our Hospital's Trademark Principles:

- **Integrative Care** - where oncologists work closely with staff nutritionists, mind-body therapists, naturopathic doctors, physical therapists and spiritual support to treat the whole person; all under one roof.
- **The Mother Standard®** - a standard required at CTCA that exceeds the level of care found at most hospitals. This is the standard of care CTCA staff would want for their own mothers and has created the "gold standard" in cancer care across the nation.
- **Patient Empowerment Medicine** – a treatment model wherein patients and caregivers are positioned at the center of their care, voicing opinions and participating in their own treatment decisions.
- **Advanced Technologies and Treatment Protocols** - TomoTherapy® radiation treatment to pinpoint and more safely treat cancer, High-Dose Brachytherapy, Radiofrequency Ablation of Metastatic Tumors, Intra-arterial and Chemoembolization, and many others.

The Accreditations Held by Our Hospitals:

- The Joint Commission
- Community Hospital Comprehensive Cancer Center as designated by the American College Surgeons Commission on Cancer
- Association of Community Cancer Centers
- College of American Pathologists
- American Association of Blood Banks
- American College of Radiology

Cancer Treatment Centers of America®

Cancer Survival Outcomes 2010



Cancer Treatment Centers of America

Winning the fight against cancer, every day.™

Cancer Treatment Centers of America®

Our Vision

To be recognized and trusted by people living with cancer as the premier center for healing and hope.

Our Mission

CTCA is the home of integrative and compassionate cancer care.

We never stop searching for and providing powerful and innovative therapies to heal the whole person, improve quality of life and restore hope.

Our Values

Hopeful
Compassionate
Empowering
Ethical
Responsive
Innovative
Team Spirited

Letter from the President

Cancer Treatment Centers of America® (CTCA) is a national health system singularly focused on the provision of cancer care. We treat approximately 12,000 patients a year at our four hospitals, and we offer patients all the services they need, from diagnosis through treatment and aftercare, at each of our locations. We also provide them, their families, and their caregivers with the clear information they need to make one of the most important decisions of their lives: choosing where they will go for cancer treatment.

We maintain a commitment to share outcomes data that is central to the evolving national healthcare dialogue. Higher quality, lower cost care, and improved access to medical treatment can only transpire if our industry fully engages the consumer. At CTCA, we are working on several fronts to enhance the transparency of our communications with consumers in order to support their decision-making process.

One of those areas of transparency is survival outcomes. To that end, we publish our survival outcomes data and patient experience data on our website, *http://www.cancercenter.com*, which is now viewed by over 6 million unique visitors a year who are researching their oncology options. Through this move, we have increased awareness of and access to our clinical outcomes in the area of our unique expertise, which is treating the toughest and most advanced cases of cancer. CTCA is among the first cancer treatment hospitals to publish such a clear and comprehensive array of treatment results for complex and advanced stage cancers.

We believe it is important to provide this information in greater technical detail to employers and insurance companies whose stakeholders may be fighting cancer. Because of that we published this booklet, which contains summaries of our outcomes reports with the supporting technical data for the eleven most prevalent cancers we treat. We hope our key payor audiences will find this information helpful to their decision-making processes.

Sincerely,
Stephen B. Bonner
President and CEO
Cancer Treatment Centers of America®

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Introduction

Cancer Treatment Centers of America® (CTCA) is one of very few cancer treatment hospitals that publish cancer survival outcomes data. CTCA believes that patients, caregivers, health insurance companies, and employers have the right to know this information. We publish advanced-stage survival statistics on our website in language patients and caregivers can understand for eleven of the most prevalent cancers we treat. This booklet, which is intended for employers and health insurance companies, contains the same outcomes data as our website along with more technical information, including an explanation of the statistical methodology employed.

We publish our outcomes data because we believe that consumers, employers, and insurance companies should be able to compare CTCA's advanced-stage survival data to an appropriate national benchmark. Unfortunately, such a benchmark does not exist. To help solve that problem, we asked an independent biostatistician from Washington University in St. Louis to conduct a comparison of CTCA's patient survival data to selected data from the National Cancer Institute's (NCI) Surveillance, Epidemiology, and End Results (SEER) database. NCI collects cancer incidence and survival data from cancer registries at hospitals and treatment centers across the US and makes that information available to the public on its SEER website at *http://SEER.cancer.gov*. We consider this to be the best available data source available for our comparison.

A complete explanation of the methodology used to compare CTCA patient data to the SEER database is included in the Statistical Methodology section of this booklet, which is followed by summaries of the analytical results for each of the eleven most prevalent cancers treated at CTCA.

Statistical Methodology

Selection of Comparison Samples

In 2009, CTCA implemented a project to compare the cancer survival outcomes between patients who were treated by CTCA since diagnosis and patients from the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program database.

The comparative analyses were conducted for a total of eleven cancer types. For each cancer type, the CTCA sample contained all eligible cancer patients diagnosed between 2000 and 2005 from both CTCA at Southwestern Regional Medical Center in Tulsa, OK, and CTCA at Midwestern Regional Medical Center in Zion, IL. This study was restricted to only include cancer patients from CTCA who had been exclusively treated by CTCA since their initial diagnosis (i.e., the analytic cases). CTCA site managers prepared the database. Basic cancer and patient characteristics such as age at initial diagnosis, year of initial diagnosis, cancer stages, cancer primary sites, and gender were first examined with the CTCA sample. These characteristics were then used to identify the comparison cancer cases from the SEER database for our analysis.

The SEER database is an authoritative source of information on cancer incidence and survival in the United States. The SEER comparison sample for this project was chosen by matching basic characteristics on some of the most important factors that affect survival outcomes, such as age at diagnosis, cancer severity stage, and cancer site. More specifically, the SEER comparison sample included patients from the SEER database whose age at diagnosis was within the same age range as the CTCA sample at time of diagnosis. The SEER comparison sample excluded patients whose stage of cancer severity as staged by the SEER Summary Stages or SSS, (see *http://www.seer.cancer.gov/tools/ssm/*) or tumor sites (as coded by ICD-O-3) were not present in the CTCA sample. The latest SEER Limited-Use Database as of 1/29/2009 was used (*http://seer.cancer.gov/data/access.html*) to select the SEER comparison sample.

For both CTCA and SEER samples, only cancer patients whose initial diagnosis occurred between 2000 and 2005 were analyzed. Cancer cases with missing information on either the date of initial diagnosis or the date of last contact were deleted from the CTCA database because the survival time or censoring time for such patients could not be computed. Cancer patients with missing SEER Summary Stages were also excluded from the analyses. For patients with multiple cancers in the SEER and CTCA database, only the first of the cancer type under analysis was used for the survival comparisons.

Statistical Methods

The time of survival outcome from the CTCA database was computed as the time from the initial cancer diagnosis to death, and was computed in number of years as the difference between the date of death and the date of initial diagnosis divided by 365.25. The survival outcome from the SEER database was provided by the SEER Limited-Use Data File as the number of completed years and the number of completed months. These were then converted to the number of years by dividing the total number of survival months by 12. For those patients who

Statistical Methodology

were still alive or lost to follow-up at the time of entering the databases, their survival time was treated as statistically censored [1] at the difference between the date of last contact and the date of initial diagnosis.

For each cancer type, the survival curve (defined as the probability of cancer patient survival as a function of time after the initial diagnosis) was estimated by the Kaplan-Meier nonparametric product-limit estimator [1]. Three statistical tests were used to compare the survival curves between the CTCA database and the SEER database.

Two of these tests, the logrank test and Wilcoxon test are nonparametric in the sense they are valid to compare survival curves that have any shapes [1]. They are different, however, in the sensitivity (or the power) to detect survival differences. The logrank test is generally the most sensitive or powerful when the risk or the hazard of death between CTCA and SEER samples is approximately proportional, whereas the Wilcoxon test tends to be more sensitive when the ratio of hazards of death is higher at earlier times than at later ones. The third test, the likelihood ratio test [2], is the most restrictive of the three in the sense that it is appropriate to use only for very special survival curves (called exponential distributions) whose hazards of death are constant across time.

Ninety-five percent confidence interval (95% CI) estimates for the individual survival rates as well as for the difference of survival rates between the CTCA and SEER samples at specific time points after diagnosis were based on the estimated survival curves and the relevant asymptotic normal distributions. All these analyses were implemented using the standard SAS package of statistical tests, i.e., SAS/PROC LIFETEST [3] and SAS macros.

Limitations

This study shares similar limitations that apply to all observational studies. First, because the study was not randomized and the CTCA and SEER samples were convenience samples, no causal interpretation (i.e., cause and effect relationship) on the comparative analyses results should be attempted. Second, although some types of matching as described above were implemented to select the appropriate SEER comparison sample, many factors other than those considered in the study, and available from the database, could have contributed to the survival outcomes. The possible confounding of these factors to the analyses results can not be ruled out. Third, the comparison for each cancer type was based on the statistical comparisons on the rate of death from all possible causes, not solely the cancer-specific death. Finally, although a large cancer sample was available from the SEER database, the sample sizes from CTCA for several cancer types were limited; therefore, a larger CTCA sample size would provide a more definitive answer for those cancer types.

Notes

- At the time of the analyses, the most recent stage-specific data available within the SEER database was limited to patients who were diagnosed between 2000 and 2003. We extended the CTCA sample through 2005 to enlarge the sample size. The rate of survival for CTCA patients diagnosed in 2004 and 2005 is consistent with the rate of survival of CTCA patients diagnosed between 2000 and 2003, allowing for a larger CTCA sample size to achieve more accurate estimates of survival rates.
- Results for the majority of the cancers in this booklet are reported out to 4.5 years following diagnosis; however, results for breast cancer are reported out to 5 years, results for small-cell lung cancer and pancreatic cancer are reported out to 3 years, and results for stomach cancer are reported out to 2.5 years. The variations in reporting are a result of the amount of follow-up data available for each cancer type and how long patients in the sample survived.
- The number of years in the X axis of each graph was determined by the longest surviving CTCA patient in the patient sample. However, as the sample size decreases at the far right of the survival curve, a statistical estimation of the survival rate would become subject to a large variation and, therefore, would be highly unreliable. Hence, the corresponding table extends out fewer years than the graph.
- When the sample size for a certain cancer is too small to calculate a reliable confidence level, "NR" (Not Reliable) takes the place of a percentage in the charts and tables.
- "Analytic" refers to patients who have been exclusively treated at CTCA since their initial diagnosis.

References

1. Kalbfleisch JD, Prentice RL. The Statistical Analysis of Failure Time Data. New York: John Wiley, 1980.
2. Lawless JF. Statistical Methods and Methods for Lifetime Data, New York: John Wiley & Sons, Inc., 1982.
3. SAS Institute Inc., SAS/STAT User's Guide, Volume 2, Version 6, 1990. Cary, NC, USA.

Survival Outcomes
Breast Cancer

Cancer Stages/Sites:
SEER: Advanced stage breast cancer, defined by SEER as distant metastasis Summary Stage 7 (SSS), diagnosed between 2000 and 2003.

CTCA: Analytic cases of advanced stage breast cancer, defined by SEER as distant metastasis Summary Stage 7 (SSS), diagnosed between 2000 and 2005.

Results of Comparison:
Following statistical analysis, patients with advanced stage breast cancer (SEER Summary Stage 7) from the CTCA database had a statistically significant greater chance of survival than patients with a similar diagnosis from the SEER database. Specifically, CTCA patient survival was:

- 21.8 percentage points higher at 6 months
- 27.7 percentage points higher at 1 year
- 24.1 percentage points higher at 1.5 years
- 19.2 percentage points higher at 2 years
- 19.0 percentage points higher at 2.5 years
- 13.7 percentage points higher at 3 years
- 13.0 percentage points higher at 3.5 years

These survival differences are all statistically significant. Survival differences between CTCA patients and SEER patients were not statistically significant 4 or more years (but within 5 years) after the initial diagnosis.

See **Figure 1** for the estimated survival rates for CTCA and SEER patients.

