Thoughts and recommendations on cancer care site of service

Matthew E. Brow,[1,2] Theodore A. Okon, MBA,[3] Edward R. George, MD,[2,4] David Eagle, MD,[3,5] Debra A. Patt, MD, MPH,[2,6] Bruce Gould, MD,[3,7] Barry Brooks, MD,[2,6] Patrick Cobb, MD,[3,8] Charles S. "Terry" White, MD,[2,6] Scott Tetrault, MD,[3,9] and Roy A. Beveridge, MD[1,2]

[1]McKesson Specialty Health; [2]The US Oncology Network, Washington, DC/The Woodlands, Texas; [3]Community Oncology Alliance, Washington, DC; [4]Virginia Oncology Associates, Norfolk; [5]Lake Norman Oncology, Mooresville, North Carolina; [6]Texas Oncology, Austin/Dallas; [7]Northwest Georgia Oncology Centers, Marietta; [8]Frontier Cancer Centers & Blood Institute, Billings, Montana; [9]Florida Cancer Specialists & Research Institute, Tallahassee

Within community practice, we are faced with the dual challenge of providing health care and operating a viable business entity. This problem is not unique to oncology; however, the specialty has been unfairly burdened with preferential payment incentives that favor treatment in hospital outpatient departments (HOPDs) over independent community-based clinics. This trend toward HOPD care has caused a shift in the model of delivery of care and remains a problem for those who practice in community clinics. Furthermore, the shift is driving spending for oncology care higher at a time when payers and patients are contending with rising, unsustainable costs. Providers in individual practices who are focused on the daily responsibilities of caring for cancer patients understandably may find it difficult to keep abreast of national policy changes and understand how those changes might affect their ability to take care of patients. The US Oncology Network and the Community Oncology Alliance (COA) are collaborating to interpret this proposed policy change and to make recommendations for improvement to empower community oncologists to comprehend the impact of this policy and to work toward a better outcome. We will present this proposed policy change in 2 parts: first, an analysis of the impact of current policies on community oncology practice, and second, recommendations for proposed changes to ensure balanced payment amounts for delivery of equivalent services and strategic initiatives for value-based cost reduction.

Commun Oncol 2012;9:382-388
http://dx.doi.org/10.1016/j.cmonc.2012.11.004

Current payment policies

Recent shifts in cancer care sites of service

We have observed with increasing concern recent significant shifts of outpatient cancer care delivery from the physician office to the HOPD. COA has been tracking about 1,250 practices for more than 4 years and has quantified the aggregate effects of the factors that contribute to the shift in cancer care services from community-based treatment centers to HOPDs.[1] As of April 2012, 47 of the 1,250 practices were referring all of their patients elsewhere for treatment, 241 oncology office locations had closed, 132 practices had merged or been acquired by a corporate entity other than a hospital, and 392 oncology groups had entered into a professional services agreement or been acquired by a hospital. Another 442 oncology practices reported that they were struggling financially. The 2012 report reflects increasing pressures from March 2011 with year-over-year increases of 21% in clinic closures, 19% in mergers or corporate acquisitions, 24% in practices with hospital arrangements, and 20% in practices that report being financially strapped.

Community oncologists and COA are not the only ones to observe and comment on this trend. In testimony before the House Small Business Committee on July 19, 2012, Mark Smith, the president of Merritt Hawkins, a physician search and consulting firm, presented survey results demonstrating that 36% of physicians reported that Medicare reimbursement did not cover their costs.[2] Others testified that the continued short-term fixes of the sustainable growth rate (SGR) problem by Congress also are causing financial

uncertainty for physicians in smaller group practices. Smith noted that if current trends were to continue, within 2 years, 75% of all newly hired physicians will be hospital employees.

Data presented in the Medicare Payment Advisory Commission's (MedPAC's) March 2012 Report to Congress show a 6.7% increase in level 3 evaluation and management (E/M) visits furnished in HOPDs from 2009 to 2010[3] and a 2010 growth rate of 12.9% in the proportion of such E/M office visits provided in HOPDs.[3] MedPAC attributed those increases to the fact that hospitals are purchasing physician practices and converting them into HOPDs and it suggested the following as some of the causes of the increases in hospital ownership and delivery of HOPD-based care:

- Community-based physicians are burdened by rising costs, including layout for new technology;
- Hospitals' goal of ensuring a stable stream of tests, admissions, and referrals;
- Hospitals' efforts to position themselves to establish accountable care organizations;
- Substantially higher Medicare payments (and corresponding beneficiary costs) to HOPDs than to community-based physicians for many services that can be performed in either a physician office or a HOPD.

