Memorial Sloan Kettering
Cancer Center

Joint Legislative Budget Hearing – Health
Fiscal Year (FY) 2022-23 Executive Budget Proposal

Thank you, Senate Finance Chair Krueger, Assembly Ways and Means Chair Weinstein, and distinguished Members of the Senate and Assembly for the opportunity to testify. My name is Carol Brown, MD, FACS. I am testifying on behalf of Memorial Sloan Kettering Cancer Center (MSK), where I am Senior Vice President and Chief Health Equity Officer; the incumbent of the Nicholls-Biondi Chair for Health Equity; and a practicing board-certified gynecologic cancer surgeon who cares for women with ovarian, uterine, and cervical cancer. A central focus of my career is reducing and eliminating cancer health disparities experienced by medically underserved populations – the subject that brings me before you today.

Eliminating disparities is essential to our mission of achieving cancer health equity. Equity means that every patient who has cancer has the best possible outcome irrespective of socioeconomic status, race or ethnicity, English proficiency, or type of health insurance. Despite recent decreases in overall incidence and mortality rates from cancer in the United States, such disparities in cancer outcomes persist. Death rates for Black women with cancer, for example, are higher than those of White women, despite White women having a significantly higher cancer incidence.[i] Cancer mortality is also greater in populations affected by persistent poverty than among the general population.[ii] Race/ethnicity, socio-economic status, English proficiency, distance from health services, and health insurance status all have an impact on how likely you are to survive cancer in the United States.

Fortunately there are effective strategies to address the negative impact of these demographic factors on cancer survival. I recently had the honor of going to the White House to attend President Biden's announcement relaunching the Cancer Moonshot, which will take a multi-faceted approach to end cancer as we know it. Among the President's key goals are addressing "stark inequities in access to cancer screening, diagnostics and treatment across race, gender, region, and resources" and ensuring that "every community in America – rural, urban, Tribal, and everywhere else – has access to cutting-edge cancer diagnostics, therapeutics, and clinical trials." This is the subject of my testimony today.

Part P of the Governor's Health and Mental Hygiene bill includes a provision that would help New York state to achieve these Cancer Moonshot goals by improving access to National Cancer Institute (NCI)-designated cancer centers – a proposal that is also being advanced in the Assembly and Senate (A.7976-A, Seawright/S.7614, Krueger).

Why is access to an NCI-designated cancer center important? Established by the National Cancer Act in 1971, the NCI cancer center designation program recognizes cancer centers that meet rigorous standards for transdisciplinary, state-of-the-art research focused on developing new and better approaches to preventing, diagnosing, and treating cancer. These institutions are at the forefront of advancing cancer care through basic research and clinical trials, and patients receiving care at NCI-designated cancer centers often receive cutting edge care that is not yet available elsewhere. To give one example, when the breakthrough of chimeric antigen receptor therapy (CAR-T) was first approved for large B-cell lymphoma, it was only available at 16 approved treatment sites, all of which were NCI-designated cancer centers.

In fact, NCI-designated cancer centers' emphasis on pioneering new treatments has been shown to impact patient outcomes. A 2015 study in the journal *Cancer* looked at survival rates for five types of common cancers - breast, colorectal, lung, pancreatic, gastric or bile duct – and found that patients initially treated at NCI-designated cancer centers had superior survival.[iii] Unfortunately, that study also identified African American or Hispanic race/ethnicity, low socioeconomic status, and lack of private insurance to be key barriers to receiving treatment at NCI-designated cancer centers.[iv]

MSK's experience in the Medicaid managed care, Essential Plan, and Affordable Care Act (ACA) markets, which notably do not offer out-of-network benefits, bears this out. The nearly 5 million New Yorkers enrolled in Medicaid managed care, who are at greater risk for experiencing a poor cancer outcome related to their socioeconomic status, currently have very limited access to MSK. Just one Medicaid managed care plan and one Essential plan currently include MSK in-network, and not a single ACA plan has included MSK in-network since 2015.

MSK has remained committed to achieving cancer equity for these underserved patients by providing access to our innovative treatments and clinical trials despite these barriers. In fact, MSK provides care for among the highest number of people with cancer covered by Medicaid of any single hospital in New York State; 2017 state-reported data on the number of inpatient discharges for Medicaid patients with a primary diagnosis of cancer show that MSK treated about 500 more patients than the hospital with the next highest volume (1,547 compared to 1,030). However, many of these patients must navigate a complex, time-consuming, and stressful out-of-network authorization process and receive health plan approval before they can receive services at MSK. Despite MSK employing a team of staff devoted to securing out-of-network authorizations for these patients, not all of our requests are approved, and the process is daunting enough that some patients who could benefit from our services never even pursue it.

For myself and my colleagues at MSK, this barrier to high quality care for New Yorkers who enroll in coverage outside of the employer-sponsored market, i.e., those enrolled in Medicaid managed care, the Essential plan, and the ACA qualified health plan markets is both frustrating and heartbreaking. For our patients, overcoming this barrier can mean getting state-of-the-art, innovative treatment that can be life-saving. These barriers have been a source of frustration for my work, creating difficulties for individual patients and frustrating my work to improve underrepresented groups participation in clinical trials through MSK's Cancer Health Equity Research Program (CHERP). To provide one example, the out-of-network authorization process for a patient with cancer, who was eligible and wanted to enroll in a phase II therapeutic clinical trial at MSK, took so long that the trial spot was no longer available by the time the plan authorization came through.

Limiting access to MSK for patients in Medicaid managed care and ACA plans is largely due to concerns about "adverse selection" among these health plans. In other words, Medicaid managed care and ACA health plans fear if they are the only plan or one of a few plans to include MSK in their network, they will attract a disproportionately high number of high-cost patients with cancer.

Governor Hochul's budget proposal, like the Assembly and Senate bills (A.7976-A/S.7614), would eliminate the potential problem of adverse selection – and thereby improve access – by requiring all Medicaid managed care, Essential plan, and ACA health plans to contract with any NCI-designated cancer center operating in the health plan's service area that is willing to contract with all plans in that market. If all plans are in-network, the possibility of adverse selection due to the inclusion of MSK or any another NCI-designated cancer center in-network is eliminated.

Enacting the provision in the Governor's budget to eliminate adverse selection will improve access to NCI-designated cancer centers – and to the cutting edge therapies they help to develop – for the millions of New Yorkers who rely on Medicaid managed care, Essential, or ACA plans for their health coverage. This is an important step that the Legislature can take now to help reduce disparities in access to high-quality cancer care and, ultimately, to reduce and eliminate disparities in cancer outcomes.

Again, I thank you for the opportunity to submit testimony to the record. If I can answer any questions or be a resource to you, please reach out anytime.

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[i] National Cancer Institute. Cancer Stat Facts: Cancer Disparities. Accessed January 31, 2022. Available at: https://seer.cancer.gov/statfacts/html/disparities.html.
[ii] National Cancer Institute. Persistent Poverty Linked to Increased Risk of Dying from Cancer. Accessed January 31. 2022. Available at: https://www.cancer.gov/news-events/cancer-currents-blog/2020/persistent-poverty-increased-cancer-death-risk
[iii] Wolfson, J.A., Sun, C.-L., Wyatt, L.P., Hurria, A. and Bhatia, S. Impact of care at comprehensive cancer centers on outcome: Results from a population-based study. *Cancer,* 2015;121: 3885-3893. https://doi.org/10.1002/cncr.29576
[iv] Ibid.