See **Table 1** for the percentage of CTCA and SEER patients who survived from 6 months to 5 years after diagnosis, and **Table 2** for the differences between the CTCA and SEER survival rates 6 months to 5 years after diagnosis.

Number of Patients in Comparison:
- SEER database: 7,538
- CTCA sample: 71

Selection of Patients in Comparison:
- **CTCA:** Patient data from the cancer registries of CTCA at Midwestern Regional Hospital, Zion, IL and CTCA at Southwestern Regional Hospital, Tulsa, OK were combined. All CTCA patients included in the comparison had been treated at one of the two CTCA hospitals since initial diagnosis.
- **SEER:** Patient data was extracted from the national, population-based, SEER data source.

Survival Outcomes
Breast Cancer

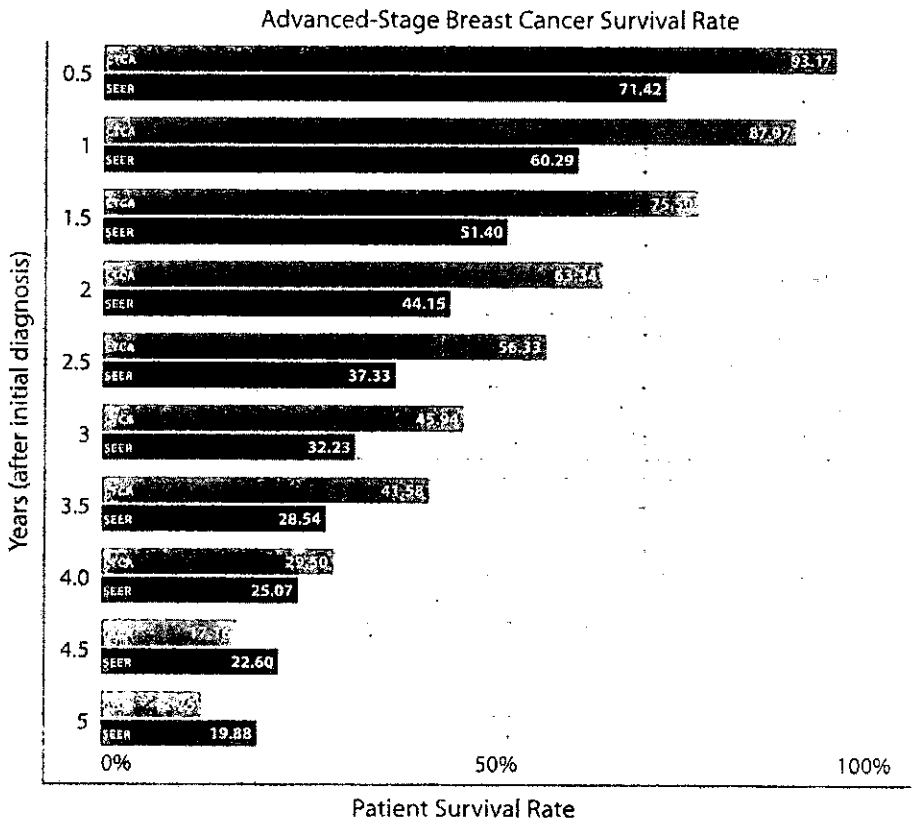
How Patient Populations Were Matched:
Patient data from SEER database and CTCA cancer registry was used for comparison only if patients met all of the following criteria:

- Initial diagnosis between 2000 and 2005
- Female
- 24 to 88 years old
- Advanced stage (SEER Summary Stage 7)
- Primary cancer sites C500-C509 (ICD-O-3)

Which Patients Were Excluded from the Comparison:
Cancer cases were excluded from the comparison if patients met one of the following criteria:

- Initial date of diagnosis was missing from either SEER or CTCA databases
- Date of last contact was missing from either SEER or CTCA databases
- SEER Summary Stages (SSS) were missing from either SEER or CTCA databases

Statistical Tests Used:
See "Statistical Methodology" in this booklet for a full explanation of the methods and tests that were used to create the comparisons between the CTCA database and the SEER database.



Survival Outcomes
Breast Cancer

Table 1.
Proportion of survival (in %) for breast cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	% for CTCA (n=71)	95% CI for CTCA (n=71)	% for SEER (n=7538)	95% CI for SEER (n=7538)
0.5	93.17	(87.31, 99.03)	71.42	(70.40, 72.44)
1.0	87.97	(80.40, 95.53)	60.29	(59.19, 61.40)
1.5	75.50	(65.50, 85.50)	51.40	(50.27, 52.53)
2.0	63.34	(52.13, 74.55)	44.15	(43.03, 45.28)
2.5	56.33	(44.75, 67.91)	37.33	(36.23, 38.44)
3.0	45.94	(34.29, 57.59)	32.23	(31.13, 33.33)
3.5	41.58	(29.96, 53.20)	28.54	(27.45, 29.63)
4.0	29.50	(18.43, 40.57)	25.07	(23.97, 26.17)
4.5	17.16	(7.82, 26.50)	22.60	(21.47, 23.72)
5.0	12.75	(6.39, 19.11)	19.88	(18.70, 21.06)

Table 2.
Difference on the proportion of survival (in %) for breast cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	Difference (CTCA-SEER)	95% CI to difference (CTCA-SEER)
0.5	21.75	(15.80, 27.69)
1.0	27.68	(20.03, 35.31)
1.5	24.10	(14.03, 34.16)
2.0	19.19	(7.92, 30.45)
2.5	19.00	(7.35, 30.63)
3.0	13.71	(2.00, 25.41)
3.5	13.04	(1.36, 24.71)
4.0	4.43	(-6.70, 15.55)
4.5	-5.44	(-14.85, 3.97)
5.0	-7.13	(-13.60, -0.66)

Survival Outcomes
Colon Cancer

Cancer Stages/Sites:
SEER: Advanced stage colon cancer, defined by SEER as distant metastasis Summary Stage 7 (SSS), diagnosed between 2000 and 2003.

CTCA: Analytic cases of advanced stage colon cancer defined by SEER as distant metastasis Summary Stage 7, diagnosed between 2000 and 2005.

Results of Comparison:
Following statistical analysis, patients with advanced stage colon cancer (SEER Summary Stage 7) from the CTCA database had a statistically significant greater chance of survival than patients with a similar diagnosis from the SEER database. Specifically, CTCA patient survival was:

- 20.88 percentage points higher at 6 months
- 15.53 percentage points higher at 1 year
- 11.36 percentage points higher at 1.5 years

These survival differences are all statistically significant. Survival differences between CTCA patients and SEER patients were not statistically significant 2 or more years (but within 4.5 years) after the initial diagnosis.

See **Table 1** for the percentage of CTCA and SEER patients who survived from 6 months to 4.5 years after diagnosis, and **Table 2** for the differences between the CTCA and SEER survival rates 6 months to 4.5 years after diagnosis.

Number of Patients in Comparison:
- SEER database: 7,611
- CTCA sample: 129

Selection of Patients in Comparison:
- **CTCA:** Patient data from the cancer registries of CTCA at Midwestern Regional Hospital, Zion, IL and CTCA at Southwestern Regional Hospital, Tulsa, OK were combined. All CTCA patients included in the comparison had been treated at one of the two CTCA hospitals since initial diagnosis.
- **SEER:** Patient data was extracted from the national, population-based, SEER data source.

How Patient Populations Were Matched:
Patient data from SEER database and CTCA cancer registry was used for comparison only if patients met all of the following criteria:

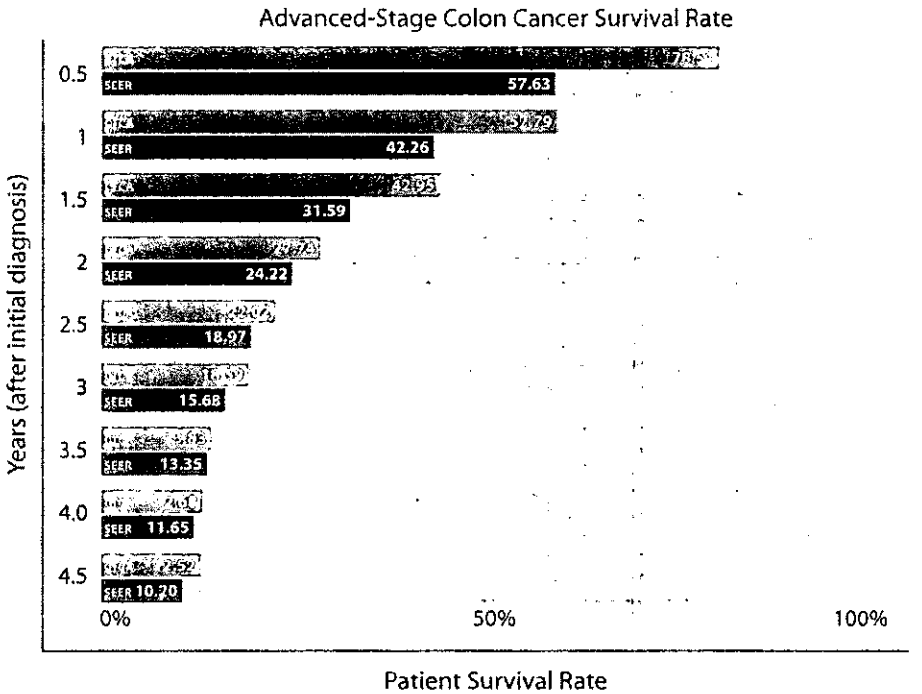
- Initial diagnosis between 2000 and 2005
- 32 to 85 years old
- Advanced stage (SEER Summary Stage 7)
- Primary cancer sites C180-C189 (ICD-O-3)

Survival Outcomes
Colon Cancer

Which Patients Were Excluded from the Comparison:
Cancer cases were excluded from the comparison if patients met one of the following criteria:

- Initial date of diagnosis was missing from either SEER or CTCA databases
- Date of last contact was missing from either SEER or CTCA databases
- SEER Summary Stages (SSS) were missing from either SEER or CTCA databases

Statistical Tests Used:
See "Statistical Methodology" in this booklet for a full explanation of the methods and tests that were used to create the comparisons between the CTCA database and the SEER database.



Survival Outcomes
Colon Cancer

Table 1.
Proportion of survival (in %) for colon cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	% for CTCA (n=129)	95% CI for CTCA (n=129)	% for SEER (n=7611)	95% CI for SEER (n=7611)
0.5	78.51	(71.37, 85.65)	57.63	(56.52, 58.75)
1.0	57.79	(49.20, 66.37)	42.26	(41.14, 43.37)
1.5	42.95	(34.34, 51.55)	31.59	(30.55, 32.64)
2.0	27.74	(19.95, 35.53)	24.22	(23.25, 25.18)
2.5	22.02	(14.81, 29.24)	18.97	(18.07, 19.86)
3.0	18.59	(11.76, 25.42)	15.68	(14.82, 16.53)
3.5	13.83	(7.59, 20.06)	13.35	(12.52, 14.18)
4.0	12.68	(6.57, 18.79)	11.65	(10.83, 12.48)
4.5	12.52	(6.54, 18.51)	10.20	(9.36, 11.03)

Table 2.
Difference on the proportion of survival (in %) for colon cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	Difference (CTCA-SEER)	95% CI to difference (CTCA-SEER)
0.5	20.88	(13.65, 28.10)
1.0	15.53	(6.86, 24.19)
1.5	11.36	(2.67, 20.02)
2.0	3.52	(-4.33, 11.36)
2.5	3.05	(-4.22, 10.32)
3.0	2.91	(-3.97, 9.80)
3.5	0.48	(-5.81, 6.76)
4.0	1.03	(-5.15, 7.18)
4.5	2.32	(-3.72, 8.36)

Survival Outcomes
Esophageal Cancer

Cancer Stages/Sites:
SEER: Advanced stage esophageal cancer, defined by SEER as distant metastasis Summary Stage 7 (SSS), diagnosed between 2000 and 2003.

