February 15, 2022

The Honorable Kevin Hern
U.S. House of Representatives
1019 Longworth House Office Building
Washington, D.C. 20515

The Honorable Rick Allen
U.S. House of Representatives
570 Cannon House Office Building
Washington, D.C. 20515

The Honorable Victoria Spartz
U.S. House of Representatives
1523 Longworth House Office Building
Washington, D.C. 20515

Dear Representatives Hern, Allen, and Spartz,

On behalf of The US Oncology Network (The Network), which represents more than 10,000 oncology physicians, nurses, clinicians, and cancer care specialists nationwide, thank you for the opportunity to provide comments to the Healthy Future Task Force Affordability Subcommittee.

The Network, based in The Woodlands, TX is one of the nation's largest and most innovative networks of community-based oncology physicians, treating more than 1.2 million cancer patients annually in more than 450 locations across 25 states. The Network unites over 1,400 like-minded 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. We share the goals of the Subcommittee to "increase price transparency, lower barriers to competition, and empower consumers to have more choice in their healthcare providers."

In response to the Subcommittee's request for information, The Network would like to provide comment on increasing competition and identifying anti-competitive consolidation. Our comments speak specifically to the importance of site-neutral payment policies and 340B Drug Discount Program reform. Addressing both of these issues will greatly improve healthcare affordability for American consumers.

Site-Neutral Payment Reform

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. We supported the 2018 final rule equalizing Medicare payment rates for clinic visit services performed at off-campus hospital outpatient departments (HOPDs) and independent physician offices to control unnecessary volume increases in the outpatient setting. For these reasons, we share the Subcommittee's interest in expanding site neutral payment policies further.

Medicare payment differentials for identical services provided in HOPDs and independent physician offices have been well documented. According to the most recent CMS payment rules, chemotherapy administration is reimbursed $326 in the HOPD setting and only $140 in the physician office setting. Similar trends exist among other commonly billed services, such as cardiac imaging and colonoscopy services.[1] Another recent

[1] http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/021919-Avalere-PAI-Physician-Employment-Trends-Study-2018-Update.pdf?ver=2019-02-19-162735-117

study found that hospital-integrated physicians would receive $114,000 more in annual Medicare reimbursements for outpatient services compared to non-integrated physicians.[2] According to the *Health Savers Initiative,* Medicare could save nearly $2.8 billion in imaging services and nearly $1 billion in drug administration services by shifting to site neutral payments for all HOPDs.[3] Over 10 years, they find Medicare spending could be reduced by more than $150 billion and beneficiary premiums and cost-sharing could be reduced by nearly $100 billion by transitioning to site neutral payments for all HOPDs.[4]

These disparities not only increase costs to Medicare, but also to patients. Over a three-year period, Medicare paid 27% more ($2.7 billion) and patients spent 21% more ($411 million) for specific cardiology, orthopedic, and gastroenterology services provided in the HOPD setting rather than the community setting.[5] The Network strongly believes that patients and Medicare should be paying the same amount for the same service.

Site of service payment differentials do not just exist in Medicare. According to a 2019 analysis by the *Health Care Cost Institute,* the average price for a given service was always higher when performed in the HOPD setting and average prices rose faster in the outpatient setting compared to the physician office setting. For example:

- The average price for a level 3 diagnostic and screening ultrasound visit increased 4% in office settings from 2009 to 2017, from $233 to $241, and 14% in outpatient settings, from $568 to $650.
- The average price for a level 5 drug administration visit increased 15% in office settings from 2009 to 2017, from $220 to $254, and 57% in outpatient settings, from $423 to $664.
- The average price for a level 4 endoscopy upper airway visit increased 14% in office settings from 2009 to 2017, from $463 to $527, and 73% in outpatient settings, from $1,552 to $2,679.

As the Subcommittee recognizes, this is one of the driving forces of healthcare provider consolidation, resulting in reduced patient access to community-based care (see oncology-specific acquisition trends below). Unfortunately, HOPD growth is only expected to grow, outpacing the growth of independent physician practices. According to Congressional Budget Office projections, Medicare hospital outpatient payments will grow by 100% over the next decade; by comparison, physician fee schedule payments are only expected to grow by 31%.[6] These projections come on the heels of years of modest reimbursement increases to physicians as hospital outpatient reimbursements have skyrocketed.

