Statement of the
Association of Community Cancer Centers
(revised July 25, 2016)

Before the
Advisory Panel on Hospital Outpatient Payment
August 22-23, 2016

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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 20,000 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 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.

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: (1) ensuring that the HOP Panel continues to be useful and relevant to the development of the OPPS and (2) protecting Medicare beneficiaries' access to high quality cancer care.

I. CMS and the HOP Panel should revise the timing of the summer meeting to provide CMS, the Panel, and stakeholders vital opportunities to discuss refinements to the OPPS.

In the OPPS proposed rule for calendar year 2017, CMS proposes significant expansions of its packaging policies and comprehensive ambulatory payment classifications (C-APCs). CMS proposes to create 25 new C-APCs, including one for allogeneic hematopoietic stem cell transplantation; change the logic for conditionally packaged services to apply to services billed on the same claim, rather than on the same day; terminate the unrelated test exception to the laboratory packaging policy; and increase the packaging threshold for drugs and biologicals to $110. These proposals come on top of other expansions of packaging policies in recent years and are part of CMS's efforts to make "payments for all services paid under the OPPS more consistent with those of a prospective payment system and less like those of a per service fee schedule."[1]

Although we understand CMS's desire to encourage more efficient provision of high-quality care, we remain concerned that rapid expansions of packaging in the OPPS will not achieve this goal. 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

[1] 81 Fed. Reg. 45604, 45627-28 (July 14, 2016).

high-quality 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.

The OPPS is a complicated system, and each change to the packaging policies raises questions about whether the proposed rates truly reflect the historic costs of care and whether they will be sufficient to protect access to care in the future. These questions can be difficult to answer, not only because the OPPS rate calculations are challenging to replicate, but also because the effects of a new payment policy are not reflected in the claims data until well after they are implemented.

We are deeply disappointed that as the OPPS methodology moves toward greater packaging and increasingly complex ratesetting calculations, the Panel's meetings have become less relevant to development of the OPPS. At recent meetings, the agenda has been shortened, and the Panel has issued fewer recommendations than in the past. CMS also already has announced that the winter 2017 meeting has been cancelled. We understand that the number of issues brought before the Panel may have decreased in recent years, but contrary to CMS's assertions that this is due to a more mature, stable OPPS,[2] we believe this reflects growing frustration with the Panel's deadlines, not greater comfort with the OPPS. We believe stakeholders bring fewer issues to the Panel because they cannot complete a meaningful analysis of the proposals and develop alternative approaches before the submission deadline.

This year, even after the extension from July 15 to July 18, we had only 12 days from release of the proposed rule to the HOP Panel deadline to develop our comments. This simply is not enough time to develop detailed comments. In fact, the few analysts who can replicate CMS's calculations need at least two weeks once they receive the data from CMS to discuss questions with CMS staff, refine their models, and calculate payment rates under alternative scenarios. Moreover, each time CMS expands the categories of items and services that are packaged, creates new C-APCs, or changes its approach to packaging, these actions require the analysts to adjust their models and confront new challenges in replicating CMS's calculations. If these experts cannot begin to provide detailed analysis before the testimony deadline, then it is nearly impossible for organizations such as ACCC to provide detailed, meaningful comments.

We ask CMS and the HOP Panel to ensure that the Panel's meetings continue to serve their intended purpose of discussing concerns about the OPPS in depth and developing useful recommendations for CMS. To this end, the summer meeting should be scheduled for the last

[2] 81 Fed. Reg. 31941, 31942 (May 20, 2016).

week of the comment period and the deadline for submission of statements should be pushed back as much as possible to allow time for analysis of the OPPS data and alternative APC assignments.

We also ask the Panel to recommend to CMS that implementation of any expansions in packaging and new C-APCs be delayed for at least one year, as CMS did with C-APCs in 2014, to allow stakeholders and CMS more time to verify the accuracy of the agency's calculations. CMS and the Panel should discuss these proposals in depth before CMS considers including them in the proposed rule for the next year.

II. The HOP Panel should recommend that CMS pay separately at average sales price plus six percent for all drugs and biologicals that are separately reimbursed in the physician office setting.

Although we are not able to provide detailed recommendations on many of the proposed APC assignments and packaging proposals at the time of the HOP Panel's deadline, we want to make several general recommendations. First, to maintain stable and predictable reimbursement for important cancer therapies and other drugs, we ask the HOP Panel to recommend that CMS finalize its proposal to 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. 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. We ask the HOP Panel to recommend that CMS implement these proposals, too.

Second, ACCC continues to be deeply troubled by CMS's expanded list of "policy packaged drugs" and proposed increase in the packaging threshold.[3] 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 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.

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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.

[3] Id. at 45660.