



January 29, 2016

The Honorable Orrin Hatch
Chair, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Kevin Brady
Chair, House Ways & Means Committee
1135 Longworth House Office Building
Washington, DC 20515

The Honorable Sander Levin
Ranking Member, House Ways & Means Committee
1106 Longworth House Office Building
Washington, DC 20515

Dear Chairman Hatch, Ranking Member Wyden, Chairman Brady and Ranking Member Levin:

The US Oncology Network, which represents over 10,000 oncology physicians, nurses, clinicians and cancer care specialists nationwide, appreciates the opportunity to provide feedback on improvements to the Stark Law. As a network of providers treating one of the most common and costly medical conditions today, we applaud your interest in improving care coordination while preserving clinical integration and access to high-quality, affordable care for our nation's seniors.

As background, The US Oncology Network is one of the nation's largest and most innovative networks of community-based oncology physicians, treating more than 750,000 cancer patients annually in more than 450 locations across 40 states. The Network unites over 1,000 like-minded physicians around a common vision of expanding patient access to the highest quality, most cost-effective integrated cancer care to help patients fight cancer, and win.

Stark Law and Cost-Effective Integrated Cancer Care

As you seek ways to improve the Stark law, preserving the in-office ancillary services exception (IOASE) to the "Stark" law is of utmost importance to community oncology practices. The provision was included to preserve the longstanding practice of bringing together advanced treatment options when the service or procedure is ancillary to the original patient diagnosis. This provision is of particular importance to cancer care in the community setting in that it provides patient access to chemotherapy, radiation therapy and advanced imaging together - all under one roof with the same team of caregivers on the same EHR. Congress and the Centers for Medicare and Medicaid Services (CMS) have examined this policy on numerous occasions, continually recognizing its distinct and profound benefits on patient care.

In a 2015 report from BRG Healthcare, *A Detailed Diagnosis Of Integrated Community Oncology*, researchers examined integrated community oncology practices, which they call a cornerstone of cancer care because they provide efficient, quality cancer care to patients in their community at a cost that is lower to both the patient and payers, including Medicare.¹

Benefits of integrated care include:

¹ BRG Healthcare, "A Detailed Diagnosis Of Integrated Community Oncology," 2015.

- Coordination of traditional cancer care, such as chemotherapy and radiation therapy, with ancillary services, such as social support,
- Access to cutting edge innovations in the fight against cancer, including participation in new cancer care models like the Oncology Care Model (OCM) and
- Costs that are demonstrably lower than hospital outpatient-based care.

Preserving the IOASE is an important component in combating the disparity in cost for cancer care based on the site of service. The cost of providing cancer care in a hospital outpatient department is significantly higher than the *exact same care* delivered at a community cancer clinic: charging approximately 126 percent higher costs for administering common cancer drugs and 100 percent higher costs for drug infusion services overall. Hospital-based radiation therapy services are also paid 13 percent more than the same care provided in a freestanding community based clinic.

These payment disparities are resulting in a significant shift in the delivery of certain services from the community to the hospital outpatient setting, increasing costs to Medicare, patients and taxpayers. A December 2015 report released by the GAO examined trends in vertical consolidation between hospitals and physicians and found that the number of vertically consolidated hospitals increased from about 1,400 to 1,700, while the number of vertically consolidated physicians doubled from about 96,000 to 182,000.²

Fortunately, Congress has recognized the negative consequences this policy has on patients, taxpayers and businesses and included a site-neutral payment provision in the recent Bipartisan Budget Act. The measure includes a provision aligning payments for all newly acquired provider-based off campus HOPDs with payments to physician practices paid under either the Ambulatory Surgical Center (ASC PPS) or the Medicare PFS. This policy is expected to save Medicare approximately \$9 billion over 10 years. The US Oncology Network urges you to preserve the IOASE to stem the tide of hospital acquisitions of community cancer clinics and protect Medicare beneficiaries and taxpayers by ensuring access to high quality, ethical care in a setting that benefits the patient and facilitates care coordination.

Stark law and MACRA implementation

Congress has repeatedly recognized the importance of preserving patient access to integrated care and including these services into new payment and delivery models. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) included a provision establishing “appropriate use criteria” (AUC) for advanced medical imaging, which is the proper way to address potential inappropriate utilization across all settings of care. The Network supports the development, adoption and use of physician-developed, peer reviewed AUC for advanced imaging and other ancillary services.

In December 2015, Congress passed legislation averting substantial cuts to radiation therapy. The Patient Access and Medicare Protection Act provided payment stability for radiation therapy services as CMS transitions to a new, episodic alternative payment model in 2019. The legislation requires the Secretary of Health and Human Services to submit to Congress a report on the development of an episodic alternative payment model for payment under the Medicare program within 18 months. This legislation provides certainty for community cancer clinics and our patients. The Network is looking forward to

² GAO, “Medicare: Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform,” December 2015.

working with the Secretary in developing and participating in the new payment model for radiation therapy.

The Network worked closely with CMS and the Center for Medicare & Medicaid Innovation (CMMI) on the Oncology Care Model (OCM), an episode-based payment model aimed at improving care coordination, appropriateness of care, and access to care for beneficiaries undergoing chemotherapy. Thirteen practices within The US Oncology Network, representing 787 providers, have applied to participate in the OCM which is set to launch on July 1, 2016. Our physicians are ready and willing to participate in these patient-centered pilot programs that focus on integration with hopes of improving outcomes for chemotherapy and radiation patients while realizing savings for the healthcare system.

The IOASE is a critical avenue for integrated cancer care in the community setting. Without access to integrated care, a vast majority of the nation's cancer patients who are treated in outpatient settings will be denied comprehensive care services and forced into the more expensive hospital setting. In addition to ensuring patient access, the IOASE saves CMS and the healthcare system valuable funding by offering care in the most cost-effective setting. Fragmentation of care will hurt patients, over-burden hospital systems and increase costs for patients, taxpayers and businesses.

On behalf of the nation's leading community cancer care providers, we appreciate the opportunity to share our ideas and look forward to working with you to improve care coordination for Medicare patients. Feel free to use us as a resource throughout this process as we are happy to provide any additional insight.

Sincerely,

A handwritten signature in cursive script that reads "Lucy Langer".

Dr. Lucy Langer
Chair, National Policy Board
The US Oncology Network