



# The US Oncology Network

June 19, 2015

Senator Johnny Isakson  
Co-Chair of Chronic Care Working Group  
131 Russell Building  
Washington, DC 20510

Senator Mark Warner  
Co-Chair of Chronic Care Working Group  
475 Russell Building  
Washington, DC 20510

Dear Senator Isakson and Senator Warner,

Thank you for your commitment to our nation's seniors and the effective management of the chronic diseases many older Americans face later in life. As a provider of one of the most common and costly chronic medical conditions today, I fully understand how challenging it is to improve care coordination and rein in spending, and I applaud your efforts to ensure access to quality healthcare services for our nation's seniors.

I am a physician and leader in The US Oncology Network. We are the nation's largest and most innovative network of community-based oncology physicians, treating more than 750,000 cancer patients annually in more than 450 locations across 40 states. The Network unites over 1,000 like-minded physicians around a common vision of expanding patient access to the highest quality, most cost-effective integrated cancer care to help patients not only survive, but to thrive during their fight with cancer.

Over 14 million Americans with a history of cancer are alive today and that number is expected to rise to 19 million by 2024. More than eight million of those people are over the age of 65, and approximately half of all cancer spending is for Medicare beneficiaries<sup>1</sup>. America's world-class cancer care is expensive. In a 2010 study<sup>2</sup>, Milliman reported that in 2007, a cancer patient receiving chemotherapy incurred average costs of approximately \$111,000, three times the cost of a coronary artery disease patient, and six times the cost of a diabetes patient. The National Cancer Institute states that the U.S. spent over \$125 billion on cancer care in 2010 and projects that cancer care costs will increase to \$156 billion by 2020<sup>3</sup>. As a result, the United States is the world leader in providing high-quality cancer care and our survival rates are higher than the averages in Europe and Canada for 13 of 16 types of cancer<sup>4</sup>.

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<sup>1</sup> The National Cancer Institute <http://www.cancer.gov/about-cancer/what-is-cancer/statistics>

<sup>2</sup> Milliman Client Report: Cancer patients receiving chemotherapy: Opportunities for better management. March 30, 2010. Bruce Pyenson and Kate Fitch. <http://publications.milliman.com/research/health-rr/pdfs/cancer-patients-receiving-chemotherapy.pdf>

<sup>3</sup> The National Cancer Institute <http://www.cancer.gov/about-cancer/what-is-cancer/statistics>

<sup>4</sup> <http://www.ncpa.org/pub/ba596>

According to recent data the cost of treating cancer patients is significantly lower to both patients and the Medicare program when high quality care is delivered in community-based cancer clinics as opposed to the outpatient hospital setting. Total Medicare spending on patients receiving chemotherapy in the community clinic is 14.2 percent lower than the hospital outpatient department (HOPD), which results in \$623 million in Medicare savings per year.<sup>5</sup> An April 2012 study released by Avalere Health<sup>6</sup> found that chemotherapy provided in a physician's office costs, on average, 24 percent less than chemotherapy provided in the hospital outpatient setting.

The cost of providing cancer care in a hospital outpatient department is significantly higher than the *exact same care* delivered at a community cancer clinic with hospitals charging approximately 126 percent higher costs for administering common cancer drugs.

Patients also prefer community-based cancer care. In addition to offering patients a convenient, comprehensive, state-of-the-art cancer care setting close to home, it costs them less. Patient co-payments are approximately 10 percent lower in the clinic, equaling more than \$650 in savings for each Medicare beneficiary. Additionally, the average out-of-pocket patient cost for commonly used cancer drugs is \$134 less per dose if received in an oncologist's office.<sup>7</sup>

These costs add up. Between 2009 and 2012, Medicare beneficiaries paid \$4.05 million more in out-of-pocket costs because of the higher patient co-payments in HOPD for chemotherapy services that could have been performed in a community cancer practice for a fraction of the cost.<sup>8</sup>

Unfortunately, over the last decade we have seen an alarming shift in the delivery of cancer care from the community to the hospital outpatient setting, resulting in increased costs to the Medicare program and its beneficiaries. Worse, this shift is creating access to care problems for vulnerable cancer patients. Because care delivered in the HOPD setting is reimbursed at a higher rate, today's Medicare payment structure puts community-based cancer clinics at a direct disadvantage. Between 2005 and 2011, the proportion of chemotherapy delivery in the lower cost office-based setting declined from 86.5 percent to 67 percent nationally<sup>9</sup>. This shift in care from more convenient, less costly community setting to the higher cost hospital setting is harder on the budgets of both the patients and Medicare.