CTCA: Analytic cases of advanced stage esophageal cancer defined by SEER as distant metastasis Summary Stage 7, diagnosed between 2000 and 2005.

Results of Comparison:
Following statistical analysis, patients with advanced stage esophageal cancer (SEER Summary Stage 7) from the CTCA database did not have a statistically significant difference in survival compared to patients with a similar diagnosis from the SEER database. Specifically, CTCA patient survival was:

- 0.13 percentage point lower at 6 months*
- 1.35 percentage points lower at 1 year*
- 2.12 percentage points lower at 1.5 years*

* Difference not statistically significant at 5% level.

See **Figure 1** for the estimated survival curves for CTCA (SSS 7) and SEER patients.

See **Table 1** for the percentage of CTCA and SEER patients who survived from 6 months to 2.5 years after diagnosis, and **Table 2** for the differences between the CTCA and SEER survival rates 6 months to 2.5 years after diagnosis.

Number of Patients in Comparison:
- SEER database: 3,074
- CTCA sample: 37

Selection of Patients in Comparison:
- **CTCA:** Patient data from the cancer registries of CTCA at Midwestern Regional Hospital, Zion, IL and CTCA at Southwestern Regional Hospital, Tulsa, OK were combined. All CTCA patients included in the comparison had been treated at one of the two CTCA hospitals since initial diagnosis.
- **SEER:** Patient data was extracted from the national, population-based, SEER data source.

How Patient Populations Were Matched:
Patient data from SEER database and CTCA cancer registry was used for comparison only if patients met all of the following criteria:

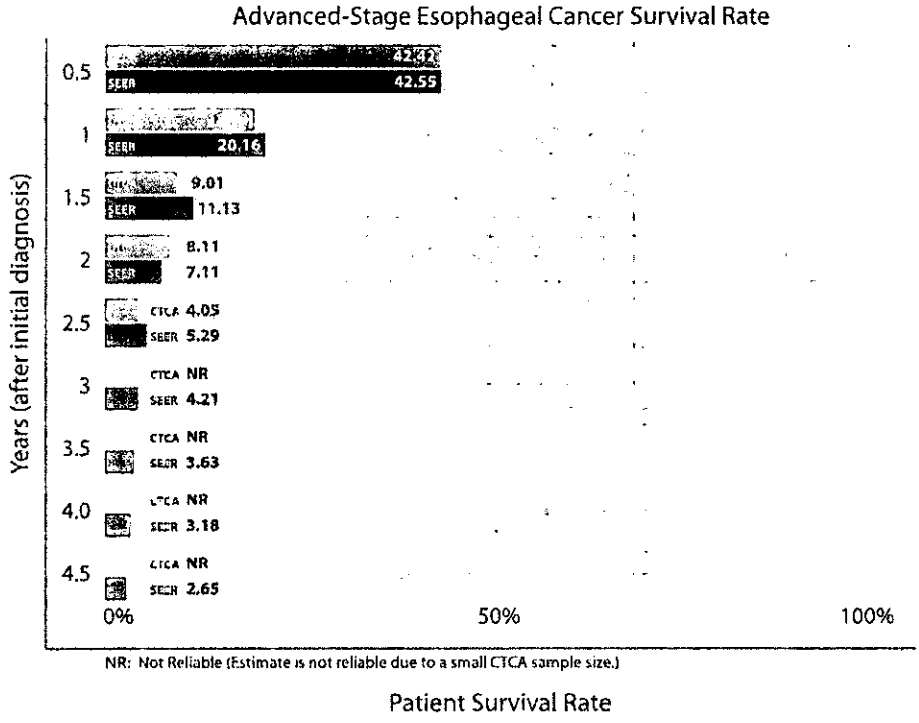
- Initial diagnosis between 2000 and 2005
- 32 to 87 years old
- Advanced stage (SEER Summary Stage 7)
- Primary cancer site C150-C159 (ICD-O-3)

Survival Outcomes
Esophageal Cancer

Which Patients Were Excluded from the Comparison:
Cancer cases were excluded from the comparison if patients met one of the following criteria:

- Initial date of diagnosis was missing from either SEER or CTCA databases
- Date of last contact was missing from either SEER or CTCA databases
- SEER Summary Stages (SSS) were missing from either SEER or CTCA databases

Statistical Tests Used:
See "Statistical Methodology" in this booklet for a full explanation of the methods and tests that were used to create the comparisons between the CTCA database and the SEER database.



Survival Outcomes
Esophageal Cancer

Table 1.
Proportion of survival (in %) for esophagus cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	% for CTCA (n=37)	95% CI for CTCA (n=37)	% for SEER (n=3074)	95% CI for SEER (n=3074)
0.5	42.42	(26.50, 58.34)	42.55	(40.80, 44.30)
1.0	18.81	(6.22, 31.40)	20.16	(18.74, 21.58)
1.5	9.01	(0.00, 18.21)	11.13	(10.01, 12.24)
2.0	8.11	(0.00, 16.91)	7.11	(6.19, 8.02)
2.5	4.05	(0.00, 11.18)	5.29	(4.48, 6.09)
3.0	NR	NR	4.21	(3.47, 4.95)
3.5	NR	NR	3.63	(2.93, 4.34)
4.0	NR	NR	3.18	(2.50, 3.87)
4.5	NR	NR	2.65	(1.98, 3.33)

NR: Not Reliable (Estimate is not reliable due to a small CTCA sample size.)

Table 2.
Difference on the proportion of survival (in %) for esophagus cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	Difference (CTCA-SEER)	95% CI to difference (CTCA-SEER)
0.5	-0.13	(-16.15, 15.88)
1.0	-1.35	(-14.03, 11.32)
1.5	-2.12	(-11.39, 7.14)
2.0	1.00	(-7.85, 9.84)
2.5	-1.24	(-8.42, 5.94)
3.0	NR	NR
3.5	NR	NR
4.0	NR	NR
4.5	NR	NR

NR: Not Reliable (Estimate is not reliable due to a small CTCA sample size.)

Survival Outcomes
Kidney Cancer

Cancer Stages/Sites:
SEER: Advanced stage kidney cancer, defined by SEER as distant metastasis Summary Stage 7 (SSS), diagnosed between 2000 and 2003.

CTCA: Analytic cases of advanced stage kidney cancer, defined by SEER as distant metastasis Summary Stage 7 (SSS), diagnosed between 2000 and 2005.

Results of Comparison:
Following statistical analysis, there was some statistical evidence suggesting that patients with advanced stage kidney cancer (SEER Summary Stage 7) from the CTCA database had a greater chance of survival than patients with a similar diagnosis from the SEER database. Specifically, CTCA patient survival was:

- 12.61 percentage points higher at 6 months**
- 13.53 percentage points higher at 1 year**
- 17.58 percentage points higher at 1.5 years*

* Difference statistically significant.
** Difference not statistically significant.

See **Figure 1** for the estimated survival rates for CTCA (SSS 7) and SEER patients.

See **Table 1** for the percentage of CTCA and SEER patients who survived from 6 months to 4.5 years after diagnosis, and **Table 2** for the differences between the CTCA and SEER survival rates 6 months to 4.5 years after diagnosis.

Number of Patients in Comparison:
- SEER database: 5,116
- CTCA sample: 35

Selection of Patients in Comparison:
- **CTCA:** Patient data from the cancer registries of CTCA at Midwestern Regional Hospital, Zion, IL and CTCA at Southwestern Regional Hospital, Tulsa, OK were combined. All CTCA patients included in the comparison had been treated at one of the two CTCA hospitals since initial diagnosis.
- **SEER:** Patient data was extracted from the national, population-based, SEER data source.

How Patient Populations Were Matched:
Patient data from SEER database and CTCA cancer registry was used for comparison only if patients met all of the following criteria:

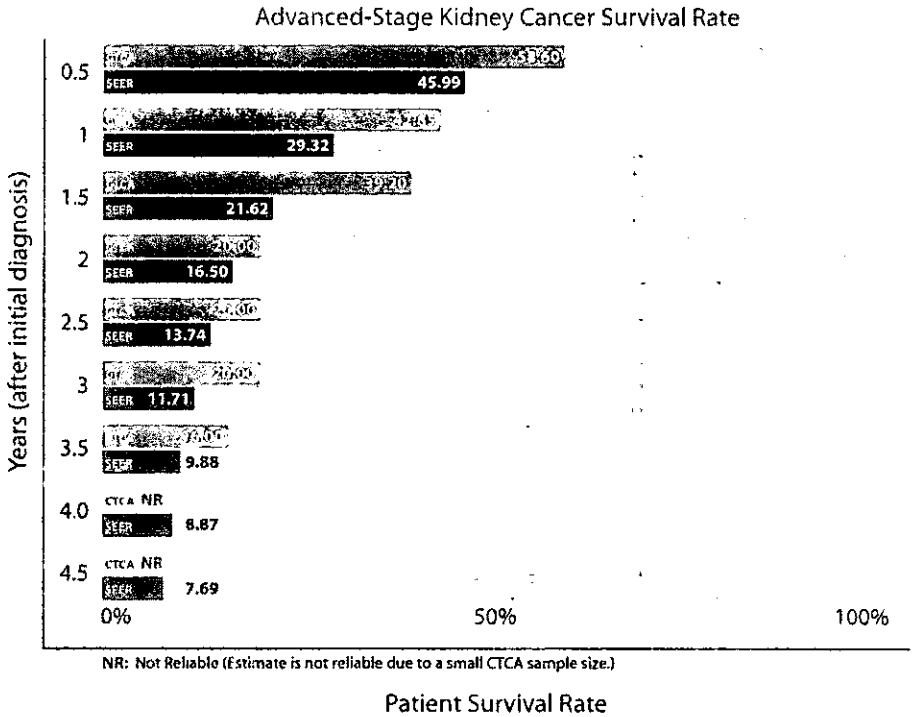
- Initial diagnosis between 2000 and 2005
- 20 to 88 years old
- Advanced stage (SEER Summary Stage 7)
- Primary cancer site C649 (ICD-O-3)

Survival Outcomes
Kidney Cancer

Which Patients Were Excluded from the Comparison:
Cancer cases were excluded from the comparison if patients met one of the following criteria:

- Initial date of diagnosis was missing from either SEER or CTCA databases
- Date of last contact was missing from either SEER or CTCA databases
- SEER Summary Stages (SSS) were missing from either SEER or CTCA databases

Statistical Tests Used:
See "Statistical Methodology" in this booklet for a full explanation of the methods and tests that were used to create the comparisons between the CTCA database and the SEER database.



Survival Outcomes
Kidney Cancer

Table 1.
Proportion of survival (in %) for kidney cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	% for CTCA (n=35)	95% CI for CTCA (n=35)	% for SEER (n=5116)	95% CI for SEER (n=5116)
0.5	58.60	(42.29, 74.91)	45.99	(44.62, 47.36)
1.0	42.85	(26.46, 59.25)	29.32	(28.07, 30.57)
1.5	39.20	(23.03, 55.36)	21.62	(20.49, 22.75)
2.0	20.00	(6.74, 33.25)	16.50	(15.48, 17.52)
2.5	20.00	(6.75, 33.24)	13.74	(12.78, 14.70)
3.0	20.00	(6.75, 33.24)	11.71	(10.80, 12.63)
3.5	16.00	(3.28, 28.71)	9.88	(9.00, 10.76)
4.0	NR	NR	8.87	(8.00, 9.73)
4.5	NR	NR	7.69	(6.83, 8.55)

NR: Not Reliable (Estimate is not reliable due to a small CTCA sample size.)

Table 2.
Difference on the proportion of survival (in %) for kidney cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	Difference (CTCA-SEER)	95% CI to difference (CTCA-SEER)
0.5	12.61	(-3.77, 28.97)
1.0	13.53	(-2.91, 29.97)
1.5	17.58	(1.36, 33.78)
2.0	3.50	(-9.80, 16.78)
2.5	6.26	(-7.04, 19.53)
3.0	8.29	(-5.00, 21.56)
3.5	6.12	(-6.63, 18.85)
4.0	NR	NR
4.5	NR	NR

NR: Not Reliable (Estimate is not reliable due to a small CTCA sample size.)