Although we do not disagree with any of MedPAC's explanations for the shift in care delivery, we believe that the commission also should have recognized that a key driver of the shift is the steady erosion of revenues in the physician office setting because of the significant changes in Medicare payment policies that have caused unprecedented financial challenges for many physician practices. This is particularly true in specialties such as oncology that treat a high proportion of Medicare patients and where Medicare beneficiaries typically comprise about half the patient population.

Medicare payment differentials

Because Medicare's payment systems have been developed independently, are based on different payment constructs, and have different update trajectories, reimbursement for the same service provided to similarly situated patients at different sites of care can sometimes vary widely. Often, the differential payment rates fail to reflect meaningful differences in the services that are delivered; the quality and efficiency of care; disease acuity and severity; beneficiary costs, preferences, or access; or overall program expenditures. Such is the state of cancer care reimbursement today. We share the following examples below, some of which can be influenced directly by the Centers for Medicare and Medicaid Services (CMS) in its discretionary authority for setting payment rates and policies, and others of which it would take congressional action to achieve changes.

Code-specific payment differentials. Table 1 summarizes the site-of-service differentials for drug administration codes billed by oncology practices. The 2012 physician fee schedule (PFS) rate for current procedural terminology (CPT) Code 96413, "Chemo, iv infusion, 1 h"—the most common drug administration code billed by oncology practices—is $139, but the payment rate for the same service under the 2012 Hospital Outpatient Prospective Payment System (HOPPS) fee schedule is 50% higher at $208. The differential will expand further if the proposed PFS and HOPPS rules are finalized as currently published and Congress passes a 0% update for 2013. In that case, we estimate the PFS rate for Code 96413 will decrease to $132, whereas the HOPD rate will increase to $231, or 175% of the PFS rate. Aggregate, utilization-weighted payment for drug administration services will be about 55% higher at the HOPD.

Table 2 shows the current and proposed site-of-service differentials for the codes that are most commonly billed by medical and radiation oncologists other than those associated with the drug administration services detailed in Table 1, assuming the 2013 PFS and HOPPS proposed rules are finalized as drafted and Congress provides for a 0% update to the PFS conversion factor for 2013. This scenario creates a substantial disconnect between payments for radiation oncology services in community- and hospital-based settings, with HOPD payments about 25% higher than community practice payments overall and a significantly higher percentage differential for intensity-modulated radiation therapy (IMRT) delivery (70%) and stereotactic body radiotherapy (SBRT; 188%). This is due to the deep cuts in payment for IMRT (CPT Code 77418) and SBRT (CPT Code 77373) associated with the proposed changes in the time assumptions for these codes, cuts for all radiation therapy delivery codes because of the transition to the use of data from the Physician Practice Information Survey in the determination of practice expense relative value units (PE RVUs), the change in the interest rate assumptions, budget neutrality impacts of other proposed changes, and increases in the HOPPS payment rates.

Even with a conversion factor increase set at 0%, if the 2013 Medicare PFS proposed rule were to be implemented, it would remove $300 million from cancer care and reduce overall reimbursement for radiation oncology and freestanding radiation treatment centers by 15% and 19%, respectively. Given that nearly two-thirds of all cancer patients now receive radiation therapy as part of their treatment regimen, the financial implications of such

TABLE 1 Site-of-service cost differentials associated with drug administration codes

