

# Lung Cancer Screening

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Insights from the *2016 Lung Cancer Screening Quick Poll*

# Take Your Cancer Program to the **Next Level**

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When hospital executives think of cancer care, they typically think of strong volume growth and stable reimbursement. And they're right—but running a successful cancer program is getting more difficult. Cancer services are growing more complicated and competition is increasing, all the while cancer patients are becoming more self-directed.

This report is just one example of how the Oncology Roundtable provides cancer leaders like you with the tools and insights you need to run a high-quality, patient-centered, financially healthy cancer care organization.



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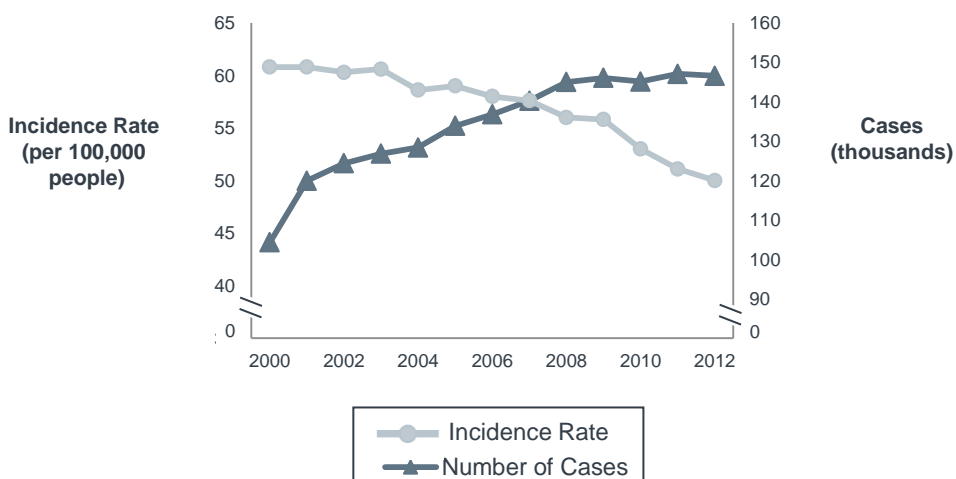


# Executive Summary

## Number of lung cancer cases expected to increase, but growth in new cases will plateau

Lung cancer is one of the most common cancers in the US, with more than 221,000 cases in 2015. The overall number of lung cancer cases will continue to grow due to the aging and growth of the population. Almost 70% of lung cancers are diagnosed in people age 65 and older, and that population is swelling due to the Baby Boomers. The good news is that overall lung cancer incidence rates are declining as a result of declines in smoking rates. As lung cancer incidence rates drop, the growth in new cases will plateau.

### Incidence Rates and Case Volumes of Lung and Bronchus Cancers



## Lung cancer treatment volumes will increase rapidly

Over the next 10 years, lung cancer treatment volumes will increase more than those of the other major tumor sites because treatment options are expanding. In particular, inpatient surgical volumes and outpatient radiation therapy volumes will grow significantly. More patients will receive surgery and radiation as screening catches disease earlier, new minimally invasive surgical techniques become more widespread, and new evidence emerges on the efficacy of radiation therapy for lung cancers.

## Lung cancer screening could impact the outcomes of many lung cancer patients

Perhaps the most important development in recent years is the advent of low-dose CT screening for high-risk patients. According to the National Lung Cancer Screening Trial (NLST), screening heavy smokers has the potential to reduce mortality by as much as 20%. This benefit comes from diagnosing patients with earlier stage disease when they have more treatment options. Now that both public and private payers are reimbursing for low-dose CT screening for high-risk patients, many organizations are seizing the opportunity to invest in this service, which has the potential to save lives and increase volumes.

## 2016 Lung Cancer Screening Poll looks at where we are and where we are going

The 2016 Lung Cancer Screening Quick Poll was distributed as an online survey to Oncology Roundtable members via email on June 14, 2016. A total of 130 people submitted responses over the subsequent two weeks. The survey, which has been run annually for the past four years, enables members to look at longitudinal changes taking place in lung cancer screening programs. This document contains several insights from the survey that will help you understand how other programs are currently organizing and operating their lung cancer screening programs.

