October 5, 2023

The Honorable Jason Smith
Chairman
Committee on Ways and Means
1139 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Smith,

On behalf of The US Oncology Network (The Network), which represents over 15,000 oncology physicians, nurses, clinicians, and cancer care specialists nationwide, thank you for the opportunity to provide feedback on ways to improve access to care in rural America. The Network is one of the nation's largest and most innovative networks of independent, community-based oncology physicians, uniting over 2,300 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.

Network practices treat over 1.2 million cancer patients annually in more than 500 locations across 29 states. Practices in The Network offer truly integrated cancer care by providing a comprehensive range of services all under one roof. These services include chemotherapy and biological therapy, hormonal therapy, immunotherapy, radiation therapy, advanced diagnostic and laboratory services, clinical research, support services like nutrition or financial counseling, and medically-integrated dispensing. Patients respond best to treatment when they receive integrated care close to home, where they have the support of family and friends and can maintain their daily routines throughout the treatment process. As a result, the community cancer model is focused on serving patients where they live and work, so they don't have to travel long distances to receive high-quality treatment.

The Network is also a worldwide leader in research, offering our patients access to the latest cancer clinical trials close to home through one of the largest clinical research networks, US Oncology Research. The Network, through US Oncology Research, has contributed to the approval of more than 100 FDA-approved therapies since its inception. We have enrolled more than 88,000 patients in clinical trials with approximately 500 active trials across ten disease states at any given time. Patient access to these novel clinical trials is usually limited to major academic centers and urban hospital systems, but we work to provide clinical research in community-based cancer clinics to ensure our patients have access to new and novel therapies. The Network is proud to offer access to clinical trials at more than 160 sites across the country, and our participation in these efforts accelerates the progress of modern cancer therapy. In 2022, The Network formed a joint venture with the Sarah Cannon Research Institute to further expand access to clinical trials in the community setting.

<u>Sustainable Provider Financing</u>
The Centers for Medicare and Medicaid Services (CMS) is proposing an additional -3.3% across-the-board reduction in Medicare reimbursement under the Physician Fee Schedule (PFS) in 2024, the fourth straight year of cuts to physician payment. While Congress has thankfully passed legislation to help mitigate these proposed cuts, inflation and practice expenses have continued to rise. The cost of staffing and interest rates continue to grow. According to the American Medical Association, when adjusting for the full impact of inflation on practice costs, Medicare physician payment has declined by 26% from 2001 to 2023.

Medicare's failure to ensure physician payments keep pace with inflation, combined with year-over-year cuts, contributes to market consolidation and the reduction in independently practicing physicians. According to the

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Physicians Advocacy Institute,[1] hospitals acquired nearly 5,000 physician practices (58,000 individual physicians) from just 2019-2021, resulting in an 11% increase in the percentage of hospital-employed physicians. Oncology has been especially affected by consolidation pressures; since 2008, over 400 clinics have closed and more than 700 practices have been acquired by hospitals.[2] To reverse this trend and preserve patient access, especially in rural and underserved areas, Congress must prioritize investment in the Medicare physician payment system. The Network supports H.R.2474, the Strengthening Medicare for Patients and Providers Act, which would provide an annual Medicare physician payment update that is tied to inflation. This is an important first step toward much-needed long-term physician payment reform.

Aligning Sites of Service

As Medicare reimbursement for independent physicians is declining, Medicare payment rates for facilities paid on the Hospital Outpatient Prospective Payment System (OPPS) continue to increase. For CY 2024, CMS is proposing to increase OPPS payments by 2.8%. According to our internal analysis of the CY 2024 proposed rules, this translates to Medicare paying, on average, 52% more for the exact same radiation oncology services provided in the hospital outpatient setting compared to those provided in the physician office setting. Medical oncology has an even greater disparity, with OPPS rates for drug administration 151% higher when provided in the hospital outpatient setting. This growing disparity is simply unsustainable and incentivizes hospitals to acquire community cancer practices, forcing patients to receive care in a more expensive setting. This increases costs to patients and to the Medicare system.

Network practices, like Missouri Cancer Associates, Cancer Center of Kansas, and Texas Oncology, are committed to providing access to care in rural areas and work to identify creative solutions to the provider shortage challenge. For example, several of our practices operate satellite clinics that are open for only a few days a week or a few hours a month. This ensures cancer patients can see their oncologist regularly without having to travel long distances. These sites are often the only option for cancer treatment close to home for patients in very rural areas. Unfortunately, these sites are often the first to close when hospitals acquire a community cancer practice, as hospitals view them as unprofitable.[3]

The Network appreciates the Committee's efforts this Congress to bring attention to the harmful effects of consolidation and supports Section 203 of H.R. 5378, the Lower Costs, More Transparency Act, which would require site neutral payments for drug administration services. We believe the Committee can and should go further to level the playing field across sites of service. To that end, we support H.R. 4473, the Medicare Patient Access to Cancer Treatment Act, by Rep. Jodey Arrington, which would require payment parity for outpatient cancer services.

Considering physician payments are frozen indefinitely under current law and subject to the 2% Medicare sequester (before CMS makes any policy changes with budget neutral requirements that further reduce reimbursement), it is clear more needs to be done to protect the viability of independent practices. The Network encourages the Committee to consider payment parity policies that set reimbursement at a rate that falls between the current higher OPPS rate and the lower PFS rate. A new consistent rate shared across settings would support access to community clinics, while removing the unfair payment advantage currently awarded to hospital-owned facilities, while still yielding considerable savings for patients and Medicare.

