

ONE HUNDRED THIRTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
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June 11, 2014

Dr. Reginald W. Coopwood
President and CEO
Regional Medical Center
877 Jefferson Avenue
Memphis, TN 38103

Dear Dr. Coopwood:

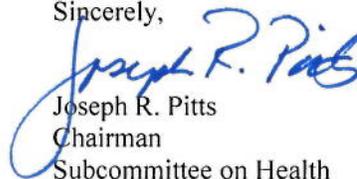
Thank you for appearing before the Subcommittee on Health on Wednesday, May 21, 2014, to testify at the hearing entitled "Keeping the Promise: Site of Service Medicare Payment Reforms."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Wednesday, June 25, 2014. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C., 20515 and emailed in Word format to Sydne.Harwick@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

Attachment—Additional Questions for the Record

The Honorable Joseph R. Pitts

1. Medicare is currently facing insolvency, which would jeopardize care for millions of seniors that depend on the program. What policies or payment reforms would you recommend Congress consider to help keep the promise to seniors by saving Medicare from insolvency?
2. What do you think about the possible savings to beneficiaries if Congress were to combine the A/B cost-sharing and adopt a catastrophic cap? This reform has been recommended by MedPAC, former Sen. Lieberman, and the President's Fiscal Commission.

The Honorable Mike Rogers

1. Can the AHA quantify how many oncology practices have been acquired by a hospital in the last 10 years? How many brought the physicians onto the hospital campus? How many stayed within the existing physician office building?
2. What are the patient advantages from receiving outpatient cancer care in the hospital setting vs. the physician office setting? Why is there such an increase in co-pays? Is there a quality differential?
3. Why are there vast differences between the two site-of-service payments between HOPD's and physician office setting? Why do some codes have a 10% advantage and some have a 400% advantage? Why such a large disparity?
4. How are hospitals responsible for quantifying where the additional payments are being spent? Where is the transparency on the differential of payments in the outpatient setting?
5. Do you believe that Medicare dollars should be spent on Medicare patients? How can Medicare be sure that the additional 126% reimbursement HOPD's receive for the most commonly billed chemotherapy code in the outpatient setting is being used for Medicare patients?
6. Would you speak to a recent link Methodist and Baptist (in Memphis) have with oncology practices resulting in HOPD-based billing and (340B pricing), how has effected overall costs to patients and payers? The below NYT article seems to imply the only benefits in these mergers has been for hospitals, not patients.
<http://www.nytimes.com/2013/02/13/business/dispute-develops-over-340b-discount-drug-program.html?pagewanted=all&r=0>

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 administration of drugs, it seems to me that this program would have nothing to do with site neutrality.

Would you describe how your hospital uses the savings from the 340B program? What would be the implications to your hospital and 340B hospitals in general if the 340B program did not exist or was sharply scaled back? Do you believe that 340B hospitals are using their savings primarily for patient care purposes?