The US Oncology Network

September 27, 2019

VIA ELECTRONIC SUBMISSION THROUGH www.regulations.gov

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1717-P
P.O. Box 8013
Baltimore, MD 21244-1850

Re: Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; etc. (CMS-1717-P)

Dear Administrator Verma:

On behalf of the National Policy Board and physicians of The US Oncology Network (The Network), I thank you for the opportunity to comment on CMS-1717-P "Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; etc. (CMS-1717-P)" (Proposed Rule), as published on August 9, 2019, in the Federal Register.

The Network is committed to working with the Centers for Medicare & Medicaid Services (CMS) to enhance the delivery of cancer care and protect patient access to high-quality care in the most efficient manner. We are one of the nation's largest and most innovative networks of community-based oncology physicians, treating more than 850,000 cancer patients annually in more than 400 locations across 25 states. Community-based oncology centers, like those in The Network, are central to success in the battle against cancer. The Network unites physicians around a common vision of expanding patient access to the highest quality state-of-the-art care close to home, and at lower costs for patients and the health care system as a whole. Our mission is to help patients fight cancer, and win.

Unfortunately, access to community-based practices has declined over the past decade due in part to reimbursement policies and regulations that disadvantage independent physician practices in favor of large, complex healthcare systems. The Network applauds the Administration and CMS' continued efforts to curb consolidation in the healthcare marketplace, promote competition, and improve the viability of private practicing physicians which will lead to lower healthcare costs.

The Network will focus our comments on two specific provisions included in this Proposed Rule:

1. Method to Control Unnecessary Increases in the Volume of Clinic Visit Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs);

2. CY 2020 OPPS Payment Methodology for 340B Purchased Drugs

Method to Control Unnecessary Increases in the Volume of Clinic Visit Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs)

In the CY 2019 OPPS/ASC final rule, CMS finalized a proposal to institute the PFS-equivalent rate for clinic visit services performed at excepted off-campus provider based departments (PBD) to control unnecessary volume increases in the outpatient setting for these services. This policy was to be phased-in over two years, under which one-half of the total 60-percent payment reduction (a 30-percent reduction) was applied in CY 2019. For CY2020, CMS is proposing to apply the total reduction (60-percent) in payment for all clinic visit services performed at off-campus PBDs. The Network strongly supports the site neutral policy which is at the core of this proposal and encourages CMS to finalize implementation of this policy.

For more than a decade, The Network has raised awareness of the negative consequences payment disparity across sites of service has on our nation's healthcare system. Reimbursement policies that pay hospital-owned outpatient facilities higher rates for the exact same services provided in independent physician practices have increased costs to patients, insurers and taxpayers, as well as resulted in marketplace consolidation that limits patient choice by reducing access to care in the community-setting. Data shows that hospital acquisitions of private practices has skyrocketed in recent years - between 2012 and 2018, the number of physician practices employed by hospitals grew by 44,000 practices with 8,000 physician practices acquired from July 2016 to January 2018 alone[1]. Community oncology practices have been hit particularly hard by consolidation. A study in Health Affairs on hospital-physician consolidation found oncology had the highest rate of vertical integration at 54 percent in 2017[2], a substantial increase from an already concerning 20 percent in 2007.

Implementing site neutral payments not only reduces incentives for hospitals to acquire community-based practices, but it also results in lower out-of-pocket costs for patients and reduced costs across the Medicare program. As CMS notes, clinic visits are the most common service billed under the OPPS, and patients and the Medicare program pay more for the exact same service in the hospital outpatient setting than in the physician office. If finalized, this proposal would reduce the average beneficiary cost share for a clinic visit from $23 in 2018 to $9 in 2020. CMS estimates that this policy would save Medicare beneficiaries $160 million in copayments and lead to $650 million in savings to the Medicare program in 2020 alone. We recognize this provision in the CY 2019 OPPS/ASC final rule is currently under litigation. However, the principle of site neutrality is not in question, and The Network continues to strongly support CMS' efforts to enact site neutral payment policies.

Congress recognized the negative impact payment differentials have on the healthcare system when it passed the Bipartisan Budget Act of 2015, which included a site neutral payment provision for all newly acquired and newly built off-campus PBDs. Unfortunately, the majority of existing off-campus PBDs continue to receive the higher OPPS rate, so the payment disparity between PBDs and physician offices persists across the OPPS. The Network encourages CMS to explore additional opportunities to expand site neutral payments for all clinically appropriate outpatient services.

One such opportunity is the proposal in HHS' Blueprint to Lower Drug Costs and Reduce Out-of-Pocket Costs (HHS-OS-2018-0010) to implement site neutral payments for drug administration. The Network

[1] PAI: Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment, 2012-2018; February 2019.

