I

113TH CONGRESS
1ST SESSION

# H. R. 2869

To amend title XVIII of the Social Security Act to establish payment parity under the Medicare program for ambulatory cancer care services furnished in the hospital outpatient department and the physician office setting.

---

IN THE HOUSE OF REPRESENTATIVES

JULY 31, 2013

Mr. ROGERS of Michigan (for himself and Ms. MATSUI) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

# A BILL

To amend title XVIII of the Social Security Act to establish payment parity under the Medicare program for ambulatory cancer care services furnished in the hospital outpatient department and the physician office setting.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Medicare Patient Access to Cancer Treatment Act of 2013''.

**SEC. 2. FINDINGS; SENSE OF CONGRESS.**

(a) FINDINGS.—Congress finds the following:

(1) The National Cancer Institute estimates that approximately 13.7 million Americans with a history of cancer were alive on January 1, 2012.

(2) About 8 million of the 13.7 million Americans living with cancer are over age 65, and approximately half of cancer care spending is associated with Medicare beneficiaries.

(3) National spending on cancer care in 2010 is estimated at $125 billion.

(4) In 2011, the National Cancer Institute released projections of the cost of cancer care in the United States, finding the total cost of cancer care in 2020 is expected to be $206 billion.

(5) In a 2010 study, Milliman reported that in 2007 a cancer patient receiving chemotherapy incurred average costs of approximately $111,000, three times the cost of a coronary artery disease patient, and six times the cost of a diabetes patient.

(6) Over the last several years, the United States has been touted as world leader in providing high-quality cancer care.

(7) United States cancer survival rates are higher than the average in Europe and Canada for 13 of 16 types of cancer.

(8) Until recently, over 80 percent of United States cancer patients received care in the community setting.

(9) Over the past several years, the country has experienced a significant shift of outpatient cancer care delivery from the physician's office to the hospital outpatient department.

(10) Reports show that over the past six years, 43 community practices have started referring all of their patients elsewhere for treatment, 288 oncology office locations have closed, 131 practices have merged or were acquired by a corporate entity other than a hospital, and 469 oncology groups have entered into an employment or professional services agreement with a hospital.

(11) Over 1,000 clinics or practices have been impacted over the last 3 years out of a population of only 6,000 oncologists in community practice in the United States.

(12) A 2013 study published by The Moran Company (''Moran study'') found that, between 2005 and 2011, there was a 150 percent increase in administered chemotherapy in the hospital outpatient setting for Medicare fee-for-service beneficiaries (increasing from 13.5 percent in 2005 to

33.0 percent in 2011) as compared to administration in physician community cancer clinics.

(13) The Moran study found that, in 2005, almost 87 percent of Medicare patients were receiving their care in the community setting, by 2011 only 67 percent were utilizing the community setting.

(14) The Moran study reports that Medicare payments for chemotherapy administered in hospital outpatient settings have more than tripled since 2005 (from $90 million to $300 million) while payments to physician community cancer clinics have actually decreased by 14.5 percent.

(15) The Medicare physician fee schedule rate in 2012 for CPT Code 96413 (Chemo, iv infusion, 1 hr), the most common drug administration code billed by oncology practices, is $139 but the payment rate for the same service under the Medicare hospital outpatient prospective payment system (HOPPS) fee schedule in 2012 is 50 percent higher at $208.

(16) Utilization-weighted Medicare payment for infusion services is approximately 55 percent higher at the hospital outpatient department than in a physician's office.

(17) Medicare proposed in 2012 to pay hospital outpatient departments 25 percent more for radiation therapy services than for the same services performed in physicians' offices, including a 70 percent differential for intensity modulated radiation treatment (IMRT) and a 188 percent differential for stereotactic body radiation therapy delivery (SBRT).

(18) One third of hospitals in the United States purchase chemotherapy drugs through the section 340B program at a discount of up to 50 percent, resulting in a net cost to such hospitals that typically is at least 30 percent below reimbursement rate (which is based on 106 percent of the average sales price) for community oncologists for such drugs.

(19) Medicare reimburses 70 percent of hospital bad debt (uncollectable coinsurance).

(20) According to an October 2011 Milliman study, the cost of treating cancer patients is significantly lower for both Medicare patients (10 percent lower in copayment amounts, more than $650 savings a year) and the Medicare program (14.2 percent less, a savings of $6,500 a year per patient) when provided in community-based cancer settings as compared to the same treatment in hospital outpatient departments.

(21) The April 1, 2013, sequestration cuts to Medicare allowed for a 28 percent cut to the services reimbursement in Medicare part B drugs to community oncologists.

(22) A recent Community Oncology Alliance survey showed that 69 percent of practices surveyed reported that patient treatment or operational changes already have been made due to the sequester cut to cancer drugs, with 49 percent of practices forced to send Medicare patients elsewhere for treatment, and 62 percent of practices reported that they will be forced to send Medicare patients elsewhere for treatment if the sequestration cuts stay in place through July 31, 2013.

(23) The June 2013 report of the Medicare Payment Advisory Commission highlighted the large disparities in payment in outpatient settings and noted that the payment variations across settings should be addressed quickly due to the fact that current disparities have created incentives for hospitals to buy physician practices, driving up costs for the Medicare program and for beneficiaries.

(b) SENSE OF CONGRESS.—It is the sense of Congress that, to ensure the future of community cancer care, Medicare reimbursement should be equal for the same

service provided to a cancer patient regardless of whether the service is delivered in the hospital outpatient department or physician's office.

**SEC. 3. EQUALIZING MEDICARE REIMBURSEMENT IN HOSPITAL OUTPATIENT DEPARTMENTS AND PHYSICIANS' OFFICES FOR CANCER CARE SERVICES.**

(a) IN GENERAL.—Section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) is amended—

(1) in paragraph (2)—

(A) in subparagraph (G), by striking ''and'' at the end;

(B) in subparagraph (H), by striking the period at the end and inserting ''; and''; and

(C) by inserting after subparagraph (H) the following new subparagraph:

''(I) payment for covered OPD services that are cancer care services (as defined in subparagraph (B) of paragraph (18)) shall be made consistent with subparagraph (A) of such paragraph.''; and

(2) by adding at the end the following new paragraph:

''(18) SPECIAL PAYMENT RULE FOR CANCER CARE SERVICES.—

''(A) IN GENERAL.—In the case of cancer care services that are furnished on or after January 1, 2014, the payment amount for such services under this subsection and under section 1848 shall be a budget neutral combination (as determined by the Secretary) of—

''(i) the amount otherwise payable under this subsection for such services; and

''(ii) the amount otherwise payable under section 1848 for such services.

''(B) CANCER CARE SERVICES DEFINED.—For purposes of this subsection, the term 'cancer care services' means covered OPD services or physicians' services for which payment is made under section 1848 that are furnished in conjunction with the diagnosis or treatment of cancer.''.

(b) CONFORMING AMENDMENT.—Section 1848(a) of Social Security Act (42 U.S.C. 1395w–4(a)) is amended by adding at the end the following new paragraph:

''(9) APPLICATION OF SPECIAL RULE FOR CANCER CARE SERVICES.—In the case of physicians' services that are cancer care services (as defined in subparagraph (B) of section 1833(t)(18)) that are

furnished on or after January 1, 2014, the payment amount for such services under this section shall be the payment amount for such services determined under subparagraph (A) of such section.''.

○