The US Oncology Network

August 5, 2013

Congressman Joseph R. Pitts
Chairman
House Energy and Commerce Committee Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Congressman Pitts,

Thank you for allowing me to testify before the Subcommittee on Health on Friday, June 28, 2013, at the hearing entitled, "Examining Reforms to Improve the Medicare Part B Drug Program for Seniors."

It was an honor and a privilege to address the committee on the current issues facing oncologists and Medicare Part B drugs. As requested I have attached to this letter responses to the additional questions submitted on behalf of the committee.

Thank you again for the opportunity, and should you need anything in the future feel free to contact me.

Sincerely,

Barry Brooks

Dr. Barry Brooks
Chairman
Pharmacy and Therapeutics Committee
The US Oncology Network

**The Honorable Mike Rogers**

1. **According to the recent analysis by the Moran Group, there has been a shift in the site of service for chemotherapy services in Medicare from the Physician Office Setting (POS) to the Hospital Outpatient Department (HOPD) over the 2005 to 2011 period.**

   **According to the Community Oncology Practice Impact Report released this week, in the past year 288 clinics sites closed, 407 practices were financially struggling and 469 practices had entered into a contractual relationship of had been acquired by a hospital.**

   **What impact do you believe the shift in the delivery of cancer care from the community oncology clinic to the hospital outpatient has on (a) patient access to cancer treatment and (b) the cost of cancer treatment to patients?**

   **What change in Medicare payment policies do you believe would stem the tide of oncology clinic closures?**

Answer:

Congressman Rogers, the 20% shift in site of outpatient cancer care over six years has had serious effects on cancer patients and on costs. When a community oncology clinic closes or physicians move into a hospital outpatient setting the patient is displaced from their current community clinic and forced to find a nearby hospital outpatient department for care. That patient will have to drive further, take off more time from work, spend more time away from their family, pay more in gas, wait in longer lines at the hospital, run the risk of acquiring more infections at the hospital, pay more in co-pays ($650 more a year per patient according to the 2011 Milliman Study I referenced in my testimony) , and may not get the same personal attention they were receiving in the community clinic. Over time, it will be harder and more expensive for patients to continue their cancer treatment. Additionally, if the site of service shift trend continues and intensifies, hospitals will not have the capacity to handle the influx of cancer patients and access to treatment for Americans fighting cancer will be imperiled.

To stem the tide, Congress should level the playing field between community oncology and the hospital outpatient department. The first step to a level playing field is equalizing Medicare payments for the same services regardless of setting. Congress should act on MedPAC's recent call for payment parity across outpatient settings. If a patient is receiving quality care in the community clinic, that practice should be receiving the same reimbursement as the hospital outpatient department. Today, Medicare reimbursement for oncology services is significantly higher in the hospital outpatient department, which tilts the competitive landscape unfavorably for both Medicare and seniors fighting cancer. The US Oncology Network applauds you and Congresswoman Matsui for your leadership in introducing HR 2869, the Medicare Patient Access to Cancer Treatment Act of 2013 which would address this issue; we look forward to working with you to enact this common sense approach. Additionally, Congress should pass (1) H.R. 800 to make reimbursement for Medicare Part B drugs more accurate by removing the prompt pay discount reduction from Average Sales Price (ASP); and (2) H.R. 1416, to eliminate the 2% sequestration cut on costs of the drugs physicians purchase on behalf of CMS.

These three legislative opportunities would go a long way toward the creation of a level playing field for community oncology, and ensure that in the future community cancer care is there for cancer patients when they need it.

**The Honorable Cathy McMorris Rodgers**

1. **In your testimony, you indicated that spending for cancer drugs is rapidly increasing in the hospital outpatient setting compared to the community setting, and you suggest that 340B program is contributing to this shift in care from the community setting.**

   **Are many community –based oncologists choosing to affiliate with hospitals so they can continue to serve their patients in difficult circumstances?**

   **What market forces, irrespective of 340B, are causing oncologists and other physicians to move from individual or small group practices into hospital settings?**

   **Is there any data to suggest that 340B hospitals are buying oncology practices more rapidly than non-340B hospitals?**

Answer:

Congresswoman McMorris Rodgers, there has been a 20% shift in site of outpatient cancer care over six years according to a recent analysis of Medicare data. This shift has had serious effects on patients and on costs. When a community oncology clinic closes or physicians move into a hospital outpatient setting the patient is displaced from their current community clinic and forced to find a nearby hospital outpatient department for care. That patient will have to drive further, take off more time from work, spend more time away from their family, pay more in gas, wait in longer lines at the hospital, run the risk of acquiring more infections at the hospital, pay more in co-pays ($650 more a year per patient according to the 2011 Milliman Study I referenced in my testimony) , and may not get the same personal attention they were receiving in the community clinic. Over time, it will be harder and more expensive for patients to continue their cancer treatment. Additionally, if the site of service shift trend continues and intensifies, hospitals will not have the capacity to handle the influx of cancer patients and access to treatment for Americans fighting cancer will be imperiled.

Right now oncologists all over the country are making difficult decisions regarding their practices and their patients. Depending on each of their situations some will merge/affiliate with a hospital, some will retire, some will eliminate staff, and some will stop seeing new patients or certain types of patients. Our mission as physicians is to take care of our patients, and we take pride in that mission, but when a practice is not sustainable due to the government rules, regulations and reimbursement issues, tough decisions must be made that impact the practice and the patients we serve. The bottom line is that the private practice of community oncology is no longer economically viable unless we receive prompt legislative relief.

While 340B pricing gives hospitals a substantial advantage in drug costs, it is only one of the issues driving physicians into the hospital setting. There are many factors driving this shift including: (1) Medicare doesn't cover the costs of community oncology, and (2) Medicare payments and rules are tilted to advantage the hospital. Low Medicare reimbursements, issues like the prompt pay discount, sequestration cuts to the underlying drug costs, being reimbursed for drugs on the basis of prices two quarters in arrears, and uncollectible beneficiary insurance leave us underwater on most of our Medicare patients. Currently, 50% of the patients I serve are Medicare eligible, which means I am losing money on 50% of my patients.

At the same time hospital outpatient departments receive anywhere from 50% to 300% more in reimbursement from Medicare and private payers for the same outpatient services, hospitals get reimbursed by Medicare for uncollectible coinsurance, and a third of hospitals with 340B pricing are able to buy cancer drugs at a 30-50% discount. For example, a dose of Rituxan can cost Texas Oncology, which is my practice, $10,000. On the other hand, 340B hospitals can buy this drug for $5000 and get reimbursed more than $10,000 by CMS.

Our observation is that over the past several years approximately 70% of the hospitals that have acquired community oncology practices are 340B hospitals, including all of the oncology practice acquisitions in Washington State over the past few years. This trend and the 340B hospital drug margin contributes to the decrease in cancer patient access to care and the increase in the overall cost of cancer care for Medicare, taxpayers, payers and patients alike.