



Submitted Testimony of Dr. Barry Brooks on
Keeping the Promise: Site of Service Medicare Payment Reforms
Energy and Commerce Health Subcommittee Hearing
May 21, 2014

Chairman Pitts and Ranking Member Pallone, thank you for the opportunity to testify today on behalf of The US Oncology Network¹ before the Energy and Commerce Subcommittee on Health on *the Medicare Patient Access to Cancer Treatment Act*, H.R. 2869, sponsored by Congressman Mike Rogers and Congresswoman Doris Matsui. Members of the Health Subcommittee have been especially committed to the nation's cancer patients and care providers over the years and many of the Members on this Committee can take credit for policies that have shaped our world-class cancer care delivery system. Thanks for your dedication and support for Americans and their families fighting cancer and for those of us who work to help patients live longer, happier, better lives.

I'm honored to be appearing before the Committee again. My name is Barry Brooks, and for the last 32 years I have spent the majority of my time taking care of cancer patients as a practicing oncologist. On an average day I work 12 hours and treat around 14-20 patients, in addition to the

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. For more information, visit www.usoncology.com.

significant administrative duties that come along with taking a leadership role in my practice and The US Oncology Network. Slightly over 40 percent of my patients rely on Medicare and another 5-10 percent are either covered by Medicaid or are uninsured, but throughout the country over 60% of cancer patients rely on Medicare. Many seniors fighting cancer have more complex cases with co-morbidities and many also face difficulties navigating their care. Fortunately, community oncology clinics such as the one where I practice expand access for them with high-quality, state-of-the-art care close to home with lower co-insurance and other costs. So I am proud to be a small part of the most effective and successful cancer care delivery system in the world. And finally, after nearly 100 years of increasing cancer death rates in the United States, we have started to turn the corner in this fight: cancer mortality has fallen by 20 percent from a 1991 peak and cancer patients from around the world seek care here because Americans enjoy the best cancer survival rates in the world.

Despite significant progress in treatment and survival rates you all know that we still have a long way to go in beating this disease. The American Cancer Society estimates that in 2014 nearly 1.7 million Americans will be diagnosed with cancer and more than 585,000 will die of cancer, which is 1 out of every 4 deaths in America.

One of the main reasons cancer care works so well in America is the existence of a network of community based cancer clinics that provide patients with convenient, comprehensive, state-of-the-art cancer treatment close to home. Just a decade ago more than 85 percent of cancer patients were receiving their cancer treatment in community cancer clinics. However, in recent years we have seen a sharp decline in the availability of community based cancer care, leaving

cancer patients with fewer options and higher medical bills. Unfortunately, the crisis in community based cancer care has continued to worsen in the short time since I last spoke before the Committee.

I will use my time with you today to discuss why the nationwide network of community based cancer clinics are under so much strain and, more importantly, to explain how H.R. 2869 is an important first step to relieve this pressure in a way that is beneficial to patients, to care providers, and taxpayers.

I want to preface this by saying that every oncologist nationwide, regardless of where they practice medicine, will tell you that hospitals play a critical role in cancer care delivery, inpatient and outpatient. Each of us wants and expects quality acute care to be available at hospitals when we need it. Nor do I fault the many community oncologists throughout the country who have been forced to accept employment or other arrangements in hospital-based programs. It is not easy to run a vibrant independent practice these days with government-imposed hospital advantages and referral sources often owned by the hospitals as well. My testimony is not intended to diminish their choices or the value of the services they provide. Instead, I want to highlight the predictable, and unfortunately now realized, access and cost consequences to patients and the health system of an environment that financially favors hospital-based outpatient cancer care over the same quality care provided in community cancer clinics. Policymakers need not allow the continued destruction of the community cancer care patients need and prefer in order to continue to support hospital-based care. This unlevel playing field should be adjusted

by those who support patient choice and access to affordable, quality care so that patients have options among provider settings and locations.

Site of Service Shift over Recent Years

In 2005, over 87 percent of U.S. cancer patients received treatment in their preferred community clinic setting. By 2011, that number was less than 65 percent and today it is likely less than 60 percent. Over the past several years, the country has experienced a significant shift of outpatient cancer care delivery from the community to the hospital outpatient department (HOPD).

