March 20, 2023

United States Senate Committee on Health, Education, Labor, and Pensions (HELP)

Attn:
The Honorable Bernard Sanders, Chair
The Honorable Bill Cassidy, MD, Ranking Member

Re: US Senate HELP Committee Healthcare Workforce Shortages Request for Information (RFI)

Submitted Electronically via HealthWorkforceComments@HELP.Senate.gov

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Dear Senators Sanders and Cassidy:

OneOncology was founded by community oncologists, for community oncologists, with the mission of improving the lives of everyone living with cancer. Our goal is to enable community oncology practices to remain independent and to improve patient access to care in their communities, all at a lower cost than in the hospital setting. OneOncology supports our platform of community oncology practices through group purchasing, operational optimization, practice growth, and clinical innovation. Our 750 cancer care providers care for 478,000 patients at 546 sites of care nationwide, including approximately 238,000 Medicare beneficiaries per year (inclusive of Medicare Advantage) and approximately 129,000 traditional Medicare beneficiaries per year. Our fifteen OneOncology partner practices combine to offer approximately 700 clinical trials and enrolled approximately 2,000 patients in clinical trials during 2022. OneOncology physician investigators participate in trials beginning at Phase I development of early novel therapies and continuing through late phase trials that lead to new therapies that significantly enhance the lives of patients and families impacted by cancer and blood disorders.

OneOncology greatly appreciates the interest of the Senate Health, Education, Labor and Pensions (HELP) Committee in addressing the current and anticipated future health care provider workforce shortage. Improving access to health care can only be meaningful to patients if enough skilled and committed health care professionals are available to provide the actual care delivery. This is particularly true in the field of oncology.

Cancer is the second leading cause of death in the nation. With our aging population, the incidence of cancer is expected to increase. It is therefore critical we find ways to ensure there are enough cancer care professionals to treat this growing patient demand. According to data published by American Medical Association (AMA) and studies conducted by the Association for

Clinical Oncology (ASCO), the current oncologist workforce that is nearing retirement age is far outpacing early-career and new entrants in this critical field.[1, 2]

Fortunately, our nation's commitment to cancer research has produced an ongoing scientific revolution that has produced better treatments such as targeted therapy, immunotherapy, and others. These treatments now meaningfully extend the lives of cancer patients often with drastically less treatment side effects and improved quality of life. It will be critical that the future oncology workforce be able to deliver increasingly complex and scientifically advanced treatments while simultaneously meeting the deep emotional needs of patients and their families. For the purposes of this RFI, we will restrict our comments to cancer care.

Oncology is a wonderful field. Cancer care professionals have the privilege of caring for vulnerable patients with the latest and greatest scientific technology. It is deeply meaningful work. Cancer care professionals often seek oncology specifically often due to prior family experiences with cancer. Few individuals just “end up” in oncology. Becoming an oncologist, radiation oncologist, or surgical oncologist requires dedication to years of rigorous and stressful training after graduation from college. The typical medical oncologist participates in four years of medical school, three years of internal medicine training, and three years of fellowship. Many trainees attain additional research training. It is self-evident that an adequate supply of oncologists will require an adequate number of training programs and fellowship positions to provide instruction.

After completing training, oncologists then enter a split screen world of actual medical practice. In this split screen world, each day oscillates between moments of meaningful and even spiritual bonds with cancer patients alternating with exasperating structural challenges in the delivery of cancer care: patient visits which are too short, insurance prior authorization which produces bad treatment choices, unskilled and unsupportive hospital employer administrators, and myriad other threats to medical autonomy and career satisfaction. It is these latter problems that threaten retention of our critical future supply of compassionate and competent oncology professionals and will be the subject of the remainder of our comments.

Oncologists and other cancer professionals have entered a health care profession in rapid evolution. This evolution has included massive consolidation of healthcare. Not all change is progress. Much of this evolution has not prioritized the improvements in access to care and costs for patients and families living with cancer and blood disorders. In fact, quite the opposite. Many of the changes have had the effect of restricting physicians’ clinical decision-making ability, impeding patient-physician communication, and transferring economic control of our cancer care delivery system to hospital executives and insurance companies. Such effects also include de facto forcing oncologists into hospital employment through differential payment models favoring hospitals that have given hospitals control over entire markets. Fifteen years ago almost 90% of cancer patients received treatment in the community setting, that number is now roughly 50%.