Innovative Care Models

The Network has long been an avid proponent of value-based care because it motivates better quality, outcomes, and patient experience at a sustainable cost. Physicians in The Network represented approximately

[1] physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI Avalere Physician Employment Trends Study 2019-21 Final.pdf
[2] https://mycoa.communityoncology.org/education-publications/practice-impact-reports/2020-community-oncology-alliance-practice-impact-report
[3] https://legislink.com/dr-ralph-heaven-pens-op-ed-on-need-for-site-neutral-payments-in-cancer-care/

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25% of physicians in the Oncology Care Model (OCM), a voluntary alternative payment model (APM) from the Center for Medicare and Medicaid Innovation (CMMI) running from 2016-2021. The OCM required participating practices to manage all aspects of a cancer patient's care delivery (including prescription drugs and emergency department visits) for a 6-month episode. Over the duration of the 6-year model, Network practices enrolled more than 125,000 unique patients and saved the Medicare program over $330 million relative to benchmark prices.

Many physician practices, particularly those in rural areas, may be enthusiastic about the premise of value-based care but simply lack the resources to pursue it. Therefore, it is critical that APMs are designed with enough flexibility to allow participation from all providers that comprise our healthcare delivery system. The Network encourages the Committee to consider the following when contemplating new APMs and ways to encourage broader participation in value-based care models:

1. Stability in the Medicare Physician Fee Schedule is critical. As discussed above, reliable, sufficient reimbursement is the foundation for advancing innovative payment models. Without payment certainty and predictability, independent physician practices will be reluctant to take on additional risk.

2. Introduction and testing of new APMs must be voluntary. The OCM was a voluntary model, yet it still received robust patient and provider enrollment and produced meaningful results. CMMI has proposed mandatory models, such as the Medicare Part B Drug Demo, the International Pricing Index, the Most Favored Nation Model, and the Radiation Oncology (RO) Model, but they were met with strong stakeholder pushback due to their punitive nature and CMMI ultimately did not finalize them. A voluntary model can be phased-in and iterative to allow more sophisticated practices to test the model before expanding it to practices that may have less resources.

3. Stakeholder engagement and physician-buy in must remain a cornerstone of any transition to new payment models. Two-way dialogue and transparency between CMS and interested practices is crucial to model success. This can help inform model adjustments so small or rural practices feel confident in participating. It also includes transparency into model payment methodology. If providers are able to fully understand a model's impact on their practice's financials and benefit to patient care, they are more likely to embrace the model. The high level of provider enrollment in the OCM also reflects the collaborative approach that CMMI took in developing and implementing the model, during which CMMI addressed stakeholder questions and concerns.

4. Practice transformation takes time and resources. Our experience in standing up value-based care models in both Medicare and commercial plans has taught us that there is typically significant upfront and ongoing financial investment required. In the OCM, CMS provided a monthly enhanced oncology services (MEOS) payment on a per-member basis that was instrumental in helping practices make that investment. For example, participating practices used the MEOS payment to invest in services like patient navigation, afterhours access, social work, psychosocial/ mental health, telehealth, palliative care, advance care planning, and nutrition, which, in turn, improved the patient experience and reduced costs by mitigating clinical deterioration and hospitalization. Many of these services are typically not reimbursed otherwise, making it difficult for practices to offer them. While a MEOS-type payment is a critical component of any model that requires practices to offer entirely new services with new staffing, it is especially key for attracting the participation of small and community-based practices that can also help meet health equity goals. In contrast, models proposed by CMS (such as the RO Model) that were mandatory and would have required immediate cuts while increasing provider burden received significant stakeholder pushback.

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The Network is enthusiastic about the Enhancing Oncology Model (EOM), a successor model to the OCM, which began on July 1, 2023. Network providers across 12 practices will comprise about 50% of total providers participating in the EOM. Like the OCM, the EOM is a total cost of care model, meaning participating providers are responsible for any costs a patient encounters during an episode, not just the cost of their cancer treatment. The EOM also contains new challenges, such as the requirement for participating practices to accept two-sided risk on Day 1. This means practices must implement new workflows, change practice patterns, and test cost saving strategies, and then they are required to share in any losses resulting from failure to meet performance benchmarks beginning with the first performance period. The EOM also has a lower upfront payment to fund enhanced services (MEOS) and covers a smaller patient population. Overall, practices in EOM are taking on a very high level of financial risk and being asked to do more with less.

At the same time, the reward for participating and taking on this risk is lower. Under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), providers that participate in an Advanced APM and achieve Qualifying Participant (QP) status are exempt from Merit-Based Incentive Payments System (MIPS) reporting requirements and eligible to receive additional financial incentives. Under current statute, the 5% lump sum bonus for those achieving QP status has been reduced to 3.5% and transitions to a much lower 0.75% Medicare payment adjustment in 2024. Additionally, despite taking on these high levels of risk, the design of certain models such as the EOM may preclude practices from achieving QP status at all and the QP thresholds are set to increase in 2024.

We note there are significantly fewer practices participating in the EOM than anticipated and we believe the factors outlined above are deterring participation. This is especially true for practices who did not participate in OCM and did not make earlier investments in software or staffing that are necessary for successful participation in a model like the EOM. We encourage the Committee to examine the criteria for AAPM and QP status to ensure that the providers who are taking on risk, improving care, and bending the cost curve are being rewarded accordingly.

Conclusion

On behalf of The US Oncology Network, thank you for the opportunity to provide feedback. We welcome the opportunity to discuss the issues outlined above and any 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,

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The US Oncology Network

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