September 8, 2021

The Honorable Charles E. Schumer  
Majority Leader  
United States Senate  
322 Hart Senate Office Building  
Washington, D.C. 20510

The Honorable Mitch McConnell  
Minority Leader  
United States Senate  
317 Russell Senate Office Building  
Washington, D.C. 20510

The Honorable Nancy Pelosi  
Speaker  
United States House of Representatives  
1236 Longworth House Office Building  
Washington, D.C. 20515

The Honorable Kevin McCarthy  
Minority Leader  
United States House of Representatives  
2468 Rayburn House Office Building  
Washington, D.C. 20515

Dear Majority Leader Schumer, Minority Leader McConnell, Speaker Pelosi, and Minority Leader McCarthy:

On behalf of the Board of Directors of the Community Oncology Alliance (“COA”), we are writing to ask that you please help address the unfolding cancer care “infrastructure” crisis in this country and not make it worse with destructive policy and regulations that threaten America’s patients. While Congress is working to address physical and “human” infrastructure, it is overlooking the very real threats to the nation’s cancer care infrastructure and the strain it is under.

As background, COA is an organization dedicated to advocating for the complex care and access needs of patients with cancer and the community oncology practices that serve them. COA is the only non-profit organization in the United States dedicated solely to independent community oncology practices, which serve the majority of Americans receiving treatment for cancer. Since its grassroots founding close to 20 years ago, COA’s mission has been to ensure that patients with cancer receive quality, affordable, and accessible cancer care in their own communities where they live and work, regardless of their racial, ethnic, demographic, or socioeconomic status.

According to the National Cancer Institute, an estimated 1.9 million Americans in 2021 will be diagnosed with cancer, and over 600,000 will die from the disease.\(^1\) And cancer is the leading cause of death for those under 65 years of age.\(^2\) However, as the data clearly shows, we are extremely concerned that many Americans will not be diagnosed – or diagnosed at a much later stage of cancer – due to screening shortfalls as a result of the COVID-19 public health emergency (“PHE”).

Independent community oncology practices have bravely managed to keep their doors open during the pandemic to treat Americans with cancer while the COVID-19 virus is still ravaging the country, forcing hospitals to focus on treating COVID patients. The Herculean efforts of community oncology practices during the pandemic have once again proven their value as the backbone of the nation’s cancer care infrastructure. Unfortunately, the emotional and financial pressure

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2 Ibid.
that oncologists and practice teams have faced during these challenging times has been enormous. We optimistically believed that we were seeing the light at the end of the tunnel of this pandemic, but the spread of the Delta variant of the virus created another devastating wave of COVID. We are very concerned that cancer screening shortfalls over the last 18 months are now worsening during this resurgence, resulting in even more patients going undiagnosed or presenting with advanced cancers. This will put additional pressure on independent community oncology practices as hospitals in many areas of the country, especially in rural areas, must dedicate their resources almost exclusively to treating patients with COVID.

Rather than our government asking what it should be doing to help community oncology practices keep their doors open to treat Americans with cancer, it is doing the exact opposite – risking putting even more strain on practices that serve as the foundational infrastructure of cancer care in the United States. Consider what Congress and this administration are doing or proposing:

- Congress is considering advancing harmful proposals like H.R. 3 that would empower Medicare to “negotiate” Part B drug prices. This threatens to a) limit the cutting-edge, life-saving treatments that oncologists have in this country to treat Americans with cancer, and b) to make these drugs financially unfeasible to administer in independent community oncology practices, forcing cancer care into the much more expensive hospital setting.
- Congress is paying for the bipartisan infrastructure bill in part by extending the Medicare sequester cut for yet another year, rather than stopping this onerous financial burden on community oncology practices.
- The Centers for Medicare & Medicaid Services (“CMS”) is proposing devastating Medicare payment cuts to cancer care diagnosis and treatment, including the administration of potentially life-saving chemotherapy and immunotherapy drugs, as well as radiation therapy.
- CMS, via its Center for Medicare and Medicaid Innovation (“CMMI”), is forcing community oncology practices to participate in a mandatory experiment on radiation cancer treatment in the middle of the ongoing PHE and pandemic.

In the face of what Congress and the administration are doing or proposing, community oncology practices are fighting back the growing intrusions of pharmacy benefit managers (“PBMs”) and their corporate-affiliated insurers dictating how oncologists treat their patients, as well as how and where patients receive their drugs. Patients with cancer are inhumanely being forced to “fail first” (step therapy) on substandard cancer treatments dictated by the PBM/insurer before they can receive the optimal cancer treatment prescribed by their oncologists. Tragically, patients with cancer are often forced to wait weeks, and even months in some cases, for their drugs to be authorized and delivered by PBM mail-order pharmacies.

