April 14, 2016

Chairman William Lippert, Jr.
House Committee on Health Care
Vermont General Assembly

Representative William J. Lippert, Jr. and members of the House Committee on Health Care:

On behalf of The US Oncology Network, we submit these comments in support of S. 245, an act relating to notice to patients of new health care provider affiliations, as passed by the Senate.

The US Oncology Network (The Network) is one of the nation's largest networks of integrated, community-based oncology practices dedicated to advancing high-quality, evidence-based cancer care. A physician-led organization, The Network unites like-minded physicians and clinicians around a common vision of improving patient outcomes and quality of life. The Network is committed to strengthening patient access to integrated care in local communities across the nation, including collaboration with a variety of payers and providers.

Improving the quality and efficiency of healthcare in order to control costs has been an ongoing priority for policy makers, employers, payers, patients, and providers alike. Efforts to improve patient safety and outcomes, while tying payments to quality instead of quantity, have resulted in seismic shifts in the delivery of healthcare over recent years. This is true in oncology as well.

Yet amid these major changes and cost-cutting improvements, we still see examples of not only questionable and costly federal policies that undercut the progress being made elsewhere, but state and commercial reimbursement rates also create an unlevel playing field upon which independent physicians must compete. S. 245 rightly addresses these state and commercial payer issues.

A December 2015 study[1] showed that hospitals with fewer competitors have substantially higher prices, beyond those accounted for by cost or quality differences. Hospitals that have monopolized their markets are able to leverage prices 15% higher than those in areas with 4+ competitors. The study also showed that hospitals with only one competitor have prices more than 6 percent higher, and those that face two competitors have prices almost 5 percent higher. Working with cancer care providers, we are all too familiar with the higher rates for oncology services that hospitals command. The ongoing payment disparity between cancer care provided in community settings and the same care provided in hospital outpatient departments (HOPDs) is fueling the trend of hospitals aggressively and rapidly acquiring community oncology practices, which has only accelerated in recent years. According to the Community Oncology Alliance's 2014 Practice Impact Report,[2] there is still an "unabated consolidation of the nation's cancer care delivery system led once again by hospital acquisitions."

When the specific service is not dependent on the hospital facility's associated technologies, and in the absence of any evidence-based rationale, paying more for a service in the hospital is wasteful, costly, and endangers patient access and choice. The proposed site neutral payment policy in S. 245, to ensure Medicaid does not pay a higher rate for the same outpatient services just because a hospital acquired a physician practice, is a step toward the right policy, and would mirror action taken by

[1] http://www.cmu.edu/news/stories/archives/2015/december/hospital-prices-vary.html
[2] http://www.communityoncology.org/pdfs/Community_Oncology_Practice_Impact_Report_10-21-14F.pdf

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Congress in the Bipartisan Budget Act of 2015. Further, the current bill wording, to have the Green Mountain Care Board also consider expanding the same site neutral payment policies to commercial health insurers is something we support. Similarly, the bipartisan leadership of the Connecticut Senate has introduced legislation to address site neutral payments in the commercial payer space in both the 2015 and 2016 legislative sessions. We believe more states are seeing the damaging effects of the unlevel playing field between physician practices and large hospital systems, and will follow the lead of Vermont and Connecticut on introducing site neutral legislation at the state level.

A decade ago, nearly 90% of Americans being treated for cancer had many options for care in the community setting, but changes in reimbursement methodologies have made the previous landscape almost unrecognizable. Today, fewer than 65% of patients receive care in these centers, while HOPDs saw a 150% increase in patient volume in just 6 years.[3] And alarmingly, while hospitals reaped more than triple their previous reimbursement amounts (from $90 million to $300 million from 2005 to 2011), many freestanding cancer centers nationwide have been forced to close their doors.

