July 11, 2017

The Honorable Pat Roberts
109 Hart Senate Office Building
Washington, DC 20510

The Honorable Sherrod Brown
713 Hart Senate Office Building
Washington, DC 20510

The Honorable Debbie Stabenow
731 Hart Senate Office Building
Washington, DC 20510

The Honorable Robert Casey Jr.
393 Russell Senate Office Building
Washington, DC 20510

Dear Senators Roberts, Stabenow, Brown, and Casey:

The undersigned organizations are writing in support of S. 1304 because we believe it will help patients access care in their communities by stabilizing Part B reimbursement. We must protect community-based providers and ensure they remain viable to ensure patient access. Doing so will lower costs for taxpayers and patients.

Multiple studies have illustrated that flawed Medicare reimbursement policies are causing community-based practices to close their doors or integrate with larger health systems, affecting patient access and increasing costs. For example, according to the Community Oncology Alliance, more than 1,300 community cancer care centers have closed, consolidated, or reported financial problems since 2008.[1] As a result, many patients have no choice but to access care in more expensive settings, sometimes at a great distance from their homes. According to Milliman, from 2004 to 2014, the portion of chemotherapy infusions delivered in hospital outpatient departments increased from 15.8 percent to 45.9 percent in the Medicare population.[2]

As patients lose access to community-based care and are forced to seek care in larger health systems, Medicare's cost-sharing requirements dictate they pay more for identical treatment regimens, and incur additional transportation and lodging costs. In fact, Medicare pays $6,500 more per beneficiary annually for chemotherapy administration in a hospital outpatient department (HOPD) as compared to a community cancer clinic, and Medicare patients correspondingly face $650 more in out-of-pocket copayments in the hospital setting.[3]

This is why we support your legislation which excludes from ASP any customary prompt pay discounts from manufacturers to wholesalers in calculating Medicare payments for Part B drugs – simply put, Part B physicians should be reimbursed adequately to ensure patients are treated in the most cost-effective, high quality site of care. Putting an end to this practice is crucial to

[1] "The Changing Landscape of Cancer Care." Community Oncology Alliance, 21 Oct 2014. http://www.pactcoalition.org/wp-content/uploads/2014/10/Community_Oncology_Practice_Impact_Report_10-21-14F.pdf

[2] "Cost Drivers of Cancer Care: A Retrospective Analysis of Medicare and Commercially Insured Population Claim Data 2004-2014." Milliman, Apr 2016. http://www.milliman.com/uploadedFiles/insight/2016/trends-in-cancer-care.pdf

[3] Cost Differences in Cancer Care Across Settings, Moran Company, August, 2013 https://media.gractions.com/E5820F8C11F80915AE699A1BD4FA0948B6285786/adebd67d-dcb6-46e0-afc3-7f410de24657.pdf

maintaining access to quality, affordable, community-based care because community-based providers are not able to absorb the lower reimbursement rates.

We thank you for your leadership on this issue and look forward to working with you to pass this important legislation.

Sincerely,

ADAP Advocacy Association (aaa+)
Alliance for the Adoption of Innovations in Medicine (Aimed Alliance)
AmerisourceBergen
Caregiver Action Network
Community Access National Network (CANN)
Community Liver Alliance
Community Oncology Alliance (COA)
Cutananeous Lymphoma Foundation
Empower U Community Health Center
Healthcare Distribution Alliance
ION Solutions
Lung Cancer Alliance
Patients Rising
Prevent Cancer Foundation
RetireSafe
The US Oncology Network
Us TOO International Prostate Cancer Education & Support
ZERO - The End of Prostate Cancer