ALLIANCE OF DEDICATED CANCER CENTERS
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February 19, 2016

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Joseph Pitts
Chairman
Subcommittee on Health
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

**RE: Request for Comments on Section 603 of the Bipartisan Budget Act of 2015: Site of Service Legislation**

Dear Chairman Upton and Chairman Pitts,

On behalf of the Alliance of Dedicated Cancer Centers (ADCC), we are writing in response to your request for comments on Section 603 of the Bipartisan Budget Act of 2015. The ADCC is comprised of eleven institutions that have a singular focus on cancer; unlike other hospitals that care for patients suffering from any condition, the Dedicated Cancer Centers exclusively treat cancer patients. Much of the progress in understanding cancer's biology and successful treatment methods is directly attributable to the work of ADCC members. Our institutions are at the forefront of innovative treatment options in precision medicine, immunotherapies, and other state of the art diagnostic and patient care technologies. Our institutions annually are engaged in over 4600 active clinical trials**.** We are committed to disseminating best practices for patient treatment to the community at large–from the wisdom of watchful waiting and prevention to the most up-to-date therapies. Our members serve as regional, national, and international resources in developing the most effective and efficient ways to treat cancer patients.

The ADCC appreciates the opportunity to provide comments to the Energy and Commerce Committee on site of service legislation. We understand the policy rationale behind Section 603 and support efforts by Congress to close loopholes that allow patients to receive care from a provider one day and the next day receive the same services in the same facility, with no change in the underlying service but greater expense to the patient and the Medicare program. The Dedicated Cancer Centers do not engage in these kinds of abuses. We are uniquely and significantly impacted by this legislation because Section 603 changed the definition of "covered outpatient services" to exclude services provided by new off-campus hospital outpatient departments. This definitional change prevents Dedicated Cancer Centers from receiving the Medicare payment adjustments granted to us because of our exclusive focus on cancer, which are tied to the provision of "covered outpatient services." We therefore urge the Committee to enact legislation that protects Dedicated Cancer Centers from the unintended consequences resulting from Section 603.

**Our cancer services are not the same as those provided in physician offices**

It is inaccurate to say that the care that we and our brethren National Cancer Institute (NCI)-designated Comprehensive Cancer Centers provide is "the same" as care provided in the community oncology setting. Cancer, as you may know, was historically treated in the inpatient setting. A cancer patient is unique not only because of the physical severity of the illness and accompanying psychosocial symptoms, but also with respect to the dramatic side effects that can result from treatment. In the early years of cancer treatment, a patient would typically be admitted to a hospital for days to allow doctors to manage such side effects and ensure the patient's well-being. Recognizing the tremendous toll that this takes on patients, institutions such as ours developed scientific advances that allowed cancer to be treated in the outpatient setting. For example, we have developed: anti-nausea drugs that permit chemotherapy to be better tolerated; targeted chemotherapy that achieves better results and is more cost efficient; new supportive care drugs that permit outpatient treatments for bone marrow transplants; and minimally invasive surgery, including robotic surgery. Patients treated in our centers also receive sub-specialty care from physicians who are used to seeing a broad range of patients within only one type of cancer.

Clinical advances at the Dedicated Cancer Centers and the expertise of our oncologists have allowed treatment in the outpatient setting to continue to grow. Our outpatient cancer treatment—which is 100 percent of the type of treatment that ADCC members provide—has grown from approximately 25% in 1996 to greater than 66% in 2012.[1] In comparison, hospitals on average offer 34% of their services (both cancer and non-cancer) in the outpatient setting.[2] Overall, the shift to outpatient from inpatient care is much less expensive for the Medicare program. With respect to Medicare, we develop therapies that enable this shift for cancer care *notwithstanding* that the outpatient setting is where we lose the most money on Medicare patients. We do this because our mission is to provide the best care possible for patients and their families.