Survival Outcomes
Lung Cancer: Non-small Cell

Cancer Stages/Sites:

SEER: Advanced stage non-small cell lung cancer, defined by SEER as distant metastasis Summary Stage 7 (SSS), diagnosed between 2000 and 2003.

CTCA: Analytic cases of advanced stage non-small cell lung cancer, defined by SEER as distant metastasis Summary Stage 7 (SSS), diagnosed between 2000 and 2005.

Results of Comparison:

Following statistical analysis, patients with advanced stage non-small cell lung cancer (SEER Summary Stage 7) from the CTCA database had a statistically significant greater chance of survival than patients with a similar diagnosis from the SEER database. Specifically, CTCA patient survival was:

- 21.66 percentage points higher at 6 months
- 16.13 percentage points higher at 1 year
- 11.15 percentage points higher at 1.5 years
- 5.92 percentage points higher at 2 years
- 4.38 percentage points higher at 2.5 years
- 5.04 percentage points higher at 3 years

These survival differences are all statistically significant. Survival differences between CTCA patients and SEER patients were not statistically significant 3.5 or more years (but within 4.5 years) after the initial diagnosis.

See **Figure 1** for the estimated survival rates for CTCA (SSS 7) and SEER patients.

See **Table 1** for the percentage of CTCA and SEER patients who survived from 6 months to 4.5 years after diagnosis, and **Table 2** for the differences between the CTCA and SEER survival rates 6 months to 4.5 years after diagnosis.

Number of Patients in Comparison:

- SEER database: 64,374
- CTCA sample: 346

Selection of Patients in Comparison:

- **CTCA:** Patient data from the cancer registries of CTCA at Midwestern Regional Hospital, Zion, IL and CTCA at Southwestern Regional Hospital, Tulsa, OK were combined. All CTCA patients included in the comparison had been treated at one of the two CTCA hospitals since initial diagnosis.
- **SEER:** Patient data was extracted from the national, population-based, SEER data source.

Survival Outcomes
Lung Cancer: Non-small Cell

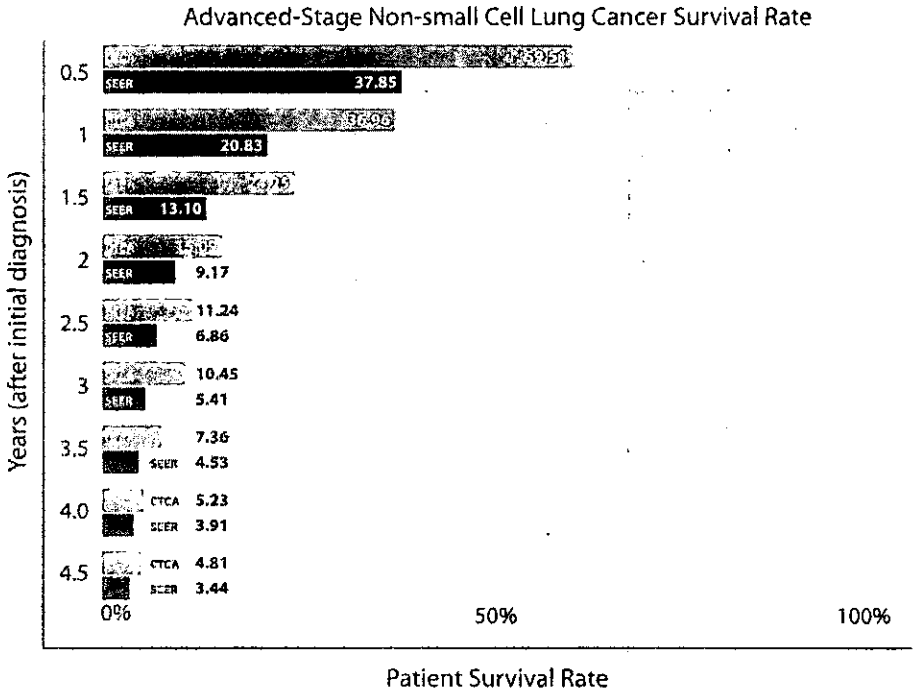
How Patient Populations Were Matched:
Patient data from SEER database and CTCA cancer registry was used for comparison only if patients met all of the following criteria:

- Initial diagnosis between 2000 and 2005
- 26 to 90 years old
- Advanced stage (SEER Summary Stage 7)
- Primary cancer sites C340-C343 and C348-C349 (ICD-O-3)

Which Patients Were Excluded from the Comparison:
Cancer cases were excluded from the comparison if patients met one of the following criteria:

- Initial date of diagnosis was missing from either SEER or CTCA databases
- Date of last contact was missing from either SEER or CTCA databases
- SEER Summary Stages (SSS) were missing from either SEER or CTCA databases

Statistical Tests Used:
See "Statistical Methodology" in this booklet for a full explanation of the methods and tests that were used to create the comparisons between the CTCA database and the SEER database.



Survival Outcomes
Lung Cancer: Non-small Cell

Table 1.
Proportion of survival (in %) for non-small cell lung cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	% for CTCA (n=346)	95% CI for CTCA (n=346)	% for SEER (n=64374)	95% CI for SEER (n=64374)
0.5	59.51	(54.33, 64.68)	37.85	(37.47, 38.22)
1.0	36.96	(31.87, 42.05)	20.83	(20.51, 21.14)
1.5	24.25	(19.72, 28.77)	13.10	(12.84, 13.37)
2.0	15.09	(11.31, 18.86)	9.17	(8.94, 9.39)
2.5	11.24	(7.93, 14.55)	6.86	(6.66, 7.06)
3.0	10.45	(7.21, 13.68)	5.41	(5.22, 5.59)
3.5	7.36	(4.38, 10.35)	4.53	(4.35, 4.70)
4.0	5.23	(2.54, 7.93)	3.91	(3.74, 4.08)
4.5	4.81	(2.18, 7.43)	3.44	(3.27, 3.61)

Table 2.
Difference on the proportion of survival (in %) for non-small cell lung cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	Difference (CTCA-SEER)	95% CI to difference (CTCA-SEER)
0.5	21.66	(16.47, 26.85)
1.0	16.13	(11.02, 21.23)
1.5	11.15	(6.61, 15.67)
2.0	5.92	(2.13, 9.70)
2.5	4.38	(1.06, 7.68)
3.0	5.04	(1.79, 8.28)
3.5	2.83	(-0.16, 5.82)
4.0	1.32	(-1.39, 4.01)
4.5	1.37	(-1.27, 3.99)

Survival Outcomes
Lung Cancer: Small Cell

Cancer Stages/Sites:

SEER: Advanced stage small cell lung cancer, defined by SEER as distant metastasis Summary Stage 7 (SSS), diagnosed between 2000 and 2003.

CTCA: Analytic cases of advanced stage small cell lung cancer, defined by SEER as distant metastasis Summary Stage 7 (SSS), diagnosed between 2000 and 2005.

Results of Comparison:

Following statistical analysis, there was some statistical evidence suggesting that patients with advanced small cell lung cancer (SEER Summary Stage 7) from the CTCA database had a greater chance of survival than patients with a similar diagnosis from the SEER database. Specifically, CTCA patient survival was:

- 28.0 percentage points higher at 6 months*
- 10.49 percentage points higher at 1 year *
- 1.80 percentage points higher at 1.5 years**

* Difference statistically significant.
** Difference not statistically significant.

See **Figure 1** for estimated survival rates for CTCA (SSS 7) and SEER patients.

See **Table 1** for the percentage of CTCA and SEER patients who survived from 6 months to 3 years after diagnosis, and **Table 2** for the differences between the CTCA and SEER survival rates 6 months to 3 years after diagnosis.

Number of Patients in Comparison:

- SEER database: 12,891
- CTCA sample: 78

Selection of Patients in Comparison:

- **CTCA:** Patient data from the cancer registries of CTCA at Midwestern Regional Hospital, Zion, IL and CTCA at Southwestern Regional Hospital, Tulsa, OK were combined. All CTCA patients included in the comparison had been treated at one of the two CTCA hospitals since initial diagnosis.
- **SEER:** Patient data was extracted from the national, population-based, SEER data source.

How Patient Populations Were Matched:

Patient data from SEER database and CTCA cancer registry was used for comparison only if patients met all of the following criteria:

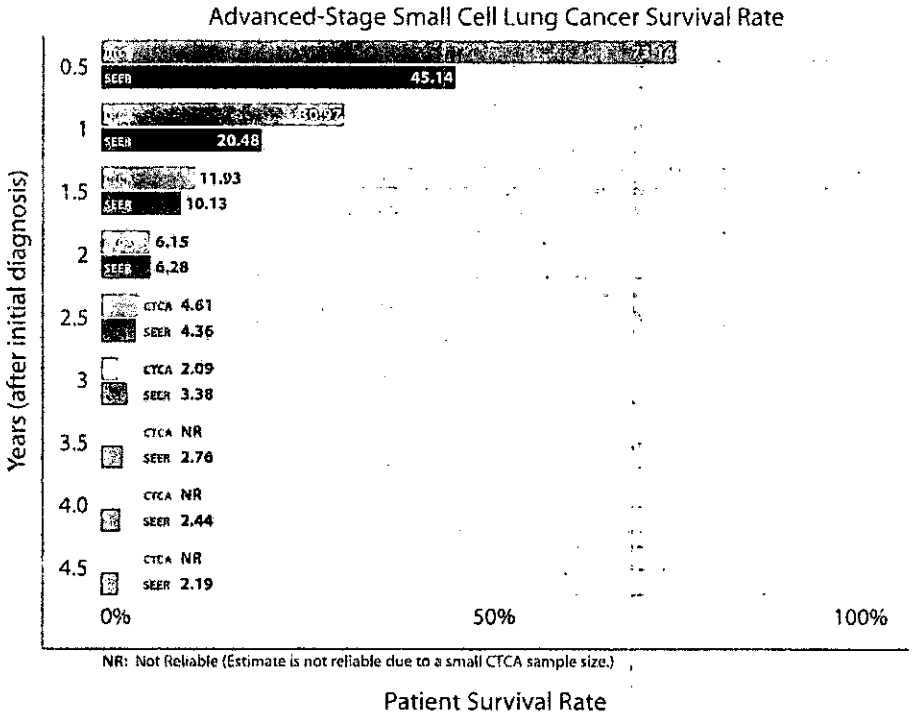
- Initial diagnosis between 2000 and 2005
- 38 to 89 years old
- Advanced stage (SEER Summary Stage 7)
- Primary cancer sites C340-C343 and C348-C349 (ICD-O-3)

Survival Outcomes
Lung Cancer: Small Cell

Which Patients Were Excluded from the Comparison:
Cancer cases were excluded from the comparison if patients met one of the following criteria:

- Initial date of diagnosis was missing from either SEER or CTCA databases
- Date of last contact was missing from either SEER or CTCA databases
- SEER Summary Stages (SSS) were missing from either SEER or CTCA databases

Statistical Tests Used:
See "Statistical Methodology" in this booklet for a full explanation of the methods and tests that were used to create the comparisons between the CTCA database and the SEER database.



Survival Outcomes
Lung Cancer: Small Cell

Table 1.
Proportion of survival (in %) for small cell lung cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	% for CTCA (n=78)	95% CI for CTCA (n=78)	% for SEER (n=12891)	95% CI for SEER (n=12891)
0.5	73.14	(63.31, 82.98)	45.14	(44.28, 46.00)
1.0	30.97	(20.70, 41.23)	20.48	(19.78, 21.18)
1.5	11.93	(4.74, 19.12)	10.13	(9.60, 10.65)
2.0	6.15	(0.70, 11.59)	6.28	(5.86, 6.70)
2.5	4.61	(0.00, 9.46)	4.36	(4.00, 4.72)
3.0	2.09	(0.00, 5.44)	3.38	(3.05, 3.71)
3.5	NR	NR	2.76	(2.45, 3.07)
4.0	NR	NR	2.44	(2.14, 2.74)
4.5	NR	NR	2.19	(1.88, 2.49)

NR: Not Reliable (Estimate is not reliable due to a small CTCA sample size.)

