Site Parity
Community Oncology Alliance Position Statement

Community Oncology Alliance Position:
The Community Oncology Alliance (COA) strongly believes that payments for the same services should be reimbursed at the same rates regardless of the setting in which they are delivered and is an advocate for site parity and site neutral payments. Site parity would equalize patients’ cost of cancer care despite the ever-increasing dominance of the more costly hospital-based cancer care.

Background:

A Historical Look at the Site of Care
In the late 1970s and early 1980s, chemotherapy transitioned from a hospital-based inpatient procedure to a community oncology, physician office-based outpatient procedure. Over the last 10 years, various market factors, which will be examined later in this position paper, have caused cancer care to begin transitioning to hospital outpatient departments. Community oncologists, who in 2009 cared for 84 percent of all patients with cancer, now care for about 55 percent of patients with cancer.

Why the Site of Care Changed and is Changing Again
In the 1960s, medical oncology did not exist as a clinical specialty. The main issue of the day was whether cancer drugs caused more harm than good and talk of curing cancer with drugs was not considered compatible with sanity. The move from inpatient to outpatient care was facilitated by the rapid increase in infusion pumps that enabled physicians to provide chemotherapy in their offices, the development of antiemetics that enabled better control of adverse events during chemotherapy, and the development of drugs that were increasingly more effective and less toxic.

In 2009, despite these advances and more, cancer care began to migrate back to hospitals, in outpatient clinics this time rather than as inpatient care. Three factors were largely responsible for the trend reversal.

The Medicare Fee for Service (FFS) Physician Fee Schedule (PFS), a complete listing of fees used by Medicare to pay doctors or other providers/suppliers and from which private payers also often base reimbursement for care provided to non-Medicare patients, began showing a distinct trend. For each year between 2012 and 2019, the PFS for hospital outpatient physicians increased slightly while the FFS for non-hospital-based physicians was flat or decreased.

The 340B Drug Payment Program, a safety net program whereby hospitals may purchase drugs, including antineoplastic drugs, at a significantly reduced price was intended to assist hospitals treating uninsured and indigent patients. The program has gone awry because hospitals, having discovered that the 340B discount is applied to all drugs purchased and not just those for underinsured, uninsured, and indigent patients, realized that having an outpatient cancer clinic could be very profitable due to the profit margins on expensive cancer drugs purchased at a 340B
discount. Hospitals have aggressively pursued participation in the 340B program and the subsequent establishment of outpatient cancer clinics.

The Budget Control Act of 2011 called for automatic cuts to spending, known as sequestration. These cuts, which began in March 2013, included a two percent cut to the reimbursement of Part B injectable antineoplastic drugs. This caused the reimbursement for some drugs to be less than the cost of acquisition. Some community oncology practices could not sustain the economics of treating patients with those lower- or under-reimbursed drugs. Practices were forced to send patients to hospital cancer clinics or be absorbed into hospital run outpatient departments.

Data Show Extreme Site of Care Cancer Treatment Cost Differences
There have been over 30 studies conducted between October 2011 and March 2019 that have all reached very similar conclusions. The cancer care provided in a physician office-based setting costs less than the same care when provided in the hospital outpatient department (HOPD).

The February 2019 study, “Hospital Prices Grew Substantially Faster Than Physician Prices For Hospital-Based Care In 2007–14”, concluded that not only were hospital prices higher than physician prices, but in the period 2007-2014, they grew at a faster rate. The study found that for hospital-based outpatient care, hospital prices grew 25 percent, while physician prices grew six percent. Most of the growth in payments for inpatient and hospital-based outpatient care was driven by growth in hospital prices, not physician prices.³

In the 2017 study, “The Value of Community Oncology Site of Care Cost Analysis", the authors found across all cancers, the mean total cost paid per month was significantly lower in patients who were treated in a community-based practice ($12,548) compared with those who were treated in a hospital-owned practice ($20,060). Further, the lower costs associated with patients treated in community practices were observed irrespective of treatment regimen, branded vs generic agents used, or tumor type. Importantly, it was found that the cost differential is largely driven by lower chemotherapy costs and physician visits in community-based practices.⁴

Another 2017 study, “Differences in Health Care Use and Costs Among Patients with Cancer Receiving Intravenous Chemotherapy in Physician Offices Versus in Hospital Outpatient Settings”, examined a sample including 18,740 patients who had a mean age of 51.6 years and a Deyo-Charlson Comorbidity Index score of 5.37. The study concluded that despite similar resource use, all-cause and cancer-related health care costs in HOPDs were significantly higher compared with those in community oncology clinic settings.⁵

Health insurers are increasingly creating programs to encourage patients to move away from hospitals and instead use lower-priced outpatient providers or in-home services to reduce health care costs and hold down premiums. For example, insurers are requiring prior authorization for services done at hospitals for administration of intravenous drugs and want patients to use lower-priced outpatient providers or get infusion services done at home by a visiting nurse. Employers are demanding health insurers restrain rising costs and patients also are realizing they pay more out of pocket with high-deductible benefit plans if they go to higher-cost settings.⁶

Patients Pay Substantially More for Cancer Care in Higher Cost Hospital Settings
To better understand the true patient impact of the site of care cost differential, studies on a cancer type basis, have demonstrated the comparative cost.