In ADCC outpatient settings, we provide care that is substantively different from physician offices:

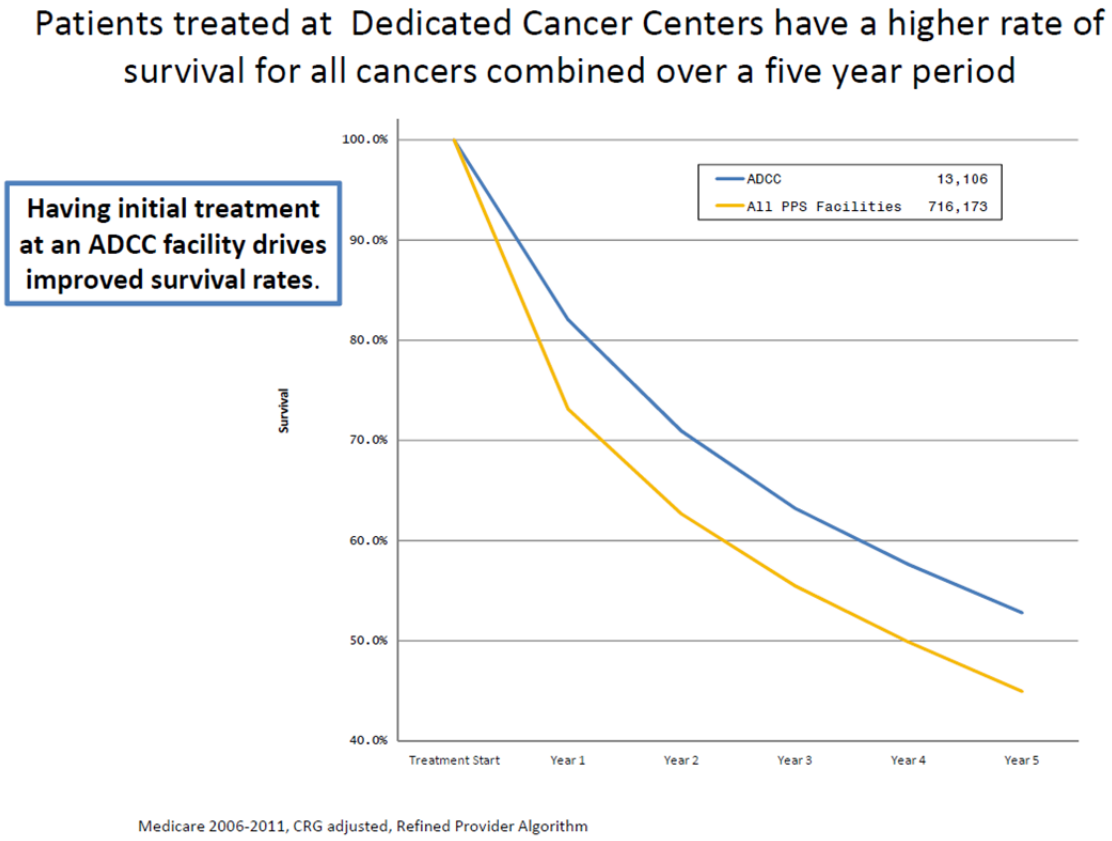
- Patients are served by a team of subspecialists in medical oncology, radiation oncology, and surgery;
- Patients are cared for by trained oncology nurses;
- Pharmacists and pharmacy IT systems are capable of providing complex chemotherapy regimens safely;
- Other professional disciplines such as in mental health, rehabilitation, nutrition and others are available;
- Patients have immediate access to clinical trials and innovative treatments; and
- Patients have their imaging read by sub-specialty radiologists who quickly and accurately identify the staging and progress of the cancer leading to the most appropriate treatment.

[1] Based on Medicare 2012 data.

[2] *Id*.

All of these services are provided at Dedicated Cancer Centers.[3] They are not typical of community oncology practices.

The difference in care between Dedicated Cancer Centers and physician practices is further and more importantly evidenced by the superior outcomes that are achieved at Dedicated Cancer Centers. In a study which recently appeared in the peer-reviewed publication JAMA Oncology (October 2015), survival rates at ADCC institutions were found to be significantly higher than survival rates at community hospitals:




Significantly, we have taken steps to further investigate this outcomes analysis to show that we achieve superior outcomes *at no greater cost* than other hospitals. Our analysis of Medicare patients over the full course of their chronic condition demonstrates that Dedicated Cancer Centers provide superior outcomes at a total cost that is comparable to community physicians/hospitals. While community physicians provide care at a lower unit cost, they bring patients to their offices more frequently and use more infusions than Dedicated Cancer Centers for the same types of cancer. In addition, they admit patients to the hospital more frequently than Dedicated Cancer Centers. These differences in approaches to treatment can cost the Medicare program millions of dollars.