Table 2.
Difference on the proportion of survival (in %) for small cell lung cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	Difference (CTCA-SEER)	95% CI to difference (CTCA-SEER)
0.5	28.00	(18.12, 37.86)
1.0	10.49	(0.20, 20.77)
1.5	1.80	(-5.41, 9.01)
2.0	-0.13	(-5.59, 5.33)
2.5	0.25	(-4.61, 5.11)
3.0	-1.29	(-4.66, 2.07)
3.5	NR	NR
4.0	NR	NR
4.5	NR	NR

NR: Not Reliable (Estimate is not reliable due to a small CTCA sample size.)

Survival Outcomes
Ovarian Cancer

Cancer Stages/Sites:
SEER: Advanced stage ovarian cancer, defined by SEER as distant metastasis Summary Stage 7 (SSS), diagnosed between 2000 and 2003.

CTCA: Analytic cases of advanced stage ovarian cancer, defined by SEER as distant metastasis Summary Stage 7 (SSS), diagnosed between 2000 and 2005.

Results of Comparison:
Following statistical analysis, there was no evidence that patients with advanced stage ovarian cancer (SEER Summary Stage 7) from the CTCA database had a statistically significant difference in survival compared to patients with a similar diagnosis from the SEER database. Specifically, CTCA patient survival was:

- 3.24 percentage points higher at 6 months*
- 1.67 percentage points lower at 1 year*
- 0.59 percentage points lower at 1.5 years*

*Difference not statistically significant at 5% level.

See **Figure 1** for the estimated survival rates for CTCA (SSS 7) and SEER patients.

See **Table 1** for the percentage of CTCA and SEER patients who survived from 6 months to 4.5 years after diagnosis, and **Table 2** for the differences between the CTCA and SEER survival rates 6 months to 4.5 years after diagnosis.

Number of Patients in Comparison:
- SEER database: 10,979
- CTCA sample: 28

Selection of Patients in Comparison:
- **CTCA:** Patient data from the cancer registries of CTCA at Midwestern Regional Hospital, Zion, IL and CTCA at Southwestern Regional Hospital, Tulsa, OK were combined. All CTCA patients included in the comparison had been treated at one of the two CTCA hospitals since initial diagnosis.
- **SEER:** Patient data was extracted from the national, population-based, SEER data source.

How Patient Populations Were Matched:
Patient data from SEER database and CTCA cancer registry was used for comparison only if patients met all of the following criteria:

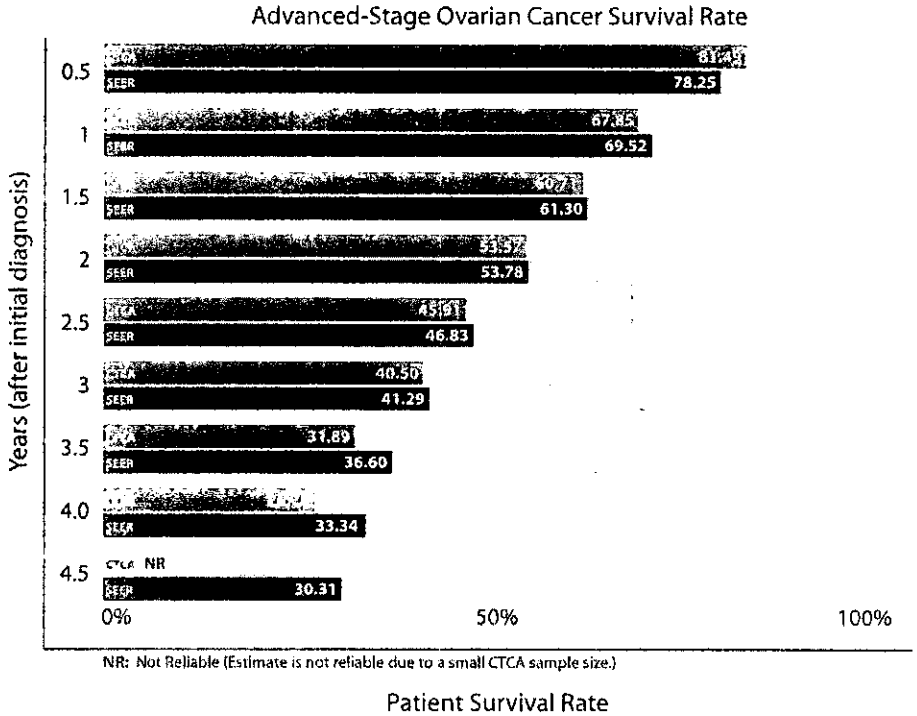
- Initial diagnosis between 2000 and 2005
- 21 to 84 years old
- Advanced stage (SEER Summary Stage 7)
- Primary cancer site C569 (ICD-O-3)

Survival Outcomes
Ovarian Cancer

Which Patients Were Excluded from the Comparison:
Cancer cases were excluded from the comparison if patients met one of the following criteria:

- Initial date of diagnosis was missing from either SEER or CTCA databases
- Date of last contact was missing from either SEER or CTCA databases
- SEER Summary Stages (SSS) were missing from either SEER or CTCA databases

Statistical Tests Used:
See "Statistical Methodology" in this booklet for a full explanation of the methods and tests that were used to create the comparisons between the CTCA database and the SEER database.



Survival Outcomes
Ovarian Cancer

Table 1.
Proportion of survival (in %) for ovarian cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	% for CTCA (n=28)	95% CI for CTCA (n=28)	% for SEER (n=10979)	95% CI for SEER (n=10979)
0.5	81.49	(67.12, 95.86)	78.25	(77.47, 79.02)
1.0	67.85	(50.55, 85.15)	69.52	(68.66, 70.38)
1.5	60.71	(42.62, 78.80)	61.30	(60.39, 62.21)
2.0	53.57	(35.09, 72.04)	53.78	(52.85, 54.72)
2.5	45.91	(27.28, 64.55)	46.83	(45.89, 47.78)
3.0	40.50	(22.07, 58.94)	41.29	(40.34, 42.25)
3.5	31.89	(14.26, 49.51)	36.60	(35.63, 37.56)
4.0	26.78	(9.98, 43.58)	33.34	(32.36, 34.32)
4.5	NR	NR	30.31	(29.31, 31.32)

NR: Not Reliable (Estimate is not reliable due to a small CTCA sample size.)

Table 2.
Difference on the proportion of survival (in %) for ovarian cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI))

# years after initial diagnosis	Difference (CTCA-SEER)	95% CI to difference (CTCA-SEER)
0.5	3.24	(-11.15, 17.63)
1.0	-1.67	(-18.99, 15.65)
1.5	-0.59	(-18.71, 17.52)
2.0	-0.21	(-18.72, 18.28)
2.5	-0.92	(-19.58, 17.73)
3.0	-0.79	(-19.25, 17.66)
3.5	-4.71	(-22.35, 12.93)
4.0	-6.56	(-23.39, 10.26)
4.5	NR	NR

NR: Not Reliable (Estimate is not reliable due to a small CTCA sample size.)

Survival Outcomes
Pancreatic Cancer

Cancer Stages/Sites:
SEER: Advanced stage pancreatic cancer, defined by SEER as distant metastasis Summary Stage 7 (SSS), diagnosed between 2000 and 2003.

CTCA: Analytic cases of advanced stage pancreatic cancer, defined by SEER as distant metastasis Summary Stage 7 (SSS), diagnosed between 2000 and 2005.

Results of Comparison:
Following statistical analysis, patients with advanced stage pancreatic cancer (SEER Summary Stage 7) from the CTCA database had a statistically significant greater chance of survival than patients with a similar diagnosis from the SEER database. Specifically, CTCA patient survival was:

- 26.51 percentage points higher at 6 months
- 18.75 percentage points higher at 1 year
- 8.06 percentage points higher at 1.5 years
- 7.77 percentage points higher at 2 years
- 7.60 percentage points higher at 2.5 years

These survival differences are all statistically significant.

See **Figure 1** for the estimated survival rates for CTCA (SSS 7) and SEER patients.

See **Table 1** for the percentage of CTCA and SEER patients who survived from 6 months to 3 years after diagnosis, and **Table 2** for the differences between the CTCA and SEER survival rates 6 months to 3 years after diagnosis.

Number of Patients in Comparison:
- SEER database: 12,494
- CTCA sample: 169

Selection of Patients in Comparison:
- **CTCA:** Patient data from the cancer registries of CTCA at Midwestern Regional Hospital, Zion, IL and CTCA at Southwestern Regional Hospital, Tulsa, OK were combined. All CTCA patients included in the comparison had been treated at one of the two CTCA hospitals since initial diagnosis.
- **SEER:** Patient data was extracted from the national, population-based, SEER data source.

How Patient Populations Were Matched:
Patient data from SEER database and CTCA cancer registry was used for comparison only if patients met all of the following criteria:

- Initial diagnosis between 2000 and 2005
- 31 to 87 years old
- Advanced stage (SEER Summary Stage 7)
- Primary cancer sites C250-C254 and C257-C259 (ICD-O-3)

Survival Outcomes
Pancreatic Cancer

Which Patients Were Excluded from the Comparison:
Cancer cases were excluded from the comparison if patients met one of the following criteria:

- Initial date of diagnosis was missing from either SEER or CTCA databases
- Date of last contact was missing from either SEER or CTCA databases
- SEER Summary Stages (SSS) were missing from either SEER or CTCA databases

Statistical Tests Used:
See "Statistical Methodology" in this booklet for a full explanation of the methods and tests that were used to create the comparisons between the CTCA database and the SEER database.

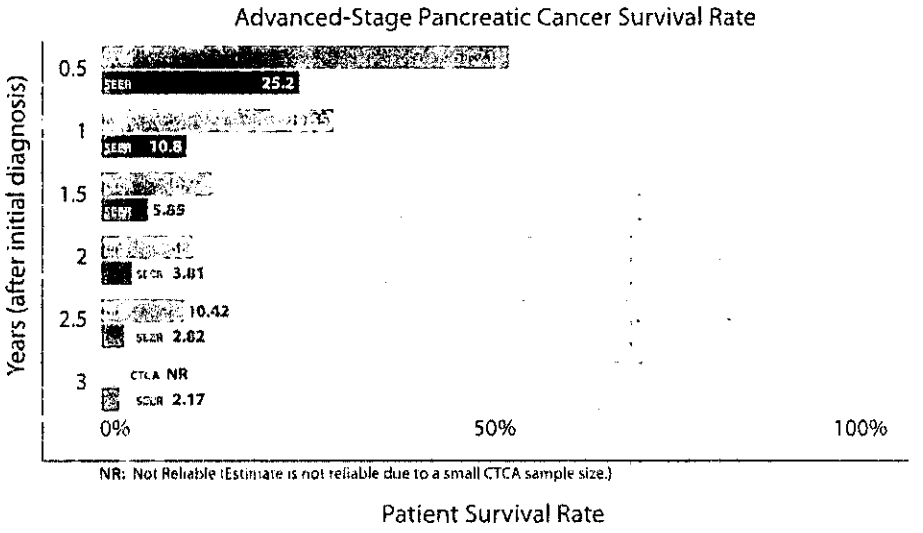


Table 1.
Proportion of survival (in %) for pancreatic cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	% for CTCA (n=169)	95% CI for CTCA (n=169)	% for SEER (n=12494)	95% CI for SEER (n=12494)
0.5	51.71	(44.17, 59.24)	25.2	(24.44, 25.97)
1.0	29.55	(22.67, 36.43)	10.8	(10.25, 11.35)
1.5	13.91	(8.66, 19.16)	5.85	(5.43, 6.26)
2.0	11.58	(6.72, 16.45)	3.81	(3.47, 4.14)
2.5	10.42	(5.77, 15.06)	2.82	(2.53, 3.12)
3.0	NR	NR	2.17	(1.90, 2.44)

NR: Not Reliable (Estimate is not reliable due to a small CTCA sample size.)

