To the Rules and Beyond: CMS, CMMI, and Administrative Power

BY BLAIR BURNETT

In September 2018, the Association of Community Cancer Centers (ACCC) submitted comments to the Centers for Medicare & Medicaid Services (CMS) in response to both the 2019 Physician Fee Schedule (PFS) and Hospital Outpatient Prospective Payment System (OPPS) proposed rules. The arrival of autumn signals seasonal changes, but one constant is the policy implications of the proposed Medicare payment rules for the upcoming calendar year.

Key Concerns in the Calendar Year 2019 PFS and OPPS Proposed Rules

Site-neutral payment structure and healthcare delivery remained a huge focus for CMS in the calendar year 2019 OPPS proposed rule as the agency sought to lessen the gap in payment differentials between nonexcepted and excepted hospital off-campus provider-based departments (PBDs). CMS is expected to finalize a proposal to reduce reimbursement to 40 percent of the OPPS rate for clinic visits, including hematology and oncology, as well as any excepted off-campus PBD that has engaged in service line expansion since November 2015. ACCC commented against both proposals in alignment with CMS's own Advisory Panel on Hospital Outpatient Payment, which finalized its recommendations in August. CMS continues to cite an "unnecessary increase" in the volume of outpatient clinic visits, but the 2019 OPPS Proposed Rule provides no data or analysis to support this claim, and the agency's proposals would drastically impact cancer delivery for patients across the country. Should the agency finalize these proposals, it is likely that providers will be forced to scale back services or close off-campus PBDs, requiring patients receiving treatment to seek care farther from their homes. For the intent of these proposals to be realized, hospitals must be given the flexibility to adapt use of PBDs to better meeting their patients' needs.

The 2019 OPPS proposed rule also included an additional Request for Information on the potential revitalization of Medicare's failed 2006-2008 Competitive Acquisition Program. ACCC commented strongly that CMS should ensure that any model based on Competitive Acquisition Program authority is voluntary for all participants, preserves patient access to treatment and provider flexibility, and promotes cost efficiency through more effective distribution and delivery of drugs and biologicals rather than utilization management tools.

The CMS Physician Fee Schedule 2019 proposed rule also signals significant changes on the horizon for cancer care delivery. Most notable, CMS proposed a consolidated reimbursement structure for levels 2-5 Evaluation and Management-coded visits. In comments to the agency, ACCC voiced strong concern over the impact of this policy proposal and stated that there is a continued need to work with other oncology patient and provider advocacy stakeholders before finalizing this consolidation. Due to the complexity of cancer treatment, oncology providers often use level 4 and 5 visits, and there is strong concern that condensing these evaluation and management codes will devalue the work of these providers. Accordingly, ACCC opposes this reimbursement structure.

Beyond PFS and OPPS: How Healthcare Leadership is Exercising Their Authority

Outside of the PFS and OPPS 2019 proposed rules, CMS and various members of the administration's healthcare leadership team have taken large actions to reform cancer care on regulatory authority alone. Most notable, CMS issued a policy memo stating that on Jan. 1, 2019, Medicare Advantage plans will be able to infuse step therapy as a utilization management tool for their beneficiaries accessing Medicare Part B drugs. ACCC has commented in opposition of this policy shift due to the access implication this regulation has for patients with cancer across the country; however, with regulatory authority and no comment period in sight, this change could potentially signal more movement to come. News of this memo was released on Aug. 7, 2018, and was followed by an Aug. 29 agency memo announcing changes to Medicare Part D plans and news of "indication-based pricing" in 2020. Even more important to remember: healthcare leadership under this administration has untapped regulatory authority for potential mandatory demonstrations to test other value-based arrangements through the CMS Center for Medicare and Medicaid Innovation. ACCC continues to work with CMS, the Center for Medicare and Medicaid Innovation, and other patient and provider stakeholder organizations to proactively address and understand how best to navigate the future cancer delivery landscape in 2019 and beyond. OI

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