In 2013, we spoke with the Committee about site neutrality issues, which at that time was considering an approach to site of service legislation that would identify meaningful differences between the types of services provided in the hospital and physician office settings, for example, through stricter attestation requirements. We understand why Congress ultimately took the approach that it did and sincerely appreciate that it did not apply the legislation retroactively to existing off-campus hospital outpatient facilities. However, as Medicare Payment Advisory Commission Executive

[3] Furthermore, the services listed above are services for which Dedicated Cancer Centers incur costs and frequently are *not* reimbursed by Medicare. They also do not include the overhead costs and associated regulatory burdens generally associated with being a hospital.

Director Mark Miller described in a previous hearing before this Subcommittee: "… the Medicare program should pay the same amount for the same service, regardless of the setting in which it is provided, unless payment differentials are justifiable by differences in patient mix, provider mission, or other justifiable factors." In other words, there are criteria that lawmakers should consider when deciding whether to deviate from an otherwise sound site neutrality policy. Section 603 significantly impacts the mission of Dedicated Cancer Centers, which includes improving the cancer care for a region pursuant to our NCI designation, which we have done through achieving improved outcomes for patients. Without the ability to provide this care in new sites in the community, these ongoing improvements in survival will be limited to patients who are fortunate enough to live in our existing service areas. In addition, the GAO report cited in your request for comments criticizes payment changes associated with vertical consolidation—not the practices of hospitals which genuinely seek to expand access to transformative care in surrounding communities.

**Section 603 disproportionately impacts Dedicated Cancer Centers**

As you know, Dedicated Cancer Centers are distinguished because of their *exclusive* focus on cancer patients. Congress and the Centers for Medicare and Medicaid Services (CMS) have continuously recognized the need to protect Dedicated Cancer Centers over the past 30 years because institutions that exclusively treat cancer patients would suffer catastrophic losses under Medicare PPS. Without any payment adjustments, we would incur devastating losses under PPS—a *negative* 52.4 percent overall Medicare margin—significantly worse than any other hospital group in the country. Even with payment adjustments, our Medicare margins are materially worse than that of PPS hospitals, negative 10.7 percent versus negative 4.5 percent.[4]

The way our payment adjustments are applied to our outpatient departments is that CMS links our floor on reimbursement to the yearly "payment-to-cost ratio" (PCR) of all PPS hospitals– i.e., CMS ensures that our *losses* from providing Medicare outpatient services do not exceed those of an average PPS hospital. This adjustment is based on a study conducted by CMS that was authorized under the Affordable Care Act. In 2016, this reimbursement floor is 92% of allowable Medicare costs.

Our singular focus on cancer and unique payment structure is what leads to the extremely negative impact that Section 603 has on our institutions. Because reimbursement for *existing* Dedicated Cancer Center hospital outpatient departments, including those on and off our campuses, is tied to the PCR for all hospitals, the losses that hospitals will suffer as a result of Section 603 on their new, off-campus facilities (which will surely result in a reduction in the national PCR) is likely to affect our *entire* Medicare outpatient reimbursement. Making this impact even more damaging is that, because of our exclusive focus on cancer patients and the shift to outpatient care that is described above, the vast majority of our treatment is provided in the outpatient setting. As noted above, Dedicated Cancer Centers provide nearly 66 percent of their hospital services in the outpatient setting, as compared to PPS hospitals, whose outpatient services comprise only 34 percent of their total care.[5] Therefore, the potential impact to Dedicated Cancer Centers of Section 603 is highly disproportionate to that of other hospitals.

It would be tragic if, at a point in time when cancer research is at the cusp of historic progress that promises untold benefits for patients, the Dedicated Cancer Centers are compelled to siphon off funds that would otherwise be directed at research or other critical clinical programs in order to further subsidize the Medicare program. This would be particularly ironic given the simultaneous advancement of the 21st Century Cures legislation, a multi-faceted effort to accelerate clinical

[4] Based on Medicare 2014 data.

[5] Based on Medicare 2012 data.

innovation and the development of effective therapies for chronic diseases like cancer, as well as the recently announced National Cancer Moonshot initiative.

If the level of services that we offered were truly the same as those offered in physician offices, we would support the manner in which Congress has implemented Section 603. However, they are not. We therefore respectfully urge the Committee to approve legislation that protects Dedicated Cancer Centers from the unintended impact of the Bipartisan Budget Act. We believe there is bipartisan support for such legislation in both houses of Congress. Thank you very much for your consideration.

Respectfully submitted,

Karen Bird