The US Oncology Network

February 16, 2016

The Honorable Fred Upton
Chairman
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Joe Pitts
Chairman
Subcommittee on Health
2415 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton and Chairman Pitts,

On behalf of The US Oncology Network, which represents over 10,000 oncology physicians, nurses, clinicians and cancer care specialists nationwide, thank you for the opportunity to provide feedback on the site neutral payment policy included in the Bipartisan Budget Act of 2015. As a provider treating one of the most common and costly chronic medical conditions today, I have seen firsthand the impact unequal payment policies can have on cancer patients and freestanding community cancer clinics. The US Oncology Network applauds Congress for taking this difficult, but necessary step in addressing payment parity and we urge lawmakers to consider avenues to expand site neutral payment reforms to ensure patient access to care and reduce healthcare spending.

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.

Cancer continues to be one of our nation's most costly and prevalent chronic conditions. Today there are over 14 million Americans with a history of cancer and more than eight million of those people are currently over the age of 65, resulting in approximately half of all cancer spending going towards care for Medicare beneficiaries[1]. The National Cancer Institute states that the U.S. spent over $125 billion on cancer care in 2010 and projects that cancer care costs will increase to $156 billion by 2020[2].

Exacerbating cancer's impact on the US health care system is the substantial disparity in the cost of 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: costing Medicare approximately 126 percent morefor administering common cancer drugs.

Treating cancer patients in community-based cancer clinics as opposed to the outpatient hospital setting results in significantly lower costs to both patients and the Medicare program. Total Medicare spending on patients receiving chemotherapy in the community clinic is 14.2 percent lower than the hospital outpatient department (HOPD), which equals $623 million in Medicare savings per year.[3] In addition, an April 2012 study released by Avalere Health found that chemotherapy provided in a physician's office

[1] The National Cancer Institute http://www.cancer.gov/about-cancer/what-is-cancer/statistics
[2] The National Cancer Institute http://www.cancer.gov/about-cancer/what-is-cancer/statistics
[3] Milliman Client Report: Site of Service Cost Differences for Medicare Patients Receiving Chemotherapy. October 19, 2011. Kate Fitch and Bruce Pyenson. http://publications.milliman.com/publications/health-published/pdfs/site-of-service-cost-differences.pdf

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costs, on average, 24 percent less than chemotherapy provided in the hospital outpatient setting[4]. Patient co-payments are approximately 10 percent lower in the clinic, equaling more than $650 in savings for each Medicare beneficiary fighting cancer per year. Additionally, the average out-of-pocket patient cost for commonly used cancer drugs is $134 less per dose if received in an oncologist's office.[5]

These costs add up. Between 2009 and 2012, Medicare beneficiaries paid $4.05 million more in out-of-pocket costs because of higher patient co-payments associated with higher HOPD rates for chemotherapy services that could have been performed at a community cancer practice for a fraction of the cost.[6]

As noted in your letter, many non-partisan economists and health policy experts have expressed concern that this payment disparity has resulted in consolidation of the healthcare marketplace and a significant shift in the delivery of certain services from the community to the hospital outpatient setting, resulting in increased costs to patients and the Medicare program. A recent GAO report examining trends in vertical consolidation between hospitals and physicians corroborates this claim. The December 2015 report 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 rate for a mid-level E/M office visit was $51 higher when the service was performed in an HOPD instead of a freestanding physician's office.[7]

Fortunately, Congress recognized the negative consequences this policy has on patients, taxpayers and businesses and included Section 603 in the Bipartisan Budget Act. The provision appropriately aligns payments for all newly acquired provider-based off campus HOPDs with payments to physician practices paid under either the Ambulatory Surgical Center Perspective Payment System (ASC PPS) or the Medicare PFS. Section 603 is expected to not only save Medicare approximately $9 billion over 10 years, but it also removes the perverse incentive for hospitals to purchase community cancer centers, change only the sign on the door and charge patients significantly more in out-of-pocket costs.

