



# The US Oncology Network

June 25, 2014

The Honorable Joseph R. Pitts  
Chairman  
Energy and Commerce Subcommittee on Health  
2125 Rayburn House Office Building  
Washington, DC 20515

Dear Chairman Pitts,

Thank you again for the opportunity to testify in the Energy and Commerce Subcommittee Hearing on “Keeping the Promise: Site of Service Medicare Payment Reforms” on May 21, 2014. I have attached my responses to the questions submitted for the record from the hearing.

If you have any questions or concerns please do not hesitate to contact me. Thanks again.

Sincerely,



Barry Brooks, MD  
Chairman of the Pharmacy and Therapeutics Committee  
The US Oncology Network

Dr. Barry Brooks Response to Questions  
Energy and Commerce Subcommittee on Health Hearing  
“Keeping the Promise: Site of Service Medicare Payment Reforms”  
May 21, 2014

**The Honorable Gus Bilirakis**

- 1) I hear from oncologists in my district and other parts of Florida who are struggling due to the lack of payment parity with hospitals and continued sequester payment cuts to cancer drugs. I am very concerned that the consolidation of cancer care is driving up costs for Medicare and what this means for seniors on fixed incomes. A recent report by the Institute for Healthcare Informatics states, “sites of care that increase patient contribution and cost sharing may actually lead to a significant increase in the total cost of care.” Stakeholders are questioning the sustainability of the rapid growth among hospital outpatient facility settings for oncology drug administration. How can we preserve choices so that our seniors have options when seeking treatment?**

To ensure patient choice in cancer treatment it is essential that Congress alleviate some of the pressures on community oncologists. Currently, there are several hospital based incentives that are driving the acceleration of hospitals purchasing struggling community oncology offices. Right now hospital outpatient departments receive double the reimbursement for the exact same services than the physician setting, many receive large 340B discounts on expensive cancer drugs, hospitals can write off or get reimbursed by Medicare for their uncollected coinsurance and a large number of hospitals are currently exempt from state and federal taxes. These advantages that the hospitals enjoy create an unlevel playing field that limit the economic viability of community oncology and make it difficult to even keep their doors open to patients.

Congress has introduced several ideas to help alleviate the pressure on community physicians as well as level the playing field in the outpatient setting. Congressmen Ed Whitfield and Gene Green have introduced H.R. 800 to remove the prompt pay discount from the physicians Medicare reimbursement. This is a discount between a manufacturer and distributor that is not passed on to the provider. Removal of this discount would ensure proper reimbursement for a drug that the physician has already purchased.

Congresswoman Renee Ellmers has introduced H.R. 1416, which would remove the sequester cut from the full reimbursement on cancer drugs. Physicians actually took a 27% cut to their reimbursement when CMS decided to apply the 2% sequester cut on the full ASP+6% instead of the 6% that is the actual reimbursement to the doctors (resulting in ASP +4.3%). As cancer providers we understand the need to save money in the health care system, but cancer providers are taking a much larger hit on the drug side of sequester than providers in other professions.

Most importantly, Representative Mike Rogers and Doris Matsui introduced H.R. 2869 to level the playing field and provide a uniformed payment for cancer services in the

outpatient setting. According to the same IMS Institute for Healthcare Informatics (IMS Inst.) study<sup>1</sup> you reference in your question, of the 10 most common chemotherapy treatments hospital outpatient departments charged 189% more than the same infusions would cost in the physician setting. H.R 2869 would provide equal payments for the same service regardless of outpatient setting.

Building subsidies into HOPD payments for cancer care services to cover hospitals' indirect expenses associated with standby services does not appropriately target the added resources to those services. It also distorts pricing for outpatient cancer services that require the same level of resource commitment regardless of the site of care. Such subsidies in combination with other site-specific Part B drug payment and policy issues have been major contributors to the rapid increase in hospital employment of physicians in general, and oncologists in particular. By breaking down some of the barriers in the cancer care delivery system and passing the three above mentioned bills, I believe Congress would go a long way to ensure choice and access to our nation's seniors struggling with cancer.