Furthermore, PBM’s and managed care payers have exerted increasing control over the treatment decisions and care delivery goals that should be solely established between clinicians and patients. This has also resulted in administrative burdens that make it increasingly difficult

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[1] Physician Masterfile, AMA. www.ama-assn.org/practice-management/masterfile/ama-physician-masterfile

[2] “2020 Snapshot: State of Oncology Workforce in America.” *JCO Oncology Practice*. Vol. 17, Issue 1. Published online January 6, 2021. Accessed via https://ascopubs.org/doi/pdf/10.1200/OP.20.00577?role=tab.

to provide the care that patients need and receive reasonable compensation for that care. These trends fule the oncology workforce shortages detract from patient access to treatment for cancer and blood disorders, especially for underserved communities that rely on access to community oncology clinics.

Physician dissatisfaction has become so pervasive that it has now evolved into a conceptualization termed burnout. This condition results when the combination of work and additional life pressures exceeds one's ability to cope, producing physical and mental distress that renders a professional less capable of optimal performance. Recent studies have estimated that 45% or more of oncologists report symptoms related to burn out. The high prevalence of burnout risks losing highly trained physicians from the workforce through early retirement and causes less productive engagement with patients in need.

Various factors appear to contribute to burn out and include high occupational demands, lack of control over daily work processes, increased administrative responsibilities, use of electronic medical records, limited decision making, health care system change, and the inherent challenge of caring for terminally ill patients. We would add two additional causes of burnout rarely recognized in modern discussions.

The first is a worsening separation of authority and responsibility. Physician authority over their work environment, work processes, and clinical decision making has been severely eroded over the past two decades. Much of this has occurred due to explicit government policies pushing oncologists into hospital employment. Concurrently, outside entities such as insurance companies have increasing influence over physician decision making through mechanisms such as prior authorization and step-edits. Despite this erosion in authority, the responsibility for any adverse outcomes to patients continues to rest squarely with the physician. This growing dichotomy is unacceptable and greatly adds to physician professional dissatisfaction.

The second cause may be described as moral distress or a moral gap. Oncology reimbursement has declined substantially over the past two decades forcing physicians to see more and more patients each day to maintain a financially viable practice. A predictable consequence of increased patient volume is less time available for each patient. This can easily lead to enhanced patient dissatisfaction for struggling cancer patients with very high, legitimate emotional needs. Oncology continues to become ever more complex. Patients and families expect and deserve comprehensive discussion of the growing array of treatment choices. Any feeling of failure to meet these legitimate needs produces strong feelings of moral distress among practicing oncologists.

In conclusion, we applaud the work of the Senate Finance Committee in examining the worsening health care workforce shortage. We would emphasize that this shortage has developed due to gradually evolving, fundamental, and largely intentional changes in the health care delivery system. The changes include shifting clinical and economic control from those on the front lines of care delivery to large, centralized corporations and government agencies. This has resulted in decreasing professional satisfaction which threatens recruitment and retention of the talented professionals needed to provide the desired high-quality care in an era of both an aging population and rapid medical scientific advancement. We strongly believe that the solution can only begin with this recognition of the fundamental nature of the problem. Attempts at temporizing efforts or quick fixes will only prolong patient harm.

We've provided an Appendix A to this letter that species necessary policy solutions to address the trends we've described above. We've also provided a key references Appendix B that highlights several published reports on oncology workforce shortages, the findings of which are critical to understanding the policy reforms that are necessary to reversing the ominous trajectory of oncology workforce shortages.

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You may contact me, or Aaron Lyss (aaron.lyss@OneOncology.com), Senior Director of Payment and Policy Innovation for OneOncology, at any time with any questions regarding these comments.

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APPENDIX A – Policy Recommendations for Cancer Care Workforce Shortages

The net effects of any policy reforms targeting oncology workforce shortages are entirely dependent on extent to which such targeted solutions are implemented alongside more structural health policy reforms that are urgently necessary. Below we've provided examples of the structural reforms that are necessary to effectively mitigate the current trajectory of oncology work force shortages.

1. Prohibit payers from using utilization management (UM), step therapy (ST), and prior authorization practices to restrict access to medications for treating cancer and blood disorders when used in FDA approved indications.