		2012			2013		
		Site of service			Site of service		
HCPCS	Description	Office, $	OPD, $	Differential, %	Office, $	OPD, $	Differential, %
90471	Immunization admin, single	24	35	44	25	39	56
90472	Immunization admin, 2+	12	25	108	13	27	116
96360	Hydration IV infusion, init	57	73	27	57	75	32
96361	Hydration IV infusion, add-on	15	25	62	15	27	82
96365	Ther/proph/diag IV INF, init	73	127	75	73	146	100
96366	Ther/proph/diag IV N F add-on	21	35	62	21	27	27
96367	Tx/proph/DG addl seq IV INF	32	35	8	31	39	26
96371	SC ther infusion, reset pump	86	35	−60	96	39	−59
96372	Ther/proph/diag inj SC/IM	24	35	44	25	39	56
96374	Ther/proph/diag inj IV push	56	35	−38	56	39	−30
96375	Tx/pro/dx inj new drug add-on	22	35	55	22	39	78
96401	Chemo, anti-neopl, sq/im	73	35	−52	73	39	−47
96402	Chemo admin; hormonal antineoplastic	34	35	3	32	39	23
96405	Chemo intralesional, up to 7 LS	85	35	−59	82	39	−52
96406	Chemo intralesional, > 7 LS	121	127	5	115	146	27
96409	Chemo, IV push, single drug	111	127	14	109	146	34
96411	Chemo admin IV push tech each add substance drug	62	73	17	61	75	23
96413	Chemo, IV infusion, 1 hr	139	208	50	132	231	74
96415	Chemo, IV infusion, addl hr	31	35	14	30	39	31
96416	Chemo prolong infuse w/pump	138	208	50	127	231	82
96417	Chemi IV infusion each addl seq	71	73	2	69	75	8
96446	Chemo admin peritoneal cavity via indwelling port or catheter	192	127	−34	193	146	−24
96450	Chemo intrathecal via LP	187	208	11	176	231	31
96521	Refill/maint, portable pump	137	127	−7	136	146	7
96522	Refill/maint pump/resvr syst	111	127	14	111	146	32
96523	Irrig drug delivery device	25	43	69	24	49	102
96542	Chemo intrathecal via omaya	123	73	−41	118	75	−36

reductions in Medicare reimbursement are unsustainable. Physician practices and freestanding radiation treatment centers operate as small businesses. An online survey conducted by the American Society for Therapeutic Radiation Oncology (ASTRO) from July 7-11, 2012[4] substantiates that community-based practices and treatment centers cannot absorb the revenue reductions contemplated by the proposed rule. The survey reports that 35% of respondents in free-standing centers anticipate having to close their practices if the proposed cuts are finalized, and 64% anticipate having to consolidate offices. In addition, 70% of respondents reported they might have to limit their Medicare patient load, and 49% indicated they could be forced to stop accepting Medicare patients entirely.

The negative impacts for beneficiary access will be widespread, but likely will be particularly pronounced in rural areas where radiation therapy is not always available through local hospitals. We note that a practice in the US Oncology Network is the only provider of radiation therapy services in 14 of the markets it services, meaning that if it were to close an office, patients would have to travel significant distances to receive care even from an HOPD. In fact, 35% of respondents to the ASTRO survey estimated that patients would have to drive more than 50 miles round trip, often about 1.5-2.5 hours, to reach the nearest radiation oncology provider if they were to close their doors. Such increases in travel time and expense can pose a significant barrier to care for patients who require radiation therapy treatments daily for 6-8 weeks. For example, a

TABLE 2 Site-of-service differentials associated with codes commonly billed by medical and radiation oncologists other than drug administration codes

		2012			2013		
		Site of service			Site of service		
MCR code	Description	Office, $	OPD, $	Differential, %	Office, $	OPD, $	Differential, %
71260TC	CT thorax w/contrast	232	300	29	196	298	52
74177TC	CT abdomen & pelvis w/ contrast (T)	271	581	115	262	484	85
77280	Simulation simple	153	108	−30	147	110	−25
77290	Simulation complex	460	264	−43	454	291	−36
77295	Simulation 3-D tumor volume	275	954	247	221	985	346
77300	Rad dosim Caclul	37	108	190	36	110	203
77301	Radiotherapy dose plan IMRT	1,591	954	−40	1,496	85	−34
77315	ISOS plan complex	61	264	333	57	291	411
77334	Tx devices com	88	200	128	89	202	127
77336	Radiation physics consult	47	108	131	45	110	145
77373[a]	SBRT delivery[b]	1,596	3,370	111	1,142	3,294	188
77373	SBRT delivery[c]	1,596	2,518	58	1,142	2,361	107
77413	RT delivery complex 6-10 MEV	241	169	−30	231	180	−22
77414	RT delivery complex 11-19 MEV	271	169	−38	260	180	−31
77418	Radiation tx delivery IMRT	476	458	−4	285	484	70
77470	Special radiation treatment	71	395	457	48	393	713
88185	Flow cytometry/tc, add-on	50	17	−66	50	12	−75
99204	Office/OP visit new	161	130	−19	162	128	−21
99205	Office/OP visit new	199	177	−12	201	174	−14
99211	Level 1 EST visit	20	54	172	20	57	189
99214	Office visit/OP EST	104	95	−9	105	97	−8
99215	Office visit/OP EST	140	130	−7	141	128	−9