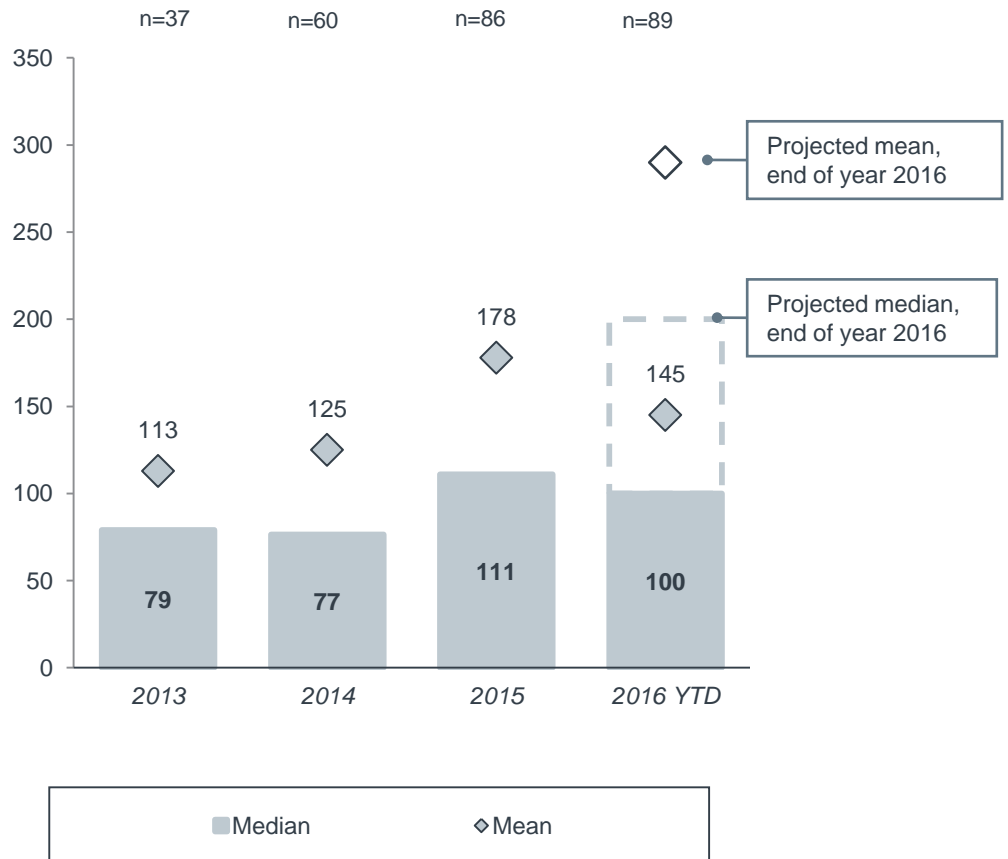
# Number of Programs and Volumes Continue to Grow

In the past four years, the percentage of our survey respondents offering lung screening has jumped dramatically from only 32% in 2012 to 92% in 2016. However, it's important to note that because this survey focuses exclusively on lung screening, programs offering lung screening might have been more likely to respond to the survey.

The volume of patients screened has also steadily increased since 2012. From 2014 to 2015, the median number of patients screened per program jumped from 77 to 111 patients. As of June 2016, the median number of patients screened has already reached 100, suggesting that the patient volumes for this year will greatly surpass the 2015 volumes. On average, about 2% of patients screened are subsequently diagnosed and treated at that organization.

## Number of patients screened, 2013-2016

Median and mean number of patients screened



# Reimbursement Continues to Be Challenging

While commercial payers started reimbursing for low-dose CT screening on January 1, 2015, Medicare did not specify reimbursement for lung cancer screening codes until its [2016 Hospital Outpatient Prospective Payment System](#). Many cancer program members expressed concern over the processing, coding, and billing for lung screening services provided between February and December of 2015. Despite those concerns, the majority (56%) of programs indicated that they did not have to write off any costs associated with providing lung screening to Medicare and/or Medicaid patients in 2015.