Unfortunately, the data are clear: our world-class community cancer care delivery system is struggling to survive. Since 2008, 1,338 community cancer care centers have closed, consolidated, or reported financial problems; 288 oncology office locations have closed, 407 practices merged or were acquired by a corporate entity other than a hospital, and 469 oncology groups have entered into an employment or professional services agreement with a hospital.²

Also by 2011, a third of Medicare's outpatient chemotherapy and anti-cancer drugs had moved to the hospital setting, a more than 150 percent increase for HOPDs. As a result, Medicare spending on payments for chemotherapy administration services in HOPDs has more than tripled since 2005, while payments to community cancer clinics have actually decreased by 14.5 percent.³ Sadly, the flight from community oncology did not end in 2011. Since early 2012,

² Community Oncology Alliance Practice Impact Report, June 25, 2013. Online at:

http://www.communityoncology.org/UserFiles/Community_Oncology_Practice_Impact_Report_6-25-13F.pdf

³ Analyses of Chemotherapy Administration Utilization and Chemotherapy Drug Utilization, 2005-2001 for Medicare Fee-for-Service Beneficiaries; The Moran Company (May 2013), available at

<https://media.gractions.com/E5820F8C11F80915AE699A1BD4FA0948B6285786/01655fe9-7f3d-4d9a-80d0-d2f9581673a1.pdf>

there has been a 20 percent increase in clinic closings and hospital acquisitions, which means increasingly more patients are facing reduced access and more expensive care.⁴

Year after year, as I watch colleagues being forced – either for financial or competitive reasons – to merge with a hospital, it has become clear that congressional action is necessary to halt the patient access and cost consequences that come along with the shift to hospital-based care. With reduced access to community cancer clinics, not only are patients forced from their preferred treatment setting, forced to drive further and wait longer, they are also charged more for the same service. In many cases, patients see the same physicians, nurses and caregivers in the same offices and sit in the same chairs, but pay significantly more because of the change in ownership and billing from physician practice to hospital outpatient department. In other cases of consolidation, outlying clinics are closed when they are too remote from the hospital facility to qualify for provider-based billing and purchasing, resulting in increased travel and hassle for patients trying to fight their disease. Patients fighting cancer should not bear the brunt of nonsensical policies that distort the health care system.

Differential Costs and Payment Rates across Outpatient Settings

Recent studies show that the shift to hospital outpatient cancer treatment has reduced patient access and increased costs to the Medicare program, taxpayers and patients. A 2011 Milliman study finds that the cost of treating cancer patients is significantly lower for both Medicare

⁴ Community Oncology Alliance Practice Impact Report, June 25, 2013.

patients and the Medicare program when performed in community clinics as compared to the same treatment in the hospital setting.⁵

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. Keep in mind, the median income of Medicare beneficiaries is less than \$23,000. I ask the Committee today, why would we favor a system that requires the nation's most vulnerable to pay more for the exact same service, just in a different, less accessible setting? Put another way, why would we continually subsidize higher overhead costs and impose higher costs to cancer patients while at the same time underfunding the more efficient lower-cost community cancer offices?

Not only are HOPDs charging more for the same service, their spending is higher when caring for patients with the same diagnosis and stage of cancer. A new analysis of 2009-2011 Medicare claims data by The Moran Company indicates that by a variety of metrics, chemotherapy spending is higher at the HOPD than the physician office despite lower unit payment rates for drugs in the OPPS during that period [it is now equal in both settings at ASP+6% or +4.3% after considering the sequester impact]. Patients receive more chemotherapy administration sessions on average when treated in the HOPD—and the dollar value of chemotherapy services used is meaningfully higher in the HOPD. On a per beneficiary basis, HOPD chemotherapy spending was 25 to 47 percent higher than physician office chemotherapy spending across the 2009-2011

⁵ K. Fitch and B. Pyenson, Milliman Client Report, Site of Service Cost Differences for Medicare Patients Receiving Chemotherapy (Oct. 19, 2011), available

period and HOPD chemotherapy administration spending was 42 to 68 percent higher than physician office chemotherapy administration spending.⁶

In the face of this trend, the Centers for Medicare and Medicaid Services continued to widen the difference in reimbursement for the same services across outpatient settings this year. The 2014 Medicare Physician Fee Schedule rate for one hour of chemo infusion (96413) by intravenous therapy is \$133.26, but the payment rate for the same service under the 2014 Hospital Outpatient Prospective Payment Schedule (HOPPS) is 125 percent higher at \$299.53.