The 2018 study, “Cost Differences Associated with Oncology Care Delivered in a Community Setting Versus a Hospital Setting: A Matched-Claims Analysis of Patients With Breast, Colorectal, and Lung Cancers”, found striking differences. Cost data for 6,675 patients with breast, colorectal, and lung cancer were analyzed as cost per patient per month (PPPM). Patients treated within a community setting were matched (2 to 1) with those treated at a hospital clinic based on cancer type, chemotherapy regimen, receipt of radiation therapy, presence of metastatic disease, sex, prior surgery, and geographic region. The mean total costs per patient per month were determined as listed below.

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Community Practice</th>
<th>Hospital Based Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with breast cancer</td>
<td>$11,599</td>
<td>$19,279</td>
</tr>
<tr>
<td>Patients with lung cancer</td>
<td>$17,566</td>
<td>$25,980</td>
</tr>
<tr>
<td>Patients with colorectal cancer</td>
<td>$12,368</td>
<td>$19,346</td>
</tr>
</tbody>
</table>

Accordingly, the authors observed significantly increased costs of care for the patient population treated at hospital-based clinics versus those treated at community-based clinics, largely driven by the increased cost of chemotherapy and provider visits in hospital-based clinics. If the site of cancer care delivery continues to shift toward hospital-based clinics, the increased health care spending for payers and patients should be better elucidated and addressed.

**Why Site Parity and Site Neutral Payments Matter**

A cancer diagnosis and the immediate search for treatment often precludes a thorough cost comparison when selecting a cancer provider. Most patients have selected either a community oncology physician or a hospital-based physician unaware that that choice will have profound impact of the cost of their care.

In 2011, a study by Milliman, “Site of Service Cost Differences for Medicare Patients Receiving Chemotherapy”, concluded that Medicare costs are $6,500 higher for patients receiving chemotherapy in the HOPD versus the physician-office setting and costs were about 10 percent higher in the HOPD resulting in an additional $650 out of pocket cost per patient per year.

In its 2013 study, “Cost Differences in Cancer Care Across Settings”, the Moran Group concluded patients receive more chemotherapy administration sessions on average when treated in the HOPD—and that the cost of chemotherapy services used is meaningfully higher in the hospital outpatient department. Additionally, on a per beneficiary basis, hospital chemotherapy spending was approximately between 25 percent and 47 percent higher than physician office chemotherapy spending.

The 2018 study, “Cost Differences Associated with Oncology Care Delivered in a Community Setting Versus a Hospital Setting: A Matched-Claims Analysis of Patients with Breast, Colorectal, and Lung Cancers”, affirms the differential remains, and the cost of care was still higher in the hospital outpatient departments than in physician or community-based clinics.
When it comes to the various costs of cancer care, including chemotherapy, immunotherapy, emergency department (ED) visits, outpatient care, daily expenditures, and 6-month expenditures, hospital-based practices continue to be outperformed by community cancer clinics. In the current oncology climate, the search for affordable access to cancer care is a growing concern because of the steep price of treatment advancements, inpatient, outpatient, and ED costs, and financial bankruptcy or mergers that limit the number of community cancer clinics.\(^\text{12}\)

In a time of payment reform and with a national imperative to lower health care costs, one must address a significant source of rising costs – namely, the growing shift of care from independent community practices to the more expensive hospital outpatient departments. Higher costs and utilization of drugs and services in HOPDs, combined with ever-expanding use of HOPDs due to provider consolidation, are driving escalating cancer care costs. The same cancer care using the same antineoplastic agents should not vary in cost based on the site of care. This troubling pattern encourages the implementation of site neutral cost system to level the playing field between cancer care delivered in hospital and community practice settings. This leveling will have the effect of reducing costs to seniors, employers, Medicare, and taxpayers.

**Summary:**

COA advocates for site parity and site neutral payments for community-based cancer care no matter the site of service. COA is committed to ensuring that patients with cancer can receive care in the highest quality and best value settings. Today, the cost of cancer care varies substantially based on whether it was delivered at an independent, community practice versus a hospital or hospital-affiliated outpatient department. Hospital-based cancer care is much more expensive, often as much as 55 percent more, than the same care delivered in a community practice. A cancer diagnosis and the immediate search for treatment often precludes a thorough cost comparison when selecting a cancer provider. Additionally, because of hospital mergers and consolidation, most patients and payers are unaware or powerless to make informed site of care decisions that have a profound impact on the cost of their care.

**Date:**

Approved by the COA Board of Directors on September 16, 2019.

**References:**

2. FFS Trends, Center for Medicare and Medicaid Services, April 19, 2018
5. *Differences in Health Care Use and Costs Among Patients With Cancer Receiving Intravenous Chemotherapy in Physician Offices Versus in Hospital Outpatient Settings*, Maxine D. Fisher, PhD, Rajeshwari Punekar, PhD, Yeun

6 Health Insurers Push Patients Away from Hospitals, Jay Greene, Crain’s Detroit Business, April 01, 2018.

7 Cost Differences Associated With Oncology Care Delivered in a Community Setting Versus a Hospital Setting: A Matched-Claims Analysis of Patients With Breast, Colorectal, and Lung Cancers

8 Ibid.

9 Ibid.

10 Milliman 2011 Site of Service Cost Differences for Medicare Patients Receiving Chemotherapy

11 Cost Differential by Site of Service for Cancer Patients Receiving Chemotherapy, Jad Hayes, MS, ASA, MAAA; J. Russell Hoverman, MD, PhD; Matthew E. Brow, BA; Dana C. Dilbeck, BA; Diana K. Verrilli, MS; Jody Garey, PharmD; Janet L. Espirito, PharmD; Jorge Cardona, BS; and Roy Beveridge, MD., The American Journal of manages Care, Vol. 21 No. 3, March 29=015.