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August 24, 2010

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1504-P - Proposed Changes to the Hospital Outpatient Prospective Payment System (OPPS) and CY 2011 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2011 Payment Rates; Proposed Changes to Payments to Hospitals for Certain Inpatient Hospital Services and for Graduate Medical Education Costs; and Proposed Changes to Physician Self-Referral Rules and Related Changes to Provider Agreement Regulations

Dear Dr. Berwick:

The National Patient Advocate Foundation (NPAF) would like to thank you for the opportunity to comment on the Proposed Rule CMS-1504-P, "Proposed Changes to the Hospital Outpatient Prospective Payment System (OPPS) and CY 2011 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2011 Payment Rates; Proposed Changes to Payments to Hospitals for Certain Inpatient Hospital Services and for Graduate Medical Education Costs; and Proposed Changes to Physician Self-Referral Rules and Related Changes to Provider Agreement Regulations" (the "Proposed Rule") published in the *Federal Register* on August 3, 2010.[1] We hope the Centers for Medicare and Medicaid Services (CMS) finds our recommendations helpful as it finalizes the outpatient prospective payment system payment rates for 2011.

NPAF is a non-profit organization dedicated to improving access to healthcare services through both federal and state policy reform. Our mission is to be the voice for millions of patients who have sought care after a diagnosis of a chronic, debilitating or life-threatening illness. The advocacy activities of NPAF are informed and influenced by the experience of patients who receive direct, sustained services from Patient Advocate Foundation (PAF), which provides professional case management assistance to patients. In 2009, PAF resolved 55,384 patient cases and received four million additional inquires from patients nationally from all 50 states. Many of these patients are Medicare beneficiaries. Our comments are intended to give voice to the access and delivery systems concerns of the patients PAF serves.

Proposed Conversion Factor Update

NPAF is extremely pleased that all hospital outpatient departments (OPDs) subject to OPPS that satisfactorily reported quality data in 2010 will receive a 2.15% market basket update in 2011. This update reflects a 2.4% inflationary increase in the conversion factor minus the 0.25% reduction

[1] 74 *Fed. Reg.* 46169 (Aug. 3, 2010).

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mandated by the Affordable Care Act (ACA). The update is certainly appropriate given that a growing proportion of healthcare services are being provided cost-efficiently and in a patient-friendly manner in hospital outpatient departments.

NPAF is firmly committed to the proposition that patients can, and will take more responsibility for their own care if quality data is available to them when they select service providers. In our experience, quality transparency is particularly important to the patients with chronic, debilitating and life-threatening diseases who reach out to PAF for assistance with access to care issues. We support CMS' quality reporting initiatives for all sites of care and we endorse the planned movement from quality reporting to quality-based purchasing of healthcare services by Medicare. We see the incentive programs designed to encourage broader adoption by physicians and hospitals of electronic medical records over the next five years as crucial because of their potential for reducing costs, preventing errors, improving transparency and informing a wide range of value and quality initiatives that should greatly benefit patients.

Proposed Adjustment for Certain Cancer Hospitals

We recognize that the proposed market basket OPPS update must be adjusted downward by a fraction of a percent for all hospitals to maintain budget neutrality. We also understand the American Hospital Association (AHA) has some concerns about the primary budget neutrality adjustment to the conversion factor – an across-the-board reduction of approximately 0.7% applicable to all hospitals except the eleven cancer hospitals described in Social Security Act § 1886(d)(1)(B)(v). This adjustment reflects CMS' decision to provide the eleven prospective payment system-exempt cancer hospitals with hospital-specific payment increases ranging from 5.9% to 82.6% to raise their OPD payment-to-cost ratios (PCRs) to the weighed average PCR of all other hospitals paid under OPPS. Unlike AHA, NPAF heartily endorses this needed adjustment as well as CMS's commitment to periodically provide future updates to keep reimbursement for these critical cancer hospitals current with their costs. We note that the proposed adjustments based on a study required under ACA § 3138, appear to be based on sound data, and are consistent with the ACA mandate to effectuate study-based adjustments if the study revealed higher costs.

These eleven cancer hospitals are critical to many patients battling the toughest or most advanced cancers. They also conduct substantial amounts of clinical research that often underlies significant advances in cancer care. Their continued financial viability and accessibility to cancer patients is contingent upon adequate reimbursement. PAF patients are loudly applauding the proposed payment adjustments.