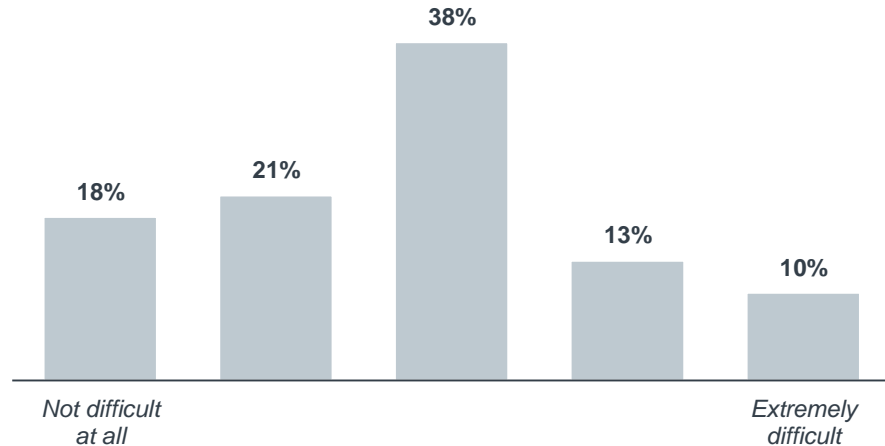
Additionally, cancer programs do not report any major difference in how difficult it is to secure reimbursement from CMS versus private payers. In this year's survey, 23% of respondents indicated that securing reimbursement was "difficult" or "extremely difficult" for both CMS and private payers. In fact, securing reimbursement from CMS seems slightly easier with 24% of programs saying they had no difficulty at all securing reimbursement from CMS, compared to 18% of programs reporting no difficulty at all from private payers.

## Almost a Quarter Struggle to Secure Reimbursement

### How difficult has it been to secure reimbursement from private payers for screening since January 1, 2015?<sup>1</sup>

Percentage of respondents<sup>2</sup>

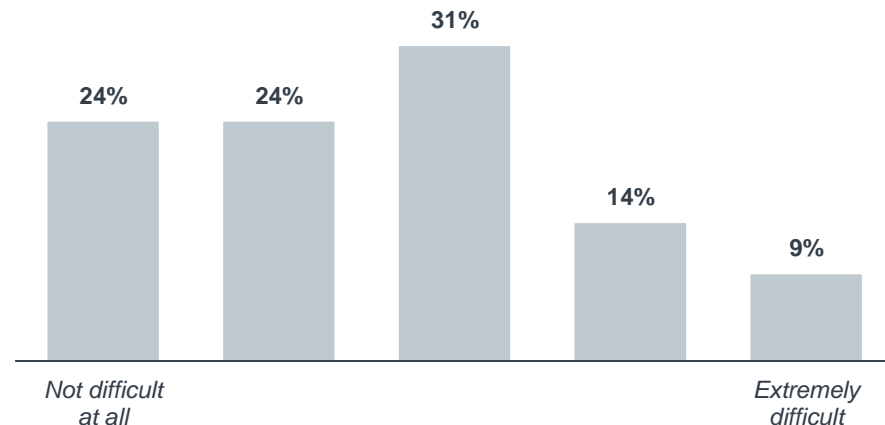
n=82



### How difficult has it been to secure reimbursement from CMS for screening since January 1, 2016?<sup>1</sup>

Percentage of respondents<sup>2</sup>

n=81



1) Rating on a 5-point scale from "not difficult at all" (1) to "extremely difficult" (5).  
2) Percentages may not add up to 100% due to rounding.

# Most Lung Screening Programs Staffed with Part-Time FTE

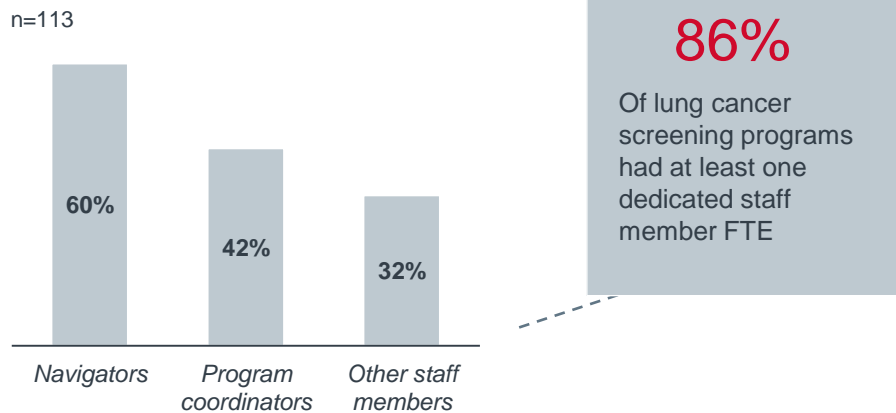
In keeping with the results from our 2015 survey, navigators are the most common FTE associated with lung screening programs. 60% of respondents reported they have a dedicated nurse navigator for their lung screening program. However, our 2016 survey also showed an increase in the median number of FTE program coordinators and other staff members dedicated to the lung screening program. The median number of program coordinators increased from 0.5 FTE in 2015 to 1 FTE in 2016 and the median number of "other" staff jumped from 0.2 FTE to 1 FTE. In total, 86% of the lung screening programs surveyed had at least one dedicated staff member FTE.