[a] 77373 not paid under OPPS. Report multisession SBRT in the hospital setting as G0339 for the first fraction and G0340 for fractions 2-5 (may be 2,3,4, or 5, but not to exceed 5 treatments in total); [b] SBRT 77373 vs GO339 – first fraction; [c] SBRT 77373 vs G0340 – fractions 2-5.

retrospective study of breast cancer patients showed that increased travel time to the nearest radiation facility is associated with declining odds of receiving radiation therapy.[5]

Aside from increased travel time, the proposed reductions in radiation oncology reimbursement could affect patient access to quality care in other significant ways. Practices may respond to the loss of revenue by reducing both physician and nonphysician staff at their cancer centers, cutting staff salaries and benefits (including health insurance), or both. The ASTRO survey showed that 53% of community-based practices would likely respond to cuts on the order of those in the proposed rule by laying off physicians, and that 81% would lay off other professional staff, such as nurses. Core supportive services, such as nutritional counseling and patient navigator services, could well become luxuries that many cancer centers could no longer afford. Finally, financially stressed oncology practices could be forced to reduce the proportion of Medicare beneficiaries in their patient censuses and cut back on uncompensated care.

Non-code-specific payment differentials. The ability of almost one-third of the hospitals in the country to purchase single-source chemotherapy drugs through the 340B program at discounts of up to 50% below the prices available to private practice physicians further exacerbates the site-of-service differentials for infusion services that medical oncologists face. The proposed PFS and HOPPS rules for 2013 will bring parity to reimbursement for drugs themselves by raising the payment rates in the OPD for all physician-administered drugs that are separately

payable from this year's specified covered outpatient drug (SCOD) rate of average sales price (ASP) plus 4% to the ASP plus 6% rate applicable to physician offices. However, if CMS believes that ASP+6% is the appropriate payment rate for hospitals even when one-third of them purchase drug at discounts far below ASP, we believe that CMS should also support increasing physician office payment rates beyond ASP+6% and/or support HR 905 and S 733 legislation, which would make the ASP calculation more accurate by excluding wholesaler prompt pay discounts. We recommend that CMS clarify whether equating HOPD payment with the physician office rate means that HOPDs will be subject to average manufacturer price (AMP) substitution, should it be called for under the regulation adopted in last year's PFS Final Rule. Not doing so would represent another discretionary decision to exacerbate payment differentials based on site of care.

Notably, unlike physician offices, hospitals are reimbursed by Medicare reimbursement for a portion of the bad debt incurred by Medicare beneficiaries. Since the Medicare Modernization Act of 2003, a significant proportion of Medicare beneficiaries are unable to pay the required 20% coinsurance, often on expensive underlying bills. This differential is particularly meaningful in high-cost areas like medical oncology, where the average patient's treatment costs exceed $100,000. Medicare beneficiaries who seek cancer care in physician office settings are no more or less likely to be able to afford significant coinsurance payments than are Medicare beneficiaries who seek cancer care in hospital outpatient departments. It has been the experience of practices in the US Oncology Network that about 25% of the 20% Medicare beneficiary coinsurance (about 5% of the Medicare allowable) is uncollectible and ends up as bad debt. Although this is meaningful even in the context of services that involve a physician, nurse, or therapist's time and fixed assets that constitute capital expenditures, it is even more consequential in the context of Part B drugs where the practice buys the drug and is then reimbursed at ASP+6%. When 5% of the allowable is bad debt, an ASP+6% Medicare allowable effectively becomes an ASP+1% receivable. If, like hospitals, physicians were also reimbursed 70% (65% in 2013) of their Medicare bad debt, the actual receivable would increase to ASP+4.5% (4.25% in 2013) after bad debt and bad debt reimbursement.

