The US Oncology Network

Written Statement
House Budget Committee
Breaking Up Health Care Monopolies: Examining the Budgetary Effects of Health Care Consolidation
May 23, 2024

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 submit this written statement for the House Budget Committee hearing on "Breaking Up Health Care Monopolies: Examining the Budgetary Effects of Health Care Consolidation."

The Network is one of the nation's most innovative networks of independent, community-based oncology physicians, treating more than 1.4 million cancer patients annually at approximately 600 sites of care in 31 states. The Network unites over 2,500 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 healthcare system. We commend the House Budget Committee for exploring the role of consolidation in rising healthcare costs.

Oncology as a specialty as seen a high rate of consolidation. In fact, from 2007 to 2017, oncology had the highest overall rate of hospital-physician consolidation across all medical specialties, with over half (54%) of physician practices reporting they were owned by a hospital or health system by 2017[1]. Today, the incentives for consolidation remain high, primarily due to payment policies that reimburse hospital-owned physician clinics (considered to be hospital outpatient departments, HOPDs) at rates that are significantly higher than independent physician clinics for the exact same services. Depending on the hospital's tax status, the facility may also be eligible for the 340B Drug Discount Program, disproportionate share hospital payments, graduate medical education funding, and state or federal tax exemptions, whereas community cancer clinics are not eligible for these same benefits. These inherent advantages distort the market in favor of these large participants and ultimately limit competition and patient choice.

The payment disparity between hospital-owned physician clinics, which are paid under the Medicare outpatient prospective payment system (OPPS), and independent physician clinics, which are paid under the Medicare physician fee schedule (PFS), continues to grow. Today, Medicare reimburses hospital-owned physician practices at rates that are three times higher than independent physician practices for the exact same services, without any measurable improvement in quality or outcomes. For certain cancer-related services, hospital-owned physician practices may receive reimbursement rates than are five to six times higher[2].

This payment disparity creates an incentive for hospitals to acquire independent physician practices and shift care into the more expensive setting. The Medicare Payment Advisory Commission's (MedPAC) June 2022 report found that Medicare payment rates often vary for the same services provided to similar patients in different settings and "encourage arrangements among providers—such as the consolidation of physician practices with hospitals—that result in care being billed at the payment rates of the provider with the highest rates, increasing program and beneficiary spending without meaningful changes in patient care[3]." According to MedPAC, in 2012, approximately 65 percent of chemotherapy services were provided in the physician office setting, but by 2019, this share had shrunk to

[1] https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1520
[2] https://www.fightcancer.org/sites/default/files/acs_can_site_neutral_issue_brief_-_final_10-19-23.pdf
[3] https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf

only 50 percent,[4] reversing previous trends. This dynamic is even more pronounced in the commercial insurance segment, as hospitals with a larger market share can command higher reimbursement from commercial payers.

Reimbursement policies that pay hospital-owned physician practices higher rates for the exact same services provided in independent physician practices have increased costs to patients, insurers, employers, and taxpayers. Site neutral policies, or policies that align payment across sites of service, would reduce costs and help lower incentives for consolidation. To consider the potential impact, let's examine two types of services commonly used in outpatient cancer care: evaluation and management services and drug administration.

1. *Evaluation and Management (E/M) Services*

    a. In the CY2018 and CY2019 OPPS final rules, CMS finalized a proposal to equalize payments for E/M services at a rate of 40% of what they would have been paid under the OPPS fee schedule, which was considered to be a proxy for the physician fee schedule rate at the time. This policy went into effect in January 2019.

    b. A report by the Department of Health and Human Services Office of Inspector General (OIG) issued in June 2022 compared Medicare reimbursement between provider-based facilities (HOPDs) and freestanding facilities (independent physician offices) for E/M services in eight selected states from calendar years 2010-2017. According to the OIG report, if the above policy had been in effect from 2010-2017, the Medicare program and its beneficiaries in the selected states would have seen a combined savings of $1.4 billion.

    c. Additionally, according to the report, if the provider-based facilities and hospitals in the selected states had been paid at the freestanding PFS rate during this period, the Medicare program could have realized cost savings of $1.3 billion and its beneficiaries could have realized cost savings of $334 million, for a combined savings of over $1.6 billion[5]. The OIG determined that even after implementation of the CY2019 OPPS rule, provider-based facilities would continue to receive higher payments for E/M services than freestanding facilities would, thereby recommending CMS pursue legislative or regulatory changes to truly equalize payment between both settings.