Table 2.
Difference on the proportion of survival (in %) for pancreatic cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	Difference (CTCA-SEER)	95% CI to difference (CTCA-SEER)
0.5	26.51	(18.93, 34.07)
1.0	18.75	(11.84, 25.65)
1.5	8.06	(2.79, 13.33)
2.0	7.77	(2.90, 12.65)
2.5	7.60	(2.93, 12.24)
3.0	NR	NR

NR: Not Reliable (Estimate is not reliable due to a small CTCA sample size.)

Survival Outcomes
Prostate Cancer

Cancer Stages/Sites:
SEER: Advanced stage prostate cancer, defined by SEER as distant metastasis Summary Stage 7 (SSS), diagnosed between 2000 and 2003.

CTCA: Analytic cases of advanced stage prostate cancer, defined by SEER as distant metastasis Summary Stage 7 (SSS), diagnosed between 2000 and 2005.

Results of Comparison:
Following statistical analysis, patients with advanced stage prostate cancer (SEER Summary Stage 7) from the CTCA database had a statistically significant greater chance of survival than patients with a similar diagnosis from the SEER database. Specifically, CTCA patient survival was:

- 8.58 percentage points higher at 6 months
- 12.66 percentage points higher at 1 year
- 18.97 percentage points higher at 1.5 years
- 23.81 percentage points at 2 years
- 25.18 percentage points at 2.5 years
- 26.57 percentage points at 3 years
- 21.10 percentage points at 3.5 years
- 19.24 percentage points at 4 years

These survival differences are all statistically significant.

See **Figure 1** for the estimated survival rates for CTCA (SSS 7) and SEER patients.

See **Table 1** for the percentage of CTCA and SEER patients who survived from 6 months to 4.5 years after diagnosis, and **Table 2** for the differences between the CTCA and SEER survival rates 6 months to 4.5 years after diagnosis.

Number of Patients in Comparison:
- SEER database: 3,702
- CTCA sample: 45

Selection of Patients in Comparison:
- **CTCA:** Patient data from the cancer registries of CTCA at Midwestern Regional Hospital, Zion, IL and CTCA at Southwestern Regional Hospital, Tulsa, OK were combined. All CTCA patients included in the comparison had been treated at one of the two CTCA hospitals since initial diagnosis.
- **SEER:** Patient data was extracted from the national, population-based, SEER data source.

Survival Outcomes
Prostate Cancer

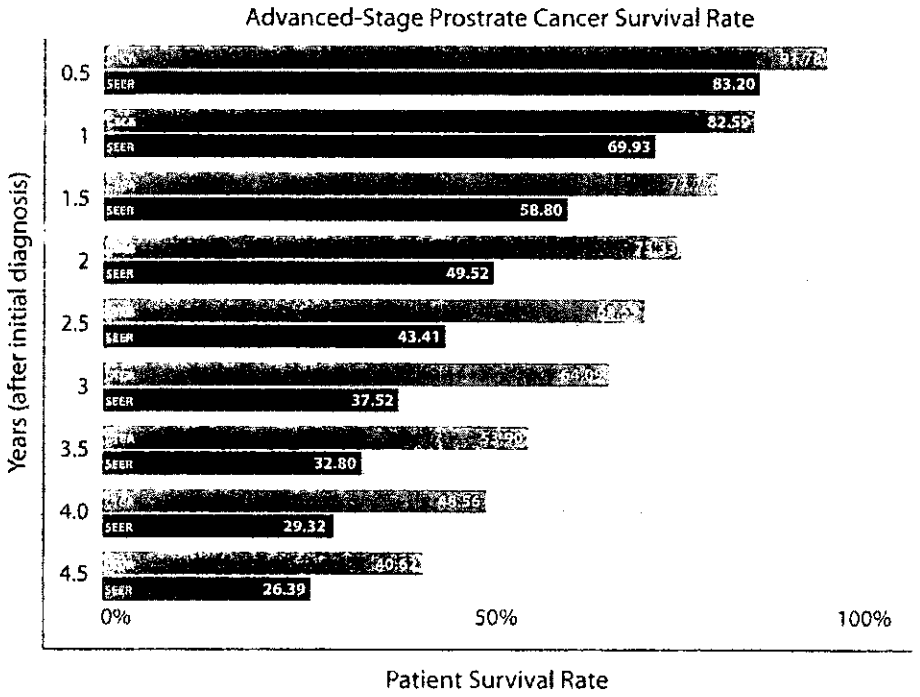
How Patient Populations Were Matched:
Patient data from SEER database and CTCA cancer registry was used for comparison only if patients met all of the following criteria:

- Initial diagnosis between 2000 and 2005
- 39 to 87 years old
- Advanced stage (SEER Summary Stage 7)
- Primary cancer site C619 (ICD-O-3)

Which Patients Were Excluded from the Comparison:
Cancer cases were excluded from the comparison if patients met one of the following criteria:

- Initial date of diagnosis was missing from either SEER or CTCA databases
- Date of last contact was missing from either SEER or CTCA databases
- SEER Summary Stages (SSS) were missing from either SEER or CTCA databases

Statistical Tests Used:
See "Statistical Methodology" in this booklet for a full explanation of the methods and tests that were used to create the comparisons between the CTCA database and the SEER database.



Survival Outcomes
Prostate Cancer

Table 1.
Proportion of survival (in %) for prostate cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	% for CTCA (n=45)	95% CI for CTCA (n=45)	% for SEER (n=3702)	95% CI for SEER (n=3702)
0.5	91.78	[illegible]	83.20	(81.99, 84.40)
1.0	82.49	(71.51, 93.66)	69.93	(68.45, 71.41)
1.5	77.77	(65.63, 89.92)	58.80	(57.21, 60.39)
2.0	73.33	(60.41, 86.25)	49.52	(47.91, 51.14)
2.5	68.59	[illegible]	43.41	(41.79, 45.03)
3.0	64.09	(49.87, 78.31)	37.52	(35.90, 39.14)
3.5	53.90	(38.67, 69.12)	32.80	(31.17, 34.42)
4.0	48.56	(32.96, 64.16)	29.32	(27.67, 30.96)
4.5	40.62	(24.89, 56.43)	26.39	(24.70, 28.08)

Table 2.
Difference on the proportion of survival (in %) for prostate cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	Difference (CTCA-SEER)	95% CI to difference (CTCA-SEER)
0.5	8.58	(0.49, 16.67)
1.0	12.66	(1.48, 23.83)
1.5	18.97	(6.71, 31.22)
2.0	23.81	(10.78, 36.82)
2.5	25.18	(11.42, 38.93)
3.0	26.57	(12.25, 40.88)
3.5	21.10	(5.79, 36.41)
4.0	19.24	(3.55, 34.92)
4.5	14.23	(-1.68, 30.13)

Survival Outcomes
Rectal Cancer

Cancer Stages/Sites:

SEER: Advanced stage rectal cancer, defined by SEER as distant metastasis Summary Stage 7 (SSS), diagnosed between 2000 and 2003.

CTCA: Analytic cases of advanced stage rectal cancer, defined by SEER as distant metastasis Summary Stage 7 (SSS), diagnosed between 2000 and 2005.

Results of Comparison:

Following statistical analysis, there was some statistical evidence suggesting that patients with advanced stage rectal cancer (SEER Summary Stage 7) from the CTCA database had a greater chance of survival than patients with a similar diagnosis from the SEER database. Specifically, CTCA patient survival was:

- 18.78 percentage points higher at 6 months*
- 11.45 percentage points higher at 1 year **
- 11.12 percentage points higher at 1.5 years**

* Difference statistically significant.
** Difference not statistically significant.

See **Figure 1** for the estimated survival rates for CTCA (SSS 7) and SEER patients.

See **Table 1** for the percentage of CTCA and SEER patients who survived from 6 months to 4 years after diagnosis, and **Table 2** for the differences between the CTCA and SEER survival rates 6 months to 4 years after diagnosis.

Number of Patients in Comparison:

- SEER database: 5,432
- CTCA sample: 57

Selection of Patients in Comparison:

- **CTCA:** Patient data from the cancer registries of CTCA at Midwestern Regional Hospital, Zion, IL and CTCA at Southwestern Regional Hospital, Tulsa, OK were combined. All CTCA patients included in the comparison had been treated at one of the two CTCA hospitals since initial diagnosis.
- **SEER:** Patient data was extracted from the national, population-based, SEER data source.

How Patient Populations Were Matched:

Patient data from SEER database and CTCA cancer registry was used for comparison only if patients met all of the following criteria:

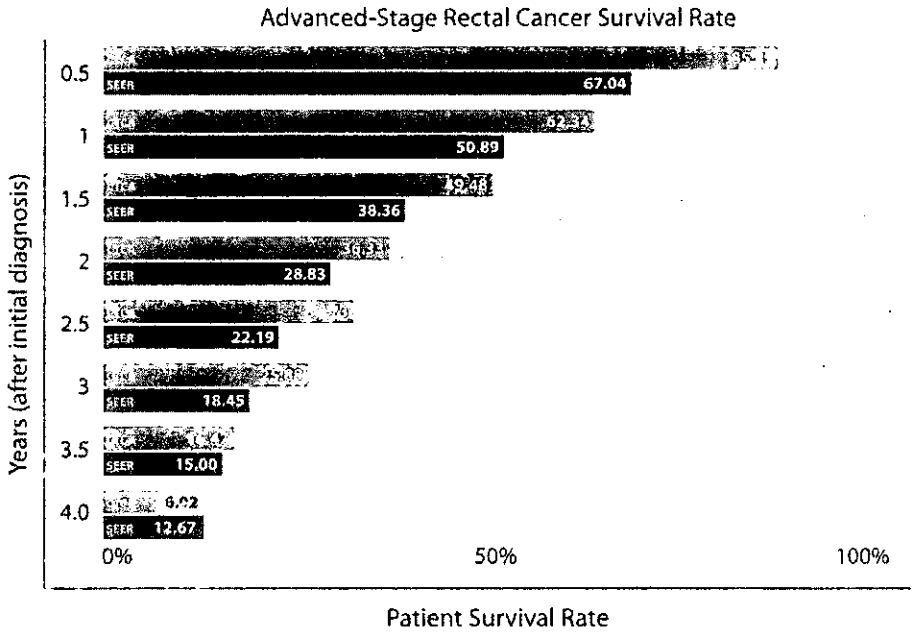
- Initial diagnosis between 2000 and 2005
- 30 to 89 years old
- Advanced stage (SEER Stage 7)
- Primary cancer site of C199 and C209 (ICD-O-3)

Survival Outcomes
Rectal Cancer

Which Patients Were Excluded from the Comparison:
Cancer cases were excluded from the comparison if patients met one of the following criteria:

- Initial date of diagnosis was missing from either SEER or CTCA databases
- Date of last contact was missing from either SEER or CTCA databases
- SEER Summary Stages (SSS) were missing from either SEER or CTCA databases

Statistical Tests Used:
See "Statistical Methodology" in this booklet for a full explanation of the methods and tests that were used to create the comparisons between the CTCA database and the SEER database.