For many community cancer centers, keeping the doors open has often meant making the difficult decision to consolidate with hospitals and large hospital systems. Although this gambit allows an individual practice to survive, these consolidations due to payment disparities increase costs overall and ultimately affect patients by increasing out-of-pocket expenses and limiting patient choice. A recent study of the medical records of 4.5 million patients published in The Journal of the American Medical Association (*JAMA)* concluded that expenditures per patient were 10.3% higher for physician groups owned by hospitals than for independent practices, and expenditures were 19.8% higher for physician groups owned by multihospital systems.[4]

A 2015 study by the IMS Institute also concluded that Americans are paying higher prices for cancer treatments because of these acquisitions. According to the report, reimbursement levels for drug administration costs in hospital outpatient facilities average 189% higher than physician office reimbursement costs for commercially insured patients under the age of 65 years. In 2014, Medicare paid HOPDs twice as much as a physician's offices for the same drug administration service.[4] The pain in the pocketbook doesn't end there: a report by the Milliman research group concluded that Medicare beneficiaries pay $650 more in out-of-pocket co-payments when cancer care is delivered in the hospital setting as opposed to a physician's office.

According to an April 2016 study by Milliman[5], during the last decade, the total costs of treating patients with cancer in the United States have risen no faster than overall costs for Medicare and commercially insured populations. The study reveals the cancer care costs have actually not outpaced other health care spending trends, but rather the total costs of treating cancer patients have increased at nearly the same rate as overall health care spending over the 2004-2014 period. The study also looked in-depth at cost trends in the site of service for chemotherapy infusion. It found that the site of service for chemotherapy infusion in America has dramatically shifted away from the physician office to the generally higher-cost hospital outpatient settings. The study found that the proportion of chemotherapy infusions delivered in hospital outpatient departments nearly tripled, increasing from 15.8% to 45.9% in the Medicare population during the study period. For the commercially

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[3] Results of analyses for chemotherapy administration utilization and chemotherapy drug utilization, 2005-2011, for Medicare fee-for-service beneficiaries. Community Oncology Alliance website. http://www.communityoncology.org/UserFiles/Moran_Site_Shift_Study_P1.pdf. Published May 2013. Accessed July 28, 2015. - See more at: http://www.ajmc.com/journals/evidence-based-oncology/2015/august-2015/Equalize-Payment-Across-Site-of-Service#sthash.UF5eYhYk.dpuf

[4] Robinson JC, Miller K. Total expenditures per patient in hospital-owned and physician-owned physician organizations in California. *JAMA*. 2014;312(16):1663-1669. See more at: http://www.ajmc.com/journals/evidence-based-oncology/2015/august-2015/Equalize-Payment-Across-Site-of-Service#sthash.UF5eYhYk.dpuf

[5] Cost Drivers of Cancer Care: A Retrospective Analysis of Medicare and Commercially Insured Population Claim Data 2004-2014. See more at: http://www.communityoncology.org/pdfs/Trends-in-Cancer-Costs-White-Paper-FINAL-20160403.pdf

insured population the increase was much more dramatic, going from 5.8% to 45.9%. We suspect the shift in this site of care has also occurred in the Medicaid population, driving costs higher for states. As of 2014, 340B hospitals accounted for 50.3% of all hospital outpatient chemotherapy infusions in the Medicare population.

The US healthcare system today is unquestionably complex, with a great many variables affecting the cost of care. However, some problems are easier to fix than others, and this one has a common sense solution: to have policy makers help neutralize payments across sites of service and ensure payments are equivalent for the same services, regardless of where it is performed.

President Obama and Congress came together last fall to include prospective site neutral payment policy in the Bipartisan Budget Act of 2015, and it is our hope that the momentum from support for similar changes in federal policy will carry over in Vermont. The AARP supports equalizing payments for physician services between hospital outpatient and office settings. This will save billions for seniors and taxpayers, and Vermont would be taking a national leadership position on the policy at a state level.

Site neutrality is a critical step in the journey toward better healthcare for all Americans and a healthy future the affordability of healthcare nationally. As such, we encourage you to support S. 245.

Sincerely,

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