**2) In your testimony, you mentioned that hospitals receive Medicare payments to offset bad debt from non-payment, but that physician offices do not receive payments. How much bad debt do you deal with and how does that affect your business?**

It is rare for physician practices to be able to collect the entire Medicare allowable rate for Part B drugs and services because of the 20% coinsurance obligation facing beneficiaries, often for very expensive therapies. The experience of the US Oncology Network has been that approximately 25% of the coinsurance amounts (approximately 5% of the Medicare allowable) due to practices are uncollectible and end up as a direct expense of the practice. HOPDs offering cancer care services likely experience similar collection issues, but a significant portion of their incurred bad debt is reimbursed by Medicare. Physician practices receive no such relief; rather, they must shoulder the entire burden of bad debt when Medicare beneficiaries are unable to pay, or to pay in full, their Part B deductible and cost-sharing obligations.

**3) If a community oncology practice is acquired by a hospital, they can reopen the same facility as a Hospital Out-Patient Department. A patient could go to the same facility, see the same physicians, use the same equipment for the same treatment, but receive a different bill – increased bill – from the center. This could be a significant sticker shock for the beneficiary. Would you talk about how much of an increase in cost the beneficiary could see?**

Unfortunately, the scenario you are portraying is happening all over the country. A large percentage of physician's offices that are acquired by the hospitals face this very problem. The May 2014 IMS Inst. report calculated that for commonly used cancer drugs, the average increased cost to the patient is \$134 per dose if received in a hospital outpatient setting rather than in an oncologist's office. And patients frequently receive multiple therapies at once which would result in a significant increase in financial burden to the patient.

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<sup>1</sup> IMS Institute for Healthcare Informatics, *Innovation in Cancer Care and Implications for Health Systems: Global Oncology Trend Report* (May 6,2014)

As far as sticker shock, a new Berkley Research Group study<sup>2</sup> titled, “Impact on Medicare Payments of Shift in Site of Care for Chemotherapy Administration,” estimates that Medicare payments were \$23.29 million higher between 2009 and 2012 for the services delivered in the hospital outpatient departments due to hospital acquisition of community cancer practices. Patient costs were also found to be significantly higher, with Medicare beneficiaries paying an additional \$4.05 million in out-of-pocket costs during that same timeframe. Researchers at BRG also examined the expansion of the delivery of oncology services by 340B hospitals in recent years through the acquisition of community cancer practices. The study found that of the 340B hospitals they identified as acquiring a community cancer practice between 2009 and 2012, Medicare and Medicare beneficiary payments on chemotherapy claims increased by an estimated \$167.28 million.

A 2011 Milliman study finds that the cost of treating cancer patients is significantly lower for both Medicare patients and the Medicare program when performed in community clinics as compared to the same treatment in the hospital setting.<sup>3</sup> The study shows HOPD-based chemotherapy costs Medicare \$6,500 more per beneficiary (over \$623 million) and seniors \$650 more in out-of-pocket spending per patient annually.

Alarming, the IMS Inst. report also mentions that patients who face higher out-of-pocket costs are more likely to drop out of treatment, citing a study showing that a bump of as little as \$30 in co-pays caused some breast cancer patients to skip or discontinue care.

So when a hospital acquires a physician’s office and just changes the name on the door, patients see a drastic shift in their medical bills which in turn could discourage the patient from even seeking cancer care services. Congress should act quickly to discourage such practices and encourage a level playing field between the two settings of care.

### **The Honorable Gene Green**

**1) My understanding is that we are talking about whether there is a need for site neutrality as it relates to payment for the administration of cancer drugs, not payment for the cost of drugs themselves. Is it not true that Medicare pays hospitals and private practices the same rate for the cost of their drugs? Given that the 340B program is about discounts on the cost of drugs, and not payment for the administrations of drugs, it seems to me that this program would have nothing to do with site neutrality.**

**Do you have any evidence that 340B hospitals are buying up community-based oncology practices at any greater rate than non 340B hospitals? How much uncompensated care does the average community-based oncology practice provide as compared to the average 340B hospital?**

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<sup>2</sup> 2014 Berkley Research Group Study “Impact on Medicare Payments of Shift in Site of Care for Chemotherapy Administration,” June 2014

<sup>3</sup> K. Fitch and B. Pyenson, Milliman Client Report, *Site of Service Cost Differences for Medicare Patients Receiving Chemotherapy* (Oct. 19, 2011), available