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 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.

Just this month, the IMS Institute for Healthcare Informatics released a study on innovations and cancer costs in the US. The report shows that Americans are increasingly paying higher prices because more patients are being treated by oncologists whose practices have been bought by hospitals, which may charge double or more for the same treatments. The report's authors calculated prices for 10 common chemotherapy treatments and found hospitals charged 189 percent more on average — or nearly triple — what the same infusions would cost in an

⁶ Cost Differences in Cancer Care Across Settings, The Moran Company, August 2013.

independent doctor's office. The higher charges, which hospitals say are needed to support overhead and administrative costs, can often translate into steeper out-of-pocket costs for insured patients.

The May 2014 IMS 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. Alarming, the 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. These types of discrepancies in reimbursement throughout oncology and other specialties greatly advantage hospital outpatient departments and subsidize their relative inefficiency. And if fighting to complete therapy and survive the disease weren't enough, cancer patients experience a financial toxicity associated with their diagnosis: they are 2.65 times more likely to file for bankruptcy than people without a cancer diagnosis.

MedPAC Recommends Site Neutral Payments

In its June 2013 report, the Medicare Payment Advisory Commission (MedPAC) recommended leveling the playing field for outpatient services, including oncology services. In the report, MedPAC highlighted the large disparities in payment in outpatient settings and noted that the payment variations across settings should be addressed quickly due to the fact that current disparities have created incentives for hospitals to buy physician practices, driving up costs for the Medicare program and for beneficiaries in a manner that cannot be easily reversed later. The report says alignment of outpatient reimbursement makes sense for services that can be

successfully and safely carried out in a physician's office, are infrequently provided in emergency rooms, involve average patient severities that are no greater in the hospital outpatient setting than in freestanding offices, and do not involve significant differences in resources as a result of packaging under the HOPPS.⁷ Most cancer care services fit this description.

The history of successful community-based cancer care establishes that successful, cost-effective outpatient oncology services do not require hospital-based delivery. MedPAC concluded that hospitals should not automatically be paid higher rates for services appropriate for delivery in physician offices simply because hospitals incur higher indirect costs associated with other services that must be provided 24 hours a day and 7 days a week, or provided to patients with higher acuity or additional legal requirements that largely focus on emergency room and inpatient care.⁸

340B Drug Discount Program and Other Hospital Advantages

In addition to these code and service specific payment differentials outlined by MedPAC, hospitals enjoy other advantages relative to government policies around Medicare Part B drugs that push more patients and physicians into that setting. Approximately, one third of US hospitals purchase chemotherapy drugs through the 340B program at discounts of up to 50 percent, typically more than 30 percent below the Medicare reimbursement rate in the physician setting.⁹ For 340B hospitals, the margin on Medicare drugs is over 30 percent, where for community clinics the margin is zero to negative 2 percent. With these high margins, it is no

⁷ MedPAC, Health Care and the Health Care Delivery System, Chapter 2, *Medicare payment differences across ambulatory settings* (June 2013).

⁸ 78 *Fed. Reg.* at 43296.

⁹ OIG Memorandum Report: Payment for Drugs Under the Hospital Outpatient Prospective Payment System OEI-03-09-00420, October 22, 2010. Online at: <http://oig.hhs.gov/oei/reports/oei-03-09-00420.pdf>

wonder that drug spending is increasing so rapidly in the hospital outpatient setting and that care is moving in that direction.

Another long-standing challenge with Medicare payments for Part B drugs and services concerns the patient coinsurance responsibility and other out-of-pocket costs that many seniors are unable to pay. 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 percent coinsurance obligation facing beneficiaries, often for very expensive therapies. The experience of the US Oncology Network has been that approximately 25 percent of the coinsurance amounts (approximately 5 percent 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.