Proposed Payment for Non-Pass-Through Drugs

Another budget neutrality adjustment of significance, albeit about a tenth the size of the adjustment for the changes in reimbursement proposed for cancer hospitals, is an adjustment of 0.06% to deal with the fact that the claims-based methodology that CMS began using several years ago to set drug and pharmacy handling costs (combined) is projected to lead to payments for non-pass-through drugs at a level of Average Sales Price (ASP) + 6% in 2011 rather than the ASP + 4% rate applicable this year. We believe the proposed payment rate is more consistent with drug costs in the market and with the significant costs of pharmacy services that accompany the operation of a hospital outpatient chemotherapy clinic. Although paying more for drugs brings down payment for everything else in a budget neutral system, the proposed change should come as welcome news to community cancer centers. The Association of Community Cancer Centers (ACCC) recently published a survey focused on cancer care trends in the community setting over the last two years.[2] In that survey, 57% of respondents reported putting a freeze on hiring, 29% had reduced staff and 10% had reduced services. The reimbursement squeeze also is affecting patient access to the most up-to-date technology used to diagnose and treat cancer. The survey showed that 61% of practices have delayed equipment

[2] *Cancer Care Trends in Community Cancer Centers, 2009-2010,* published by ACCC, Executive Summary and Podcast available at http://accc-cancer.org/surveys/surveys-openaccess2010.asp.

purchases. The numbers of linear accelerators, ultrasound imaging machines, CT scanners, MRI machines and PET or PET/CT machines budgeted for purchase in the next fiscal year is down.

NPAF is pleased to see the higher proposed payment rate for separately paid cancer drugs that are not new pass-through products. Over the years we have expressed concern about the patient access implications of a decrease in payment for outpatient drugs and about the site-of-service differential in Medicare drug reimbursement rates between OPDs and physician offices. We have been particularly concerned about the inadequate reimbursement available for the pharmacy services that are needed to support the operation of outpatient chemotherapy clinics particularly since CMS concluded that hospitals incorporate charges for pharmacy services into their drug costs. A report prepared for the GAP Project when ASP-based reimbursement first began assessed the significance of pharmacy services costs to physician and OPD providers of community cancer care.[3] That study informs our concerns, which we believe are even more relevant today, because it clearly suggests that chemotherapy-associated pharmacy costs cannot be adequately met by a combined drug/pharmacy services payment of ASP + 6%.

<u>Proposed Provision of Zero-Cost Preventive Services</u>

NPAF appreciates CMS responding quickly to the ACA provisions on preventive services. We are pleased to see that the Proposed Rule will eliminate co-payments on most Medicare-covered preventive services with the co-pay waiver applying not only to the co-pay on physician's services but also on preventive services themselves such as colonoscopies in the OPPS and Ambulatory Surgery Center settings. This is extremely good news for patients because recent research suggests that lower or no cost payments should increase the use of appropriate preventive or screening services that are typically used to measure quality and that are believed to be positively associated with improved health outcomes.[4]

Thank you for the opportunity to submit formal comments to the CY 2011 Hospital Outpatient Prospective Payment System Proposed Rule. We strive to make dialogue with the agency about payment policies give voice to the concerns of Medicare beneficiaries dealing daily with the burdens of a chronic, debilitating or life-threatening disease. We would be happy to discuss our comments with you if you have any questions about our recommendations for improving Medicare beneficiaries' access to cancer care.

Respectfully submitted,

Nancy Davenport-Ennis
President and Chief Executive Officer

CC:
Steve Miller
Executive Vice President of Regulatory Affairs

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3 GAP Study, "Documentation of Pharmacy Cost in the Preparation of Chemotherapy Infusions in Academic and Community-Based Oncology Practices," D. Brixner, *et al.*, University of Utah Pharmacotherapy Outcomes Research Center. For complete study, visit www.npaf.org
4 "What Does the RAND Health Insurance Experiment Tell Us About the Impact of Patient Cost Sharing on Health Outcomes," M. Chernew and J. Newhouse, *American Journal of Managed Care*, p 412, July 2008, available at http://www.ajmc.com/issue/managed-care/2008/2008-07-vol14-n7/Jul08-3414p412-414.