For these reasons, The Network shares the recommendations of the Alliance for Site Neutral Payment Reform as the Subcommittee considers ways to expand site neutral payment policies, including:

- *Expanding site neutral payments to all clinically appropriate outpatient services*. The FY2020 President's Budget called for expanding site neutral payments for all off-campus hospital-owned physician practices. This policy was projected to save approximately $28.7 billion over 10 years.
- *Extending site neutral payments for Part B drug administration*. More narrowly targeted than the above provision, this policy would immediately reduce out-of-pocket prescription drug costs for seniors because Medicare beneficiary cost-sharing is directly related to the Medicare payment rate for the drug and the administration of the drug. This policy is included in H.R. 19, the Lower Costs, More Cures Act of 2021.
- *Improving Medicare site-of-service transparency*. Modify the Medicare Outpatient Procedure Price Lookup tool to include information for services furnished in a physician office. This will empower patients to better understand the variations in cost by site of care and the impact on their out-of-pocket costs. This policy is also included in H.R. 19, the Lower Costs, More Cures Act of 2021.

[2] https://onlinelibrary.wiley.com/doi/epdf/10.1111/1475-6773.13613
[3] https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care
[4] Id.
[5] http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI_Medicare%20Cost%20Analysis%20--%20FINAL%2011_9_17.pdf
[6] https://www.cbo.gov/system/files/2020-03/51302-2020-03-medicare.pdf

As the Subcommittee considers site neutral payment reforms, we also would like to highlight that, according to the American Medical Association, Medicare physician pay has actually fallen by 20% over the last 20 years when adjusting for inflation in practice costs.[7] Considering physician payments are frozen indefinitely under current law and subject to the 2% Medicare sequester, while HOPDs are projected to receive another 2% payment increase in 2023, it is clear this payment disparity will only encourage further consolidation.[8] The Network encourages the Subcommittee to evaluate payment parity policies that set reimbursement for cancer drug administration and other cancer care services at a rate that falls between the current higher OPPS rate and the lower rate for physician offices. A new consistent rate shared across settings would support access to community cancer clinics, while removing the unfair payment advantage currently awarded to off-campus HOPDs, while still yielding savings for patients and Medicare.

340B Drug Discount Program Reform

While The Network supports the underlying goal of the 340B drug discount program, we believe the unrestrained growth of the program and the notable lack of transparency has been a contributing factor to the consolidation of community oncology practices by hospitals. This disturbing trend results in reduced patient access to care in the lower cost physician-office setting. The Network is encouraged that the Subcommittee is looking at reforms to the 340B Program and exploring opportunities to address the impact that the program could be having on consolidation.

The intent of the 340B Program is laudable: to stretch scarce federal resources to benefit indigent patients in critical access areas. However, due to legislative and regulatory changes and ambiguities over the past several years, the Program has seen a sharp increase in the number of covered entities, mostly hospitals, participating, from 583 in 2005 to approximately 2,500 in 2020.[9] Based on a report from the Community Oncology Alliance,[10] it is estimated that roughly 722 community cancer practices have been acquired by or affiliated with hospitals since 2008. 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. Less than 15 years ago, more than 80% of cancer care was delivered in the community-based setting – today that number is about 50%.

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.

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.

As oncologists caring for a significant portion of our nation's cancer patients, we again emphasize our support of the 340B Program's original intent, but express concern that the program has grown beyond its original scope and become another example of the unlevel playing field that disadvantages independent physician practices and incentivizes hospital consolidation. The Network appreciates the Subcommittee for

[7] https://www.ama-assn.org/system/files/medicare-pay-chart-2021.pdf
[8] https://www.medpac.gov/wp-content/uploads/2021/09/Hospital-update-MedPAC-Dec-2021.pdf
[9] https://www.gao.gov/assets/gao-21-107.pdf
[10] https://communityoncology.org/2020-community-oncology-alliance-practice-impact-report/

examining the growth of the 340B Program in an effort to lower healthcare costs for patients, stem consolidation and preserve patient access to community-based healthcare providers.

Conclusion

Thank you for the opportunity to comment on these important issues. We welcome the opportunity to discuss them with you or your staff in more detail. 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, MD
Chief Medical Officer
The US Oncology Network