It is correct that the Medicare pays hospitals and private practices the same rate for the *acquisition* cost of oncology drugs (Average Sales Price plus 6%). As I mention in my testimony, hospital outpatient departments are paid substantially higher rates compared to private practices for the *administration* of these drugs, which leads to substantially higher payments incurred by the Medicare program, the Medicare beneficiaries, and the American taxpayer. In fact, according to a June 2014 Berkley Research Group Study “Impact on Medicare Payments of Shift in Site of Care for Chemotherapy Administration,”<sup>4</sup> of the eighty-six 340B hospitals that acquired a physician’s office between 2009-2011 it is estimated that the Medicare program paid \$23.29 million and Medicare beneficiaries paid \$4.05 million more than they otherwise would have had the services been performed in the physicians’ offices.

In addition to these code and service specific payment differentials outlined by MedPAC in their site-neutral policy recommendations to Congress in the June 2013 Report<sup>5</sup> to the Congress, hospitals enjoy other advantages relative to government policies around Medicare Part B drugs that push more patients and physicians into that setting. I mentioned the 340B program in my testimony because it is one of the primary compounding factors that results in an unlevel playing field within outpatient cancer care and most certainly has contributed to the dramatic increase in the acquisition of community based cancer clinics by hospitals.

Approximately one-third of US hospitals purchase chemotherapy drugs through the 340B program at discounts of up to 50%, typically more than 30% below the Medicare reimbursement rate in the physician setting. For 340B hospitals, the margin on Medicare drugs is over 30%, while the community clinics margin is zero to negative 2%. For evidence of the effect the 340B program has had on community based oncology clinics I reference the April 2014 Berkley Research Group Study titled, “340B Covered Entity Acquisitions of Physician-based Oncology Practices.”<sup>6</sup> The studies key findings include:

- Acquisitions of physician-based oncology practices by 340B covered entities increased significantly over the 2009-2012 time period included in the study; and more recent data indicates this trend continued in 2013.
- The average volume of oncology-related 340B chargebacks at covered entities that acquired a physician-based oncology practice (“Acquiring Covered Entities”) was comparable to those entities that did not acquire a physician-based oncology practice (“Non-Acquiring Covered Entities”) in 2009, but grew to be three times greater than Non-Acquiring Covered Entities by 2012. The vast majority of this growth is attributable to 340B purchases by the acquired physician-based oncology practices (“Acquired Sites”).

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<sup>4</sup> 2014 Berkley Research Group Study “Impact on Medicare Payments of Shift in Site of Care for Chemotherapy Administration,” June 2014

<sup>5</sup> MedPAC, Health Care and the Health Care Delivery System, Chapter 2, *Medicare payment differences across ambulatory settings* (June 2013).

<sup>6</sup> Berkley Research Group Study titled, “340B Covered Entity Acquisitions of Physician-based Oncology Practices”, April 2014

- The amount of average yearly 340B chargebacks included in this study did not appear to correlate with the volume of charity care provided by the Acquiring Covered Entity. Indeed, 45% of the covered entities included in the study generated more oncology-related chargebacks than they reported in total charity care costs for the same fiscal year, thereby recouping more than their self-reported total charity care costs with just the chargebacks obtained on this subset of oncology products. This disparity would be even greater had the study examined chargebacks obtained across the hospitals' entire 340B purchases.
- The majority of the Acquired Sites reviewed in the study (83 of 144) were located in communities with higher median-incomes than that of the Acquiring Covered Entity, while only 14 Acquired Sites were located in communities with a lower medium income than that of the Acquiring Covered Entity.

The Community Oncology Alliance has been tracking the closure, consolidation and reported financial problems of community cancer clinics for a number of years. According to a report published in June 2013, 70% of the 407 oncology physician practices that affiliated with hospitals in the previous 3 years did so with 340B covered entities, even though only a third of all hospitals in the nation participate in 340B.

With respect to uncompensated care, the experience of The US Oncology Network has been that approximately 25% of the coinsurance amounts (approximately 5% of the Medicare allowable) owed to practices are uncollectible and end up as a direct expense to the practice. HOPDs offering cancer care services likely experience similar collection issues, but a significant portion of their incurred bad debt is reimbursed by Medicare. Physician practices receive no such relief; rather, they must shoulder the entire burden of bad debt when Medicare beneficiaries are unable to pay, or to pay in full, their Part B deductible and cost-sharing obligations.