[2] Health Affairs: Hospital-Physician Consolidation Accelerated in the Past Decade in Cardiology, Oncology; July 2018.

commended HHS for the inclusion of the policy, which would remove incentives for provider consolidation and reduce patient cost-sharing, and encourages CMS to consider similar policy for future rulemaking. According to MedPAC, the hospital outpatient setting has had higher growth in program spending than any other sector in Medicare, in part due to the shift of services from (lower cost) physician offices to (higher cost) hospital outpatient departments (HOPDs)[3]. From 2011 to 2016, the volume of OPPS chemotherapy administration increased by 56.1 percent (9.3 percent per year), while chemotherapy administration decreased by 13.4 percent in physician offices. We expect this trend to only continue; the 2019 PFS rate for the most common drug administration code billed by oncology practices (CPT code 96413) is $143, but the rate for the same service under the 2019 OPPS is nearly double the PFS amount, at $288.

The Network encourages CMS to evaluate implementing payment rates in a budget neutral manner by setting payments for cancer drug administration and other outpatient services at a rate that falls between the current higher rate for HOPDs and the lower rate for physician offices. The new consistent rate shared across settings would more appropriately reimburse community cancer clinics, while removing the unfair payment advantage currently awarded to HOPDs, all while maintaining budget neutrality across the Medicare Part B program (if not within a single Part B payment system). We have previously supported legislation that would equalize payment rates for cancer services, including the Medicare Patient Access to Treatment Act of 2015, which would have required changes to payment rates to be budget neutral. When evaluating implementation of site neutral payments in a budget neutral manner, we encourage CMS to ensure patient out-of-pocket costs are not negatively impacted.

CY2020 OPPS Payment Methodology for 340B Purchased Drugs

CMS is proposing to continue paying ASP-22.5 percent for 340B-acquired drugs including when furnished in nonexcepted off-campus PBDs paid under the PFS. The Network commends CMS for continuing to evaluate and address the growth of the 340B drug discount program in an effort to lower out-of-pocket costs for patients, stem consolidation and preserve patient access to community-based care.

The Network supports the underlying goal of the 340B drug discount program which is largely aimed at stretching scarce federal resources to benefit indigent patients in critical access areas. However, we believe the program's recent growth may be contributing to further consolidation of community oncology practices. Based on an internal study from the Community Oncology Alliance[4], it is estimated that roughly 658 community cancer practices have been acquired by or affiliated with hospitals since 2008, with a significant portion of those transactions believed to be leveraged with 340B benefits. This has resulted in a shift in the site of service for chemotherapy administration from the physician-office setting to other, more-costly outpatient settings.

In fact, 10 years ago over 80 percent of cancer care was delivered in the community-based setting – today that number is closer to 50 percent[5]. This trend not only creates patient access issues, but often results in

[3] March 2018 MedPAC Report to the Congress. Full Report available at: http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf?sfvrsn=0

[4] 2018 Community Oncology Alliance, Practice Impact Report. Full Report available at: https://www.communityoncology.org/downloads/pir/COA-Practice-Impact-Report-2018-FINAL.pdf

[5] Milliman Report, April 2016: Cost Drivers of Cancer Care: A Retrospective Analysis of Medicare and Commercially Insured Population Claim Data 2004-2014

higher healthcare and patient out-of-pocket costs. The Network is committed to ensuring all cancer patients receive high quality, clinically appropriate care. We firmly believe in the value of community-based providers, who are at the front line of care delivery, providing local solutions to meet the needs of their patients.

For policymakers and regulators to properly assess the scope and value of the 340B program, The Network supports increased transparency through public reporting on meaningful data that provides additional clarity on a covered entity's patient mix, savings associated with enrollment, revenue associated with 340B-eligible outpatient drugs/services and charity care or patient services underwritten by 340B proceeds. We also encourage consideration of separate detailed reporting of these transparency measures for off-campus outpatient facilities to ensure accurate savings and revenue data is understood for child sites that may have a different patient profile than that of the covered entity. As such, we also encourage CMS to publicly post data resulting from the application of the "JG" modifier so that researchers and others can review.

This data is an essential component for informed oversight and will provide an opportunity for eligible entities to demonstrate how they are using funds derived from the program to benefit patient care. To ensure overall program integrity, operability and proper analysis of the data submitted, the Health Resources and Services Administration (HRSA) needs the tools to sufficiently administer and refine the program.

Conclusion

On behalf of the National Policy Board of The US Oncology Network and our more than 10,000 oncology physicians, nurses, clinicians, and cancer care specialists nationwide, we thank you for the opportunity to provide our comments on Proposed Rule CMS-1717-P. We welcome the opportunity to discuss the issues outlined above and other critical issues impacting community cancer care with you and your staff. Should you have any questions, please contact Ben Jones, Vice President of Government Relations and Public Policy, at Ben.Jones@usoncology.com.

Sincerely,

Marcus Neubauer, M.D.
Chief Medical Officer
The US Oncology Network