## 60% of Respondents Have a Dedicated Navigator

### How many dedicated staff member FTEs are associated with your lung cancer screening program?

	n	Navigators	Program coordinators	Other
Median dedicated FTEs	113	1.0	1.0	1.0
Mean dedicated FTEs	113	1.0	0.95	1.25
Mean dedicated FTEs per 100 patients seen in 2015 <sup>1</sup>	63	0.8	0.8	0.7

### Percentage of programs with at least one dedicated staff member FTE, by staff type



# PCPs and Pulmonologists Provide Decision Counseling

While CMS requires that all patients undergo shared decision making with a qualified medical professional prior to receiving an order for LDCT lung cancer screening, they allow flexibility in who can lead the visit.<sup>1</sup>

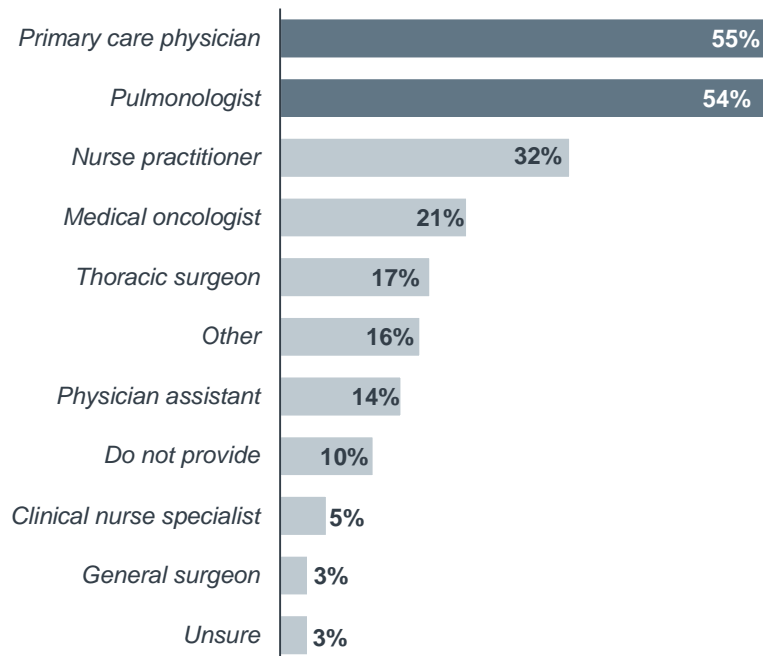
Consistent with last year's survey, the 2016 survey reveals that PCPs and pulmonologists are most often tasked with performing shared decision making visits. The percentage of respondents that have PCPs and pulmonologists conduct these visits jumped by 10% this year, and the number that uses nurse practitioners rose by 12%.

As part of the shared decision making visit, CMS requires providers to use a decision aid. This year's survey showed that brochures reviewing the risks and benefits of screening are still the primary decision aid clinicians use during lung cancer screening counseling and shared decision making visits.

## Which clinician(s) provide(s) the lung cancer screening counseling and shared decision making visits<sup>1</sup> at your institution?

