March 24, 2017

Francis J. Crosson, MD
Commissioner
Medicare Payment Advisory Commission
425 I St, NW
Suite 701
Washington, DC 20001

Dear Commissioner Crosson:

On behalf of the Board of Directors of the Community Oncology Alliance (COA), I am writing regarding the recent draft recommendations on Medicare Part B recently put forth by the Medicare Payment Advisory Commission (MedPAC) staff and discussed by the MedPAC commissioners. At COA, the first and foremost concern is the well-being of our patients—and ensuring that they have access to the highest quality, affordable cancer care, close to home. For this reason, with few exceptions, we completely disagree with the MedPAC draft Medicare Part B recommendations.

With all due respect to the MedPAC commissioners and staff, the Part B draft recommendations completely ignore the realities of the American cancer care delivery system and will backfire. If implemented, these recommendations will cause the complete opposite of their intent, fueling more increases in Part B costs for Medicare and beneficiaries.

I will try to keep this letter as brief as possible in explaining our deep opposition to the draft recommendations. We certainly offer—and hope—to meet with MedPAC staff and the commissioners to discuss this issue in more detail and share the data and studies backing our position.

The MedPAC Part B Recommendations Ignore the Dramatic Shift of Cancer Care Delivery into the Hospital Setting – And the Cost of this Shift to Medicare and Beneficiaries

Before 2004, the cancer delivery landscape was incredibly stable for decades, with 84% of chemotherapy delivered in independent, physician-run community cancer clinics (“community cancer clinics”). However, as the actuarial firm Milliman noted in a study published last year, by 2014, there had been a dramatic shift in the site of cancer care delivery, with only 54% of chemotherapy left being delivered in community cancer clinics. The remainder had moved to the far more expensive hospital outpatient setting.1

There are two major reasons for this shift in the site of care. First, Congress changed Part B drug reimbursement radically, and CMS further cut drug reimbursement, twice. Second, the dramatic expansion of the 340B program gives hospitals with substantial profit margins on cancer drugs powerful incentives to acquire community cancer clinics.

1 Cost Drivers of Cancer Care: A Retrospective Analyses of Medicare and Commercially Insured Population Claim Data 2004-2014, Milliman, April 2016.
In 2003, Congress radically changed Part B drug reimbursement in the Medicare Modernization Act. Along with a change in the basis for reimbursement to average sales price (ASP) plus 6%, CMS further reduced drug reimbursement by requiring that pharmaceutical manufacturers include wholesaler prompt pay discounts in the calculation of ASP—even though these are manufacturer-to-wholesaler financing terms that are not available to community oncology clinics. Then, in 2012, CMS decided to apply the Medicare sequester cut to drug reimbursement, cutting it even further.

Hospitals have realized that obtaining 340B status not only insulates them from the continued cuts to Part B drug reimbursement but also provides them with unprecedented profit margins on the most expensive Part B drugs. The result has been a dramatic expansion of the 340B program driven primarily by hospitals. Consider this staggering statistic: In 2004, only 3% of all Part B chemotherapy was administered in 340B hospitals, but by 2014 that had increased to close to 25% of all Part B chemotherapy. With profit margins on the most expensive cancer drugs exceeding 100% in the 340B program, hospitals have powerful incentives to acquire community cancer clinics and, in the process, use more drugs or more expensive drugs. In fact, this was a finding expressed by the government’s very own Government Accountability Office.²

The shift in cancer care into the more expensive hospital setting has been documented as increasing costs to Medicare. In 2014 alone—just one year—Milliman found that this shift cost Medicare $2 billion more than it would have had the site-of-service remained in the community practice setting.³ Obviously, an increased cost to Medicare has a corresponding increase to Medicare beneficiaries. Additionally, it is no coincidence that over the same time as this shift, Part B list drug prices have gone up, fueled, in part, by an increasing scope and magnitude of 340B discounts. Several studies have documented the widening spread between list and net drug prices.⁴

MedPAC is now recommending changes to an already unstable cancer care delivery system—changes that would further lower Part B drug reimbursement. Given the well-documented impact that historical reductions in Part B reimbursements have had, it is inescapable that the MedPAC recommendations will accelerate the shift in the site of cancer care into the more expensive hospital setting, increasing costs to Medicare and beneficiaries, while further fueling drug prices. The fact that MedPAC is taking this draft recommendation seriously is mind-boggling.

We also do not understand why MedPAC is so focused on the 6% add-on to ASP which ignores the reality that a) it is now closer to 2% with the prompt-pay and sequester cuts, and b) the 2% must cover the infrastructure and human resource costs of drug procurement, inventory, storage, monitoring, and waste disposal. However, on the other hand, 340B hospital margins of upwards of 100% on Part B drugs are pure profit, with absolutely no requirement that those profits be used to help patients in need. In fact, a study by Avalere Health found that just 24% of 340B hospitals provide 80% of all the charity care, despite representing less than half the beds available in the program.⁵ The same report also noted that 37% of 340B hospitals provided charity care representing less than 1% of total patient costs, which, it should be noted, is well below the national average for all hospitals.

The Part B Drug Value Program is Unworkable

There are numerous problems with the Part B Drug Value Program (DVP) outlined in the MedPAC draft recommendations; however, we will summarize just the key problems.