2. *Drug Administration Services*

    a. Chemotherapy is another area where hospital-owned physician clinics receive significantly higher reimbursement than independently owned physician clinics. Chemotherapy (CPT Code 96413; chemo iv infusion, 1 hr) is the most common drug administration code billed by oncology practices. Under the CY 2023 Medicare fee schedules, for example, chemotherapy administration is reimbursed $333 in the HOPD setting and only $129 in the physician office setting.

    b. H.R. 5378, the Lower Costs, More Transparency Act, would require site neutral payments for drug administration services furnished in off-campus HOPDs. According to the Congressional Budget Office, this provision would save the federal government $3.8 billion over 10 years.[6]

[4] https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf
[5] https://oig.hhs.gov/oas/reports/region7/71802815.pdf
[6] https://www.cbo.gov/system/files/2023-12/hr5378-DS-and-Revs_12-2023.pdf

c. An analysis by the American Cancer Society Cancer Action Network (ACS-CAN) and Avalere examined the cost difference for 4 rounds of chemotherapy treatment administration between HOPDs and physician offices. The analysis found an average of $6,525 in combined Part B savings to the patient and the Medicare program[7]. ACS-CAN concludes site neutral payments could reduce out-of-pocket costs for patients and potentially reduce Part B premiums, the costs of supplemental coverage, and costs for Medicare Advantage.

Today, our national debt is approaching $35 trillion and mandatory healthcare spending is a key driver of this debt[8]. Four in 10 Americans report having debt due to medical or dental bills[9]. If a service can be safely provided in the lower-cost physician office setting, there is no reason that Medicare patients or American taxpayers should be paying two to six times more for the exact same service in the HOPD setting.

The Network commends the House of Representatives for its bipartisan passage of H.R. 5378, the Lower Costs, More Transparency Act. Site neutral payments for drug administration services are a critical next step, but more work is needed to truly level the playing field, reduce incentives for consolidation, and reduce the cost of care. To that end, The Network also supports H.R. 4473, the Medicare Patient Access to Cancer Treatment (IMPACT) Act, which would require site neutral payments for outpatient cancer care; and S. 1869, the Site-based Invoicing and Transparency Enhancement (SITE) Act, which would remove the grandfathering provisions that exempt the vast majority of HOPDs from existing site neutral payment requirements under the Bipartisan Budget Act of 2015.

Without congressional action, the payment disparity between independent physician practices and hospital-owned physician practices will continue to grow, increasing the incentives for consolidation. In the Congressional Budget Office's (CBO) May 2022 baseline[10], CBO projected OPPS payments would grow by over 100% over the next decade; by comparison, PFS payments are only expected to grow by 20%[11]. According to the American Medical Association, when adjusted for inflation in practice costs, Medicare physician payment has actually declined 26% from 2001 to 2023[12]. Therefore, The Network also encourages the Committee to consider necessary investments in the Medicare PFS to protect the viability of independent physician practices and prevent care from shifting into the more expensive HOPD setting.

On behalf of The US Oncology Network, thank you for the opportunity to provide feedback on the effects of consolidation in healthcare. 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 me at Ben.Jones@usoncology.com.

Sincerely,

Ben Jones
Vice President
Government Relations and Public Policy
The US Oncology Network

[7] https://www.fightcancer.org/sites/default/files/acs_can_site_neutral_issue_brief_-_final_10-19-23.pdf
[8] https://paragoninstitute.org/paragon-pic/government-health-spending-exceeds-discretionary-budget
[9] https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/
[10] https://www.cbo.gov/system/files/2022-05/51302-2022-05-medicare.pdf
[11] https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care
[12] https://www.ama-assn.org/system/files/ama-medicare-gaps-chart-grassroots-insert.pdf