

**Statement of the
Association of Community Cancer Centers**

**Before the
Advisory Panel on Hospital Outpatient Payment (HOP)
March 10-11, 2014**

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Statement to the Advisory Panel on Hospital Outpatient Payment March 10-11, 2014

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 18,000 cancer care professionals from approximately 900 hospitals and more than 1,200 private practices nationwide. These include Cancer Program Members, Individual Members, and members from 28 state oncology societies. It is estimated that 60 percent of cancer patients nationwide are treated by a member of ACCC. As an organization, ACCC is committed to preserving and protecting the entire continuum of quality cancer care for our patients and our communities. We appreciate the thoughtful consideration that the HOP Panel has given our recommendations over the years.

The hospital outpatient prospective payment system (OPPS) is a complex and, in recent years, rapidly evolving system. For calendar year (CY) 2014, the Centers for Medicare & Medicaid Services (CMS) implemented several significant changes to payment for critical services furnished by our hospitals. First, CMS expanded packaging to five additional categories of items and services, including certain clinical diagnostic laboratory tests and drugs¹ without pass-through status that function as supplies when used in diagnostic procedures/tests or surgical procedures. Second, CMS replaced the long-standing, five-level ambulatory payment classification (APC) structure for clinic visits with a single code for all visits, regardless of complexity. Our members still are adjusting to CMS’s most recently implemented policies, and it is too early to determine what impact they will have on access to care.

We ask the HOP Panel to protect access to life-saving cancer care by recommending that CMS maintain stability in the OPPS for CY 2015. Hospitals need the assurance of predictable, appropriate payments in order to plan for the future and invest in the personnel and technologies that are essential to providing high-quality cancer care. To ensure that hospitals can continue to provide beneficiaries the best cancer care possible, ACCC urges the HOP Panel to make the following recommendations to CMS:

- Wait until the effects of current policies have been thoroughly evaluated before expanding packaging to additional items and services;
- Extend CMS’s process for gathering stakeholder input on, refining, and implementing any new packaging proposals;
- Continue to make separate payment at average sales price (ASP) plus six percent for drugs without pass-through status; and
- Continue to provide separate payment for add-on codes for drug administration services.

¹ We use “drugs” to include both drugs and biologicals.

I. CMS Should Wait until the Effects of Current Policies Have Been Thoroughly Evaluated before Expanding Packaging to Additional Items and Services.

As we noted above, CMS significantly expanded packaging under the OPPTS for CY 2014. The agency implemented these changes despite concerns expressed by the HOP Panel, ACCC, and many other stakeholders about apparent errors in CMS's initial rate calculations, the complex interaction of these proposals with each other, and CMS's lack of careful analysis of the effects of the proposals on access to care. Although we do not know yet how these policies are affecting hospitals and beneficiaries, CMS already has indicated that it is considering packaging payment for drug administration add-on codes and certain imaging services in future years.

We continue to be concerned about the appropriateness of the newly implemented payment rates. For CY 2014, CMS replaced the previous five-level APC structure for clinic visits with a single payment rate that does not capture differences in resource utilization between extremely low and high complexity cases, potentially resulting in significant losses for hospitals serving the most complex oncology patients. CMS also packaged payment for many clinical laboratory tests that are vital to diagnosing and treating cancer. Now that these policies have been implemented, we will need time to fully assess their impacts on hospitals and beneficiaries' access to cancer care before we can consider whether additional packaging is appropriate. It simply is too soon to say whether the new payment policies will help or harm access to care. To the extent that we get some early feedback from our member hospitals, we will share that with CMS and you.

In all likelihood, it will take at least a year to begin to measure the effects of these policies. As the HOP Panel knows, there typically is a two year lag in the data CMS uses to set payment rates under the OPPTS. Therefore, the effects of the newest policies will not be apparent in the cost and charge data available at the time of development of the proposed rule for CY 2015. A substantial body of claims data will not be available until at least a year from now. CMS and its stakeholders cannot begin to estimate the effects of potential expansions of packaging, such as packaging for drug administration add-on codes or imaging services, until the data on the effects of the current policies have been collected and evaluated.

CMS needs to consider not only the effects of its proposals on access to each category of packaged services, but also on the full spectrum of cancer care. We are particularly concerned about hospitals' ability to provide the extensive support services that allow patients to achieve the full benefits of their treatment regimens. In addition to managing the course of treatment, 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 were not fully

reimbursed under the OPPI prior to the expansion of packaging, and it remains to be seen whether the new payment rates will harm hospitals' ability to furnish these services.