First, looking at Part B cancer drugs, there are few instances with generic or close therapeutic substitutes. A peer-reviewed paper published just a few months ago analyzed this very issue in relation to the now withdrawn Medicare

³ See supra, n. 1.
⁵ Unfulfilled Expectations: An Analysis of Charity Care provided by 340B Hospitals. Avalere Health, 2014.
Part B Drug Purchasing Model. It found, very clearly, that “For the largest Medicare oncology drug expenditures, there is not a lower-cost option with equal efficacy for their primary indications.” The concept of negotiating Part B drug prices is fundamentally flawed when it comes to cancer care as there are simply no alternatives.

Second, introducing third-party, pharmacy benefit manager (PBM) type entities to negotiate Part B drug prices is a fatal mistake. This proposal is completely oblivious to the scrutiny PBM middlemen are currently under for actually increasing costs to Medicare and beneficiaries, as well as Part D drug prices. We call your attention to several bills in the House and the Senate dealing with PBM abuses. PBM-type middlemen will be the ones to capture the profits in this DVP scheme, while beneficiaries and Medicare pay more. That is the lesson now being learned with Part D.

Third, the idea of creating a formulary to artificially induce competition in price negotiations, administered by a third party PBM-type entity, is simply reckless. This would create obstacles to Medicare beneficiaries receiving the most appropriate cancer therapy available as decided by the physician and patient – not some corporate, profit-seeking PBM-type entity. Physicians and clinical staff across the country can attest to the fact that PBMs already have an atrocious track record of delaying or denying sometimes life-saving patient care. We regularly face 30-45 day delays in patients receiving needed medications because of problems with PBM bureaucracies, all of which are held unaccountable. The current situation of PBM middlemen is completely contrary to high-quality patient care, and MedPAC should not be encouraging proposals that would make PBM-type entities more entrenched in our health care system.

Finally, using the “stick” of lower Part B reimbursement to push community oncology practices into the Part B DVP will only accelerate practices being pressured to be acquired by hospitals – especially 340B hospitals. On the other hand, 340B hospitals with Part B drug profit margins as high as 100% will not be motivated to participate in the DVP because what is a substantial reimbursement cut to community oncology practices is a negligible cut to 340B hospitals. The net result will be to shift more cancer care to the much more expensive hospital setting, increasing cancer care costs for both Medicare and beneficiaries.

Working on Viable Solutions

No one can accuse community oncology providers, and COA specifically, of standing in the way of seeking solutions to expensive cancer therapies while ensuring that patients continue to receive the highest quality cancer care. As the front-line providers for the majority of Americans with cancer, we understand better than anyone the realities and problems of the increasing cost of cancer care.

For close to five years, COA has been working with Medicare and private insurers in advancing real payment reform in cancer care. Seven community oncology clinics participated in the Medicare COME HOME project based on the patient-centered Oncology Medical Home model that community oncologists created and continue to advance. Additionally, many community oncology practices also engage in numerous payment reform projects with private payers, including Aetna, Anthem, Cigna, Horizon, Humana, Priority, and UnitedHealthcare, to name a few. These projects are producing impressive results in both enhancing the quality of cancer care and reducing costs. During the past three years, we have also held major summits where close to 200 providers, payers, and industry representatives have come together to discuss oncology payment reform projects in the field and to share ideas in an open, cooperative, information exchange forum.

Currently, we also are hosting close to 80% of the Medicare Oncology Care Model (OCM) participants in a network cooperative to ensure the success of that model. This is helping shape our work on what we call the “OCM 2.0,” an advanced model with single-sided and double-sided risk, which will incorporate concepts related to testing value-based

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7 Creating Transparency to Have Drug Rebates Unlocked (C-THRU) Act (S.637) and Prescription Drug Price Transparency Act (H.R. 1316).
As you can clearly see, community oncology is leading progress in tackling the increasing costs of cancer care. In doing so, we are using data, market facts, and the real-world medical experience of physicians, nurses, administrators, and others on the front lines of cancer care to craft viable, patient-centric solutions. **However, the MedPAC recommendations are the antithesis of this and, just to underscore, will only make the nation’s cancer care delivery system more unstable and increase costs for beneficiaries, Medicare, and taxpayers, if enacted.**

We welcome the opportunity of discussing this and opportunities to work together on viable solutions with MedPAC staff and the commissioners.

Sincerely,

Jeff Vacirca, MD
President

cc: Hon. Kevin Brady, Chairman, House Ways and Means Committee
Hon. Richard Neal, Ranking Member, House Ways and Means Committee
Hon. Pat Tiberi, Chairman, Ways and Means Subcommittee on Health
Hon. Sander Levin, Ranking Member, Ways and Means Subcommittee on Health
Hon. Greg Walden, Chairman, House Energy and Commerce Committee
Hon. Frank Pallone, Jr., Ranking Member, House Energy and Commerce Committee
Hon. Michael Burgess, Chairman, Energy and Commerce Subcommittee on Health
Hon. Gene Green, Ranking Member, Energy and Commerce Subcommittee on Health
Hon. Orrin Hatch, Chairman, Senate Committee on Finance
Hon. Ron Wyden, Ranking Member, Senate Committee on Finance
Hon. Patrick J. Toomey, Chairman, Senate Finance Subcommittee on Health Care
Hon. Debbie Stabenow, Ranking Member, Senate Finance Subcommittee on Health Care
Hon. Phil Roe, MD., Co-Chair, GOP Doctors Caucus