    - Underserved communities are hurt the most by the current state of commercial, Medicare Advantage, and managed UM and ST practices. As an example, for patients with blood disorders characterized by iron deficiency anemia, many payers' currently have ST requirements in place that limit patient access to long-acting IV iron agents that require fewer in-office infusions than the "comparable" short-acting agents to which patients are restricted through payers' ST policies and which require more frequent infusions.[3] For both urban and rural patient populations who face logistically and financially challenging transportation barriers to more frequent infusions, the longer-acting IV iron agents that require less frequent infusions have a remarkable impact on their quality of life. However, when clinicians throughout our national network have discussed these concerns with UM reviewers, the UM reviewers often trivialize such concerns by referring to them as "patient convenience" factors that they are not compelled to consider in their clinical policies. This lack of empathy for patients that face severe health-related social needs (HRSNs) is highly prevalent among commercial, Medicare Advantage, and managed Medicaid payers, and these organizations need to be held accountable for the health equity implications that their clinical policies impose for patients with challenging HRSNs; otherwise vulnerable patient populations and their families will continue to face unnecessary hardships from such policies.

        - This example also illustrates why federal-level policies should require that when payers review prior authorization requests submitted by clinicians, the UM reviewers should be required to be licensed to practice medicine in the state in which the authorization is requested, and board certified in the same specialty as requesting physician, because payers' current UM practices have the effect of overriding patient-physician shared decision-making regarding treatment options that are in the best interest of patients' health.

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[3] David Eagle MD, Rahul Seth MD, "Doctors Push to Protech Patients with Iron Deficiency Anemia." *Empire Report.* June 7, 2022. https://empirereportnewyork.com/doctors-push-to-protect-patients-with-iron-deficiency-anemia/.

2. Reverse the Medicare Physician Fee Schedule (MPFS) reimbursement cuts for outpatient cancer-care imposed by the 2023 Medicare Physician Fee Schedule Final Rule.

    - In the 2023 MPFS final rule, CMS codified a Physician Conversion Factor reduction to $33.06 for 2023, which represents an approximately 5% reduction from the 2022 Physician Conversion Factor of $34.61. These cuts are major driver of increasing cancer care workforce shortages; and they propagate the hospital system consolidation that limits patient access to community oncology clinics, especially for underserved communities. These trends are core drivers of the rising cost of cancer care patients and payers.[4]

3. Scale back the Medicare Quality Payment Program (QPP) reporting requirements that have imposed overwhelming increases in the documentation burdens on cancer care teams year after year. These trends continue to impede clinician-patient communication, fuel hospital system consolidation, and increase cancer care team burnout.

4. Reform the 340B program with the following policy objectives:

    a. Require that the drug discounts garnered by 340B qualifying institutions are used to directly offset patient out-of-pocket expenses.

        - Currently under the 340B program, the drug acquisition price discounts that eligible hospital systems garner are not passed onto patients to any measurable degree, and rather have been used to fuel billions of dollars in bonuses for hospital executives.

    b. Prohibit current schemes in which non-profit hospital conglomerates and large for-profit pharmacy chains exploit 340B discounts, causing market consolidation, higher costs for patients and payers, reduces access to care, especially for underserved communities. The current 340B loopholes that profit-motivated qualifying institutions will continue to exploit will reduce patient access to care in high-quality community oncology clinics, and increase cost of care for patients and payers.

        - As physician-owned community oncology practices are continually consolidated into 340B-eligible hospitals,[5] the proportion of life-saving medications purchased under the program continues to skyrocket, meanwhile these hospitals continue to charge commercial insurers three to four times the discounted price for which they can acquire these medications through the 340B program,[6] and charge insurers and patients two to

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[4] 87 FR 69404, pg. 69404-70700. Document number 2022-23873. Accessed via https://www.federalregister.gov/documents/2022/11/18/2022-23873/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other.

[5] *2020 Community Oncology Practice Impact Report.* Community Oncology Alliance. 2019. Accessed via https://communityoncology.org/research-and-publications/studies-and-reports/2020-community-oncology-alliance-practice-impact-report/.

[6] Aharon (Ronny) Gal, PhD. *Examining Hospital Price Transparency, Drug Profits, & the 340B Program*. Moto Bioadvisors. Accessed via https://communityoncology.org/wp-content/uploads/2021/09/Moto-COA-340B_Hospital_Markups_Report.pdf.

three times what community oncology practices charge for the same cancer care services.[7] As 340B continues to drive private-practice physician groups into consolidation with large 340B-eligible hospital conglomerates, physician productivity declines, care delivery process efficiency is increasingly impeded by hospital bureaucracy, and thus access to high-quality cancer care declines.

- The underserved patient populations, who depend on community oncology practices for vital access to treatment for cancer and blood disorders, suffer the most from this trend in consolidation driven by the 340B program. Reforming the program is critical to enhancing access to high-quality care for cancers and blood disorders impacting underserved communities. Fifteen years ago almost 90% of cancer patients received treatment in the community setting, that number is now roughly 50%.