A new IMS Institute report finds that more Americans are receiving cancer care from oncologists whose practices have been bought by hospitals. Reimbursement levels for drug administration costs in HOPD are, on average, 189 percent higher than physician office reimbursement costs<sup>10</sup>. According to the Moran Company, HOPD chemotherapy administration spending per Medicare patients was 47 percent higher in the HOPD than in the physician-office setting between 2009 and 2011<sup>11</sup>. During that same time period, Medicare payments for chemotherapy administration services delivered in the HOPD setting increased significantly while payments for services delivered by community cancer clinics decreased.

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<sup>5</sup> Milliman Client Report: Site of Service Cost Differences for Medicare Patients Receiving Chemotherapy. October 19, 2011. Kate Fitch and Bruce Pyenson. <http://publications.milliman.com/publications/health-published/pdfs/site-of-service-cost-differences.pdf>

<sup>6</sup> Avalere Client Report: Total Cost of Cancer Care By Site of Service. March 2012. [http://www.avalerehealth.net/news/2012-04-03\\_COA/Cost\\_of\\_Care.pdf](http://www.avalerehealth.net/news/2012-04-03_COA/Cost_of_Care.pdf)

<sup>7</sup> Milliman, "Site of Service Cost Differences for Medicare Patients Receiving Chemotherapy," October 2011.

<sup>8</sup> Berkeley Research Group, "Impact on Medicare Payments of Shift in Site of Care for Chemotherapy Administration," June 2014.

<sup>9</sup> The Moran Company, "Results of Analyses for Chemotherapy Administration Utilization and Chemotherapy Drug Utilization, 2005-2011 for Medicare Fee-for-Service Beneficiaries," May 2013

<sup>10</sup> IMS Institute for Healthcare Informatics, "Innovation in Cancer Care and Implications for Health Systems: Global Oncology Trend Report," May 2014.

<sup>11</sup> The Moran Company, "Cost Difference in Cancer Care Across Settings," August 2013.

The negative result of these policies goes beyond the fiscal impact. Particularly in rural areas, many patients are losing access to their trusted healthcare providers due to the closure of community-based healthcare centers as oncologists are forced to join hospitals. Without your action, local cancer clinics will continue to close and care will continue to shift to the more expensive, less accessible hospital outpatient setting. Americans fighting cancer will experience diminished access to care, and patients, payers and taxpayers will pay more.

On behalf of the nation's leading community cancer care providers we encourage you to neutralize payments across sites of service. Pay the same fee for the same service regardless of where it is performed. This policy reform has the bipartisan support of lawmakers, the Medicare Payment Advisory Commission and a broad group of healthcare stakeholders including providers, insurers and consumers.

To advance such reforms in cancer care, Congress should adopt a policy to secure site-neutral payments to keep costs down for seniors fighting cancer, for Medicare and for taxpayers. Specifically, Congress should create a level playing field in Medicare payments for outpatient cancer care services. This would preserve patient access to high-quality, cost-effective care in the community setting and help stem the tide of hospital acquisitions of community cancer clinics.

Once again, we appreciate your commitment to the Medicare program and its beneficiaries, and we are grateful for the opportunity to inform you of some of the cost containment issues facing America's cancer care delivery system today. Feel free to use us as a resource throughout this working group discussion and we are happy to provide any additional insight or information.

Sincerely,

A handwritten signature in blue ink that reads "Barry Brooks". The signature is written in a cursive style with a large, looped initial 'B'.

Dr. Barry Brooks  
Chairman of P&T Committee  
The US Oncology Network