The pressures community oncology practices face from misguided, bad public policy, as well as Congress not reining in PBM abuses, is deeply eroding the nation’s cancer care infrastructure. From 2008 to 2020, 1,748 community oncology clinics and/or practices have closed, been acquired by hospitals, merged, or reported financial difficulties.\(^3\) Independent community oncology practices are increasingly being purchased by hospitals at a 9.7 percent increase from 2018 to 2020 alone.\(^4\) It has been extensively documented that it cost more for hospitals to deliver cancer care, and as a report that COA has commissioned and will soon release shows, hospitals participating in the 340B Drug Pricing Program (“340B”) are excessively marking up the prices of expensive cancer drugs and other specialty therapies.

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\(^4\) Ibid.
Yes, drug prices are higher in the United States than in almost all other countries. That starts with the responsibility of pharmaceutical manufacturers to lower drug prices, which COA has long been outspoken on. However, no country in the world has the same byzantine mess of regulations, secret PBM rebates, hospital 340B discounts, insurer/PBM impediments to biosimilar use, and other drug price perversions as in the United States. Effectively price-fixing drugs via “negotiation,” as contemplated in the Trump “Most Favored Nation” proposal and in H.R. 3, will simply lead to less cutting-edge, life-saving therapies, even by the most recent “optimistic” estimates by the Congressional Budget Office.⁵

The Federal government and Congress should instead focus on eliminating all the secretive “rebates” and “discounts” demanded by intermediary PBMs and insurers; stopping misguided and abused public regulations such as 340B; reexamining hospital mergers that have consolidated the nation’s health care system into large state, regional, and national monopolies; encourage more use of less expensive biosimilars, and allow more value-based drug arrangements to push pharmaceutical manufacturers to compete. Doing this will truly result in lower drug prices for Americans.

The COVID-19 pandemic continues to significantly burden community oncology practices – especially in rural and underserved areas – which have struggled to maintain the financial viability of keeping their practices open while preventing virus transmission among vulnerable patients and staff. Practices are just beginning to see the devastating effects of delayed or skipped critical cancer screenings because of the pandemic. Due to the pandemic, cancer screening rates have decreased for breast (-21 percent), colon (-32 percent), lung (-38 percent), and prostate (-17 percent) cancers as of March 2021 compared to pre-COVID levels.⁶ As seen in the graph below, radiation treatment has also decreased, likely as a result of missed cancer screenings, for breast cancer (-28 percent), colon cancer (-25 percent), and lung cancer (-31 percent) as of November 2020 compared to pre-COVID levels.⁷ Doctors warn that this will only lead to more death and suffering as later stage cancers are harder, if not impossible, to treat effectively.

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⁵ https://www.cbo.gov/publication/57010
⁶ Avalere Health and COA analysis of Inovalon Provider Clearinghouse data. Note: Claims on average represent 5-7 of Medicare FFS nationally and include CMS-1450 claims from Institutional providers and CMS-1500 claims from Non-Institutional or Professional providers.
⁷ Ibid.
Addressing the delayed cancer care screenings and treatment must remain an urgent priority for our government. Congress and the administration should be helping us address the adverse impacts of COVID on Americans with cancer, not further burdening community oncology practices. Our physicians are especially concerned that the screening shortfalls have worsened health disparities along racial, ethnic, and socioeconomic lines. We need your help!

As the politics swirl over competing infrastructure packages and how to pay for them, please help protect the nation’s cancer care infrastructure. Very specifically, we implore you to do the following:

• Stop the Medicare sequester cuts – don’t extend the sequester further.
• Stop the CMS proposed Medicare payment cuts to cancer care.
• Stop the implementation of the mandatory radiation oncology experiment.
• Rein in PBM abuses and rebates, as well as hospital 340B discounts – discounts that should be going to patients, not institutions – that are fueling drug prices.
• Help us access biosimilars and remove barriers to their use.
• Do not advance any provisions, such as in H.R. 3, that would limit oncologists’ access to and use of cutting-edge, life-saving cancer therapies.
• Remove barriers to value-based drug arrangements to push pharmaceutical manufacturers to compete in lowering drug prices.

We welcome the opportunity to discuss any of this in greater detail.

Sincerely,

Kashyap Patel, MD
President

Ted Okon
Executive Director

CC: The Honorable Ron Wyden
The Honorable Mike Crapo
The Honorable Frank Pallone
The Honorable Cathy McMorris Rodgers
The Honorable Richard Neal
The Honorable Kevin Brady
The Honorable Xavier Becerra
The Honorable Chiquita Brooks-LaSure