Statement of the
Association of Community Cancer Centers

Before the
Advisory Panel on Hospital Outpatient Payment
August 21-22, 2017

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The Association of Community Cancer Centers (ACCC) appreciates this opportunity to testify before the Advisory Panel on Hospital Outpatient Payment (the "HOP Panel"). ACCC is a membership organization whose members include hospitals, physicians, nurses, social workers, and oncology team members who care for millions of patients and families fighting cancer. ACCC represents more than 23,000 cancer care professionals from approximately 2,000 hospitals and private practices nationwide. These include cancer program members, individual members, and members from 32 state oncology societies. It is estimated that 65 percent of cancer patients nationwide are treated by a member of ACCC. ACCC is committed to preserving and protecting the entire continuum of quality cancer care for our patients and our communities.

ACCC truly appreciates the opportunities we have had over many years to speak at these meetings and to discuss our concerns with members of the HOP Panel, CMS staff, and other stakeholders. Indeed, these meetings provide a critical and unique forum for stakeholders, CMS and the Panel to discuss the hospital outpatient prospective payment system (OPPS), the current and potential effects of the system on access to care, and alternative approaches to setting payment for outpatient care. We appreciate the thoughtful consideration that the HOP Panel has given our recommendations over the years.

Our comments for this meeting address two issues that are important to protecting Medicare beneficiaries' access to high quality cancer care: (1) the proposed reductions in payment for separately payable drugs purchased under the 340B program and (2) the proposed packaging of payment for certain drug administration services. As CMS considers its approach to reimbursement for drugs and drug administration services under the OPPS, we urge the HOP Panel and the agency to recognize the full array of services required to provide quality cancer care to Medicare beneficiaries. In addition to acquiring and administering drugs, our member hospitals also provide specialized pharmacy services needed to safely prepare, dispense, and dispose of chemotherapy drugs and other complex drugs and biologicals, as well as extensive support services that allow patients to achieve the full benefits of their treatment regimens. Our member hospitals offer social services, including planning for home care, hospice and long-term care; community agency referrals and referrals for transportation assistance; and nutrition services, including evaluating the patient's nutritional status, providing information about diet and cancer, and developing nutrition plans to meet the individual patient's needs. Cancer therapy support services also include patient and family education, which entails educating newly diagnosed patients and their families about their cancer, treatment options, support resources, self-care techniques, new prescribed treatments, and coping with and managing treatment side effects. Hospitals also provide psychosocial support to address the psychological and emotional aspects of cancer and cancer treatment. Many of these services are not separately payable, and if hospitals are to continue to provide Medicare beneficiaries with comprehensive, quality cancer care, Medicare's reimbursement methods must provide appropriate payment for all of these services.

I. The HOP Panel should recommend that CMS not finalize the proposed reductions in payment for separately payable drugs purchased under the 340B program and to

support policies that encourage all oncology providers to serve indigent and low-income patients.

In the OPPS proposed rule for calendar year 2018, CMS proposes to reduce payment for separately payable drugs without pass-through status that are purchased under the 340B program to average sales price (ASP) minus 22.5 percent.[1] These drugs currently are reimbursed at ASP plus six percent. CMS explains that it is concerned that "the current payment methodology may lead to unnecessary utilization and potential overutilization of separately payable drugs," and it believes the proposed reduction in payment would "better, and more appropriately, reflect the resources and acquisition costs" that hospitals in the 340B program incur.[2] CMS says its goal is to "make Medicare payment for separately payable drugs more aligned with the resources expended by hospitals to acquire such drugs while recognizing the intent of the 340B program to allow covered entities, including eligible hospitals, to stretch scarce resources while continuing to provide access to care."[3] The proposed rate of ASP minus 22.5 percent is based on a Medicare Payment Advisory Commission analysis, and, although CMS acknowledges that it does not have acquisition cost data, it believes that this rate represents the "average minimum discount that a participating 340B hospital receives."[4]

ACCC supports the goal of the 340B program, which is to help hospitals that treat a disproportionate share of indigent patients. As CMS notes in the proposed rule, Congress intended for savings from the program to help participating entities "stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."[5] The Health Resources and Services Administration (HRSA) has informed hospitals that they may use savings from participation in the program to "invest in more services for patients"[6] and that participating entities are not required to pass on the discounts from purchasing drugs at 340B prices to patients.[7]

We appreciate CMS' goal of redirecting the savings from the 340B program to preserve the original intent of the program and more directly address the needs of underserved and low-income patients. ACCC also believes the program needs to be reformed. However, this program is unique and the proposal, as written, is focused on the Medicare beneficiary, whereas savings from the 340B program should specifically be directed to better serve indigent patients. The OPPS is an inappropriate vehicle to propose these changes. We also believe the proposed reductions in payment for drug APCs and redistribution of savings to other APCs across all outpatient services defeats the clear intent by Congress and HRSA that 340B hospitals use savings on drug costs to expand care for underserved patients. CMS also notes in the proposed rule that the agency lacks the data needed to truly understand where patients are being served and how resources are being