Overall spending differentials. A recent study indicates that Medicare and its beneficiaries pay less when cancer care is managed from the physician office compared with the hospital outpatient department. A study conducted for the US Oncology Network last year by Milliman Inc looked at site-of-service differences in chemotherapy expenditures for Medicare patients during 2006-2009.[6] Milliman used data from the Medicare Limited Data Set for Medicare FFS (fee for service) patients only and found that the average Medicare Part A and Part B costs allowed for a cancer patient receiving chemotherapy was $4,361 a month for a patient treated in an office setting, compared with $4,981 a month for a patient seen in an HOPD, a difference of over $600 a month–more than 14% higher–in the HOPD setting. On an annualized basis, taking into account the average number of months that patients receive chemotherapy in a year, total expenditures were about $47,500 a year for office and $54,000 a year for HOPD patients, for an annualized difference of about $6,500 year. Beneficiaries who received care at an HOPD also incurred about $650 year in additional cost-sharing for their therapy. Lower costs for the physician office cohort compared with the HOPD cohort were evident across cancer types.

Recommendations for achieving payment parity for cancer care across sites of care

We believe the best solution to the problems outlined here is a value-based reimbursement system that pays the same amount regardless of the site of service and differentially more for quality and cost-effective care. We are committed to making a transition to a payment system focused on outcomes. Over the past 10 years, many in the cancer care community have taken significant steps toward such a system by developing and adhering to technology-enabled reporting on evidence-based guidelines. Unfortunately, the CMS and private payers have typically not provided enhanced payments for the quality or cost control initiatives led by practices. We look forward to working with CMS and Congress to shape a system that will appropriately incentivize the efficient delivery of evidence-based care and higher-quality care at the same cost or the same quality at a lower cost. However, we are concerned that such an undertaking is likely to take 5-10 years to realize. In the interim, we urge Congress and CMS to act swiftly to sustain low-cost settings of care, in part by moving toward FFS payment parity across sites of service. We believe that a pricing differention based on site of service over time leads to greater proliferation of the higher-cost centers of care.

MedPAC favors "harmonizing payments across sites of service to remove inappropriate incentives"[7] and has declared payment parity, when providers in different sectors furnish the same service to similar patients, "a core principle that guides the Commission's thinking."[7] MedPAC recognizes that "rationalizing payments for specific services across sectors to approximate paying the costs of

the most efficient sector" can reduce overall program expenditures and lead to more patient-centric decision-making.[7] We concur so long as the objective is appropriate payment and not simply an arbitrary default to the lowest rate determined by existing FFS payment systems. We concur with MedPAC's philosophy that the Medicare program should "mak[e] sure that relative update recommendations for the sectors do not exacerbate existing incentives to choose the sector based on payment considerations."[7]

MedPAC acknowledges that payment parity is difficult to achieve given the current statutory underpinnings of the different Medicare FFS payment systems that govern reimbursement in competing payment silos.[7] We recognize this difficulty, but we believe that maintaining significant site-of-service differentials will undermine policy makers' attempts to drive cost-effectiveness in the Medicare program. Given the distorting impacts that differentials have in a dynamic health care marketplace, we urge Congress and CMS to pursue a more rational system for reimbursing outpatient services that is not susceptible to significant differences in payment rate depending solely on the site of service. Specifically, we offer the following recommendations:

- Congress should enact and CMS should support the creation of a single outpatient services fee schedule for both hospitals and physician offices that is applicable regardless of the site of service.
- CMS should consistently and actively manage code-specific payment rates on all outpatient services provided in a physician's office and a hospital outpatient department toward parity. Most rapidly, CMS should actively work to eliminate payment inequities between the PFS and HOPPS for services that are central to modern cancer care and that jeopardize the advances in community-based oncology practice, which has been at the forefront of the battle to transform cancer into a manageable chronic disease.
- CMS should recognize the importance of payment parity across sites of service as discretionary payment policy decisions are implemented under the current separate payment systems. At least one discretionary payment proposal included in the 2013 PFS proposed rule—the provision to reduce payments for IMRT and SBRT in physician offices and freestanding radiation therapy centers to rates significantly below those in HOPDs—will exacerbate existing incentives and push cancer care from community to hospital settings.
- If policy makers do not pursue or do not achieve payment parity for outpatient services, then Congress should enact and CMS should support changes to the Medicare FFS benefit design to incentivize beneficiaries through lower copays and lower co-insurance percentages to seek care at the lower cost setting.
- In the absence of a statutory change that creates a new bad debt reimbursement system for physicians, CMS should work with Congress to adopt MedPAC's recent recommendations to reduce the instance of significant beneficiary bad debt in the first place. MedPAC proposes to reform the patient coinsurance obligations under the Medicare FFS benefit design so that the 20% coinsurance is no longer limitless and instead has a reasonable beneficiary out-of-pocket maximum that would be in line with the maximums under commercial health plans.[8] This reform would reduce oncology practice bad debt and Medicare bad debt reimbursement to hospitals for uncollectible beneficiary coinsurance.
- If CMS and/or other policy makers believe the overhead costs of certain settings should be higher and therefore should be reimbursed at a higher rate, then we urge CMS to support and Congress to enact policies that remove the assumed overhead cost differential from code-specific reimbursement rates and instead reimburse those overhead costs directly to provide heightened transparency and a better opportunity for parity on a service-specific basis.

Conclusion

The principle challenges in health care today are access to care and cost of care. The proliferation of community cancer centers during the past 25 years has allowed fragile cancer patients to receive convenient, high-quality care in their local communities. Presently, access to quality cancer care has often become restricted, not by lack of available treatment facilities, but by excessive cost sharing requirements that cancer patients are not able to afford. At a time when access and cost issues are intertwined, we believe that it is important that payment amounts be commensurate with the actual services provided, not the site of care. Preferentially paying higher amounts in certain settings will predictably lead to the expansion of higher cost centers. The result will be a further increase in the cost of cancer care for those who pay for it—patients, private and government payers.

References

1. Community Oncology Alliance. The changing landscape of cancer care. http://communityoncology.org/UserFiles/files/Community_Oncology_Practice_Impact_Report_4-4-12F.pdf. Published April 4, 2012. Accessed October 31, 2012.

2. Teske S. Number of independent physician practices continues to decline, house committee told. *Bloomberg BNA Medicare Report*. July 27, 2012. http://www.bna.com/number-independent-physician-n12884910940/. Accessed October 31, 2012.

3. MedPAC. Report to Congress: Medicare Payment Policy. Hospital inpatient and outpatient services. http://www.medpac.gov/chapters/Mar12_Ch03.pdf. Published March 2012. Accessed October 31, 2012.

4. American Society of Radiation Oncology. Significant Medicare cuts to radiation oncology would devastate cancer care. https://www.astro.org/uploadedFiles/Content/Advocacy/2012factsheetCMS_final.pdf. Published July 2012. Accessed October 31, 2012.

5. Punglia RS, Weeks JC, Neville BA, et al. Effect of distance to radiation treatment facility on use of radiation therapy after mastectomy in elderly women. *Int J Radiat Oncol Biol Phys*. 2006;66:56-63.

6. Fitch K, Pyenson B. Site of service cost differences for Medicare patients receving chemotherapy. Milliman Inc. http://publications.milliman.com/publications/health-published/pdfs/site-of-service-cost-differences.pdf. Published October 19, 2011. Accessed October 31, 2012.

7. MedPAC. Report to Congress: Medicare Payment Policy. Assessing payment adequacy and updating payments in fee-for-service Medicare. http://www.medpac.gov/chapters/Mar12_Ch02.pdf. Published March 2012. Accessed October 31, 2012.

8. MedPAC. Report to Congress: Medicare Payment Policy. Reforming Medicare's payment design. http://www.medpac.gov/chapters/Jun12_ch01.pdf. Published June 2012. Accessed October 31, 2012.