The US Oncology Network

September 6, 2016

VIA ELECTRONIC SUBMISSION THROUGH **www.regulations.gov**

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1656-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program: Calendar Year (CY) 2017 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) proposed rule (CMS-1656-P)

Dear Acting Administrator Slavitt:

On behalf of the National Policy Board and physicians of The US Oncology Network[1], I thank you for the opportunity to comment on the Calendar Year (CY) 2017 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) proposed rule (CMS-1656-P) as published on July 14, 2016 in the *Federal Register*.

The US Oncology Network has organized its comments by topic area to facilitate your review.

Implementation of Section 603 of the Bipartisan Budget Act of 2015 Relating to Payment for Certain Items and Services Furnished by Certain Off-Campus Departments of a Provider

The US Oncology Network (The Network) has advocated for payment parity across site of service for several years in comment letters on past Medicare Physician Fee Schedule proposed rules. Large disparities in reimbursement for different settings of care have provided financial incentives for hospitals to acquire physician practices. This consolidation has led to hospitals charging Medicare and its beneficiaries more for the same service leading to increased cost and decreased access for patients across the country.

Section 603 of the Bipartisan Budget Act of 2015 (BBA) establishes a site neutral payment policy for all newly acquired off-campus outpatient provider-based departments (off-campus PBDs). This

[1]The US Oncology Network is one of the nation's largest networks of community-based oncology physicians dedicated to advancing cancer care in America. Like-minded physicians are united through The Network around a common vision of expanding patient access to high-quality, integrated cancer care in communities throughout the nation. Leveraging healthcare information technology, shared best practices, refined evidence-based medicine guidelines, and quality measurements, physicians affiliated with The US Oncology Network are committed to advancing the quality, safety, and science of cancer care to improve patient outcomes. The US Oncology Network is supported by McKesson Specialty Health, a division of McKesson Corporation focused on empowering a vibrant and sustainable community patient care delivery system to advance the science, technology and quality of care. More information about The US Oncology Network can be found at www.usoncology.com.

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provision marks an important first step in equalizing Medicare payments across site of service, reducing unnecessary healthcare spending and providing greater patient access to care. The Network believes that this site neutral payment policy should apply to <u>all</u> off-campus outpatient departments and will continue to work with Congress and the Administration to expand upon the progress made in the BBA. We applaud CMS' proposed implementation of Section 603 and as members of the Alliance for Site Neutral Payment Reform, we support their submitted comments on CMS-1656-P.

When cancer care is provided in a hospital outpatient department (OPD) instead of a physician office or community-based cancer treatment center, the costs to patients and the health care system increase. According to a 2011 Milliman study, the same chemotherapy regimen administered in a hospital OPD costs Medicare $6,500 more per beneficiary ($623 million annually) and Medicare beneficiaries, who have a median annual income of $23,000, pay $650 more in out- of-pocket costs annually.[2]

Not only are hospital OPDs charging more for the same medical oncology services provided in a physician's office, their spending is higher when caring for patients with the same diagnosis and stage of cancer.

Numerous studies highlight these cost differentials and the strain they place on patients and our health care system, including a May 2014 study by the IMS Institute for Healthcare Informatics that assessed 10 common chemotherapy treatment regimens and found that hospitals charged 189 percent more on average – nearly triple – than what the same infusions would have cost in a physician's office.[3] The report showed that for commonly used cancer drugs, the average cost was $134 per dose higher in a hospital OPD.[4]

An analysis of claims data from 2009-2011 by The Moran Company shows that by a variety of metrics, chemotherapy spending is higher in hospital OPDs than physician offices despite lower unit payment rates for drugs under the HOPPS rules in effect during that period.[5] The reason for this cost differential is that patients receive more chemotherapy administration sessions on average when they are treated in a hospital OPD and the dollar value of such services is meaningfully higher. On a per beneficiary basis, chemotherapy drug spending was 25 to 47 percent higher in hospital OPDs than in physician offices across the 2009-2011 time period and hospital OPD spending for chemotherapy administration was 42-68 percent higher than in physician offices.[6] The same will be true in 2017 since the payment rates for one hour of intravenous chemotherapy infusion (HCPCS Code 96413) under the CY 2017 HOPPS Proposed Rule will be $281.41, more than double the rate of $137.73 under the PFS Proposed Rule.