Survival Outcomes
Rectal Cancer

Table 1.
Proportion of survival (in %) for rectal cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	% for CTCA (n=57)	95% CI for CTCA (n=57)	% for SEER (n=5432)	95% CI for SEER (n=5432)
0.5	85.32	(76.70, 94.95)	67.04	(65.79, 68.29)
1.0	62.34	(49.66, 75.03)	50.89	(49.56, 52.22)
1.5	49.48	(36.31, 62.65)	38.36	(37.07, 39.66)
2.0	36.33	(23.50, 49.15)	28.83	(27.62, 30.04)
2.5	31.73	(19.22, 44.24)	22.19	(21.06, 23.31)
3.0	25.38	(13.91, 37.85)	18.45	(17.37, 19.53)
3.5	16.47	(5.43, 27.51)	15.00	(13.95, 16.04)
4.0	6.99	(0.00, 15.69)	12.67	(11.64, 13.70)

Table 2.
Difference on the proportion of survival (in %) for rectal cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	Difference (CTCA-SEER)	95% CI to difference (CTCA-SEER)
0.5	18.78	(9.57, 27.99)
1.0	11.45	(-1.31, 24.20)
1.5	11.12	(-2.12, 24.35)
2.0	7.50	(-5.39, 20.37)
2.5	9.54	(-3.03, 22.10)
3.0	7.43	(-4.59, 19.45)
3.5	1.47	(-9.62, 12.55)
4.0	-5.75	(-14.59, 3.07)

Survival Outcomes
Stomach Cancer

Cancer Stages/Sites:
SEER: Advanced stage stomach cancer, defined by SEER as distant metastasis Summary Stage 7 (SSS), diagnosed between 2000 and 2003.

CTCA: Analytic cases of advanced stage stomach cancer, defined by SEER as distant metastasis Summary Stage 7 (SSS), diagnosed between 2000 and 2005.

Results of Comparison:
Following statistical analysis, there was some statistical evidence suggesting that patients with advanced stomach cancer (SEER Summary Stage 7) from the CTCA database had a greater chance of survival than patients with a similar diagnosis from the SEER database at six months and one year after diagnosis. Specifically, CTCA patient survival was:

- 26.06 percentage points higher at 6 months*
- 7.91 percentage points higher at 1 year**
- 1.07 percentage points lower at 1.5 years**

* Difference statistically significant.
** Difference not statistically significant.

See **Figure 1** for the estimated survival rates for CTCA (SSS 7) and SEER patients.

See **Table 1** for the percentage of CTCA and SEER patients who survived from 6 months to 2.5 years after diagnosis, and **Table 2** for the differences between the CTCA and SEER survival rates 6 months to 2.5 years after diagnosis.

Number of Patients in Comparison:
- SEER database: 6,251
- CTCA sample: 44

Selection of Patients in Comparison:
- **CTCA:** Patient data from the cancer registries of CTCA at Midwestern Regional Hospital, Zion, IL and CTCA at Southwestern Regional Hospital, Tulsa, OK were combined. All CTCA patients included in the comparison had been treated at one of the two CTCA hospitals since initial diagnosis.
- **SEER:** Patient data was extracted from the national, population-based, SEER data source.

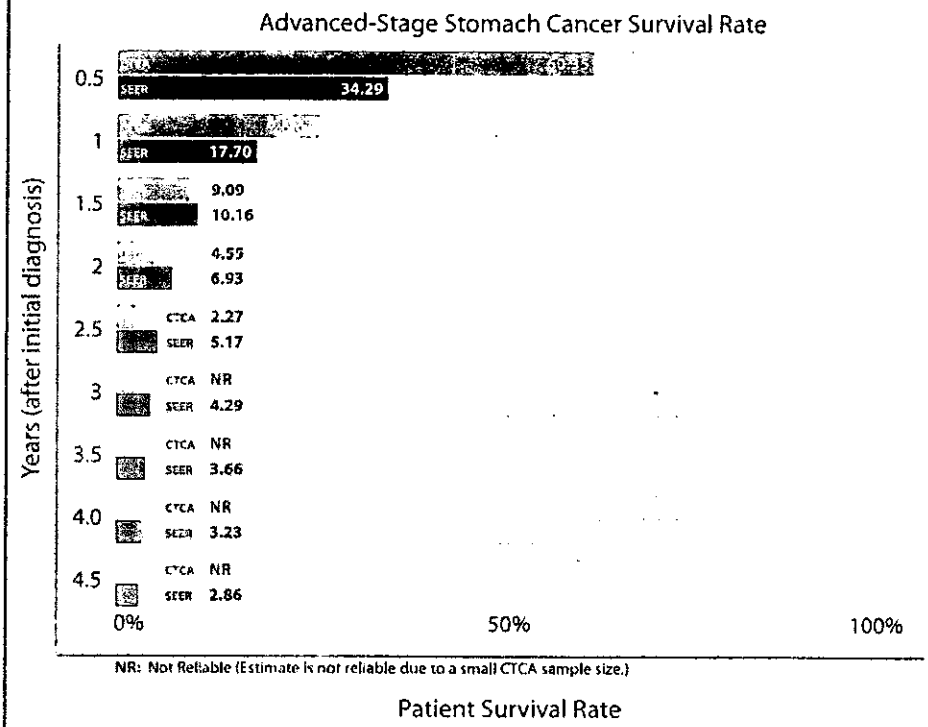
How Patient Populations Were Matched:
Patient data from SEER database and CTCA cancer registry was used for comparison only if patients met all of the following criteria:
- Initial diagnosis between 2000 and 2005
- 31 to 96 years old
- Advanced stage (SEER Summary Stage 7)
- Primary cancer sites C160-C169 (ICD-O-3)

Survival Outcomes
Stomach Cancer

Which Patients Were Excluded from the Comparison:
Cancer cases were excluded from the comparison if patients met one of the following criteria:

- Initial date of diagnosis was missing from either SEER or CTCA databases
- Date of last contact was missing from either SEER or CTCA databases
- SEER Summary Stages (SSS) were missing from either SEER or CTCA databases

Statistical Tests Used:
See "Statistical Methodology" in this booklet for a full explanation of the methods and tests that were used to create the comparisons between the CTCA database and the SEER database.



Survival Outcomes
Stomach Cancer

Table 1.
Proportion of survival (in %) for stomach cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	% for CTCA (n=44)	95% CI for CTCA (n=44)	% for SEER (n=6251)	95% CI for SEER (n=6251)
0.5	60.35	(45.90, 74.80)	34.29	(33.11, 35.47)
1.0	25.61	(12.72, 38.50)	17.70	(16.75, 18.66)
1.5	9.09	(0.59, 17.58)	10.16	(9.40, 10.92)
2.0	4.55	(0.00, 10.70)	6.93	(6.29, 7.57)
2.5	2.27	(0.00, 6.67)	5.17	(4.60, 5.73)
3.0	NR	NR	4.29	(3.76, 4.82)
3.5	NR	NR	3.66	(3.15, 4.17)
4.0	NR	NR	3.23	(2.73, 3.73)
4.5	NR	NR	2.86	(2.36, 3.37)

NR: Not Reliable (Estimate is not reliable due to a small CTCA sample size.)

Table 2.
Difference on the proportion of survival (in %) for stomach cancer patients with a SEER Summary Stage of 7 between the CTCA sample and the SEER sample (95% CI)

# years after initial diagnosis	Difference (CTCA-SEER)	95% CI to difference (CTCA-SEER)
0.5	26.06	(11.56, 40.56)
1.0	7.91	(-5.03, 20.83)
1.5	-1.07	(-9.61, 7.45)
2.0	-2.38	(-8.58, 3.80)
2.5	-2.9	(-7.35, 1.53)

A Final Word

At Cancer Treatment Centers of America®
Integrative Cancer Care Makes the Difference

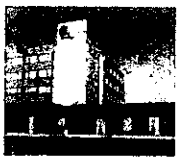
Individualized, integrative cancer care is the difference between Cancer Treatment Centers of America® (CTCA) and other US hospitals and medical centers. We have a comprehensive model that provides everything from diagnostics to treatment to aftercare – all under one roof. By combining our expertise in traditional cancer treatments with complementary therapies, we offer an alternative approach focused on treating the whole person, not just the disease.

CTCA Conventional Treatments are State-of-the-Art

- **Surgery:** Studies show that surgical outcomes can vary widely depending on the experience of the hospital and its physicians. CTCA surgeons, led by nationally recognized surgical oncologists, specialize in cancer-related surgical procedures.
- **Radiation Therapy:** CTCA radiation oncologists offer techniques that other cancer treatment facilities may not, including TomoTherapy®, MammoSite®, high-dose rate brachytherapy, TheraSphere®, intensity modulated radiation therapy, and 3D conformal radiation.
- **Chemotherapy:** CTCA oncologists specialize in delivering chemotherapeutic agents in ways that maximize their effectiveness with minimal side effects. Delivery methods include chemoembolization, and intra-arterial, intraperitoneal, and metronomic chemotherapy.

Our Complementary Treatments Are Scientifically Based

- **Naturopathic Medicine:** CTCA naturopathic clinicians work with the treatment team to strengthen patients' immune systems and boost their energy.
- **Nutritional Support:** Registered nutritionists work closely with patients to prevent malnutrition and help reduce the side effects of treatment.
- **Mind-Body Medicine:** Licensed psychotherapists counsel patients and their families, teach stress management techniques, and lead support groups that can help patients cope with their disease.
- **Rehabilitation:** CTCA offers physical, occupational, speech, and massage therapy to help patients overcome the physical effects of cancer treatment.
- **Pain Management:** Pain management professionals provide conventional pain reduction treatments as well as alternatives, such as acupuncture, acupressure, and meditation.
- **Spiritual Support:** CTCA believes there is a significant connection between spirituality and healing; therefore, we offer patients of any faith the spiritual support they need to combat their cancer.



Eastern Regional Medical Center
Philadelphia, PA



Midwestern Regional Medical Center
Zion, IL



Southwestern Regional Medical Center
Tulsa, OK



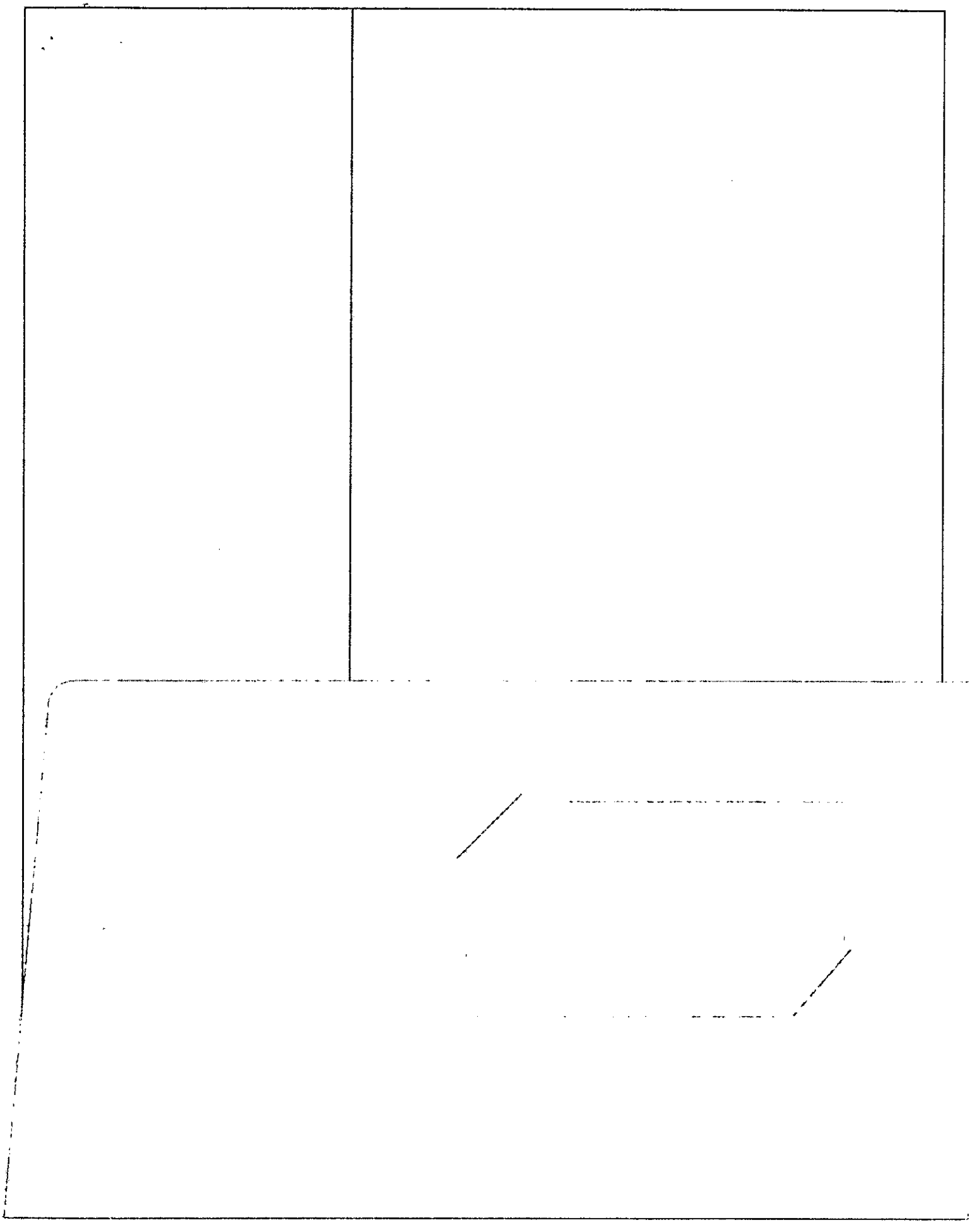
Western Regional Medical Center
Goodyear, AZ



