Statement of the
Association of Community Cancer Centers

Before the
Advisory Panel on Hospital Outpatient Payment
August 20-21, 2018

Leah Ralph
Association of Community Cancer Centers
1801 Research Boulevard, Suite 400
Rockville, MD 20852
301.984.9496, ext.223

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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 1,100 hospitals and more than 1,000 private practices nationwide. These include cancer program members, individual members, and members from 34 state oncology societies. It is estimated that 65 percent of cancer patients nationwide are treated by a member of ACCC

In the Hospital Outpatient Prospective Payment System (OPPS) Proposed Rule for calendar year 2019 (the "Proposed Rule"), CMS proposes several significant changes to payment for items and services that are critical to cancer care. These proposals include drastic reductions in payment for clinic visits at off-campus departments that are excepted from Section 603 of the Bipartisan Budget Act of 2015. Payment for these services would be reduced to 40 percent of the standard OPPS rate, the amount CMS currently pays for services in nonexcepted off-campus departments. CMS cites the statutory provision on development of a "method for controlling unnecessary increases in the volume of covered [outpatient department] OPD services"[1] as authority for this proposal. CMS proposes to implement this change in a non-budget neutral manner, and the agency estimates that this change would reduce payments under the OPPS by 1.2 percent, with hospitals in smaller cities and rural areas seeing greater reductions in payments. CMS also proposes to apply the same rate to services in certain "clinical families" furnished at excepted off-campus departments. The Proposed Rule does not estimate the potential effect of the payment reduction for expanded clinical services.

ACCC is deeply concerned about these proposals and the harmful effects they could have on access to cancer care if implemented. We believe these proposals merit thorough analysis and discussion to verify the data underlying CMS's proposals and estimated impacts, test the validity of the agency's conclusion that the increase in volume for clinic visits is "unnecessary," assess whether the proposed payment rates appropriately reflect the cost of care in hospital outpatient departments, measure potential effects on our member hospitals, and examine the legal authority for these proposals.

Our statement cannot address all of these points because there simply was not enough time between release of the Proposed Rule on July 25 and the deadline for submission of this statement on July 30 to conduct these analyses. ACCC is disappointed that CMS has not allowed stakeholders more time to review the Proposed Rule and develop their statements before this deadline. We are hopeful that, despite the short timeframe for responding to the Proposed Rule, the Panel, CMS staff, and stakeholders will be able to hold an open and robust discussion of these proposals.

Although we lacked the time to analyze these proposals in depth, we wish to comment on four aspects of these proposals.

[1] Social Security Act (SSA) § 1833(t)(2)(F).

First, CMS poses a series of questions in the Proposed Rule about how it might develop a "method for controlling unnecessary increases" in the volume of OPD services other than clinic visits. These are important questions, and they require thoughtful consideration, analysis, and input from all stakeholders, including the HOP Panel, before such a method is applied to any services, including clinic visits. It is particularly important to define "unnecessary increases" in light of all of the changes taking place in how care is provided in the United States. Changes in patient demographics and clinical needs, technological advances, and changing economic incentives from CMS and other payers could explain increases in volume in hospital outpatient services that might appear, at first glance, to be "unnecessary."

Second, before using a reduction in payment for clinic visits as a "method for controlling unnecessary increases in the volume of covered OPD services," CMS first should analyze the effects of the same payment reduction in nonexcepted departments. That change took effect on January 1, 2018, following a year of payment at 50 percent of the OPPS rate. CMS presents no data in the Proposed Rule explaining how these payment rates affected utilization of clinic visits or other services. Without an analysis of the effect the 40 percent payment adjustment has had on the volume of clinic visits in nonexcepted departments, and it is premature to conclude that applying this reduction to excepted departments would not harm access to care.

Third, we believe that the proposed payment rates for clinic visits and expanded clinical families at excepted off-campus departments of 40 percent of the OPPS rates would be inadequate to support access to these important services. We have not had time to do an in-depth analysis, but we sincerely believe that the proposed rates do not reflect the costs of providing care in hospital outpatient departments. We also note that CMS has not provided a solid rationale supporting payment for any service at 40 percent of the OPPS rate.

A reimbursement cut of 60 percent in one year for any service would be difficult to absorb. A cut of 60 percent to clinic visits – a widely performed service that is central to all cancer care – would have a shocking effect on hospitals. Expanding these cuts to services in certain clinical families would be further destabilizing to cancer care. Moreover, because this reduction would be implemented in a non-budget neutral manner, the cut in payment for these services would not be balanced by increases in payment for other services. If these cuts are implemented, hospitals would need to consider reducing access to care at off-campus departments, increasing burdens on patients who would need to travel farther to the main hospital campus and potentially causing delays in treatment as hospitals adjust to treating more patients on campus.

Fourth, as CMS has recognized in the past, applying the payment reduction to expansions of services in certain clinical families currently paid under the OPPS would be "operationally complex and could pose an administrative burden to hospitals, CMS, and our contractors to identify, track, and monitor billing for clinical services."[2] Under the current proposal, each hospital would need to identify the services it provided at each excepted off-campus department in the relevant baseline period, identify the Ambulatory Payment Classification (APC) assigned to each service, and determine which modifier to apply to each service going forward to obtain

[2] 81 Fed. Reg. 79,562, 79,707 (Nov. 14, 2016).

the correct payment rate. This analysis would be site-specific and would be difficult for CMS's contractors to verify.

We also believe that the proposed reduction could significantly undermine a provider's ability to provide full-service cancer care in settings that are convenient for patients. Cancer care often requires multiple specialties and types of services including imaging, drug administration, and radiation oncology. Many of ACCC's members provide a mixture of these services at their off-campus PBDs throughout their communities, and they report that offering a variety of services at a single location is essential to providing quality care. In addition, most patients prefer it. Limiting payment under the OPPS to the clinical families a facility billed for before November 1, 2015, could deny a hospital the ability to update its services and facilities to meet patients' needs. It likely would lead to less convenient care for patients, as patients increasingly would be required to travel between locations for care or would need to seek all of their care at the main hospital, instead of at a PBD closer to home. In addition, many of our members are participating in new delivery models such as the Oncology Care Model and Accountable Care Organizations, created by the Center for Medicare & Medicaid Innovation to achieve better care for patients, better health for our communities, and lower costs through improvement of our health care system. Continued access to improved care will be hampered if hospitals are not given flexibility to adapt service lines and facilities to better meet their patients' needs.

For all of these reasons, we ask the HOP Panel to recommend that CMS not implement the proposed reductions in payment for clinic visits and expanded clinical families of services at excepted off-campus departments in the OPPS final rule for calendar year 2019.

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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.