The concept of site neutral payments has broad, bipartisan support from lawmakers, the Administration, the Medicare Payment Advisory Commission, the Government Accountability Office and a broad group of healthcare stakeholders including patients, providers, and insurers. To paraphrase MedPAC Executive Director Mark Miller, Ph.D.: "Medicare should pay the same amount for the same service, regardless of the setting."

While the provision in the Bipartisan Budget Act is an important first step in instituting payment parity across sites of service, HOPDs billing Medicare prior to November 2, 2015 are able to continue billing at the much higher OPPS rate for the same services. Efforts are also underway to exempt, carve out or grandfather certain outpatient facilities which would result in increased costs for those Medicare patients, Medicare, payers and employers.

[4] Avalere Client Report: Total Cost of Cancer Care By Site of Service. March 2012. http://www.avalerehealth.net/news/2012-04-03_COA/Cost_of_Care.pdf
[5] Milliman, "Site of Service Cost Differences for Medicare Patients Receiving Chemotherapy," October 2011.
[6] Berkeley Research Group, "Impact on Medicare Payments of Shift in Site of Care for Chemotherapy Administration," June 2014.
[7] GAO, "Medicare: Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform," December 2015.

The US Oncology Network strongly urges Congress to stand by Section 603 of the BBA and expand site-neutral payment reform to all off-campus outpatient services which is estimated to save an additional $10-$20 billion. Medicare should be paying the same fee for the same service regardless of where it is performed, regardless of whether a facility was billing Medicare prior to November 2 and regardless of whether a facility was under construction prior to enactment of BBA. This would level the playing field for all off-campus outpatient care and removes the need to exempt or carve out certain facilities.

Our seniors should not be subjected to higher out-of-pocket costs based on an arbitrary date or the name that happens to be on the sign outside the clinic. This is especially relevant as it pertains to cancer care. As mentioned, the current hospital outpatient payment system incentivizes hospitals to purchase community oncology practices given the high reimbursement, low cost investment for chemotherapy administration. An even more lucrative incentive exists for PPS-exempt cancer hospitals (PCHs) with outpatient departments. PCH outpatient reimbursement is based on the OPPS system with an aggregate add-on adjustment based on PCH reported costs. This unique payment structure means that PCHs have little reason to reduce costs and can, in fact, collect greater Medicare revenue by increasing their costs. In 2012, the outpatient setting accounted for the majority of Medicare payments for most PCHs. According to a 2015 GAO report, Medicare payment adjustments to PCHs resulted in overall reimbursements that were 37 percent higher, on average, than payments Medicare would have made to HOPDs for the same set of services[8]. If this cost differential is allowed to persist, PCHs can continue building and expanding outpatient departments to capitalize on this disparity in cancer care services.

Given the specific implications this policy has on community cancer care, The US Oncology Network has been leading the charge to implement site neutral payment reform. In May 2014, Dr. Barry Brooks testified on behalf of The US Oncology Network at a hearing entitled *Keeping the Promise: Site of Service Medicare Payment Reforms* held by the House Energy and Commerce Subcommittee on Health. In addition to highlighting the alarming shift of cancer care from the community setting to the hospital outpatient setting, Dr. Brooks urged lawmakers to support The Medicare Patient Access to Cancer Treatment Act (H.R. 2869), a bill sponsored by Representatives Mike Rogers (R-MI) and Doris Matsui (D-CA), to establish payment parity under the Medicare program for cancer care services. The US Oncology Network continues to support the Medicare Patient Access to Cancer Treatment Act (H.R. 2895) which was re-introduced in the 114th Congress with bipartisan support from Representatives Mike Pompeo (R-KS) and Don Beyer (D-VA).

The US Oncology Network would welcome the opportunity to discuss this issue further in a broader setting such as a Committee hearing or a Member or staff briefing. We would be happy to provide our expertise and recommend others that could be helpful in this realm.

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 preserve and expand site neutral payment reforms. Feel free to use us as a resource throughout this process as we are happy to provide any additional insight.

[8] GAO, "Payment Methods for Certain Cancer Hospitals Should Be Revised to Promote Efficiency." February 2015

Sincerely,

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

Cc: The Honorable Frank Pallone, Jr., Ranking Member
The Honorable Gene Green, Ranking Member, Subcommittee on Health