We urge the HOP Panel to advise CMS to evaluate the effects of its recently-implemented policies before considering further expansions of its packaging policies. CMS, hospitals, and other stakeholders need to learn from their experience with the newest policies before implementing any additional packaging proposals.

II. CMS Should Extend Its Process for Gathering Stakeholder Input on, Refining, and Implementing Any New Packaging Proposals.

In addition to taking time to assess the effects of the most recently implemented policies, CMS must provide sufficient time to evaluate, refine, and implement any new packaging proposals. As we learned during the comment period on the CY 2014 proposed rule, 60 days is not enough time for stakeholders to replicate CMS's calculations, analyze the results, and provide meaningful comments. This is particularly true when CMS's proposals involve increasingly complex packaging rules, such as conditional packaging and comprehensive APCs. Moreover, hospitals often need more than 60 days after the final rule is released to fully digest the changes and implement the required changes to their billing systems.² CMS acknowledged this fact in the final rule for CY 2014, when it delayed implementation of the comprehensive APCs until 2015 to allow more time for hospitals and the agency to assess the impact of this change in policy and verify the accuracy of the payment rates.

To facilitate thorough analysis of any new packaging proposals by all stakeholders, we ask the HOP Panel to recommend that CMS extend its process for gathering comments on its proposals. Specifically, we recommend that the HOP Panel ask CMS to present its proposals at the first HOP Panel meeting of the year before publishing them in the proposed rule. This would allow CMS to benefit from two rounds of comments on its ideas: one at the HOP Panel meeting and another in response to the proposed rule. If CMS finalizes the proposals, it should delay implementation for at least one year, as it did with the comprehensive APCs, to allow hospitals time to adjust to the proposals and permit the agency to verify the appropriateness of its methodologies by applying them to an additional year of data. This extended time period for the development and implementation of any new packaging proposals would be similar to CMS's process for the adoption of quality measures, which the agency frequently announces several years before implementation to allow ample time for evaluation and comment.

III. CMS Should Continue to Reimburse Hospitals for Acquisition Cost of Separately Payable Drugs at ASP Plus Six Percent.

To maintain stable and predictable reimbursement for important cancer therapies and other drugs, we ask the HOP Panel to recommend that CMS continue to reimburse the acquisition cost of separately payable drugs at ASP plus six percent. This payment rate helps ensure that hospitals can continue to provide high quality cancer care to Medicare beneficiaries.

² This year, the government shutdown delayed the release of the final rule and shortened the time available for CMS and all stakeholders to adjust to the new payment policies.

In addition, because this payment rate is equivalent to the rate provided for drugs in the physician office setting, it removes incentives to select one setting over another and helps protect access to care in the most clinically appropriate setting for each beneficiary.

ACCC also continues to be deeply troubled by CMS's expanded list of "policy packaged drugs" and increased packaging threshold. We believe these policies disregard the clear language of the statute and Congressional intent, and they make it increasingly difficult for hospitals to furnish critical therapies and diagnostic drugs. We ask the HOP Panel to recommend that separate payment should be made for all drugs with 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.

IV. CMS Should Continue to Provide Separate Payment for Add-on Codes for Drug Administration Services.

In addition to allowing sufficient time to evaluate and implement any new packaging proposals, we particularly urge the HOP Panel to recommend that CMS continue to provide separate payment for add-on codes for drug administration services. CMS correctly recognized that further study would be needed before packaging payment for drug administration add-on codes due to the wide variety of drugs and treatment protocols that would be affected by this policy. In oncology, it is common for treatments to involve multiple administration services and infusions on a single day. Under CMS's proposal for CY 2014, only the initial service per access site would have remained separately payable, and payment for all additional administration services and hours of infusion services would have been packaged. Drugs below the packaging threshold and policy-packaged drugs also would have been included in the packaged payments. As a result of this proposal, the payment rates for the separately payable drug administration services would have increased by 38 to 298 percent, and payment for a dozen services would have been packaged. Drastic payment changes such as these require considerable time and expertise to replicate and analyze. CMS should continue to study this policy and allow stakeholders ample time to analyze any proposals and their effects on beneficiary access to care before implementing any changes.

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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.