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[2] Milliman, *Site of Service Cost Differences for Medicare Patients Receiving Chemotherapy* (October 2011), available at http://us.milliman.com/insight/health/Site-of-Service-Cost-Differences-for-Medicare-Patients-Receiving-Chemotherapy/

[3] IMS Institute for Healthcare Informatics, "Innovations in Cancer Care and Implications for Health Systems: Global Oncology Trend Report" (May 2014), available at http://340breform.org/userfiles/IMSH_Oncology_Trend_Report.pdf.

[4] *Id.*

[5] The Moran Company ,"Analyses of Chemotherapy Administration Utilization and Chemotherapy Drug Utilization, 2005-2011, for Medicare Fee-for-Service Beneficiaries" (May 2013), available at http://glacialblog.com/userfiles/76/Moran_Site_Shift_Study_P1.pdf.

[6] *Id.*

As oncologists, this differential makes us a target for hospital acquisitions. **We commend CMS' proposed restriction on the scope of services "excepted" off-campus PBDs are able to furnish and bill at the higher OPPS rate.** CMS correctly concluded that allowing "excepted" facilities to expand beyond their current scope of services will perpetuate the acquisition of community-based practices by hospitals and fail to achieve the BBA's intent of curtailing consolidation and achieving savings in the Medicare system.

From the perspective of The US Oncology Network, subsidies that have been built into hospital OPD payments for cancer care to cover hospitals' indirect expenses associated with standby services, in combination with other site-specific Medicare payment policies, have contributed to the rapid increase in hospital employment of physicians in general, and oncologists in particular. These subsidies have increased the cost to the government and patients alike for effective cancer treatment. Just as importantly, the higher Medicare allowables and the associated higher beneficiary co-payments applicable to chemotherapy and certain radiation therapy services delivered in hospital OPDs do not add value to the cancer care Medicare patients receive.

Stemming consolidation in the healthcare marketplace was a key driver in the creation of Section 603 as policymakers are recognizing the negative effects that hospital acquisition of independent physician practices has on healthcare costs and access to care. A recent report from the Government Accountability Office (GAO) from December 2015 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 from 2007-2013. The study also revealed the total Medicare payment rates for a mid-level E/M office visit are $51 higher when performed in a hospital outpatient department (HOPD) instead of a freestanding physician's office.[7] **The Network supports CMS' interpretation that the BBA to prohibit relocation of "excepted" facilities.** Allowing for relocation of "excepted" off-campus PBDs would provide an opportunity for these facilities to move into a larger space, acquire more physicians and continue to charge Medicare and beneficiaries the higher rates.

While the BBA is a good first step to site neutral payment reform, The Network believes that the site neutral payment policy should apply to <u>all</u> off-campus outpatient departments. Medicare should be paying the same payment for the same service regardless of where it is performed. CMS estimates that implementation of Section 603 will save Medicare $330 million in 2017 alone while data suggest that expanding this policy to <u>all</u> off-campus provider-based facilities could save an additional 10 to 20 billion dollars[8] - adding much needed solvency to the Medicare trust fund. Patients should not be burdened with higher costs for similar care solely because a hospital purchased their physician's office on November 1st instead of November 2nd.

Ensuring Medicare pays the most appropriate amount for the same service regardless of the setting has support from bipartisan lawmakers, the Administration, MedPAC, GAO, OIG and a broad group of healthcare stakeholders. We appreciate the Administration's leadership on this cost-saving proposal, and hope the Agency will move toward expanding policies that level the playing field for on-

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[7] GAO, "Medicare: Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform," December 2015.
[8] CBO, Proposals for Health Care Programs—CBO's Estimate of the President's Fiscal Year 2016 Budget, March 2015

cology services. Legislation aimed at providing the authority for such sorely needed changes has been introduced by Reps. Mike Pompeo (R-KS) and Don Beyer (D-VA). The Medicare Patient Access to Cancer Treatment Act (H.R. 2895) would equalize Medicare payments between hospital OPDs and physician offices for cancer care services. The US Oncology Network strongly supports this legislation, and we urge CMS to do the same and use existing administrative authority to establish payment policies that that do not further distort provider incentives.

On behalf of the National Policy Board of The US Oncology Network and our more than 10,000 oncology physicians, nurses, clinicians and cancer care specialists nationwide, thank you for the opportunity to provide our comments on Proposed Rule CMS-1656-P. We are grateful to be able to engage in substantive discussions and welcome practice site visits with CMS officials.

Sincerely,

Lucy R Langer MD

Lucy Langer, MD
Chair, National Policy Board
The US Oncology Network

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