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Reimbursement gap is hurting community clinics and patients

A new federal bill can level the field for health care providers

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By Dr. Ralph Heaven

In the complex world of health care, one thing is simple: More competition means more choices, higher quality and lower prices. Yet, over the past decade, the health care industry has rapidly consolidated as hospital systems have acquired physician practices — forcing patients to pay more and travel farther for care. Unfortunately, misguided Medicare policy is encouraging this consolidation.

As a community oncologist, I see the real-world impacts Medicare payment policy have on my patients and my clinic. This system stacks the deck in favor of hospitals by paying more for services provided in hospital outpatient departments than it does community-based facilities like mine that provide the same treatments at less expense.

Community oncology practices provide essential services — from chemotherapy and radiation therapy to genetic testing — to support cancer patients throughout their treatment. The community setting allows patients to receive high-quality, integrated care close to home, where they have the support of family and friends and can maintain their daily routines throughout their treatment. Patients also benefit from highly personalized care provided by a team of experts as well as access to the most advanced technologies and treatments and groundbreaking clinical trials. By paying independent practices less than hospital outpatient departments, Medicare is endangering this type of cancer care delivery altogether.

Medicare reimbursement data provides a clear picture of the widening payment gap between outpatient departments and physician offices. Take chemotherapy, for instance. In 2016, the first hour of chemotherapy infusion — one of the most common services billed by oncology practices — was reimbursed at $136 for physician's offices, while payment for hospital outpatient departments was 106% higher, at $280, according to the Centers for Medicare and Medicaid Services. This year, this payment disparity has jumped to 158%, with physician reimbursement declining to $129 and the outpatient department rate increasing to $333. This means that today, chemotherapy is nearly three times more expensive when provided in the hospital outpatient department setting. There is no practical reason for this markup. And it is increasing costs for patients and the health care system by billions.

Further, this payment disparity is incentivizing hospitals to acquire lower-cost, community-based providers. When this happens, a patient may continue to receive the same care from the same physician

at the same location. However, because the hospital now owns the practice, it is able to charge much higher rates, so the patient's out-of-pocket costs increase dramatically.

In other cases, hospital acquisition is not only driving higher costs, but it is reducing access to care for patients living in rural areas. Community cancer practices often operate satellite sites that bring state-of-the-art oncology services directly to rural patients, allowing them to avoid traveling long distances. Since these sites may only be open a few days a week purely to provide access to underserved areas, they are often the first to close when hospitals buy up community oncology practices, as hospitals may view them as unprofitable.

While my clinic has been able to continue providing independent care to patients, hospital merger pressures have forced 44 of Texas' independent cancer centers to close their doors — leaving cancer patients without access to their trusted community providers. Nationwide, more than 1,000 community oncology practices have closed or been acquired by hospitals over the past 15 years. As a result, care is actually shifting from the community setting to the more expensive outpatient department setting, reversing previous trends. While this effect is particularly pronounced in oncology, the share of all physician practices owned by hospitals has more than doubled from 2013 to 2018.

Clearly, more action is needed to stop the forces driving consolidation and level the playing field for community cancer care. Thankfully, Rep. Jodey Arrington, R-Texas; Rep. Debbie Lesko, R-Arizona; and Rep. Michael Burgess, R-Texas, have put forth a commonsense, straightforward solution to this growing problem: equalizing Medicare payment across sites of service.

The Medicare Patient Access to Cancer Treatment Act would require Medicare to pay the same amount for the same cancer care services regardless of where they are provided. This critical legislation will protect access to affordable cancer care for patients in Texas and across the country and help community oncologists like myself retain the ability to practice independently. I thank Rep. Arrington for his leadership and urge other Texas representatives to support this bill to reduce the cost of cancer care for patients and taxpayers.

Dr. Ralph Heaven is a hematologist-oncologist at Texas Oncology-Abilene. He wrote this column for The Dallas Morning News.