Seattle Cancer Treatment & Wellness Center
Seattle, WA

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Schaumburg, Illinois 60173

tel 847-342-7400
web www.cancercenter.com

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Voting Sheets

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

EXECUTIVE SESSION on HB 1642-FN

BILL TITLE: **relative to destination cancer hospitals.**

DATE: February 24, 2012

LOB ROOM: 205

Amendments:

Sponsor: Rep. Reagan	OLS Document #:	2012	1017h
Sponsor: Rep.	OLS Document #:		
Sponsor: Rep.	OLS Document #:		

Motions: (OTP) OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. Ward

Seconded by Rep. Schmidt

Vote: 11-7 (Please attach record of roll call vote.) AMENDMENT

Motions: OTP, (OTP/A), ITL, Interim Study (Please circle one.)

Moved by Rep. Blankenbeker

Seconded by Rep. Donovan

Vote: 10-8 (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE:

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. J. Gail Barry, Clerk

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

EXECUTIVE SESSION on HB 1642-FN

BILL TITLE: **relative to destination cancer hospitals.**

DATE: 2/24/2012

LOB ROOM: 205

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. Reagan OLS Document #: 2012-1017h

Sponsor: Rep. OLS Document #:

Motions: Amendment
OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. WARD

Seconded by Rep. SCHMIDT

Vote: (Please attach record of roll call vote.) 11-7

Motions: OTP, (OTP/A), ITL, Interim Study (Please circle one.)

Moved by Rep. Blankenbeker

Seconded by Rep. Donovan

Vote: (Please attach record of roll call vote.) 10-8

CONSENT CALENDAR VOTE:

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. J. Gail Barry, Clerk

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

Bill #: 1642-FN Title: Relative to destination cancer hospitals

PH Date: 2 / 7 / 2012 Exec Session Date: 2 / 24 / 2012

Motion: OTP adopt on Amendment Amendment #: 2012-1017h

MEMBER	YEAS	NAYS
Reagan, John M, Chairman	✓	
Kotowski, Frank R, V Chairman	✓	
Pilliod, James P		✓
McMahon, Charles E	✓	
Barry, J. Gail, Clerk	✓	
Millham, Alida I	✓	
Case, Frank G		
Blankenbeker, Lynne F	✓	
Cusson-Cail, Kathleen J	✓	
Donovan, Daniel A	✓	
Fredette, Robert A		
LeBrun, Donald L		✓
Schmidt, Stephen J	✓	
Ward, Joanne A	✓	
MacKay, James R		✓
Merrick, Evalyn S		✓
DiPentima, Rich T		✓
Harding, Laurie		✓
Deloge, Helen M		
Rosenwald		✓
Keane	✓	
TOTAL VOTE:	11	7

Printed: 1/27/2012

OFFICE OF THE HOUSE CLERK 2012 SESSION

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

Bill #: HB 1642 Title: Relative to destination cancer hospitals

PH Date: 2/7/12 Exec Session Date: 2/29/2012

Motion: OTP/A Amendment #: 2012-1017h

MEMBER	YEAS	NAYS
Reagan, John M, Chairman	✓	
Kotowski, Frank R, V Chairman	✓	
Pilliod, James P		✓
McMahon, Charles E	✓	
Barry, J. Gail, Clerk	✓	
Millham, Alida I		✓
Case, Frank G		
Blankenbeker, Lynne F	✓	
Cusson-Cail, Kathleen J	✓	
Donovan, Daniel A	✓	
Fredette, Robert A		
LeBrun, Donald L		✓
Schmidt, Stephen J	✓	
Ward, Joanne A	✓	
MacKay, James R		✓
Merrick, Evalyn S		✓
DiPentima, Rich T		✓
Harding, Laurie		✓
Deloge, Helen M		
Rosenwald		✓
Keene	✓	
TOTAL VOTE:	10	8

Printed: 1/27/2012

Committee Report

REGULAR CALENDAR

February 23, 2012

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Majority of the Committee on HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS to which was referred HB1642-FN,

AN ACT relative to destination cancer hospitals.

Having considered the same, report the same with the following amendment, and the recommendation that the bill OUGHT TO PASS WITH AMENDMENT.

Rep. John M Reagan

FOR THE MAJORITY OF THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

MAJORITY
COMMITTEE REPORT

Committee:	**HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS**
Bill Number:	**HB1642-FN**
Title:	**relative to destination cancer hospitals.**
Date:	**February 23, 2012**
Consent Calendar:	**NO**
Recommendation:	**OUGHT TO PASS WITH AMENDMENT**

STATEMENT OF INTENT

The only successful strategy for reducing health care costs is the timely resolution of the disease or injury. Destination hospitals are successful because their specialization sees better outcomes for the patients and lower costs for the payers. Many destination specialty providers are located outside of the United States attracting American patients. The New Hampshire health delivery paradox is how can we be the healthiest state in the union but have the h9ighest per capital health care costs? The reason is obvious either we are paying the hospitals and doctors too much for too many procedures and not enough health problem resolution. We are paying too much to thonse who deliver our New Hampshire health care and have no basis for comparing the health providers success. The solution to the high price conundrum is competition between providers. Competition often brings a better outcome faster and competition always lowers the price when we allos it. We should have specialty hospitals operating their businesses in New Hampshire and advance the transparency allowing the consumer to choose his or her own best outcome. We will allow New Hampshire to enjoy the good jobs, valuable service and tax payments from new providers like all successful business provide. The amendment resolved the contentious requirement to exempt a hospital from paying the undesirable but necessary MET, Medicaid Enhancement Tax.

Vote 10-8

Rep. John M Reagan

Original: House Clerk
Cc: Committee Bill File

FOR THE MAJORITY

Original: House Clerk
Cc: Committee Bill File

REGULAR CALENDAR

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

HB1642-FN, relative to destination cancer hospitals. **OUGHT TO PASS WITH AMENDMENT.** Rep. John M Reagan for the **Majority** of HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS. The only successful strategy for reducing health care costs is the timely resolution of the disease or injury. Destination hospitals are successful because their specialization sees better outcomes for the patients and lower costs for the payers. Many destination specialty providers are located outside of the United States attracting American patients. The New Hampshire health delivery paradox is how can we be the healthiest state in the union but have the h9ighest per capital health care costs? The reason is obvious either we are paying the hospitals and doctors too much for too many procedures and not enough health problem resolution. We are paying too much to thonse who deliver our New Hampshire health care and have no basis for comparing the health providers success. The solution to the high price conundrum is competition between providers. Competition often brings a better outcome faster and competition always lowers the price when we allos it. We should have specialty hospitals operating their businesses in New Hampshire and advance the transparency allowing the consumer to choose his or her own best outcome. We will allow New Hampshire to enjoy the good jobs, valuable service and tax payments from new providers like all successful business provide. The amendment resolved the contentious requirement to exempt a hospital from paying the undesirable but necessary MET, Medicaid Enhancement Tax. **Vote 10-8.**

Original: House Clerk
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REGULAR CALENDAR

February 23, 2012

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Minority of the Committee on HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS to which was referred HB1642-FN,

AN ACT relative to destination cancer hospitals.

Having considered the same, and being unable to agree with the Majority, report with the following Resolution:

RESOLVED, That it is INEXPEDIENT TO LEGISLATE.

Rep. Donald L LeBrun

FOR THE MINORITY OF THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

MINORITY
COMMITTEE REPORT

Committee:	**HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS**
Bill Number:	**HB1642-FN**
Title:	**relative to destination cancer hospitals.**
Date:	**February 23, 2012**
Consent Calendar:	**NO**
Recommendation:	**INEXPEDIENT TO LEGISLATE**

STATEMENT OF INTENT

HB 1642
Relative to destination cancer hospitals

Minority report:

HB 1642 in its amended form allows small specialty hospitals to come into New Hampshire without going through the Certificate of Need Process (CON). The CON requires health care facilities to submit and application for review and approval before expanding or building and prior to the purchase of expensive medical technology . The goal of the CON is to contain health care costs by assuring unnecessary duplication of services and promoting rational allocation of health care resources. In addition the CON stimulates collaboration among providers to manage health care costs. Exempting specialty hospitals from the CON process gives them an unfair competitive advantage over existing health care facilities in NH. Furthermore, specialty hospitals will not take Medicaid patients which will leave our community hospitals with the Medicaid patients and patients who have no insurance . This is called "cherry picking". As a result, the cost of care will be shifted to private insurance companies who will then have to increase their premiums which will then put a significant burden on those that must pay the costs for health insurance- New Hampshire businesses. This is the reason that the BIA opposes HB 1642. Experts testified before the committee that increasing availability of health care services increases utilization of services and therefore increases health care costs. "If you build it, they will come." Any new capacity in the form of a new hospital or technology will be utilized whether or not there is a documented need for these services. This only stands to reason as the new service or equipment must be paid for. The only way you can pay for the equipment is to use it. The CON process provides for a rational review as to the need for these services in a community and the impact the service will have on the health care delivery and health care costs. The minority supports specialty hospitals coming to

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Cc: Committee Bill File

New Hampshire but opposes HB 1642 because it creates an uneven playing field for our local community hospitals.

Rep. Donald L LeBrun
FOR THE MINORITY

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REGULAR CALENDAR

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS
HB1642-FN, relative to destination cancer hospitals. **INEXPEDIENT TO LEGISLATE.**
Rep. Donald L LeBrun for the **Minority** of HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS.
HB 1642
Relative to destination cancer hospitals

Minority report:

HB 1642 in its amended form allows small specialty hospitals to come into New Hampshire without going through the Certificate of Need Process (CON). The CON requires health care facilities to submit and application for review and approval before expanding or building and prior to the purchase of expensive medical technology . The goal of the CON is to contain health care costs by assuring unnecessary duplication of services and promoting rational allocation of health care resources. In addition the CON stimulates collaboration among providers to manage health care costs. Exempting specialty hospitals from the CON process gives them an unfair competitive advantage over existing health care facilities in NH. Furthermore, specialty hospitals will not take Medicaid patients which will leave our community hospitals with the Medicaid patients and patients who have no insurance . This is called "cherry picking". As a result, the cost of care will be shifted to private insurance companies who will then have to increase their premiums which will then put a significant burden on those that must pay the costs for health insurance- New Hampshire businesses. This is the reason that the BIA opposes HB 1642. Experts testified before the committee that increasing availability of health care services increases utilization of services and therefore increases health care costs. "If you build it, they will come." Any new capacity in the form of a new hospital or technology will be utilized whether or not there is a documented need for these services. This only stands to reason as the new service or equipment must be paid for. The only way you can pay for the equipment is to use it. The CON process provides for a rational review as to the need for these services in a community and the impact the service will have on the health care delivery and health care costs. The minority supports specialty hospitals coming to New Hampshire but opposes HB 1642 because it creates an uneven playing field for our local community hospitals.

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