5. Eliminate other structural advantages for large non-profit hospital systems relative to those that apply to independent physician groups, for similar reasons described above relating to 350B reforms. For example:

   A. Eliminate non-profit hospital exemptions to the restrictions on physician non-compete clauses (per the Jan. 5 2023 Federal Trade Commission Non-Compete Clause proposed rule).[8]

   B. Allowing private practice physician groups to offer student loan-forgiveness in recruiting new physicians, just as hospitals are currently permitted to offer.

   Each of the above examples currently contribute to consolidation physician-owned community oncology practices into 340B-eligible hospitals. As physician-owned community oncology practices are continually consolidated into 340B-eligible hospitals,[9] these hospitals continue to charge insurers and patients 2-3x the amounts that high-quality community oncology practices charge for the same cancer care services. The underserved patient populations, who depend on community oncology practices for vital access to treatment for cancer and blood disorders, suffer the most from this trend in consolidation driven by the current structural advantages that 340B eligible hospitals have over independent physician groups.

6. Continue supporting technical corrections to drug pricing provisions of the Inflation Reduction Act, notably the unintended cuts to cancer care providers that are currently tied to a drug's transition from ASP to MFP-based pricing.

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[7] L. Gordon et al. "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." Journal of Clinical Oncology – Oncology Practice. Ed. 14, no. 12, e729-e738. Published online October 31, 2018. Accessed via https://ascopubs.org/doi/full/10.1200/jop.17.00040.

[8] 16 CFR Part 910; RIN 3084-AB74. Accessed via https://www.ftc.gov/system/files/ftc_gov/pdf/p201000noncompetenprm.pdf

[9] *2020 Community Oncology Practice Impact Report.* Community Oncology Alliance. 2019. Accessed via https://communityoncology.org/research-and-publications/studies-and-reports/2020-community-oncology-alliance-practice-impact-report/.

APPENDIX B – Published Reports of Cancer Care Workforce Shortages

Several published reports in recent years support the oncology workforce narrative described throughout this OneOncology response to the Senate HELP Committee's Healthcare Workforce Shortages RFI, which include the following key findings:

- 66% of rural counties in America do not have an oncologist, resulting in $32 million Americans living in a county without an oncologist. [10]

- According to a 2019 survey of "cancer program leaders"[11]:
    - 58% of respondents reported that "clinician burnout" was one of their top five concerns related to workforce planning (highest ranked concern)
    - 54% reported that "staff and clinician engagement" was one of their top five concerns related to workforce planning (2nd highest ranked concern)
    - 42% reported that "clinician workforce shortages" was one of their top five concerns related to workforce planning (5th highest ranked concern)
    - 32% of respondents reported that workforce planning (e.g., recruiting staff, managing staff shortages, retaining staff) was one of the biggest threats to future cancer program growth at their organization
    - 27% acquired private practice physicians
    - 6% transitioned hospital-based space to free-standing.
    - 49% cited "reimbursement requirements from payers" were among the "top five biggest threats to future cancer program growth (more than any other potential concern).
        - 25% cited "insurance shifting additional costs to patients" as among the "top five biggest threats to future cancer program growth
    - 52% of respondents reported that they were indending to add medical oncologist in the next 12 months (more than any other position).
    - Medical oncologists, oncology nurses, APPs, and clinical navigators were the top four responses (respectively) to the question "What staff/positions do you plan to add in the next 12 months.
    - 59% reported "medical oncologists" as among positions are you most concerned about when it comes to bandwidth/ensuring access for patients" (highest ranked response)
    - Shortages in medical oncologists, oncology nurses, financial advocacy staffs, navigators, palliative care specialists, genetic counselors, and oncology-trained advance practice providers were the top seven positions (respectively) that cancer program leaders were most concerned could result in limiting access to care for patients.

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[10] "2020 Snapshot: State of Oncology Workforce in America." *JCO Oncology Practice*. Vol. 17, Issue 1. Published online January 6, 2021. Accessed via https://ascopubs.org/doi/pdf/10.1200/OP.20.00577?role=tab.

[11] "2019 Trending Now in Cancer Care Survey," Advisory Board Company. Accessed via www.advisory.com/-/media/Project/AdvisoryBoard/shared/Research/OR/Expert-Insights/2020/2019_OR_National_Data_Trending_Now_in_Cancer_Care.pdf?WT.ac=Inline_OR_ExInsight_x_x_x_OnRd_2020Apr06_Eloqua-RMKTG+Blog