Percentage of respondents<sup>2</sup>

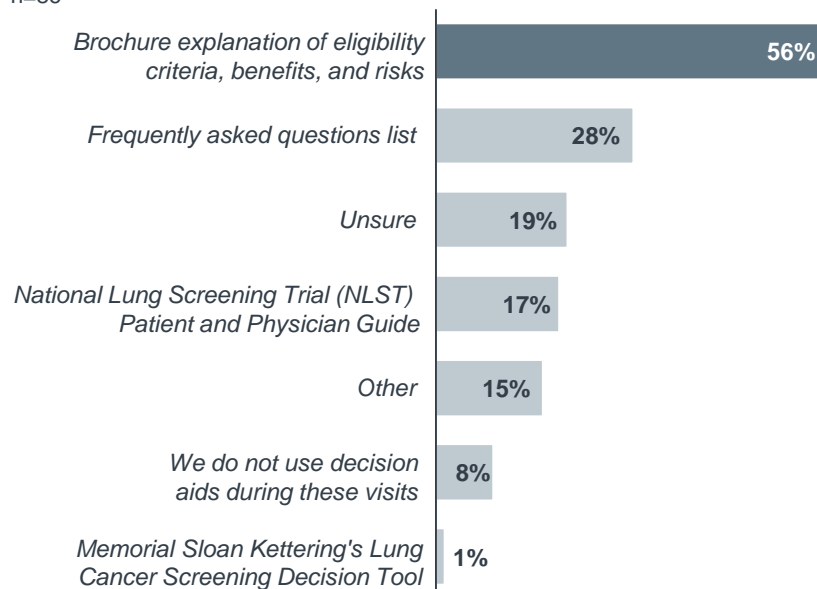
n=96



## Which decision aids do clinicians use with patients during lung cancer screening counseling and shared decision making visits?

Percentage of respondents<sup>2</sup>

n=86



1) CMS requires screening counseling and shared decision making furnished by a or qualified non-physician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist physician), as defined in §1861(r)(1) and §1861(aa)(5) of the Social Security Act; see also CMS Decision Memo for Screening for Lung Cancer with Low Dose Computed Tomography (LDCT) <https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=274>.

2) Percentages do not add up to 100% because respondents were allowed to check all that apply

# Nearly All Programs Use ACR Lung Screening Registry

88% of respondents (n=93) reported that they use or anticipate using the American College of Radiology (ACR) Lung Cancer Screening Registry—currently the only registry approved by CMS for lung cancer screening.

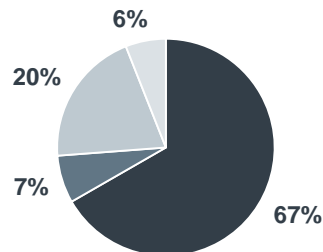
Our survey also showed a significant increase in the percentage of respondents who received ACR designation. Respondents with ACR designation more than doubled from 32% in 2015 to 67% in 2016. Only 6% of respondents reported they do not intend to seek ACR accreditation. The percentage of programs with Lung Cancer Alliance (LCA) Screening Center of Excellence remained constant from 2015 with only 44% of programs reporting accreditation, suggesting that most programs are prioritizing ACR designation.

## What is your organization's status for each of the following lung cancer screening program designations?

Percentage of respondents<sup>1</sup>

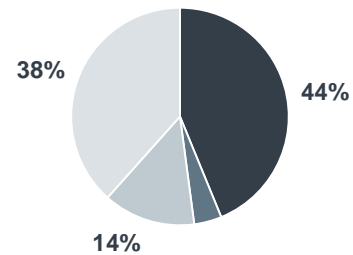
### American College of Radiology (ACR) Lung Cancer Screening Center

n=84



### Lung Cancer Alliance (LCA) Screening Center of Excellence

n=73



- Have this designation/accreditation
- Currently seeking this designation/accreditation
- Planning to seek this designation/accreditation
- Do not have this designation/accreditation, and have no plans to seek it



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## **Making the Case for Lung Cancer Screening**

Access ready-to-use, customizable slides to inform your referring physicians about your lung cancer screening program.



## **Tumor Site Centers of Excellence**

Get innovative strategies to build five best-in-class tumor site programs, including breast, lung, colorectal, gynecologic, and prostate.



## **What They Value: Five Types of Cancer Patients**

Explore this infographic to learn about the five types of cancer patients and what they value in a cancer provider.

## **For More Information**



To learn more about how the Oncology Roundtable provides oncology leaders with the forecasting tools and best practice insights needed to answer the industry's most pressing strategic and operational questions, contact Sharlene Anonick at [anonicks@advisory.com](mailto:anonicks@advisory.com) or visit [www.advisory.com/research/oncology-roundtable](http://www.advisory.com/research/oncology-roundtable)