[1] 82 Fed. Reg. 33558, 33634 (July 20, 2017).
[2] *Id*. at 33633.
[3] *Id.*
[4] *Id*. at 33634.
[5] H.R. Rep. No. 102-384, pt. 2, at 12 (1992) (cited at 82 Fed. Reg at 33632); *see also* 340B Drug Pricing Program, https://www.hrsa.gov/opa/.
[6] Elizabeth M. Duke, HRSA Administrator, Remarks to the Primary Health Care All-Grantee Meeting, June 22, 2005, http://newsroom.hrsa.gov/speeches/2005/BPHC-June.htm.
[7] *See, e.g.*, The 340B Drug Pricing Program: Your Guide to Participation, http://networkassist.ruralhealth.hrsa.gov/documents/20081119/340B_101_The_Basics_STANDARD_PPT1.ppt.

used in the 340B program. We believe this proposal is premature and that CMS should not finalize the proposal until more data and meaningful stakeholder input can be gathered.

ACCC asks the HOP Panel to recommend that CMS not finalize the proposed reductions in payment for separately payable drugs purchased through the 340B program and to support policies that encourage all oncology providers to serve indigent and low-income patients.

II. The HOP Panel should recommend that CMS not package payment for Level 1 and 2 drug administration services and pay separately for all drugs and biologicals that are separately reimbursed in the physician office setting.

CMS proposes to "conditionally package payment for HCPCS codes describing drug administration services in [ambulatory payment classification] APC 5691 [Level 1 Drug Administration] and APC 5692 [Level 2 Drug Administration], except for add-on codes and preventive services, when these services are performed with another service."[8] CMS asserts that this approach is consistent with its policies on packaging for other "ancillary" services and that it "would promote equitable payment between the physician office and the hospital outpatient department."[9]

ACCC strongly disagrees with this proposal, and we ask the Panel to recommend that CMS continue to provide separate payment for all drug administration services. Conditionally packaging payment for these drug administration services, on top of the proposed increase in the packaging threshold from $110 to $120,[10] would mean that an increasing number of services that are critical to cancer treatment would not be separately reimbursed. We understand that under CMS's methodology, the costs of these packaged items and services would be included in the mean cost data used to establish payment for services billed with them. There are many other services that could be billed on the same claim as a drug administration service, however. In a system based on averages, there is no assurance that the full costs of a packaged drug administration service or drug will be accounted for in the payment for another separately payable procedure. We have noted our concerns with the increasing complexity of CMS's packaging policies in the past, and we continue to be troubled by CMS's drive to expand its packaging policies.

In addition, contrary to CMS's statements in the proposed rule, this approach would not "promote equitable payment between the physician office and hospital outpatient department." CMS asserts that hospitals currently receive separate payment for clinical visits, while "physicians are not eligible to receive payment for an office visit when a drug administration service is also provided."[11] This is not a correct description of CMS's current policy. Under CMS's guidance, physicians can be paid for an office visit using an evaluation and management (E/M) code higher than level 1, in some circumstances. Specifically,

[8] 82 Fed. Reg. at 33585.
[9] *Id.*
[10] *Id*. at 33625.
[11] Id. at 33585.

> when a medically necessary, significant and separately identifiable [evaluation and management] service (which meets a higher complexity level than CPT code 99211) is performed, in addition to one of these drug administration services, the appropriate E/M CPT code should be reported with modifier -25.[12]

Moreover, all drugs are separately payable in the physician office setting, unlike the OPPS, in which CMS packages payment for drugs below the packaging threshold and "policy packaged" drugs. The proposed expansion of packaging to include most Level 1 and 2 drug administration services, as well as higher cost drugs, actually exacerbates differences in reimbursement between the physician office and hospital outpatient department.

We believe that the best way to ensure appropriate payment for these services is to continue to provide separate payment for all drug administration services and all drugs with Healthcare Common Procedure Coding System (HCPCS) codes just as payment is made for these drugs in physicians' offices. To the extent that certain drugs continue to be packaged, CMS should require hospitals to bill for them using HCPCS codes and revenue code 636. We ask the HOP Panel to recommend that CMS adopt these policies for calendar year 2018.

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Thank you for the opportunity to present this statement on behalf of ACCC. We appreciate your attention to these important issues and are happy to answer any questions you may have.

[12] Claims Processing Manual, ch. 12, § 30.6.7(D). Modifier -25 identifies a "significant, separately identifiable evaluation and management services by the same physician on the day of the procedure."