A substantial portion of hospitals also operate without the burden of federal and state taxes. In contrast, community cancer clinics receive no reimbursement for uncompensated care, must pay taxes and must pay the full cost of all the drugs administered to patients, even when they cannot collect the full reimbursement from payers and patients.

Conclusion

The National Cancer Institute estimated that there were approximately 13.7 million Americans living with cancer in the U.S. last year. About 8 million of those are over the age of 65 and approximately half of all cancer spending is associated with Medicare beneficiaries.¹⁰ As the baby boomers continue to reach 65 these numbers will only increase. Now is the time for Congress to act to ensure the future of community based cancer care and stop the site of service shift into more costly hospital outpatient departments.

When clinics close their doors or raise their prices, access to care is compromised for all cancer patients, but especially for vulnerable seniors. This shift to hospital-based care doesn't just reduce access to care for cancer patients, it also increases costs to Medicare, taxpayers and patients. These differences are even greater for care covered by private insurers. There is no clinical justification for migration of outpatient cancer care to the hospital setting. Patients don't want to be in a hospital and there is no practical or clinical advantage for driving care into a more expensive setting.

The US Oncology Network knows the Committee is familiar with this facet of the problem and has supported policies to equalize evaluation and management (E/M) payments across care settings. We strongly support the current bipartisan efforts by Congressman Rogers and Congresswoman Matsui to take an urgent approach to site-neutral payment for oncology services. At a time when access and cost issues are intertwined, we appreciate their collective belief that payment amounts be commensurate with actual services provided, not the site of care. Preferentially paying higher amounts in certain settings will predictably lead to the expansion of

¹⁰ Mariotto AB, et al. Projections of the Cost of Cancer Care in the United States: 2010–2020, J Natl Cancer Inst 2011;103:1–12. Online at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3107566/>

higher cost centers. The result will be further increases in the cost of cancer care for those who pay for it – patients along with private and government payers.

In fact, a strategy I encourage the Committee to explore would be to move toward the creation of a single outpatient fee schedule for all outpatient services regardless of the provider. As hospitals continue to acquire and purchase primary and specialty physicians, the cost of health care services will continue to rise while creating serious access problems nationwide. By removing the incentive for hospitals to purchase physician practices and charge more, physicians and hospitals will be able to compete on a level playing field on the basis of quality and cost, allowing patients to have greater options in their health care delivery system that cost less.

Additionally, I would just like to highlight and thank the several Members of this Committee that have written legislation and signed onto letters that assist in preserving community cancer care. Specifically, H.R. 800, sponsored by Congressmen Whitfield, Green and DeGette and 65 additional co-sponsors, would result in a more accurately aligned Part B drug reimbursement by removing any discount between the manufacturer and distributor that is included in the ASP formula but not passed on to the provider. Over 30 Members of this Committee signed a letter to CMS questioning how the Administration handled the sequestration cuts on Medicare Part B drugs, while Congresswoman Ellmers introduced H.R. 1416 and garnered 112 co-sponsors which would remove the outside impact of the administration's decision to apply the 2 percent sequestration cut to not only the services community oncologists provide, but also the underlying cost of cancer-fighting drugs physicians purchase on behalf of Medicare and administer to seniors. This cut is in effect a 28 percent cut to the payments Medicare makes to community

clinics for handling, storing, mixing and preparing drugs for administration, and in conjunction with the prompt pay discount problem and uncollectible patient coinsurance, makes Medicare Part B drugs at best a break even proposition for community cancer clinics. On behalf of all of the community cancer clinics struggling to keep the doors open, I urge the Committee and the Congress to enact these three pieces of legislation to sustain community oncology. Without your action, cancer clinics will continue to close and care will continue to shift to the more expensive, less accessible hospital outpatient setting. Americans fighting cancer will experience diminished access to care, and patients, payers and taxpayers will pay more.

The primary purpose of a doctor is to relieve suffering. My oncologist colleagues across the country and I are doing our best, but in order to continue to provide the world's best cancer care here in America, we need your help. Once again, thank you again for the opportunity to address the committee. I am happy to answer any questions the committee has regarding my testimony.